

# SUMMARY PLAN DESCRIPTION

## PRIVACY NOTICE

The Trustees of the AGC Group Health Plan are committed to respecting and protecting your privacy. The information listed below is to advise you of the privacy policy of the AGC Group Health Plan, and to help you understand the types of non-public personal information that it collects about you, how that information is collected, and to whom that information is or may be disclosed.

### NON-PUBLIC PERSONAL INFORMATION

Non-public personal information is information that identifies an individual or could be used to identify an individual and includes both personal financial information, such as payment history, policy number and social security number; and personal health information, such as medical history, medical records, and claims.

### SOURCES OF INFORMATION

It is necessary for the AGC Group Health Plan and its administrator to collect personal information in order to accurately identify you, service your account, and administer its normal business operations. Some of the sources from which information is gathered are you, your application, transactions that you conduct with us or our administrator, and health care providers.

### Disclosure of Information

The AGC Plan or its administrator may disclose this information to non-affiliated third parties, as permitted by law, in order to administer its business functions. Some examples of these functions are claims administration, underwriting, reinsurance, rate development and utilization management. The types of non-affiliated third parties to which the Plan or its administrator may disclose information may include, but are not limited to, the AGC Group Health Plan's pharmacy benefit manager, utilization manager, preferred provider organizations, persons that provide actuarial services, a government agency or other organization pursuant to an audit of the records, claims investigators and medical consultants.

There will be no disclosure of your personal financial information to non-affiliated third parties (except as permitted by law), unless you first are offered an opportunity to "opt-out" of such disclosure, or unless you provide a written authorization, as may be required by applicable state law.

There will be no disclosure of your personal health information to non-affiliated third parties (except as permitted by law), unless you first provide a written authorization.

Non-public personal information regarding a spouse or dependent children will be disclosed to the covered employee (or the covered former employee) in the form of an explanation of benefits when a claim is processed.

### Security

The AGC Group Plan and its administrator maintain procedural and electronic safeguards to protect the confidentiality of the non-public personal information that it obtains. Access to personal information is restricted to only those employees and service providers who need this information to provide products and services to you. The AGC Group Plan and its administrator will continue to abide by this policy even when a customer relationship no longer exists.

### Revision of Privacy Notice

The Trustees of the AGC Group Plan reserve the right to revise the privacy procedures at any time. If a change is made, you will be provided with a revised Privacy Notice within 60 days of the effective date of the change.

## DEFINITIONS

The following are definitions of specific terms and words used in this document.

**Accident** or **Accidental Bodily Injury** or **Injury** means the sustaining of a physical Injury by an unexpected external means that is independent of disease or bodily infirmity and for which the Covered Person is not entitled to receive any Benefits under any Worker's Compensation or Occupational Disease Law. It does not include care or treatment of injuries resulting from normal body movements, such as chewing; or care or treatment of injuries not demonstrable by visual observation, palpation, or X-ray. With respect to dental coverage, Accident or Injury means accidental dental damage inflicted by a foreign object or force. Physical damage resulting from chewing is not considered an Accident or an Injury.

**Active Employee, Actively at Work** and **Active Work** means being in attendance in person at the usual customary place or places of business acting in the performance of the duties of the Employee's occupation for a Contributing Employer on a full time basis of at least 30 hours per week, devoting full efforts and energies thereto, except that an Employee shall be deemed Actively at Work on each day of a regular paid vacation, or on any day in which he/she is absent from work due to a health factor, provided he/she was Actively at Work on the last preceding regular work day. In the case of a new enrollee, eligibility will not be denied if the Employee is absent from work due to a health factor, however, work must begin before coverage will become effective.

**Alternate Recipient** means any child of a Participant who is recognized under a Medical Child Support Order as having a right to Benefits under the Plan.

**Ambulatory Surgical Center** means any public or private establishment with an organized medical staff of Physicians, licensed and accredited by the Joint Commission on Accreditation of Hospitals ("JCAH"), and/or certified by Medicare with permanent facilities equipped and operated primarily for the purpose of performing ambulatory surgical procedures and with continuous Physician services whenever a Covered Person is in the facility, but does not provide services or other accommodations for Covered Persons to stay overnight.

**Birthing Center** means any freestanding health facility, place, professional office or institution which is not a Hospital or in a Hospital, where births occur in a home-like atmosphere. This facility must be licensed and operated in accordance with the laws pertaining to Birthing Centers in the jurisdiction where the facility is located.

The Birthing Center must provide facilities for obstetrical delivery and short-term recovery after delivery (no more than 24 hours); provide care under the full-time supervision of a Physician and either a registered nurse (R.N.) or a licensed nurse-midwife; and have a written agreement with a Hospital in the same locality for immediate acceptance of patients who develop complications or require pre- or post-delivery confinement.

**Brand Drugs** are Prescription Drugs that have been reviewed by the Food and Drug Administration ("FDA") as full new drug applications (NDA), are nationally recognized innovators, and may be, or once were, protected by patents.

**Calendar Year** means the 12-month period beginning January 1 and ending December 31.

**Child(ren)** means, for the purposes of this Plan, a Child(ren) by birth, legal adoption as of the date of placement for adoption, legal (court appointed) guardianship, or other Child(ren), who is a Dependent of the Employee as that term is defined in this Plan.

**COBRA** means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

**Cosmetic Surgery** means any surgical procedure performed to improve appearance or to correct a deformity without restoring a physical bodily function. Psychological factors, such as poor body image and difficult peer relations do not constitute a bodily function, nor do they establish Medical Necessity.

**Covered Expenses** means those expenses incurred by a Covered Person for Injury or Illness for which the Plan provides Benefits.

**Covered Person** is an Employee, Retiree or Dependent who is Covered under this Plan.

**Creditable Coverage** means Plan participants will be given "credit" toward the satisfaction of any Preexisting Condition Limitation period for the length of coverage under any of the following plans: (a) group health insurance; (b) Individual health insurance; (c) Medicare and Medicaid; and (d) Government programs such as, public health plans, state high risk pools, or military plans. The exclusion for Preexisting Conditions will be reduced by the number of months that the Employee has remained covered under any of these plans. A period of Creditable Coverage shall not be counted, with respect to enrollment of an individual under a group health plan, if, after such period and before the Enrollment Date, there was a period of sixty-three (63) days or more during all of which the individual was not covered under any Creditable Coverage (Significant Break In coverage). This sixty-three (63) day period shall not include any period that an individual is in a Waiting Period for any coverage under a group health plan (or for group health insurance coverage) or is in an affiliation period.

**Custodial Care** is care (including room and board needed to provide that care) that is given principally for personal hygiene or for assistance in daily activities and can, according to generally accepted medical standards, be performed by persons who have no medical training. It typically includes services which are for convenience, contentment or other non-therapeutic purposes. It typically maintains a physical condition when there is no prospect of affecting remission or restoration of the patient to a condition in which care would not be required. Examples of Custodial Care are help in walking and getting out of bed; assistance in bathing, dressing, feeding; or supervision over medication which could normally be self-administered.

**Date Incurred** means the date services were provided.

**Dentist** is a person who is properly trained and licensed to practice dentistry and who is practicing within the scope of his license.

**Dependent** is any one of the following persons:

Your Spouse and unmarried children from birth to 19 years of age. However, a Dependent child will continue to be covered after age 19 and through age 23, provided the child is a full-time student at an accredited school, primarily dependent upon you for support and maintenance and is unmarried. When the child ceases to be a full-time student, coverage will end on the child's birthday.

The phrase "**primarily dependent upon**" means dependent upon you for support and maintenance as defined by the Internal Revenue Code and you must declare the child as an income tax deduction. The Plan Administrator may require documentation proving dependency, including birth certificates, tax records or initiation of legal proceedings severing parental rights.

The term "children" includes natural children, adopted children or children placed with you in anticipation of adoption, or by court appointed guardianship. Stepchildren who reside in your household may also be included.

The term child also includes a child who is an alternate recipient under a Qualified Medical Child Support Order.

The phrase "**child placed with you in anticipation of adoption**" refers to a child you intend to adopt, whether or not the adoption has become final, who has not attained the age of eighteen (18) as of the date of such placement for adoption. The term "placed" means your assumption and retention of a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child must be available for adoption and the legal process must have been commenced.

A covered Dependent child also includes one who is incapable of self-sustaining employment by reason of mental retardation or physical handicap, primarily dependent upon you for support and maintenance, unmarried and covered under the Plan when reaching the limiting age. The Plan Administrator may require, at reasonable intervals during the two years following the Dependent's reaching the limiting age, subsequent proof of the child's disability and dependency.

After such two-year period, the Plan Administrator may require subsequent proof not more than once each

year. The Plan Administrator reserves the right to have such Dependent examined by a Physician of the Plan Administrator's choice, at the Plan's expense, to determine the existence of such incapacity.

Upon Plan Administrator receiving and approving a copy of an appropriate "Qualified Medical Child Support Order", the Plan will enroll under your coverage (if available from your Employer) those children for whom either You or Your lawful spouse has a court order obligation to provide health care coverage as dependents.

When You or Your lawful spouse are required by a court or administrative order to provide health coverage for a dependent child, and You or Your lawful spouse are eligible for family health coverage, the Plan shall permit You to enroll, under the family coverage, a child who is otherwise eligible for the coverage without regard to enrollment season restrictions.

**These persons are excluded as Dependents:**

- your legally separated or divorced former Spouse;
- any person who is on active duty in any military service of any country; or
- any person who is eligible for coverage under the Plan as an Employee.

If a person covered under this Plan changes status from Employee to Dependent or Dependent to Employee, and the person is covered continuously under this Plan before, during and after the change in status, credit will be given for all amounts applied to maximums.

If both you and your Spouse are Employees, your children will be covered as Dependents of one or the other, but not of both.

**Durable Medical Equipment** means equipment which meets all the following:

- can withstand repeated use;
- is primarily and customarily used to serve a medical purpose;
- generally is not useful to a person in the absence of an Illness or Injury; and
- is appropriate for use in the home.

**Employee** is a person who actually performs work for a contributing Employer on a sustained basis of at least 30 hours per week, and is regularly scheduled to work for the Employer in an Employee/Employer relationship. Compensation alone shall not be a determination of employment.

**ERISA** is the Employee Retirement Income Security Act of 1974, as amended.

**Experimental and/or Investigational** means services, supplies, care and treatment which do not constitute accepted medical practice properly within the range of appropriate medical practice under the standards of the case and by the standards of a reasonably substantial, qualified, responsible, relevant segment of the medical community or government oversight agencies at the time services were rendered.

The Plan Administrator makes an independent evaluation of the experimental/non-experimental standings of specific technologies, guided by a reasonable interpretation of Plan provisions. The decisions shall be made in good faith and rendered following a detailed factual background investigation of the claim and the proposed treatment. The Plan Administrator will be guided by the following principles:

- if the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or
- if the drug, device, medical treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval; or
- if Reliable Evidence shows that the drug, device, medical treatment or procedure is the subject of on-going phase I or phase II clinical trials; is the research, experimental, study or investigational arm of on-going phase III clinical trials; or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, or its efficacy as compared with a standard means of treatment or diagnosis; or

- if Reliable Evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, or its efficacy as compared with a standard means of treatment or diagnosis.

Reliable Evidence means only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure.

**Home Health Care Agency** is an agency that meets all of these tests: its main function is to provide Home Health Care Services and Supplies; it is federally certified as a Home Health Care Agency; and is licensed by the state in which it is located, if licensing is required.

**Home Health Care Plan** must meet these tests: it must be a formal written plan made by the patient's attending Physician which is reviewed at least every 30 days; it must state the diagnosis; it must certify that the home health care is in place of Hospital confinement; and it must specify the type and extent of home health care required for the treatment of the patient.

**Home Health Care Services and Supplies** include: part-time or intermittent nursing care by or under the supervision of a registered nurse (R.N.); part-time or intermittent home health aide services provided through a Home Health Care Agency (this does not include general housekeeping services); physical, occupational and speech therapy; medical supplies; and laboratory services by or on behalf of the Hospital.

**Hospice Agency** is an agency where its main function is to provide Hospice Care Services and Supplies and it is licensed by the state in which it is located, if licensing is required.

**Hospice Care Plan** is a plan of terminal patient care that is established and conducted by a Hospice Agency and supervised by a Physician.

**Hospice Care Services and Supplies** are those provided through a Hospice Agency and under a Hospice Care Plan and include inpatient care in a Hospice Unit or other licensed facility, home care, and family counseling during the bereavement period.

**Hospice Unit** is a facility or separate Hospital Unit, which provides treatment under a Hospice Care Plan and admits at least two unrelated persons who are expected to die within six months.

**Hospital** is an institution which is engaged primarily in providing medical care and treatment of sick and injured persons on an inpatient basis at the patient's expense and which fully meets these tests: it is accredited as a Hospital by the Joint Commission on Accreditation of Healthcare Organizations; it is approved by Medicare as a Hospital; it maintains diagnostic and therapeutic facilities on the premises for surgical and medical diagnosis and treatment of sick and injured persons by or under the supervision of a staff of Physicians; it continuously provides on the premises 24-hour-a-day nursing services by or under the supervision of registered nurses (R.N.s); and it is operated continuously with organized facilities for operative surgery on the premises.

Hospital includes the following:

- A facility operating legally as a psychiatric Hospital or residential treatment facility for mental health and licensed as such by the state in which the facility operates.
- A facility operating primarily for the treatment of Substance Abuse if it meets these tests: maintains permanent and full-time facilities for bed care and full-time confinement of at least 15 resident patients; has a Physician in regular attendance; continuously provides 24-hour a day nursing service by a registered nurse (R.N.); has a full-time psychiatrist or psychologist on the staff; and is primarily engaged in providing diagnostic and therapeutic services and facilities for treatment of Substance Abuse.

**Illness (Sickness)** with respect to medical coverage is:

- For all persons but a covered Dependent daughter: Illness, disease or Pregnancy.
- For a covered Dependent daughter: Illness or disease, not including Pregnancy or its complications.

**Illness (Sickness)** with respect to dental coverage is: a dental disorder resulting from disease, sickness, or malfunction of the teeth, (other than from chewing), or a congenital malformation which causes functional impairment, not entitling the person to receive any benefits under any Worker's Compensation or Occupational Disease Law.

**Injury or Accident or Accidental Bodily Injury** means the sustaining of a physical Injury by an unexpected external means that is independent of disease or bodily infirmity and for which the Covered Person is not entitled to receive any Benefits under any Worker's Compensation or Occupational Disease Law. It does not include care or treatment of injuries resulting from normal body movements, such as chewing; or care or treatment of injuries not demonstrable by visual observation, palpation, or X-ray. With respect to dental coverage, Injury means accidental dental damage inflicted by a foreign object or force. Physical damage resulting from chewing is not considered an Accident or an Injury.

**Intensive Care Unit** is a separate, clearly designated service area that is maintained within a Hospital solely for the care and treatment of patients who are critically ill. This also includes what is referred to as a "coronary care unit" or an "acute care unit." It has: facilities for special nursing care not available in regular rooms and wards of the Hospital; special life saving equipment which is immediately available at all times; at least two beds for the accommodation of the critically ill; and at least one registered nurse (R.N.) in continuous and constant attendance 24 hours a day.

**Lifetime** means while covered under this Plan. Under no circumstances does Lifetime mean during the lifetime of the Covered Person. Should a Covered Person terminate Coverage under the Plan, and subsequently become Covered again, all amounts previously applicable to a Lifetime for that Covered Person are applied to the Lifetime amounts under the subsequent Coverage.

**Manipulation Therapy** means skeletal adjustments, manipulation or other treatment in connection with the detection and correction by manual or mechanical means of structural imbalance or subluxation in the human body. Such treatment is done by a Physician to remove nerve interference resulting from, or related to, distortion, misalignment or subluxation of, or in, the vertebral column.

**Medical Care Facility** means a Hospital, a facility that treats one or more specific ailments or any type of Skilled Nursing Facility.

**Medical Child Support Order** means any judgment, decree, or Order (including approval of a settlement agreement) issued by a court of competent jurisdiction which:

- Provides for child support with respect to a child or a Participant under the Plan or provides for health benefit coverage to such a child;
- Is made pursuant to a state domestic relations law (including a community property law); and,
- Relates to benefits under such Plan; or,
- Enforces a law relating to medical child support described in Section 1908 of the Social Security Act (as added by Section 13822 of the Omnibus Budget Reconciliation Act of 1993) with respect to the Plan.

**Medical Emergency** means a sudden onset of a condition with acute symptoms requiring immediate medical care and includes such conditions as heart attacks, cardiovascular accidents, poisonings, loss of consciousness or respiration, convulsions or other such acute medical conditions.

**Medically Necessary** care or treatment is care and treatment which is:

- recommended or approved by a Physician;
- consistent with the patient's condition or accepted standards of good medical practice;
- medically proven to be effective treatment of the condition;
- not performed mainly for the convenience of the patient or provider;
- not conducted for research purposes; and
- the most appropriate level of services which can be safely provided to the patient.

All of these criteria must be met. Merely because a Physician recommends or approves certain care does

not mean that it is Medically Necessary.

**Medicare** is the Health Insurance for the Aged and Disabled program under Title XVIII of the Social Security Act, as amended.

**Mental Disorder** means any disease or condition that is classified as a Mental Disorder in the current edition of *International Classification of Diseases*, published by the U.S. Department of Health and Human Services or is listed in the current edition of *Diagnostic and Statistical Manual of Mental Disorders*, published by the American Psychiatric Association.

**Morbid Obesity** is a diagnosed condition in which the body weight exceeds the medically recommended weight by either 100 pounds or is twice the medically recommended weight in standard tables for a person of the same height, age and mobility as the Covered Person.

**Network Provider** or **In-Network Provider** is a Provider who has agreed to provide services and supplies for negotiated fees to Plan participants.

**No-Fault Auto Insurance** is the basic reparations provision of a law providing for payments without determining fault in connection with automobile accidents.

**Non-Network Provider** or **Out-of-Network Provider** is a Provider who is not a Network Provider.

**Out-of-Area** for Hospital expenses means that there are no Network hospitals within 25 miles of your primary residence and Out-of-Area for Provider expenses means that there are no Network providers within 25 miles of your primary residence.

**Outpatient Care** is treatment including services, supplies and medicines provided and used at a Hospital under the direction of a Physician to a person not admitted as a registered bed patient; or services rendered in a Physician's office, laboratory or X-ray facility, an Ambulatory Surgical Center, or the patient's home.

**Participant** means any Employee or former Employee of an Employer in relation to the Plan, or any member or former member of an Employee organization dealing with Employers concerning the Plan or organized for the purpose of establishing the Plan, who is eligible to receive a benefit of any type from the Plan.

**Physician** means a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Dental Surgery (D.D.S.), Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C.), Audiologist, Certified Nurse Anesthetist, Licensed Professional Counselor, Licensed Professional Physical Therapist, Midwife, Occupational Therapist, Optometrist (O.D.), Physiotherapist, Psychiatrist, Psychologist (Ph.D.), Speech Language Pathologist and any other practitioner of the healing arts who is licensed and regulated by a state or federal agency and is acting within the scope of his or her license.

**Plan Year** is the Calendar Year.

**Preadmission Tests** are diagnostic lab tests and X-ray exams that are:

- performed on an outpatient basis within seven days before a Hospital confinement;
- related to the condition which causes the confinement; and
- performed in place of tests while Hospital confined.

**Pre-Existing Condition** is a condition (regardless of the cause of the condition) for which medical advice, diagnosis, care or treatment was recommended or received within the six months prior to the enrollment date. Treatment includes receiving medical care, services and supplies, including consultations, diagnostic tests or Prescription or over-the-counter medication prescribed or recommended by a Physician. Pregnancy is not considered a Pre-Existing Condition.

**Pregnancy** is childbirth and conditions associated with Pregnancy, including complications.

**Prescription Drug** means any of the following: a drug or medicine which, under federal law, is required to bear the legend: "Caution federal law prohibits dispensing without prescription"; injectable insulin; hypodermic

needles or syringes, but only when dispensed upon a written prescription of a licensed Physician. Such drug must be Medically Necessary in the treatment of a Sickness or Injury.

**Provider** means a Physician or other medical professional performing services within the scope of the provider's licensure.

**Qualified Beneficiary** is an individual who is covered under the Plan either as the Spouse or the Dependent child of a covered Employee on the day before the Employee's Qualifying Event. A child born, adopted, or placed for adoption with an Employee while the Employee is on COBRA continuation is also a qualified beneficiary.

**Qualified Medical Child Support Order ("QMCSO")** means a Medical Child Support Order which creates or recognizes the existence of an Alternate Recipient's right to, or assigns to an Alternate Recipient the right to, receive benefits under the Plan and which meets the requirements set forth in the Section entitled "Procedural Rules For Determining Qualified Medical Child Support Orders."

**Qualifying Event** is any of the following events that result in an Employee or Qualified Beneficiary's loss of coverage:

- Death
- Termination of coverage due to loss of employment (other than for gross misconduct) or reduction of hours
- Medicare Entitlement
- Loss of Dependent Status
- Employer Bankruptcy
- Disability Extension
- Divorce or legal Separation

**Retired Employee and Retiree** mean a person who:

- has left employment at or after age 62 and
- has completed a minimum of five years of employment with a contributing Employer and
- is covered under this Plan at the time of retirement and
- during the period the Retired Employee is covered as a Retiree under this Plan the Employer continues to be a contributing Employer to this Plan.

**Sickness or Illness** is:

- For all persons but a covered Dependent daughter: Illness, disease or Pregnancy.
- For a covered Dependent daughter: Illness or disease, not including Pregnancy or its complications.

**Significant Break In Coverage** means a period of 63 or more consecutive days falling immediately prior to the Employee's eligibility for coverage in this Plan, during which time the person does not have any Creditable Coverage. If any of the 63 or more days was part of a waiting period to be eligible for benefits, then the waiting period will not count against the 63 days.

**Skilled Nursing Facility** is a facility that fully meets all of these tests:

- It is licensed to provide professional nursing services on an inpatient basis to persons convalescing from Injury or Sickness. The service must be rendered by a registered nurse (R.N.) or by a licensed practical nurse (L.P.N.) under the direction of a registered nurse. Services to help restore patients to self-care in essential daily living activities must be provided.
- Its services are provided for compensation and under the full-time supervision of a Physician.
- It provides 24 hour per day nursing services by licensed nurses, under the direction of a full-time registered nurse.
- It maintains a complete medical record on each patient.
- It has an effective utilization review plan.
- It is not, other than incidentally, a place for rest, Custodial or educational care, the aged, or a place for care or treatment of Substance Abuse, mental retardation, or Mental Disorders.
- It is approved and licensed by Medicare.

This term also applies to charges incurred in a facility referring to itself as an extended care facility,

convalescent nursing home or any other similar nomenclature.

**Spouse** means your legally recognized marital partner.

**Substance Abuse** is the condition caused by regular excessive compulsive drinking of alcohol and/or physical habitual dependence on drugs that results in a chronic disorder affecting physical health and/or personal or social functioning. This does not include dependence on tobacco and ordinary caffeine-containing drinks.

**Temporomandibular Joint (TMJ)** syndrome is the treatment of jaw joint disorders including conditions of structures linking the jaw bone and skull and the complex of muscles, nerves and other tissues related to the temporomandibular joint. Care and treatment may include, but are not limited to orthodontics, crowns, inlays, physical therapy and any appliance that is attached to or rests on the teeth.

**Usual and Reasonable Charge** is the charge for Medically Necessary services or supplies and will be determined by the Plan Administrator or its designee to be the lowest of:

- The usual charge by the health care provider for the same or similar service or supply;
- 80% of the Prevailing Charge of most other health care providers in the same or similar geographic area for the same or similar health care service or supply;
- With respect to a PPO Provider, the charge set forth in the agreement between the PPO Provider and the PPO or the Plan; **or**
- The health care provider's actual charge.

The "Prevailing Charge" of most other health care providers in the same or similar geographic area for the same or similar health care service or supply shall be determined by the Plan Administrator who shall use proprietary data that is updated no less frequently than annually, and provided by a reputable company or entity.

## **ELIGIBILITY**

### **HOW AND WHEN COVERAGE BEGINS, CONTINUES AND ENDS**

#### **YOUR COVERAGE**

##### ***FOR ACTIVE EMPLOYEES***

If you are an Active full-time Employee of a covered Employer in a Covered category, you are eligible for Coverage the first of the month following completion of your Eligibility Period - a stated period of time determined by your Employer.

##### ***FOR RETIREES***

Retired Employees are eligible for medical coverage only, and not eligible for Dental and Vision Benefits, Life Insurance, or the Accident and Sickness Benefit. A Retired Employee must pay his/her own premium (and that for any additional covered family member) for coverage, but receives the same coverage for medical benefits as the Employer from whom the Retired Employee retired provides for Active Employees until the Retired Employee (or Covered family member) is eligible for Medicare. Once the Retired Employee or other covered family member is eligible for Medicare, the coverage for that person becomes integrated with Medicare and may contain additional limitations. Medicare pays its benefits first, and the benefits under this Plan pay secondary to Medicare (see page 47 for special circumstances). The benefit from this Plan in combination with the benefit from Medicare will not exceed what would have been covered by the Plan without Medicare.

A covered Spouse of a deceased Retired Employee who was covered at the time of the Retired Employee's death may continue coverage on a self-pay basis so long as the Employer of that deceased Retired Employee continues to be a contributing Employer to the AGC Group Health Plan, and for the same medical benefits provided to Active Employees, as modified by eligibility for Medicare with additional limitations, if applicable.

#### **WHO PAYS FOR THE COVERAGE**

The amount you must pay for your coverage is determined by your Employer; unless you are covered through COBRA, a Retired Employee or family member of a Retired Employee or Spouse of a deceased Retired Employee, in which case you must pay the premium for the Coverage.

#### **HOW TO ENROLL**

In order to enroll, you must be eligible for Coverage and you must fill out and sign an enrollment application.

An enrollment is either "Timely" or "Late":

***TIMELY ENROLLMENT*** - Your enrollment will be "timely" if the completed form is received by the Plan Administrator no later than 31 days after your date of hire.

If two Employees (husband and wife) are separately covered under the Plan where one Employee covers Dependent Children and that Employee terminates coverage, the coverage for those Dependent Children may be continued by the other Covered Employee, consistent with the provisions of Portability of Satisfaction of Pre-existing Condition Waiting Periods.

***LATE ENROLLMENT*** - An enrollment is "late" if it is not made on a "timely basis", and is subject to the Preexisting Condition Limitation of up to 18 months if there is no Creditable Coverage.

#### **WHEN YOUR COVERAGE ENDS**

Your coverage and the coverage of your Covered Dependents ends on the earliest of these dates:

- The last day of the month in which you are no longer an Employee, except as you continue Coverage as a Retired Employee or terminated Employee eligible for and covered under COBRA.

- The date your Employer (or former Employer if you are a Retired Employee) stops being a covered Employer.
- The date you stop making any contributions required for your Coverage.
- The day the Plan is terminated.
- The day your COBRA eligibility terminates.

### **REINSTATEMENT OF COVERAGE**

If your coverage ends because you are no longer employed and you are later rehired, you must satisfy the waiting period previously selected by your Employer. However, if you are returning to work and have been continuously covered under the Plan's COBRA continuation option or Retired Employee Coverage, you do not need to satisfy the waiting period.

### **CONTINUATION DURING PERIODS OF DISABILITY, LEAVE OF ABSENCE OR LAYOFF**

You may remain eligible for Medical and Dental coverage for up to 12 months if you are away from work due to Disability, leave of absence or layoff. However, you will need to pay the entire monthly premium for Coverage during a leave of absence or layoff. Notwithstanding, the Trustees reserve the authority to determine all questions of eligibility. See page 14 for continuation of Life Insurance.

### **CONTINUATION DURING FAMILY AND MEDICAL LEAVE (FMLA)**

This Plan will at all times comply with the Family and Medical Leave Act of 1993 as promulgated in regulations issued by the Department of Labor.

This Plan will comply with the Family and Medical Leave Act of 1993 as follows:

- Your Employer has the responsibility to determine whether the Employer is covered by, or are exempted from, the FMLA.
- Your Employer must notify you and the AGC Group Health Benefit Fund whether your request for a leave of absence is covered by the FMLA. The AGC Group Health Benefit Fund reserves the right to verify that your Employer's determination is correct.
- Having made the determination that you are eligible for FMLA leave, your Employer will continue to pay the Employer's share, if any, of the premium, and you will pay your share, if any, throughout the duration of the leave. Nonpayment of premium by either you or your Employer will result in termination of your eligibility. Upon your return to work, however, you may reestablish eligibility without regard to health status, Pre-Existing Conditions, or waiting periods.

### **EFFECT OF MILITARY SERVICE**

If you are called into active service for up to 31 days, your Coverage during that leave period will be continued. If your Coverage is contributory, you must pay your portion of the cost. If you are called into active service for more than 31 days, you can continue your Coverage for up to 18 months under COBRA. See COBRA continuation option on page 12 for more information.

Upon your return, you will be reinstated immediately with no Pre-Existing Conditions exclusions applied. However, Exclusions and waiting periods may be imposed for any Sickness or Injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, military service.

Your Covered Dependents continue to be Covered under this Plan during the period you are called into active service. If their Coverage is contributory, they must pay their portion of the cost.

### **YOUR DEPENDENTS' COVERAGE**

If you are eligible for Coverage, your eligible Dependents may also receive coverage under the Plan,

including a Dependent as stipulated by a Qualified Medical Child Support Order.

Your Dependents' Coverage will take effect on:

- the date your Coverage under the Plan starts and you have completed the enrollment forms if Dependent Coverage is not contributory; or
- the date you enroll your Dependents and pay the necessary portion of the cost, if the Dependent Coverage is contributory.

### **Coverage for a Dependent under a Qualified Medical Child Support Order (QMCSO)**

A Medical Child Support Order shall meet the requirements of this Plan to be "Qualified" only if such Order clearly specifies:

- The name and last known mailing address, if any, of the Participant and the name and mailing address of each Alternate Recipient covered by the Order;
- A reasonable description of the type of coverage to be provided by the Plan to each such Alternate Recipient, or the manner in which such type of coverage is to be determined;
- The period to which such Order applies; and,
- The Plan to which such Order applies.

An Alternate Recipient under a QMCSO shall be eligible for benefits from the Plan only if the Employee, Retired or disabled individual, widow or widower is eligible. In the event that the Employee, Retired or disabled individual, widow or widower loses eligibility and later regains eligibility, the eligibility of an Alternate Recipient under an un-expired QMCSO will automatically be reinstated.

A Medical Child Support Order meets these requirements only if such Order does not require the Plan to provide any type or form of benefits, or an option, not otherwise provided under the Plan, except to the extent necessary to meet the requirements of a law relating to medical child support described in Section 1908 of the Social Security Act (as added by Section 13822 of the Omnibus Budget Reconciliation Act of 1993).

### **Notice Upon Receipt of an Order**

Upon the Plan's receipt of a Medical Child Support Order with respect to a Participant, the Plan Administrator or designee shall promptly acknowledge receipt of the Order and give notice of these Procedures to the Participant and to each person specified in the Order as entitled to payment of any Plan benefits under the Order, at the addresses the Order specifies. An Alternate Recipient may designate a representative for receipt of copies of notices that are sent to the Alternate Recipient.

### **Determination**

The Plan Administrator or designee shall promptly determine whether a Medical Child Support Order is a QMCSO.

### **Notification of "Qualified" Status**

When the Plan Administrator or designee determines that the Order satisfies the requirements to be a QMCSO, the Plan Administrator or designee shall notify, in writing, each person named in the Order and each representative designated in writing by each person ("Interested Party") that a tentative determination has been made that the Order is a QMCSO.

### **Notification of Denial of Qualified Status**

If it appears that the Order is not a QMCSO, the Plan Administrator or designee shall notify, in writing, each Interested Party that a tentative determination has been made that the Order is not a QMCSO. Such notice shall state the reasons for the determination. Alternatively, the Plan Administrator or designee may directly contact the legal counsel involved for the purpose of amending the Order appropriately.

### **Procedures Upon Final Determination**

Within a reasonable period of time after receipt of the Order, the Plan Administrator or designee shall make a final determination that the Order (as modified, if applicable) is a QMCSO, and shall notify the individuals designated in the Order (or their designated agents) of the decision. Thereafter, the Plan Administrator or designee shall follow the terms of the QMCSO. The Plan Administrator or designee shall authorize payment of Benefits subject to the QMCSO. Any payment for Benefits made by the Plan pursuant to a QMCSO in reimbursement for expenses paid by an Alternate Recipient, or an Alternate

Recipient's custodial parent or legal guardian, shall be made to the Alternate Recipient or the Alternate Recipient's custodial parent or legal guardian.

If the Plan Administrator or designee determines that the Medical Child Support Order is not a QMCSO, as soon as practicable following the determination that a Medical Child Support Order is not a QMCSO (hereinafter, "Initial Determination"), the Plan Administrator or designee shall notify, in writing, the Participant and the Alternate Recipient named in such Order. Such notice shall inform each such person:

- Of such determination,
- The date thereof and, to the extent reasonably possible, explain the reasons therefore and describe the possible modifications the issuing court or other court of competent jurisdiction must thereafter make to such Order so as to make such Order, as so modified, a QMCSO;
- Of his or her opportunity to receive further assistance as described below; and,
- That the Plan Administrator or designee will review the modified QMCSO.

#### **Further Assistance**

If, subsequent to the adverse Initial Determination, the Participant, the Alternate Recipient or any person then entitled to receive notices desires further assistance in modifying or further modifying such Order so as to correct its defects, the Plan Administrator or designee will, to the extent reasonably possible and not in violation of such applicable laws, respond to any such written request for assistance. Such response, if any, by the Plan Administrator or designee, shall be in writing and a copy of such response together with a copy of such request, shall be sent to the Participant and the Alternate Recipient.

### **Review of Modified Order**

Within a reasonable period of time after it is received, by the Plan Administrator or designee, the Plan Administrator or designee shall determine whether such Order, as modified subsequent to the Initial Determination, meets all the requirements for classification as a QMCSO. Assuming such Order, as modified, is determined by the Plan Administrator or designee to be a QMCSO. If the modified Order is a QMCSO then:

- As soon as practicable following such determination, the Plan Administrator or designee shall notify, in writing, the Participant and the Alternate Recipient of such determination and the date thereof;
- The terms of the QMCSO shall be observed by the Plan and Plan fiduciaries; and
- The Plan Administrator or designee shall take whatever action necessary with respect to record keeping and administration to ensure compliance with the terms of the QMCSO.

If the modified Order is once again determined to be not qualified, the Plan Administrator or designee shall notify the Participant, Alternate

Recipient and other such person entitled to receive such notices of the determination and of the following information:

- The reason(s) for rejection and possible suggested further modifications to such Order so that, as modified, the Medical Child Support Order may be "Qualified";
- The opportunity to receive further assistance as described above; and,
- The Plan Administrator or designee will again review the Order and make another determination as to its qualified status.

### **ENROLLMENT FOR NEWBORN CHILDREN**

A newborn child is covered under the parent's coverage for routine nursery care and associated professional services provided within the first 31 days after the child's birth. For coverage of any other care or for Sickness or Injury, including Medically Necessary care and treatment of congenital defects, birth abnormalities or complications resulting from prematurity, **the newborn child must be enrolled as a Dependent under this Plan within 31 days of the child's birth.** If enrollment takes place within that 31 day time period, the effective date of the child's coverage will be the date of birth. If the child is not enrolled within 31 days of birth, the enrollment will be considered a Late Enrollment, and the child's coverage will be effective no earlier than the date enrolled.

### **WHEN DEPENDENT COVERAGE ENDS**

A Dependent's coverage ends on the earliest of:

- The date that your coverage under the Plan ends.
- The date the Dependent no longer meets the Plan's definition of a Dependent.
- The date you stop making any contributions required for Dependent coverage.
- The date the Plan ceases to provide Dependent coverage.

### **COBRA CONTINUATION OPTIONS**

The Consolidated Omnibus Budget Reconciliation Act (COBRA) allows you to extend medical and/or dental coverage for yourself and your Dependents when certain circumstances, or Qualifying Events, would normally cause coverage to end. However, you will need to pay the entire monthly premium.

COBRA does not apply to the Life Insurance Benefit or the Accident and Sickness Benefit.

### **MAXIMUM TIME PERIODS**

These Qualifying Events and the duration of coverage are shown in the chart below. Under no circumstances will coverage continue for more than 36 months beyond the date of the original Qualifying Event.

IF YOU HAVE THIS QUALIFYING EVENT	COVERAGE MAY CONTINUE FOR	FOR A MAXIMUM DURATION
Your hours are reduced so that you no longer meet eligibility requirements or you are terminated from employment (for reasons other than gross misconduct)	You and your Covered Dependents	18 months (29 months for any Covered person who is disabled at the time of the Qualifying Event or within 60 days of that event)*
You become Permanently and Totally Disabled	You and your Covered Dependents	18 or 29* months
You die	Your Covered Dependents	36 months
You become entitled to Medicare	Your Covered Dependents	36 months
You are divorced or legally separated from your Spouse	Your Covered Spouse	36 months
Children no longer qualify as eligible Dependents	Your Covered Dependent children	36 months

*\* You must qualify as being disabled for Social Security purposes and you must notify the Plan Administrator within 60 days of the Social Security Administration's determination of disability.*

**NOTICE REQUIREMENTS**

When coverage ends due to your death, termination or eligibility for Medicare, your Employer has 30 days in which to notify the Plan Administrator of the Qualifying Event.

When coverage terminates due to divorce or change of Dependent status, the qualified beneficiary has 60 days from the Qualifying Event in which to notify the Plan Administrator that the Qualifying Event has occurred.

Complete instructions on how to elect continuation will be provided by the Plan Administrator within 14 days of receiving notice of the Qualifying Event. Covered Persons then have 60 days in which to elect continuation. The 60 day period is measured from the later of the date coverage terminates or the date the person receives notice of the right to continue. If continuation is not elected in that 60-day period, then the right to elect continuation ceases.

If you choose to continue coverage, you or your Dependents will be required to pay the COBRA rates set by the Plan Administrator. These rates may change from time to time.

**WHEN COBRA COVERAGE ENDS**

COBRA continuation coverage will end on the earliest of the following:

- At the end of the maximum duration corresponding to your Qualifying Event.
- When you do not pay your premiums on time.
- When you or a Dependent become covered under any other Group Health Care Plan (This would not apply if you or your Dependent were excluded from the other plan because of a Pre-existing Condition).
- When you or a Dependent becomes entitled to (i.e., enrolled in) Medicare.
- When this Plan ends.

**CERTIFICATION OF COVERAGE WHEN COVERAGE ENDS**

When your coverage ends, you will be provided with certification of your length of coverage under the Plan.

## **EMPLOYER WITHDRAWS FROM THE PLAN**

In the event that a contributing Employer in the AGC Group Health Benefit Trust Fund withdraws or terminates its membership in a sponsoring Association, all Participants and beneficiaries of that Employer shall cease to be eligible for benefits at the end of the month in which the termination is effective. It is specifically understood that when an Employer withdraws from or terminates its membership in a sponsoring Association, thereby terminating coverage for all participating Employees, such an event shall not be considered a Qualifying Event under COBRA.

## LIFE INSURANCE AND ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

**You have benefits under this section only if the Schedule of Benefits indicates you have life insurance and/or accidental death and dismemberment benefits. To make a claim for Benefits under this section, please call the Plan Administrator for instructions.**

Your employer may have chosen an optional life insurance/accidental death and dismemberment benefit. If so, the plan is identified in the Schedule of Benefits.

### LIFE INSURANCE

Your life insurance benefit helps to protect your family from a sudden loss of income in the event of your death. If you die while you are an eligible, Active Employee, the life insurance benefit will be paid to your beneficiary. You may assign your life insurance benefits, and your life insurance benefit will terminate at retirement.

Your Employer determines the amount of your Basic Life Insurance, subject to minimum requirements. You have the option to purchase additional Supplemental Life and AD&D insurance for yourself, your Spouse, and/or your Child(ren).

### COVERAGE DURING TOTAL DISABILITY

If you become Totally Disabled (as defined below) before age 60, your life insurance Coverage will continue at no cost to you, provided you remain Totally Disabled until your death.

For the purpose of this benefit, you are considered Totally Disabled<sup>†</sup> if:

- the cause is an Injury or Sickness which happens after you are eligible; and
- the disability starts while you are eligible; and
- the disability starts before you reach age 60; and
- the disability lasts 6 months or more; and
- you:
  - have lost the use of both legs; or
  - have lost the use of both arms; or
  - have lost the use of one leg and one arm; or
  - have lost the sight of both eyes; or
  - cannot do the main duties of your job daily for the first 2 years of disability; or
  - cannot work in any reasonable job based on past training and experience after 2 years of disability.

*This benefit does not cover disability from any act of war, declared or undeclared, or intentional self-Injury.*

### CONTINUING YOUR COVERAGE

If you lose your eligible status for this insurance for reasons other than Total Disability (as defined in this section), you will have the opportunity to convert this policy to an individual policy by paying the monthly premiums. Please contact the Plan Administrator to be forwarded to the appropriate carrier for information on conversion.

### ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) BENEFIT

AD&D benefits are payable if you sustain an Accidental Injury resulting in the loss of your life, a limb, or your eyesight within 90 days after the Accident. Your AD&D benefits will reduce by 50% when you reach age 75 and will terminate upon retirement.

TYPE OF LOSS	PERCENT OF LIFE INSURANCE AMOUNT
Life	100%
Both hands or both feet or sight of both eyes	100%
	100%

One foot and one hand One foot, one hand or sight of one eye	50%
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Benefits for loss of life are payable to your designated beneficiary. Benefits for any other loss are payable to you.

## **BENEFICIARIES**

You may name anyone you wish as your beneficiary. You may change your beneficiary at any time by completing the proper form and returning it to the Plan Administrator. The change will be effective the date the form is signed.

There are three different levels of beneficiaries:

- **Primary Beneficiary**            This person, or persons, is paid the full benefit if they are living at the time of your death.
- **Contingent Beneficiary**       This person is paid the full benefit if the Primary Beneficiary is deceased at the time of your death.
- **Last Contingent Beneficiary** This person is paid the full benefit if the Primary Beneficiary and the Contingent Beneficiary are deceased at the time of your death.

If no beneficiary is living at the time of your death, the full benefit will be paid to your estate.

## **OPTIONAL WEEKLY ACCIDENT AND SICKNESS BENEFIT**

**You have benefits under this section only if the Schedule of Benefits indicates you have weekly accident and sickness benefits. To make a claim for Benefits under this section, please call the Plan Administrator for instructions.**

Your employer may have chosen an optional weekly accident and sickness benefit. If so, the plan is identified in the Schedule of Benefits. The Plan includes benefits that provide you with a basic level of income if you become Disabled and cannot work because of a non-occupational Injury or Illness. Disability benefits are not available while you are covered under COBRA.

The Plan will pay an amount per week as stated in the Schedule of Benefits . For each period of non-occupational Illness or Injury, payments will be made for a maximum of 26 weeks. Benefits are payable starting on the first day of a non-occupational Injury and the eighth day of a non-occupational Illness.

### **SUCCESSIVE PERIODS OF DISABILITY**

Successive periods of Disability due to the same or related causes are considered one period of Disability unless separated by a return to active, full-time work for a period of two weeks.

### **BENEFIT EXCLUSIONS**

Benefits are not payable for:

- intentionally self-inflicted Injury;
- any act of war, declared or undeclared, or terrorism;
- any Disability due to an Accidental bodily Injury arising out of or in the course of employment or which are in connection with a disease covered by Workers' Compensation or similar legislation; or
- any period of Disability during which you are not under the regular care of a Physician.

## MEDICAL NETWORKS AND UTILIZATION MANAGEMENT

### PREFERRED PROVIDER ORGANIZATION (PPO)

The Plan has entered into agreements with Preferred Provider Organizations (PPOs). The PPOs are networks of Hospitals, Physicians and other health care Providers who have agreed to provide services and supplies for negotiated fees to Plan Participants. The Physicians and service Providers within the PPO networks are independent contractors and are not employed by the AGC Group Health Benefit Fund. The Preferred Provider Organization is exclusively responsible for credentialing the Providers within their network.

You can obtain Covered health care services from any Provider you choose. However, if you receive Covered care from a Network Provider, your out-of-pocket costs will be lower.

You can determine if a Provider is in the Network by calling the PPO Network number listed on the back of your medical ID card or consulting the PPO Network website. Providers who participate in the PPO are added and deleted during the year. You should verify that the Provider from whom you choose to obtain services participates in the PPO at the time of that service.

### CENTERS OF EXCELLENCE

The Plan has entered into an agreement with a Centers of Excellence program called the LifeTrac Network. The LifeTrac is a network of specialized facilities that have agreed to perform transplant procedures for negotiated fees to Plan Participants. See page 25 for more information on organ transplants. Call the Plan Administrator if you need an organ transplant.

### UTILIZATION MANAGEMENT

Utilization management is a program designed to help you receive necessary and appropriate health care while avoiding unnecessary services that are more costly than others that can achieve the same result. The Plan has contracted with a firm specializing in Utilization Management to provide certain services to the Plan. **You may contact the Utilization Management firm by calling the telephone number which is listed on the back of your medical ID card.**

The program consists of:

- **Pre-certification.** Review of Hospitalizations before you are admitted for non-emergencies and as soon after emergency admissions as possible.
- **Concurrent Review.** Ongoing assessment of the health care as it is being provided, especially (but not limited to) inpatient confinement in a Hospital.
- **Retrospective Review.** Review of health care services after they have been provided.
- **Discharge Planning.** Planning for discharge from a Medical Care Facility or cessation of medical treatment.

Utilization Management is not designed to direct the practice of medicine or to be a substitute for the medical judgment of the attending Physician or other health care Provider. You may obtain any medical care you and/or your Provider chooses. However, benefits are payable only for Covered services as detailed in this agreement, and consistent with the requirements of this agreement, including any Utilization Management requirements.

If a particular course of treatment or medical service is not certified by the Utilization Management firm, benefits under the Plan may not be payable, or payable only for a limited amount. In order to be sure you take appropriate actions to become eligible for the maximum Plan reimbursement, please read the following provisions carefully.

#### **PRE-CERTIFICATION**

Before you or your Covered Dependent enters a Medical Care Facility on a non-emergency basis or receives

other listed medical services, the care must be certified as appropriate by the Utilization Management firm. A non-emergency stay in a Medical Care Facility is one that can be scheduled in advance.

You should call the Utilization Management firm **at least seven (7) days before** services are scheduled to be rendered. You should be prepared to provide all the following information:

- The name of the patient and relationship to the Covered Employee
- The name, Social Security number and address of the Covered Employee
- The name of the Plan
- The name and telephone number of the attending Physician
- The name of the Medical Care Facility, proposed date of admission, and proposed length of stay
- The diagnosis and/or type of surgery
- The medical services proposed to be provided

In the case of an **emergency** admission to the Medical Care Facility, you, a family member, the Medical Care Facility or attending Physician must contact the Utilization Management firm within **48** hours of the admission.

**Pre-certification of a medical service or inpatient Hospital stay does not determine eligibility for benefits, nor does it guarantee the payment of any Benefits for the service so certified.** If a Covered Person received an adverse pre-certification determination, in which Benefits are denied in whole or in part, the Covered Person may contact the Plan to request a review, which will be conducted in accordance with the provisions as established by applicable law.

**Non-Compliance Penalty: Failure to follow this procedure will reduce reimbursement received from the Plan.** If pre-certification has not been obtained, any Benefit payment otherwise payable will be reduced by the lesser of the otherwise amount to be paid or \$500.

#### ***CONCURRENT REVIEW AND DISCHARGE PLANNING***

Concurrent review of a course of treatment and discharge planning from a Medical Care Facility are parts of the Utilization Management program. The Utilization Management firm will monitor the Medical Care Facility stay or use of other medical services and coordinate with the attending Physician, Medical Care Facilities and the patient regarding the scheduled release or an extension of the Medical Care Facility stay or extension or cessation of the use of other medical services.

If the attending Physician feels that it is Medically Necessary for the patient to receive additional services or to stay in the Medical Care Facility for a greater length of time than has been precertified, the Physician must notify the Utilization Management firm and receive certification for the additional services or days. Days or services that have not been certified may not be Covered under this Plan, or if otherwise Covered, payment for those days or services may be reduced.

#### **CASE MANAGEMENT**

When a catastrophic condition, such as a spinal cord Injury or a premature birth occurs, a person may require long-term, perhaps Lifetime, care. After the person's condition is diagnosed, he or she might need extensive services or might be able to be moved into another type of care setting -- even to his or her home.

Case Management is a program whereby a case manager monitors these patients and explores, discusses and recommends coordinated and/or alternate types of appropriate medical care, typically in lieu of inpatient Hospital care. The case manager consults with the patient, the family and the attending Physician in order to develop a plan of care for approval by the patient's attending Physician and the patient. This plan of care may include some or all of the following:

- personal support to the patient;
- contacting the family to offer assistance and support;
- monitoring Hospital or nursing home care;
- determining alternative care options; and
- assisting in obtaining any necessary equipment and services.

Case Management occurs in the following situations:

- The catastrophic Injury or Sickness must have occurred while the patient was covered and the Injury or Sickness must have been covered under the Plan.

- An alternate benefit will be beneficial to both the patient and the Plan.

The case manager will coordinate and implement the Case Management program by providing guidance and information on available resources and suggesting the most appropriate treatment plan. The Plan Administrator, attending Physician, patient and patient's family must all agree to the alternate treatment plan.

Once agreement has been reached, the Plan Administrator will direct the Plan to reimburse for expenses as stated in the treatment plan, even if these expenses normally would not be paid by the Plan, when in lieu of other services covered under the Plan for which payment would have been made, and when the costs of the alternate care do not exceed what otherwise would have been paid.

## COMPREHENSIVE MEDICAL BENEFITS

Comprehensive Medical Benefits are payable when you or your Dependent incur expenses for care of an Accidental Injury or Sickness while Covered under the Plan.

### HOW THE COMPREHENSIVE MEDICAL BENEFIT WORKS

**Calendar Year Deductible.** Before benefits can be paid in a Calendar Year, you or your Dependent must meet the Deductible shown in the Schedule of Benefits. There are different Deductibles for In-Network expenses and Out-of-Network expenses. *If you use Network and Non-Network Providers, you will need to meet the In-Network Deductible before the Plan starts paying any In-Network Benefits and you will need to meet the Out-of-Network Deductible before the Plan starts paying any Out-of-Network Benefits.*

**Deductible Carryover.** Covered expenses incurred in and applied toward the Deductible in October, November and December in one year will be applied toward the Deductible in the next Calendar Year.

**Family Deductible.** When the amount shown in the Schedule of Benefits has been incurred by any combination of Covered members of your family, any remaining individual Deductibles for any Covered Person in your family will be considered satisfied for that year. There are different family Deductibles for In-Network expenses and Out-of-Network expenses. If you use Network and Non-network Providers, you will need to meet the In-Network Deductible before the Plan starts paying any In-Network Benefits and you will need to meet the Out-of-Network Deductible before the Plan starts paying any Out-of-Network Benefits.

**Deductible For A Common Accident.** If two or more Covered members of your family are injured in the same Accident, only one Deductible for the Calendar Year in which the Accident occurred will be required for treatment of all Covered Persons for Injuries sustained in that Accident.

**Non-Compliance Pre-certification Penalty.** The Non-Compliance Penalty of \$500 applies if you do not obtain pre-certification for an inpatient Hospitalization.

**Office Visit Copayment.** You must pay a Copayment, listed in your Schedule of Benefits, for office visits to your In-Network primary care Physician or Network specialist. After you pay the Copayment, you have no further liability for any Covered Services rendered during that office visit. The Copayment provisions do not apply to:

- Office visits for Mental Disorders, Substance Abuse, or visits to a chiropractor, or
- Allergy testing, or
- Laboratory tests, x-rays or other diagnostic tests performed by or sent to a facility outside the office of the Physician, regardless of whether the fluids/materials for the laboratory tests were obtained during the office visit, or
- Office visits to a Physician who is not a Network Physician

The services referenced above for which the Copayment does not apply are payable, when those services are Covered Services, after satisfaction of the Deductible(s), and at the percentage Coinsurance listed in your Schedule of Benefits.

**Out-of-Pocket Maximum.** Covered Medical Expenses are payable at the percentage shown in the Schedule of Benefits until the Out-of-Pocket Maximum shown in the Schedule of Benefits is reached. Covered Medical Expenses are then payable at 100% for the rest of that year.

The following **do not** count toward the Out-of-Pocket Maximum, and are never covered at 100% regardless of whether the Out-of-Pocket

Maximum is reached:

- any Non-Compliance Penalties
- the Calendar Year Deductible
- Copayments for prescription drugs, office visits and emergency room visits
- Coinsurance for services for Mental Disorders, or Substance Abuse
- Copayments/coinsurance for chiropractic services

### HOW THE PLAN PAYS BENEFITS

Except for Prescription Drugs, office visits for which the Office Visit Copayment is applicable, and emergency room visits for which the Emergency Room Copayment is applicable, after you pay the Calendar Year Deductible(s), benefits will be paid for the Covered charges of a Covered Person. Payment will be made at the rate shown in the Schedule of Benefits.

## MAXIMUM BENEFIT

The maximum benefit payable for each Covered Person is shown in the Schedule of Benefits. It is the total amount of benefits that will be paid under the Plan for all Covered charges, less Deductibles, Copayments and Coinsurance paid by the Covered Person, incurred by the Covered Person in his Lifetime.

## COVERED MEDICAL EXPENSES

Covered Medical Expenses are the Usual and Reasonable Charges that are incurred for the Covered Medically Necessary services and supplies. A charge is incurred on the date that the service or supply is performed or furnished.

Note: The AGC Health Plan applies CMS correct coding initiatives.

1. **Hospital Care.** The medical services and supplies furnished by a Hospital or Ambulatory Surgical Center or a Birthing Center, including routine nursery care provided after a newborn child's birth. After 23 observation hours, a confinement will be considered an inpatient confinement. Payment for a private room is limited to the regular daily charge for a semi-private room.
2. **Room charges** made by a Hospital having only private rooms will be paid at 80% of the average private room rate.
3. **Maternity Services.** Services that are Pregnancy-related are covered on the same basis and subject to the same limitations as any other Illness. In no circumstances will maternity Benefits be restricted for any length of stay in connection with childbirth for the mother or newborn Child to less than forty-eight (48) hours following a normal vaginal delivery or less than ninety-six (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). It is unnecessary for a Provider to obtain pre-certification from the Plan for a length of stay within these time limitations.
  - a. Maternity coverage does not include a Covered Person's Dependent Child or a Dependent Child's Spouse, or a Dependent Child's newborn.
  - b. Prenatal ultrasounds are limited to two (2) routine ultrasounds per Covered Pregnancy unless more than two ultrasounds are deemed Medically Necessary by the Physician due to a condition of risk to the mother or child.
4. **Emergency Room Care.** If you need emergency care for a life threatening Illness or Injury, your emergency room care will be covered at the In-Network rate (Copayment, Benefit level, Deductible, and Out-of-Pocket Maximum) whether or not the emergency care was In or Out-of-Network.
5. **Skilled Nursing Facility/Extended Care Facility/Rehabilitation Care Facility Care.** The room and board and nursing care furnished by a Skilled Nursing Facility will be payable, subject to day limits shown in the Schedule of Benefits, if and when:
  - a. the patient is confined as a bed patient in the facility;
  - b. the confinement starts within 14 days of a Hospital confinement of at least three days;
  - c. the attending Physician certifies that the confinement is needed for further care of the condition that caused the Hospital confinement; and
  - d. the attending Physician completes a treatment plan, which includes a diagnosis, the proposed course of treatment and the projected date of discharge from the Skilled Nursing Facility.
  - e. Coverage is not provided for Custodial Care, or for any period during which the patient is not making progress toward independent living.
  - f. Coverage is not provided for convenience items or other services or items which in the opinion of the Plan are not Medically Necessary.

The amount of Covered Expenses for the daily room charge incurred at a Skilled Nursing Facility/Extended Care Facility/Rehabilitation Care Facility is limited to 50% of the most common daily charge for a Semi-private room by the Hospital in which the Covered Person was confined immediately prior to entering the Skilled Nursing Facility/Extended Care Facility/Rehabilitation Care Facility.

6. **Surgical Services.** The professional services of a Physician for surgical services.
  - a. The Plan covers surgical procedures performed by the primary surgeon.
  - b. The Plan also covers one surgical assistant per surgery if Medically Necessary, and payment is limited to 20% of the amount allowable under the primary surgeon's charges.
  - c. Multiple or Bilateral Surgical Procedures.
    - i. When multiple or bilateral surgical procedures which add significant time or complexity to patient care are performed at the same operative session through the same incision, the available Benefits shall be the value of the major procedure plus 50% of the value of the lesser procedure.
    - ii. When multiple procedures are performed through separate incisions or in separate sites, whether by one surgeon or more than one primary surgeon (not a surgical assistant), the available Benefit shall be the value of the major procedure plus 75% of the lesser procedure(s). Incidental procedures such as an incidental appendectomy, incidental scar excision, puncture of ovarian cysts, and simple lysis of adhesions, are covered under the principal amount payable and no additional Benefit is available.
  - d. Surgical supplies used in the office for surgery performed in that setting are covered in the Benefit payable for the surgery, and are not separately covered except where specifically permitted under the CMS correct coding initiative.
7. **Medical Services.** The professional services of a Physician for medical services.
8. **Physician Consultations.** Limited to one Physician or Provider Visit per day per Physician or Provider:
  - a. The Plan covers Hospital Physician's Visits if the Employee or Dependent is confined in a Hospital. This Benefit ceases on the day that a surgical procedure takes place.
  - b. If during a Hospitalization, the patient is scheduled for, or has undergone, surgery, no Benefits are payable for a Hospital visit by the surgeon or surgeons, or any surgical assistant made during that Hospitalization.
  - c. Consultations requested by the attending Physician. One consultation is allowed per specialist per Sickness or Injury.
  - d. Concurrent Physicians Services:
    - i. A patient who has been Hospitalized for a surgical procedure and who receives Hospital medical care from a Physician other than the surgeon for a condition not related to the surgical service received, is entitled to both the Hospital Physician care Benefit and the Benefit for the surgical service.
    - ii. A patient who is admitted to the Hospital for a medical condition and is then transferred to the Hospital's surgical service for the same condition but under the care of another Physician, is entitled to Hospital Physician care only from the date of admission to the date of transfer to the surgical service. Thereafter, the patient is only entitled to the surgical Benefit for surgical services unless the surgery performed is diagnostic, a myelogram, or endoscopic procedure.
    - iii. In the event the patient receives concurrent Hospital care from more than one Physician during the same admission (whether or not it is for the same condition), the patient is entitled to Benefits for services of only the attending Physician. If the Plan determines that due to the medical complexity of the patient's condition the services of more than one Physician were required, the services provided by the additional Physician will be covered.
  - e. Routine Physician charges for the examination of a newborn while Hospital confined.
  - f. Medically Necessary Physician office visits.
9. **Home Health Care Services and Supplies** are covered only for care and treatment of an Injury or Sickness when Hospital or Skilled Nursing Facility confinement would otherwise be required. The diagnosis, care and treatment must be certified by the attending Physician and be contained in a Home Health Care Plan.

The care must be:

  - a. For home Visits rendered outside a Hospital;
  - b. Ordered by the attending Physician;
  - c. Requiring the technical proficiency and scientific skills of an RN or LPN; and
  - d. The RN or LPN is not a member of the Covered person's immediate family or who does

not ordinarily reside in the Covered Person's home.

A home health care visit will be considered a periodic visit by either a nurse or therapist, and one 4-hour visit is allowed per day.

Benefits are subject to the Home Health Care limit shown in the Schedule of Benefits.

10. **Hospice Care Services and Supplies** are covered only when:
  - a. the attending Physician has diagnosed the Covered Person's condition as being terminal, meaning that the person is not expected to live more than six months; and
  - b. has placed the person under a Hospice Care Plan and
  - c. the Plan is reviewed monthly by the Physician, and
  - d. the services are not for any curative treatment, and
  - e. the Plan includes a statement that the Hospice and the Physician believe that the Hospice Care will be less costly than any comparable alternativeHospice Care includes: (a) services and supplies furnished by a Home Health Agency or licensed Hospice, including Custodial Care; (b) confinement in a Hospice as a bed patient as long as charges do not exceed 150% of the average Semi-Private room daily rate in short term Hospitals in the area in which the Hospice is located; and (c) palliative and supportive medical and nursing services.
11. **Anesthetic:** anesthesia service to achieve general or regional (but not local) anesthesia at the request of the attending Physician and performed by a Physician other than the operating Physician or the Assistant. Services of a nurse anesthetist who is not employed by the Hospital and who bills for services provided are also covered, but only if a Hospital Employee or Physician-anesthesiologist is unavailable.
12. **Oxygen; blood and blood derivatives** that are not donated or replaced; intravenous injections and solutions.
13. **Diagnostic tests, including laboratory tests and X-rays.** Expenses incurred for any laboratory tests, X-ray examinations, pathological services, or machine diagnostic tests done solely for diagnostic purposes and authorized by the attending Physician and/or surgeon, will be paid as set forth in the Schedule of Benefits. Routine screening mammograms, pap smears, and PSA tests are covered under Well Care, and subject to the provisions applicable to Well Care.
14. **Radiation or chemotherapy and treatment with radioactive substances.** The materials and services of technicians are included.
15. **Rental of durable medical or surgical equipment.** Such equipment must be prescribed by a Physician, and in the opinion of the Plan, must be Medically Necessary. The Plan may determine to purchase such items in lieu of rental. Supplies are limited to once per year. For the purpose of this Benefit, the term Durable Medical Equipment includes wheelchairs, Hospital beds, home monitoring equipment, and similar mechanical equipment. There is no allowance for maintenance of any items purchased under this section.
16. **Local Medically Necessary professional land or air ambulance service:** only if the service is to the nearest Hospital or Skilled Nursing Facility where necessary treatment can be provided, but in any event, no more than 50 miles from the place of pickup, unless a longer trip was Medically Necessary. Air ambulance will not be covered if conditions would permit transport by ground ambulance.
17. **Surgical dressings, splints, casts and other devices used in the reduction of fractures and dislocations.**
18. **Fitted prosthetic devices,** including the initial purchase, fitting, repair and replacement, which replace body parts.
19. **Orthotic appliances,** including the initial purchase, fitting, repair and replacement, such as braces, splints or other appliances which are required for support for an injured or deformed part of the body as a result of a disabling congenital condition or an Injury or Sickness. No Benefits are payable for

shoes, or related supportive or corrective devices, except shoes which are an integral part of a brace and which would have no use absent the brace. The maximum Benefit is listed in the Schedule of Benefits.

20. **Physical therapy by a licensed physical therapist.** The therapy must be in accord with a Physician's exact orders as to type, frequency and duration and to restore a body function lost due to Injury or Sickness. Benefits for Outpatient physical/occupational therapy are limited as shown in the Schedule of Benefits.
21. **Speech therapy by a licensed speech therapist.** Therapy must be ordered by a Physician and follow either: (i) surgery for correction of a congenital condition of the oral cavity, throat or nasal complex (other than a frenectomy); (ii) an Injury; or (iii) a Sickness that is other than a learning or Mental Disorder.
22. **Occupational therapy by a licensed occupational therapist.** Therapy must be in accord with a Physician's exact orders as to type, frequency and duration, and to restore a bodily function lost due to Injury or Sickness. Covered medical expenses do not include recreational programs, maintenance therapy or supplies used in occupational therapy. Benefits for Outpatient physical/occupational therapy are limited as shown in the Schedule of Benefits.
23. **Cardiac rehabilitation:** such as, but not limited to, the use of common exercise equipment provided services are rendered
  - a. Under the supervision of a Physician;
  - b. In a formal rehabilitation program at an accredited facility pursuant to a Physician's prescription,
  - c. In connection with a myocardial infarction, coronary occlusion or coronary bypass surgery; and
  - d. Initiated within 12 weeks of the onset of the qualifying condition
24. **Sterilization procedures.**
25. **Initial contact lenses or glasses** required following cataract surgery.
26. **Prescription Drugs.** As described in the section labeled Prescription Drugs
27. **Care and treatment of jaw joint conditions,** limited to the amount in the Schedule of Benefits.
28. **A wig following a course of chemotherapy.**
29. **Spinal manipulation/chiropractic services,** up to the maximum shown in the Schedule of Benefits.
30. **Mastectomy/Reconstructive Services:** In accordance with the Women's Health and Cancer Rights Act (WHCRA), the Plan covers mastectomies for the treatment of breast cancer and reconstructive surgery after a mastectomy for the treatment of breast cancer. Benefits include Hospital inpatient care for a period of time as determined by the attending Physician and as is determined to be Medically Necessary following a mastectomy, a lumpectomy, or a lymph node dissection; and reconstructive breast surgery resulting from a mastectomy that resulted from breast cancer.
  - a. All stages of reconstruction on the breast on which the mastectomy was performed;
  - b. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
  - c. Prostheses and treatment of physical complications of the mastectomy including lymphedema.

Under WHCRA, coverage of mastectomies and breast reconstruction benefits are subject to Deductibles, Copayment, and Coinsurance limitations consistent with those established for other benefits under the Plan. Following the initial reconstruction, any additional modification or revision is covered only to the extent that it is not otherwise limited or excluded from Coverage by the Plan. Revisions requested as the result of the normal aging process will not be covered.

"Mastectomy" means the surgical removal of all or part of a breast as a result of breast cancer.

“Reconstructive breast surgery” means surgery performed as a result of a mastectomy to establish symmetry between the breasts. The term includes augmentation mammoplasty, reduction mammoplasty, and mastopexy.

Benefits for reconstructive breast surgery include, but are not limited to, the costs of one bra and/or prostheses per breast per Lifetime and benefits for Outpatient chemotherapy following surgical procedures in connection with the treatment of breast cancer.

31. **Morbid Obesity.** Benefits are subject to the Coverage and limits specified in the Schedule of Benefits and Coverage is limited to treatment when the patient meets the following criteria:

- a. The obesity meets the definition of Morbid Obesity; and is
  - i. Endogenous obesity which is caused by the body, such as metabolic factors and treatment is Medically Necessary; OR
  - ii. Exogenous obesity (caused by overeating) if a diagnosis of Morbid Obesity is given and a separate medical condition is present which is aggravated by obesity, such as high blood pressure and treatment is Medically Necessary.

Medically necessary means all of the following conditions must be met:

- b. Patient must have Physician documented proof of inability to control weight through diet for a minimum of 5 years;
- c. Patient must suffer from a Physician documented separate condition which is aggravated by obesity;
- d. Patient must be psychologically stable; and
- e. Patient must obtain second opinion from a licensed Physician.

32. Pulmonary rehabilitation therapy while under a Physician's care in a formal rehabilitation program at an accredited facility pursuant to a Physician's prescription. This benefit is limited to a maximum of \$500 per occurrence and must be within ninety (90) days following the diagnosis of pulmonary illness or surgery.

33. **Epidural injections for back pain** are limited to three (3) per month, and no more than six (6) per Calendar Year.

34. **Sleep studies and the treatment of sleep apnea** as set forth in the Schedule of Benefits. Treatment to diagnose and to correct snoring is not covered.

35. **Injury To or Care of Mouth, Teeth and Gums**

Charges for Injury to or care of the mouth, teeth, gums and alveolar processes will be considered covered medical expenses only if that care is for the following oral surgical procedures:

- a. Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth.
- b. Emergency repair due to Injury (other than from chewing) to sound natural teeth. This repair must be made within 12 months from the date of the Injury.
- c. Surgery needed to correct Accidental injuries to the jaws, cheeks, lips, tongue, floor and roof of the mouth. This repair must be made within 12 months from the date of the Accident.
- d. Excision of benign bony growths of the jaw and hard palate.
- e. External incision and drainage of cellulitis.
- f. Incision of sensory sinuses, salivary glands or ducts.
- g. Removal of impacted teeth.

No Benefits are payable under the Medical Benefits for dental and oral surgical procedures related to or involving orthodontic care of the teeth, periodontal disease or preparing the mouth for the fitting of or continued use of dentures.

36. **Treatment of Mental Disorders and Substance Abuse**

Benefits for care and treatment of Mental Disorders and Substance Abuse, except as otherwise excluded, will be limited as follows:

- a. Benefits for treatment are subject to the benefit payment maximums shown in the Schedule of Benefits.
- b. Physician's visits are limited to one per day.

Psychiatrists (M.D.), psychologists (Ph.D.) or counselors (Ph.D.) may bill the Plan directly. Other licensed mental health practitioners must bill the Plan through these professionals.

This Plan conforms to all of the requirements of the Mental Health Parity Act.

**37. Organ and Tissue Transplant and Implant Coverage**

- a. Services for care and treatment due to an organ or tissue transplant must be pre-authorized by the Plan in writing. All transplants and implants require a second opinion (and at the discretion of the Plan, a third opinion).
- b. The transplant must be performed to replace an organ or tissue of the Covered Person.
- c. The transplant is a Covered transplant: heart, lung, heart/lung, liver, kidney, pancreas, kidney/pancreas, autologous bone marrow, allogenic bone marrow, and stem cell.
  - i. Includes any and all other procedures involving bone marrow or bone marrow components as an adjunct to high dose chemotherapy, including services related to any evaluation, treatment or therapy involving the use of myeloablative chemotherapy with autologous hematopoietic stem cell and/or colony stimulating factor support (MC-AHSC/CSF).
  - ii. The following terms are defined as follows: (i) "Myeloablative Chemotherapy" means a dose of chemotherapy which is expected to destroy the bone marrow; (ii) "Autologous Hematopoietic Stem Cell" means an infusion of primitive cells capable of replication and differentiation into mature blood cells which are harvested from the Covered Person's blood stream or bone marrow prior to the administration of the myeloablative chemotherapy; (iii) "Colony Stimulating Factor" means a substance which increases the reproduction, differentiation, and maturation of blood cellular components.
- d. All organs for transplants must be natural body organs. No Benefits are available for any mechanical-electronic appliances or mechanical-electronic organs of any type.
- e. Any organ not specifically listed as covered is specifically excluded.
- f. Benefits for all services related to transplant procedures performed during a Covered Person's Lifetime are limited to the amount shown in the Schedule of Benefits.
- g. Services for obtaining donor organs are Covered under the Plan when the recipient is a Covered Person. When the donor has medical coverage, his or her plan will pay first. The Benefits under this Plan will be reduced by those payable under the donor's plan. Donor charges include those for:
  - i. Evaluating the organ;
  - ii. Removing the organ from the donor; and
  - iii. Transportation of the organ from within the United States and Canada to the place where the transplant is to take place.
  - iv. If the organ donor is a Covered Person and the recipient is not, then, the Plan will cover donor organ charges for:
    1. Evaluating the organ; and
    2. Removing the organ from the donor.

There are no Benefits for transportation.

The Plan will always pay secondary to any other coverage.

Benefit payments for donor charges are subject to the separate Donor Maximum Benefit limit as shown in the Schedule of Benefits.

Call the Plan Administrator if you need information on organ transplants.

**38. Preventive Care**

Benefits are payable for well and preventive care up to the maximum listed in the Schedule of Benefits. Services for well and preventative care in excess of the annual limit, or when provided by Non-Network Providers, are subject to the satisfaction of the applicable annual Deductible and Coinsurance.

- a. Well Child Care includes Benefits for physicals and related lab services, periodic office visits for the purpose of monitoring growth and development, or for health screening tests and immunizations for a Covered Dependent Child under 19 years of age, according to the

schedule.

b. Well Adult Care

Benefits include:

- i. Colorectal cancer screening up to once every three years if you are
  1. At least 40 years old, or
  2. Classified as high risk because a first-degree family member has a history of colorectal cancer (substantiated by letter from your Physician)
- ii. PSA prostate exam and test;
- iii. Pap smear exam and test; and
- iv. Physicals and related lab services
- v. Mammograms, according to the following schedule:

<b>Age</b>	<b>Frequency</b>
35 through 39	One single baseline
40 through 49	mammogram
50 and over	Once every 2 years
	Once every year

Physicals required for business or travel, or for obtaining insurance coverage are not Covered.

## **PRE-EXISTING CONDITIONS**

### **Benefits are limited for Pre-Existing Conditions**

A Pre-Existing Condition is a condition (regardless of the cause of the condition) for which medical advice, diagnosis, care or treatment was recommended or received within the six months prior to the enrollment date. Treatment includes receiving medical care, services and supplies, including consultations, diagnostic tests or Prescription or over-the-counter medicines prescribed or recommended by a Physician. Pregnancy is not considered a Pre-Existing Condition.

Benefits for Pre-Existing Conditions are payable only after the Deductible has been satisfied and are limited to a maximum payment of \$500 during the person's first 12 consecutive months of coverage under the Plan minus any applicable time to be credited toward the person's Pre-Existing Condition Waiting Period because of prior Creditable Coverage.

In determining whether a Pre-Existing Condition applies, the Plan will credit the time the person was previously covered by a private or public health benefit plan if the previous coverage was continuous to a date not more than 62 days prior to the effective date of coverage hereunder, exclusive of any applicable waiting period, and will reduce the Pre-Existing Condition Waiting Period by any waiting period the Employee must satisfy before becoming eligible for Coverage.

The Pre-Existing Condition waiting period is waived for newborns and for children adopted or placed for adoption before the age of 19, who are enrolled for coverage in this Plan within 30 days of birth, adoption, or placement for adoption. This waiver will also apply to newborns and children adopted or placed for adoption who were enrolled for Creditable Coverage in another Plan within 30 days of birth, adoption or placement for adoption, and subsequently enrolled in this Plan without a Significant Break In Coverage.

If coverage in the Plan terminates and is subsequently reinstated within 12 months of such termination, the Pre-Existing Condition Waiting Period on reinstatement will be reduced by the length of the Pre-Existing Condition Waiting Period satisfied prior to such termination.

### **Proving Creditable Coverage From Other Plans**

An Eligible Person who had Creditable Coverage in another plan should receive a Certificate of Creditable Coverage ("Certificate") verifying the nature and duration of their Creditable Coverage from the other plan. Normally, the Certificate will be provided automatically at or shortly after the time coverage in the other plan terminates. The Eligible Person is also entitled to request a Certificate from the other plan anytime within 24 months of the date coverage terminates.

If the Eligible Person, who was in a plan prior to this Plan, has an urgent medical condition that necessitates a determination before the Certificate can be delivered from the other plan because: 1) the other plan fails to provide a Certificate; 2) the other plan is not required by law to provide a Certificate; or, 3) the Certificate is lost and cannot be replaced, the Eligible Person can demonstrate Creditable Coverage through an appropriate combination of other means such as:

- Providing relevant corroborating evidence of some Creditable Coverage during the period claimed (NOTE: This might include: Explanation of Benefit forms and/or correspondence from the other plan showing coverage, pay stubs showing deductions for coverage, coverage ID cards, etc);
- Cooperating with the Plan's efforts to obtain verification of Creditable Coverage from the other plan (NOTE: Cooperation includes providing at this Plan's request written authorization for this Plan to request information or for this Plan to request a Certificate of Creditable Coverage from the other plan on behalf of the Eligible Person); or,
- A telephone call from a representative of the prior plan to this Plan verifying Creditable Coverage.

Upon request, the Plan Administrator of this Plan will assist the Eligible Person to obtain Certificates of Creditable Coverage from the other plan.

While this Plan may refuse to credit coverage where the Eligible Person fails to cooperate with the Plan's efforts to verify coverage, inability to obtain a Certificate of Creditable Coverage will not be considered

evidence of the absence of Creditable Coverage. An Eligible Person who provides a Certificate of Creditable Coverage will receive written notification from this Plan explaining the period still covered by the Pre-Existing Condition Exclusion, the basis for the determination (including the source and substance of any information used in making the determination) and the appeals procedure. This notification will be provided within a reasonable time period based on the relevant facts and circumstances. This Plan may change an initial determination of Creditable Coverage if subsequent events reveal that the initial determination is in error.

No notification will be issued if this Plan determines that the Eligible Person is NOT subject to a Pre-Existing Condition Exclusion Period.

### **Creditable Coverage From This Plan**

This Plan will provide a written Certificate of Creditable Coverage by first class mail to the Eligible Person's last known address:

- When coverage as an Employee or Dependent terminates;
- When COBRA continuation coverage ends; or,
- Upon request made within 24 months of termination of Coverage.

To request a Certificate of Creditable Coverage from this Plan, contact the Plan Administrator.

## PREScription DRUG BENEFITS

Prescription Drugs may be obtained through both the Retail Pharmacy Program and the Mail-Order Program. The Copayment amount is less if the Prescription is filled with a Covered Generic Drug when such Generic Drug is available.

Benefits for refills for any one Prescription are limited to the lesser of:

- The number of times specified by a Physician.
- Up to one year from the date of Prescription order by a Physician.

**The Copayments and/or Coinsurance applicable to Prescription Drugs are listed in the Schedule of Benefits.**

Benefits under the Prescription Drug Benefit are restricted to:

- Drugs and medicines that require a Prescription Order; and
- Insulin, disposable insulin needles and syringes; and
- Disposable blood/urine glucose/acetone testing agents (e.g. Chemstrips, Clinitest tablets, Diastix Strips and Tes-Tape); and
- Glucose elevating agents; and
- Lancets for diabetics.

Expenses and Prescription Drugs purchased through the Prescription Drug Copayment Plan do not apply to the Major Medical Deductible or the Out-of-Pocket yearly maximum. Prescription Drugs not purchased through the Prescription Drug Copayment Plan will be paid as set forth in the Schedule of Benefits upon submission to the Plan. Mail order drugs are only Covered if purchased through the Prescription Drug Copayment Plan. Prescription Drugs that exceed the manufacturer's recommended dosage or the dosage established by the Food and Drug Administration ("FDA") are not Covered.

**Retail Pharmacy Program:** Benefits are payable for Covered Prescription Drugs when filled at a retail (neighborhood) pharmacy.

Any one Prescription filled at a Retail Pharmacy is limited to the greater of a 34-day supply or a 100-unit dose.

### **Mandatory Mail Order Program**

**Once you have the same Prescription filled at a retail pharmacy three times, you must begin using the mail order program for that prescription. There is no Benefit under the Plan for any Prescription filled for the fourth or more times at a retail pharmacy.**

Benefits are payable for Covered Prescription Drugs when filled through the Mail Order Program.

Any one Prescription filled through the Mail Order Program may be filled for a maximum supply of 90 days. Benefits include up to three additional refills per year, consistent with the Physician's order. It is most convenient if the Physician writes the Prescription for the maximum period of time (12 months), up to a maximum of 90 days per each fill.

## OPTIONAL DENTAL BENEFITS

**You have these benefits only if the Schedule of Benefits indicates you have dental benefits.**

### HOW THE DENTAL PLAN WORKS

**Calendar Year Deductible:** Before any benefits can be paid in a Calendar Year, you or your Dependent must meet the Dental Deductible shown in the Schedule of Benefits.

**Deductible Carry Over:** Dental charges incurred in one Calendar Year can also be used in the next Calendar Year if they were incurred in the last three months of the prior year and were applied to the prior year's Dental Deductible.

**Family Deductible:** When the amount shown in the Schedule of Benefits has been incurred by Covered members of your family, the Dental Deductibles of all Covered Persons in your family will be considered satisfied for that year.

### HOW THE PLAN PAYS BENEFITS

After you pay the Calendar Year Deductible, the Plan will reimburse you for Covered Dental expenses. Payment will be made at the rate shown in the Schedule of Benefits.

### PLAN MAXIMUMS

The Maximum Dental Benefit the Plan will pay each Calendar Year is shown in the Schedule of Benefits. The Maximum applies separately to you and each of your Covered Dependents. In addition, for Coverage which includes Orthodontic benefits, there is a Lifetime Orthodontic benefit shown in the Schedule of Benefits.

### COVERED DENTAL EXPENSES

Covered Dental Expenses are the Usual and Reasonable Charges made by a Dentist or other Physician for necessary care, appliances or other dental material listed below as a dental service, provided to you or your Dependent while Covered under this Plan.

A Dental expense is incurred on the date the service or supply for which it is made is performed or furnished. However, there are times when one overall charge is made for all or part of a course of treatment. In this case, the Plan Administrator will apportion that overall charge to each of the separate visits or treatments. The pro rata charge will be considered to be incurred as each visit or treatment is completed.

### ***PREVENTIVE DENTAL SERVICES***

Covered expenses for preventive services include:

1. Routine oral exams. This includes the cleaning and scaling of teeth. Limit of two exams per person each Calendar Year, no more frequently than once every 6 months.
2. One bitewing X-ray series each Calendar Year.
3. One full mouth X-ray each 36 months.
4. One fluoride treatment each Calendar Year.
5. Space maintainers for children under age 19 to replace primary teeth.
6. Sealants as prescribed by the American Dental Association for children under age 19.

### ***BASIC DENTAL SERVICES***

Covered expenses for basic services include:

1. Dental X-rays (radiographs) not included as a Preventive Service.
2. Oral surgery. Oral surgery is limited to removal of teeth, preparation of the mouth for dentures and removal of tooth-generated cysts of less than 1/4 inch.
3. Periodontics (treatment for conditions of the gums and jawbone).
4. Endodontics (root canal).
5. Extractions. This service includes the giving of anesthesia.
6. Recementing bridges, crowns or inlays.
7. Fillings, other than gold.

**MAJOR DENTAL SERVICES**

**Note: No benefits are payable for Major Services for the first 12 months a person is covered under the Plan, unless the person had continuous dental coverage for the prior 12 months immediately prior to being covered by this Plan.**

Covered expenses for major services include:

1. Gold restorations, including inlays, onlays and foil fillings. The cost of gold restorations in excess of the cost for amalgam, synthetic porcelain or plastic materials will be included only when the teeth must be restored with gold.
2. Installation of crowns.
3. Installing precision attachments for removable dentures.
4. Installing partial, full or removable dentures to replace one or more natural teeth, for teeth that were removed or extracted no more than twelve months prior to the installation. This service also includes all adjustments made during a six-month period following the installation.
5. Addition of clasp or rest to existing partial removable dentures.
6. Initial installation of fixed bridgework to replace one or more natural teeth, for teeth that were removed or extracted no more than twelve months prior to the installation.
7. Repair of crowns, bridgework and removable dentures.
8. Rebasing or relining of removable dentures.
9. Replacing an existing removable partial or full denture or fixed bridgework; adding teeth to an existing removable partial denture; or adding teeth to existing bridgework to replace newly extracted natural teeth. However, this item will apply only if one of these tests is met:
  - The replacement or addition of teeth is required because of one or more natural teeth that were extracted no more than twelve months prior to replacement or addition.
  - Existing denture or bridgework was installed at least five years prior to its replacement and cannot currently be made serviceable.
  - The existing denture is of an immediate temporary nature. Further, replacement by permanent dentures is required and must take place within 12 months from the date the temporary denture was installed.

**ORTHODONTIC TREATMENT AND APPLIANCES**

Expenses for orthodontic services, when Covered as specified in the Schedule of Benefits, include:

1. Orthodontic diagnostic procedures.
2. Initial and subsequent, if any, installations of orthodontic appliances.

Expenses for orthodontic services, when Covered, are limited as specified in the Schedule of Benefits.

**ALTERNATE TREATMENT**

Many dental conditions can be treated in more than one way to produce a satisfactory result. This Plan will pay Benefits based on the cost of the treatment that provides professionally satisfactory results at the most cost-effective level. You may choose a more costly procedure. If you do, you will be responsible for paying the difference between the charges for the more costly procedure and the Benefits paid by the Plan.

For example, if a regular amalgam filling is sufficient to restore a tooth to health, and you and your Dentist decide to use a gold filling, the Plan will base its reimbursement on the Usual and Reasonable Charge of an amalgam filling. You will have to pay the difference in cost.

**EXPENSES NOT COVERED UNDER ANY DENTAL PLAN**

This benefit will not cover a charge for any of the following:

1. Services that, to any extent, are payable under the Comprehensive Medical Benefit.
2. Services that are not included in the list of Covered dental services.
3. Crowns for teeth that are restorable by other means or for the purpose of Periodontal Splinting.
4. Crowns, fillings or appliances that are used to connect (splint) teeth, or changes or alters the way the teeth meet; including altering the vertical dimension, restoring the bite (occlusion) or are cosmetic in nature.
5. Implants and any appliances and/or crowns and the surgical insertion or removal of implants.
6. Replacement of lost or stolen appliances.
7. Orthognathic surgery.
8. Services related to diagnosis or treatment of the temporomandibular joint (TMJ). Coverage may be available under the Comprehensive Medical Benefit.

## OPTIONAL VISION BENEFITS

**You have these benefits only if the Schedule of Benefits indicates you have vision benefits.**

Your employer may have chosen an optional vision plan. If so, the plan is identified in the Schedule of Benefits. The plan pays 100% of costs for vision examinations, frames, prescription lenses and contact lenses furnished by a qualified optometrist or ophthalmologist up to the Annual Maximum specified in the Schedule of Benefits. The plan also covers corrective procedures, including laser procedures such as radial keratotomy, PRK and LASIK surgery.

The plan does not cover:

- Cleaning solutions, heat-cleaning units, contact lens insurance, scratch resistant coating or tinting of lenses.
- Charges that are considered Comprehensive Medical Benefits.

## PLAN EXCLUSIONS

Services and Charges for the following are not covered:

1. Care, treatment or supplies incurred before a person was Covered under this Plan or incurred after a person is no longer Covered under this Plan.
2. Services, treatments and supplies that are not specified as covered under this Plan.
3. Charges excluded by the Plan, as described in this document.
4. Charges incurred for which the Plan has no legal obligation to pay.
5. Expenses covered by any workers' compensation law; Employers' liability law (or legislation of similar purpose); occupational disease law; or for Injury or Illness arising out of, or in the course of, employment for compensation, wages or profit, including self-employment.
6. Care, treatment, services or supplies unless they were Medically Necessary and prescribed by a Physician or Provider acting within the scope of their license.
7. Care and treatment for which there would not have been a charge if no coverage had been in force, or for which the Covered Person, or guardian of the Covered Person is not obligated to pay.
8. Care and treatment that is either Experimental/Investigational or not Medically Necessary. This exclusion also applies to services, supplies, or accommodations provided in connection with the same.
9. The part of an expense for care and treatment of an Injury or Sickness that is in excess of the Usual and Reasonable Charge. This does not apply to services rendered by a Network Provider.
10. Services received as a result of Injury or Sickness caused by or contributed to by engaging in an illegal act or occupation; by committing or attempting to commit any crime, criminal act, assault or other felonious behavior; or by participating in a riot or public disturbance.
11. Care or treatment of an Accident, Illness or Injury caused by, or arising out of the following: riot; terrorism; war; an act of war while in military, naval, or air services of any country at war, including but not limited to, declared or undeclared war; or acts of aggression committed by a person otherwise entitled to Benefits.
12. Professional services performed by a person who ordinarily resides in the Covered Person's home or who is the Covered Person's Spouse, parent, child, brother or sister, whether the relationship is by blood or exists in law, or is the Covered person's Employer.
13. Care and treatment provided for cosmetic reasons, except as specifically provided under this Plan.
14. Surgery on the eye to improve refraction and treatment for refractive error of vision, including but not limited to radial keratotomy, orthokeratology, corneal carving, and corneal slicing, except as may be covered under an Optional Vision Plan, if this Coverage has been selected and premium has been paid.
15. Services incurred with respect to the eye for diagnostic procedures (including but not limited to eye refraction, the filling of eyeglasses or contact lenses, and orthoptic evaluation or training). This exclusion does not apply to lens implants (either donor or artificial) for cataracts, or when required as part of an examination to diagnose an Illness or Injury (other than refractive errors of vision), aphakic patients and soft lenses or sclera shells intended for use as corneal bandages. Coverage may be provided under an Optional Vision Plan if this Coverage has been selected and premiums have been paid.
16. Hearing examinations, hearing aids and exams for their fitting. This exclusion does not apply when

such services are required as part of an examination to diagnose Illness or Injury.

17. Routine or periodic examinations, screening examinations, evaluation procedures, preventive medical care, or treatment or services not directly related to the diagnosis or treatment of a specific Injury, Sickness or Pregnancy-related condition which is known or reasonably suspected, unless such care is specifically shown herein as a Covered expense.
18. Services or supplies provided mainly as a rest cure, maintenance or Custodial Care of a physically or mentally disabled person where the care does not specifically reduce the Disability so that the person can live without assistance, or outside a Medical Care Facility or nursing home.
19. Replacement of braces of the leg, arm, back, neck, or artificial arms or legs, unless there is sufficient change in the Person's physical condition to make the original device no longer functional.
20. Service for educational or vocational testing or training or counseling.
21. Professional services billed by a Physician or nurse who is an Employee of a Hospital or Skilled Nursing Facility and paid by the Hospital or facility for the service.
22. Personal comfort items or other equipment, such as, but not limited to, air conditioners, air-purification units, humidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, elastic bandages or stockings, non-Prescription Drugs and medicines, and first-aid supplies and non-Hospital adjustable beds.
23. Care and treatment of obesity, weight loss, or dietary control whether or not it is, in any case, a part of the treatment plan for another Sickness except as explicitly stated as Covered (see coverage for Morbid Obesity). This exclusion includes, but is not limited to, stomach stapling; gastric bypass; balloon implant; other similar surgical procedure; and Prescription Drugs for the purpose of weight loss or weight control.
24. Expenses in connection with reversal of a gastric or intestinal bypass, balloon implant, gastric stapling, or other similar surgical procedure, and supplies, services and accommodations provided in connection with such treatment, regardless of whether or not such services were covered under this Plan.
25. Care, services or treatment for psychosexual identity disorder, psychosexual dysfunction, transsexualism, gender dysphoria or sexual reassignment or change, including medications, implants, hormone therapy, surgery, medical or psychiatric treatment.
26. Care and treatment for reversal of surgically performed sterilization or re-sterilization.
27. Care and treatment for erectile dysfunction, including but not limited to, penile prosthesis, penile implant, any device that restores sexual function (such as a pump) or Prescription Drugs for or related to sexual dysfunction.
28. Care and treatment for infertility, including but not limited to, diagnosis, surgery, Prescription Drugs, and/or other treatments, including but not limited to, gamete intrafallopian transfer (GIFT), artificial insemination or in-vitro fertilization, and all procedures to preserve sperm or ova.
29. Care and treatment for hair loss including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a Physician, except for a wig after chemotherapy or radiation therapy.
30. Care and treatment for smoking cessation programs, including smoking deterrent patches, unless Medically Necessary due to a severe active lung Illness such as emphysema or asthma.
31. Care and treatment for sleep disorders, except in the case of those persons requiring continuous positive airway pressure (CPAP) for treatment of sleep apnea or monitoring of respiration, as specified in the Schedule of Benefits.

32. Exercise programs for treatment of any condition, except for Physician-supervised Occupational or Physical Therapy or Rehabilitation programs as specified in the Schedule of Benefits, or elsewhere in this Plan.
33. Treatment or services or supplies for any Injury caused directly or indirectly from sky diving, competitive auto or sports car racing, motorcycle racing, bungee jumping or such other dangerous sports, which, to the reasonable person, would be considered life endangering or carry with such activities great risk of extreme bodily harm.
34. Any service associated with Pregnancy, unless the patient is the female Covered Employee or the Covered Spouse of a male Covered Employee.
35. Services related to an elective abortion, including any medications/Prescription Drugs that are for the purpose of inducing abortion. An "elective abortion" means an abortion for any reason other than to preserve the life or health of the female upon whom the abortion is performed.
36. Care and treatment billed by a Hospital for non-Medical Emergency admission on a Friday or a Saturday. This does not apply if surgery is performed within 24 hours of admission.
37. Care or treatment of elective surgery, complications of elective surgery, or complications of care or treatment not Covered under this Plan.
38. Travel or accommodations, whether or not recommended by a Physician.
39. Transportation (except Medically Necessary ambulance services as set forth in the Schedule of Benefits). This exclusion includes, but is not limited to, the following:
  - a. Ambulance services when the Covered Person could be safely transported by means other than ambulance;
  - b. Air ambulance services when the Covered Person could be safely transported by ground ambulance or by means other than ambulance; and
  - c. Ambulance services beyond transportation to the nearest facility expected to have appropriate services for the treatment of the Injury or Illness involved.
40. Services, supplies, care or treatment to a Covered Person for an Injury or Sickness which occurred as a result of that Covered Person's being intoxicated or under the influence of any narcotic, controlled substance, drug or hallucinogen unless administered on the advice of a Physician. Expenses will be Covered for Injured Covered Persons other than the person intoxicated or under the influence of a substance.
41. Hospital or Skilled Nursing Facility confinement days incurred before the Covered Person's Effective Date when admission began before the Covered Person's effective date.
42. Charges covered under automobile payment provisions or under an automobile No-Fault Insurance Act, or charges which would have been covered under No-Fault insurance coverage when the party is legally responsible for having No-Fault coverage in place, whether or not the No-Fault coverage is actually in effect.
43. Examinations, reports, or appearances in connection with legal proceedings or services, supplies, or accommodations provided pursuant to a court order, whether or not Sickness or Injury is involved.
44. Drugs labeled "Caution - limited by federal law to investigational use", or experimental drugs, or drugs which are being prescribed for a purpose for which they are not specifically approved by the U.S. Food and Drug Administration, even though a charge is made to the individual.
45. Charges in connection with genetic studies, including genetic counseling and counseling with regard to the results of genetic studies.
46. Care or treatment of a Mental Disorder unless and until there exists a confirmed diagnosis of a Mental Disorder. The diagnosis must be made pursuant to a personal examination of the patient by a Provider duly licensed to make such diagnosis.

47. Care or treatment of marital or family problems; behavior disorders, chronic situational reactions; or social, occupational, religious or other social maladjustment, including drugs for the same.
48. Care or treatment of attention deficit disorder for persons over 23 years old (including Prescription Drugs), learning disability, mental retardation, chronic organic brain syndrome or personality disorder, except services required to diagnose any of these disorders.
49. Milieu therapy, behavior modification, biofeedback therapy, sensitivity training, electrosleep therapy or electronarcosis.
50. Alleviation of chronic, intractable pain by a pain control center or under a pain control program to the extent that those charges exceed the Usual and Reasonable Charges for semiprivate room accommodations, one hour of psychotherapy and one-and-one-half hours of group therapy per day.
51. Rest cures.
52. In connection with institutional care which, as determined by the Plan, is for the primary purpose of controlling or changing the environment of the Covered Person, or for which the care does not specifically reduce disability.
53. Services, supplies or accommodations and for care provided by the health care professional or nonprofessional Employees of any private or public school or halfway house.
54. Speech therapy, unless required to restore to function speech loss or impediments due to a Sickness or Injury as specified under this Plan.
55. Services for diagnostic purposes that are not related to an Injury or Sickness, unless otherwise provided for by the terms of the Plan.
56. Routine physical exams or X-ray or laboratory procedures when there are no symptoms of Sickness or Injury except as specifically provided by the terms of this Plan.
57. Mental examinations or psychological tests when there are no symptoms of a Mental Disorder.
58. Preventive care services that are not specifically Covered, except for vaccinations, such as for rabies or tetanus, received in conjunction with treatment for an Accidental Injury, except as specifically provided in the Schedule of Benefits.
59. Missed appointments.
60. Charges in connection with upper or lower jaw augmentation or reduction procedures (orthognathic surgery) or appliances or restorations necessary to increase vertical dimensions or restore occlusion, including restorative treatment, prosthodontic treatment, full mouth rehabilitation, orthodontic treatment, bone resection, injection of joints, splints, physical therapy and bite guards, except as specifically Covered under the Optional Dental Plan, if Dental Coverage has been selected and premiums have been paid.
61. Diagnosis or treatment of temporomandibular joint (TMJ) dysfunction, by any name called, in excess of limits as specified in the Schedule of Benefits.
62. Confinement in a Skilled Nursing Facility, except as specifically provided elsewhere in the Plan.
63. More than one visit on any one day for treatment of a Mental Disorder or Substance Abuse, Physical Therapy, Occupational Therapy or Spinal Manipulation.
64. Any service or charges which are not specifically included as Covered.
65. Shipping, handling, delivery, sales tax, postage, interest, finance charges, or completion of claim forms assessed by Physicians.

66. Services in connection with transplants (except as specifically set forth in the Schedule of Benefits). This exclusion applies whether the Covered Person is the donor or the recipient.
67. Care or treatment of learning disability, developmental Disorder, mental retardation, chronic organic brain syndrome, personality disorder, or for care or treatment of psychiatric or psychosocial conditions for which reasonable improvement cannot be expected. This exclusion does not apply to services required to diagnose any of the above.
68. Expenses in connection with institutional care, which (as determined by the Administrator) is for the primary purpose of controlling or changing the environment of the Covered Person.
69. Services incurred for intentional self-destruction or self-Injury or any attempt at self-destruction, unless the Injury resulted from an act of domestic violence or a medical condition (including both physical conditions and Mental Disorders). This exclusion applies regardless of whether or not the Covered Person is sane or insane.
70. Telephone consultations, whether initiated by the Covered Person or the Provider.
71. The care and treatment of: teeth, gums, or alveolar process, including an intraoral alveolar abscess, dentures, dental appliances, or supplies used in such care and treatment except as specifically provided for by the terms of the Plan or in the Schedule of Benefits. Such expenses may be considered for Benefits under the Optional Dental Plan if Dental coverage has been selected and premiums have been paid.

72. Treatment of:
  - a. Flat feet, fallen arches, weak or strained feet, instability, or imbalance of the foot.
  - b. Toenails (including cutting or removal by any method other than the removal of the nail matrix or root), corns, or calluses.
73. Corrective shoes (unless they are an integral part of a lower body brace) or for special shoe accessories.
74. Acupuncture or acupressure.
75. Radioallergosorbent ("RAST") testing.
76. Preventative medication; food supplements, sports therapy, equipment, services and applications of such.
77. Services, supplies, and treatment for hair loss, including, but not limited to, the use of minoxidil and Rogaine.
78. Autopsy procedures.
79. Circumcisions not performed within thirty (30) days of birth or adoption.
80. Massage therapy.
81. Occupational Therapy, except as specified elsewhere in this Plan.
82. Incurred as the result of the Covered Person or any Covered Person committing a fraudulent insurance act.
83. Any charge for the administration of a covered Prescription Drug.
84. Prescription drugs or other drugs which, except as specifically Covered elsewhere in the Plan:
  - a. Can legally be bought without a written Prescription. This does not apply to injectable insulin.
  - b. Require a Prescription by state law, but not federal law (state controlled).
  - c. Are compound medications unless at least one ingredient is a legend drug.
  - d. Are Class IV controlled substances (Propoxyphene Napsylate/APAP is covered).
  - e. Are Class V controlled substances.
  - f. Are DESI Drugs: Drugs determined by the Food & Drug Administration as lacking substantial evidence of effectiveness.
  - g. Are Non-legend drugs.
  - h. Are to be taken or administered to an individual, in whole or in part, while he or she is a patient in a Hospital, rest home, sanitarium, extended care facility, convalescent Hospital, nursing home or similar institution which operates on its premises, or allows to be operated on its premises, a facility for dispensing pharmaceuticals.
  - i. Are Injectable drugs. Exceptions: Antivirals, specifically indicated for the treatment of HIV/AIDS, Insulin, and Sumatripan Succinate (e.g. Imitrex) are covered. Other drugs may be covered under the Medical Plan, after you satisfy the deductible.
  - j. Are devices of any type, even though such devices may require a Prescription. These include, but are not limited to, therapeutic devices, artificial appliances, needles, syringes (except for diabetics), braces, support garments, or any similar device.
  - k. Are immunization agents; biological sera; blood or blood plasma; or oxygen, including its administration.
  - l. Are labeled "Caution - limited by federal law to investigational use".
  - m. Are Experimental drugs and medicines, even though a charge is made to the Covered Person.
  - n. Are Contraceptives, oral or other, whether medication or device, regardless of intended use, unless Medically Necessary.
  - o. Are RU486.

- p. Are anabolic steroids.
  - q. Are for treatment of attention deficit disorder for individuals 23 years of age or older.
  - r. Are anorectics (any drug used for the purpose of weight loss).
  - s. Are cosmetic dermatologicals, including but not limited to, Lac-Hydrin, anti-wrinkle agents (e.g. Renova), and hair growth stimulants.
  - t. Are mineral and nutrient supplements.
  - u. Are vitamins, singly or in combination, with the exception of legend prenatal vitamins.
  - v. Are growth hormones.
  - w. Are fluoride supplements.
  - x. Are hematinics.
  - y. Are infertility medications.
  - z. Are pigmenting/depigmenting agents.
- 
- aa. Are smoking deterrent medications containing nicotine or any other smoking cessation aids in all dosage forms.
  - bb. Are treatments for erectile dysfunction, including but not limited to, Viagra.
  - cc. Are interferon.
  - dd. Are levonorgestrel (Norplant).

## CLAIMS PROCEDURES

### HOW TO FILE YOUR CLAIMS OR OBTAIN PRE-CERTIFICATION WHEN REQUIRED

Certain rules and regulations have been established by the Trustees which must be followed by you when you or a Covered Dependent incurs a Covered service, or when you expect to incur a Covered service which requires pre-certification. These rules and procedures are explained below. You are encouraged to become familiar with them before you or a Covered Dependent incurs a service which you anticipate will be Covered by the Plan.

#### Pre-Certification Required for Certain Claims - Your Responsibilities

Under some circumstances it is necessary for you to obtain approval for Coverage of a service in advance of the treatment being provided and the charge being incurred. This type of approval is generally required in three different instances, as follows:

1. **Pre-Certification** - As explained in the Schedule of Benefits, the Plan requires that all inpatient Hospital admissions be certified in advance regardless of whether or not the Hospital is an In-Network facility. A Utilization Management firm has been selected to provide this service. Failure to secure pre-certification of an inpatient Hospital admission will result in a **\$500 reduction** in the Benefits paid for each admission. You may contact the Utilization Management firm 24 hours a day, seven days a week, including all holidays, by calling the telephone number which is listed on the back of your medical ID card to review all requests.

**Non-emergency Hospital admissions must be certified at least 24 hours in advance of the admission. Emergency admissions must be certified within 48 hours after the admission begins.**

- a. Pre-certification gives the Hospital and your Physician the opportunity to not only review the need for your Hospitalization, but to review your continuing stay requirements as well. As part of that process, your Physician and the Utilization Management firm will review and discuss the Medical Necessity and appropriateness of treatment as long as you or your Covered Dependent remain Hospitalized.
  - b. Coverage will not be provided under the Plan for Hospital admissions which begin on Friday, Saturday or Sunday unless the confinement is for a Medical Emergency or surgery is performed within 24 hours of admission.
2. **Necessary Treatment Approval** - As explained in this booklet, a charge must be for Medically Necessary treatment to be Covered by the Plan. Not all treatment which is Medically Necessary is Covered by your Benefits. However, any service which is otherwise covered by your Benefits must be determined by your Plan to be Medically Necessary. In some circumstances the opinion of an independent professional organization will be required. If you believe it is necessary or helpful for you to obtain a decision in advance as to whether expected treatment is Medically Necessary, you should call for assistance to determine whether proposed treatment is Medically Necessary. The Utilization Management firm is available to review the appropriateness of a person's care. In addition to determination of Necessity of Treatment and Pre-Certification, the Utilization Management firm also offers pre-procedure review, continued stay review, discharge planning and obstetrical review.
  3. **Compliance with Plan Provisions, Exclusions and Limitations** - In an effort to help control the cost of providing Benefits under the Plan and limiting Coverage to benefits for treatment of a medical nature, various Plan provisions, exclusions and limitations have been adopted and are included in the Plan. These are very specific and are fully described in this booklet. Sometimes, however, questions arise as to whether a particular provision, exclusion or limitation applies to a specific condition or treatment.

#### The Plan's Responsibilities to Respond to Your Requests for Pre-Certification

You have the right under the Plan to request pre-certification of all treatment which may be Covered by the Plan. As explained in the preceding sections; pre-certification is sometimes required. Other times, the proposed treatment may be of a non-routine nature and you would like assurances that related expenses will be Covered by the Plan or you may simply prefer to secure pre-certification.

**THE ADMINISTRATOR'S STAFF OR, IF APPLICABLE, THE UTILIZATION MANAGEMENT FIRM WILL RESPOND TO ALL SUCH REQUESTS IN A TIMELY MANNER, AS FOLLOWS:**

### **Timeframes for Decisions**

**Urgent Care Treatment**- If proposed treatment is determined to be **urgent** in nature, as defined below, a decision on your request for pre-certification will be made and communicated to you **within 72 hours of receipt of your request**. If it is determined that additional information is necessary to make a decision on your claim, you will be notified as soon as possible, but **in no instance more than 24 hours** after receipt of your request. You will then be given **not less than 48 hours** to provide the required information. If you seek review of an Urgent Care Treatment decision, you will be notified of the decision as soon as possible but no later than 72 hours after the Administrator receives the request for the review of the decision.

An **Urgent Care Treatment** is a treatment which, if treated as a treatment for non-urgent care:

- a. Could seriously jeopardize the life or health of the patient or the ability of the claimant to regain maximum function; or
- b. In the opinion of a Physician with knowledge of the patient's medical condition, would subject the patient to severe pain that cannot be adequately managed without the care or treatment.

**Non-Urgent Care Treatment** - If proposed treatment is determined to be of a **non-urgent** nature, a decision on your request for pre-certification will be made and communicated to you within a reasonable time "appropriate to the medical circumstances" but no later than **within 15 days** of receipt of your request. If it is determined that additional information is necessary to make a decision on your request, the Plan may require up to an additional **15 days** to make a decision. If such an extension is required, you will be notified **within 15 days** of receipt of your request regarding the extension and a decision will be made as soon as possible. If the extension is required because it is necessary for you to provide additional information, you will be given **at least 45 days** to provide the requested information. If you seek review of a Non Urgent Care Treatment decision, and the Plan calls for a single review, then you will be provided notice of the review decision within a reasonable time, but no later than within 30 days after the Administrator receives the request for review of the decision. If the Plan calls for two reviews, then the first one will be completed within 15 days. The second review will be completed within 15 days following the first review. The total time elapsed between receipt by the Administrator of your request for a review of the decision and the completion of the second review will be no more than 30 days.

These procedures for processing requests for pre-certification of both urgent and non-urgent care treatment have been adopted solely as guidelines and to assure compliance with applicable federal law. It will continue to be the practice and intent of the Trustees, as the Plan Administrator, and the Utilization Management firm to timely process all requests for pre-certification review and to respond to all such requests immediately where possible, but always within the time periods prescribed above.

### **Filing Bills Is Your Responsibility**

If you are a Covered Employee or Dependent and incur a health care service, your bill must be filed directly with the Administrator's office. The procedures you must follow to file a bill and the guidelines by which the Administrator will process your bill are explained below.

### **How to File Your Bill**

When you or a Covered Dependent incur charges for which a bill will be filed with the Plan, you must contact the Administrator. If you are eligible for Benefits, either you or the provider of care must submit the bill.

You or the provider of care can file a bill by sending the original bill for the services received to the Administrator. Keep a copy for your own records. **ALL BILLS MUST SHOW:**

- Name of Plan
- Group number of Plan
- Your name
- Name of patient
- Name, address, telephone number of the Provider of care
- Diagnosis
- Type of services rendered, with diagnosis and/or procedure codes
- Date of services
- Charges

**Send the bill for services to the Plan Administrator at this address:**

Consociate Group  
 P.O. Box 1068  
 Decatur, Illinois 62525-1068  
 (217) 423-7788 or (888) 242-4357  
 fax: (217) 423-4575

The Plan Administrator will determine if enough information has been submitted to enable proper consideration of the bill. If not, more information may be requested.

If you or the provider of care fails to include **all** requested information, the bill will be returned as soon as a determination has been made that requested information is missing, but in **no event more than 30 days** after the bill was initially received.

It is also your responsibility to provide the attending Physician/surgeon, the Hospital and any other medical service Providers with information about your Coverage with the Plan and about their responsibility to file all bills directly with Administrator. The information they will require for this purpose is provided on the reverse side of the identification card which has been provided to you. Photocopies of medical bills will not be accepted except when this Plan provides only secondary Coverage.

**Payment of Bills by Administrator**

All bills received by the Administrator will be processed for payment as soon as possible after their receipt. **However, no bill can be processed until information necessary to determine if it is Covered by the Plan has been received by the Administrator.** This may include the annual Member Statement. Sometimes bills must also be received from more than one medical service Provider before any bill can be paid. For example, it may be necessary to receive a bill from the attending Physician before a Hospital bill is paid so one or more diagnoses can be confirmed, or so other information necessary to pay the bill can be obtained.

Once the information required to make a determination as to whether a bill is payable has been received, a decision will be promptly made by the Administrator staff and you will be notified regarding any payment made. However, in no event will the decision regarding payment be made **more than 30 days after the bill** has been fully and properly filed.

**Time Limit for Filing Bills and Responding to Requests**

No bill for reimbursement of medical expenses filed with the Administrator more than one year after the date the expense was incurred will be paid by the Plan. As explained above, no bill will be considered properly filed until information necessary to determine Coverage has been provided to the Administrator. If a bill is received **within the last 45 days** of the one year filing period, and additional information is necessary to determine Coverage, the filing deadline will be automatically **extended for 45 days** beyond the one year filing period. Bills filed later than that date may be declined or reduced **unless** the person is not legally capable of submitting the bill on a timely basis.

**Assignment of Benefits**

When you incur expenses for which Benefits are to be paid by the Plan, the medical service Provider (Hospital, Physician, etc.) may require you to complete an assignment of benefits form. When benefits are assigned, it is the Plan's practice to pay benefits directly to the service Provider. In those instances

you will be notified about the payment.

**You Must Notify the Administrator About Changes**

It is a very important requirement of the Plan that you immediately notify the Administrator whenever you:

1. Change your home address;
2. Wish to change your beneficiary;
3. Receive workers' compensation benefits;
4. Return to work after a disability ceases;
5. Get married or divorced;
6. Gain a Dependent or your Dependent is no longer eligible as a Dependent.
7. Have a Dependent covered under other health benefits as an employee.
8. Have a Dependent Child(ren) covered under a Spouse's health benefits.

## APPEALS PROCEDURE IF YOUR BILL IS DENIED

### Adverse Benefit Determination

An adverse benefit determination is:

- A denial
- Reduction or termination of a Benefit
- Failure to make payment for a Benefit

The Plan Administrator will notify you, in writing, if payment of your bill is subject to an Adverse Benefit Determination in whole or in part and explain the reasons why, with reference to the Plan provisions in which the Adverse Benefit Determination was based.

If your bill for Benefits payment is subject to an Adverse Benefit Determination, you may appeal the determination. This appeal provision allows you to:

- Request from the Plan Administrator a review of the eligibility status for any bill subject to an Adverse Benefit Determination.
- Request from the Provider of Benefits a review of any bill payment. Such request must include: your name, your Social Security number, the name of the patient and the Group Identification Number, if any.
- File the request for review in writing, stating in clear and concise terms the reason or reasons for this disagreement with the handling of the bill.

The request for review must be directed to the Plan Administrator within 60 days after the bill payment date or the date of the notification of an Adverse Benefit Determination.

A review of the Adverse Benefit Determination will be made by the Trustees and the Plan Administrator will provide you a written response within a reasonable time, but not later than 60 days following the date the Plan Administrator receives your written request for review. If, because of extenuating circumstances, the Trustees are unable to complete the review process within 60 days, the Plan Administrator will notify you of the delay within the 60 day period and will provide a final written response to the request for review within 120 days of the date the Plan Administrator received your written request for review.

The Plan Administrator's written response of the Trustee's decision will, if the Adverse Benefit Determination is upheld, include specific reasons for the decision, written in a manner calculated to be understood by you as well as cite the specific Plan provision(s) upon which the Adverse Benefit Determination is based.

### Bill Submissions

A patient or an "authorized representative" of a patient can submit bills. The Plan can establish reasonable procedures to determine whether a representative has been authorized. The Plan must recognize a health care professional with knowledge of a patient's medical condition as the patient's authorized representative in the case of an Urgent Care Treatment Bill.

## TRUSTEE AUTHORITY

Subject to the stated purposes of the Fund and the provisions of this Agreement, the Trustees shall have full and exclusive authority to determine all questions of Coverage and Eligibility, methods of providing or arranging for Benefits and all other related matters. They shall have full power to construe the provisions of this Agreement, the terms used herein and the by-laws and regulations issued thereunder. Any such determination and any such construction adopted by the Trustees in good faith shall be binding upon all of the parties hereto and the Beneficiaries hereof.

It is the intent of the drafters of this Plan document that the Trustees possess the discretion to determine Eligibility for Benefits and to construe the terms of the Trust and/or plan governing Benefits. It is also the intent of the drafters of this Trust, by adopting the discretionary power specified above, the decisions of the Trustees as to the granting or denial of Benefits and the construing of terms of the Trust and benefit Plan, are reviewed pursuant to an "arbitrary and capricious" standard by a reviewing court, as enunciated by the United States Supreme Court in *Firestone Tire and Rubber Company et al. v. Richard Brucha* 57 LW 4194 (February 21, 1989).

Retiree Benefits have been made available by the Trustees as a privilege, not a right. No person acquires a vested right to such Benefits either before or after his or her retirement. The Trustees may expand, reduce or cancel Coverage for Retirees; change eligibility requirements or the amount of contributions; and otherwise exercise their prudent discretion at any time without legal right or recourse by a Retiree or any other person.

## COORDINATION OF BENEFITS

### COORDINATION OF THE BENEFIT PLANS

Coordination of benefits sets out rules for the order of payment when two or more plans -- including Medicare -- are paying. When you are covered by this Plan and another plan, or your Spouse is covered by this Plan and by another plan or your children are covered under two or more plans, the plans will coordinate benefits when a claim is received.

The plan that pays first according to the rules will pay as if there were no other plan involved. The secondary and subsequent plans will pay the balance up to each one's plan formula. The total reimbursement will never be more than the secondary (or subsequent) plan's formula -- 50% or 80% or 100% -- whatever it may be. The balance due, if any, is your responsibility.

*Example:* John's wife, Sally, is covered by her Employer's plan and the AGC \$250 Plan. Sally's Employer plan is primary. Sally had some minor surgery for which she used Network Providers. The total cost was \$1,100. Sally's Employer plan paid \$600.

Medical Cost:	\$1,100
Sally's Plan Paid:	<u>\$ 600</u>
Remaining Balance:	\$ 500

FROM AGC PLAN:

Sally's Deductible:	\$ 250
AGC Plan Pays:	\$ 225 (90% of remainder or \$500 - \$250)
Sally's Coinsurance	\$ 25

Sally's employer's plan paid \$600, Sally paid \$275 and the AGC Plan paid \$225.

### BENEFIT PLAN

This provision will coordinate the medical benefits of a benefit plan. The term benefit plan means this Plan or any one of the following plans:

- Group or group-type plans, including franchise or blanket benefit plans.
- Blue Cross and Blue Shield group plans.
- Group practice and other group prepayment plans.
- Federal government plans or programs. This includes Medicare.
- Other plans required or provided by law. This does not include Medicaid or any benefit plan like it that, by its terms, does not allow coordination.
- No Fault Auto Insurance, by whatever name it is called, when not prohibited by law.

### ALLOWABLE CHARGE

For a charge to be allowable it must be a Usual and Reasonable Charge and at least part of it must be covered under this Plan.

In the case of HMO (Health Maintenance Organization) plans: This Plan will not consider any charges in excess of what an HMO Provider has agreed to accept as payment in full. Also, when an HMO pays its benefits first, this Plan will not consider as an allowable charge any charge that would have been covered by the HMO had the Covered Person used the services of an HMO Provider.

In the case of service type plans where services are provided as benefits, the reasonable cash value of each service will be the allowable charge.

### AUTOMOBILE LIMITATIONS

When medical payments are available under vehicle insurance, the Plan will pay excess benefits only. This Plan will always be the secondary carrier regardless of the individual's election under PIP (personal Injury protection) coverage with the auto carrier.

## BENEFIT PLAN PAYMENT ORDER

When two or more plans provide benefits for the same allowable charge, benefit payment will follow these rules.

- Plans that do not have a coordination provision, or one like it, will pay first. Plans with a coordination provision will be considered next.
- Plans with a coordination provision will pay their benefits by these rules up to the allowable charge:
  - The benefits of the plan which covers the person as an Employee, member or subscriber (that is, other than as a Dependent) are determined before those of the plan which covers the person as a Dependent; except that: if the person is also a Medicare beneficiary, and as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is:
    - i. Secondary to the plan covering the person as a Dependent, and
    - ii. Primary to the plan covering the person as other than a Dependent (e.g. a retired Employee),

Then the benefits of the plan covering the person as a Dependent are determined before those of the plan covering that person as other than a Dependent.

- The benefits of a benefit plan which covers a person as an Employee who is neither laid off nor retired are determined before those of a benefit plan that covers that person as a laid-off or Retired Employee. The benefits of a benefit plan which covers a person as a Dependent of an Employee who is neither laid off nor retired are determined before those of a benefit plan which covers a person as a Dependent of a laid off or Retired Employee. If the other benefit plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.
- The benefits of a benefit plan which covers a person as an Employee who is neither laid off nor retired or a Dependent of an Employee who is neither laid off nor retired are determined before those of a plan which covers the person as a COBRA beneficiary.
- When a child is covered as a Dependent and the parents are not separated or divorced, these rules will apply:
  - vi. The benefits of the benefit plan of the parent whose birthday falls earlier in a year are determined before those of the benefit plan of the parent whose birthday falls later in that year;
  - vii. If both parents have the same birthday, the benefits of the benefit plan that has covered the patient for the longer time are determined before those of the benefit plan that covers the other parent.
- When a child's parents are divorced or legally separated, these rules will apply:
  - i. This rule applies when the parent with custody of the child has not remarried. The benefit plan of the parent with custody will be considered before the benefit plan of the parent without custody.
  - ii. This rule applies when the parent with custody of the child has remarried. The benefit plan of the parent with custody will be considered first. The benefit plan of the stepparent that covers the child as a Dependent will be considered next. The benefit plan of the parent without custody will be considered last.
  - iii. This rule will be in place of items (i) and (ii) above when it applies. A court decree may state which parent is financially responsible for medical and dental benefits of the child. In this case, the benefit plan of that parent will be considered before other plans that cover the child as a Dependent.
  - iv. If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the

child, the plans covering the child shall follow the order of benefit determination rules outlined above when a child is covered as a Dependent and the parents are not separated or divorced.

If there is still a conflict after these rules have been applied, the benefit plan which has covered the patient for the longer time will be considered first.

- Medicare will pay primary, secondary or last to the extent stated in federal law. When Medicare is to be the primary payer, this Plan will base its payment upon benefits that would have been paid by Medicare under Parts A and B, regardless of whether or not the person was enrolled under both of these parts.

## **EMPLOYERS WITH FEWER THAN 20 EMPLOYEES**

The Medicare Secondary Payer (MSP) law has a special provision for Employers with fewer than 20 Employees. Active Employees of such Employers who are eligible for Medicare may continue their Employer's health Plan coverage but identify that Medicare is the primary payer. Three months prior to your 65th birthday, you should contact the Plan Administrator and the nearest Social Security Office to determine the appropriate procedures.

## **CLAIMS DETERMINATION PERIOD**

Benefits will be coordinated on a Calendar Year basis. This is called the claims determination period.

## **RIGHT TO RECEIVE OR RELEASE NECESSARY INFORMATION**

To make this provision work, this Plan may give or obtain needed information from another insurer or any other organization or person. This information may be given or obtained without the consent of or notice to any other person. A Covered Person will give this Plan the information it asks for about other plans and their payment of allowable charges.

## **FACILITY OF PAYMENT**

This Plan may repay other plans for benefits paid that the Plan Administrator determines it should have paid. That repayment will count as a valid payment under this Plan.

## **RIGHT OF RECOVERY**

This Plan may pay benefits that should be paid by another benefit plan. In this case this Plan may recover the amount paid from the other benefit plan or the Covered Person. That repayment will count as a valid payment under the other benefit plan.

Further, this Plan may pay benefits that are later found to be greater than the allowable charge. In this case, this Plan may recover the amount of the overpayment from the source to which it was paid.

## **THIRD PARTY RECOVERY PROVISION RIGHT OF SUBROGATION AND REFUND**

### **WHEN THIS PROVISION APPLIES**

You or your Dependent may incur medical or dental charges due to injuries that may be caused by the act or omission of a third party. In such circumstances, you may have a claim against that third party, or insurer, for payment of the medical or dental charges. Accepting benefits under this Plan for those incurred medical or dental expenses automatically assigns to the Plan any rights you may have to recover payments from any third party or insurer. This subrogation right allows the Plan to pursue any claim that you have against any third party, or insurer, whether or not you choose to pursue that claim. The Plan may make a claim directly against the third party or insurer, but in any event, the Plan has an equitable lien on any amount you recover whether or not designated as payment for medical expenses. This equitable lien will remain in effect until the Plan is repaid in full.

You or your Dependent must:

- assign to the Plan your rights against any third party or insurer when this provision applies; and
- repay to the Plan the benefits paid on your behalf out of any recovery made from the third party or insurer.

### **AMOUNT SUBJECT TO SUBROGATION OR REFUND**

You agree to recognize the Plan's right to subrogation and reimbursement. These rights provide the Plan with a priority over *any* funds paid by a third party to you relative to the Injury or Sickness, including a priority over any claim for non-medical or dental charges, attorney fees, or other costs and expenses. Notwithstanding its priority to funds, the Plan's subrogation and refund rights, as well as the rights assigned to it, are limited to the extent to which the Plan has made, or will make, payments for medical or dental charges as well as any costs and fees associated with the enforcement of its rights under the Plan.

If you or your dependent bring a liability claim against a third party, benefits payable under the Fund must be included in the claim. When the claim is resolved, you or your attorney (if your attorney is holding the monetary recovery) must hold any monetary recovery in constructive trust and promptly reimburse the Fund for the benefits provided, up to the amount of monetary recovery. You and your attorney (if your attorney is holding the monetary recovery) shall be fiduciaries with respect to the monetary recovery. The Fund shall have an equitable lien upon, and will have first priority in, any recovery regardless of whether you have been "made whole" by the settlement. The Fund's reimbursement will not be reduced by attorney's fees, absent consent of the Board of Trustees.

When a right of recovery exists, you must execute and deliver all required instruments and papers as well as doing whatever else is needed to secure the Plan's right of subrogation as a condition to having the Plan make payments. In addition, you can do nothing to prejudice the right of the Plan to subrogate.

### **DEFINED TERMS**

"Recovery" means monies paid to you and your Dependent by way of judgment, settlement, or otherwise to compensate for all losses caused by the Injuries or Sickness whether or not said losses reflect medical or dental charges covered by the Plan.

"Subrogation" means the Plan's right to pursue you or your Dependent's claims for medical or dental charges against the other person.

"Refund" means repayment to the Plan for medical or dental benefits that it has paid toward care and treatment of the Injury or Sickness.

### **ASSIGNMENT OF RIGHTS**

As a condition to the Plan making payments for any medical or dental charges, the Covered Person must

assign to the Plan his or her rights to any recovery arising out of or related to any act or omission that caused or contributed to the Injury or Sickness for which such benefits are to be paid. The scope of this assignment is consistent with the amount subject to subrogation or refund set forth above.

**Note: The Plan's right of full recovery, either by way of subrogation or right of reimbursement, may be from funds you or your Dependent or guardian receives or is entitled to receive from the third party, any liability or other insurance covering the third party, the Covered Person's own uninsured motorist insurance, underinsured motorist insurance, any medical payments, no-fault or school insurance coverage which are paid or payable.**

The fund shall be entitled to recover in accordance with these rules, even if you do not sign or return its forms. Your failure to cooperate may result in you and your dependents' disqualification from receipt of future benefits from the Fund. The Fund may offset any future benefits otherwise payable to you or your dependents.

## OTHER INFORMATION

### CLERICAL ERROR

Any clerical error by the Plan Administrator or an agent of the Plan Administrator in keeping pertinent records or a delay in making any changes will not invalidate Coverage otherwise validly in force or continue Coverage validly terminated.

### AMENDING AND TERMINATING THE PLAN

Nothing in this statement is meant to interpret or extend or change in any way the provisions expressed in the Plan. If the Plan is terminated, the rights of the Plan Participants are limited to expenses incurred before termination. The Trustees of the AGC Group Health Benefit Fund intend to maintain this Plan indefinitely; however, they reserve the right, at any time, to amend, suspend or terminate the Plan in whole or in part. This includes amending the Benefits under the Plan. The Trustees of the AGC Group Health Benefit Fund are vested with the authority to amend, suspend or terminate the Plan in whole or in part.

### MISTAKE IN PREMIUM PAYMENT

Where there has been a mistake in payment of premium by way of overpayment, the Trustees may upon good cause shown, refund overpayments for a period not to exceed 1 year from the date the Trustees or administrator became aware of the overpayment.

### CERTAIN EMPLOYEE RIGHTS UNDER ERISA

As a Participant in this Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA specifies that all Plan Participants shall be entitled to:

- Examine, without charge, at the Plan Administrator's office, all Plan documents and copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports and Plan descriptions.
- Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required, by law, to furnish each Participant with a copy of this summary annual report.

In addition to creating rights for Plan Participants, ERISA imposes obligations upon the people who are responsible for the operation of the Plan. The people who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan Participants and their beneficiaries. No one, including your Employer or any other person, may fire you or otherwise discriminate against you in any way so as to prevent you from obtaining benefits under the Plan or from exercising your rights under ERISA.

Under ERISA there are steps that you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in federal court. In such a case, the court may require the Plan Administrator to provide the materials and to pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in state or federal court.

If you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or 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 the claim or suit to be frivolous.

If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or your rights under ERISA, you should contact the nearest Area Office of the Pension and Welfare Benefits Administration, U. S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

**Be informed that:**

Under the Health Insurance Portability and Accountability Act (HIPAA), the Plan must provide you with a "Certificate of Creditable Coverage" if you lose health care coverage under the Plan for any reason. This Certificate reports data on prior period of health coverage under the Plan compiled in accordance with federal regulations. Participants should retain this "Certificate of Creditable Coverage" and submit it to a new Employer if the new Employer maintains a group health care Plan. The new Employer may be required under federal law to credit such coverage toward any waiting period for coverage of Pre-existing Conditions under the Employer's plan.

You should be provided a certificate of Creditable Coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of Creditable Coverage, you may be subject to a Pre-existing Condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

The Plan is in compliance with the non-discrimination requirements set forth in Section 2590.701-2 of the DOL's HIPAA regulations. These regulations state that a group health care plan may NOT establish eligibility rules based on any of the following factors: (1) health status; (2) medical condition (including both physical and mental illness); (3) prior claims experience; (4) actual receipt of health care; (5) medical history; (6) genetic information; (7) evidence of insurability (including conditions arising out of domestic violence); or, (8) disability.

Under the Newborns' and Mothers' Health Protection Act, group health plans and health insurance issuers offering group health insurance coverage generally may NOT restrict benefits for any Hospital stay in connection with childbirth for the mother or newborn child to less than 48 hours following vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the Plan, or issuer, may pay for a shorter stay if the attending Provider (e.g., your Physician, nurse midwife, or Physician assistant), after consultation with the mother, discharges the mother or newborn earlier. Under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48 hour or 96 hour stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay. In addition, a plan or issuer may not, under federal law, require that a Physician or other health care Provider obtain authorization for prescribing a length of stay of up to 48 hours or 96 hours, as applicable. However, to use certain Providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain pre-certification. For information on pre-certification, contact your Plan Administrator.

Under the Women's Health and Cancer Rights Act, group health plans and health insurance issuers offering group health insurance coverage that includes medical and surgical benefits with respect to mastectomies shall include medical and surgical benefits for breast reconstructive surgery as part of a mastectomy procedure. Breast reconstructive surgery benefits in connection with a mastectomy shall at a minimum provide coverage for: (1) reconstruction of the breast on which the mastectomy has been performed; (2) surgery and reconstruction of the other breast to produce a symmetrical appearance; (3) prostheses; and, (4) physical complications for all stages of mastectomy, including lymphedemas. Such surgery shall be in a manner determined in consultation with the attending Physician and the patient. As part of the Plan's Schedule of Benefits, such benefits are subject to the Plan's appropriate cost control provisions, such as deductibles and coinsurance.

You may continue health care coverage for yourself, Spouse, or Dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event. You or your Dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

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## GENERAL PLAN INFORMATION

### TYPE OF ADMINISTRATION

Associated General Contractors Group Health Benefit Fund is fully liable for all medical and dental Benefits under the Plan. An insurance company insures the life insurance and accident and sickness benefits. Consociate Group administers payment of claims, but does not insure or otherwise guarantee any of the Benefits under the Plan.

### PLAN NAME

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### PLAN NUMBER

501

### TAX ID NUMBER

37-0343360

### PLAN EFFECTIVE DATE

June 1, 1998

### PLAN YEAR ENDS

December 31<sup>st</sup>

### PLAN ADMINISTRATOR

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