



MIDDLETOWN WORKS
HOURLY & SALARIED UNION
RETIREES HEALTH CARE FUND

Summary Plan Description
Revised January 1, 2025





Middletown Works Hourly & Salaried
Union Retirees Health Care Fund
1201 Crawford Street • Middletown, OH 45044
PH: (513) 217-4818 • TOLL FREE: (877) 392-9991 • Fax: (513) 672-9622
Website: www.middletownworkshcf.com

MIDDLETOWN WORKS HOURLY AND SALARIED UNION RETIREES HEALTH CARE FUND

SUMMARY OF MATERIAL MODIFICATIONS

November 21, 2025

Dear Participant:

We are pleased to inform you of the following benefit improvements:

Improvement to the Vision Benefit

Effective October 1, 2025, there will no longer be a copay for anti-reflective coating. In addition, retinal imaging will now be a covered benefit.

Health Reimbursement Account (HRA) Funding Amount

For the Plan Year beginning January 1, 2026, the HRA benefit (**provided through the Wex card**) will increase from \$750 to \$1,250 for each single retiree (or Surviving Spouse) and from \$1,500 to \$2,500 for each family. Remember that the full amount provided will be available at the beginning of the year and any amounts that are not used in that year will carry forward to future years.

No Place Like Home Benefit

- ***Frequency of the Home Assessment Benefit.*** The frequency of the Home Assessment Benefit is adjusted to read: Generally, the Home Assessment Benefit is limited to one home assessment over a 48-month period. However, if within 48 months of a Participant's home assessment, the Participant incurs a serious impairment of bodily function, the Participant will be eligible for another Home Assessment Benefit within 48 months of the Participant's prior home assessment.
- ***Increase to the Home Modification Benefit's Lifetime Maximum.***

Effective October 24, 2025, the Home Modification Benefit's lifetime maximum is increased from \$750 to \$1,250:

- The Plan reimburses you the lesser of (1) your out-of-pocket costs or (2) \$1,250 for preapproved safety, fall prevention, and accessibility modifications to the Participant's home. Should two or more Participants reside in the same home (e.g., retiree and spouse), and should each Participant be preapproved for safety, fall prevention, or accessibility modifications to the home the Participants' share, then the Plan will reimburse each Participant the lesser of (1) that Participant's out-of-pocket costs or (2) \$1,250.

Please note that a Participant's properly documented out-of-pocket costs for authorized home modifications incurred prior to October 24, 2025 that are included with a Home Modification Claim Form submitted to the Fund Administrator on or after October 24, 2025 will be reimbursed in accordance with the Home Modification Benefit's new \$1,250 lifetime maximum.



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- The Home Modification Benefit is intended to be a lifetime maximum benefit. However, the Board of Trustees will consider a one-time waiver of the lifetime maximum upon a Participant's written request if the Participant establishes that: (1) he or she must move to a new home that requires safety, fall prevention, and/or accessibility modifications. No such request will be considered earlier than 48 months after the Participant's exhaustion of the initial Home Modification Benefit.

New Benefit for Acupuncture

Effective January 1, 2026, the Plan covers acupuncture when medically necessary for the treatment of pain and as an alternative to anesthesia. Acupuncture must be provided by a Physician, nurse practitioner licensed in acupuncture, or acupuncture providers certified by the National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM). The Plan's acupuncture benefit generally consists of 20 visits per calendar year; visits in excess of 20 in a calendar year require prior authorization from the Fund Administrative Office. The Plan will pay up to the Usual and Customary Charge for each covered visit.

New Surviving Spouse Eligibility Rule

Effective September 1, 2025, the language from the Summary Plan Description, page 8, is changed to the following:

- If a New Spouse is at least 57 years old as of the date of the retiree's death, the New Spouse will be eligible for all benefits of this Plan for the remainder of the New Spouse's lifetime
- If a New Spouse is less than 57 years old as of the date of the retiree's death, the New Spouse will be eligible for all benefits of this Plan for an additional two years from the date of the retiree's death. However, if at the end of that two year period, the New Spouse has attained the age of 57, the New Spouse's benefits will continue for the remainder of the New Spouse's lifetime
- The New Spouse benefit described above requires that a New Spouse be married to the retiree for a minimum of two years before the retiree's death in order to qualify for the benefit.

**Sincerely,
Board of Trustees**

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This information only highlights certain features of the Middletown Works Hourly and Salaried Union Retirees Health Care Fund. Full details are contained in the documents that establish the Plan provisions. If there is a discrepancy between the wording here and the documents that establish the Plan, the document language will govern. The Trustees reserve the right and have the authority to amend, modify, or eliminate benefits at any time, or terminate the Plan when financial conditions dictate. In addition, the Trustees, or such other persons as delegated by the Trustees, have the discretion to interpret and construe the Plan's provisions.



Middletown Works Hourly & Salaried

Union Retirees Health Care Fund

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July 17, 2025

**MIDDLETOWN WORKS HOURLY AND SALARIED UNION
RETIREES HEALTH CARE FUND
SUMMARY OF MATERIAL MODIFICATIONS**

Dear Participant:

We are pleased to provide you with information on the following benefit enhancements:

- **Increase to the vision frame allowance, effective July 1, 2025:** The vision frame allowance will increase from \$250 to \$290. In addition, if you use a provider in the EyeMed PLUS network, the frame allowance will increase from \$300 to \$340.
- **Reduction in Copayments for generic prescription medications, effective July 1, 2025:** The Copayment for all generic medications will be \$0. This applies to all plan participants both at retail pharmacies and for medications provided through mail order.
- **Reduction in Copayments for brand name prescription medications, effective January 1, 2026:** The Copayment for brand name medications will change as follows:
 - 30-Day supply:
 - Preferred brand: from \$15 to \$5
 - Non-Preferred brand: from \$24 to \$20
 - 90-Day supply:
 - Preferred brand: from \$30 to \$10
 - Non-Preferred brand: from \$48 to \$40
- **Increase to the dental annual maximum, effective January 1, 2026:** The annual maximum for the dental plan will increase from \$4,000 per person per plan year to \$6,000.
- **New benefit for orthodontia services, effective January 1, 2026:** In addition to the current dental benefits, a new benefit is available for those participants who need orthodontia (e.g., braces). The new benefit will provide 100% coverage, up to a lifetime benefit of \$4,000 per person. This includes coverage of devices such as Invisalign.

Please keep this notice along with your Summary Plan Description (SPD) book. If you do not have your SPD, contact the Fund office to have one sent to you or stop by at your convenience.

To request a copy of this document, you may email the Fund office: mwrmemberservices@wpas-inc.com.

To access an electronic copy of the Summary Plan Document: <https://www.middletownworkshcf.com/>

**Sincerely,
Board of Trustees**

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Enclosures

This information only highlights certain features of the Middletown Works Hourly and Salaried Union Retirees Health Care Fund. Full details are contained in the documents that establish the Plan provisions. If there is a discrepancy between the wording here and the documents that establish the Plan, the document language will govern. The Trustees reserve the right and have the authority to amend, modify, or eliminate benefits at any time, or terminate the Plan when financial conditions dictate. In addition, the Trustees, or such other persons as delegated by the Trustees, have the discretion to interpret and construe the Plan's provisions.

Middletown Works Hourly and Salaried Union Retirees Health Care Fund

1201 Crawford St.
Middletown, OH
45044
1-877-392-9991

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Fund Administrative Office

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Revised Effective January 1, 2025

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Introduction

Introduction

The Middletown Works Hourly and Salaried Union Retirees Health Care Fund (Middletown Works Retirees Fund or Plan, for short) provides medical, prescription drug, dental, vision, and life insurance benefits. This Summary Plan Description (SPD), which also serves as the Plan Document, describes the benefits available to eligible Retired Employees and Dependents as of January 1, 2025.

In this booklet, benefits are described as completely as possible and in everyday language. In addition, the booklet is organized in a way that will be useful to you. This booklet includes:

- Information about the Plan's eligibility requirements for you and your Dependents;
- A life events section designed to show you how your benefits work and how they fit into the different stages of your life;
- An explanation of your medical and prescription drug coverage under the Pre-Medicare benefit program;
- An explanation of your medical and prescription drug coverage under the Medicare-eligible benefit program;
- An explanation of the dental and vision benefits;
- An explanation of the No Place Like Home and the Health Reimbursement Arrangement (HRA) benefits;
- The life insurance benefit for both Pre-Medicare and Medicare eligible retirees, their eligible spouses and Surviving Spouses;
- Information about how to file claims and appeals and how benefits are paid;
- General administrative information; and
- A glossary of important terms.

In addition, included with this booklet are:

- *Summary of Benefits*, which summarize the benefits available under the Plan; and
- *Important Contact Information*, which provides additional information you may need.

This booklet is designed to help you understand the benefits available to you. Please read this booklet and share it with your family. You should keep this booklet with your important papers so you can refer to it when needed.

If you have any questions about the information contained in this Document or about your benefits in general, contact the Fund Administrative Office by:

- Calling 1-877-392-9991 or 513-217-4818; or via email at mwrmemberservices@wpas-inc.com
- Writing to or visiting their office at 1201 Crawford Street, Middletown, Ohio 45044. or via the Internet at <https://www.middletownworkshcf.com>

This booklet contains a summary in English of your rights and benefits under the Plan. If you have difficulty understanding any part of this booklet, contact the Fund Administrative Office.

This booklet has been prepared for eligible Participants of the Middletown Works Hourly and Salaried Union Retirees Health Care Fund and describes the benefits in effect as of January 1, 2025. This SPD/Plan Document replaces and supersedes any previous Summary Plan Description and/or Plan Documents. The Trustees reserve the right and have the authority to amend, modify, or eliminate benefits at any time, or terminate the Plan when financial conditions dictate. In addition, the Trustees, or such other persons as delegated by the Trustees, have the discretion to interpret and construe the Plan's provisions.

Eligibility Requirements

Initial Eligibility

Retired Employees

You are eligible for coverage as a Retired Employee if you:

No new retired employees are eligible for coverage under the Plan; only new Dependents may be added to coverage.

- Worked for AK Steel or one of its predecessors at the Middletown Works (and related facilities covered by the collective bargaining agreement for the Middletown Works) under a collective bargaining agreement covering hourly or salaried employees, negotiated between AK Steel or one of its predecessors (including Armco, Inc., Armco Steel Corporation, and Armco Steel Company, L.P.) and AEIF or the Union; and
- Retired from AK Steel between January 1, 1957 and May 31, 2007, if you were an hourly employee or retired between January 1, 1984 and May 31, 2007 if you were a salaried employee; and
- Were eligible to participate in the (1) AK Steel Hourly Retiree Hospital and Medical Benefits Plan or a predecessor plan, or the (2) AK Steel Corporation Hospital and Medical Benefits Plan (for AEIF Salaried Represented Pensioners, Surviving Spouse Benefit Recipients and Eligible Dependents) or a predecessor plan, at the time you retired and continued to be eligible to participate in one of these plans as of February 29, 2008.

Dependents

Surviving Spouses, those who met the eligibility requirements to participate in the AK Steel health plans as of May 31, 2008, will continue to be eligible to participate in this Plan, provided premiums for coverage, to the extent they are required by the Plan rules, are paid. In addition, if you are eligible as a Retired Employee under this Plan, your Surviving Spouse will generally continue to be eligible to participate in the Plan upon your death.

A Retired Employee's spouse and children are eligible for coverage if they meet the Plan's definition of Dependent, as stated on page 91.

A Surviving Spouse's children are eligible for coverage if they meet the Plan's definition of Dependent, as stated on page 91.

For more information on what you need to do to add a new Dependent, see the *Life Events* section, beginning on page 7.

A New Spouse, defined as an individual whom a Retired Employee marries on or after June 1, 2008, will be eligible to participate in this Plan until the Retired Employee's death, provided premiums for coverage, to the extent they are required by the Plan rules, are paid. Certain New Spouses will continue to be eligible to participate in this Plan after the Retired Employee's death, as described on page 8.

Continuing Eligibility

Your coverage will continue on a month-by-month basis as long as you pay the required premium by the date due, **to the extent premiums are required by the Plan rules**. The monthly premium applies to you and each member of your family that is covered under the Middletown Works Retirees Fund. However as set forth on page 4, the Plan has established, with some limited exceptions, a maximum premium for family coverage. Your participation in the Middletown Works Retirees Fund is completely voluntary, so you decide whether you want to pay the per person monthly premium to continue retiree coverage or not.

The amount of your monthly premium depends on when you retired (or if you are a Surviving Spouse, when the Retired Employee retired), whether you are an hourly or salaried retiree, and whether or not you and/or your Dependents are eligible for Medicare. If a Retired Employee is eligible for Medicare

Eligibility Requirements

and his/her spouse or other Dependents are not, different premiums will apply for each of you.

To the extent premiums are required by the Plan rules, please note that the monthly premium for children, including children deemed disabled under Medicare, is the premium charged to a Participant or Dependent that is pre-Medicare. This pre-Medicare premium rate applies to the child regardless of whether or not you and/or your spouse are charged the pre-Medicare or Medicare eligible premium. In addition, as explained below, if you add a New Child to the Plan on or after June 1, 2008, the premium amount for the New Child will be doubled.

If the retiree or spouse are Medicare eligible and receive a reimbursement for part or all of the Medicare Part B premium, the premium for the health insurance coverage will first be deducted from the Plan's Medicare Part B premium reimbursement benefit. Depending on your situation, you will either be charged for the remaining premium due (if any) or receive the balance (if any after the deduction of your monthly premium) of the Medicare Part B premium reimbursement payable to you under this Plan.

New Child Eligibility

To the extent premiums are required by the Plan, if you enroll a New Child in the Plan, you are required to pay a monthly premium for your New Child's coverage. The monthly premium is two times the highest monthly, pre-Medicare, premium rate charged to Participants and Dependents.

A "New Child" is a child who was not your child (either biological, adoptive, or through legal guardianship) before June 1, 2008. This does not include a Dependent who was your child (either biological, adopted, or through legal guardianship) on and before June 1, 2008 who is eligible to enroll in the Plan but who delays enrollment (by completing the required Retiree Opt-Out form) in the Plan until later (see page 5 for more information). The premium for a New Child is in addition to the premiums paid for you and your other eligible Dependents and does not qualify for the premium cap that is described below.

Premium Cap

Your premiums for coverage are limited to three premiums per family. However, this premium limit, or cap, does not apply to a "New Child," as described in the previous two subsections.

Automatic Monthly Retiree Premium Deductions

In order to continue your coverage, you must authorize the deduction of your monthly Middletown Works Retirees Fund premium directly from your bank account to allow these deductions when premiums are required by the Plan. This will reduce your costs by not having to mail in a check each month. Plus, payment is automatic, so you don't have to worry about late or missed payments and your coverage can continue uninterrupted.

Your Medicare Part B premium reimbursement benefit will be deposited directly into your bank account. In order to receive your Medicare Part B premium reimbursement benefit, you must authorize the deduction of your monthly Fund premiums from your bank account.

If you have not already done so, you must authorize the deductions by completing and returning an *Authorization to deduct for Payment of Fund Premiums*.

Eligibility Requirements

Opting-Out of Health Benefit Coverage

To be eligible to opt-out and resume medical and prescription drug retiree coverage later, you and/or your Dependents must be covered under another health plan, such as through your spouse's employer.

Realizing that you and/or your Dependents may have other coverage and therefore not need health benefits (consisting of medical, prescription drug, dental, vision, No Place Like Home, and HRA coverage) through the Middletown Works Retirees Fund at all times, you may suspend health benefits, and still be able to resume this coverage later. This allows you to have access to your retiree benefits when you need them (and not have to pay monthly premiums while coverage is suspended).

You may elect to opt-out and suspend health benefits for yourself and your Dependents, for yourself only, or for your Dependents only. Once you elect to opt out, you cannot re-enroll in the Plan for a minimum of six months. To be eligible to opt-out and resume this retiree coverage later, you and/or your

Dependents must be covered under another health plan such as through your or your spouse's employer.

Even if you opt out of the health benefits, you will continue to be eligible for life insurance and the Medicare Part B premium reimbursement benefits while your health benefits are suspended. No premium will be charged for the life insurance benefit.

What You Need to Do to Opt-Out

To opt-out and suspend health benefits until a later date, complete and return a *Retiree/Surviving Spouse Opt-Out* form to the Fund Administrative Office. If you elect to suspend coverage, coverage will be suspended as of the first day of the month following receipt of your completed form.

In the event you die as a Retired Employee while coverage is suspended, your life insurance beneficiary will be eligible for the life insurance benefit and your eligible Surviving Spouse and his/her Dependents will have the option to resume coverage (see the following section).

A Retired Employee may opt-out and return to the Plan up to three times; after the fourth opt-out, neither you nor your Surviving Spouse will be eligible to resume Plan coverage.

To Resume Coverage

You may resume coverage at any time after having suspended coverage for at least six months. To resume coverage for yourself and/or your eligible Dependents, you must:

- File a written application with the Fund Administrative Office within 60 days following the date the other coverage ends;
- Provide proof of continuous coverage (such as a Certificate of Creditable Coverage) from the other plan from the date coverage under this Plan was suspended (if proof of continuous health coverage is not provided, you and/or your Dependents will not be eligible for coverage); and
- Make the required monthly premium payment for coverage at the rate in effect at the time coverage resumes.

Coverage will resume as of the first day of the month after your application for coverage is approved, provided the required monthly premium is paid.

When Eligibility Ends

For Retired Employees

Your eligibility for Plan coverage will end:

- On the last day of the month for which a premium payment is made if a monthly premium is due and not received;
- On the last day of the month before the month in which you opt out of the Plan; for example, if you opt out of coverage on June 1, the last day of your eligibility is May 31;
- On the date of your death; or
- On the date the Plan ends.

For Your Dependents

Your Dependent's eligibility for coverage will end:

- On the last day of the month in which your Dependent no longer meets the Plan's definition of Dependent;
- On the last day of the month for which a premium payment is made if a monthly premium is due and not received;
- On the last day of the month before the month in which you opt out of the Plan;
- On the last day of the month in which your Dependent does not qualify for continued coverage after your death or for any other reason;
- For Surviving Spouses, on the date of the Surviving Spouse's remarriage or death;
- For New Spouses, on the date of the Retired Employee's death (but see additional information regarding continued coverage for New Spouses in the Life Events section, page 8, In the Event of Death);
- For dependent children, on the date the Retired Employee or Surviving Spouse dies;
- On the date the Plan no longer provides Dependent benefits; or
- On the date the Plan ends.

Life Events

Since different life events can affect your benefits coverage, this section describes how your coverage is affected and what you may need to do when different events occur.

Getting Married

When a Retired Employee marries, the New Spouse is eligible for all benefits of this Plan as of the date of your marriage. However, you must apply for coverage for your spouse within 30 days of the marriage and pay any required additional monthly amount for coverage. If you do not apply for coverage for your spouse within 30 days of the marriage, your spouse will not be covered under the Plan. However, if your spouse is covered under his or her employer's plan, you may elect to suspend coverage for your spouse (see page 5).

Contact the Fund Administrative Office to apply for coverage (or suspended coverage) for your New Spouse.

Adding a Child

Your biological child will be eligible for coverage on the date of birth. If you adopt a child (including having a child placed with you for adoption), he or she will be eligible for coverage on the date of placement as long as your child meets the Plan's definition of a Dependent. Stepchildren who live in your home are eligible for coverage on the date of your marriage.

However, you must apply for coverage for your child within 30 days of the date you acquire the Dependent and pay any required additional monthly amount for coverage. If you do not apply for coverage for your child within 30 days of the event, the child will not be covered under the Plan. However, if your child is covered under your spouse's employer's plan, you may elect to suspend coverage for your child (see page 5).

A Qualified Medical Child Support Order (QMCSO) could have an effect on your benefit coverage. If you are required by a QMCSO or court order, as defined by ERISA and/or applicable federal law, to enroll your child in the Plan, you are allowed to enroll your child at any time and Plan benefits will be provided in accordance with the applicable requirements of the order. The child's coverage under this provision will not extend beyond the Plan's age limits for Dependent children. Any Plan benefits will be paid, at the Plan's discretion, to the child or the child's custodial parent or legal guardian, for any expenses paid by the child, custodial parent, or legal guardian.

Please notify the Fund Administrative Office if your situation involves a QMCSO. Conversely, the Fund Administrative Office will notify you and any alternate recipients if a QMCSO is received. You or your Dependent may request a free copy of the Fund's procedures for handling these orders.

Contact the Fund Administrative Office to apply for coverage (or suspend coverage) for your child. In most circumstances you will be required to pay an additional monthly premium to add a child to the Plan (see page 4).

Getting Divorced

If a Retired Employee and his/her spouse get a divorce, the spouse (other than a spouse who is also a Retired Employee) will no longer be eligible for coverage and you must immediately notify the Fund Administrative Office. ***Note that you and your spouse will be responsible for all costs incurred for medical services for your spouse as of the date of divorce.*** However, your spouse may elect to continue coverage under COBRA for up to 36 months. You or your spouse must notify the Fund Administrative Office within 60 days of the divorce for your spouse to be eligible to elect COBRA Continuation Coverage.

Life Events

Child Losing Eligibility

Limiting Age

Under the Plan, the limiting age for your unmarried Dependent child is age:

- ♣ 21; or
- ♣ 25 if your child is a full-time student (see page 92)

In general, your Dependent child is no longer eligible for coverage when he or she marries, reaches the limiting age, or does not otherwise meet the Plan's definition of a Dependent (see page 91). You should notify the Fund Administrative Office when one of these events occurs.

Your Dependent child may elect to continue coverage under COBRA for up to 36 months. You or your Dependent child must notify the Fund Administrative Office within 60 days of the date your Dependent child no longer meets the eligibility requirements to obtain COBRA Continuation Coverage.

If your Dependent child is disabled when he or she attains the limiting age, your child may be eligible for continued coverage (see below).

In the Event of Death

As a Retired Employee, in the event of your death, your Surviving Spouse (except certain New Spouses) and Dependents may continue coverage until your Surviving Spouse dies or remarries, provided any required monthly premium is paid. Your spouse and Dependents' coverage may end sooner if your eligibility for coverage under the AK Steel health plan for which you received benefits before January 1, 2009 was due to receiving a benefit from the AK Steel Corporation Long-Term Disability Benefits Plan and you had less than 13 years of continuous service with AK Steel before becoming disabled. In this situation, your spouse and Dependents may continue coverage for up to six months from the date of your death, provided they make the required premium payment.

Benefits for New Spouses in the event of your death are as follows:

- If a New Spouse is at least 65 years old as of the date of the retiree's death, the New Spouse will be eligible for all benefits of this Plan for the remainder of the New Spouse's lifetime.
- If a New Spouse is less than 65 years old as of the date of the retiree's death, the New Spouse will be eligible for all benefits of this Plan for an additional two years from the date of the retiree's death. However, if at the end of that two-year period, the New Spouse has attained the age of 65, the New Spouse's benefits will continue for the remainder of the New Spouse's lifetime.
- The New Spouse benefit described above requires that a New Spouse be married to the retiree for a minimum of two years before the retiree's death in order to qualify for the benefit.
- New Spouse monthly premiums will be the same as those for current spouses.
- A New Spouse's eligibility for all benefits of this Plan ends when the New Spouse remarries.

If a Retired Employee does not have a spouse at the time of his/her death, coverage for Dependent children will end as of the last day of the month in which the Retired Employee's death occurs.

If a Surviving Spouse or New Spouse dies or remarries, coverage for Dependent children will end as of the last day of the month in which the spouse's death or remarriage occurs.

As an alternative to the above, in the event of your death, your New Spouse and eligible Dependents may continue coverage for up to 36 months by electing COBRA Continuation Coverage and making the necessary monthly self-payments (see following section).

COBRA Continuation Coverage

Under the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, your Dependents may continue health care coverage past the date coverage would normally end. COBRA Continuation

Life Events

Coverage is the same medical, HRA and prescription drug coverage your Dependents had the day before beginning COBRA Continuation Coverage (life insurance and other benefits under this Plan are not included in COBRA Continuation Coverage). COBRA Continuation Coverage is only available to your eligible Dependents if they experience a qualifying event that causes them to lose the Plan's medical and prescription drug coverage. If eligible, your Dependents may elect to continue coverage for up to 36 months.

Qualifying Events

COBRA Continuation Coverage is offered to your Dependents if your Dependents lose coverage as a result of your:

If your Dependent's coverage ends due to a qualifying event, you or your Dependent must notify the Fund Administrative Office within 60 days of the event to be eligible to elect COBRA Continuation Coverage.

- Death;
- Divorce or legal separation; or
- Child no longer meeting the Plan's definition of a Dependent.

Notify the Fund Administrative Office

Your Dependent must notify the Fund Administrative Office of any qualifying events within 60 days of the event. If your Dependent does not notify the Fund Administrative Office within 60 days of the qualifying event, he or she will lose the right to elect COBRA Continuation Coverage.

You may be able to get coverage through the Health Insurance Marketplace that costs less than COBRA continuation coverage. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums and cost-sharing reductions (amounts that lower your out-of-pocket costs for deductibles, coinsurance, and copayments) right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Through the Marketplace you'll also learn if you qualify for free or low-cost coverage from Medicaid or the Children's Health Insurance Program (CHIP). You can access the Marketplace for your state at www.HealthCare.gov. Being offered COBRA continuation coverage won't limit your eligibility for coverage or for a tax credit through the Marketplace. You can also end your COBRA continuation coverage early and switch to a Marketplace plan if you have another qualifying event such as marriage or birth of a child through something called a "special enrollment period." Once you've exhausted your COBRA continuation coverage and the coverage expires, you'll be eligible to enroll in Marketplace coverage through a special enrollment period, even if Marketplace open enrollment has ended. If you sign up for Marketplace coverage instead of COBRA continuation coverage however, you cannot switch to COBRA continuation coverage under any circumstances. Additionally, you may be eligible to enroll in coverage under another group health plan (like a spouse's plan), if you request enrollment within 30 days of the loss of coverage.

When the Fund Administrative Office is notified of a qualifying event, the Fund Administrative Office will notify all affected individuals, within 30 days, as to whether or not they have the right to elect COBRA Continuation Coverage. Notification to a spouse is treated as notification to all other affected Dependents residing with the spouse at the time notification is made.

If your Dependents elect to receive COBRA Continuation Coverage, the Fund Administrative Office must receive their election at least 60 days from the later of the date:

- Coverage will end; or
- Of the notice advising your Dependents of their right to COBRA Continuation Coverage.

Each Dependent eligible for COBRA Continuation Coverage has an independent right to elect this coverage. In general, a parent may elect to continue coverage for Dependent children. However, a Dependent child who is 18 years or older has the right to elect COBRA Continuation Coverage independently, regardless of whether or not your spouse elects this coverage.

In determining whether to elect COBRA Continuation Coverage, your Dependent should consider that he or she:

Life Events

- May have a pre-existing condition exclusion applied by other group health plans if there is more than a 63-day gap in health coverage. Election of COBRA Continuation Coverage may help to avoid this gap;
- May lose the guaranteed right to purchase individual health insurance policies that do not impose pre-existing condition exclusions if COBRA Continuation Coverage is not elected for the maximum period available; or
- Has special enrollment rights under federal law, which include the right to request special enrollment in another group health plan for which he or she is otherwise eligible (such as a plan sponsored by the Dependent's employer) within 30 days after medical and prescription drug benefits under this Plan end due to a qualifying event. A Dependent will also have the same special enrollment rights at the end of COBRA Continuation Coverage 36-month period.

Paying for COBRA Continuation Coverage

The Fund Administrative Office will notify your Dependents of the cost of COBRA Continuation Coverage when it notifies them of their right to coverage. The cost for COBRA Continuation Coverage will be determined by the Trustees on a yearly basis and will not exceed 102% of the cost (retiree premium and Fund cost combined) to provide this coverage.

The first payment for COBRA Continuation Coverage must include payments for any months retroactive to the day your Dependents' coverage under the Plan ended. This payment is due no later than 45 days after the date you or your Dependents sign the election form and return it to the Fund Administrative Office.

Subsequent payments are due the first of the month. If payment is not made by the required due date, coverage under the Plan will end. Once COBRA Continuation Coverage ends, it cannot be reinstated. Your Dependents will be notified when their COBRA Continuation Coverage ends.

Loss of Dependent Continued Coverage

The period of COBRA Continuation Coverage for your Dependents may end or be reduced before 36 months if:

- Your Dependents do not make the required monthly self-payments within 30 days of the due date;
- The Plan ends;
- Your Dependents become covered under any other group health care plan after the date COBRA Continuation Coverage is elected (provided the plan does not contain any pre-existing condition exclusions or limitations);
- Your Dependent becomes entitled to Medicare after the date COBRA Continuation Coverage is elected; or
- Your Dependent obtains coverage through the Health Insurance Marketplace - see the description of Health Insurance Marketplace on page 9 above.

If COBRA Continuation Coverage ends before the end of the 36-month COBRA Continuation Coverage period, your Dependents will be notified that their coverage has ended and why.

Pre-Medicare Medical and Prescription Drug Benefits

Pre-Medicare Medical Benefits

Medical Benefits are designed to help protect you and your Dependents against unexpected and/or costly medical expenses. While Medical Benefits cover a wide range of services and supplies, including Physician charges, diagnostic testing, Hospital charges, and surgery, they are not designed to cover every health care expense. The Plan pays the Network Charge (for network Providers) or the Usual and Customary Charge (for non-network Providers) for Medically Necessary Covered Services, up to the limits and under the conditions established by the Plan's rules.

The decisions about how and when you receive medical care are up to you and your Physician—not the Plan. The Plan determines how much it will pay; you and your Physician must decide what medical care is best for you.

It is your responsibility to pay for any charges that are:

If you need to see a Physician:

- ♣ Call to make an appointment.
- ♣ Write down any questions you may have before your appointment. This way, you will not forget to ask your Physician important questions during your appointment.
- ♣ Make a list of any medications you are taking. Be sure to note how often you take the medications.
- ♣ Show your ID card when you go to your appointment.

Most network Providers will file claims for you. If your Provider does not, be sure to file a claim with the Plan as soon as possible. It's a good idea to make a copy of the claim form and any supporting materials before submitting your claim.

- Not considered Covered Services;
- In excess of the Usual and Customary Charge;
- Used to satisfy any applicable Deductibles;
- Not paid by the Plan after the Plan has paid the Plan's portion; and
- In excess of any specific Plan maximum or limitation.

The Plan provides two types of medical coverage:

- Pre-Medicare Medical Coverage, which is for non-Medicare eligible Participants that is described in this section of the SPD; and
- Medicare Medical Coverage, which is for Medicare-eligible Participants (including Medicare-eligible Dependent children, regardless of their age), and which is described in the section beginning on page 33. Please note that, as provided on page 4, the pre-Medicare premium rate applies to the child, regardless of whether or not you and/or your spouse are charged the pre-Medicare or Medicare eligible premium.

It is possible that a Retired Employee and spouse and/or other Dependents will have different medical coverage. For example, if a Retired Employee is eligible for Medicare, but the spouse is not, the Retired Employee will be eligible for the Plan's Medicare Medical Coverage and the spouse will be eligible for Pre-Medicare Medical Coverage.

If you or a Dependent are not eligible for Medicare, you or your Dependent will be covered under the Plan's Pre-Medicare Medical Coverage until you or your Dependent become eligible for Medicare (provided you remain eligible and make the required premium payments). Once you become eligible for Medicare, you will be covered under the Plan's Medicare Medical Coverage.

No benefits will be paid for any claims submitted later than the end of the calendar year following the calendar year in which the services were incurred. In addition,

no action may be commenced in court against the Fund or the Trustees in connection with a denied claim for benefits more than two years after the later of the denial of the claim or the denial of an appeal, if a timely appeal is filed.

The following information and the Summary of Benefits outline specific coverage available under the Plan's Pre-Medicare Medical and Prescription Drug Coverage.

Pre-Medicare Medical and Prescription Drug Benefits

How Pre-Medicare Medical Coverage Works

The Pre-Medicare Medical Coverage is a Preferred Provider Organization (PPO) plan. It provides the highest benefit if you use Providers who participate in the PPO network. If you use a network Provider, there is no deductible, and the Plan's share of the cost after the deductible (coinsurance) is 100%. This is described in greater detail below and on page 14. The Fund may contract with both an Administrator to process claim payments and a separate organization to manage the PPO Provider network. See the Claims and Appeals and Benefit Payment Information section of this document for more information. For each calendar year (January 1 through December 31), Pre-Medicare Medical Coverage works as described in the following section:

1. **Medical Deductibles:** The deductible is the dollar amount you pay each calendar year for medical Covered Services before the Plan begins to pay benefits. Currently, the Plan rules require a deductible only for out-of-network services. See the Summary of Benefits for specific amounts. Here are some points to remember about the medical deductible:

Copayments you pay for prescription drugs do not apply toward your medical deductible or out-of-pocket maximum.

- You must pay the deductible(s) each calendar year before the Plan pays benefits (other than for office visit copayments and preventive care services).
- You are responsible for meeting the deductible each calendar year.
- No one family member can apply more than the individual deductible amount toward meeting the family maximum. However, payments toward the

individual deductible are limited to the family maximum; so once payments toward the individual deductible for all family members covered under the Plan's Pre-Medicare Medical Coverage reach the family maximum, individual deductibles for all family members will automatically be satisfied for that year. If you have some eligible family members covered under the Pre-Medicare Medical Coverage, and others covered under the plan for Medicare-eligible Medical Participants, each individual must meet the applicable individual deductible and each Pre-Medicare-covered group and Medicare-eligible covered group must meet the family deductible as a Pre-Medicare-covered group or Medicare-eligible covered group.

- There are separate network and non-network deductibles (see *Preferred Provider Organization* on the next page for more information about network and non-network Providers). Only amounts paid for Covered Services provided by network Providers apply to the network deductible (currently zero) and only non-network Provider amounts apply toward the non-network deductible.
- The non-network deductible applies to all Covered Services except emergency medical care, which has a separate copayment, as listed in the *Summary of Benefits* insert. The non-network deductible also does not apply to preventive care benefits.
- If two or more family members who are covered under the Plan's Pre-Medicare Medical Coverage are injured in the same accident, only one deductible will apply to charges related to that accident.
- Prescription drug copayments do not apply toward your medical deductible.

2. **Coinsurance:** Once you meet the applicable medical annual deductible, the Plan pays a percentage of Covered Services, and you pay the rest. Currently, there is no Participant coinsurance if you use Providers who participate in the PPO network.

The Plan's Pre-Medicare Medical Coverage pays a higher percentage of Covered Services when you use a network Provider.

3. **Out-of-Pocket Maximum:** The out-of-pocket maximum (which only applies to non-network benefits) helps limit your out-of-pocket medical expenses. Once the coinsurance amounts you pay for Covered Services reach the out-of-pocket maximum each calendar year, the Plan pays 100% of most Covered Services for the remainder of that calendar year.

- Once amounts paid by all family members covered under the Plan's Pre-Medicare Medical Coverage reach the family out-of-pocket maximum, the Plan pays 100% of most Covered Services for all family members covered under the Plan's Pre-Medicare Medical Coverage for the remainder of the calendar year.

Pre-Medicare Medical and Prescription Drug Benefits

- Only amounts paid for Covered Services provided by non-network Provider amounts apply toward the non-network out-of-pocket maximum.
 - The out-of-pocket maximum includes amounts you pay toward meeting your deductible. Copayments you pay Emergency Medical Care and Prescription Drugs do not apply toward the out-of-pocket maximum.
4. **Lifetime Maximum:** The Plan pays medical benefits up to a lifetime maximum amount, as listed on the Summary of Benefits.
- The lifetime maximum is a per person maximum that applies to all medical benefits paid on your or your Dependent's behalf.
 - There is a lifetime maximum for non-network benefits only. Only amounts paid for Covered Services provided by non-network Provider amounts apply toward the non-network lifetime maximum.
 - If you deplete your lifetime maximum, the Plan will restore a portion of the lifetime maximum each year, as provided in the Summary of Benefits.

Maximizing Your Pre-Medicare Medical Coverage Benefits

Pre-Medicare Medical Coverage has two cost management programs designed to help manage certain health care costs:

- Preferred Provider Organization (PPO); and
- Utilization Review.

Preferred Provider Organization

To save you and the Fund money, the Fund has entered into an agreement with a Preferred Provider Organization (PPO) network. Providers that participate in the PPO network (network Providers) have agreed to charge negotiated prices. The Fund's current PPO network is found in the Glossary under Administrator.

Each time you seek care, you have a choice of using a network or non-network Provider. While the same basic range of services and treatment is covered, the amount you pay through deductibles, coinsurance, and out-of-pocket maximums is different for network and non-network Providers. When you or your Dependents use a network Provider, you maximize the amount of health care benefits you receive. Be sure to show your medical ID card so your Provider knows where to file claims.

Network Provider
A health care Provider who participates in the network and has agreed to charge negotiated rates.

The Fund Administrator provides claims payment services only and does not assume any financial risk or obligation with respect to claims

Since network Providers have agreed to negotiated rates, you help control health care costs for you and the Plan when you use network Providers.

When you use a network Provider (for example, a hospital), but that network Provider uses a non-network Provider to render services for you, those out-of-network services will be paid using the network deductible and the network coinsurance percentage applied to the Plan's Usual and Customary payment rate for that service.

Pre-Medicare Medical and Prescription Drug Benefits

Example

Let's compare what Jake pays when using a network Hospital versus a non-network Hospital.

	Network Hospital	Non-Network Hospital
Total Hospital Covered Service Expenses	\$10,000	\$10,000
Less Network Hospital Discount *	<u>-2,000</u>	<u>-0</u>
Base Hospital Covered Service Expenses	\$8,000	\$10,000
Jake's Deductible	<u>- \$0</u>	<u>- \$700</u>
Amount Subject to Coinsurance	\$8,000	\$9,300
Jake's Coinsurance Percentage	<u>x 0%</u>	<u>x 30%</u>
Jake's Coinsurance Payment	\$0	\$2,790
Total Amount Jake Pays (Deductible + Coinsurance)	\$0	\$3,490

Jake could pay \$3,490 less by using a network Hospital.

* This example assumes a PPO savings rate of approximately 20%; actual savings will vary.

Generally, the Provider network is large enough to provide most health care services that you and your family will need. However, since health care is a very personal issue, sometimes you might prefer to go to a Provider that does not participate in the Plan's network. The network/non-network Provider feature of the Plan accommodates these circumstances. Each time you receive medical care, you can choose whether to use a network or non-network Provider. To encourage you to use network Providers whenever possible, the Plan pays a higher percentage of your health care expenses when you go to a network Provider.

The Fund's Provider network is nationwide, so you have access when you are traveling or temporarily away from home.

To take advantage of the savings the network provides, you must check to see if your Provider is in the network (Providers participating in the network change periodically). In addition, you must show your ID card at the time that you receive services. Finding a network Provider is easy.

- Ask your Provider if he/she participates in the network; or
- Contact the network directly-by phone or by visiting their web site (see *Important Contact Information* insert). There is no charge for this information.

If there is no network Provider for the care you require within fifty (50) miles of your residence, you can go to a non-network Provider and the Fund will pay the network percentage of the Usual and Customary charge for those services. If you obtain services requiring Pre-Certification from such a non-network Provider, you must obtain Pre-Certification (see page 15) before obtaining those services or you will have to pay the entire cost of those services.

Utilization Review Program for Pre-Medicare Medical Benefits

The Utilization Review (UR) Program helps ensure that you receive quality care in a way that uses valuable health care resources as wisely as possible. However, to make it work, you need to become involved in the decisions regarding your care, which is why the Plan includes the UR Program. The UR Provider (currently the same provider as for the PPO network - see the Claims and Appeals and Benefit Payment Information section of this document), provides the Pre-Certification and case management services.

Note that Pre-Certification does not guarantee coverage for or payment of the service or procedure reviewed.

Pre-Certification: Pre-Certification is basically like a pre-treatment evaluation. For example, when you or your Physician notify the UR Provider of an inpatient treatment, the UR Provider evaluates if the Hospital is the place you should be, and if it is, how long you can expect to be there.

Pre-Medicare Medical and Prescription Drug Benefits

IMPORTANT NOTICE:

If you are using a non-network Provider, you are responsible for obtaining Pre-Certification from the Utilization Review provider for the services listed below. If you do not obtain Pre-Certification from the UR provider before obtaining any of the services listed below from a non-Network Provider, you will have to pay the entire cost of those services. See the Claims and Appeals and Benefit Payment Information section of this SPD for contact information (pages 63-77).

Be sure to call the number listed on your medical ID card for pre-certification at least 48 hours in advance of admission or treatment.

The Plan requires Pre-Certification for:

- Any non-Emergency inpatient hospital admissions, including admissions for Behavioral Health treatment (you do not need to get pre-certification for Emergency or maternity admissions);
- Home health care services; and
- Durable medical equipment

Network Providers are responsible for obtaining Pre-Certification, and the Provider, not you, will be responsible for any penalties assessed by the Plan for not obtaining Pre-Certification.

Case Management: The UR Provider's case management services include evaluation of Medical Necessity (of both the services and the setting) and the appropriate length of stay for admissions or on-going treatment. For example, case management includes concurrent reviews of a Hospital stay. Concurrent review is designed to prevent unnecessary Hospital confinement after a patient has recovered to the extent that he or she can return home or can safely receive care in an alternate care setting or even on an outpatient basis. Once you are admitted to a Hospital, the UR provider can monitor the Hospital stay and if additional days are required because of complications or other medical reasons, your stay can be recertified for the appropriate number of additional days of inpatient care.

Pre-Medicare Medical Covered Services

The Plan covers the Network Charges (for in-network benefits) or the Usual and Customary Charges (for non-network benefits) for the Medically Necessary services and supplies listed in this section. All Covered Services are subject to the Plan's conditions, exclusions, limitations, terms, and provisions. Covered Services do not include Experimental/Investigative services. In addition, the fact that a Provider prescribes, orders, recommends, or approves a service, treatment, or supply does not make it Medically Necessary or a Covered Service and does not guarantee payment. To receive maximum benefits for Covered Services, you must follow Plan terms.

Preventive Care Services

Preventive care services, which vary based on the age, gender, and personal history, include screenings and other services for adults and children with no current symptoms or prior history of a medical condition. **Preventive Care Services are covered at 100% and require no cost sharing on your part. These services are not subject to the deductible and the Plan's coinsurance is 100%.** Covered Services include, but are not limited to:

1. Routine or periodic exams, including, but not limited to:
 - a. School enrollment physicals.
 - b. Well-baby and well-childcare, including child health supervision services, based on American Academy of Pediatric Guidelines. Child health supervision services include, but are not limited to, review of a child's physical and emotional status performed by a Physician (or by a health care professional under the supervision of a Physician), in accordance with the recommendations of the American Academy of Pediatrics, and a history, complete physical examination, developmental assessment, anticipatory guidance, appropriate immunizations, and laboratory tests.
 - c. Adult routine physical examinations.

Pre-Medicare Medical and Prescription Drug Benefits

- d. Pelvic examinations.
- e. Routine EKG, chest X-ray, laboratory tests, such as complete blood count, comprehensive metabolic panel, and urinalysis.
- f. Immunizations, including those required for school, following the current childhood and adolescent immunization schedule as approved by the Advisory Committee on Immunization Practice (ACIP), American Academy of Pediatrics (AAP), and American Academy of Family Physicians (AAFP). For adults, the Plan follows the adult immunization schedule by age and medical condition as approved by the Advisory Committee on Immunization Practice (ACIP) and accepted by the American College of Gynecologists (ACOG) and American Academy of Family Physicians, including, but not limited to:
 - Hepatitis A vaccine
 - Hepatitis B vaccine
 - Hemophilus influenza B vaccine (Hib)
 - Influenza virus vaccine
 - Rabies vaccine
 - Diphtheria, Tetanus, Pertussis (DTP) vaccine
 - Mumps virus vaccine
 - Measles virus vaccine
 - Rubella virus vaccine
 - Poliovirus vaccine
 - Covid vaccine
 - RSV vaccine
 - Shingles vaccine
 - Pneumococcal vaccine

Physical exam and immunizations required for travel, enrollment in an insurance program, as a condition of employment, for licensing, sports programs, or for other purposes, are not Covered Services.

2. Screening examinations, including:
 - a. Routine digital screening mammograms. If, after a routine digital screening mammogram, your Physician determines that further testing is Medically Necessary, the Plan will cover additional mammography views, including 3D mammograms, and any ultrasound screening for breast cancer.
 - b. Routine cytologic and chlamydia screening (including pap test).
 - c. Routine bone density testing for women.
 - d. Routine prostate specific antigen (PSA) testing.
 - e. Routine colorectal cancer examination and related laboratory tests. Examinations and tests will be covered more often as recommended by the current American Cancer Society guidelines or by your Physician.
3. Diabetes self-management training for a Participant with insulin dependent diabetes, non-insulin dependent diabetes, or elevated blood glucose levels induced by pregnancy or another medical condition when Medically Necessary, ordered in writing by a Physician or a podiatrist, and provided by a Provider who is licensed, registered, or certified under state law.
4. Transportation to and from the place where those services described in paragraphs 1 through 3 above are performed by a private carrier (including taxi or other licensed private carrier) when other means of transportation are not reasonably available, up to \$25 per round trip and \$50 per month.

The list of covered Preventive Services is determined each year by the Federal Government as part of the Affordable Care Act. The current list can be found at the following website: www.healthcare.gov/coverage/preventive-care-benefits.

Physician Office Services

Office Services include care in a Physician's office, including:

Pre-Medicare Medical and Prescription Drug Benefits

1. Office visits for medical care and consultations to examine, diagnose, and treat an illness or injury performed in the Physician's office.
2. Office visits injections, including allergy injections. When an allergy injection or allergy serum is the only charge from a Physician's office no copayment or coinsurance will be required.
3. Diagnostic services when required to diagnose or monitor a symptom, disease, or condition.
4. Surgery and surgical services, including anesthesia and supplies (surgical fee includes normal post-operative care).
5. Therapy services for physical medicine therapies and other therapies.
6. Transportation to and from the Physician office by a private carrier (including taxi or other licensed private carrier) when other means of transportation are not reasonably available, up to \$25 per round trip and \$50 per month.

Inpatient Services

Inpatient services include:

1. Room, board, and general nursing services, which includes a:
 - a. Room with two or more beds.
 - b. Private room, but only when Medically Necessary for isolation and no isolation facilities are available.
 - c. Room in a special care unit that has facilities, equipment, and supportive services for intensive care of critically ill patients.
2. Ancillary services, which include:
 - a. Operating, delivery, and treatment rooms and equipment.
 - b. Prescribed medications.
 - c. Anesthesia, anesthesia supplies, and services given by an employee of the Hospital or other Provider.
 - d. Medical and surgical dressings, supplies, casts, and splints.
 - e. Diagnostic services.
 - f. Therapy services.
3. Professional services, which include:
 - a. Medical care visits, limited to one visit per day by any one Physician.
 - b. Intensive medical care for constant attendance and treatment when a condition requires it for a prolonged time.
 - c. Concurrent care for a medical condition by a Physician who is not the surgeon while confined in the Hospital for surgery. Care by two or more Physicians during one Hospital stay when the nature or severity of the condition requires the skills of separate Physicians is covered.
 - d. Consultation, which is a personal bedside examination by another Physician when requested by your Physician. Staff consultations required by Hospital rules are excluded.
 - e. Surgery and the administration of general anesthesia.
 - f. Newborn exam when performed by a Physician other than the Physician who performed the obstetrical delivery.

Pre-Medicare Medical and Prescription Drug Benefits

As noted above on page 13, if a network Hospital uses non-network Providers, such as emergency room physicians, anesthesiologists, or pathologists, the Plan will apply the network deductible and pay the network coinsurance percentage of the Usual and Customary Charge.

Outpatient Services

Outpatient services include facility and professional charges when rendered as an outpatient at a Hospital, Alternative Care Facility, or other Provider as determined by the Plan. Professional charges only include services billed by a Physician or other professional.

Emergency Medical Care and Urgent Care Services

1. Emergency Medical Care, including emergency room services are defined as Medically Necessary services to treat an Emergency condition.

Follow-up care is not considered Emergency Medical Care. Care and treatment provided once you are stabilized is not Emergency Medical Care.

- a. Emergency Medical Care will be covered at the network level regardless of whether it is provided by a network or non-network Provider. However, continuation of care from a non-network Provider beyond that needed to evaluate or stabilize your condition in an Emergency will be paid at the non-network level if provided by a non-network Provider.
 - b. If you contact your Physician and are referred to a Hospital Emergency room, benefits will be provided at the Emergency Medical Care level.
 - c. Whenever you are admitted as an inpatient directly from a Hospital Emergency room, pre-certification is not required. However, you must call for pre-certification within 48 hours or as soon as possible after the admission if using a non-network Provider.
2. Urgent Care Center services. Often an urgent rather than an Emergency medical problem exists. An urgent care medical problem is an unexpected episode of Illness or Injury requiring treatment that cannot reasonably be postponed for regularly scheduled care. It is not considered an Emergency. Urgent care medical problems include, but are not limited to, earache, sore throat, and fever (not above 104 degrees). Treatment of an Urgent Care medical problem is not life threatening and does not require use of an Emergency room at a Hospital. For such situations:
 - a. If you call your Physician before receiving care for an urgent medical problem and your Physician authorizes you to go to an Emergency room, your care will be covered as Emergency Medical Care.
 - b. Urgent care services can be received from a network or non-network Provider.

Ambulance Services

The Plan covers transportation by a vehicle designed, equipped, and used to transport Ill and Injured persons, and staffed by Emergency Medical Technicians (EMT), paramedics, or other certified medical professionals:

Ambulance services do not include trips to a clinic or Physician's office or to a morgue or funeral home.

1. From your home, the scene of the accident, or medical Emergency to a Hospital.
2. Between Hospitals.
3. Between Hospital and Skilled Nursing Facility.
4. From a Hospital or Skilled Nursing Facility to your home.

Ambulance services are a Covered Service only when Medically Necessary, except when:

1. Ordered by an employer, school, fire, or public safety official and the Participant is not in a position to refuse.
2. A Participant is required, by the Plan, to move from a non-network to a network Provider.

Pre-Medicare Medical and Prescription Drug Benefits

Trips must be to the closest local facility that can give Covered Services appropriate for the condition. If none, trips to the closest facility outside the local area are covered. Ambulance usage is not covered when another type of transportation can be used without endangering the Participant's health. Any ambulance usage for the convenience of the Participant, family, or Physician is not covered.

Diagnostic Services

Diagnostic services are tests or procedures generally performed when specific symptoms are present to detect or monitor the condition. Covered Services include, but are not limited to:

1. X-ray and other radiology services, including mammograms for any person diagnosed with breast disease.

This Plan complies with the Women's Health Act and Cancer Rights Act, which requires group health plans, such as this Plan, that provide medical and surgical benefits in connection with a mastectomy to provide benefits for certain reconstructive surgery, including:

♣ Reconstruction of the breast on which the mastectomy has been performed;

♣ Surgery and reconstruction of the other breast to produce a symmetrical appearance; and

♣ Protheses and physical complications at all stages of mastectomy, including lymphedemas.

This coverage is subject to the same copayments, deductibles and coinsurance applicable to other physical conditions covered under the Plan

2. Magnetic Resonance Imaging (MRI).
3. CAT scans.
4. Laboratory and pathology services.
5. Cardiographic, encephalographic, and radioisotope tests.
6. Ultrasound services.
7. Allergy tests.
8. Electrocardiograms (EKG).
9. Electromyograms (EMG), except that surface EMG's are not covered.
10. Echocardiograms.
11. Bone density studies.
12. Positron Emission Tomography (PET scanning).
13. Central supply (IV tubing) or pharmacy (dye) necessary to perform tests are covered as part of the test.
14. Colonoscopies, other than when performed as part of routine preventive testing.

In general, participants must use network laboratories for preliminary services. If a network laboratory sends samples for further testing to a non-network laboratory, the patient responsibility will be at the network level. As noted on page 13, if a network Hospital uses non-network Providers, the Plan will apply the network deductible and pay the network coinsurance percentage of the Usual and Customary Charge (for a non-network provider).

Surgical Services

Covered surgical services include, but are not limited to:

1. Performance of generally accepted operative and other invasive procedures.
2. Correction of fractures and dislocations.
3. Anesthesia (including services of a Certified Registered Nurse Anesthetist) and surgical assistance when Medically Necessary.

Pre-Medicare Medical and Prescription Drug Benefits

The Plan may combine payment when more than one surgery is performed during the same operative session.

4. Usual and related pre-operative and post-operative care.
5. Operative and cutting procedures.
6. Endoscopic examinations, such as arthroscopy, bronchoscopy, colonoscopy, or laparoscopy.
7. Other invasive procedures, such as angiogram, arteriogram, amniocentesis, tap, or puncture of brain or spine.

Craniomandibular or Temporomandibular Joint (TMJ) Disorder

Covered Services include diagnostic, X-ray, and surgical procedures when there is a diagnosis of osteoarthritis, degenerative arthritis, traumatic arthritis, ankylosis, or any other organic condition of the TMJ.

Morbid Obesity Treatment Services

Surgical services for morbid obesity are covered the same as other Medically Necessary surgical services and include surgical treatment of morbid obesity:

1. That has persisted for at least five years; and
2. For which non-surgical treatment supervised by a Physician has been unsuccessful for at least 18 consecutive months.

Morbid obesity means a body mass index of at least:

Body mass index equals weight in kilograms divided by height in meters squared.

1. 35 kilograms per meter squared with co-morbidity or coexisting medical conditions, such as hypertension, cardiopulmonary conditions, sleep apnea, or diabetes; or
2. 40 kilograms per meter squared without co-morbidity.

Sterilization

The Plan covers sterilization services.

Maternity Services

Maternity services include inpatient, outpatient, and Physician office services for normal pregnancy, complications of pregnancy, miscarriage, therapeutic abortion, and ordinary routine nursery care for a well newborn.

If maternity services are not covered for any reason, Hospital charges for ordinary routine nursery care for a well newborn are also not covered.

Coverage will be for the length of stay recommended by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists in their Guidelines for Prenatal Care. The Plan complies with federal law that prohibits restricting benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section. However, health care Providers are not required to obtain authorization from the Plan for Hospital stays within these guidelines. Federal law does not prohibit the Physician, after consultation with the mother, from discharging the mother and/or her newborn earlier than 48 (or 96) hours.

Coverage for a length of stay shorter than the minimum period mentioned above may be permitted if your attending Physician determines further inpatient postpartum care is not necessary for you or your newborn child, provided the following are met and the mother concurs:

1. In the opinion of your attending Physician, the newborn child meets the criteria for medical stability in the Guidelines for Prenatal Care prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists that determine the appropriate length of stay based upon evaluation of the:

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- a. Antepartum, intrapartum, and postpartum course of the mother and infant;
 - b. Gestational stage, birth weight, and clinical condition of the infant;
 - c. Demonstrated ability of the mother to care for the infant after discharge; and
 - d. Availability of post-discharge follow-up to verify the condition of the infant after discharge.
2. Covered Services include at-home post-delivery care visits at your residence by a Physician or nurse when performed no later than 48 hours following your and your newborn child's discharge from the Hospital. Coverage includes, but is not limited to:
- a. Parent education.
 - b. Physical assessments.
 - c. Assessment of the home support system.
 - d. Assistance and training in breast or bottle feeding.
 - e. Performance of any maternal or neonatal tests routinely performed during the usual course of inpatient care for you or your newborn child, including the collection of an adequate sample for the hereditary and metabolic newborn screening.

Infertility Services

Benefits include inpatient, outpatient, and Physician office services for the diagnosis of infertility only; treatment is not covered.

Elective Abortion

Regardless of Medical Necessity, the Plan covers Provider services for elective abortion accomplished by any means.

Therapy Services

The Plan covers the following therapies that will result in a practical improvement in the level of functioning within a reasonable period:

1. Physical therapy, including treatment by physical means, hydrotherapy, heat, or similar modalities, physical agents, biomechanical and neuro-physiological principles and devices. This therapy is given to relieve pain, restore function, and to prevent disability following illness, injury, or loss of a body part.
2. Speech therapy for the correction of a speech impairment.
3. Occupational therapy for the treatment of a physically disabled person by means of constructive activities designed and adapted to promote the restoration of the person's ability to satisfactorily accomplish the ordinary tasks of daily living and those tasks required by the person's particular occupational role. Occupational therapy does not include diversional, recreational, or vocational therapy (e.g. hobbies, arts and crafts).
4. Chiropractic services for the manipulation of the spine to correct, by manual or mechanical means, structural imbalance or subluxation to remove nerve interference from or related to distortion, misalignment, or subluxation of or in the vertebral column. Chiropractic care includes the following:
 - a. Initial consultation and work-up x-rays necessary to diagnose;
 - b. Initial care: up to 10 visits for the first 30 days, or up to 20 visits for the first 60 days; and
 - c. Continuing care: up to one visit per month, except as stated below in Recurrence of Acute Condition.
 - d. For the Recurrence of Acute Condition: up to eight visits for the first 30 days, up to 10

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visits for the next 60 days; thereafter, up to one visit per month.

5. Cardiac rehabilitation to restore an individual's functional status after a cardiac event. However, home programs, on-going conditioning, and maintenance are not covered.
6. Chemotherapy treatment of disease by chemical or biological antineoplastic agents, including the cost of such agents.
7. Dialysis treatments of an acute or chronic kidney ailment, which may include the supportive use of an artificial kidney machine.
8. Radiation therapy for the treatment of disease by X-ray, radium, or radioactive isotopes.
9. Inhalation therapy for the treatment of a condition by the administration of medicines, water vapors, gases, or anesthetics by inhalation.
10. Physical medicine and rehabilitation services, which includes a structured therapeutic program of an intensity that requires a multidisciplinary coordinated team approach to upgrade the patient's ability to function as independently as possible, including skilled rehabilitative nursing care, physical therapy, occupational therapy, speech therapy, and services of a social worker or psychologist. The goal is to obtain practical improvement in a reasonable length of time in the appropriate setting. Physical medicine and rehabilitation involve several types of therapy, not just physical therapy, and a coordinated team approach. The variety and intensity of treatments required is the major differentiation from an admission primarily for physical therapy.
11. Transportation to and from the place of covered Therapy Services by a private carrier (including taxi or other licensed private carrier) when other means of transportation are not reasonably available, up to \$25 per round trip and \$50 per month.

Home Care Services

Home care services are those performed by a Home Health Care Agency or other Provider in your residence. The services must be provided on a part-time visiting basis according to a course of treatment. Covered Services include, but are not limited to:

1. Intermittent skilled nursing services by a registered nurse or licensed practical nurse.
2. Diagnostic services.
3. Medical/social services.
4. Nutritional guidance.
5. Home health aide services.
6. Therapy services.
7. Medical/surgical supplies.
8. Durable medical equipment
9. Prescription medications, but only when provided and billed by a Home Health Care Agency.
10. Private duty nursing.
11. Home infusion therapy, which includes a combination of nursing, durable medical equipment, and pharmaceutical services delivered and administered intravenously in the home. Home IV therapy includes, but is not limited to:
 - a. Injections (intra-muscular, subcutaneous, and continuous subcutaneous).
 - b. Total Parenteral Nutrition (TPN).

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- c. Enteral nutrition therapy.
- d. Antibiotic therapy.
- e. Pain management.
- f. Chemotherapy.

Skilled Nursing Facility Benefits

If you are admitted to an approved Participating Skilled Nursing Facility, benefits will be provided for semi-private accommodations and all other services provided by the facility for up to 100 days per benefit period provided you:

1. Have completed a 3-day minimum Medically Necessary inpatient hospital stay for a related illness or injury;
2. Your doctor certifies that you need daily skilled care like intravenous injections or physical therapy and;
3. Provided (i) your condition requires professional and practical nursing care provided by a Skilled Nursing Facility and (ii) you remain under active medical supervision of a licensed physician.

If you occupy a private room in a Participating Skilled Nursing Facility, you will be entitled to all of the above described benefits but you will be required to pay the facility the excess, if any, of its regular charge for the private room over the facility's most common charge for semi-private rooms.

The need for confinement in a Skilled Nursing Facility must be certified by the licensed Physician in charge of the case, in a form satisfactory to and as required from time to time by the Fund Administrator. The Fund Administrator will make the initial determination as to whether or not the condition is a covered condition and is of the nature to require care or continued care in such facility.

If you meet the requirements set forth above but are confined in an approved Skilled Nursing Facility which is not a Participating Facility, you will be entitled to the same amount that would have been paid had the facility in question been a Participating Skilled Nursing Facility, but not in excess of 90% of the charges of the facility in question.

A facility will be approved by the Fund Administrator if:

1. It qualifies as a Skilled Nursing Facility under Medicare; or
2. It is accredited as a Skilled Nursing Facility by the Joint Commission on Accreditation of Hospitals or if the Plan's Preferred Provider Organization determines that it meets the standards for such accreditation; and
3. Where necessary, has been approved by the applicable area wide Health Care Planning Agency.

Before you or one of your dependents enter a Skilled Nursing Facility, you should ask the Fund Administrator whether such facility meets the above requirements.

A new maximum benefit period will commence only when there has been a lapse of at least ninety days between the date of last discharge from a Skilled Nursing Facility and the date of the next admission to a Skilled Nursing Facility due to the same or related causes, whether or not benefits were provided for the prior admission.

Benefits are not provided for:

1. Confinement which is principally for custodial care;
2. Care for the deaf or blind;
3. Care for senility, mental deficiency or retardation;
4. Care for mental illness, other than for short-term convalescent care when the prognosis for recovery or improvement is deemed favorable;
5. Care not requiring continued professional and practical nursing care provided by a Skilled Nursing Facility;

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6. Care that could be managed by an approved Home Care Agency where such Agency is available;
7. Expenses for which payment or reimbursement is received by or for the account of the individual as a result of a legal action or settlement;
8. Confinements, services, supplies or treatments which are not necessary according to accepted standards of medical practice;
9. Confinements, services, supplies or treatments for which no charge is made that you are legally obligated to pay or for which no charge could be made in the absence of this coverage; or
10. Confinements, services, supplies or treatments received for illness or injury due to war (declared or undeclared) or any act of war, if such illness or injury occurred while insured for this coverage.

Hospice Services

Hospice Care may be provided in the home or a Hospice Facility and are medical, social, and psychological services used as palliative treatment for Participants with a terminal illness, including routine home care, continuous home care, inpatient Hospice Care, and inpatient respite care. To be eligible for hospice benefits, the patient must have a life expectancy of six months or less, as certified by the attending Physician.

Covered Services include:

1. Skilled nursing services by a registered nurse or licensed practical nurse.
2. Diagnostic services.
3. Physical, speech, and inhalation therapies.
4. Medical supplies, equipment, and appliances.
5. Counseling services, except bereavement counseling.
6. Inpatient confinement at a Hospice Facility.
7. Prescription medications obtained from the Hospice Facility.

Human Organ and Tissue Transplant Services

The Plan covers Medically Necessary human organ and tissue transplants or stem cell/bone marrow transplants and transfusions, including necessary acquisition procedures, harvest and storage, and Medically Necessary preparatory myeloablative therapy. The Plan covers transplant procedures and all covered services directly related to the disease that has necessitated the transplant procedure or that arises as a result of the transplant procedure within a covered transplant benefit period, including any diagnostic evaluation for the purpose of determining a Participant's appropriateness for a procedure.

Covered Transplant Benefit Period: This period starts with a covered transplant procedure and continues for one year. If, within this time frame, a second transplant procedure occurs, the period will begin with the second transplant procedure and continue for one year.

Notification: You should contact the number on the back of your Identification Card and ask for the transplant coordinator when you need transplant procedures for coverage information, including details regarding what is covered and whether any exclusions apply.

Transplant Related Travel Benefit: When preapproved by the Fund Administrator, the Plan provides assistance with reasonable and necessary travel expenses when you are required to travel more than 75 miles from your residence to reach the facility where your procedure will be performed. Assistance includes transportation to and from the facility and lodging for the patient and one companion. If the Participant receiving treatment is a minor, then reasonable and necessary expenses for transportation and lodging may be allowed for two companions.

The Maximum Plan Benefit for transplant related travel expenses, including transportation, lodging and

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meals for the patient and one family member or companion is \$10,000 per transplant. Reimbursement is available at 100% for round trip “coach” airfare, and up to a maximum of \$150 per day for lodging and meals received during the pre-operative work-up, transplant operation, and post-transplant treatment phases for up to one-year post-transplant. Receipts are required when submitting lodging, meals, and travel expenses for payment consideration. This travel benefit is available only when the transplant occurs in a contracted network facility (PPO facility). The following are not covered: car rental, telephone calls, personal care items such as shampoo, entertainment expenses, alcohol/tobacco, souvenirs, and expenses for persons other than the patient and his/her designated family member/companion.

Medical Supplies, Durable Medical Equipment, and Appliances

Covered Services include, but are not limited to:

1. Medical and surgical supplies, such as syringes, needles, oxygen, surgical dressings, splints, and other similar items that serve only a medical purpose. Covered Services do not include items usually stocked in the home for general use like band-aids, thermometers, and petroleum jelly.
2. Durable medical equipment, which means the rental (or, at the Plan’s option, the purchase) of durable medical equipment prescribed by a Physician or other Provider. Durable medical equipment is equipment that:
 - a. Can withstand repeated use (i.e., could be rented and used by successive patients);
 - b. Is primarily and customarily used to serve a medical purpose;
 - c. is generally not useful to a person in the absence of illness or injury; and
 - d. Is appropriate for use in a patient's home.

Examples include, but are not limited to, wheelchairs, crutches, Hospital beds, and oxygen equipment. Rental costs must not be more than the purchase price. Repair of medical equipment is covered. Non-covered items include, but are not limited to, air conditioners, humidifiers, dehumidifiers, special lighting, or other environmental modifiers, surgical supports, and corsets or other articles of clothing.

3. Prosthetic appliances, which means artificial substitutes for body parts and tissues and materials inserted into tissue for functional or therapeutic purposes. Covered Services include purchase, fitting, needed adjustment, repairs, and replacements of prosthetic devices and supplies that replace all or part of a missing body part and its adjoining tissues or all or part of the function of a permanently useless or malfunctioning body part. Covered Services for prosthetic appliances include, but are not limited to:
 - a. Aids and supports for defective parts of the body including, but not limited to, internal heart valves, mitral valve, internal pacemaker, pacemaker power sources, synthetic or homograft vascular replacements, fracture fixation devices internal to the body surface, replacements for injured or diseased bone and joint substances, mandibular reconstruction appliances, bone screws, plates, and vitallium heads for joint reconstruction.
 - b. Left Ventricular Artificial Devices (LVAD) when used as a bridge to a heart transplant.
 - c. Breast prosthesis whether internal or external, following a mastectomy, and four surgical bras per calendar year.
 - d. Minor devices for repair such as screws, nails, sutures, and wire mesh.
 - e. Replacements for all or part of absent parts of the body or extremities, such as artificial limbs, artificial eyes, etc.
 - f. Intraocular lens implantation for the treatment of cataract or aphakia. Contact lenses or glasses are often prescribed following lens implantation and are Covered Services. The Plan covers all types of implanted lenses, including the cost of lenses exceeding the Usual and

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Customary Charge.

- g. Artificial gut systems (parenteral devices necessary for long-term nutrition in cases of severe and otherwise fatal pathology of the alimentary tract) formulae, and supplies.
- h. Cochlear implant.
- i. Electronic speech aids in post-laryngectomy or permanently inoperative situations.
- j. Space shoes when used as a substitute device when all or a substantial portion of the forefoot is absent.
- k. Wigs following cancer treatment.

Non-covered prosthetic appliances include, but are not limited to dentures (replacing teeth or structures directly supporting teeth), dental appliances, non-rigid appliances (such as elastic stockings, garter belts, arch supports, and corsets), artificial heart implants, hairpieces for male pattern alopecia (baldness), and wigs (except as described for cancer treatment).

- 4. Orthotic devices, which include the initial purchase, fitting, and repair of a custom made rigid or semi-rigid supportive device used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body, or that limits or stops motion of a weak or diseased body part. The cost of casting, molding, fittings, and adjustments are included. Covered orthotic devices include, but are not limited to:
 - a. Cervical collars.
 - b. Ankle foot orthosis.
 - c. Corsets (back and special surgical).
 - d. Splints (extremity).
 - e. Trusses and supports.
 - f. Slings.
 - g. Wristlets.
 - h. Built-up shoe.
 - i. Custom made shoe inserts.

Orthotic appliances may be replaced once per year per Participant when Medically Necessary. However, additional replacements will be allowed for Participants under age 18 due to rapid growth or for any Participant when an appliance is damaged and cannot be repaired.

If any of the above supplies, equipment, or appliances include comfort, luxury, or convenience items or features that exceed what is Medically Necessary, payment will be based on the Network Charge or the Usual and Customary Charge for a standard item that is a Covered Service, serves the same purpose, and is Medically Necessary. Any expense that exceeds the Usual and Customary Charge for the standard item that is a Covered Service is your responsibility. For example, the reimbursement for a motorized wheelchair will be limited to the reimbursement for a standard wheelchair, when a standard wheelchair adequately accommodates the condition.

Non- Covered Services include, but are not limited to:

- a. Orthopedic shoes.
- b. Foot support devices, such as arch supports and corrective shoes, unless they are an integral part of a leg brace.
- c. Standard elastic stockings, garter belts, and other supplies not specially made and fitted (except as specified under medical supplies).
- d. Garter belts or similar devices.

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Accident Related Dental Services

Dental work and oral surgery is covered if provided for the initial repair of an Injury to the jaw, sound natural teeth, mouth or face that are not excessive in scope, duration, or intensity to provide safe, adequate, and appropriate treatment without adversely affecting the Participant's condition. This only includes dental work to repair Injuries when performed within 12 months of the Injury or as reasonably soon thereafter as possible, including all examinations and treatment to complete the repair. However, for a child requiring facial reconstruction due to dental related Injury, there may be several years between the accident and the final repair. Dental implants are excluded from this coverage.

Covered Services for accidental dental include, but are not limited to:

1. Oral examinations.
2. X-rays.
3. Tests and laboratory examinations.
4. Restorations.
5. Prosthetic services.
6. Oral surgery.
7. Mandibular/maxillary reconstruction.
8. Anesthesia.

Dental/Oral Surgery

Charges for outpatient facility services are covered when the patient's medical condition or the dental procedure requires a hospital setting to ensure the safety of the patient. Completely bony impacted extractions are covered as surgery, including completely impacted wisdom teeth. In addition, both fully and partially bony impactions are covered. Extractions of non-impacted teeth are covered if a concurrent hazardous condition exists. Professional surgical charges are covered if a series of recurrent or related surgeries are performed for treatment of the same disease or injury.

Behavioral Health Services

In conjunction with the limits noted in the Summary of Benefits, Covered Services include but are not limited to:

1. Inpatient services, which include individual or group psychotherapy, psychological testing, family counseling with family members to assist in diagnosis and treatment, convulsive therapy, including electroshock treatment or convulsive drug therapy.
2. Partial hospitalization, which is a structured, intensive, multidisciplinary treatment program that provides psychiatric, medical, and nursing care. The program usually is offered in an acute setting, but the patient goes home in the evening and on weekends. The program delivers a highly structured environment of at least four to six hours of treatment per day. Patients are expected to participate up to five days per week. Intensive outpatient treatment or day treatment, which is a structured program, offered at least three times per week for at least three hours per day. The program may be managed by a licensed Behavioral Health professional with a psychiatrist on staff and therapy is provided by a licensed Behavioral Health professional.
3. Outpatient (or individual or group) treatment, which is office-based services, for example diagnostic evaluation, counseling, psychotherapy, family therapy, and medication evaluation. The service may be provided by a licensed Behavioral Health professional if, in the case of a professional

Two days of partial hospitalization treatment or intensive outpatient treatment are the equivalent of one inpatient day.

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who is not a psychiatrist, it is coordinated by a psychiatrist.

The following behavioral health services are not covered under the Plan:

1. Residential treatment services, which means individualized and intensive treatment in a residential setting, including observation and assessment by a psychiatrist weekly or more frequently, individualized program of rehabilitation, therapy, education, and recreational or social activities.
2. Custodial or Domiciliary Care.
3. Supervised living or halfway houses.
4. Room and board charges unless the treatment provided is Medically Necessary for the inpatient admission for the condition.

Hearing Benefits

The Plan provides hearing benefits, which include hearing aids, and the testing, prescription and fitting of such appliances.

Hearing benefits are limited to the actual charges for covered services, up to the amount listed in the Summary of Benefits for each Participant (you and each of your Dependents) in any three consecutive calendar year period. The per-person maximum shown in the Summary of Benefits is for the purchase of the hearing aid only. Provider visits and/or tests related to your hearing are covered under the medical plan. Provider visits and/or tests are subject to office visit copayments, the deductible and network provisions.

Fitness Benefit

The Plan's fitness benefit provides for annual reimbursement for membership in a local fitness center (see the Summary of Benefits for the amount). In addition to fitness center membership, other physical wellness activities are eligible for reimbursement. In order to qualify as a reimbursable benefit, the physical activity must be conducted by a certified instructor. Examples of such activities are exercise (Yoga, Tai Chi, Jazzercise, Zumba, Pilates, cycling, aerobics, water aerobics, bodyweight, personal trainer) programs, dancing (ballroom, jazz, ballet, tap) lessons and sports instruction (swimming, tennis, pickle ball, golf, bowling) lessons. It is the cost of the sports instruction itself that can be reimbursed. For example, greens fees, tennis court fees and bowling lane fees are not reimbursable unless they are included in the approved instruction. Virtual fitness instruction which meets the above requirements is covered.

Reimbursement for VA Out-of-Pocket Expenses

Participants who receive services from the VA and are required to pay a portion of the cost may submit documentation of these out-of-pocket expenses to the Plan for reimbursement.

Medical Expenses Not Covered Under the Plan

The Plan covers many medical expenses related to an illness or injury. However, you should be aware that some expenses are not covered by the Plan. Procedures, equipment, services or supplies that are not Medically Necessary or are experimental or investigative are not covered by the Plan. See the information listed in this section as well as the items listed in *General Plan Exclusions and Limitations* on pages 60-62 for expenses that are not covered under the Plan.

Pre-Medicare Prescription Drug Benefits

Prescription drug expenses are rising faster than most other health care expenses and can be a significant expense for you and your family. Recognizing this, the Fund offers prescription drug benefits to you and your Dependents. The Fund has contracted with a Pharmacy Benefit Manager (PBM) to provide you with access to a retail pharmacy and mail order program. Information on the PBM can be found in the Claims and Appeals and Benefit Payment Information section of this document. The PBM also provides certain programs, including step therapy, quantity management, and prior authorization programs, designed to ensure the prescriptions you take are safe, appropriate, and effective. These programs are discussed in more detail later in this section.

Generic Equivalents and Brand Name Medications

Many prescription drugs have two names: the generic name and the brand name. By law, both generic and brand name medications must meet the same standards for safety, purity, and effectiveness. However, on average, generic medications cost less than their brand name alternatives. This can be a significant source of savings for you and the Plan.

A generic equivalent is a copy of a brand name medication that is no longer protected by a patent. A generic medication usually serves the same purpose as the original (brand name) medication and costs less.

Often several types of medications can be used to treat the same condition.

To ensure high-quality care and to help manage costs, most prescription drug programs have a list of preferred medications. The list consists of prescription medications (preferred medications) that are either more effective than others in their class are, or as effective, and less costly.

Remember, it costs less and is more convenient to use participating pharmacies

Under the Plan's prescription drug benefits, there are three levels of copayments: generic, preferred brand, and non-preferred brand. The current copayments can be found in the latest Summary of Benefits provided by the Plan. Refer to the Important Contact Information for contact information to get a copy of the preferred medication list.

If your doctor prescribes less than a full month's supply of certain drugs, you will pay a daily cost-sharing rate based on the actual number of days of the drug you receive.

You should discuss the Plan's preferred medication list with your Physician for any prescriptions you need filled. Your Physician or pharmacist can assist you in substituting generic or preferred brand name medications when appropriate.

For Brand Name Medications with a Generic Equivalent

If your Physician prescribes a brand name drug which has a generic equivalent, you will pay the generic copayment plus the difference in cost between the brand name drug and its generic substitute. For most people, the generic form of the drug is just as effective as the brand name version, and it is much less expensive. This provision is designed to encourage as many participants as possible to switch to generic drugs. Remember that if your Physician feels that you should continue to take the brand name drug, he/she may pursue a clinical appeal exception with the PBM.

Retail Pharmacy Program

When you are eligible for benefits under the Plan, you receive a prescription ID drug card. You can only use your card at a pharmacy that participates in the network (participating pharmacy). Refer to the Important Contact Information for information on how to find a participating pharmacy.

When you go to a participating pharmacy, simply show the pharmacist your prescription drug ID card. No forms, receipts, or submission of claims is necessary. You simply pay the required copayment, which varies depending on the type of medication (generic, preferred brand, or non-preferred brand) when you fill your prescription.

Pre-Medicare Medical and Prescription Drug Benefits

Maintenance medications are prescription drugs that are used on a non-going basis. These prescriptions can be used to treat chronic conditions such as:

- ♣ Arthritis;
 - ♣ Diabetes;
 - ♣ Emotional distress;
 - ♣ Heart disorders;
 - ♣ High blood pressure;
- or
- ♣ Ulcers

If you have a prescription filled at a non-participating pharmacy or you do not have your ID card with you when purchasing a prescription, you must pay the full cost of the prescription when you have it filled and then submit a claim for reimbursement. You will be reimbursed the amount the prescription would have cost at a participating retail pharmacy minus your copayment amount.

Mail Order Program

If you need to have a prescription filled for long-term or maintenance medication, you may want to use the mail order program. The mail order program provides a safe, convenient way for you to have your medications delivered right to your home.

You must complete and send in a mail order form, along with your prescription and copayment amount. It will take approximately 8-14 days from the time you send in your order until you receive your prescription(s).

If your written prescription indicates that refills are available, you will receive a refill number with your prescription order. You then have several options on refilling your prescription; you can refill your prescription online, by phone, or by mail.

Specialty Pharmacy

In addition, the Plan covers prescription drugs for treatment of complex conditions, such as immune deficiency, Hepatitis C, multiple sclerosis, growth hormone deficiency, rheumatoid arthritis, certain cancers, and hemophilia, with specialty medications. Specialty medications are most often injectable medications administered either by you or a healthcare professional. They often require special handling. If you use specialty medications, they will be provided through the PBM's Specialty Pharmacy. Information on the Specialty Pharmacy can be found in the Claims and Appeals and Benefit Claim Information section of this document. Certain specialty medications require prior authorization from the PBM, so you should always check with the PBM to see if a prior authorization is required. If your Physician prescribes a new specialty medication that requires prior authorization, you must receive prior authorization before the Plan will provide coverage for the medication.

Services available from the Specialty Pharmacy group include a toll-free phone line available twenty-four hours a day, seven days a week to provide answers to your questions or concerns by a specialty-trained pharmacist, personalized counseling from a team of registered nurses and pharmacists, coordination of home care, if appropriate, expedited delivery of your medications at no extra charge, up to a 90-day supply of your specialty medication for just one payment, safety checks to help prevent potential drug interactions, and refill reminders.

Preferred Drug Step Therapy, Quantity Management and Prior Authorization Programs

The Plan has certain programs in place to help ensure the prescriptions you take are safe, appropriate, and effective. The Programs include Preferred Drug Step Therapy, Quantity Management and Prior Authorization. These programs review new drugs such as ADHD agents, antipsychotics, dermatologicals, hormone management, non-narcotic analgesics, glaucoma, and those that treat rheumatoid arthritis, multiple sclerosis, certain cancers, Hepatitis C, and gout. These programs may require you to try generic or preferred brand drugs before non-preferred drugs, an adjustment to the quantity that can be dispensed when filling a prescription, or that a prior authorization process be completed before the drug can be dispensed. The purpose of these programs is to make sure the drugs you get work best for you and don't cause medical complications. You may call the PBM or the Fund Administrative Office if you have any questions about this program.

Covered Prescription Drugs and Supplies

Generally, the Plan covers the following prescription drugs and supplies (up to a 90-day supply either at a retail pharmacy or through the mail order program):

- Federal legend drugs;

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- State restricted drugs;
- Compounded medications, of which at least one ingredient is a legend drug (note that coverage is limited and subject to review by the PBM);
- Insulin;
- Needles and syringes;
- Over-the-counter diabetic supplies (all dosage forms);
- Oral (except emergency contraceptives), transdermal, intravaginal, and injectable contraceptives;
- Standard specialty drugs;
- Medications to treat erectile dysfunction (subject to prior authorization and limited to eight doses per month); and
- Certain preventive medications are covered in full with no copayment required. Examples include: generic (over the counter) aspirin; smoking cessation medications (zero copay applies for the first 180 days in a 365-day period); certain vaccines; generic statins; and bowel preparation agents. In order to make sure you receive this benefit, you will need to get these medications at your pharmacy

A Physician or Dentist must write the prescriptions, and a licensed pharmacist must dispense these prescriptions.

Prescription Drug Benefits Requiring Prior Authorization

Prescriptions for certain drugs must have prior authorization before the Plan will cover the expenses. You may check with the Fund Administrative Office or with the PBM to determine whether your prescription requires prior authorization.

Expenses Not Covered by Prescription Drug Benefits

Except for insulin and certain preventive medications described under “Covered Prescription Drugs and Supplies” above, the Plan does not cover any drugs or medicines that can be purchased over-the-counter without a prescription. Specific prescription drug benefit exclusions are as follows:

- Drugs purchased outside the United States or its territories;
- Drugs prescribed for use other than what is indicated on a prescription drug’s label as approved by the Food and Drug Administration;
- Drugs used for the relief of cough and cold symptoms;
- Prescription vitamins and mineral products, except prenatal and pediatric vitamins;
- Non-federal legend drugs;
- Non systemic contraceptives, devices or implants;
- Emergency contraceptives;
- Xenical;
- Therapeutic devices or appliances;
- Allergy sera;
- Mifeprex;

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- Drugs whose sole purpose is to promote or stimulate hair growth or for cosmetic purposes only;
- Drugs labeled “Caution - limited by Federal law to investigational use,” or experimental drugs, even though a charge is made to the individual;
- Medication for which the cost is recoverable under any workers’ compensation or occupational disease law or any state or governmental agency, or medication furnished by any other drug or medical service for which no charge is made to the claimant;
- Medication which is to be taken by or administered to an individual, in whole or in part, while he or she is a patient in a licensed Hospital, rest home, sanitarium, extended care facility, Skilled Nursing Facility, convalescent hospital, nursing home or similar institution which operates on its premises or allow to be operated on its premises, a facility for dispensing pharmaceuticals;
- Any prescription refilled in excess of the number of refills specified by the Physician, or any refill dispensed after one year from the Physician’s original order; and
- Other than for covered vaccines, charges for the administration or injection of any drug.

Since not all prescription drug expenses are covered by the Plan, see *General Plan Exclusions and Limitations* on pages 60-62 for expenses that are not covered under the Plan.

Medicare Medical and Prescription Drug Benefits

Medical Benefits for Medicare-Eligible Retirees

The Plan provides medical benefit coverage that is designed to help protect you and your Dependents against unexpected and/or costly medical expenses. When you are Medicare-eligible, you must enroll in both Part A (hospitalization) and Part B (medical) of Medicare in order to maximize your coverage. Medicare will then pay for most of your hospital and other medical expenses and the Plan then pays a portion of the costs that Medicare does not cover.

The decisions about how and when you receive medical care are up to you and your Physician—not the Plan. For Medicare-eligible participants, Medicare generally determines the amount Providers can charge for covered services and then determines the amount it will pay. The Plan will then determine how much it will pay of the balance due. Under Medicare rules, when you use a Provider that participates in Medicare,

you are not responsible for any amounts over the amount Medicare allows for the service.

It is your responsibility to pay for any charges that are:

- Not considered Covered Services;
- In excess of the Medicare Approved Amount (if you use a Provider who does not accept Medicare assignment);
- Not paid by the Plan after the Plan has paid the Plan's portion; and
- In excess of any specific Plan maximum or limitation.

The Plan provides two types of medical coverage:

- Pre-Medicare Medical Coverage, which is for non-Medicare eligible Participants, and which is described in the previous section; and
- Medicare Medical Coverage, which is for Medicare-eligible Participants (including Medicare eligible Dependent children, regardless of their age), and which is described in this section. Please note that, as provided on page 4, the pre-Medicare premium rate applies to the child, regardless of the premium charged to the Retired Employee and spouse.

It is possible that a Retired Employee and spouse and/or other Dependents will have different medical coverage. For example, if a Retired Employee are eligible for Medicare, but his/her spouse is not, the Retired Employee will be eligible for the Plan's Medicare Medical Coverage and the spouse will be eligible for Pre-Medicare Medical Coverage.

If you or a Dependent are not eligible for Medicare, you or your Dependent will be covered under the Plan's Pre-Medicare Medical Coverage until you or your Dependent become eligible for Medicare (provided you remain eligible and make the required premium payments). Once you become eligible for Medicare, you will be covered under the Plan's Medicare Medical Coverage.

No benefits will be paid for any claims submitted later than the end of the calendar year following the calendar year in which the services were incurred. In addition,

no action may be commenced in court against the Fund or the Trustees in connection with a denied claim for benefits more than two years after the later of the denial of the claim or the denial of an appeal, if a timely appeal is filed

The following information and the Summary of Benefits outline specific coverage available under the Plan's Medical and Prescription Drug Coverage for Medicare-eligible participants.

If you need to see a Physician:

- ♣ Call to make an appointment.
- ♣ Write down any questions you may have before your appointment. This way, you will not forget to ask your Physician important questions during your appointment.
- ♣ Make a list of any medications you are taking. Be sure to note how often you take the medications.
- ♣ Show your ID card when you go to your appointment.

Most Providers will file claims for you. If your Provider does not, be sure to file a claim with the Plan as soon as possible. It's a good idea to make a copy of the claim form and any supporting materials before submitting your claim.

Coordination with Medicare. If you are eligible for Medicare, your benefits will be coordinated with Medicare.

Enroll in Medicare as soon as you are eligible. When you are eligible, the Plan treats you as if you were enrolled in Medicare, so you should enroll in Medicare Part A and Part B to keep your expenses down.

How Medical Coverage Works for Medicare-Eligible Retirees

When a Retiree or an eligible Dependent is eligible for Medicare, the Plan coordinates the Plan's benefits with your Medicare benefits. For services covered by Medicare, the Plan provides secondary coverage only, regardless of whether you actually enroll in Medicare, and regardless of whether, in order to enroll in Medicare, you must pay a premium for Medicare Part A or Part B or both. In order to minimize your out-of-pocket medical costs, you should enroll in Medicare Part A (hospitalization) and Part B (medical) as soon as you are eligible. While Medicare Part A is generally free, individuals who do not have sufficient work quarters of Medicare covered employment may be required to pay a monthly premium to obtain Part A coverage. Everyone must pay a premium to obtain Medicare Part B coverage.

Medicare Part B Premium Reimbursement

The Plan reimburses Medicare-eligible Retiree Employees and eligible spouses for all or part of the Medicare Part B premium. Generally, your Medicare Part B premium is deducted from your Social Security check. In order to receive the Part B premium reimbursement, you must provide the Plan with proof of your Medicare Part B enrollment to obtain reimbursement of Medicare Part B premiums from the Plan.

The Medicare Part B Premium reimbursement rate is based on the standard Medicare Part B premium.

Additionally, the Plan does not reimburse the Medicare Part B Premium of a retiree or spouse who is receiving nursing home care and covered under Medicaid. If a Participant, who is covered under Medicaid and receiving nursing home care, has an eligible Dependent Spouse who is Medicare-eligible and enrolled in Medicare Part B, the Spouse's Medicare Part B reimbursement benefit from the Plan will be paid directly to the Spouse. If this applies to you and the Plan has not changed your Medicare Part B premium, please contact the Fund Administrative Office at 1-877-392-9991.

Each calendar year (January 1 through December 31), Medical Coverage for Medicare-eligible Participants works like this:

Medical Deductible: When the Plan coordinates with Medicare, there are potentially three sets of deductibles: two established by Medicare, for Part A and Part B (which generally changes each year), and one established by the Plan. However, the Plan currently does not impose a separate deductible; in addition, the Plan is responsible for both the Medicare Part A and the Medicare Part B deductibles. Information about the amount of the Medicare Deductibles which usually change each year, is available at the Medicare Web site www.medicare.gov.

Your Medicare-Eligible benefits are designed to supplement Medicare up to the Plan limits but not to duplicate benefits provided through Medicare.

Coinsurance: Medicare requires that you pay a portion of the cost (Coinsurance) after you have met the Medicare deductible. The Plan pays 100% of Covered Services that Medicare does not cover in full.

Lifetime Maximum: There is no lifetime maximum for medical benefits for Medicare-eligible Participants.

Hospital Day Limits: Medicare provides coverage for a certain number of inpatient days per benefit period (which begins the day you're admitted as an inpatient in a hospital and ends when you haven't gotten any inpatient hospital care for 60 days in a row). There is no Medicare coinsurance for the first 60 days of a benefit period. There is a Medicare coinsurance amount for days 61 through 90 and then a higher Medicare coinsurance amount for lifetime reserve days (up to 60 days per lifetime for hospital stays longer than 90 days). The Fund will pay the Medicare coinsurance amounts for inpatient stays beginning with your 61st day of confinement.

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If you have exhausted all of your Medicare inpatient benefits, including all of your lifetime reserve days, the Fund will pay a lifetime maximum of 90 additional days of inpatient benefits. This benefit will be limited to the amount of the inpatient benefit Medicare approved on the day that Medicare inpatient benefits were exhausted. If no Medicare rate is readily available for any service provided during the stay, the Fund will limit the amount it will pay to a Usual and Customary Charge as determined by the Fund.

The continued inpatient stay must be determined by the Fund to be medically necessary, and that no other more economical, effective, and medically acceptable option is available. The Fund Trustees have the discretion to make these determinations or to contract with an independent review organization or similar utilization management entity to make an initial and ongoing review of the need for continued hospitalization.

While the Plan is designed to supplement your Medicare benefits, it is not meant to duplicate any Hospital or medical benefits provided through Medicare. In addition, the Plan assumes that Medicare has paid its share of the medical expenses and the Plan limits its payments accordingly.

Medical Covered Services for Medicare-Eligible Participants

The Plan coordinates with Medicare to cover the Medicare Approved Amount for a comprehensive range of Medically Necessary services and supplies which are listed in this section. To receive maximum benefits for Covered Services, you must be enrolled in both Medicare Part A and Part B and follow the terms of the Plan.

All Covered Services are subject to the Plan's conditions, exclusions, limitations, terms, and provisions. Covered Services do not include services that are considered to be Experimental/Investigative services. In addition, the fact that a Provider prescribes, orders, recommends, or approves a service, treatment, or supply does not make it Medically Necessary or a Covered Service and does not guarantee payment. To receive maximum benefits for Covered Services, you must follow Plan terms.

The Plan covers any service which is a Medicare allowed benefit, even if such service is listed as an exclusion in this Summary Plan Description. Note however, that the Plan will process claims according to the Plan's benefit provisions if the Plan's level of coverage is different from that of Medicare.

Physical exam and immunizations required for travel, enrollment in an insurance program, as a condition of employment, for licensing, sports programs, or for other purposes, are not Covered Services.

Preventive Care Services

Preventive care services, which vary based on the age, gender, and personal history, include screenings and other services for adults and children with no current symptoms or prior history of a medical condition. Covered Services include, but are not limited to:

1. Routine or periodic exams, including, but not limited to:
 - a. School enrollment physicals.
 - b. Well-baby and well-childcare, including child health supervision services, based on American Academy of Pediatric Guidelines. Child health supervision services include, but are not limited to, review of a child's physical and emotional status performed by a Physician (or by a health care professional under the supervision of a Physician), in accordance with the recommendations of the American Academy of Pediatrics, and a history, complete physical examination, developmental assessment, anticipatory guidance, appropriate immunizations, and laboratory tests.
 - c. Adult routine physical examinations.

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- d. Pelvic examinations.
 - e. Routine EKG, chest X-ray, laboratory tests, such as complete blood count, comprehensive metabolic panel, and urinalysis.
 - f. Immunizations, including those required for school, following the current childhood and adolescent immunization schedule as approved by the Advisory Committee on Immunization Practice (ACIP), American Academy of Pediatrics (AAP), and American Academy of Family Physicians (AAFP). For adults, the Plan follows the adult immunization schedule by age and medical condition as approved by the Advisory Committee on Immunization Practice (ACIP) and accepted by the American College of Gynecologists (ACOG) and American Academy of Family Physicians, including, but not limited to:
 - Hepatitis A vaccine
 - Hepatitis B vaccine
 - Hemophilus influenza B vaccine (Hib)
 - Influenza virus vaccine
 - Rabies vaccine
 - Diphtheria, Tetanus, Pertussis (DTP) vaccine
 - Mumps virus vaccine
 - Measles virus vaccine
 - Rubella virus vaccine
 - Poliovirus vaccine
 - Covid vaccine
 - RSV vaccine
 - Shingles vaccine
 - Pneumococcal vaccine
2. Screening examinations, including:
 - a. Routine digital screening mammograms. If, after a routine digital screening mammogram, your Physician determines that further testing is Medically Necessary, the Plan will cover additional mammography views, including 3D mammograms, and any ultrasound screening for breast cancer.
 - b. Routine cytologic and chlamydia screening (including pap test).
 - c. Routine bone density testing for women.
 - d. Routine prostate specific antigen (PSA) testing.
 - e. Routine colorectal cancer examination and related laboratory tests. Examinations and tests will be covered more often as recommended by the current American Cancer Society guidelines or by your Physician.
 3. Diabetes self-management training for a Participant with insulin dependent diabetes, non-insulin dependent diabetes, or elevated blood glucose levels induced by pregnancy or another medical condition when Medically Necessary, ordered in writing by a Physician or a podiatrist, and provided by a Provider who is licensed, registered, or certified under state law.
 4. Transportation to and from the place where those services described in paragraphs 1 through 3 above are performed by a private carrier (including taxi or other licensed private carrier) when other means of transportation are not reasonably available, up to \$25 per round trip and \$50 per month.

The list of covered Preventive Services is determined each year by the Federal Government as part of the Affordable Care Act. The current list can be found at the following website:

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www.healthcare.gov/coverage/preventive-care-benefits.

Physician Office Services

Office Services include care in a Physician's office, including:

1. Office visits for medical care and consultations to examine, diagnose, and treat an Illness or Injury performed in the Physician's office.
2. Allergy services, including injections, serum and allergy testing.
3. Diagnostic services when required to diagnose or monitor a symptom, disease, or condition.
4. Surgery and surgical services, including anesthesia and supplies (surgical fee includes normal post-operative care).
5. Therapy services for physical medicine therapies and other therapies.
6. Transportation to and from the Physician office by a private carrier (including taxi or other licensed private carrier) when other means of transportation are not reasonably available, up to \$25 per round trip and \$50 per month.

Inpatient Services

Inpatient services include:

1. Room, board, and general nursing services, which includes a:
 - a. Room with two or more beds.
 - b. Private room; however, the allowance is the Hospital's average semi-private room rate unless it is Medically Necessary to occupy a private room for isolation and no isolation facilities are available.
 - c. Room in a special care unit that has facilities, equipment, and supportive services for intensive care of critically ill patients.
2. Ancillary services, which include:
 - a. Operating, delivery, and treatment rooms and equipment.
 - b. Prescribed medications.
 - c. Anesthesia, anesthesia supplies, and services given by an employee of the Hospital or other Provider.
 - d. Medical and surgical dressings, supplies, casts, and splints.
 - e. Diagnostic services.
 - f. Therapy services.
3. Professional services, which include:
 - a. Medical care visits, limited to one visit per day by any one Physician.
 - b. Intensive medical care for constant attendance and treatment when a condition requires it for a prolonged time.
 - c. Concurrent care for a medical condition by a Physician who is not the surgeon while confined in the Hospital for surgery. Care by two or more Physicians during one Hospital stay when the nature or severity of the condition requires the skills of separate Physicians is covered.
 - d. Consultation, which is a personal bedside examination by another Physician when requested by

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- your Physician. Staff consultations required by Hospital rules are excluded.
- e. Surgery and the administration of general anesthesia.
 - f. Newborn exam when performed by a Physician other than the Physician who performed the obstetrical delivery.

Outpatient Services

Outpatient services include facility and professional charges when rendered as an outpatient at a Hospital, Alternative Care Facility, or other Provider as determined by the Plan. Professional charges only include services billed by a Physician or other professional.

Emergency Medical Care and Urgent Care Services

Follow-up care is not considered Emergency Medical Care. Care and treatment provided once you are stabilized is not Emergency Medical Care.

1. Emergency Medical Care, including emergency room services are defined as Medically Necessary services to treat an Emergency condition. Care and treatment provided once you are stabilized is not Emergency Care. Continuation of care from a Provider beyond that needed to evaluate or stabilize your condition in an Emergency may not be covered unless the Plan authorizes the continuation of care and it is Medically Necessary.

2. Urgent Care Center services. Often an urgent rather than an Emergency medical problem exists. An urgent care medical problem is an unexpected episode of illness or injury requiring treatment that cannot reasonably be postponed for regularly scheduled care. It is not considered an Emergency. Urgent care medical problems include, but are not limited to, earache, sore throat, and fever (not above 104 degrees). Treatment of an Urgent Care medical problem is not life threatening and does not require use of an Emergency room at a Hospital. If you call your Physician before receiving care for an urgent medical problem and your Physician authorizes you to go to an Emergency room, your care will be covered as Emergency Medical Care.

Ambulance Services

The Plan covers transportation by a vehicle designed, equipped, and used to transport ill and injured persons and staffed by Emergency Medical Technicians (EMT), paramedics, or other certified medical professionals:

Ambulance services do not include trips to a Physician's office or clinic or to a morgue or funeral home.

1. From your home, the scene of the accident, or medical Emergency to a Hospital.
2. Between Hospitals.
3. Between Hospital and Skilled Nursing Facility.
4. From a Hospital or Skilled Nursing Facility to your home.

Ambulance services are a Covered Service only when Medically Necessary, except when:

1. Ordered by an employer, school, fire, or public safety official and the Participant is not in a position to refuse.
2. A Participant is required, by the Plan, to move from a non-network to a network Provider.

Trips must be to the closest local facility that can give Covered Services appropriate for the condition. If none, trips to the closest facility outside the local area are covered. Ambulance usage is not covered when another type of transportation can be used without endangering the Participant's health. Any ambulance usage for the convenience of the Participant, family, or Physician is not covered. Ambulance trips to a Physician's office or clinic, or to a morgue or funeral home are not covered.

Diagnostic Services

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Diagnostic services are tests or procedures generally performed when specific symptoms are present to detect or monitor the condition. Covered Services include, but are not limited to:

1. X-ray and other radiology services, including mammograms for any person diagnosed with breast disease.
2. Magnetic Resonance Imaging (MRI).
3. CAT scans.
4. Laboratory and pathology services.
5. Cardiographic, encephalographic, and radioisotope tests.
6. Ultrasound services.
7. Allergy tests.
8. Electrocardiograms (EKG).
9. Electromyograms (EMG), except that surface EMG's are not covered.
10. Echocardiograms.
11. Bone density studies.
12. Positron Emission Tomography (PET scanning).
13. Central supply (IV tubing) or pharmacy (dye) necessary to perform tests are covered as part of the test.

Surgical Services

Covered surgical services, include, but are not limited to:

1. Performance of generally accepted operative and other invasive procedures.
2. Correction of fractures and dislocations.
3. Anesthesia (including services of a Certified Registered Nurse Anesthetist) and surgical assistance when Medically Necessary.
4. Usual and related pre-operative and post-operative care.
5. Operative and cutting procedures.
6. Endoscopic examinations, such as arthroscopy, bronchoscopy, colonoscopy, or laparoscopy.
7. Other invasive procedures, such as angiogram, arteriogram, amniocentesis, tap, or puncture of brain or spine.

The surgical fee includes normal post-operative care. The Plan may combine the reimbursement when more than one surgery is performed during the same operative session.

Craniomandibular or Temporomandibular Joint (TMJ) Disorder

TMJ services cover medically appropriate surgical procedures and appliances. Services include coverage when the diagnosis is for one of the following: osteoarthritis, improperly healed or fresh fractures, degenerative arthritis, severe deforming arthritis, ankylosis, tumors, or any other organic condition of TMJ.

TMJ services coverage for dental services (E.G., crowns/bridges), Coronoplasty, Injection of Muscles, or dental prosthetic devices are not covered.

This Plan complies with the Women's Health Act and Cancer Rights Act, which requires group health plans, such as this Plan, that provide medical and surgical benefits in connection with a mastectomy to provide benefits for certain reconstructive surgery, including:

- ♣ Reconstruction of the breast on which the mastectomy has been performed;
- ♣ Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- ♣ Prostheses and physical complications at all stages of mastectomy, including lymphedemas.

This coverage is subject to the same copayments, deductibles, and coinsurance applicable to other physical conditions covered under the Plan

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Morbid Obesity Treatment Services

Surgical services for morbid obesity are covered the same as other Medically Necessary surgical services and include surgical treatment of morbid obesity:

1. That has persisted for at least five years; and
2. For which non-surgical treatment supervised by a Physician has been unsuccessful for at least 18 consecutive months.

Morbid obesity means a body mass index of at least:

Body mass index equals weight in kilograms divided by height in meters squared.

1. 35 kilograms per meter squared with co-morbidity or coexisting medical conditions, such as hypertension, cardiopulmonary conditions, sleep apnea, or diabetes; or
2. 40 kilograms per meter squared without co-morbidity

The Plan may combine payment when more than one surgery is performed during the same operative session.

Sterilization

The Plan covers sterilization services, regardless of Medical Necessity.

Maternity Services

Maternity services include inpatient, outpatient, and Physician office services for normal pregnancy, complications of pregnancy, miscarriage, therapeutic abortion, and ordinary routine nursery care for a well newborn.

If maternity services are not covered for any reason, Hospital charges for ordinary routine nursery care for a well newborn are also not covered.

Coverage will be for the length of stay recommended by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists in their Guidelines for Prenatal Care. The Plan complies with federal law that prohibits restricting benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section. However, health care Providers are not required to obtain authorization from the Plan for Hospital stays within these guidelines. Federal law does not prohibit the Physician, after consultation with the mother, from discharging the mother and/or her newborn earlier than 48 (or 96) hours.

Coverage for a length of stay shorter than the minimum period mentioned above may be permitted if your attending Physician determines further inpatient postpartum care is not necessary for you or your newborn child, provided the following are met and the mother concurs:

1. In the opinion of your attending Physician, the newborn child meets the criteria for medical stability in the Guidelines for Prenatal Care prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists that determine the appropriate length of stay based upon evaluation of the:
 - a. Antepartum, intrapartum, and postpartum course of the mother and infant;
 - b. Gestational stage, birth weight, and clinical condition of the infant;
 - c. Demonstrated ability of the mother to care for the infant after discharge; and
 - d. Availability of post discharge follow-up to verify the condition of the infant after discharge.
2. Covered Services include at-home post-delivery care visits at your residence by a Physician or nurse when performed no later than 48 hours following your (and your newborn child's) discharge from the Hospital. Coverage includes, but is not limited to:
 - a. Parent education.
 - b. Physical assessments.

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- c. Assessment of the home support system.
- d. Assistance and training in breast or bottle feeding.
- e. Performance of any maternal or neonatal tests routinely performed during the usual course of inpatient care for you or your newborn child, including the collection of an adequate sample for the hereditary and metabolic newborn screening.

Infertility Services

Benefits include inpatient, outpatient, and Physician office services for the diagnosis of infertility only; treatment is not covered.

Elective Abortion

Regardless of Medical Necessity, the Plan covers Provider services for elective abortion accomplished by any means.

Therapy Services

The Plan covers the following therapies that will result in a practical improvement in the level of functioning within a reasonable period:

1. Physical therapy, including treatment by physical means, hydrotherapy, heat, or similar modalities, physical agents, biomechanical and neuro-physiological principles and devices. This therapy is given to relieve pain, restore function, and to prevent disability following illness, injury, or loss of a body part.
2. Speech therapy for the correction of a speech impairment.
3. Occupational therapy for the treatment of a physically disabled person by means of constructive activities designed and adapted to promote the restoration of the person's ability to satisfactorily accomplish the ordinary tasks of daily living and those tasks required by the person's particular occupational role. Occupational therapy does not include diversional, recreational, or vocational therapy (e.g. hobbies, arts and crafts).
4. Chiropractic services for the manipulation of the spine to correct, by manual or mechanical means, structural imbalance or subluxation to remove nerve interference from or related to distortion, misalignment, or subluxation of or in the vertebral column. Chiropractic care includes the following:
 - a. Initial consultation and work up x-rays necessary to diagnose;
 - b. Initial Care: up to 10 visits for the first 30 days, or up to 20 visits for the first 60 days;
 - c. Continuing Care: up to 1 visit per month, except as stated below in Recurrence of Acute Condition;

For the Recurrence of Acute Condition: up to eight visits for the first 30 days, up to 10 visits for the next 60 days, thereafter, up to one visit per month.

5. Cardiac rehabilitation to restore an individual's functional status after a cardiac event. However, home programs, on-going conditioning, and maintenance are not covered.
6. Chemotherapy treatment of disease by chemical or biological antineoplastic agents, including the cost of such agents.
7. Dialysis treatments of an acute or chronic kidney ailment, which may include the supportive use of an artificial kidney machine.
8. Radiation therapy for the treatment of disease by X-ray, radium, or radioactive isotopes.
9. Inhalation therapy for the treatment of a condition by the administration of medicines, water vapors, gases, or anesthetics by inhalation.
10. Physical medicine and rehabilitation services, which includes a structured therapeutic program of an intensity that requires a multidisciplinary coordinated team approach to upgrade the patient's ability to function as independently as possible, including skilled rehabilitative nursing care,

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physical therapy, occupational therapy, speech therapy, and services of a social worker or psychologist. The goal is to obtain practical improvement in a reasonable length of time in the appropriate setting. Physical medicine and rehabilitation involve several types of therapy, not just physical therapy, and a coordinated team approach. The variety and intensity of treatments required is the major differentiation from an admission primarily for physical therapy.

11. Transportation to and from the place of covered Therapy Services by a private carrier (including taxi or other licensed private carrier) when other means of transportation are not reasonably available, up to \$25 per round trip and \$50 per month.

Home Care Services

Home care services are those performed by a Home Health Care Agency or other Provider in your residence. The services must be provided on a part-time visiting basis according to a course of treatment. Covered Services include, but are not limited to:

1. Intermittent skilled nursing services by a registered nurse or licensed practical nurse.
2. Diagnostic services.
3. Medical/social services.
4. Nutritional guidance.
5. Home health aide services.
6. Therapy services.
7. Medical/surgical supplies.
8. Durable medical equipment.
9. Prescription medications, but only when provided and billed by a Home Health Care Agency.
10. Private duty nursing.
11. Home infusion therapy, which include a combination of nursing, durable medical equipment, and pharmaceutical services delivered and administered intravenously in the home. Home IV therapy includes, but is not limited to:
 - a. Injections (intra-muscular, subcutaneous, and continuous subcutaneous).
 - b. Total Parenteral Nutrition (TPN).
 - c. Enteral nutrition therapy.
 - d. Antibiotic therapy.
 - e. Pain management.
 - f. Chemotherapy

Skilled Nursing Facility Benefits

If you are admitted to an approved Participating Skilled Nursing Facility, benefits are provided by Medicare for semi-private accommodations and all other services provided by the facility for up to 100 days provided you:

1. Have completed a 3-day minimum Medically Necessary inpatient hospital stay for a related illness or injury;
2. Your doctor certifies that you need daily skilled care like intravenous injections or physical therapy;
3. And provided (i) your condition requires professional and practical nursing care provided by a Skilled Nursing Facility and (ii) you remain under active medical supervision of a licensed physician.

You pay nothing for the first 20 days of each Medicare benefit period. Medicare pays all but a set coinsurance amount per day for days 21-100 of each Medicare benefit period. The Plan will cover the

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Medicare daily coinsurance amount for days 21-100. There is no coverage beyond 100 days each benefit period. Neither Medicare, nor the Plan covers long-term or custodial care.

If you occupy a private room in a Participating Skilled Nursing Facility, you will be entitled to all of the above described benefits but you will be required to pay the facility the excess, if any, of its regular charge for the private room over the facility's most common charge for semi-private rooms.

The need for confinement in a Skilled Nursing Facility must be certified by the licensed Physician in charge of the case, in a form satisfactory to and as required from time to time by the Fund Administrator. The Fund Administrator will make the initial determination as to whether or not the condition is a covered condition and is of the nature to require care or continued care in such facility.

If you meet the requirements set forth above but are confined in an approved Skilled Nursing Facility which is not a Participating Facility, you will be entitled to the same amount that would have been paid had the facility in question been a Participating Skilled Nursing Facility, but not in excess of 90% of the charges of the facility in question.

A facility will be approved by the Fund Administrator if:

1. It qualifies as a Skilled Nursing Facility under Medicare; or
2. It is accredited as a Skilled Nursing Facility by the Joint Commission on Accreditation of Hospitals or if the Plan's Preferred Provider Organization determines that it meets the standards for such accreditation; and
3. Where necessary, has been approved by the applicable area wide Health Care Planning Agency.

Before you or one of your dependents enter a Skilled Nursing Facility, you should ask the Fund Administrator whether such facility meets the above requirements.

A new maximum benefit period will commence only when there has been a lapse of at least ninety days between the date of last discharge from a Skilled Nursing Facility and the date of the next admission to a Skilled Nursing Facility due to the same or related causes, whether or not benefits were provided for the prior admission.

Benefits are not provided for:

1. Confinement which is principally for custodial care;
2. Care for the deaf or blind;
3. Care for senility, mental deficiency or retardation; care for mental illness, other than for short-term convalescent care when the prognosis for recovery or improvement is deemed favorable;
4. Care not requiring continued professional and practical nursing care provided by a Skilled Nursing Facility;
5. Care that could be managed by an approved Home Care Agency where such Agency is available;
6. Expenses for which payment or reimbursement is received by or for the account of the individual as a result of a legal action or settlement;
7. Confinements, services, supplies or treatments which are not necessary according to accepted standards of medical practice;
8. Confinements, services, supplies or treatments for which no charge is made that you are legally obligated to pay or for which no charge could be made in the absence of this coverage; or
9. Confinements, services, supplies or treatments received for illness or injury due to war (declared or undeclared) or any act of war, if such illness or injury occurred while insured for this coverage.

Hospice Services

Hospice Care may be provided in the home or a Hospice Facility and are medical, social, and psychological services used as palliative treatment for Participants with a terminal illness, including routine home care, continuous home care, inpatient Hospice Care, and inpatient respite care. To be eligible for hospice benefits, the patient must have a life expectancy of six months or less, as certified by the attending Physician.

Covered Services include:

1. Skilled nursing services by a registered nurse or licensed practical nurse.

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2. Diagnostic services.
3. Physical, speech, and inhalation therapies.
4. Medical supplies, equipment, and appliances.
5. Counseling services, except bereavement counseling.
6. Inpatient confinement at a Hospice Facility.
7. Prescription medications obtained from the Hospice Facility.

Human Organ and Tissue Transplant Services

The Plan covers Medically Necessary human organ and tissue transplants or stem cell/bone marrow transplants and transfusions, including necessary acquisition procedures, harvest and storage, and Medically Necessary preparatory myeloablative therapy. The Plan covers transplant procedures and all covered services directly related to the disease that has necessitated the transplant procedure or that arises as a result of the transplant procedure within a covered transplant benefit period, including any diagnostic evaluation for the purpose of determining a Participant's appropriateness for a procedure.

Covered Transplant Benefit Period: This period starts with a covered transplant procedure and continues for one year. If, within this time frame, a second transplant procedure occurs, the period will begin with the second transplant procedure and continue for one year.

Notification: You should contact the number on the back of your Identification Card and ask for the transplant coordinator when you need transplant procedures for coverage information, including details regarding what is covered and whether any exclusions apply.

Transplant Related Travel Benefit: When preapproved by the Fund Administrator, the Plan provides assistance with reasonable and necessary travel expenses when you are required to travel more than 75 miles from your residence to reach the facility where your procedure will be performed. Assistance includes transportation to and from the facility and lodging for the patient and one companion. If the Participant receiving treatment is a minor, then reasonable and necessary expenses for transportation and lodging may be allowed for two companions.

The Maximum Plan Benefit for transplant related travel expenses, including transportation, lodging and meals for the patient and one family member or companion is \$10,000 per transplant. Reimbursement is available at 100% for round trip "coach" airfare, and up to a maximum of \$250 per day for lodging and meals received during the pre-operative work-up, transplant operation, and post-transplant treatment phases for up to one-year post-transplant. Receipts are required when submitting lodging, meals, and travel expenses for payment consideration. The following are not covered: car rental, telephone calls, personal care items such as shampoo, entertainment expenses, alcohol/tobacco, souvenirs, and expenses for persons other than the patient and his/her designated family member/companion.

Medical Supplies, Durable Medical Equipment, and Appliances

Covered Services include, but are not limited to:

1. Medical and surgical supplies, such as syringes, needles, oxygen, surgical dressings, splints, and other similar items that serve only a medical purpose. Covered Services do not include items usually stocked in the home for general use like band-aids, thermometers, and petroleum jelly.
2. Durable medical equipment, which means the rental (or, at the Plan's option, the purchase) of durable medical equipment prescribed by a Physician or other Provider. Durable medical equipment is equipment that:
 - a. Can withstand repeated use (i.e., could be rented and used by successive patients);
 - b. Is primarily and customarily used to serve a medical purpose;
 - c. Generally is not useful to a person in the absence of illness or injury; and
 - d. Is appropriate for use in a patient's home.

Examples include, but are not limited to, wheelchairs, crutches, Hospital beds, and oxygen

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equipment. Rental costs must not be more than the purchase price. Repair of medical equipment is covered. Non-covered items include, but are not limited to, air conditioners, humidifiers, dehumidifiers, special lighting, or other environmental modifiers, surgical supports, and corsets or other articles of clothing.

3. Prosthetic appliances, which means artificial substitutes for body parts and tissues and materials inserted into tissue for functional or therapeutic purposes. Covered Services include purchase, fitting, needed adjustment, repairs, and replacements of prosthetic devices and supplies that replace all or part of a missing body part and its adjoining tissues or all or part of the function of a permanently useless or malfunctioning body part. Covered Services for prosthetic appliances include, but are not limited to:
 - a. Aids and supports for defective parts of the body including, but not limited to, internal heart valves, mitral valve, internal pacemaker, pacemaker power sources, synthetic or homograft vascular replacements, fracture fixation devices internal to the body surface, replacements for injured or diseased bone and joint substances, mandibular reconstruction appliances, bone screws, plates, and vitallium heads for joint reconstruction.
 - b. Left Ventricular Artificial Devices (LVAD) when used as a bridge to a heart transplant.
 - c. Breast prosthesis whether internal or external, following a mastectomy, and four surgical bras per calendar year.
 - d. Minor devices for repair such as screws, nails, sutures, and wire mesh.
 - e. Replacements for all or part of absent parts of the body or extremities, such as artificial limbs, artificial eyes, etc.;
 - f. Intraocular lens implantation for the treatment of cataract or aphakia. Contact lenses or glasses are often prescribed following lens implantation and are Covered Services. The Plan covers all types of implanted lenses, including the cost of lenses exceeding the Medicare Approved Amount.
 - g. Artificial gut systems (parenteral devices necessary for long-term nutrition in cases of severe and otherwise fatal pathology of the alimentary tract) formulae, and supplies.
 - h. Cochlear implant.
 - i. Electronic speech aids in post-laryngectomy or permanently inoperative situations.
 - j. Space shoes when used as a substitute device when all or a substantial portion of the forefoot is absent.
 - k. Wigs following cancer treatment.

Non-covered prosthetic appliances include, but are not limited to dentures (replacing teeth or structures directly supporting teeth), dental appliances, non-rigid appliances (such as elastic stockings, garter belts, arch supports, and corsets), artificial heart implants, hairpieces for male pattern alopecia (baldness), and wigs (except as described for cancer treatment).

4. Orthotic devices, which include the initial purchase, fitting, and repair of a custom made rigid or semi-rigid supportive device used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body, or that limits or stops motion of a weak or diseased body part. The cost of casting, molding, fittings, and adjustments are included. Covered orthotic devices include, but are not limited to:
 - a. Cervical collars.
 - b. Ankle foot orthosis.
 - c. Corsets (back and special surgical).
 - d. Splints (extremity).
 - e. Trusses and supports.
 - f. Slings.
 - g. Wristlets.
 - h. Built-up shoe.
 - i. Custom made shoe inserts.

Orthotic appliances may be replaced once per year per Participant when Medically Necessary.

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However, additional replacements will be allowed for Participants under age 18 due to rapid growth or for any Participant when an appliance is damaged and cannot be repaired.

If any of the above supplies, equipment, or appliances include comfort, luxury, or convenience items or features that exceed what is Medically Necessary, payment will be based on the Medicare Approved Amount for a standard item that is a Covered Service, serves the same purpose, and is Medically Necessary. Any expense that exceeds the Medicare Approved Amount for the standard item that is a Covered Service is your responsibility. For example, the reimbursement for a motorized wheelchair will be limited to the reimbursement for a standard wheelchair, when a standard wheelchair adequately accommodates the condition. Non-Covered Services include, but are not limited to:

- a. Orthopedic shoes.
- b. Foot support devices, such as arch supports and corrective shoes, unless they are an integral part of a leg brace.
- c. Standard elastic stockings, garter belts, and other supplies not specially made and fitted (except as specified under medical supplies).
- d. Garter belts or similar devices.

Accident Related Dental Services

Dental work and oral surgery is covered if provided for the initial repair of an Injury to the jaw, sound natural teeth, mouth or face that are not excessive in scope, duration, or intensity to provide safe, adequate, and appropriate treatment without adversely affecting the Participant's condition. This only includes dental work to repair Injuries when performed within 12 months of the Injury or as reasonably soon thereafter as possible, including all examinations and treatment to complete the repair. However, for a child requiring facial reconstruction due to dental related Injury, there may be several years between the accident and the final repair. Dental implants are excluded from this coverage.

Covered Services for accidental dental include, but are not limited to:

1. Oral examinations.
2. X-rays.
3. Tests and laboratory examinations.
4. Restorations.
5. Prosthetic services.
6. Oral surgery.
7. Mandibular/maxillary reconstruction.
8. Anesthesia.

Dental/Oral Surgery

Charges for outpatient facility services are covered when the patient's medical condition or the dental procedure requires a hospital setting to ensure the safety of the patient. Completely bony impacted extractions are covered as surgery, including completely impacted wisdom teeth. In addition, both fully and partially bony impactions are covered. Extractions of non-impacted teeth are covered if a concurrent hazardous condition exists. Professional surgical charges are covered if a series of recurrent or related surgeries are performed for treatment of the same disease or injury. Note: A series of surgeries is defined as three surgeries or greater.

Behavioral Health Services

Covered Services include but are not limited to:

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1. Inpatient services, which include individual or group psychotherapy, psychological testing, family counseling with family members to assist in diagnosis and treatment, convulsive therapy, including electroshock treatment or convulsive drug therapy.

Two days of partial hospitalization treatment or intensive outpatient treatment are the equivalent of one inpatient day

2. Partial hospitalization, which is a structured, intensive, multidisciplinary treatment program that provides psychiatric, medical, and nursing care. The program usually is offered in an acute setting, but the patient goes home in the evening and on weekends. The program delivers a highly structured environment of at least four to six hours of treatment per day. Patients are expected to participate up to five days per week.
3. Intensive outpatient treatment or day treatment, which is a structured program, offered at least three times per week for at least three hours per day. The program may be managed by a licensed Behavioral Health professional with a psychiatrist on staff and therapy is provided by a licensed Behavioral Health professional.
4. Outpatient (or individual or group) treatment, which is office-based services, for example diagnostic evaluation, counseling, psychotherapy, family therapy, and medication evaluation. The service may be provided by a licensed Behavioral Health professional if, in the case of a professional who is not a psychiatrist, it is coordinated by a psychiatrist.

The following services are not covered under the Plan:

1. Residential treatment services, which means individualized and intensive treatment in a residential setting, including observation and assessment by a psychiatrist weekly or more frequently, individualized program of rehabilitation, therapy, education, and recreational or social activities.
2. Custodial or Domiciliary Care.
3. Supervised living or halfway houses.
4. Room and board charges unless the treatment provided is Medically Necessary for the inpatient admission for the condition.

Hearing Benefits

The Plan provides hearing benefits, which include hearing aids, and the testing, prescription and fitting of such appliances.

Hearing benefits are limited to the actual charges for covered services, up to the amount listed in the Summary of Benefits for each Participant (you and each of your Dependents) in any three consecutive calendar year period. The per-person maximum shown in the Summary of Benefits is for the purchase of the hearing aid only. Provider visits and/or tests related to your hearing are covered under the medical plan.

Fitness Benefit

The Plan's fitness benefit provides for annual reimbursement for membership in a local fitness center (see the Summary of Benefits for the amount). In addition to fitness center membership, other physical wellness activities are eligible for reimbursement. In order to qualify as a reimbursable benefit, the physical activity must be conducted by a certified instructor. Examples of such activities are exercise (Yoga, Tai Chi, Jazzercise, Zumba, Pilates, cycling, aerobics, water aerobics, bodyweight, personal trainer) programs, dancing (ballroom, jazz, ballet, tap) lessons and sports instruction (swimming, tennis, pickle ball, golf, bowling) lessons. It is the cost of the sports instruction itself that can be reimbursed. For example, greens fees, tennis court fees and bowling lane fees are not reimbursable unless they are included in the approved instruction.

Reimbursement for VA Out-of-Pocket Expenses

Participants who receive services from the VA and are required to pay a portion of the cost may submit documentation of these out-of-pocket expenses to the Plan for reimbursement.

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Medical Expenses Not Covered Under the Plan

Medical benefits provide coverage for many medical expenses related to an illness or injury. You should be aware that some expenses are not covered by the Plan. See information listed in this section as well as the items listed in *General Plan Exclusions and Limitations* on pages 60-62 for expenses that are not covered under the Plan.

Prescription Drug Benefits for Medicare-eligible Participants

Prescription drug expenses are rising faster than most other health care expenses and can be a significant expense for you and your family. Recognizing this, the Fund offers prescription drug benefits to you and your Dependents. The Fund has contracted with a Pharmacy Benefit Manager (PBM), to provide you with access to a retail pharmacy and mail order program. Information on the Plan's PBM, including customer service phone numbers and website can be found in the Claims and Appeals and Benefit Payment Information section of this SPD.

Prescription Drug Plan Benefit

The Prescription Drug Plan for Medicare-eligible participants is a combination of a Medicare Part D prescription drug plan and additional benefits provided by the PBM. Participants are automatically enrolled in Medicare Part D and the Plan currently pays the standard Medicare Part D premium. The copayment amounts for prescription drugs are described in the Summary of Benefits provided by the Plan.

Generic Equivalents and Brand Name Medications

Many prescription drugs have two names: the generic name and the brand name. By law, both generic and brand name medications must meet the same standards for safety, purity, and effectiveness. However, on average, generic medications cost less than their brand name alternatives. This can be a significant source of savings for you and the Plan.

Often several types of medications can be used to treat the same condition. To ensure high-quality care and to help manage costs, most prescription drug programs have a list of preferred medications. The list consists of prescription medications (preferred medications) that are either more effective than others in their class are, or as effective, and less costly.

A generic equivalent is a copy of a brand name medication that is no longer protected by a patent. A generic medication usually serves the same purpose as the original (brand name) medication and costs less.

If your doctor prescribes less than a full month's supply of certain drugs, you will pay a daily Cost-sharing rate based on the actual number of days of the drug you receive.

You may receive up to a 90-day supply of certain maintenance drugs (medication taken on a long-term basis) by mail through the PBM's home delivery service. There is no charge for standard shipping. You may also use retail pharmacies for maintenance drugs. Note that not all drugs are available at a 90-day supply; please contact the PBM for more information.

Long-Term Care Pharmacy

Long-term care pharmacies must dispense brand-name drugs in amounts less than a 14-day supply at a time. They may also dispense less than a one month's supply of generic drugs at a time. Contact the PBM if you have questions about cost-sharing or billing when less than a one-month supply is dispensed.

IMPORTANT PLAN INFORMATION

- The service area for this plan is all 50 states, the District of Columbia and Puerto Rico.
- You must live in one of these areas to participate in this plan.
- Your Plan uses a formulary (a list of covered drugs) which is determined by Medicare and

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administered by the PBM. The PBM may periodically add or remove drugs, make changes to coverage limitations on certain drugs, or change how much you pay for a drug. If any formulary change limits your ability to fill a prescription, you will be notified before the change is made.

- The plan may require you to first try one drug to treat your conditions before it will cover another drug for that condition
- Your health care provider may be required to obtain prior authorization from the PBM for certain drugs
- If the actual cost of a drug is less than the normal cost-sharing amount for that drug, you will pay the lower actual cost

This Plan offers Benefits Equivalent to a Medicare Part D Prescription Drug Plan. Therefore, you may not enroll in any other Medicare Part D Plan. If you do enroll, you will no longer be covered by the Plan's Prescription Drug Benefit

- If you request an exception for a drug, and the PBM approves the exceptions, you will pay the non-preferred copay amount for that drug
- You must continue to pay your Medicare Part B premium, if not otherwise paid for under Medicaid or another third-party.

Effect of Enrollment in Other Part D Coverage

By virtue of your participation in this Plan, you are automatically enrolled in Medicare Part D. If you are Medicare-eligible you MAY NOT participate in the Fund's prescription drug program if you sign up for any other Medicare Part D plan. Accordingly, if you are a Medicare-eligible participant, and you enroll in another Medicare Part D plan, you will be excluded from participation in the

Fund's prescription drug program as of the effective date of your enrollment in another Medicare Part D plan. In addition, if the Retired Employee enrolls, his/her Spouse and eligible Dependent(s) will also be excluded from participation in the Plan's prescription drug program. Similarly, if a Medicare-eligible Spouse or Dependent enrolls in another Medicare Part D plan, the Retired Employee, his/her Spouse and Dependent(s) will all be excluded from the Plan's prescription drug program even if the Retired Employee is not enrolled in another Medicare Part D plan. There will be no reduction in your monthly premium contribution as a result of the Retired Employee, Spouse, Surviving Spouse or Dependent's enrollment in another Medicare Part D plan and loss of prescription drug coverage under this Plan.

If you are excluded from participation in the Fund's prescription drug benefit program, however, you will still be entitled (along with your eligible Spouses and Dependents) to participate in the *medical and all other benefits (as applicable)* offered by the Plan, regardless of your or your Dependents' participation in any Medicare program.

As required by the Medicare Prescription Drug Improvement and Modernization Act of 2003, as a Medicare-eligible Participant, you will periodically receive a notice, called a Notice of Creditable Coverage, advising whether the Fund's prescription drug plan continues to be actuarially equivalent to Medicare Part D. You are also entitled to receive such Notices upon request to the Fund Administrator.

Your Income May Affect Your Medicare Part D Premium

Medicare will charge most people the standard Medicare Part D contributions and that premium is paid by the Fund as part of the Plan's prescription drug program. However, some people may have to pay an extra amount because of their yearly income. If your modified adjusted gross incomes as reported on your IRS tax return for two years ago (the most recent tax return information provided to Social Security by the IRS) is more than \$106,000 for individuals and married individuals filing separately, or more than \$212,000 for married individuals filing jointly, Social Security will charge you and extra amount for your Medicare Part D prescription drug coverage (note that these amounts are for 2025 returns and are adjusted annually for inflation). This extra amount is called the Income-Related Monthly Adjustment Amount (IRMAA). If you have to pay an extra amount, Social Security will send you a letter telling you what the extra amount will be and how to pay it. The extra amount will typically be withheld from your Social Security check. *The Fund will reimburse you for any income-related extra Medicare Part D contribution Social Security charges you. You should send proof of payment to the Fund (such as your annual SSA-1099 form) and you will be reimbursed for that additional income related Part D premium.*

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If you have any questions about this extra amount, contact Social Security at 1-800-772-1213 between 7:00 am and 7:00 pm Monday through Friday.

Medication Therapy Management Program

The Medication Therapy Management Program is a free service offered by the PBM to help Participants who meet the criteria for services manage their medications. You may be invited to participate in a program designed for your specific health and pharmacy needs. You may decide not to participate, but it is recommended that you take full advantage of this service if you are selected. Contact the PBM for more details. Under the Plan's prescription drug benefits, there are three levels of copays: generic, preferred brand and non-preferred drug. Refer to Important Contact Information for contact information to get a copy of the preferred medication list.

You should discuss the Plan's preferred medication list with your Physician for any prescriptions you need filled. Your Physician or pharmacist can assist you in substituting generic or preferred brand name medications when appropriate.

Retail Pharmacy Program

When you are eligible for benefits under the Plan, you receive a prescription drug card. You can only use your card at a pharmacy that participates in the network (participating pharmacy).

When you go to a participating pharmacy, simply show the pharmacist your prescription drug ID card. No forms, receipts, or submission of claims is necessary. You simply pay the required copayment, which varies depending on the type of medication (generic, preferred brand, or non-preferred brand) when you fill your prescription.

If you have a prescription filled at a non-participating pharmacy or you do not have your ID card with you when purchasing a prescription, you must pay the full cost of the prescription when you have it filled and then submit a claim for reimbursement. You will be reimbursed the amount the prescription would have cost at a participating retail pharmacy minus your copayment amount.

You must use the PBM's Medicare network pharmacies to fill your prescriptions. Covered Medicare Part D drugs are available at out-of-network pharmacies only in special circumstances, such as illness while traveling outside the plan's service area where there is no network pharmacy. You may have to pay additional costs for drugs received at an out-of-network pharmacy. Please contact the PBM's Medicare Customer Service for more details.

Mail Order Program

For certain kinds of prescription medications you can use the Plan's network mail order service. Generally, the medications provided through mail order are prescription drugs that you take on a regular basis for a chronic or long-term medical condition. The medications that are not available through the mail order service are marked as "NM" for not available at mail in the PBM's Drug List. There may be additional drugs that are not available through mail order that are not marked NM, including some hepatitis B medications, post-transplant medications, and oral medications used to treat HIV.

There are three ways that you can start a new prescription request with SilverScript Pharmacy: online, by phone or by mail. **Online:** Simply sign in to your SilverScript Pharmacy account and select "Start a new prescription" from the home page. Enter your prescription details and your prescriber's information and submit. If you have a SilverScript account, your username and password can be used to sign into your SilverScript Pharmacy account.

When you have a prescription filled at a participating pharmacy

- ♣ Present your ID card.
- ♣ Pay your copayment, as shown on the *Summary of Benefits* insert.

When you have a prescription filled at a non-participating pharmacy or do not present your ID card at a participating pharmacy

- ♣ Pay the full cost of the prescription.
- ♣ Submit a claim for reimbursement.

Maintenance medications are prescription drugs that are used on an on-going basis. These prescriptions can be used to treat chronic conditions such as:

- ♣ Arthritis;
- ♣ Diabetes;
- ♣ Emotional distress;
- ♣ Heart disorders;
- ♣ High blood pressure; or
- ♣ Ulcers.

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Phone: Call the toll-free automated system 24 hours a day, 7 days a week at 1-833-844-5642.. Follow the directions and submit your new prescription request by phone.

Mail: To get order forms and information about filling your prescriptions by mail, please visit Caremark.com or contact Customer Care. Usually a mail order pharmacy order will be delivered to you in no more than ten (10) days.

Specialty Pharmacy

In addition, the Plan covers prescription drugs for treatment of complex conditions, such as immune deficiency, Hepatitis C, multiple sclerosis, growth hormone deficiency, rheumatoid arthritis, certain cancers, and hemophilia, with specialty medications. Specialty medications are most often injectable medications administered either by you or a healthcare professional. They often require special handling. If you use specialty medications, they will be provided through the PBM's Specialty Pharmacy. Information on the Specialty Pharmacy can be found in the Claims and Appeals and Benefit Claim Information section of this document. Certain specialty medications require prior authorization from the PBM, so you should always check with the PBM to see if a prior authorization is required. If your Physician prescribes a new specialty medication that requires prior authorization, you must receive prior authorization before the Plan will provide coverage for the medication.

Some prescriptions must be filled at a specialized pharmacy. Specialized pharmacies include:

- Pharmacies that supply prescriptions drugs for home infusion therapy;
- Pharmacies that supply prescription drugs for residents of a long-term care (LTD) facility. Usually, and LTC facility (such as a nursing home) has its own pharmacy. If you have any difficulty accessing your Part D benefits in an LTC facility, please contact Customer Care.
- Pharmacies that serve the Indian Health Service/Tribal/Urban Indian Health Program (not available in Puerto Rico). Except in emergencies, only Native Americans or Alaska Natives have access to these pharmacies in the PBM network;
- Pharmacies that dispense prescription drugs that are restricted by the FDS to certain locations or that require special handling, provider coordination, or education on their use (note: this scenario should happen rarely).

To locate a Specialty Pharmacy, call the customer service team (the number for which is found in the Claims and Appeals and Benefit Payment Information section of this SPD).

Note that Specialty medications are limited to a thirty (30) day supply.

Covered Prescription Drugs and Supplies

Generally, the Plan covers the following prescription drugs and supplies:

- Federal legend drugs;
- State restricted drugs;
- Compounded medications, of which at least one ingredient is a legend drug (note that coverage is limited and subject to review by the PBM);
- Insulin;
- Needles and syringes;
- Over-the-counter diabetic supplies (all dosage forms);
- Oral (except emergency contraceptives), transdermal, intravaginal, and injectable contraceptives;
- Standard specialty drugs;
- Medications to treat erectile dysfunction (subject to prior authorization and limited to eight doses per month); and
- Certain preventive medications are covered in full with no copayment required. Examples include:

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generic (over the counter) aspirin; smoking cessation medications (zero copay applies for the first 180 days in a 365-day period); certain vaccines; generic statins; and bowel preparation agents. In order to make sure you receive this benefit, you will need to get these medications at your pharmacy.

A Physician or Dentist must write the prescriptions, and a licensed pharmacist must dispense these prescriptions.

Expenses Not Covered by Prescription Drug Benefits

Except for insulin and certain preventive medications described under “Covered Prescription Drugs and Supplies” above, the Plan does not cover any drugs or medicines that can be purchased over-the-counter without a prescription. Specific prescription drug benefit exclusions are as follows:

- Drugs that would be covered under Medicare Part A or Part B;
- Drugs purchased outside the United States or its territories;
- Drugs prescribed for use other than what is indicated on a prescription drug’s label as approved by the Food and Drug Administration;
- Drugs used for the relief of cough and cold symptoms;
- Prescription vitamins and mineral products, except prenatal and pediatric vitamins;
- Non-federal legend drugs;
- Non systemic contraceptives, devices or implants;
- Emergency contraceptives;
- Xenical;
- Therapeutic devices or appliances;
- Allergy sera;
- Mifeprex;
- Drugs whose sole purpose is to promote or stimulate hair growth or for cosmetic purposes only;
- Drugs labeled “Caution—limited by Federal law to investigational use,” or experimental drugs, even though a charge is made to the individual;
- Medication for which the cost is recoverable under any workers’ compensation or occupational disease law or any state or governmental agency, or medication furnished by any other drug or medical service for which no charge is made to the claimant;
- Medication which is to be taken by or administered to an individual, in whole or in part, while he or she is a patient in a licensed Hospital, rest home, sanitarium, extended care facility, Skilled Nursing Facility, convalescent hospital, nursing home or similar institution which operates on its premises or allow to be operated on its premises, a facility for dispensing pharmaceuticals;
- Any prescription refilled in excess of the number of refills specified by the Physician, or any refill dispensed after one year from the Physician’s original order; and
- Other than for covered vaccines, charges for the administration or injection of any drug.

Since not all prescription drug expenses are covered by the Plan, see *General Plan Exclusions and Limitations* on pages 60-62 for expenses that are not covered under the Plan.

No Place Like Home Benefits

The Plan's *No Place Like Home Program* provides two related benefits:

- **Home Assessment Benefit.** The Plan covers the reasonable costs of a Licensed Occupational Therapist's written assessment of a Participant's home, called a *Home Assessment Report*. The *Home Assessment Report* provides the Plan with the information necessary to preapprove a Participant's *Home Modification Benefit*.
- **Home Modification Benefit.** The Plan provides financial assistance to help defray the costs of certain safety, fall prevention, and accessibility modifications to a Participant's home as set forth in the *Home Assessment Report*.

Highlights of the *No Place Like Home Program*:

Home Assessment Benefit.

- The Plan has retained a Licensed Occupational Therapist to provide assessments of Participants' homes. The Plan covers the entire cost of a home assessment conducted by the Plan's Licensed Occupational Therapist.
- If an assessment of your home cannot be conducted by the Plan's Licensed Occupational Therapist (for example, if you reside out of state), the Plan and the Plan's Licensed Occupational Therapist will attempt to refer your home assessment to another qualified Licensed Occupational Therapist in your area who will accept the Fund's Standard Reimbursement Rate of \$300.00 (or \$400.00 if the home assessment applies to two or more Participants of the Plan (e.g., retiree and spouse)). If another qualified Licensed Occupational Therapist referred by the Fund charges in excess of the Fund's Standard Reimbursement Rate, you must pay the difference unless the higher rate is pre-approved by the Trustees.
- If an assessment of your home cannot be conducted by the Plan's Licensed Occupational Therapist or the Plan is unable to refer your home assessment to another Licensed Occupational Therapist, you may obtain a home assessment from another Licensed Occupational Therapist. You will need to pay that Licensed Occupational Therapist out-of-pocket and seek reimbursement from the Plan. The Plan will reimburse you up to its Standard Reimbursement Rate.
- The *Home Assessment Benefit* is limited to one home assessment over a 48-month period.

Home Modification Benefit Lifetime Maximum.

The Plan reimburses you the lesser of (1) your out-of-pocket costs or (2) \$750.00 for preapproved safety, fall prevention, and accessibility modifications to the Participant's home. Should two or more Participants reside in the same home (e.g., retiree and spouse), and should each Participant be preapproved for safety, fall prevention, or accessibility modifications to the home the Participants share, then the Plan will reimburse each Participant the lesser of (1) that Participant's out-of-pocket costs or (2) \$750.00

This *Home Modification Benefit* is intended to be a lifetime maximum benefit. However, the Board of Trustees will consider a one-time waiver of the lifetime maximum upon a Participant's written request if the Participant establishes that: (1) he or she must move to a new home that requires safety, fall prevention, and/or accessibility modifications, or (2) a significant change in the Participant's health requires additional safety, fall prevention, and accessibility modifications. No such request will be considered earlier than 48 months after the Participant's exhaustion of the initial Home Modification Benefit.

How to Apply for the *Home Modification Benefit* under the *No Place Like Home Program*

Home Modification Benefit Preapproval Process.

To receive the *Home Modification Benefit*, you must first receive preapproval from the Fund Administrator as follows:

STEP 1: Schedule Your Home Assessment. Contact the Fund Administrator at (513) 217-4818 or toll free at (877) 392-9991 to schedule a home assessment with the Plan's Licensed Occupational Therapist. The Fund Administrator will promptly notify you whether the Plan's Licensed Occupational Therapist will conduct the home assessment or whether a Referred Licensed Occupational Therapist will conduct the home assessment. While it is unlikely, in the event neither the Plan's Licensed Occupational

No Place Like Home Benefits

Therapist nor a Referred Licensed Occupational Therapist can conduct your home assessment, you will be advised that you have the option to obtain a home assessment from another Licensed Occupational Therapist, pay the Licensed Occupational Therapist out-of-pocket, and then request reimbursement from the Plan.

STEP 2: A Licensed Occupational Therapist Conducts Your Home Assessment. If your home assessment is conducted by the Plan's Licensed Occupational Therapist or a Referred Licensed Occupational Therapist, you will be required to sign the Plan's Consent to Home Assessment form before your scheduled home assessment. The Plan's Licensed Occupational Therapist or Referred Licensed Occupational Therapist will submit your signed Consent to Home Assessment form to the Fund Administrator on your behalf.

If your home assessment is conducted by the Plan's Licensed Occupational Therapist or a Referred Licensed Occupational Therapist, upon completion of the assessment, the Plan's Licensed Occupational Therapist or a Referred Licensed Occupational Therapist will prepare a written **Home Assessment Report** and advise you on what the **No Place Like Home Program** may cover under the **Home Modification Benefit**.

STEP 3: Submission of Your Home Assessment Report for Fund Administrator Preapproval. The Plan's Licensed Occupational Therapist or a Referred Licensed Occupational Therapist will submit your **Home Assessment Report** to the Fund Administrator, and if the **Home Assessment Report** recommends certain safety, fall prevention, and/or accessibility modifications, the Fund Administrator will review those recommendations for preapproval.¹ Upon completion of its review of the recommended safety, fall prevention, and/or accessibility modifications included in the **Home Assessment Report** and any other relevant documentation submitted by the Licensed Occupational Therapist, the Fund Administrator will promptly notify you in writing what recommended modifications qualify for reimbursement under the **Home Modification Benefit** (Claim Approval Notice). The Claim Approval Notice will include the maximum amount the Plan will reimburse for each recommended modification you may wish to have covered by the **Home Modification Benefit**.

If the Fund Administrator determines that you are not eligible for a **Home Modification Benefit** or if you otherwise disagree with the Fund Administrator's determination, you may appeal that adverse benefit determination to the Board of Trustees in accordance with the Plan's appeals procedures for denial of a pre-service medical benefit claim. See pages 63-77 of your Summary Plan Description.

Home Modification Benefit Reimbursement Process

Once preapproved safety, fall prevention, and accessibility modifications to your home have been completed, you may submit to the Fund Administrator a **Home Modification Benefit** Claim Form which should include:

- Copies of invoices or other documents that show the modifications have been completed, and
- Proof of the total amount you paid out-of-pocket for those modifications.

If you decide to move ahead with some but not all preapproved safety, fall prevention, and/or accessibility modifications, the Plan will only pay for those preapproved safety, fall prevention, and/or accessibility modifications that were made to your home, up to the maximum reimbursement amount described above.

If you decide to move ahead with safety, fall prevention, and/or accessibility modifications that were preapproved by the Fund Administrator along with other home modifications that either cost you more than the maximum reimbursement amount described above or were not preapproved by the Fund Administrator, the Plan will only pay for those safety, fall prevention, and/or accessibility modifications that were made to your home that were preapproved by the Fund Administrator, up to the maximum reimbursement amount described above.

The Fund Administrator will process your **Home Modification Benefit** Claim Form in accordance with the

¹ If a Certified Occupational Therapist other than the Plan's Certified Occupational Therapist or a Referred Certified Occupational Therapist conducts your home assessment, you may submit that Certified Occupational Therapist's **Home Assessment Report** along with the Certified Occupational Therapist's home assessment invoice to the Fund Administrator for preapproval and processing.

No Place Like Home Benefits

Plan's post-service medical claims procedures. See pages 63-77 of your Summary Plan Description. In the event the Fund Administrator denies your **Home Modification Benefit** claim (in whole or in part) or you disagree with the Fund Administrator's determination, you may appeal that adverse benefit determination to the Board of Trustees in accordance with the Plan's appeals procedures for denial of post-service medical benefit claims. See pages 63-77 of your Summary Plan Description.

Expenses Covered Under the *No Place Like Home Program*

If recommended by the Licensed Occupational Therapist, the reasonable costs, up to the maximum benefit amount, of the following modifications to a Participant's home will generally be approved by the Plan:

- Furnish/install step/no-trip thresholds
- Furnish/install adjustable-height, handheld shower heads
- Furnish/install non-slip strips in or around the home
- Furnish/Install toilet risers or other toilet safety assists
- Furnish/install handrails and support bars
- Furnish Transfer tub bench
- Furnish/install wheelchair ramps
- Furnish/install door hardware modifications (e.g., swing clear door hinges)
- Furnish/install Stair Lifts or Lift Chairs
- Widen/modify *interior* doorways
- Furnish/install ADA Compliant Toilets
- Furnish/install/modify ADA compliant Bathroom Sinks

If the Licensed Occupational Therapist recommends a modification to your home that is not listed above and is not listed as Non-Covered Expenses below, the matter may be referred to the Board of Trustees for consideration before the modification will be preapproved or denied.

Please Note: While the **Home Modification Benefit** is available to both homeowners and renters, Participants who rent their homes should review their lease agreements and/or contact the property owner before moving forward with any safety enhancements, fall prevention and accessibility modifications.

Expenses Not Covered under the *No Place Like Home Benefit*

Whether or not recommended by a Licensed Occupational Therapist, the following modifications to a Participant's home are not covered by the of the **Home Modification Benefit**:

- Widening doorways at entrances or exits to your home
- Lowering or modifying kitchen cabinets and equipment
- Moving or modifying electrical outlets and fixtures
- Modifying fire alarms, smoke detectors, and other warning systems

Other Exclusions

In addition to the General Plan Exclusions and Limitations listed in the Summary Plan Description (see pages 60-62), the **Home Modification Benefit** shall not be used to defray the costs for any of the following:

- Any benefit otherwise covered by the Plan, including but not limited to Durable medical equipment and appliances that are covered under the Plan's Medical Supplies, Durable Medical Equipment, and Appliances benefit.
- The cost of a safety, fall prevention, or accessibility modification that is paid or required to be paid by a third-party, including Medicare.
- The cost of a safety, fall prevention, or accessibility modification that is not primarily for the Participant or the Participant's eligible Dependent.
- The cost of a safety, fall prevention, or accessibility modification that has not been preapproved by the Plan.

Health Reimbursement Arrangement

As of January 1, 2025 each Participant will be provided with a Health Reimbursement Account (HRA) which can be used to pay for certain IRS-qualified healthcare expenses, for example:

- Plan out-of-pocket expenses (like prescription copayments, medical non-network deductible or coinsurance, and dental/vision expenses not covered by the Plan)
- Many over-the-counter medications and products like the ones noted above now available at a discount; but note that some items (like vitamins and supplements) will require a physician's prescription and/or statement of medical necessity
- Medical Alert Systems (like Life Alert, Medical Guardian, etc.)

You can use the following website to research items available for coverage under the HRA: www.fsastore.com.

Information on Plan funding can be found in the Summary of Benefits. The full amount provided will be available at the beginning of the year and any amounts that are not used in that year will carry forward to future years. Participants will receive a debit card which can be used at pharmacies and certain other locations (like provider's offices). There is also an option to submit claims manually or through a mobile app.

If your HRA includes reimbursements for any Code Section 213(d) expense, the IRS requires that the expense is:

- For the diagnosis, cure, mitigation, treatment or prevention of disease and for treatments affecting any part or function of the body, and
- Primarily to alleviate or prevent a physical or mental defect or illness.

Expenses NOT generally eligible for reimbursement are those:

- Solely for cosmetic reasons, or
- Merely beneficial to one's general health (for example, health spas, vacations)

Your debit card shall be subject to the debit card's terms of use and any other requirements established by the Plan for this purpose. If a debit card is used to pay for an expense that is not a Qualifying Medical Expense, the Administrator shall apply correction procedures as set forth in guidance promulgated pursuant to Section 125 of the Internal Revenue Code.

If your debit card transaction is approved, you must retain your written receipts as the Administrator is required to audit certain debit card transactions. If adequate written substantiation cannot be provided, the Administrator will apply IRS required correction procedures, which may include you repaying the amount of the unsubstantiated transaction to the plan. Information on the HRA Administrator can be found in the Claims and Appeals section of this SPD.

Dental and Vision Benefits

Anyone who is eligible for benefits under the Medical Plan is also eligible for the Dental and Vision plans. Unless the Board of Trustees suspends premiums, there are separate premiums required for the Dental and Vision plans. Dental and Vision may be elected even if an eligible participant has opted out of the medical and drug plan.

Dental PPO Plan

The Dental PPO plan provides comprehensive benefits for most major services. Information about the Administrator of the dental plan can be found in the Claims and Appeals and Benefit Payment Information section of this document. You may receive dental treatment from any dentist of your choosing. The Administrator uses a different schedule of allowed amounts depending on whether or not the dentist participates in one of the Administrator's networks. The Plan pays the same percentage of the allowed amount regardless of the dentist you use; however, you will minimize your out-of-pocket expense by using a dentist who is in either the PPO or the Premier network. When you receive services from a participating dentist (either in the PPO or the larger Premier network) the dentist cannot charge more than the amount allowed by the Administrator. However, if you receive services from a non-participating dentist, the dentist may charge more than what the Administrator allows. In that case, you will be responsible for the difference between what the dentist charges and what the Administrator allows in addition to any coinsurance responsibility you may have. You will have the lowest out of pocket amount if you receive services from a PPO dentist. These dentists accept the lowest allowance from the Administrator, and this means any coinsurance responsibility you have will be the lowest possible.

The percentage coinsurance the plan will pay for each covered service is included in the Summary of Dental Plan Benefits as provided by the Dental plan administrator.

Maximum Plan Payment - Please refer to the Summary of Benefits.

Deductible - None.

Covered Services -

- Oral exams (including evaluations by a specialist) are payable four times per calendar year.
- Prophylaxes (cleanings) are payable four times per calendar year.
- Fluoride treatments are payable twice per calendar year for people up to age 19.
- Bitewing X-rays are payable once per calendar year and full mouth or panorex X-rays (which include bitewing X-rays) are payable once in any three-year period.
- Composite resin (white) restorations are Covered Services on posterior teeth.
- Porcelain and resin facings on crowns are optional treatment on posterior teeth.
- Implants and implant related services are payable once per tooth in any five-year period.
- Bone replacement grafts.
- Sedation dentistry.

Dental and Vision Benefits

Coverage Outside the United States

You can receive expert dental care when you are outside of the United States through the Administrator's Passport Dental program. This program gives you access to a worldwide network of dentists and dental clinics. English-speaking operators are available around the clock to answer questions and help you schedule care. For more information, check the Administrator's Web site or contact the Fund Administrative Office to get a copy of the Administrator's Passport Dental Information sheet.

Benefit Year - January 1 through December 31

Vision Plan

The Vision Plan provides coverage for routine vision exams, as well as eyeglasses and contact lenses. You can receive a benefit regardless of the vision provider you use, but you will receive the greatest benefit by using a provider in the Administrator's network.

Information about the Administrator of the Vision Plan can be found in the Claims and Appeals and Benefit Payment Information section of this document. The Administrator's network of providers includes private practitioners, as well as many of the nation's premier retailers, including LensCrafters, Target Optical, and most Pearle Vision locations.

When making an appointment with a provider in the Administrator's network, mention that you are a Participant in one of the Administrator's plans and provide your name and the name of your organization or Benefit number, located on the front of your ID card. Confirm the provider is an in-network provider of the Administrator. When you receive services at a participating network provider office, the provider will file your claim.

Benefit Year - January 1 through December 31

The benefits provided in the Vision plan are included in the Summary of Benefits provided by the Vision plan administrator.

Life Insurance Benefits

Retired Employees and Spouses

Life insurance benefits are provided for both Pre-Medicare and Medicare-eligible Retired Employees, and for their spouses (including Surviving Spouses if married at the time of retirement). New Spouses are eligible for life insurance at the same level of benefit as other spouses provided that a New Spouse be married to the retiree for a minimum of two years before the retiree's death in order to qualify for the benefit. Life insurance benefits are not provided for dependent children. In the event of a Retired Employee's death, his/her designated beneficiary, or an eligible spouse's designated beneficiary are eligible to receive the Life Insurance Benefit, as provided in the Summary of Benefits.

You are eligible for Life Insurance Benefits as of the date you became eligible for Plan coverage, or the date the benefit was provided for all Retirees or spouses. When your Plan coverage ends, you are no longer eligible for Life Insurance Benefits. However, if you elect to suspend medical and prescription drug coverage for yourself, your life coverage will continue even though your medical and drug coverage is suspended. No premium will be charged for this coverage.

Your Designated Beneficiary

Your designated beneficiary is the last-named beneficiary on file with the Fund Administrative Office. You may change your beneficiary at any time by contacting the Fund Administrative Office. Once you designate or update a beneficiary, the designation is effective as of the date the notice is provided. If you do not designate a beneficiary or your beneficiary is not living at the time of your death, payment may be made to:

- To your Surviving Spouse;
- If you have no Surviving Spouse, to your children in equal shares; or
- If you have no Surviving Spouse and no surviving children, to the executor or administrator of your estate.

Insurer Provisions

Life Insurance Benefits may be provided through either an insured contract or from Fund Assets. Information about the Life Insurance provider can be found in the Claims and Appeals and Benefit Payment Information section of this document. The terms of the insurance contract determine when and under what conditions benefits are paid. Insurers and contract provisions are subject to change at any time. You may contact the Fund Administrative Office for a copy of the group insurance contract.

Conversion Provision

If your Life Insurance Benefit reduces at age 62 or ends for any reason other than non-payment of the premium, you may be able to apply for a conversion policy with the Life Insurance provider, if you do so within 31 days. Contact the Fund Administrative Office for more information.

General Plan Exclusions and Limitations

The Plan provides coverage for many medical and prescription drug benefits. In addition to any specific exclusions and limitations listed throughout this booklet, Plan benefits will not be paid or payable for any item listed in this section.

1. Any procedure, equipment, service, or supply that is not Medically Necessary or does not meet the Plan's provisions (such as a Fund Administrator's medical policy, clinical coverage guideline, or benefit policy guideline).
2. Any procedure, equipment, service, or supply received from an individual or entity that is not a Provider.
3. Any procedure, equipment, service, or supply that is Experimental, Investigative, or related to such.
4. Any condition, disease, defect, ailment, or Injury arising out of and in the course of employment if benefits are available under any workers' compensation act or similar law.
5. Any procedure, equipment, service, or supply provided as benefits by any governmental unit, unless otherwise required by law or regulation.
6. Any Illness or Injury that occurs as a result of any act of war, declared or undeclared, or while serving in the armed forces.
7. Any condition resulting from direct participation in a riot, civil disobedience, nuclear explosion, or nuclear accident.
8. Care required while incarcerated in a federal, state, or local penal institution or required while in custody of federal, state, or local law enforcement authorities, including work release programs, unless otherwise required by law or regulation.
9. Membership, administrative, or access fees charged by Physicians or other Providers. Examples of administrative fees include, but are not limited to, fees charged for educational brochures or calling a patient to provide test results.
10. Court ordered testing or care unless Medically Necessary.
11. Any procedure, equipment, service, or supply for which you have no legal obligation to pay in the absence of this or like coverage.
12. Any procedure, equipment, service, or supply received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, or similar person or group.
13. Any procedure, equipment, service, or supply prescribed, ordered, or referred by or received from a member of a Participant's immediate family, including a spouse, child, brother, sister, parent, or self.
14. Completion of claim forms or charges for medical records or reports, unless otherwise required by law or regulation.
15. Missed or canceled appointments.
16. Mileage costs or other travel expenses, except as otherwise listed as a Covered Service.
17. Benefits payable under Medicare Part A and/or Part B (or that would have been payable if a Participant was eligible and had applied for Part A and/or Part B), except as otherwise listed as a Covered Service or as otherwise prohibited by federal law. For the purposes of the calculation of benefits for Medicare-eligible Participants, if the Participant has not enrolled in Medicare, the Plan will calculate benefits as if he or she had enrolled.
18. Charges in excess of the Usual and Customary Charge or the Medicare Approved Amount.
19. Charges incurred before you were eligible and covered under the Plan.

General Plan Exclusions and Limitations

20. Charges incurred after coverage ends, except as otherwise listed as a Covered Service.
21. Any procedure, service, equipment, or supply provided in connection with cosmetic services, which are services primarily intended to preserve, change, or improve appearance or that are furnished for psychiatric or psychological reasons. No benefits are available for surgery or treatments to change the texture or appearance of skin or to change the size, shape, or appearance of facial or body features (such as the nose, eyes, ears, cheeks, chin, chest, or breasts). However, benefits are provided for a reconstructive service performed to correct a physical functional impairment of any area caused by disease, trauma, congenital anomalies, or previous therapeutic process. Other reconstructive services are not covered, unless otherwise required by law or regulation (such as restorative treatment related to mastectomies, as described on pages 28 and 48).
22. Services performed solely to preserve the present level of function or prevent regression of functions for an illness, injury, or condition that is resolved or stable.
23. Custodial Care, Domiciliary Care, or other convalescent care, whether or not recommended or performed by a professional.
24. Foot care solely to improve comfort or appearance, including, but not limited to, care for flat feet, subluxations, corns, bunions (except capsular and bone surgery), calluses, and toenails. However, certain Medically Necessary foot care may be covered, including, but not limited to, foot care for diagnosis of diabetes or for impaired circulation to the lower extremities.
25. Other than as provided under the Voluntary Dental program, any treatment of teeth, gums, or tooth related service, except as otherwise listed as a Covered Service.
26. Weight loss programs, other than Morbid Obesity Treatment Services (see pages 28 and 48), whether or not they are under Physician supervision. Weight loss programs include, but are not limited to, commercial weight loss programs such as Weight Watchers, Jenny Craig, and LA Weight Loss or fasting programs.
27. Marital counseling.
28. Other than as provided under the Voluntary Vision program, prescription, fitting, or purchase of eyeglasses or contact lenses, except as otherwise listed as a Covered Service. This does not apply for initial prosthetic lenses or sclera shells following intra-ocular surgery or for soft contact lenses due to a medical condition.
29. Services or supplies primarily for educational, vocational, or training purposes, except as otherwise listed as a Covered Service.
30. Reversal of sterilization.
31. Infertility treatment, artificial insemination, fertilization (such as in vitro or GIFT), or procedures and testing related to fertilization, including infertility medications and related services following the diagnosis of infertility.
32. Personal hygiene and convenience items.
33. Non-Emergency Medical Care received in an emergency room, except as otherwise listed as a Covered Service.
34. Health spa or similar facility.
35. Self-help training and other forms of non-medical self-care, except as otherwise listed as a Covered Service.
36. Examinations relating to research screening

General Plan Exclusions and Limitations

37. Stand-by charges of a Physician.
38. Physical exams and immunizations required for enrollment in any insurance program, as a condition of employment, for licensing, or for other purposes.
39. Radial keratotomy, keratomileusis, or excimer laser photo refractive keratectomy.
40. Any mechanical equipment, device, or organ.
41. Private Duty Nursing Services, except as otherwise listed as a Covered Service.
42. Services and supplies related to male or female sexual or erectile dysfunctions or inadequacies, regardless of origin or cause (unless directly related to sex transformation surgery or procedures), including penile prostheses or implants, vascular or artificial reconstruction, and all other procedures and equipment developed for or used in the treatment of impotency and related diagnostic testing.
43. Any New FDA Approved Drug Product or Technology (including, but not limited to, medications, medical supplies, or devices) available in the marketplace for dispensing by the appropriate source for the product or technology (including pharmacies), for the first six months after the product or technology received FDA new drug or other applicable FDA approval.
44. Services or supplies related to alternative or complementary medicine, which include, but are not limited to, acupuncture, holistic medicine, homeopathy, hypnosis, aroma therapy, massage therapy, reiki therapy, herbal, vitamin or dietary products or therapies, naturopathy, thermograph, orthomolecular therapy, contact reflex analysis, bioenergal synchronization technique (BEST), and iridology-study of the iris.
45. Drugs, devices, products, or supplies with over the counter equivalents, including any drug, device, product, or supply that is therapeutically comparable to an over the counter drug, device, product, or supply (except as specifically noted on pages 30 and 31 under the section Covered Prescription Drugs and Supplies).
46. Sclerotherapy for the treatment of varicose veins of the lower extremities, including ultrasonic guidance for needle and/or catheter placement and subsequent sequential ultrasound studies to assess the results of on-going treatment.
47. Treatment of telangiectatic dermal veins (spider veins).
48. Medications in quantities that exceed Plan limits.
49. Dental implants (other than as provided under the Voluntary Dental program).
50. No benefits will be paid for any claims submitted later than the end of the calendar year following the calendar year in which the services were incurred (unless a different time limit is specified elsewhere in this Summary Plan Description). In addition, no action may be commenced in court against the Fund or the Trustees in connection with a denied claim for benefits more than two (2) years after the later of the denial of the claim or the denial of an appeal, if a timely appeal is filed.

Claims and Appeals and Benefit Payment Information

Where you submit your claims and appeals for benefits depends on the type of benefit you are submitting for payment. The claims and appeals procedures for each type of benefit the Plan provides are detailed in this section of the booklet and should be reviewed carefully. The table below is included as a quick reference to help you identify the claims administrator for a specific type of benefit.

Type of Benefit Claim	Claims Administrator for Filing Claims	File Appeals with...
Eligibility, Medical Benefits (Medicare), No Place Like Home Benefit	Fund Administrator WPAS, Inc. Middletown Works Retiree Health Care Fund 1201 Crawford St. Middletown, Ohio 45044 Tel. 1-877-392-9991 Fax 1-513-672-9622 mwrmemberservices@wpas-inc.com	Board of Trustees Middletown Works Retiree Health Care Fund 1201 Crawford St. Middletown, Ohio 45044 Tel. 1-877-392-9991 Fax 1-513-672-9622 mwrmemberservices@wpas-inc.com
Medical Benefits (Pre-Medicare)	UMR UMR Nurse Line: 1-877-950-5083 Customer Service: 1-800-826-9781 www.umar.com	UMR Claims Appeal Unit PO Box 30546 Salt Lake City, UT 84103
Prescription Drug Benefits (Medicare)	SilverScript Insurance Company Submit Paper Claims to: Claims Form Processing PO Box 52066 Phoenix, AZ 85072-2066	SilverScript Insurance Company PO Box 52000, MC109 Phoenix, AZ 85072-2000 Fax 1-855-633-7673 Expedited Appeals: (24 hours a day, 7 days a week) Tel. 1-866-235-5660 TTY: 711
Prescription Drug Benefits (Pre-Medicare)	CVS Caremark (In most cases the claim is processed at the pharmacy when you purchase a prescription.) Specialty Drug Claims are processed by: CVS Specialty Pharmacy General Customer Service: 1-833-845-4696 CVS Specialty Pharmacy: 1-800-237-2767	CVS Caremark Appeals Department MC109 PO Box 52084 Phoenix, AZ 85072-2084 Fax 1-866-689-3092
Dental Benefits	Delta Dental Customer Service: 1-800-524-0149	Delta Director Delta Dental PO Box 30416 Lansing, Michigan 48909-7916
Vision Benefits	EyeMed To find a provider near you visit: www.eyemedvisioncare.com	FAA/EyeMed Vision Care, LLP Attn: Quality Assurance Dept. 4000 Luxottica Place Mason, Ohio 45040
Life Insurance Benefits	Metropolitan Life Insurance Company Submit claims to: Metropolitan Life Insurance Company Group Life Claims PO Box 6100 Scranton, PA 18505-6100 Fax 1-570-558-8645 Customer Service: 1-800-638-6420	Metropolitan Life Insurance Company Group Life Claims PO Box 6100 Scranton, PA 18505-6100 Fax 1-570-558-8645
Health Reimbursement Account (HRA)	WEX Health, Inc. Customer Service: 1-866-451-3399	WEX Health, Inc. 4321 20 th Avenue South Fargo, ND 58103 Fax: 1-866-451-3245

Claims and Appeals and Benefit Payment Information

Eligibility and Medicare Medical Benefit Claims and Appeals:

All claims pertaining to eligibility to participate in the Plan are handled by WPAS, Inc. Medicare medical benefit claims are also processed by WPAS. In most cases the provider will submit the claim to WPAS but if you are submitting a medical claim directly to the Plan you should submit it to the Fund Administrative Office at the following address:

Fund Administrator
WPAS, Inc.
Middletown Works Health Care Fund
1201 Crawford St.
Middletown, Ohio 45044
Telephone No. 1-877-392-9991
Fax No. 513-672-9622
Mwrmemberservices@wpas-inc.com

Appeals pertaining to eligibility, medical benefit claims, payment of premiums or plan interpretation should be submitted to the Board of Trustees at this same address.

Pre-Medicare Medical Benefit Claims and Appeals:

The Administrator for the Pre-Medicare PPO Network and Utilization Review is UMR. To search for a network Provider, use the UMR website at: www.umar.com. The Plan's provider network is the United Healthcare ChoicePlus Network. You may contact the UMR Nurse Line any time at 877-950-5083.

The general customer service number for UMR is 800-826-9781.

Pre-Medicare medical claims and appeals are processed by UMR. If you need to appeal an adverse determination by UMR, write to:

Claims Appeal Unit
PO Box 30546
Salt Lake City, UT 84130-0546

Most providers will accept assignment and coordinate payment with UMR on your behalf. The phone number for prior authorization when you are using a non-Network provider is 866-494-4502. If a non-Network provider needs to submit a claim the address is as follows:

UMR
P. O. Box 30541
Salt Lake City, UT 84130-0541

Prescription Drug Claims and Appeals:

For Pre-Medicare Participants: Prescription drug claims and appeals are processed by CVS Caremark, the Fund's contracted Pre-Medicare Pharmacy Benefit Manager (PBM). Specialty drug claims are processed by CVS Specialty Pharmacy. In most cases the claim is processed at the pharmacy when you purchase a prescription. The general Customer Service number is 833-845-4696. The CVS Specialty Pharmacy number is 800-237-2767. If you need to appeal an adverse determination, write to: CVS Caremark Appeals Department MC109, P.O. Box 52084, Phoenix, AZ, 85072-2084 (or FAX at 1-866-689-3092).

The Trustees have added a second-level appeal should a claim to use a brand drug over a generic equivalent be denied by CVS Caremark. The Trustees will review these denials to determine, within their judgment and discretion, if there is sufficient basis to grant the appeal. You may submit a second-level appeal to the Fund Administrative Office noted above.

For Medicare Participants: Prescription drug claims and appeals are processed by SilverScript, the

Claims and Appeals and Benefit Payment Information

Fund's contracted Medicare Pharmacy Benefit Manager (PBM). Participants have the right to appeal a negative claims determination. For more information on how claims are processed and how to appeal, please reference the Evidence of Coverage (EOC) provided to you by SilverScript beginning on page 63. If you have additional questions, please call SilverScript's customer service team at 833-844-5642. SilverScript is responsible for processing claims and appeals. This includes interpreting benefit eligibility. For complete details regarding appeals, please reference your Evidence of Coverage (EOC).

Dental/Vision Claims and Appeals:

Claims and appeals involving dental benefits are handled by Delta Dental and appeals involving vision benefits are handled by First American Administrators, Inc., a wholly-owned subsidiary of Eye-Med. Delta Dental and Eye-Med will provide you with a written explanation of their claims and appeals procedures. Dental and vision claims and appeals should be sent to the following addresses:

Delta Dental - The Customer Service number is 800-524-0149. Live operators are available Monday-Friday from 8:30 a.m. to 8 p.m. ET. Automated system is available at all other times. If you receive notice of an Adverse Benefit Determination, you, or your Authorized Representative, should seek a review as soon as possible, but you must file your request for review within 180 days of the date that you received that Adverse Benefit Determination. To request a formal review of your Claim, send your request in writing to:

Dental Director
Delta Dental
P.O. Box 30416
Lansing, Michigan 48909-7916

Please include your name and address, the Participants Member ID, the reason why you believe your Claim was wrongly denied, and any other information you believe supports your Claim.

Eye-Med - To locate EyeMed providers near you, visit www.eyemedvisioncare.com and choose the Insight Network. The Customer Service number is 866-723-0513. The address for appeals is:

FAA/EyeMed Vision Care, LLP,
Attn. Quality Assurance Dept.,
4000 Luxottica Place
Mason OH, 45040.

Health Reimbursement Account (HRA) Claims and Appeals:

Health Reimbursement Account (HRA) claims and appeals are processed by Wex, Inc., the Fund's contracted HRA Administrator. The general Customer Service number is 866-451-3399. If you need to appeal an adverse determination, write to:

Wex Health, Inc.
4321 20th Avenue South
Fargo, ND 58103
Fax: 866-451-3245

Life Insurance Claims and Appeals:

Life insurance claims and appeals are processed by MetLife. An individual claiming a benefit as a beneficiary under the life insurance policy should submit a claim to MetLife. This company will also

Claims and Appeals and Benefit Payment Information

process an appeal if a claim is denied. Life insurance claims and appeals should be submitted to the following address:

Metropolitan Life Insurance Company - Group Life Claims
PO Box 6100
Scranton, PA 18505-6100
Fax -(570) 558-8645
Customer Service (800) 638-6420

Filing Claims

Most health care Providers will submit your claims for you. Be sure to show your ID card to your Physician, Hospital or other provider so they will know where to submit your claim. If your Provider does not submit a claim for you, it is your responsibility to do so if you want a claim to be paid. Please contact the Fund Administrative Office for information as to how to submit your own claim.

Benefits will not be paid for any claims submitted later than the end of the calendar year following the calendar year in which the Covered Services were incurred. Claims not filed within this period will not be paid by the Plan.

Release of Information

To the extent consistent with applicable state and federal law, any Participant applying for benefits is required to authorize any Physician, Hospital, employer, government, agency, or any other person, corporation, or organization having relevant health related information that may be required for a proper determination of the claim by the Plan, to release the information to the Plan. Each Participant will also authorize the Plan to release relevant health related information to third parties, if necessary to provide medical services, or to facilitate the payment of benefit claims, provided, however, no authorization will be required if the authorization would violate applicable state and federal laws. To the extent a Participant fails to authorize any release required to pay benefits under the Plan, these benefits may be withheld.

Claim Types

Medical Claims: For purposes of determining how a claim will be processed including your right to receive a timely response to your claim or an appeal, Medical claims can be separated into the following types of claims:

- **Health Care Claims:** Health care claims include medical and prescription drug claims. Procedures differ for the different types of health care claims, which are as follows:
- **Pre-Service:** A pre-service claim (also sometimes referred to as a “pre-certification” claim) is a claim for a benefit for which the Plan requires approval of the benefit (in whole or in part) before you obtain the services. The Plan will not deny benefits for pre-service claims if it is not possible for you to obtain pre-certification or if the pre-certification process would jeopardize your life or health. See page 15 for information about pre-certification, penalties for failure to pre-certify certain services, and a list of services for which you need to obtain pre-certification.
- **Medical care.** The Plan will not deny benefits for pre-service claims if it is not possible for you to obtain pre-certification or if the pre-certification process would jeopardize your life or health. See page 15 for information about pre-certification, penalties for failure to pre-certify certain services, and a list of services for which you need to obtain pre-certification.
- **Urgent Care:** An urgent care claim is a claim for medical care or treatment with respect to which the application of the periods for making pre-service claim determinations would seriously jeopardize your life or health or your ability to regain maximum function if normal pre-certification standards were applied, or would subject you to severe pain that cannot be adequately managed without the care or treatment for which approval is sought, in the opinion of a Physician with knowledge of your condition.

Claims and Appeals and Benefit Payment Information

- **Concurrent Care:** A concurrent care claim is a claim over the reduction or termination of an ongoing course of treatment that was previously approved or pre-certified. It may also involve a claim to extend an ongoing course of treatment beyond the time or number of treatments previously approved
- **Post-Service:** When you file a post-service claim, you have already received the services in your claim. Basically, any health care claim that is not a pre-service, urgent care or concurrent care claim is a post-service claim.
- **Life Insurance Claims:** In the event of your death, your beneficiary should contact the Fund Administrative Office for help in filing a claim with the insurer.

Claim Decisions and Benefit Payment

- **Claims for Benefits:** When a claim for benefits is submitted, the Fund Administrator (or UMR in the case of Pre-Medicare medical benefits, CVS Caremark in the case of Pre-Medicare prescription drug benefits, SilverScript in the case of Medicare prescription drug benefits, MetLife in the case of life insurance benefits, Delta Dental for dental benefits and First American Administrators/EyeMed for vision benefits) will determine if you are eligible for benefits and calculate the amount of benefits payable, if any.
- **Medical Claims (note that this section applies both to Pre-Medicare claims processed by UMR and Medicare claims processed by WPAS, Inc.):** Generally, these claims will be paid as soon as possible after acceptable proof is received. However, certain deadlines apply to the different types of medical claims, as follows:
 - **Pre-Service Claims:** For properly filed pre-service claims, you will be notified of a decision within 15 days from receipt of the claim unless additional time is needed. The time for response may be extended up to 15 days if necessary due to matters beyond the Plan's control. You will be notified of the circumstances requiring the extension and the date by which the Plan expects to render a decision. If an extension is needed because the Plan needs additional information from you, the extension notice will specify the information needed. In this case, you and/or your Physician will have 45 days from receipt of the notification to supply the additional information. If you do not provide the information within that time, your claim will be decided based on the information that the Plan has and your claim may be denied. During the period in which you are allowed to supply additional information, the normal period for making a decision on the claim will be suspended. The deadline is suspended from the date of the extension notice until either 45 days or the date you respond to the request (whichever is earlier). The Plan then has 15 days to make a decision on a pre-service claim and notify you of the determination.
 - **Urgent Care Claims:** You and/or your Physician will be notified of a determination by telephone as soon as possible taking into account the medical exigencies, but no later than 72 hours after receipt of the claim. The determination will also be confirmed in writing. If an urgent care claim is received without sufficient information to determine whether or to what extent benefits are covered or payable, you will be notified within 24 hours of receipt of the claim of the information needed to complete the claim. You will have at least 48 hours to provide the information. You will be notified of the Plan's decision within 48 hours of the earlier of the Plan's receipt of the requested information or the end of the period afforded to you to provide the information.
 - **Concurrent Care Claims:** There is no formal deadline to notify you of the termination or reduction of a pre-certified benefit (other than by Plan amendment or termination). However, you will be notified of the decision as soon as possible, and in time to allow you to have an appeal decided before the benefit is reduced or terminated. If you request an extension of approved urgent care treatment, the Plan will act on your request within 24 hours after receiving it, as long as your claim is received at least 24 hours before the expiration of the approved treatment. A request to extend approved treatment that does not involve urgent care will be decided according to pre-service or post-service timeframes, whichever applies.

Claims and Appeals and Benefit Payment Information

- **Post-Service Claims:** Ordinarily, you will be notified of the decision on your post-service claim within 30 days from receipt of the claim. This period may be extended once for up to 15 days if the extension is necessary due to matters beyond the Plan's control. If an extension is necessary, you will be notified before the end of the initial 30-day period of the circumstances requiring the extension and the date by which a decision is expected to be made. If an extension is needed because the Plan needs additional information from you, the extension notice will specify the information needed. In that case, you will have 45 days from receipt of the notification to supply the additional information. If you do not provide the information within that time, your claim will be decided based on the information that the Plan has and your claim may be denied. During the period in which you are allowed to supply additional information, the normal period for making a decision on the claim will be suspended. The deadline is suspended from the date of the extension notice until either 45 days or until the date you respond to the request (whichever is earlier). The Plan has 15 days to make a decision on a post-service claim and notify you of the determination.
- **Prescription Drug Claims: For Pre-Medicare prescription benefits,** the Trustees have delegated the responsibility of claim determinations for Prescription Drugs to CVS Caremark. CVS Caremark has the discretionary authority to decide claims and appeals, including the authority to interpret the relevant provisions of the Benefit and the authority to grant and/or deny any and all claims for Prescription Drug benefits. **For Medicare prescription benefits,** the Trustees have delegated the responsibility of claim determinations for Prescription Drugs to SilverScript. SilverScript has the discretionary authority to decide claims and appeals, including the authority to interpret the relevant provisions of the Benefit and the authority to grant and/or deny any and all claims for Prescription Drug benefits.
- **Vision Care Claims:** The Trustees have delegated the responsibility of claims determinations for the Voluntary Vision Plan to First American Administrators, Inc. (FAA), a wholly-owned subsidiary of Eye-Med. FAA has the discretionary authority to decide claims and appeals, including the authority to interpret the relevant provisions of the Benefit and the authority to grant and/or deny any and all claims for the Vision benefits.
- **Dental Care Claims:** The Trustees have delegated the responsibility of claims determinations for the Voluntary Dental plan to Delta Dental. Delta Dental has the discretionary authority to decide claims and appeals, including the authority to interpret the relevant provisions of the Benefit and the authority to grant and/or deny any and all claims for Dental benefits.

Life Insurance Claims: Claims should be submitted as soon as is reasonably possible following the insured person's death. The beneficiary should complete a claim form (available from the Fund Administrative Office, located at 1201 Crawford St., Middletown OH, 45044; phone number (877) 392-9991) and send it, along with proof of death, to MetLife as instructed on the claim form. After MetLife receives a claim for Benefits, MetLife will review the claim and notify the claimant of its decision to approve or deny the claim.

Such notification will be provided to the claimant within a reasonable period, not to exceed 90 days from the date we received the claim, unless MetLife notifies the claimant within that period that there are special circumstances requiring an extension of time of up to 90 additional days.

If MetLife denies the claim in whole or in part, the notification of the claims decision will state the reason why the claim was denied and reference the specific Plan provision(s) on which the denial is based. If the claim is denied because MetLife did not receive sufficient information, the claims decision will describe the additional information needed and explain why such information is needed. The notification will also include a description of the Plan review procedures and time limits, including a statement of the claimant's right to bring a civil action if the claim is denied after an appeal.

If a Claim is Denied

If your claim is denied (in whole or in part), you will be notified of the denial within the timeframes

Claims and Appeals and Benefit Payment Information

stated in the previous section. The notice will include:

- The specific reason or reasons for the decision;
- Reference to the Plan provision(s) on which the decision was based;
- A description of any additional information or material needed to properly process your claim and an explanation of the reason it is needed;
- A statement that any rule, guideline, protocol, or criterion on which a denial was based will be provided free of charge, upon request;
- A statement that if the claim is denied based on a medical judgment (such as Medical Necessity or Experimental treatment), an explanation regarding the scientific or clinical judgment is available, free of charge, upon request;
- An explanation of the appeal procedure along with time limits; and
- A statement that you have the right to bring civil action under ERISA section 572(a) following an appeal.
- If it is a denial of an urgent care claim, the notice will also include a description of the expedited review process.

Appealing a Denied Claim

If your claim is denied (in whole or in part) or you disagree with the determination in regard to eligibility for benefits or the amount of the benefit, you have the right to have the initial decision reviewed. You must follow the appeals procedure before you file a lawsuit under ERISA, the federal law governing employee benefits.

In general, you should send your written request for an appeal to the address listed on your claim denial form. For urgent care claims, your appeal may be made orally.

The type of benefits your appeal pertains to will determine where your appeals should be filed.

Information on where appeals should be filed is provided at the beginning of this Section on pages 63-64.

Appeals involving Medicare medical benefits, eligibility and premium payments:

Fund Administrator
WPAS, Inc.
Middletown Works Health Care Fund
1201 Crawford St.
Middletown OH 45044
Telephone No. 1-877-392-9991
Fax No. 513-217-4419

Appeals involving Pre-Medicare medical benefits:

UMR Claims Appeal Unit
P. O. Box 30546
Salt Lake City UT 84130-0546

Prescription drug benefits appeals:

CVS Caremark (Pre-Medicare)
See page 63
SilverScript (Medicare) - See page 63

Second-Level Appeal from CVS Caremark denial of use of non-generic drug:

Fund Administrator
WPAS, Inc
Middletown Works Health Care Fund
1201 Crawford St.

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Middletown, Ohio 45044
Telephone No. 1-877-392-9991
Fax No. 513-217-4419

Life insurance claims: Metropolitan Life Insurance Company-Group Life Claims
P.O. Box 6100
Scranton PA 18505-6100
Fax: (315) 792-6831
Customer Service: (800) 638-6420

Dental and Vision claims: See page 65

Health Reimbursement Account claims: See page 65

Remember, your written claim denial will tell you how and where to file your appeal. If you are in doubt or have any questions, please contact the Fund Administrative Office.

If your claim is denied or if you are otherwise dissatisfied with a determination under the Plan, you must file your written appeal within:

- 180 days after you receive the notice of denial of any health, prescription drug or eligibility claims; or
- 60 days after you receive the notice of denial for life insurance benefits.

Your written appeal must explain the reasons you disagree with the decision on your claim. You may:

- Provide any additional supporting materials, including comments, statements, or documents related to the claim;
- Request to review all relevant information; and
- Request a free copy or explanation of any:
 - Internal rule, guideline, protocol, or other similar criteria, regardless of whether or not it was relied on in deciding your claim; and
 - Medical Necessity, Experimental or Investigative treatment, or similar exclusion or limit.

The Appeal Process

The Board of Trustees, or any subcommittee thereof to whom the Board of Trustees has delegated the responsibility, will decide appeals pertaining to medical benefits, eligibility, and any interpretation of the Plan that does not involve prescription drug, death, dental, or vision benefit claims. Whenever the term "Board of Trustees" is used herein with respect to deciding appeals, it shall also mean a subcommittee thereof, where such authority has been delegated. As noted above, the Trustees have delegated the fiduciary responsibility for deciding appeals involving the denial of prescription drug, life insurance, dental and vision benefits to other providers. These providers may refer an appeal to the Trustees if it is determined that the appeal more appropriately pertains to a plan benefit or interpretation for which the Trustees have not delegated such responsibility. These other providers will supply you with information about their appeal procedures whenever they deny a claim.

Appeals to the Board of Trustees

If you are filing an appeal with the Board of Trustees, you must submit this in writing to the Fund Administrative Office. If you file your appeal on time and follow the required procedures, a new, full and independent review of your claim will be made that will not take into consideration the initial benefit decision. An appropriate fiduciary of the Plan will conduct the review and the decision will be based on all information used in the initial determination as well as any additional information submitted.

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Under the Employee Retirement Income Security Act of 1974, as amended (ERISA), you have a right to receive, upon written request and at no charge, information used to review your request for coverage. Under Section 502(a) of ERISA, you also have a right to bring a civil action if your appeal is denied.

Any civil action against the Fund or its Trustees must be brought within two years from the date of the denial, otherwise it will be barred under the terms of the Plan.

■ **Medical, Eligibility and Other Appeals Submitted to the Board of Trustees:**

Deadlines that apply to the different types of health care claims are as follows:

- **Pre-service (Pre-certification) Appeals:** A determination will be made within a reasonable timeframe given the medical circumstances, not to exceed 30 days.
- **Urgent Care Appeals:** A determination will be made within 72 hours from receipt of the appeal. Oral notice of a determination on your urgent care appeals may be provided initially. The determination will also be confirmed in writing.
- **Concurrent Care Appeals:** Depending on whether a concurrent appeal involves a pre-service, urgent or post-service claim, it will be decided within the time frames set forth in this section for these types of claims.
- **Post-Service Appeals:** Involving medical benefits, eligibility, premium payments or Plan interpretation filed with the Fund Administrator will be decided by the Trustees at their next regularly scheduled meeting. You have 180 days following the decision by the Fund Administrator to file the appeal. If the appeal and supporting documentation is received by the Fund Administrator within 30 days of that meeting; however, the Trustees may wait to make a determination until its second regularly scheduled meeting after receipt of the appeal. Under special circumstances, the Trustees may wait to make a determination on the appeal until its third regularly scheduled meeting after receipt of the appeal. Once the Trustees make their decision, you will be notified in writing within 5 days.

- **Prescription Drug Appeals to CVS Caremark:** A prescription drug benefit appeal filed with CVS Caremark will be decided within 30 business days from receipt of the appeal, unless you are asked to provide additional information, in which case a decision will be provided within 40 business days from the receipt of the appeal.

Prescription Drug Second-Level Appeals: If CVS Caremark denies a claim to use a brand drug instead of an available generic drug equivalent, the affected participant or dependent may appeal this denial to the Board of Trustees. Such appeal shall be decided by the Board of Trustees within the same time period and in the same manner as appeals pertaining to medical benefits, eligibility, premium payments or Plan interpretation as set forth above. The Trustees will review these denials to determine, within their judgment and discretion, if there is sufficient basis to grant the appeal.

- **Prescription Drug Appeals to SilverScript:** For information on how to appeal a denied claim you may also call SilverScript's customer service team at 833-844-5642.
- **Life Insurance Appeals to MetLife:** In the event a claim has been denied in whole or in part, the claimant can request a review of the claim by MetLife. This request for review should be sent in writing to Group Insurance Claims Review at the address of MetLife's office which processed the claim within 60 days after the claimant received notice of denial of the claim. When requesting a review, the claimant should state the reason the claimant believes the claim was improperly denied and submit in writing any written comments, documents, records or other information the claimant deems appropriate. Upon the claimant's written request, MetLife will provide the claimant free of charge with copies of relevant documents, records and other information.

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MetLife will re-evaluate all the information, will conduct a full and fair review of the claim, and the claimant will be notified of the decision. Such notification will be provided within a reasonable period not to exceed 60 days from the date we received the request for review, unless MetLife notifies the claimant within that period that there are special circumstances requiring an extension of time of up to 60 additional days.

If MetLife denies the claim on appeal, MetLife will send the claimant a final written decision that states the reason(s) why the appealed claim is being denied, references any specific Plan provision(s) on which the denial is based, any voluntary appeal procedures offered by the Plan, and a statement of the claimant's right to bring a civil action if the claim is denied after an appeal. Upon written request, MetLife will provide the claimant free of charge with copies of documents, records and other information relevant to the claim.

- **Dental and Vision Appeals.** You should review the material provided to you by these providers for details on their appeal processes.

Content of Notice of Decision on Appeal Decided by the Board of Trustees

You will be notified of a determination within the timeframes stated above. The notice will include:

The specific reason or reasons for the decision, including reference to the Plan provision(s) on which the decision was based;

- A statement that any rule, guideline, protocol, or criterion on which a denial was based will be provided free of charge, upon request;
- A statement that if the claim is denied based on a medical judgment (such as Medical Necessity or Experimental treatment), an explanation regarding the scientific or clinical judgment is available, free of charge, upon request; and
- A statement that you have the right to bring civil action under ERISA section 502(a) following the appeal.

Medical Judgments

If your medical benefits appeal is denied based on a medical judgment, a health care professional will be consulted. The professional will be someone who:

- Has appropriate training and experience in the field of medicine involved in the medical judgment; and
- Was not consulted (or is not subordinate to the person who was consulted) in connection with the denial of your claim.

You have the right to be advised of the identity, upon request, of any medical experts consulted in making a determination of your appeal.

Authorized Representative

You may authorize a representative to act on your behalf to file a claim or an appeal. The designation must be in writing, and you may be required to be submitted it on a form supplied by the Fund Administrator or one of the providers who handles claims and appeals. Unless your authorization states otherwise, all notices regarding your claim will be sent to your authorized representative. The Plan will honor the designated authorized representative for the length of the appeal or until revoked. You may revoke a designated authorized representative by submitting a signed statement.

An authorized representative may include your:

- Health Care Provider;
- Spouse;
- Dependent child age 18 or older;

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- Parents or adult siblings;
- Grandparent;
- Court-ordered representative, such as an individual with power of attorney for health care purposes or legal guardian or conservator; or
- Other adult.

In addition, you have the right to retain legal representation, at your own expense, at, of any stage of the review process.

Sole Authority on Benefits

Under the documents creating the Plan, the Trustees, or persons to whom such authority has been delegated, have sole authority to make final determinations regarding any application for benefits, interpretation of the Plan, and any administrative rules adopted. Benefits under this Plan will be paid only if and when the Trustees or persons to whom such decision-making authority has been delegated by the Trustees, in their sole discretion, decide that the individual is entitled to benefits under the Plan's terms. The Trustees', or persons to whom the Trustees have been delegated such decision-making authority, decisions in such matters are final and binding on all persons dealing with the Plan or claiming a Plan benefit. The Trustees will make every effort to interpret Plan provisions in a consistent and equitable manner.

You must follow and exhaust the Plan's claims and appeals procedures completely before you bring an action in court under the Employee Retirement Income Security Act (ERISA) to obtain benefits. You or any other claimant may not begin any legal action, including proceedings before administrative agencies, until you have followed and exhausted the review procedures described in this section.

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

Benefit Payments to an Incompetent Person

If benefits are payable to a person who is judged to be incompetent or to a person who, by reason of mental or physical disability, in the opinion of the Trustees, is unable to administer the payments properly, the Trustees may make payments of the incompetent person as they deem best. The Trustees will have no duty or obligation to see that the funds are used or applied for the purpose or purposes for which paid if they are paid:

- Directly to the person;
- To the legally appointed guardian or conservator of the person;
- To any spouse, child, parent, brother, or sister of the person for the welfare, support, and maintenance of that person; or
- By the Trustees directly for the support, maintenance, and welfare of the person.

If any question or dispute arises concerning the proper person to whom any payment will be made under the Fund, the Trustees may withhold payment until a binding adjudication of the question or dispute is made. The resolution must be satisfactory to the Trustees in their sole discretion. Alternatively, the Trustees may pay the benefits if they have been adequately indemnified to their satisfaction against any resulting loss.

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Coordination of Benefits

The Plan has been designed to help you meet the cost of medical and prescription drug benefits. It is not intended that you receive greater benefits than your actual health care expenses. The amount of benefits payable under this Plan will be coordinated with any coverage you or your Dependent has under any:

- Group insurance or group-type coverage, whether insured or uninsured, including prepayment group practice, individual practice coverage, or other coverage (other than school accident-type coverage);

Allowable Expenses
Any necessary, usual, and customary expense, at least a portion of which is covered under at least one of the plans covering the person for which the claim is made.

- Individual insurance for individual-type coverage, including prepayment, group practice, or individual practice coverage;
- Coverage under a governmental plan or required or provided by law, except Medicaid;
- Any other coverage that, as defined by the Employee Retirement Income Security Act of 1974, is a labor-management trustee plan, union welfare plan, employee organization plan, or employee benefit organization; and
- Any other coverage provided because of sponsorship by or membership in any other association, union, or similar organization.

This Plan will always pay you either regular benefits in full (if this Plan is primary) or a reduced amount that, when added to the benefits payable by the other plan(s), will equal the total allowable expenses. No more than the maximum benefits payable under this Plan will be paid.

Please note that you must file a claim for any benefits you are entitled to from any other source.

Order of Payment

If you and/or your Dependent are covered under more than one plan, the primary plan pays first, regardless of the amount payable under any other plan. The other plan, the secondary plan, will adjust its benefit payment so that the total benefits paid do not exceed 100% of the allowable expense incurred.

In the event that this Plan's coverage is secondary but the primary plan includes a provision that results in the primary plan paying a lesser benefit because of secondary coverage, notwithstanding any other provision of this Plan, this Plan's secondary benefits will be limited to the difference between the amount that the primary plan would have paid if the primary plan had been the only plan providing coverage, and the total amount of Covered Services. In no event will this Plan pay more than the amount it would have paid as a primary payer.

If you and/or your Dependents are covered under another plan, you must report all other coverage when you file a claim.

When you or your Dependents are covered by Medicare, you should refer to the next Section entitled *Coordination of Benefits with Medicare*.

When there is a basis for a claim under this Plan and another plan, this Plan is secondary unless:

- The other Plan has rules coordinating its benefits with those of this Plan; and
- Both those rules and this Plan's rules require that this Plan's benefits be determined before those of the other Plan.

The Plan determines which plan is primary (and pays first) based on the first of the following rules that apply:

1. **Non-Dependent/Dependent.** The benefits of the plan that covers the person as an employee, subscriber, or Participant (that is, other than as a dependent) are determined before those of the plan that covers the person as a Dependent. However, if the individual is also eligible for Medicare, then Medicare is primary.

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2. **Dependent Child:** If a Dependent child is covered under more than one plan and the parents are:
 - a. ***Not divorced or legally separated (or a court decree awards joint custody, without specifying health care coverage responsibility for the child)***, the plan that covers the parent whose date of birth occurs earlier in the calendar year, excluding the year of birth, is primary. If the birthday of both parents occurs on the same date, the plan that has covered the parent for the longer period is primary.
 - b. ***Divorced or legally separated***, the following rules determine which plan's benefits are primary:
 - i. *Where there is a court decree that establishes financial responsibility for health care coverage*, the plan covering the Dependent child of the parent who has financial responsibility will pay first;
 - ii. *Where there is no court decree or a court order does not specify which plan is primary*, payment is made in the following order: plan of the parent with custody, plan of the spouse of the parent with custody (if any), plan of the parent not having custody, and plan of the spouse of the parent not having custody.
3. **Active/Inactive Participant.** The benefits of a plan that covers a person as an employee who is neither laid off nor retired or as that employee's dependent are determined before those of a plan that covers the person as a laid off or retired employee or as that employee's dependent. If the other plan does not have this rule and, as a result, the plans do not agree on the order of benefits, this rule is ignored.
4. **Continuation Coverage.** If a person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another plan, then:
 - a. The plan covering the person as an employee, subscriber, or Participant or as that person's dependent is primary; and
 - b. The continuation coverage pays secondary.If the other plan does not have this rule and, as a result, the plans do not agree on the order of benefits, this rule is ignored.
5. **Length of Coverage.** If none of the above rules determines the order of benefits, the plan that covered the person longer is primary and the plan that covered the person for the shorter period is secondary.

If none of the preceding rules determines which plan is primary, benefits will be shared equally between the plans.

For coordination of benefits purposes, this Plan:

- May, subject to the Plan's privacy rules, release to or obtain from any other insurance company or other organization or person, any claim information. Any person claiming benefits under the Plan will furnish any information that the Plan may require.
- Has the right, if an overpayment is made, to recover the overpayment from any other person, or any other insurance company or organization.
- Has the right to pay to any other organization an amount it determines to be warranted, if payments that should have been made by the Plan have been made by the organization.
- Has the right to substitute any of the above rules with the applicable rule, if any, generally recognized and applied by insurers in the applicable state, if the Plan determines that a Participant or dependent would be unfairly burdened if the Plan rules were applied.

Coordination of Benefits with Medicare

Any benefits covered under both this Plan and Medicare will be paid pursuant to Medicare Secondary Payor legislation, regulations, and CMS guidelines, subject to federal court decisions. Federal law

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controls whenever there is a conflict among state law, Plan provisions, and federal law.

Medicare is a four-part program:

- **Part A:** The first part is officially called Hospital Insurance Benefits for the Aged and Disabled, and primarily covers Hospital benefits (although it also provides other benefits).
- **Part B:** The second part is officially called Supplementary Medical Insurance Benefits for the Aged and Disabled, and primarily covers Physician's services (although it, too, covers a number of other items and services).
- **Part C:** The third part is officially called Medicare Advantage, and is Medicare's managed care offerings. If you are covered by a managed care plan, the Plan will presume that you have complied with the managed care program's rules necessary for your expenses to be covered by the managed care program.
- **Part D:** The fourth part is Medicare's Prescription Drug Coverage.

Generally, once you become Medicare-eligible, Medicare will be primary and this Plan will be secondary for all hospitalization and medical (but not prescription drug) benefits. If you do not enroll in Medicare Part A and Part B when you become eligible, this Plan will process your claims as if you were enrolled and receiving benefits from Medicare Part A and Part B and will pay only as a secondary.

If you do not enroll for Part B coverage within the three months of your 65th birthday or when you are otherwise eligible for Medicare (for example, due to disability), you may enroll for Part B coverage within seven months of the first day of the month in which you are no longer covered by the Plan without any penalty or waiting period. If you do not enroll for Part B coverage within this seven-month period, you may enroll during the general enrollment period. This general enrollment period occurs between January 1 and March 31 of each year and coverage begins the following July 1.

It's your and your Dependent's responsibility to apply for Medicare Part A and Part B. If you or your Dependent are eligible for Medicare and want information about enrollment, contact your local Social Security Administration Office three months before your 65th birthday or when you are otherwise eligible for Medicare. You must apply for Part B at least one month before you reach age 65. Contact your local Social Security Administration Office if you have any questions concerning Medicare eligibility, enrollment, or coverage.

If you are eligible for Medicare, as long as the Plan provides prescription drug benefits and as long as they are credible (generally equivalent or better than the standard Medicare Part D prescription drug plan), you will automatically be enrolled for Medicare Prescription Drug Coverage (Part D) when eligible. If you or any of your Dependents choose to enroll in another Part D plan for Medicare Prescription Drug Coverage, you and your Dependents will no longer receive prescription drug benefits from the Plan. You will continue to be eligible to receive the Plan's other Benefits; however, any required premium for coverage will not change because you are not receiving prescription drug benefits from the Plan.

Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply this Plan's COB rules, exclusions, and other provisions to determine benefits payable under this Plan and any other health benefits plan. Needed facts may be obtained from, or given to, other organizations or persons for the purpose of applying these rules and determining benefits payable under this Plan and any other health benefits plan covering the person claiming benefits.

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

Payment of Benefits

Benefits are payable to the retiree or Dependent whose Injury or Illness is the basis for a claim under

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the Plan, except that:

- In the event of a retiree's death, any Life Insurance Benefits will be paid in accordance with the Fund's contract with the insurance company;
- In the event that an unpaid Hospital, Physician, or other Provider bill is submitted to the Trustees, the payment may be made directly to the Hospital, Physician, or Provider;
- To the extent that retiree or Dependent spouse has filed a written assignment to make payment directly to a Provider, payments will be made in accordance with the assignment;
- No assignment of any present or future right, interest, or benefit under this Plan will bind the Trustees without their written consent, except as required by a "Qualified Medical Child Support order" as defined by ERISA or any applicable state or Federal law;
- Benefits payable for any loss will be paid upon receipt of written proof covering the occurrence, character, and extent of the event for which claim is made, provided the proof is provided within the time limitations specified in the claims and appeal section of this Summary Plan Description/Plan Document (see page 65).
- If any individual is, in the opinion of the Trustees, legally incapable of receiving a payment or giving a valid receipt for any payment due and no guardian has been appointed for that individual, the Trustees may, at their option, make such payment to the person or persons who, in the opinion of the Trustees, have assumed the care and principal support of the individual. If the individual dies before all amounts due and payable have been paid, the Trustees may, at their option, make such payment to the executor, administrator, or personal representative of the individual's estate or to the individual's surviving spouse, parent, child(ren), or any other person(s) who, in the Trustees' opinion, are entitled.
- Any payments made by the Trustees in accordance with these provisions fully discharge the liability of the Trustees to the extent of the payment.
- By accepting benefits from the Plan, you authorize the Plan to make payments directly to Providers for Covered Services. The Plan also reserves the right to make payments directly to you. Payments may also be made to, and notice regarding the receipt and/or adjudication of claims may be sent to, an Alternate Recipient, or that person's custodial parent or designated representative. Any payments made by the Plan will discharge the Plan's obligation to pay for Covered Services. Once a Provider performs a Covered Service, the Plan will not honor a request to withhold payment of the claims submitted.

Benefits Paid as the Result of a Mistake, Misrepresentation or Falsification of a Claim

If any individual knowingly misrepresents or falsifies any information or any matters in connection with a claim filed for Plan benefits, the Trustees may, in their sole discretion, deny all or part of the benefits that might otherwise be due in connection with the claim. In addition, if any benefit is paid as the result of a mistake, misrepresentation or falsification of a claim, the Trustees have the right to recover any amount paid in excess of amounts properly payable under the terms of the Plan. Any determination by the Plan or its Trustees not to pursue the collection of an overpayment shall not be deemed a waiver of the Plan's or its Trustees' right to pursue another overpayment.

The Trustees also have the right to offset future benefits payments payable to a participant or his dependents under the rules of the Plan, by the amount of an overpayment made by the Plan to that same participant or his dependents.

Limitations on Bringing a Lawsuit Against the Fund or the Trustees

No action may be commenced in state or federal court by a participant, dependent, or beneficiary against the Fund or the Trustees pertaining to any claim for a benefit or other entitlement under this Plan more than two (2) years after the claim is denied, or if a timely appeal is filed, more than two (2) years after the appeal is denied or otherwise finally acted upon.

Privacy Policy

The Plan is required to protect the confidentiality and security of your Protected Health Information (PHI) under the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and the rules issued by the U.S. Department of Health and Human Services. The privacy rules are effective as of April 14, 2003.

You may find a complete description of your rights under HIPAA in the Plan's Privacy Notice that describes the Plan's privacy policies and procedures and outlines your rights under the privacy rules and regulations. The Plan will distribute its Privacy Notice periodically, as required by HIPAA rules, or when changes are made to the policies and procedures. You may also request a copy of the Privacy Notice from the Fund Administrator, free of charge, at any time.

The Fund's Privacy Policy describes how your medical information may be used and disclosed and how you can have access to this information. Please review it carefully.

This Plan and the Plan Sponsor will not use or further disclose your Protected Health Information (PHI), except as necessary for treatment, payment, health plan operations, and Plan administration, or as permitted or required by law. In particular, the Plan will not, without your written authorization, use or disclose your PHI for employment-related actions and decisions or in connection with any other employee benefit plan.

The Plan hires professionals and other companies to assist it in providing health care benefits. The Plan has required these entities, called Business Associates, to observe HIPAA's privacy rules. In some cases, you may receive a separate notice from one of the Plan's Business Associates. It will describe your rights with respect to benefits provided by that company.

Your rights under HIPAA with respect to your PHI include the right to:

- Receive confidential communications of your health information, as applicable;
- See and copy your health information;
- Receive an accounting of certain disclosures of your health information;
- Amend your health information under certain circumstances; and
- File a complaint with the Plan or with the Secretary of Health and Human Services if you believe your rights under HIPAA have been violated.

Protection and Security of PHI

The Plan Sponsor:

If you need a copy of the Privacy Notice, please contact the Fund Administrative Office.

- Implements administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan;
- Ensures that an adequate separation between the Plan and Plan Sponsor, specific to electronic PHI, by supporting reasonable and appropriate security measures;
- Ensures that any business associate, agent, or subcontractor, to whom it provides electronic PHI, agrees to implement reasonable and appropriate security measures to protect electronic PHI; and
- Reports to the Plan any security incident of which it becomes aware concerning electronic PHI.
- Investigate and provide notice, including notice to affected participants or dependents of any breach of PHI, as required by law or regulation.

Plan's Use and Disclosure of PHI

The Plan will use your PHI to the extent and in accordance with the uses and disclosures permitted by HIPAA. Specifically, the Plan will use and disclose PHI for purposes related to health care treatment, payment for health care, and health care operations.

The Plan will use and disclose your PHI as required by law and as permitted by your authorization or the authorization of your Beneficiary. With an authorization, the Plan will disclose PHI to a retirement plan, disability plan, reciprocal benefit plan, and/or workers' compensation insurers for purposes related to administration of these plans.

Payment Defined

Payment includes activities undertaken by the Plan to obtain premiums or determine or fulfill its responsibility for Plan coverage and provision that relate to an individual to whom health care is provided. These activities include, but are not limited to, the following:

- Determination of eligibility, coverage, and cost sharing amounts (e.g, benefit cost, Plan maximums, and Copayments as determined for an individual's claim);
- Coordination of benefits;
- Adjudication of health benefit claims (including appeals and other payment disputes);
- Subrogation of health benefit claims;
- Establishing employee contributions;
- Risk adjusting amounts due based on enrollee health status and demographic characteristics;
- Billing, collection activities, and related health care data processing;
- Claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes, and responding to Participant (and/or authorized representatives) inquiries about payments;
- Obtaining payment under a contract for reinsurance (including stop-loss and excess of loss insurance);
- Medical Necessity reviews or reviews of appropriateness of care or justification of charges;
- Utilization review, including pre-certification, concurrent review, and retrospective review;
- Disclosure to consumer reporting agencies related to collection of premiums or reimbursement (the following PHI may be disclosed for payment purposes: Name and address, date of birth, Social Security number, payment history, account number, and name and address of the Provider and/or health plan); and
- Reimbursement to the Plan.

Health Care Operations Defined

Health Care Operations include, but are not limited to, the following activities:

- Quality Assessment;
- Population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting of health care Providers and patients with information about treatment alternatives, and related functions;
- Rating Provider and Plan performance, including accreditation, certification, licensing, or

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credentialing activities;

- Underwriting, premium rating, and other activities relating to the creation, renewal, or replacement of a contract of health insurance or health benefits, and ceding, securing, or placing a contract for reinsurance of risk relating to claims for health care (including stop-loss insurance and excess of loss insurance);
- Conducting or arranging for medical review, legal services, and auditing functions, including fraud and abuse detection and compliance programs;
- Business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the entity, including formulary development and administration or development or improvement of methods of payment or coverage policies; and
- Business management and general administrative activities of the entity, including, but not limited to:
 - Management activities relating to implementation of and compliance with the requirements of HIPAA administrative simplification;
 - Customer service, including the provision of data analyses for policyholders, plan sponsors, or other customers;
 - Resolution of internal grievances; and
 - Due diligence in connection with the sale or transfer of assets to a potential successor in interest, if the potential successor in interest is a covered entity or, following completion of the sale or transfer, will become a covered entity.

Plan's Disclosure of PHI to the Trustees

For purposes of the Plan's privacy rules, the Trustees are the Plan Sponsor. The Plan will disclose PHI to the Plan Sponsor as long as this Summary Plan Description/Plan Document incorporates the following provisions. With respect to PHI, the Plan Sponsor agrees to:

- Not use or further disclose the information other than as permitted or required by this Summary Plan Description/Plan Document or as otherwise required by law;
- Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan, agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information;
- Not use or disclose the information for employment-related actions and decisions unless authorized by the individual;
- Not use or disclose the information in connection with any other benefit or employee benefit plan of the Plan Sponsor unless authorized by the individual;
- Report to the Plan any use or disclosure of the information of which it becomes aware that is inconsistent with the uses or disclosures provided for in this document;
- Make PHI available to the individual in accordance with the access requirements of HIPAA;
- Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;
- Make the information available that is required to provide an accounting of disclosures;
- Make internal practices, books, and records relating to the use and disclosure of PHI received from the group health Plan available to the Secretary of Health and Human Services for the purposes of determining compliance by the Plan with HIPAA; and
- If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made. If return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible.

Privacy Policy

Adequate separation between the Plan and the Plan Sponsor will be maintained. Therefore, in accordance with HIPAA, unless the Plan Sponsor, service provider or business associate is entitled to PHI under the Plan policy or under the law, only the following employees or classes of employees will be given access to PHI:

- The Fund Administrator; and
- Staff designated by the Fund Administrator.

The persons described above will only have access to and will only use and disclose PHI for Plan administration functions that the Plan Sponsor performs for the Plan. If these persons do not comply with this Summary Plan Description/Plan Document, the Plan Sponsor will provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

Reimbursement, Subrogation and Right of Recovery

These provisions apply when Plan benefits are paid due to Injuries or Illness sustained when you have a right to recovery from another party.

Subrogation

A rule that gives the Plan the right to be repaid for benefits it pays on a claim if a third party is responsible for paying the expenses for which the claim is made.

Subrogation

- The Plan has the right to recover payments made on your behalf from any source, including a third party or your own insurance policy, as a result of or compensation for an injury, illness, expense or loss caused by a third party. Please note:
 - As a condition of receiving benefits under this Plan, the Plan may request you to assign or subrogate your claim against a third party. By accepting benefits from this Plan, you agree that the Plan has an equitable lien on any recovery you receive to the extent of the medical, prescription drug and other benefits paid by the Plan.
- The Plan has first priority for the full amount of benefits paid from any recovery, commencing with the first dollar of your recovery, regardless of whether you are fully compensated and regardless of whether the payments received make you whole for your losses and Injuries.
- You and your legal representative must fully cooperate with the Plan and do whatever is necessary to enable the Plan to exercise its rights and do nothing to prejudice them.
- The Plan has the right to take whatever legal action it sees fit against any party or entity to recover the Plan benefits paid.
- To the extent that the total assets from which a recovery is available are insufficient to satisfy in full the Plan's subrogation claim and any claim still held by you, the Plan's subrogation claim will be satisfied first before any part of a recovery is applied to your claim, attorney fees, or other expenses or costs.
- The Plan is not responsible for any attorney fees, other expenses, or costs without prior written consent from the Plan. In addition, note the "common fund" doctrine does not apply to any funds recovered by any attorney you hire regardless of whether funds recovered are used to repay benefits paid by the Plan.

Reimbursement

- Regardless of whether or not the Plan requests you to assign or subrogate your claim against a third party, if you obtain a recovery from any source, including a third party or your own insurance policy, as a result of or as compensation for an injury, illness, expense or loss caused by a third party, and the Plan has not been repaid for benefits paid on your behalf, the Plan has the right to be repaid from the recovery the benefit amounts paid on your behalf and the following apply:
 - The Plan is not required to provide you benefits to which you would normally be entitled to under this plan if the injury or illness you suffer is caused by a third party. The Plan may provide you benefits while you are awaiting payment from or resolution of a claim against a third party. As a condition of receiving benefits you are agreeing to the Plan's right of reimbursement. The Plan may, but need not, request you to sign additional forms to facilitate the enforcement of the Plan's right of reimbursement and at its discretion it may refuse to pay your benefits, in whole or part for injuries or illnesses of this nature.
- By accepting benefits from this Plan, you agree that the Plan has an equitable lien on any recovery you receive to the extent of the medical, prescription drug and other benefits paid by the Plan.
- You must reimburse the Plan to the extent of Plan benefits paid on your behalf from any recovery.

Reimbursement, Subrogation and Right of Recovery

- Notwithstanding any allocation made in a settlement agreement or court order, the Plan has the right of recovery, in first priority, against any recovery.
- You and your legal representative must hold in trust for the Plan the proceeds of the gross recovery (i.e., the total amount of your recovery before attorney fees, other expenses, or costs) to be paid to the Plan immediately upon your receipt of the recovery. You must reimburse the Plan, in first priority and without any set-off or reduction for attorney fees, other expenses, or costs.
- The “common fund” doctrine does not apply to any funds recovered by any attorney you hire regardless of whether funds recovered are used to repay benefits paid by the Plan.
- If you do not repay the Plan, the Plan is entitled to deduct any of the unsatisfied portion of the amount of benefits paid or the amount of your recovery, whichever is less, from any future Plan benefit.
- If you do not disclose to the Plan the amount of your settlement, the Plan is entitled to deduct the amount of its lien from any future Plan benefit.
- The Plan is entitled to recover any of the unsatisfied portions of the amount paid or the amount of your settlement, whichever is less, directly from the Providers to whom the Plan has made payments. In such a circumstance, it may then be your obligation to pay the Provider the full-billed amount, and the Plan has no obligation to pay the Provider.
- The Plan is entitled to reimbursement from any recovery, in first priority and commencing with the first dollar of your recovery, even if the recovery does not fully satisfy the judgment, settlement, or underlying claim for damages or fully compensate or make you whole.

Your Responsibilities

- You must notify the Fund Administrator promptly of how, when, and where an accident or incident resulting in personal Injury or Illness to you occurred and all information regarding the parties involved.
- You must cooperate with the Plan in the investigation, settlement, and protection of the Plan’s rights and sign any forms the Plan provides to facilitate subrogation or reimbursement.
- You must not do anything to prejudice the Plan’s rights.
- You must send copies of all police reports, notices, or other papers received in connection with the accident or incident resulting in personal Injury or Illness to you.
- You must promptly notify the Plan if you retain an attorney or if a lawsuit is filed on your behalf.

Right of Recovery

Whenever payment has been made in error, the Plan has the right to recover such payment from you or, if applicable, the Provider. The Plan reserves the right to deduct or offset any amounts paid in error from any pending or future claim. To the extent an overpayment has been made to you, the Plan has an equitable lien on this money, and you will be deemed to hold this money in trust for the Plan.

The Plan has oversight responsibility for compliance with Provider and vendor and subcontractor contracts. The Plan may enter into a settlement or compromise regarding enforcement of these contracts and may retain any recoveries made from a Provider, vendor, or subcontractor resulting from these audits if the return of the overpayment is not feasible. The Plan has established recovery policies to determine which recoveries are to be pursued, when to incur costs and expenses, and settle or compromise recovery amounts. The Plan will not pursue recoveries for overpayments if the cost of collection exceeds the overpayment amount. The Plan may not provide you with notice of overpayments made by the Plan or you if the recovery method makes providing such notice administratively burdensome.

Administrative Information

Plan Name

The name of the Plan is the Middletown Works Hourly and Salaried Union Retirees Health Care Fund. Commonly, the Plan is known as the Middletown Works Retirees Fund or the Plan

Together the Plan's name, number, and the Trustees' EIN identify the Plan with government agencies.

Plan Numbers

The Employer Identification Number (EIN), assigned to the Fund by the Internal Revenue Service, is 36-7485085. The Plan number, assigned by the Trustees, is 001.

Plan Sponsor and Plan Administrator

The Trustees are both the Plan Sponsor and Plan Administrator. The Trustees consist of Retiree and Public representatives. If you wish to contact the Trustees, you may use the address and phone number below:

Middletown Works Hourly and Salaried Union Retirees Health Care Fund
1201 Crawford St.
Middletown Ohio 45044
1-877-392-9991

Trustees

Retiree Representatives

Michael Stephenson
8362 Free Short Pike
Camden, OH 45311

Brian C. Daley
608 Cedar Knoll Place
Trenton, OH 45067

Michael A. Bailey
9 Baltimore Street
Middletown, OH 45044

Public Representatives

Roger J. McClow
32683 Franklin Rd.
Franklin, MI 48025

Francis J. Martorana
1201 Crawford St.
Middletown, OH 45044

Middletown, OH 45044

In addition, the Trustees have delegated administrative responsibilities as follows:

- WPAS, Inc. maintains eligibility records, process Medicare medical claims, accounts for self-payments and answers inquiries.
- UMR processes Pre-Medicare medical claims, administers the Plan's PPO medical network and the Plan's UR program.
- CVS Caremark is the Plan's Pre-Medicare Pharmacy Benefits Manager (PBM) and administers the Plan's retail pharmacy network and mail order program for Pre-Medicare participants.
- SilverScripts is the Plan's Medicare Pharmacy Benefit Manager (PBM) and administers the Plan's retail pharmacy network and mail order program for Medicare participants.
- Metropolitan Life Insurance Company (200 Park Ave. New York, NY 10166, policy # 179582-1-G insures and administers the Plan's Life Insurance Benefit.)
- Delta Dental administers the Dental PPO Plan
- EyeMed administers the Vision Plan

Administrative Information

- Wex, Inc. administers the Health Reimbursement Account Plan

Agent for Service of Legal Process

Fund Counsel, John M. McIntire, Esq. is the Plan's agent for service of legal process. Accordingly, if legal disputes involving the Plan arise, any legal documents should be served on:

John M. McIntire, Esq.
O'Donoghue & O'Donoghue, LLP
5301 Wisconsin Avenue, N.W.
Suite 800
Washington, D.C. 20015

In addition, any legal documents may be served upon an individual Representative or the Trustees at the Fund Administrative Office at:

Middletown Works Retirees Fund
Fund Administrative Office
c/o WPAS, Inc.
1201 Crawford St.
Middletown OH 45044
1-877-392-9991

Plan Funding

Employer contributions and Participant self-payments finance the benefits described in this booklet. All Employer contributions have been paid in full to the Trust Fund as established in the Settlement Agreement in the case of *Bailey v. AK Steel Corporation* Case No. C-1:06CV460, U.S. District Court for the Southern District of Ohio, filed October 25, 2007.

This Settlement Agreement specifies the amount of contributions, due date of contributions, and retirees covered by the Agreement.

The Plan's medical, prescription drug, dental and vision benefits are self-funded from accumulated assets and are provided directly from the Fund. A portion of Fund assets is allocated for reserves to carry out the objectives of the Plan. The Plan's life insurance benefits are provided through a group insurance contract with the Metropolitan Life Insurance Company.

The Trustees hold all assets in trust. Benefits and administrative expenses are paid from the Trust.

Plan Year

The Plan Year is the calendar year beginning each January 1 and ending December 31.

Plan Type

This Plan is considered a welfare plan, providing medical, prescription drug, dental, vision, and life insurance benefits for Participants who meet the eligibility requirements described in this booklet. It is a tax-exempt employee welfare benefit fund, known under Section 571(c)(9) of the Internal Revenue Code as amended, as a "Voluntary Employees' Beneficiary Association" or "VEBA."

Plan Amendment and Termination

The Trustees expect that the Plan will continue indefinitely. However, neither you nor any eligible Dependent, has a vested, non-forfeitable right to future Plan coverage or to the continuation of any given Plan benefit. The Trustees have the sole discretion and authority to amend this Plan, to increase, decrease, or change benefits, eligibility rules, or other provisions of the Plan of Benefits as they may determine to be in the best interests of Participants and beneficiaries. Any amendment will be communicated in writing and will not affect valid claims that originated before the date of the amendment.

Administrative Information

This Plan may be discontinued or terminated under certain circumstances. In such event, all coverage for individuals will end on the date determined by the Trustees. Any discontinuation will not affect valid claims that originate before the termination date of the Plan as long as the Plan's assets are more than the Plan's liabilities. Full benefits may not be paid if the Plan's liabilities are more than its assets, and benefit payments will be limited to the assets available in the Trust Fund for these purposes. The Trustees will not be liable for the adequacy or inadequacy of assets. If there are any excess assets remaining after the payment of all Plan liabilities, those excess assets will be used for purposes determined by the Trustees in accordance with the provisions of the Trust Agreement.

Severability Clause and Conformity with the Law

If any Plan provision or any amendment is deemed or held to be unlawful, or unlawful as to any person or instance, such facts will not adversely affect other Plan provisions to any other person or instance, unless such illegality will make impossible or impracticable the functioning of the Plan.

To the extent permitted by law, the Trustees will not be held liable for any act done or performed in pursuance of any provisions hereof before the time that such act or provision is held unlawful by a court of competent jurisdiction.

If any provision of this Plan is contrary to any law to which it is subject, that provision is hereby amended to conform to such law.

Governing Law

All questions pertaining to the validity and construction of the Trust Agreement, Plan, acts and transactions of the Trustees, or any matter affecting the Fund will be determined under federal law where applicable federal law exists. Where no applicable federal law exists, the laws of the state of Ohio will apply.

Trustees' Discretion and Authority

The Trustees or, where Trustee responsibility has been delegated to others, the other persons, will be the sole judges of the standard of proof required in any case and the application and interpretation of the Plan, and decisions of the Trustees or their delegates are final and binding. **Benefits under this Plan will be paid only when the Trustees, or persons delegated by them, decide, in their discretion, that you or a beneficiary is entitled to benefits in accordance with the terms of the Plan.** In the event a claim for benefits has been denied, no lawsuit or other action against the Fund or its Trustees may be filed until the matter has been submitted for review under the ERISA-mandated review procedure adopted by the Trustees. The decision on review is binding upon all persons dealing with the Plan or claiming any benefit hereunder, except to the extent that the decision may be determined to be arbitrary or capricious by a court or arbitrator having jurisdiction over the matter.

You or any other claimant may not begin any legal action, including proceedings before administrative agencies, until you have followed and exhausted the Plan's mandatory claims and appeals procedures. You may, at your own expense, have legal representation at any stage of the review process.

The Trustees have the right and authority to increase, decrease, or change benefits, or change eligibility rules or other provisions of the Plan as may in their discretion be proper or necessary for the sound and efficient administration of the Fund, provided that such changes are not prohibited by applicable law or the Trust Agreement, as amended.

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

Administrative Information

Your ERISA Rights

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

Receive Information About Your Plan and Benefits

You have the right to:

- Examine, without charge, at the Fund Administrative Office and at other specified locations, all documents governing the Plan, including insurance contracts, Collective Bargaining Agreements, and a copy of the latest annual report (Form 5550 series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration (EBSA);
- Obtain, upon written request to the Fund Administrator, copies of documents governing the operation of the Plan, including insurance contracts, Collective Bargaining Agreements, and copies of the latest annual report (Form 5550 series) and updated Summary Plan Description (the Fund Administrator may make a reasonable charge for the copies); and
- Receive a summary of the Plan's annual financial report, which the Fund Administrator is required by law to provide to each Participant.

Continue Group Health Plan Coverage

You also have the right to:

- Continue health care coverage for a Retired Employee's spouse or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event (your spouse or Dependents may have to pay for the coverage; review this Summary Plan Description/Plan Document and any documents governing the Plan on the rules governing your COBRA Continuation Coverage rights); and
- Reduce or eliminate exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have creditable coverage from another 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;
 - You become entitled to elect COBRA Continuation Coverage; or
 - Your COBRA Continuation Coverage ends.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

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

Administrative Information

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. However, you may be required to exhaust the Plan's claim and appeal procedures before you may begin legal action (see page 63). In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court. If you believe that Plan fiduciaries have misused the Plan's money, or if you believe that you have been discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance With Your Questions

If you have any questions about your Plan, you should contact the Fund Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Fund Administrator, you should contact the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration as follows:

National Office:

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue N.W.
Washington, D.C. 20210
866-444-3272

Nearest Regional Office:

Employee Benefits Security Administration
Cincinnati Regional Office
1885 Dixie Highway, Suite 210
Ft. Wright, KY 41011-2664
859-578-4680

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration. For more information on your rights and responsibilities under ERISA or for a list of EBSA offices, contact the EBSA by visiting the web site of the EBSA at www.dol.gov/ebsa.

Glossary

Terms defined in this section are used throughout this booklet. For your convenience, these defined terms are capitalized in the text of this booklet.

Administrator

An organization or entity that the Trustees contract with to provide administrative and/or claims payment services under the Plan. The Administrator provides administrative and/or claims payment services only and does not assume any financial risk or obligation with respect to claims. The Administrator for:

- Eligibility, Medicare medical claims processing, and premiums is WPAS, Inc. (referred to as the Fund Administrator);
- Pre-Medicare medical claims processing, Preferred Provider Network (PPO) and Utilization Review (UR) is United Health Care
- Pre-Medicare Prescription drug benefits is CVS/Caremark, referred to as the Pre-Medicare Pharmacy Benefits Manager (PBM)
- Medicare Prescription drug benefits is SilverScript, referred to as the Medicare Pharmacy Benefits Manager (PBM)
- Dental benefits is Delta Dental; and
- Vision benefits is EyeMed
- Health Reimbursement Arrangement is Wex Health, Inc.

Administrators provide administrative services only and do not assume any financial risk or obligation with respect to claims.

Alternative Care Facility

A non-Hospital health care facility or attached facility designated as free standing by a Hospital that provides outpatient services primarily for, but not limited to:

- Diagnostic services such as Computerized Axial Tomography (CAT scan) or Magnetic Resonance Imaging (MRI);
- Surgery; and
- Therapy services or rehabilitation.

Ambulatory Surgical Facility

A Provider that:

- Is licensed as such, where required;
- Is equipped mainly to do surgery;
- Has the services of a Physician and registered nurse at all times when a patient is present;
- Is not an office maintained by a Physician for the general practice of medicine or dentistry; and
- Is equipped and ready to initiate Emergency procedures with personnel who are certified in advanced cardiac lifesaving skills.

Behavioral Health

This includes a:

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- Mental health condition, which manifests symptoms that are primarily mental or nervous, regardless of any underlying physical causes; and
- Substance abuse condition, which is brought about when an individual uses alcohol or other drug(s) in a manner that impairs his or her health and/or ability to control actions.

To determine whether or not a particular condition is a Behavioral Health condition, the Plan may refer to the most current edition of the *Diagnostic and Statistical Manual of Mental Conditions of the American Psychiatric Association* or the *International Classification of Diseases (ICD) Manual*.

Birthing Center

A Provider, other than a Hospital, where births take place following normal, uncomplicated pregnancies that are:

- Constituted, licensed, and operated as set forth in the laws that apply;
- Equipped to provide low-risk maternity care;
- Adequately staffed with qualified personnel who:
 - Provide care at childbirth;
 - Are practicing within the scope of their training and experience; and
 - Are licensed if required; and
- Equipped and ready to initiate Emergency procedures in life threatening events to mother and baby by personnel who are certified in advanced cardiac lifesaving skills.

Certified Registered Nurse Anesthetist

Any individual:

- Licensed as a registered nurse by the state in which he or she practices;
- Who holds a certificate of completion of a course in anesthesia approved by the American Association of Nurse Anesthetists or a course approved by that state's appropriate licensing board; and
- Who maintains certification through a recertification process administered by the Council on Recertification of Nurse Anesthetists.

Covered Service

Services, supplies, or treatments covered under the Plan that are:

- Performed, prescribed, directed, or authorized by a Provider;
- Medically Necessary or otherwise specifically listed as covered by the Plan;
- Within the scope of the license of the Provider performing the service;
- Provided while eligible for coverage under the Plan;
- Not Experimental, Investigative, and/or otherwise excluded or limited under this Plan; and
- Authorized in advance by the Plan if pre-certification is required by the Plan.

Custodial Care

Care that is:

- Primarily for the purpose of assisting in the activities of daily living or in meeting personal rather than medical needs;
- Not specific treatment for an Illness or Injury; and
- Not expected to substantially improve a medical condition and has minimal therapeutic value.

Custodial Care includes, but is not limited to:

- Assistance with walking, bathing, or dressing;
- Transfer or positioning in bed;

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- Normally self-administered medicine;
- Meal preparation;
- Feeding by utensil, tube, or gastrostomy;
- Oral hygiene;
- Ordinary skin and nail care;
- Catheter care;
- Suctioning;
- Using the toilet;
- Enemas; and
- Preparation of special diets and supervision over medical equipment or exercises or over self-administration of oral medications not requiring constant attention of trained medical personnel.

Dependent

Eligible Dependents include your:

- Legal spouse; and
- Unmarried children dependent on you for over one-half of their support for the calendar year and who are:
 - Under age 21 at the end of the calendar year and have the same principal place of abode as you for more than one-half the calendar year;
 - At least age 21, but less than age 25, at the end of the calendar year provided they are full-time students at an accredited school and have the same principal place of abode as you for more than one-half the calendar year (A full-time student is a child who attends an accredited college, university, or vocational school on a full-time basis, as defined by the institution attended. School vacation periods during any calendar year that interrupt, but do not terminate, a continuous course of study are considered school attendance.); or
 - Any age provided they have a physical or mental disability that began before age 21 that prevents them from engaging in any self-sustaining employment, they have received a disability determination from the Social Security Administration, they have the same principal place of abode as you, due to their financial dependency on their parents.
- In cases of divorce or separation, if the child does not have the same principal place of abode as you for over one-half the calendar year or if you do not provide over one-half of the child's support, the child will be an eligible Dependent if you and the child's other parent are:
 - Divorced or legally separated under a decree of divorce or separate maintenance;
 - Separated under a written separation agreement; or
 - Living apart at all times during the last six months of the calendar year;
- You and the child's other parent provide over one-half of the child's support during the calendar year;
- The child is in the custody of one or both of his or her parents for more than one-half of the calendar year; and
- The child meets all other eligibility provisions.

Children include your biological children, step-children, legally adopted children (including children placed with you for adoption), and children for who you have legal guardianship. A child is considered placed for adoption if you assume a legal obligation for the total or partial support of a child in anticipation of the adoption of that child. A child for who you have legal guardianship includes a child who:

- Is under age 21, a full-time student age 21 or older but less than age 25, or age 21 or older who has a permanent physical or mental condition that began before age 21 that prevents the child from engaging in any self-sustaining employment;
- Came under your guardianship before age 21;

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- Has the same principal place of abode as you for the entire calendar year;
- Is a member of your household for the entire calendar year; and
- Is dependent upon you for over one-half of his or her support for the calendar year.

The Fund may require proof of dependent status at any time. Proof of dependent status includes, but is not limited to, tax returns, adoption or custody forms, certification of full-time student status, marriage, or birth certificate, or other proof.

Any person eligible to participate in this or any other group insurance program as a Retired Employee cannot also be covered as a Dependent.

Domiciliary Care

Care, consisting mainly of room and board (even if therapy is included) provided in a residential institution, treatment center, halfway house, or school because home arrangements are not available or are unsuitable.

Emergency

A traumatic bodily injury or other medical condition that arises suddenly and unexpectedly and manifests itself by acute symptoms of such severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine to:

- Place an individual's health in serious jeopardy;
- Result in serious impairment to the individual's bodily functions; or
- Result in serious dysfunction of a bodily organ or part of the individual.

Emergency Medical Care

Covered Services provided by a Provider that are needed to evaluate or stabilize a Participant in an Emergency.

Experimental or Investigative

Any drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply used in or directly related to the diagnosis, evaluation, or treatment of a disease, illness, injury, or other health condition that:

- Cannot be legally marketed in the United States without the final approval of the Food and Drug Administration (FDA), or other licensing or regulatory agency, and such final approval has not been granted;
- Has been determined by the FDA to be contraindicated for the specific use;
- Is provided as part of a clinical research protocol or clinical trial or is provided in any other manner that is intended to evaluate its safety, toxicity, or efficacy;
- Is subject to review and approval of an Institutional Review Board or other body serving a similar function; or
- Is provided pursuant to informed consent documents that describe it as Experimental or Investigative or otherwise indicate that its safety, toxicity, or efficacy is under evaluation.

In determining Experimental or Investigative, the Plan will look at if the:

- Scientific evidence is conclusory concerning the effect of the service on health outcomes;
- Evidence demonstrates the service improves net health outcomes of the total population for whom the service might be proposed by producing beneficial effects that outweigh any harmful effects;
- Evidence demonstrates the service has been shown to be as beneficial for the total population for whom the service might be proposed as any established alternatives; and
- Evidence demonstrates the service has been shown to improve the net health outcomes of the total population for whom the service might be proposed under the usual conditions of medical practice

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outside clinical investigatory settings.

Any of the following information may be considered or evaluated when making a determination of Experimental or Investigative:

- Published authoritative, peer-reviewed medical or scientific literature, or the absence thereof;
- Evaluations of national medical associations, consensus panels, and other technology evaluation bodies;
- Documents issued by and/or filed with the FDA or other federal, state, or local agency with the authority to approve, regulate, or investigate its use;
- Documents of an Institutional Review Board or other similar body performing substantially the same function;
- Consent document(s) and/or the written protocol(s) used by the treating Physicians, other medical professionals, or facilities or by other treating Physicians, other medical professionals or facilities studying substantially the same drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply;
- Medical records; or
- Opinions of consulting Providers and other experts in the field.

Home Assessment Report

A written recommendation that states the suggested safety, fall prevention, and/or accessibility modifications to your home prepared by the Licensed Occupational Therapist who has conducted an assessment of your home.

Home Health Care Agency

A public or private agency or organization licensed in the state in which it is located to provide home health care services.

Hospice Facility or Hospice Care

A coordinated plan of home, inpatient, and outpatient care that provides:

- Palliative and supportive medical and other health services to terminally ill patients;
- A program of planned and continuous care by an interdisciplinary team, of which the medical components are under the direction of a Physician; and
- Care 24 hours a day, seven days a week.

The Hospice Facility must meet the licensing requirements of the state or locality in which it operates.

Hospital

An institution:

- Constituted, licensed, and operated as set forth in the laws that apply to Hospitals;
- Provides room and board and nursing care for its patients;
- Has a staff with one or more Physicians available at all times;
- Provides 24-hour nursing service;
- Maintains on its premises all the facilities needed for the diagnosis, medical care, and treatment of an illness or injury; and
- Is fully accredited by the Joint Commission on Accreditation of Health Care Organizations.

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The term Hospital does not include a Provider, or that part of a Provider, used mainly for:

- Nursing care;
- Rest care;
- Convalescent care;
- Care of the aged;
- Custodial Care;
- Educational care; or
- Treatment of alcohol or drug abuse.

Illness

Any bodily sickness or disease, including pregnancy or any congenital abnormality of a newborn child, as diagnosed by a Physician and as compared to the person's previous condition.

Injury

Any damage to a body part resulting from trauma from an external source.

Licensed Occupational Therapist

An occupational therapist who practices within compliance with federal and state laws and (1) has graduated from an occupational therapy program accredited by the Accreditation Council for Occupational Therapy Education ("ACOTE") or predecessor organizations; (2) has successfully completed a period of supervised fieldwork experience required by the recognized educational institution where the applicant met the academic requirements of an educational program for occupational therapists that is accredited by ACOTE or predecessor organizations; (3) has passed a nationally recognized entry-level examination for occupational therapists; and (4) fulfills state requirements for licensure, certification, or registration.

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Medically Necessary or Medical Necessity

An intervention that is or will be provided for the diagnosis, evaluation, and treatment of a condition, illness, injury, or disease determined to be:

- Medically appropriate for and consistent with the symptoms and proper diagnosis or treatment of the Participant's condition, illness, injury, or disease;
- Obtained from a Provider;
- Provided in accordance with applicable medical and/or professional standards;
- Known to be effective, as proven by scientific evidence, in materially improving health outcomes;
- The most appropriate supply, setting, or level of service that can safely be provided and that cannot be omitted consistent with recognized professional standards of care (which, in the case of hospitalization, also means that safe and adequate care could not be obtained in a less comprehensive setting);
- Cost-effective compared to alternative interventions, including no intervention (cost effective does not mean lowest cost);
- Not Experimental and/or Investigative; and
- Not primarily for the convenience of the Participant, Participant's family, or Provider.

Clinical guidelines, which are used to assist in the interpretation of Medical Necessity, include Fund Administrator's corporate medical policy, nationally recognized utilization review guidelines, Fund Administrator developed medical review criteria, Medicare guidelines, and other decision support material. Medical technology and standards of care are constantly changing, and the Plan reserves the right to review and update these clinical guidelines periodically.

The fact that a Provider may prescribe, order, recommend, or approve care, treatment, services or supplies does not, of itself, make such care, treatment, services or supplies Medically Necessary. In addition, any care, treatment, service or supply that is a Plan exclusion is not considered Medically Necessary

Medicare Approved Amount

The amount approved by Medicare for services covered by Medicare. If a Participant receives Medicare covered services from a Provider who does not accept Medicare assignments, the Fund will pay only the Medicare Approved Amount for those services.

Network Charge

The amount that constitutes payment in full under the network Provider's participation agreement. If a network Provider accepts as full payment an amount less than the negotiated rate under the participation agreement, the lesser amount will be the Network Charge.

If a network Provider uses non-network Providers to perform services (for example, if a network hospital uses non-network emergency room physicians, anesthesiologists or pathologists), the Fund Administrator will apply the Usual and Customary Charge for those services or a charge agreed upon by the non-network Provider and the Fund Administrator or the Trustees.

New FDA Approved Drug Product or Technology

The first release of the brand name product or technology upon the initial Food and Drug Administration (FDA) New Drug Approval. Other applicable FDA approval for its biochemical composition and initial availability in the marketplace for the indicated treatment and use.

New FDA Approved Drug Product or Technology does not include:

- New formulations (a new dosage form or new formulation of an active ingredient already on the market);

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- Already marketed drug product but new manufacturer (a product that duplicates another firm's already marketed drug product; same active ingredient, formulation, or combination);
- Already marketed drug product, but new use (a new use for a drug product already marketed by the same or a different firm); or
- Newly introduced generic medication.

New Spouse

An individual whom a Retired Employee marries on or after June 1, 2008.

Participant

A Retired Employee or Dependent who meets all of the Plan's eligibility requirements, including applying for coverage and making the required payment for coverage.

Physician

An individual that is a legally licensed doctor of medicine, doctor of osteopathy, or optometry. This may also include any other legally licensed practitioner of the healing arts rendering services that are:

- Covered by the Plan;
- Required by law to be covered when rendered by the practitioner; and
- Within the scope of his or her license.

A Physician does not include you or your spouse, parent, child, sibling, or in-law.

Provider

A duly licensed person or facility that provides services within the scope of an applicable license and is a person or facility that the Plan approves. This includes any Provider rendering services that are required by applicable state law to be covered when rendered by such Provider. Providers include, but are not limited to:

- Alternative Care Facility;
- Ambulatory Surgical Facility;
- Birthing Center;
- Certified Registered Nurse Anesthetist;
- Home Health Care Agency;
- Hospice Facility;
- Hospital;
- Physician;
- Skilled Nursing Facility; and
- Urgent Care Center.

Qualified Medical Child Support Order or QMCSO

A court order that complies with requirements of federal law requiring an individual to provide health care coverage for a Dependent child, and requiring that benefits payable on account of that Dependent child be paid directly to the Provider who rendered the services or to the custodial parent of the Dependent child. A copy of the Plan QMCSO order is available, free of charge, upon written request to the Fund Administrative Office.

Retired Employee

- An employee who worked for AK Steel or one of its predecessors at the Middletown Works (and

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related facilities covered by the collective bargaining agreement for the Middletown Works) under a collective bargaining agreement covering hourly or salaried employees, negotiated between AK Steel or one of its predecessors (including Armco, Inc., Armco Steel Corporation, and Armco Steel Company, L.P.) and AEIF or the Union; and

- Retired from AK Steel between January 1, 1957 and May 31, 2007, as an hourly employee or retired between January 1, 1984 and May 31, 2007 as a salaried employee; and
- Was eligible to participate in the (1) AK Steel Hourly Retiree Hospital and Medical Benefits Plan or a predecessor plan, or the (2) AK Steel Corporation Hospital and Medical Benefits Plan (for AEIF Salaried Represented Pensioners, Surviving Spouse Benefit Recipients and Eligible Dependents) or a predecessor plan, at the time of retirement and who continued to be eligible to participate in one of these plans as of February 29, 2008.

Skilled Nursing Facility

A Provider constituted, licensed, and operated according to applicable state law that:

- Mainly provides inpatient care and treatment for persons who are recovering from an illness or injury;
- Provides care supervised by a Physician;
- Provides 24 hour per day nursing care supervised by a full-time registered nurse;
- Is not a place primarily for care of the aged, Custodial or Domiciliary Care, or treatment of alcohol or drug dependency; and
- Is not a rest, educational, or custodial provider or similar place.

Surviving Spouse

The legal spouse of a deceased Retired Employee, who met the eligibility requirements to participate in the AK Steel health plans as of May 31, 2008.

Urgent Care Center

A health care facility that is organizationally separate from a Hospital and whose primary purpose is the offering and provision of immediate, short-term medical care, without appointment, for urgent care.

Usual and Customary (U&C) Charge

The maximum amount allowed for non-network services, determined by the Fund Administrator, based on the lesser of the non-network Provider's charge or an amount based on any one of the following factors: industry costs; peer reimbursement; utilization data; previously negotiated rates; negotiated offers that the Fund Administrator may have made; or other factors the Fund Administrator deems appropriate.

For Medicare Medical Benefits, the Usual and Customary Charge is used to determine the amount allowed for Covered Services that are not covered by Medicare.

In the absence of a negotiated amount, the Trustees or Fund Administrator has discretionary authority to establish the U&C Charge for a non-network Provider facility. The U&C Charge is the lesser of the non-network Provider facility's charge, or an amount based on any one or more of the following: industry cost, peer reimbursement, utilization data and previously negotiated rates, outstanding offers that the Fund Administrator may have made, or other factors the Fund Administrator deems appropriate.

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