UAW RETIREE MEDICAL BENEFITS TRUST

UAW CHRYSLER RETIREES MEDICAL BENEFITS PLAN
PLAN DOCUMENT

2017

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ARTICLE I — ESTABLISHMENT AND NAME OF THE PLAN

SECTION 1.1 – ESTABLISHMENT AND NAME OF THE PLAN

The Committee for the UAW Retiree Medical Benefits Trust (hereinafter also referred to as the "Trust") acting on behalf of the Employees' Beneficiary Association ("EBA") for Chrysler Group LLC Retirees has established a welfare benefit plan for the eligible Retirees and their survivors of Chrysler Group LLC hereunder that shall be known as the UAW Chrysler Retirees Medical Benefits Plan (hereinafter also referred to as the "Plan"), Plan Number 503. The Plan was originally established as of January 1, 2010, may be amended from time to time, and is maintained in accordance with the provisions of the UAW Retiree Medical Benefits Trust Agreement effective December 3, 2009 (originally effective October 16, 2008), as amended.

SECTION 1.2 – PURPOSE

This Plan document is adopted by the Committee of the Trust under the terms of the Trust Agreement. The purpose of the Plan is to provide health and welfare benefits to eligible Retirees and their survivors. The Plan is intended to be established as a single employer employee benefit plan as provided under Section 402 of ERISA and a welfare plan as defined in Section (3)(1) of ERISA.

SECTION 1.3 – INCORPORATION OF TRUST AGREEMENT, SCHEDULE OF BENEFITS, AND INSURANCE POLICIES OR CONTRACTS

This Plan incorporates the UAW Retiree Medical Benefits Trust Agreement to describe fully the operation of the Plan and the benefits provided by the Plan. In addition, the Plan incorporates the Schedule of Benefits that is currently in effect, as adopted by the Committee, and the insurance policies or contracts (including Medicare Advantage plans and Health Maintenance Organization contracts) that the Committee or its delegate has obtained to provide benefits under the Plan. Any insurance policy or contract obtained by the Committee or its delegate solely to provide benefits for Retirees residing outside of the United States is also incorporated into the Plan, but any Plan provisions required solely by United States law (e.g., ERISA) shall not apply to such policy or contract.

In the event of a conflict between the incorporated documents, the following should be the order of priority: First, the Trust Agreement, second, the Plan Document and third, the Schedule of Benefits or the applicable insurance policy or contract.

ARTICLE II — DEFINITIONS

This section contains definitions of important terms used throughout this Plan Document. When these terms are capitalized, they have the meanings shown below.

SECTION 2.1 – ACCIDENTAL INJURY

A bodily injury (such as a fracture, strain, sprain, abrasion, contusion or other condition) caused by an action, object or chemical agent. It may occur as the result of a traumatic incident, such as being struck, or by other events such as, but not limited to: ingestion of poison; overdose of medication, whether accidental or intentional; allergic reaction resulting from trauma, such as bee stings or insect bites; inhalation of smoke, carbon monoxide, or fumes; burns, frostbite, sunburn, and sunstroke.

SECTION 2.2 – ALLOWED AMOUNT

The maximum amount the Trust will pay for a covered service, supply, device, or drug, according to certain standards and considerations. In-Network Providers have agreed to accept this Allowed Amount as payment in full for covered services.

SECTION 2.3 – AMBULATORY SURGICAL FACILITY/CENTER

A facility, separate from a Hospital, which provides outpatient surgical services. Such facilities must be approved by the Carrier.

SECTION 2.4 – ANNUAL EXAM (WELLNESS)

A visit by the Enrollee to that Enrollee's physician that includes a comprehensive review of the Enrollee's medical, social, and family history, current health conditions, and prescriptions. During the visit, the physician will typically check Enrollee's blood pressure, weight, and height. The physician will also ensure that the Enrollee is up-to-date with appropriate health screenings and vaccinations.

SECTION 2.5 – APPROVED FACILITY OR TREATMENT PROGRAM

A facility or treatment program that has met criteria established by the Carrier to provide certain services covered under the Trust.

SECTION 2.6 – AUTO COMPANY

Chrysler Group LLC and certain affiliated companies or organizations.

SECTION 2.7 – CARRIER

An entity that pays benefits and/or administers a coverage or option under the Plan, including, but not limited to, a BlueCross BlueShield organization, a commercial insurance company, a Health Maintenance Organization, a Preferred Provider Organization, a Pharmacy Benefit Manager, or an administrative services provider.

SECTION 2.8 – CASE MANAGEMENT

Case management is a formal and collaborative process of evaluation, planning, facilitation, intervention, and advocacy services focused on assisting the Enrollee in meeting his or her health care needs through communication and available resources. It involves a comprehensive assessment of the member's condition; determination of available benefits and resources; and development and implementation of a case management plan with performance goals, monitoring and follow-up.

SECTION 2.9 – COMMITTEE

The Committee was formed by operation of the court-approved settlement agreement between Chrysler Group LLC and the UAW. The Committee acts on behalf of the Employees' Beneficiary Association ("EBA") for Chrysler Group LLC with regard to retiree medical coverage. The EBA, through the Committee, has established and maintains a separate employee welfare benefits plan, known as the UAW Chrysler Retirees Medical Benefits Plan.

SECTION 2.10 – CONTRIBUTIONS

The monthly amount the Enrollee must pay in order to have coverage for the Enrollee and the Enrollee's Dependents under the Plan as described in the Schedule of Benefits. In general, the required Contributions will be deducted from the Enrollee's pension or billed directly to the Enrollee. If the Enrollee does not make the required monthly Contributions, the Enrollee and the Enrollee's Dependents will be dropped from all coverage, and the Enrollee and Dependent will be disenrolled from the Plan.

SECTION 2.11 – CUSTODIAL, DOMICILIARY, OR MAINTENANCE CARE

The type of care or services which, even if ordered by a Physician or performed by a clinician or other health care provider, is primarily for the purpose of meeting the personal needs of the patient or maintaining a level of function, as opposed to specific medical, surgical, or psychiatric care or services designed to reduce the disability to the extent necessary to enable the patient to live without such care. It may include, but is not limited to, help in getting in and out of bed, walking, bathing, dressing, eating, and taking medication; ostomy care, hygiene, or incontinence care; and checking of routine vital signs.

SECTION 2.12 – CUSTODY ORDER

An order, judgment or decree from a court or agency of competent jurisdiction placing permanent responsibility and custody of a child with the Primary Enrollee or the current Spouse or same-sex domestic partner of the Primary Enrollee. Such responsibility must include, but is not limited to, responsibility for financial affairs, legal custody, and primary physical custody of the minor child, meaning that the child must live with the individual who is granted custody under the Custody Order. Appointments, orders, judgments, or decrees for temporary responsibility, custody or power of attorney are not sufficient to establish a Custody Order for purposes of the Plan.

SECTION 2.13 – DEPENDENT(S)

The Retiree's eligible Spouse, same-sex domestic partner, Dependent Children, and surviving Spouse.

SECTION 2.14 – DEPENDENT CHILD (DEPENDENT CHILDREN)

Generally, a child for whom the Primary Enrollee can legally claim an exemption on his or her federal income tax. To be eligible for coverage under the Plan, the child must meet the eligibility requirements in the section entitled "Eligibility for Dependent Children."

SECTION 2.15 – DURABLE MEDICAL EQUIPMENT

Equipment that can withstand repeated use and is primarily and customarily used for a medical purpose and is not generally useful in the absence of an Injury or Illness; and is not disposable or non-durable and is appropriate for the patient's home. Durable Medical Equipment is payable under the terms of the Plan to the extent that the service meets Plan conditions and is provided by a Participating Provider.

SECTION 2.16 – ELIGIBILITY BENEFITS CENTER

The Eligibility Benefits Center, as identified in the applicable Schedule of Benefits, is the entity responsible for administering eligibility and related issues including, but not limited to, changes in eligibility (e.g., adding or removing Dependents), changes to the Enrollee's plan elections, address changes, COBRA qualifying event notifications, questions regarding PPO, HMO, and Medicare Advantage Plan options, etc.

SECTION 2.17 – EMPLOYEE

An individual who is covered under an active Auto Company plan and is eligible to retire with health care coverage under the Plan.

SECTION 2.18 – ENROLLEE

Each Retiree or other Primary Enrollee and each of his eligible Dependents, if any.

SECTION 2.19 – ERISA

The Employee Retirement Income Security Act of 1974, as amended from time to time.

SECTION 2.20 – EXPERIMENTAL, RESEARCH, AND/OR INVESTIGATIONAL

A service, supply, device, or drug that meets any of the following conditions, as determined by the applicable Carrier:

(a) It is described as an alternative to more conventional therapies in the protocols or consent document of the Provider that performs the service or prescribes the supply;

(b) It may be given only with the approval of an Institutional Review Board as defined by federal and state law;

(c) There is a relative lack or absence of authoritative medical or scientific literature on the subject;

(d) The majority of authoritative medical or scientific literature published in the United States regards the service, supply, device, or drug as experimental or investigational or indicates that more research is required;

(e) The service, supply, device, or drug exceeds an FDA-approved limit;

(f) It has not received full approval by the Food and Drug Administration (FDA), if such FDA approval is required; or

(g) It is available only through participation in clinical trials sponsored by the FDA, the National Cancer Institute, the National Institutes of Health, a pharmaceutical company, or a medical device manufacturer.

SECTION 2.21 – FREESTANDING OUTPATIENT PHYSICAL THERAPY FACILITY

A facility, separate from a Hospital, which provides outpatient physical therapy services. Such facilities must be approved by the Carrier.

SECTION 2.22 – HIPAA

The Health Insurance Portability and Accountability Act of 1996, as amended from time to time. Except to the extent required for insured portions of the Plan, the Plan is exempt from certain of HIPAA's portability and nondiscrimination requirements under Section 732(a) of ERISA because the Plan has no participants who are current employees. The Plan is subject to HIPAA's privacy and security requirements.

SECTION 2.23 – HOME HEALTH CARE AGENCY

A centrally administered agency providing Physician-directed nursing and other paramedical services to patients at home. A Home Health Care Agency must be approved by the Carrier.

SECTION 2.24 – HOSPICE

A program of medical and non-medical services provided for terminally ill Enrollees and their families through agencies that administer and coordinate the services. A Hospice program must be approved by the Carrier.

SECTION 2.25 – HOSPITAL

A facility that, in return for compensation from its patients, provides diagnostic and therapeutic services on a continuous inpatient basis for the surgical, medical, or psychiatric diagnosis, treatment, and care of injured or acutely sick persons. These services are provided by, or under the supervision of, a professional staff of licensed Physicians and surgeons. A Hospital continuously provides 24-hour a day nursing service by registered nurses. A rehabilitation institution shall be considered to be a Hospital if the institution is approved as such under this Plan. A Hospital must meet all applicable local and state licensure and certification requirements

and be accredited as a Hospital by state or national medical or Hospital authorities or associations.

A Hospital is not, other than incidentally, a place for Custodial Care, convalescent, pulmonary tuberculosis, rest or Domiciliary Care; an institution for children; an institution to which Enrollees may be remanded by the judicial system; an institution for the treatment of the aged or substance abusers; or a Skilled Nursing Facility or other nursing care facility. It does not include a health resort, rest home, nursing home, convalescent home, or similar institution.

SECTION 2.26 – IN-NETWORK PROVIDERS

Providers that participate in the Traditional Care Network (TCN) or other networks providing Plan coverage, such as HMOs and PPOs. In-Network Providers are also referred to as "Participating Providers," "Network Providers," or "Panel Providers."

SECTION 2.27—LEGAL GUARDIANSHIP

The relationship between the Primary Enrollee or the current Spouse or same-sex domestic partner of the Primary Enrollee, who has been appointed by a court or agency of competent jurisdiction as the legal guardian for a child, and the child. Such responsibility must include, but is not limited to, responsibility for financial affairs, legal custody, and primary physical custody of the minor child, meaning that the child must live with the individual who is appointed as the legal guardian. Appointments, orders, judgments, or decrees for temporary responsibility, custody or power of attorney are not sufficient to establish Legal Guardianship for purposes of the Plan.

SECTION 2.28 – MEDICAL EMERGENCY

A permanent health-threatening or disabling condition, other than an Accidental Injury, that requires immediate medical attention and treatment. A Medical Emergency will be considered to exist only if medical treatment is secured within 72 hours after the onset of the condition. The condition must be of such a nature that severe symptoms occur suddenly and unexpectedly and that failure to render treatment immediately could result in significant impairment of bodily function, cause permanent damage to the individual's health, or place the individual's life in jeopardy. Signs and symptoms verified by the treating Physician at the time of treatment, and not the final diagnosis, must confirm the existence of a threat to life or bodily functions.

SECTION 2.29 – MEDICALLY NECESSARY (MEDICAL NECESSITY)

A service, supply, device, or drug that is (as determined by the applicable Carrier):

(a) Provided by or under the direction of a health care practitioner who is authorized to provide or prescribe it;

(b) Necessary in terms of generally accepted American medical/dental standards;

(c) Consistent with the symptoms or diagnosis and treatment of an illness or injury;

(d) Not provided primarily for the patient or Provider's convenience;

(e) Appropriate given the patient's circumstances and condition;

(f) A "cost-efficient" supply or level of service that can be safely provided to the patient; and safe and effective for the illness or injury for which it is used.

SECTION 2.30 – MEDICARE

Medicare is a federal health care program for individuals age sixty-five (65) or older, and for certain individuals under age sixty-five (65) who have a severe long-term disability, end-stage renal disease (ESRD), or undergo a kidney transplant. Medicare also refers to the services and supplies that Enrollees receive or are entitled to receive under Medicare Part A (inpatient hospital services), Part B (outpatient services) or both, Medicare Advantage, or Medicare Part D (prescription drugs).

SECTION 2.31—NON-PHYSICIAN PRACTITIONER

An individual who meets Carrier standards for the given profession and is approved for reimbursement for certain professional services in accordance with training and licensure, which would be covered under the Plan when performed by a Physician. The Carrier will assure that multiple practitioners will not be reimbursed for the same service. Plan Standards for Non-Physician Practitioners shall include, but not be limited to, the requirements that the individuals be registered, certified and/or licensed as applicable under state law; be legally entitled to practice their specialties at the time and place services are performed; that they render specified services which they are legally qualified to perform; and that they be approved for Medicare reimbursement, if applicable, for Enrollees who have Medicare as their primary coverage.

The categories of Non-Physician Practitioners include:

Advance Practice Nurses—health care professionals including, but not limited to, certified nurse practitioners, clinical nurse specialists, certified nurse mid-wives and certified nurse anesthetists. These health care professionals must be accredited by their respective national societies and approved through state licensing processes.

Physician Assistants—health care professionals licensed to practice medicine with Physician supervision. Physician Assistants must be accredited by the Accreditation Review Commission on Education for the Physician Assistant, certified by the National Commission on Certification of Physician Assistants, and meet state licensure requirements.

SECTION 2.32 – OUT-OF-NETWORK PROVIDERS

Providers that do not participate in the Traditional Care Network (TCN) or other networks providing Plan coverage, such as HMOs and PPOs. When the Enrollee uses an Out-of-Network Provider, the Enrollee generally is responsible for paying the applicable Out-of-Network deductible and co-insurance, as well as any amounts in excess of the Allowed Amount. Out-of-Network Providers also are referred to as "Non-Participating Providers," "Non-Network Providers," or "Non-Panel Providers."

SECTION 2.33 – OUTPATIENT FREESTANDING FACILITY

A facility, separate from a Hospital, which provides outpatient services. Such facilities must meet Plan Standards and be approved by the Carrier.

SECTION 2.34 – PARTIAL HOSPITALIZATION TREATMENT FACILITY

Facility that provides a semi-residential level of care for patient with mental health or substance abuse disorders who require coordinated intensive, comprehensive, and multidisciplinary treatment in a structured setting, but less than full time Hospitalization. The patient undergoes therapy for more than four (4) hours a day, and may receive additional services (e.g., meals, bed, and recreation). A Partial Hospitalization Treatment Facility must meet Plan standards and be approved by the Carrier.

SECTION 2.35 – PHYSICIAN

A doctor of medicine (M.D.) or osteopathy (D.O.) legally qualified and licensed to practice medicine or osteopathic medicine and/or perform surgery at the time and place services are rendered or performed. As used herein, Physician shall also include the following categories of limited practice professionals who are legally qualified and licensed to practice their specialties at the time and place services are performed, and who render specified services which they are legally qualified to perform.

"Dentist" means a doctor of dental surgery (D.D.S.) or a doctor of medical dentistry (D.M.D.) whose scope of practice is the diagnosis, prevention, and treatment of diseases of the teeth and related structures. Certain services of a dentist may be covered under the Plan when performed in response to a medical diagnosis and for selected dental surgeries. A dentist also may prescribe medications which may be covered under the prescription drug coverage.

"Podiatrist" means a doctor of podiatric medicine (D.P.M.) or a doctor of surgical chiropody (D.S.C.) whose scope of practice is the diagnosis, prevention, and treatment of ailments of the feet. Services of podiatrists, relating to the feet, may be covered under surgical and medical coverage. A podiatrist also may prescribe medications which may be covered under the prescription drug coverage.

"Chiropractor" means a doctor of chiropractic (D.C.) whose scope of practice is the diagnosis and treatment of subluxations or misalignments of the spinal column and related bones and tissues which produce nerve interference. Services of chiropractors which may be covered under the Plan are limited to diagnostic radiological services and emergency first aid, both pertaining to the spine and related bones and tissues. Under the Plan, a chiropractor may not prescribe medications, perform invasive procedures or incisive surgical procedures, provide outpatient physical therapy services, or perform physical examinations not related to the spine and related bones and tissues.

SECTION 2.36 – PLAN

The UAW Chrysler Retirees Medical Benefits Plan.

SECTION 2.37 – PLAN STANDARDS

Criteria established by the Plan for approval of Providers or payment.

SECTION 2.38 – PLAN YEAR

The Plan Year begins on January 1 and ends on December 31.

SECTION 2.39 – PRIMARY ENROLLEE

The person who is enrolled in the Plan and whose Dependents may be eligible for coverage because of the person's enrollment. The Primary Enrollee may be a Retiree, a surviving Spouse, or a surviving same-sex domestic partner.

SECTION 2.40 – PROSTHETIC AND/OR ORTHOTIC APPLIANCE

An artificial device which replaces an absent part of the body, or which aids the performance of a natural function of the body without replacing a missing part. Prosthetic and Orthotic Appliances are payable under the terms of the Plan to the extent that the appliance meets Plan standards and is provided by a Participating Provider.

SECTION 2.41 – PROTECTED HEALTH INFORMATION

Protected Health Information as defined by HIPAA, means information created or received by a health plan, health care provider, or health care clearinghouse that relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present or future payment for the provision of health care to an individual. In addition, the information either identifies the individual, or there is a reasonable basis to believe the information can be used to identify the individual.

SECTION 2.42 – PROVIDER

A person (such as a Physician) or a facility (such as a Hospital) that provides health care services. Providers are considered "participating" when they have signed an agreement with a Carrier to accept the Allowed Amount for a service as "payment in full."

SECTION 2.43 – RESIDENTIAL TREATMENT FACILITY

Facility that provides inpatient facility treatment for a patient with mental health and/or substance abuse disorders. A Residential Treatment Facility must meet Plan standards and be approved by the Carrier.

SECTION 2.44 – RETIREE

Any former Employee who is eligible for Retiree benefits according to the standards set forth in the Eligibility Article of this Plan Document.

SECTION 2.45 – SCHEDULE OF BENEFITS

The Schedule of Benefits as adopted from time to time by the Committee or its delegate and provided to Plan Enrollees, which contains detailed information regarding covered benefits, co-payments, co-insurance, and deductibles which are applicable to covered benefits.

SECTION 2.46 – SPOUSE

A spouse is defined as an individual married to a Retiree with a valid marriage certificate from a state, the District of Columbia, a U.S. territory, or a foreign country ("Jurisdiction") where such marriage has been recognized as legal according to the laws of that Jurisdiction, regardless of whether the individual or the Retiree is a current resident of that Jurisdiction.

SECTION 2.47 – SKILLED NURSING FACILITY

A facility providing convalescent and long-term illness care with continuous nursing and other health care services by, or under the supervision of, a Physician and a registered nurse. The facility may be operated either independently or as part of an accredited general Hospital. A Skilled Nursing Facility must be approved by the Carrier.

SECTION 2.48 – TRUST

The UAW Retiree Medical Benefits Trust, as adopted by the Committee pursuant to the terms of the court-approved settlement agreements between the UAW and Chrysler Group LLC, Ford Motor Company, and General Motors Company originally effective October 16, 2008 and most recently restated effective December 3, 2009, and as thereafter amended by the Committee. The Trust also may be referred to as the "VEBA".

SECTION 2.49 – UAW

The International Union, United Automobile, Aerospace and Agricultural Implement Workers of America.

SECTION 2.50 – UNITED STATES (U.S.)

The United States or U.S. is defined as encompassing all territories that have applied and been granted statehood to be a part of the U.S. and all territories that have been determined by the U.S. State Department to be property of the U.S., including the District of Colombia, Puerto Rico, the U.S. Virgin Islands, Guam, the Northern Mariana Islands, American Samoa, and any other territory so determined.

SECTION 2.51 – URGENT CARE

Care which is needed for an unforeseen acute or serious illness, injury, or condition such that a prudent layperson would seek medical attention within 12-24 hours but which poses no immediate threat to life or health.

SECTION 2.52 – URGENT CARE FACILITY

A public or private Hospital-based or free-standing facility that is licensed or legally operating as an Urgent Care Facility, that primarily provides minor emergency and episodic medical care, in which one or more Physicians, nurses, and x-ray technicians are in attendance at all times when the facility is open, and that includes x-ray and laboratory equipment and a life support system. Such facilities will include retail clinics. An Urgent Care Facility must meet Plan Standards and be approved by the Carrier.

SECTION 2.53 – VEBA

A voluntary employees' beneficiary association, which is a tax-exempt employee welfare benefit fund under Section 501(c)(9) of the Internal Revenue Code that is held in trust for the benefit of covered participants.

ARTICLE III — PARTICIPATION

SECTION 3.1 – GENERAL INFORMATION

Generally, to be eligible for post-retirement health coverage under the Plan, Retirees must be eligible for such coverage based on the terms that were in effect when they retired from Chrysler Group LLC and under the terms of the Trust and must make any required payments for coverage.

Retirees may cover their Spouses and Dependent Children, including children who are the subject of a Qualified Medical Child Support Order (QMCSO). Retirees may also cover a same-sex domestic partner and the same-sex domestic partner's Dependent Children who were covered under the Retiree's Auto Company medical plan prior to the Retiree's retirement. However, Retirees may not enroll a same-sex domestic partner or the same-sex domestic partner's Dependent Children after retirement.

All Retirees, their Spouses, their same sex domestic partners, and their Dependent Children must be enrolled in Medicare Part A when first eligible or entitled. This will not apply to any Enrollee who first becomes eligible for Medicare Part A before January 1, 2017.

SECTION 3.2 – CATEGORIES OF RETIREES

Retirees and surviving Spouses include two categories – "Protected" and "General." These categories relate to certain differences in the required monthly Contributions under the Plan, and may relate to certain differences in cost-sharing features, including deductibles, co-Insurance maximums, out-of-pocket expenses, and certain co-payments.

(a) Protected Retirees. A Protected Retiree or Surviving Spouse is one who is receiving both an annual pension benefit income of $8,000 or less and a monthly pension benefit rate of $33.33 or less per month per year of credited service.

(b) General Retirees. A General Retiree or Surviving Spouse is one who is receiving either an annual pension benefit income of more than $8,000 or a monthly pension benefit rate over $33.33 per month per year of credited service.

SECTION 3.3 – RETIREE ELIGIBILITY

(a) A Retiree is eligible for coverage under the Plan, provided the Retiree is eligible for such coverage based on the terms that were in effect when he or she retired from Chrysler Group LLC and under the terms of the Trust, and the Retiree makes any required Contributions for coverage.

(b) An individual is not eligible for coverage under the Plan as a Retiree if he or she:

(1) Is eligible only for a deferred vested pension benefit under his or her Auto Company's pension plan;

(2) Is not a Retiree;

(3) Was discharged for cause from the applicable Auto Company, even if he or she is receiving a pension from his or her Auto Company's pension plan;

(4) Does not enroll (voluntarily or automatically) in Medicare Part A when first eligible, if Retiree first became eligible after January 1, 2017; or

(5) Is present in the U.S. illegally, i.e., is not a U.S. citizen, does not have a legal visa, or does not have other government approved documents conferring legal status in the U.S., and is entitled to Medicare Part A and enrolled in Medicare Part B.

(c) If a Retiree and his or her Spouse both qualify as Primary Enrollees under this Plan, each may enroll in a different health benefit option. However, a Retiree cannot be listed as the Primary Enrollee on one health benefit option and also be listed as a Spouse under another health benefit option.

SECTION 3.4 – ELIGIBILITY FOR SPOUSES

(a) A Retiree's current Spouse is eligible for coverage under the Plan, provided the Retiree is eligible for and enrolled in Plan coverage and enrolls (voluntarily or automatically) in Medicare Part A when first eligible, if the Spouse first became eligible after January 1, 2017. If entitled to Medicare Part A and/or enrolled in Medicare Part B, Spouse, if present in the U.S., must be so lawfully.

(b) A Retiree's common-law Spouse is eligible for coverage under the Plan, provided the relationship is recognized by the laws of the state in which the Retiree resides and the Retiree meets the documentation requirements of the Plan. The Retiree must meet such requirements for documentation of the status as may be necessary by law and required by the Plan. The common-law Spouse must enroll (voluntarily or automatically) in Medicare Part A when first eligible, if the common-law Spouse first became eligible after January 1, 2017. If entitled to Medicare Part A and/or enrolled in Medicare Part B, common-law Spouse, if present in the U.S., must be so lawfully.

SECTION 3.5 – ELIGIBILITY FOR SAME-SEX DOMESTIC PARTNERS AND THEIR DEPENDENTS

(a) A Retiree's same-sex domestic partner who was covered under the Retiree's Auto Company medical plan at the time of the Retiree's retirement is eligible for coverage under the Plan, provided the Retiree and same-sex domestic partner meet the requirements, including documentation requirements, of the Plan. Retirees may not add a new same-sex domestic partner to their coverage after retirement.

(b) For the same-sex domestic partner to be considered a Dependent under the Plan, the Retiree and his or her same-sex domestic partner must:

(1) Be the same sex;

(2) Have shared a continuous committed relationship for no less than six (6) months, intend to do so indefinitely, and have no such relationship with another person;

(3) Be jointly responsible for each other's welfare and financial obligations;

(4) Reside in the same household;

(5) Not be related by blood to a degree of kinship that would prevent marriage from being recognized under the laws of the Retiree's state of residence;

(6) Reside in a state where marriage between persons of the same sex is not recognized as a valid marriage, or, if residing in a state that recognizes same-sex unions or marriages, enter into such union or marriage as is recognized by the state;

(7) Have reached age 18 and be legally competent to enter into a contract; and

(8) Not be married to a third party.

Retirees will be required to submit a notarized affidavit attesting that their domestic partner relationship meets all of the above criteria if audited.

(c) Dependent Children of a Retiree's same-sex domestic partner who were covered by the Retiree's Auto Company medical plan at the time of the Retiree's retirement are eligible for coverage under the Plan, provided the Retiree and same-sex domestic partner continue to meet the requirements, including documentation requirements, of the Plan and provided they continue to meet the eligibility criteria for Dependent Children. Documentation that such Dependents continue to meet the eligibility criteria will be required during periodic audit processes. Retirees may not add a same-sex domestic partner's children to their coverage after retirement.

(d) Notwithstanding the above requirements, a same-sex domestic partner and his/her Dependent Children must enroll (voluntarily or automatically) in Medicare Part A when first eligible, if the same-sex domestic partner and his/her Dependent Children first became eligible after January 1, 2017.

(e) Notwithstanding the above requirements, a same-sex domestic partner and his/her Dependent Children, if present in the U.S. and entitled to Medicare Part A and/or enrolled in Medicare Part B, must be present lawfully.

SECTION 3.6 – ELIGIBILITY FOR DEPENDENT CHILDREN

Dependent Children must meet each of the following eligibility tests in order to be eligible for coverage under the Plan:

(a) Relationship.

(1) The Retiree's natural children;

(2) The Retiree's stepchildren (children of Retiree's current Spouse or same-sex domestic partner);

(3) Children legally adopted by the Retiree or the Retiree's Spouse or same-sex domestic partner;

(4) Children placed with the Retiree for legal adoption who are under age 18; or

(5) Children by Legal Guardianship or under a Custody Order, subject to subsection (f).

(b) Age.

(1) May be eligible for coverage under the Plan until the end of the month in which they turn age twenty-six (26).

(2) Are not subject to the age restriction if they were determined to be permanently and totally disabled prior to the end of the month in which they turn age twenty-six (26). The child must be enrolled as a permanently and totally disabled Dependent Child prior to the end of the month in which he or she turns age twenty-six (26).

A Dependent Child is determined to be permanently and totally disabled if the child has a medically determinable physical or mental condition that prevents the child from engaging in substantial gainful activity (i.e., the child must not earn more than $10,000 per year from employment) and which can be expected to result in death or be of indefinite duration.

The Plan reserves the right to require periodic recertification of permanent and total disability.

(3) Enrolls (voluntarily or automatically) in Medicare Part A when first eligible, if Dependent Child first became eligible after January 1, 2017.

(4) If present in the U.S. and entitled to Medicare Part A and/or enrolled in Medicare Part B, must be present lawfully.

(c) Marital Status. Dependent Children must not be married.

(d) Residency.

(1) Live with the Primary Enrollee as a member of the household; or

(2) The Primary Enrollee must have legal responsibility for providing health care expenses for the child pursuant to a divorce decree, court order related to divorce, or a Qualified Medical Child Support Order (QMCSO) or a National Medical Support Order. The child's eligibility under this provision will not extend beyond the Plan's age limits for Dependent Children.

(e) Dependency.

(1) Be dependent on the Primary Enrollee, that is, generally someone for whom the Primary Enrollee can legally claim an exemption on his or her federal income tax; or

(2) Be the Primary Enrollee's legal responsibility for providing health coverage through a divorce decree, court order related to divorce, or a Qualified Medical Child Support Order (QMCSO). A QMCSO or a National Medical Support Order may require a Retiree to enroll his or her child in the Plan. The child's eligibility

under this provision will not extend beyond the Plan's age limits for Dependent Children.

(f) Special Rules for Children by Legal Guardianship or under Custody Order.

Notwithstanding the foregoing, including Section 3.6(b)(2) on permanent and total disability, a child for whom the Primary Enrollee or current Spouse or same-sex domestic partner of the Primary Enrollee has Legal Guardianship or has custody under a Custody Order must meet the following in order to be eligible for coverage under the Plan.

Age -- May be eligible until the end of the month in which they turn eighteen (18), except that children under Legal Guardianship or under a Custody Order on or before December 31, 2010, are eligible until the end of the month in which they turn age twenty-six (26).

An individual that could be considered a Dependent Child of more than one Primary Enrollee may be enrolled as a Dependent by only one (1) such Primary Enrollee.

SECTION 3.7 – ELIGIBILITY FOR SURVIVORS

(a) A Retiree's surviving Spouse, surviving same-sex domestic partner, and surviving Dependent Children may be eligible for coverage under the Plan if the Retiree dies while covered as an eligible Retiree under the Plan. Additionally, a surviving Spouse and surviving same-sex domestic partner may be eligible for coverage under the Plan if, at the time of death, an Employee was covered under an active Auto Company plan and was eligible to retire with health care coverage under the Plan.

(b) Coverage as a Spouse or same-sex domestic partner of a Retiree will continue to the end of the month of the Retiree's death. If eligible, coverage as a surviving Spouse or surviving same-sex domestic partner will become effective the first day of the month following the Retiree's date of death.

(c) Only surviving Spouses, surviving same-sex domestic partners, and surviving Dependent Children who were eligible for coverage at the time of the Retiree's death are eligible for coverage under the Plan. Surviving Spouses and surviving same-sex domestic partners may not add a new Spouse or domestic partner to their coverage.

(d) A surviving Spouse or surviving same-sex domestic partner may continue coverage for a Dependent Child who was enrolled by a deceased Retiree prior to death and who continues to meet the eligibility requirements under the Plan. A surviving Spouse or surviving same-sex domestic partner may enroll a new child only if the child was eligible to be enrolled by the deceased Retiree on the Retiree's date of death.

(e) At age sixty-five (65), a Retiree's surviving Spouse or surviving same-sex domestic partner must be enrolled in Medicare Part A (voluntarily or automatically) when first eligible, if the surviving Spouse or surviving same-sex domestic partner first became eligible for or entitled to Part A after January 1, 2017, and Part B in order to be eligible for continued coverage under the Plan. If a Retiree's surviving Spouse or surviving same-sex domestic partner is age sixty-five (65) or older and does not have Medicare Part B when the Retiree dies, he or she will not be eligible for coverage under the Plan, unless and until the person becomes covered under Medicare Part A (voluntarily or

automatically) when first eligible, if the surviving Spouse or surviving same-sex domestic partner first became eligible for or entitled to Part A after January 1, 2017, and Part B. Coverage will begin on the first day of the month following the date the surviving Spouse or surviving same-sex domestic partner becomes covered under Medicare Part A and B and provides acceptable notification to the Eligibility Benefits Center of such.

(1) Retiree's surviving Spouse, if present in the U.S. and is entitled to Medicare Part A and/or enrolled in Medicare Part B, must be present in the U.S. lawfully.

(f) Payment of the required Contributions is due by the first day of the month for which coverage is sought. Surviving Spouses and surviving same-sex domestic partners must make arrangements for timely payment of any required monthly Contributions if their pension benefits are not sufficient to pay the full amount of Contributions or if they are not eligible for pension benefits from an Auto Company.

(g) The following survivors are not eligible for coverage under the Plan:

(1) Survivors of Retirees eligible only for a deferred vested pension benefit;

(2) Survivors eligible only for a pre-retirement survivor benefit under the respective Company's pension plan; or

(3) Survivors eligible for receipt of pension benefits as "alternate payees" under a qualified domestic relations order pursuant to the Retirement Equity Act of 1984.

SECTION 3.8 – ENROLLMENT AND CONTRIBUTION PROCEDURES

(a) In order for a Retiree to enroll for coverage under the Plan, he or she must meet all eligibility requirements and must complete and submit to the Plan all required documentation. Failure on the part of the Retiree to provide all required documentation, including proof of Dependent status and Social Security Numbers (SSNs), may result in the denial of Dependent coverage.

(b) Payment of the required Contributions for coverage is due by the first day of the month for which coverage is sought. Retirees are required to authorize pension deductions for Contributions. If the Retiree is eligible for coverage under the Plan but not receiving a pension, or is unable to pay the required Contributions from his or her pension, the Retiree must make other arrangements for timely payment in accordance with the administrative procedures established by the Plan.

(c) If a pension deduction or other payment is made in error for a larger amount than the required Contributions, the Plan will refund the excess payment to the Primary Enrollee. If, after thirteen (13) months, reasonable attempts to locate the Primary Enrollee have been unsuccessful, the funds will be transferred back to the Trust. If the Primary Enrollee is located later, the refund will be reissued.

(d) Retirees have the option of choosing coverage for themselves, or for themselves and their eligible family members. The Primary Enrollee's choice of medical plan will apply to all of the Primary Enrollee's Dependents covered under the Plan.

(e) Enrolling a New Dependent. To add a new Dependent, the Retiree must contact the Eligibility Benefits Center to initiate the Dependent's enrollment not more than thirty (30) days from the date of marriage, birth, adoption, placement for adoption, or court order. Coverage will begin on the date of the event. If the Retiree contacts the Eligibility Benefits Center to initiate the Dependent's enrollment more than thirty (30) days from the date of marriage, birth, adoption, placement for adoption, or court order, coverage will begin on the first day of the month following the date the Retiree provides acceptable notification to the Eligibility Benefits Center.

(f) Removing Dependents from Coverage. Retirees must notify the Eligibility Benefits Center to remove a Spouse, same-sex domestic partner, or Dependent Child from coverage as soon as the individual no longer meets the eligibility requirements. Retirees will be liable for any claims paid on behalf of any individual who was not eligible for benefits.

SECTION 3.9 – INITIAL ELIGIBILITY FOR COVERAGE

An individual shall initially become eligible for coverage under the Plan as follows:

(a) Retiree. A Retiree shall initially become eligible for coverage under the Plan on the later of the effective date of the Plan or the Retiree's retirement date.

(b) Spouse. A Spouse shall initially become eligible for coverage under the Plan on the date the Retiree's coverage begins or the date the Retiree marries the spouse, if later.

(c) Same-Sex Domestic Partners and their Dependent Children. A same-sex domestic partner and the same-sex domestic partner's Dependent Children shall initially become eligible for coverage under the Plan on the date the Retiree's coverage begins, provided the same-sex domestic partner and the same-sex domestic partner's Dependent Children were covered under the Retiree's active Auto Company plan before retirement.

(d) Dependent Children. Dependent Children shall initially become eligible for coverage under the Plan on the date the Retiree's coverage begins or, if later, on the date the Dependent is acquired.

(e) Surviving Spouses and Surviving Same-Sex Domestic Partners. In the case of the Retiree's death (or the death of an Employee who, at the time of death, was covered under an active Auto Company plan, was eligible to retire, and would have been eligible for Retiree coverage under the Plan), a surviving Spouse or surviving same-sex domestic partner shall initially become eligible for coverage under the Plan as a Primary Enrollee on the day following the date his or her coverage as the Dependent of a Retiree ends.

SECTION 3.10 – APPLICABILITY OF STATE LAW

To the extent that benefits are provided under the Plan through an insurance policy or contract, the Plan will provide benefits to Enrollees as required by applicable state law. Notwithstanding the foregoing, an individual shall be eligible for coverage under the Plan only as provided by the terms of the Plan, without regard to any state law or insurance policy or contract provision to the contrary. The applicable insurance company or HMO will be responsible for enrollment,

collection of premiums, and coverage of any individual who is required to be offered coverage under state law other than those eligible under the terms of the Plan.

SECTION 3.11 – CONTINUED ELIGIBILITY FOR COVERAGE

After initially becoming eligible for coverage under the Plan, an individual shall continue to be eligible for coverage under the Plan as follows:

(a) Retiree. A Retiree shall remain eligible for coverage under the Plan, provided the Retiree continues to meet the eligibility requirements and make any required Contributions.

(b) Spouse. A Spouse shall remain eligible for coverage under the Plan, provided both the Retiree and Spouse continue to meet the eligibility requirements and the Retiree makes any required Contributions.

(c) Same-Sex Domestic Partners and their Dependent Children. A same-sex domestic partner and the same-sex domestic partner's Dependent Children shall remain eligible for coverage under the Plan, provided the Retiree, the same-sex domestic partner and the same-sex domestic partner's Dependent Children continue to meet the eligibility requirements and make any required Contributions.

(d) Dependent Children. Dependent Children shall remain eligible for coverage under the Plan, provided both the Retiree and Dependent Child continue to meet the eligibility requirements and the Retiree makes any required Contributions.

Coverage may continue after the death of the Retiree, provided the Dependent Children continue to meet the eligibility requirements and the surviving Spouse or surviving same-sex domestic partner, as a Primary Enrollee, continues to cover the Dependent Children.

(e) Surviving Spouses and Surviving Same-Sex Domestic Partners. In the case of the Retiree's death (or the death of an Employee who, at the time of death, was covered under an active Auto Company plan, was eligible to retire, and would have been eligible for Retiree coverage under the Plan), a surviving Spouse or surviving same-sex domestic partner shall remain eligible for coverage under the Plan as a Primary Enrollee, provided the surviving Spouse or surviving same-sex domestic partner continues to meet the eligibility requirements and make any required Contributions.

SECTION 3.12 – TERMINATION OF COVERAGE

An individual's coverage under the Plan shall terminate as follows:

(a) Retiree. A Retiree's coverage under the Plan shall terminate on the earlier of the following dates:

(1) The Retiree's date of death.

(2) The last day of the month preceding a month for which the Retiree fails to make any required Contributions.

(3) The date the retiree knowingly provides false or misrepresented information related to a claim or with the intent to have coverage provided to an ineligible dependent. (See Section 15.12.)

(4) The date the Plan or Trust is terminated.

(b) Spouse. A Spouse's coverage under the Plan shall terminate on the earlier of the following dates:

(1) The date of a final decree of divorce from the Retiree.

(2) The date the Retiree's coverage ends due to failure to make any required Contributions.

(3) The date of death of the Spouse.

(4) In the case of the Retiree's death, the last day of the month in which the Retiree dies (at which point the Spouse may become eligible for coverage as a surviving Spouse).

(5) The date the Dependent no longer meets the Plan's eligibility rules.

(6) The date the Dependent is removed from coverage by the Primary Enrollee.

(7) The date the Plan or Trust is terminated.

(c) Same-Sex Domestic Partners and their Dependent Children. Coverage under the Plan for a same-sex domestic partner and the same-sex domestic partner's Dependent Children shall terminate on the earlier of the following dates:

(1) The earlier of the date on which the same-sex domestic partner relationship or eligibility under the Plan ends.

(2) The date the Retiree's coverage ends due to failure to make any required Contributions.

(3) In the case of the Retiree's death, last day of the month in which the Retiree dies (at which point the same-sex domestic partner may become eligible for coverage as a surviving same-sex domestic partner).

(4) The date the Dependent no longer meets the Plan's eligibility rules.

(5) The date the Dependent is removed from coverage by the Primary Enrollee.

(6) The date the Plan or Trust is terminated.

(d) Dependent Children. A Dependent Child's coverage under the Plan shall terminate on the earlier of the following dates:

(1) The date the Dependent no longer meets the Plan's eligibility rules.

(2) The date the Dependent is removed from coverage by the Primary Enrollee.

(3) The date the Primary Enrollee fails to make any required Contributions.

(4) The last day of the month of the Retiree's date of death if there is no surviving Spouse or surviving same-sex domestic partner.

(5) The last day of the month of death of the surviving Spouse or surviving same-sex domestic partner.

(6) The date the Plan or Trust is terminated.

For a natural or adopted Dependent Child, if the divorce decree stipulates the Retiree does not have custody of the Dependent Child but is legally responsible for health care expenses or for providing health care coverage, the dependency and residency requirements are deemed to be met and coverage under the Plan will be continued for such Dependent Child.

(e) Surviving Spouses and Surviving Same-Sex Domestic Partners. Coverage under the Plan for a surviving Spouse or surviving same-sex domestic partner shall terminate on the earlier of the following dates:

(1) The date of death of the surviving Spouse or surviving same-sex domestic partner.

(2) The date the surviving Spouse or surviving same-sex domestic partner fails to make any required Contributions.

(3) The date the surviving Spouse or surviving same-sex domestic partner fails to meet the Plan's eligibility rules.

(4) The date the Plan or Trust is terminated.

SECTION 3.13 – REINSTATEMENT

(a) Reinstating a Dependent

If a Dependent Child loses eligibility for coverage under the Plan and then again becomes eligible (for example, the child ceases to live with the Primary Enrollee as a member of the household and then again begins to live with the Primary Enrollee as a member of the household), coverage may be reinstated, provided the Dependent Child meets each of the eligibility requirements under the Plan. Coverage will begin on the first day of the month following the date the Primary Enrollee provides acceptable notification to the Eligibility Benefits Center.

(b) Reinstatement after Termination for Non-Payment

Payment of the required Contributions for coverage is due by the first day of the month for which coverage is sought. Retirees are required to authorize pension deductions for Contributions. If an Enrollee is eligible for coverage under the Plan but not receiving a pension, or is unable to pay the required Contributions from his or her pension, the Enrollee must make other arrangements for timely payment. If the Enrollee does not make the required monthly Contributions in accordance with the administrative procedures established by the Plan, the Enrollee and the Enrollee's Dependents will be

dropped from coverage. If coverage is terminated because the Primary Enrollee fails to make the required Contributions for coverage, such Primary Enrollee coverage may be reinstated retroactively upon receipt of all past due monthly contributions. At the time of reinstatement, the Primary Enrollee must elect pension deductions (if receiving a pension) or direct debit from a bank account for future contributions.

(c) Reinstatement after Termination for Unlawful Presence

Enrollees and their Dependents that are terminated for failure to be present in the U.S. lawfully upon entitlement to Medicare Part A or eligibility for Medicare Part B may be reinstated effective the first of the next month after proof of lawful status is provided to the Plan. The Plan may again terminate the Enrollee and/or his/her Dependents if such lawful status lapses.

(d) Reinstatement after Termination for Failure to Enroll in/be Entitled to Medicare Part A

Enrollees and their Dependents that are terminated for failure to enroll in or be entitled to Medicare Part A may be reinstated effective the first of the next month after the Plan receives confirmation that the Enrollee is in Medicare Part A. The Enrollee should inform the Plan of his or her enrollment/entitlement; however, the Plan will require confirmation from Medicare that such enrollment/entitlement has taken place. If the Enrollee fails to maintain that enrollment/entitlement with Part A, the Plan may again terminate the Enrollee and his/her Dependents.

SECTION 3.14 – DEFERRED ENROLLMENT AND REENROLLMENT

(a) Retirees may defer enrollment in coverage under the Plan, provided: (i) the Retiree formally and timely waives coverage under the Plan because he or she has other health coverage; and (ii) such other health coverage is continuous from the date of deferral. Medicare is not considered to be other health care coverage, unless the Medicare coverage is a Medicare Advantage plan.

(b) Retirees who defer enrollment may enroll/reenroll in coverage under the Plan if they lose other health coverage due to one of the following reasons:

(1) Loss of eligibility for the other coverage, including loss resulting from legal separation, divorce, death, voluntary or involuntary termination of employment, or reduction in hours (but not including loss due to failure of the individual to pay premiums on a timely basis or termination of the other coverage for cause);

(2) Termination of, or a significant reduction in, employer contributions toward the other coverage;

(3) If the other coverage was COBRA or state continuation coverage, termination of such continuation coverage;

(4) Moving out of an HMO service area if HMO coverage terminated for that reason and, for group coverage, no other option is available under the other plan;

(5) The other plan ceasing to offer coverage to a group of similarly situated individuals;

(6) The loss of Dependent status under the other plan's terms;

(7) The termination of a material benefit option under the other plan, unless substitute coverage was offered; or

(8) The loss of eligibility due to reaching the lifetime benefit maximum on all benefits under the other plan.

To enroll/reenroll him or herself and any eligible Dependents in coverage under the Plan, the Retiree must contact the Plan no later than 30 days after the date he or she loses other health coverage and must provide acceptable proof of other health coverage. The Plan will accept as proof of the other health coverage a Certificate of Creditable Coverage (as required under HIPAA). In addition, the Plan will accept any other form of proof that demonstrates the existence of other health coverage. The effective date of coverage for Retirees and their eligible Dependents who enroll following a deferred enrollment period will be the first day of the month beginning after the Plan's receipt of a completed request for enrollment (including proof of other health coverage).

SECTION 3.15 – SPECIAL ENROLLMENT

If an individual does not formally and timely defer enrollment, as described in Section 3.13 above, he or she may, on a one (1) time basis, enroll during a special enrollment period. A special enrollment period shall be held annually for a minimum of thirty (30) days. Coverage for an individual who enrolls during the special enrollment period shall become effective on the first day of the Plan Year following the special enrollment period. Except to the extent required under HIPAA for the insured portion of the Plan, the Plan offers special enrollment on a voluntary basis.

SECTION 3.16 – QUALIFIED MEDICAL CHILD SUPPORT ORDERS (QMCSO)

If a copy of a Medical Child Support Order, as defined in ERISA Section 609(a), is filed with the Eligibility Benefits Center or the Plan, the Eligibility Benefits Center or the VEBA will promptly notify the Retiree and each alternate recipient of the receipt of such order and the Plan's procedures for determining whether the order is a Qualified Medical Child Support Order (QMCSO), as further defined in ERISA Section 609(a). The Plan will then determine whether the order is a QMCSO pursuant to the Plan's written procedures, which are available free of charge by making a request to the Eligibility Benefits Center, and will notify the Retiree and each alternate recipient of the determination. The Plan will provide benefits in accordance with the applicable requirements of any QMCSO for any child who otherwise meets the Plan's definition of Dependent. Any benefit payments made by the Plan pursuant to a QMCSO in reimbursement for expenses paid by an alternate recipient's custodial parent or legal guardian will be made to the alternate recipient or the alternate recipient's custodial parent or legal guardian.

SECTION 3.17 – UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)

Retirees may be able to continue coverage under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), including any amendments to the Act and any interpretive regulations or rulings.

SECTION 3.18 – COBRA CONTINUATION COVERAGE

A Qualified Beneficiary may elect continuation coverage under this Section as required under the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") if the Qualified Beneficiary experiences a Qualifying Event and experiences a loss of coverage due to such Qualifying Event.

(a) Qualified Beneficiaries. A Qualified Beneficiary is the Dependent of a Retiree who is covered under the Plan on the day before a Qualifying Event, and who would lose such coverage as a result of the Qualifying Event were it not for the provisions of this Section. This term also includes any child born to, adopted by, or placed for adoption with the Retiree at any time during the period of continuation coverage. For purposes of federal COBRA, a same-sex domestic partner is not considered a Qualified Beneficiary; however, the Plan allows a same-sex domestic partner to continue coverage in the same manner as a Spouse, provided the opportunity is elected in a timely manner and the required Contributions are made, or, if the same-sex domestic partnership ends, in the same manner as a divorced Spouse by making self-payments (in the same amount as the COBRA payment) for coverage for up to 36 months.

(b) Qualifying Events. Qualifying Events are any of the following events that would result in loss of coverage for a Qualified Beneficiary, were it not for the continuation coverage provisions of this Section:

(1) For the Spouse of a Retiree covered by the Plan, COBRA provides continuation of Plan coverage at the Spouse's expense if Plan coverage is lost because of:

(A) The death of the Retiree (however, because a spouse is generally permitted to continue coverage upon the Retiree's death, this Qualifying Event will generally not cause a loss of coverage, so that COBRA will not apply); or

(B) The divorce of the Retiree from the Retiree's Spouse.

(2) For a Dependent Child of a Retiree covered by the Plan, COBRA provides continuation of Plan coverage at the Dependent's expense if Plan coverage is lost because of:

(A) The death of the Retiree;

(B) The divorce of the Dependent Child's parents if, as a result of the divorce, the child no longer meets the definition of a Dependent Child (however, if the Dependent Child continues to meet the definition of a Dependent, divorce of the parents will generally not cause the Dependent Child to lose coverage); or

(C) An individual ceases to satisfy the Plan's definition of a Dependent Child.

(c) Notice Requirements

(1) General Notice. The Plan shall provide a General Notice of COBRA continuation rights to Retirees and their Spouses within ninety (90) days of such individuals'

eligibility for coverage under the Plan. This notice will be provided as part of the Summary Plan Description. Thereafter, the Plan will provide the General Notice upon request.

(2) Notice of Qualifying Event. A Qualified Beneficiary must provide the Eligibility Benefits Center with a Notice of Qualifying Event when such event is due to death of the Retiree, divorce of the Retiree from the Retiree's Spouse, or an individual ceasing to satisfy the Plan's definition of a Dependent Child. Such notice must be provided by the Qualified Beneficiary no later than sixty (60) days after the later of the date the Qualifying Event occurred or the date coverage would otherwise terminate.

(3) Election Notice. The Eligibility Benefits Center will mail an Election Notice and Election Form to applicable Qualified Beneficiaries within fourteen (14) days of the date it receives a Notice of Qualifying Event from a Qualified Beneficiary.

In order to remain eligible for COBRA continuation coverage, a Qualified Beneficiary must return the Election Form to the Eligibility Benefits Center no later than sixty (60) days after the later of:

(A) The date the Qualified Beneficiary received such Election Form; or

(B) The date coverage terminates.

A Qualified Beneficiary has the right to cancel any previous election and make a new election within the sixty (60) day election period. If the Election Form is received after its due date, the Qualified Beneficiary will no longer be eligible to elect COBRA continuation coverage.

(4) Notice of Unavailability. The Eligibility Benefits Center shall mail a Qualified Beneficiary a Notice of Unavailability in the event the Eligibility Benefits Center determines that an individual is not eligible for such coverage. The Notice of Unavailability shall be mailed within the fourteen (14) day period following the Eligibility Benefits Center's receipt of a Notice of Qualifying Event for an ineligible individual.

(5) Notice of Termination. The Eligibility Benefits Center shall mail Qualified Beneficiaries a Notice of Termination in the event the Qualified Beneficiary's COBRA continuation coverage will terminate before the end of the thirty-six (36) month maximum period of continuation coverage. The Notice of Termination shall be mailed to a Qualified Beneficiary as soon as practicable following the Eligibility Benefits Center's determination that COBRA continuation coverage is to be terminated.

(d) Independent Right to Elect COBRA Coverage. Each Qualified Beneficiary eligible for COBRA continuation coverage has an independent right to elect such coverage. In general, a parent may elect to continue coverage for Dependent Children. However, a Dependent Child who is eighteen (18) years or older has the right to elect COBRA continuation coverage independently, regardless of whether the child's parent elects this coverage.

(e) Maximum Period of Coverage. The maximum period of COBRA coverage for Qualified Beneficiaries is thirty-six (36) months when the Qualifying Event is death of the Retiree, divorce of the Retiree from the Retiree's Spouse, or an individual ceasing to satisfy the Plan's definition of a Dependent Child.

(f) Termination of Coverage. COBRA continuation coverage shall terminate on the earliest of the following dates:

(1) The day of the last period for which payment is made, if the Qualified Beneficiary fails to make the required monthly payment on a timely basis;

(2) The date on which the Plan or Trust is terminated;

(3) The date on which a Qualified Beneficiary becomes covered under any other group health care plan after the date COBRA Continuation Coverage is elected (provided that plan does not contain any pre-existing condition exclusions or limitations that affect coverage);

(4) The date on which the Qualified Beneficiary voluntarily cancels coverage;

(5) The date which is 36 months after the date coverage otherwise would terminate; or

(6) The date on which the Qualified Beneficiary becomes entitled to Medicare after the date he or she first elects COBRA Continuation Coverage. If a Qualified Beneficiary becomes entitled to Medicare prior to the date he or she is eligible to elect COBRA, the Dependent is still eligible to elect to continue coverage under COBRA. However, if the Dependent becomes entitled to Medicare after electing to continue coverage under COBRA, the Dependent's COBRA coverage will be terminated. Once coverage under COBRA has been terminated, it will not be reinstated.

(g) Payment for COBRA Continuation Coverage. Entitlement to COBRA continuation coverage shall be conditioned upon payment of monthly self-payments in such amounts as shall be established by the Plan on a yearly basis. In no event shall such payments for COBRA continuation coverage exceed 102% of the applicable cost (Retiree cost and Plan cost combined) of providing coverage, as determined by the Trust Fund's actuary.

Once a Qualified Beneficiary has elected COBRA continuation coverage, the Qualified Beneficiary must send in the first payment for such coverage no later than 45 days after the post-mark date of the Election Form. The first payment must cover the full cost of COBRA coverage for the period starting on the date COBRA is scheduled to begin (i.e., the day after coverage under the Plan terminates) through the month in which the election is received by the Eligibility Benefits Center.

Subsequent payments are due the first day of the month for which payment is made. COBRA continuation coverage will be provided on a monthly basis, provided the Qualified Beneficiary pays the COBRA payment to the Eligibility Benefits Center by the first day of such month. A COBRA payment will be considered made when it is mailed

(postmarked). If a monthly payment is made on or before its due date, coverage under the Plan will continue for that month without any break.

(h) Grace Periods for COBRA Payments. Although COBRA payments are due on the first day of the month, a grace period of 30 days is provided to make each COBRA payment. The grace period does not apply to the first COBRA payment, which is due within 45 days of election of COBRA continuation coverage, as noted above. COBRA continuation coverage will be provided for each month, as long as payment for that month is made before the end of the grace period. However, if a monthly payment is made later than the first day of the month to which it applies, but before the end of the grace period for the month, and the individual submits a claim within that period, the individual may receive an explanation of benefits that a benefit determination cannot be made due to a pending COBRA payment. This means that unless the Plan has received the COBRA payment, it will not pay benefits.

If payment is not made by the required due date plus a grace period, coverage under the Plan will end. Once COBRA continuation coverage ends, it cannot be reinstated.

SECTION 3.19 – CERTIFICATES OF COVERAGE

When a Retiree's or Dependent's coverage under the Plan ends, the Eligibility Benefits Center will provide such Retiree or Dependent with a certificate of coverage that indicates the period of time the Retiree or Dependent was covered under the Plan and certain additional information required by federal law. The certificate will be sent by first class mail within 45 days after the individual's coverage under the Plan ends. If an individual elects COBRA continuation coverage, another certificate will be provided within 60 days after the COBRA continuation coverage ends. In addition, a certificate will be provided within 45 days after receipt of a request for such certificate if the request is received within two years after the later of the date coverage under the Plan ended or the date COBRA continuation coverage ended. Except to the extent required for the insured portion of the Plan, the Plan is providing certificates of coverage on a voluntary basis.

SECTION 3.20 – ELIGIBILITY FOR MEDICARE PART D PRESCRIPTION DRUG COVERAGE UNDER THE PLAN

Notwithstanding anything in the Plan to the contrary, an Enrollee shall be eligible for Medicare Part D Prescription Drug Coverage under the Trust's Plan when he is enrolled in Medicare Parts A and/or B and meets certain requirements imposed by the Centers for Medicare and Medicaid Services (CMS). Among the requirements from CMS is that, if the Enrollee is present in the U.S., he must be present lawfully, through U.S. citizenship, legal visa, or other legal means as approved by the U.S. government authorities. An Enrollee who is eligible for Medicare may opt out of the Medicare Part D Prescription Drug Coverage under the Trust's Plan, but will have no prescription drug coverage under the Plan (unless he has prescription drug coverage under a Medicare Advantage Prescription Drug (MAPD) Plan Option). An Enrollee who has opted out of Medicare Part D Prescription Drug Coverage under the Trust's Plan shall be permitted to elect Medicare Part D Prescription Drug Coverage under the Trust's Plan on the first day of the second month following the Enrollee's request. An Enrollee's Dependents who are not eligible for Medicare shall be covered under the Plan's Prescription Drug Expense Benefit or an Health Maintenance Organization (HMO) Option, as applicable, for prescription drug coverage.

ARTICLE IV — COMPREHENSIVE BENEFIT RULES

SECTION 4.1 – GENERAL

If an Enrollee incurs medical expenses that are covered under the Plan, benefits will be paid subject to the provisions of this Article, and as described in other provisions of the Plan and the Schedule of Benefits, or as provided by the applicable insurance policy or contract. Coverage under the Plan may be offered through a choice of Plan options as described in this Article based on the residence of the Primary Enrollee and other factors, such as Medicare eligibility.

SECTION 4.2 – TRADITIONAL CARE NETWORK

The Traditional Care Network (TCN) is based on a network of Providers. This option allows services to be performed both in-network and out-of-network. However, in order to receive the highest level of benefits, Enrollees must receive services from Providers who participate in the TCN (also called Participating Providers or In-Network Providers). Participating Providers have entered into a contract or agreement with the Carrier and will accept the Carrier's Allowed Amount as payment in full for covered services (subject to applicable deductibles, co-insurance, and co-payments).

If an Enrollee chooses to receive care from an Out-of-Network Provider, he or she will be responsible for sharing additional costs unless the service is for emergency care, an authorized referral from a Participating Provider has been received, or he or she does not have the ability or control to select a Network Provider to perform the service. For those services that require a referral, the Enrollee must receive the authorized referral from a Provider who participates in the network before receiving covered services from an Out-of-Network Provider. If an advance referral is not obtained, the Enrollee will be responsible for the out-of-network co-insurance and any amount by which the Provider's charges are higher than the Allowed Amount for the service received. Any amount charged over the Allowed Amount, as determined by the Carrier, does not count toward the out-of-pocket maximum.

Primary Enrollees and Dependents who have Medicare as their primary coverage will not be subject to the out-of-network co-insurance when In-Network Providers are not used. However, if the provider does not accept Medicare assignment, payment will be limited to the amount that would have been paid to a provider who accepts assignment.

SECTION 4.3 – HEALTH MAINTENANCE ORGANIZATION (HMO) OPTION

A Health Maintenance Organization (HMO) is a health care delivery system that emphasizes preventive health care and early treatment, in addition to providing Medically Necessary care when the Enrollee is sick. In general, an HMO provides prepaid health care services, with no bills or claim forms to complete. Co-payments are typically required for certain services. The HMO Enrollee chooses a primary care Physician or facility from a list provided by the HMO, and that Physician or facility coordinates all health care needs.

The scope and level of benefits and coverage provided by an HMO may differ from those under the TCN option.

In order for services to be covered by the HMO, the services must be provided by HMO Providers. Non-emergency services obtained from Providers outside of the HMO are NOT covered at all unless the HMO primary care Physician makes the referral or the HMO preauthorizes treatment. Out-of-area emergency services are covered.

Various HMO offerings may be available under the Plan as described in the Schedule of Benefits based on where the Enrollee lives, Medicare status, and other factors.

For Enrollees who choose an HMO option, the Plan's only responsibility is payment to the HMO of the applicable premiums.

SECTION 4.4 – MEDICARE ADVANTAGE PLAN OPTION

Medicare Advantage (MA) plans are health plan options approved by the Centers for Medicare and Medicaid Services (CMS) and administered by private companies. MA plans provide all Medicare Part A (hospital) and Part B (medical) benefits and cover all services covered under the original Medicare plan and may provide Medicare Part D (prescription drug) benefits. However, MA plans may each include different deductibles, co-payments, and co-insurance. In addition, MA plans may offer benefits not provided under the regular Medicare plan (such as dental, vision and hearing benefits). Most MA plans have Provider networks, so the Enrollee may be required to see specific Physicians and use specific Hospitals.

When an individual joins a MA plan that is offered under the Plan, medical coverage will be provided and prescription drug coverage may be provided by the MA plan. Out-of pocket costs under an MA plan may be different from those in the TCN.

A MA plan may be available to Enrollees under the Plan based on where they live. Depending on the choice of plans, a Primary Enrollee and his or her family members may be required to all enroll in the same plan option.

If an Enrollee is in an HMO that offers a MA plan, at age sixty-five (65) he or she will be offered the MA plan. If the Enrollee enrolls in a MA plan, then his or her Dependents who are under sixty-five (65) may stay in the HMO plan. If the Enrollee does not enroll in a MA plan, he or she must move to a different plan with his or her Dependents. If the Enrollee is in a HMO that does not offer a MA plan, at age sixty-five (65), he or she can stay in the HMO, provided the HMO accepts such Enrollees.

For Enrollees who choose a MA plan option, the Plan's only responsibility is payment to the MA plan of the applicable premiums.

SECTION 4.5 – PREFERRED PROVIDER ORGANIZATION (PPO) OPTION

Coverage under the Preferred Provider Organization (PPO) option is available only to Primary Enrollees who are enrolled in the PPO option under the Chrysler Group LLC retiree plan on December 31, 2009. Once a Primary Enrollee changes to another option, the PPO will no longer be an available option to such Primary Enrollee. Coverage under the PPO option terminates when an individual becomes eligible for Medicare. At that point, the Primary Enrollee will be enrolled in TCN. If an HMO that accepts Medicare individuals or a Medicare Advantage Plan is available in the Primary Enrollee's area, the Primary Enrollee may elect it as an alternative.

The PPO option has a network of Providers and generally is limited to a specific geographic area. The PPO option provides a higher level of benefits when the Enrollee receives care from Providers within the PPO network. The PPO option covers all services included under the TCN option but also offers 50% payment for a home or office visit by, or on referral from, a PPO Physician.

Under the PPO option, benefits may be payable for services rendered by non-panel Providers (up to the PPO's negotiated rate) if such services are rendered on referral from a PPO panel Physician, subject to conditions below.

(a) The referring Physician is responsible for communicating the referral to the Carrier and monitoring the progress of the patient. Any subsequent referrals must be made by a panel Physician.

(b) The Carrier is responsible for monitoring referral frequency and patterns, and for ensuring that additional costs are not incurred by the Plan or the Enrollee.

(c) Referral does not apply to well baby care and immunizations that are not covered services if rendered by a non-panel Provider.

(d) A service that would not otherwise be a covered service does not become a covered service by virtue of a referral.

SECTION 4.6 – ROLLING ENROLLMENT – CHANGING PLAN OPTION ELECTION

The Primary Enrollee may change Plan elections any time of the year, provided twelve (12) months have elapsed since the Primary Enrollee's last election change and the Primary Enrollee remains eligible for coverage. To make a change, the Enrollee must contact the Eligibility Benefits Center. The change generally will take effect on the first day of the second month following the month the Eligibility Benefits Center receives the election (for example, June 1 if the election is made in April).

Once the Primary Enrollee makes a change to the Enrollee's Plan elections, he or she must wait twelve (12) months to make another change. Changes also may be allowed during the twelve (12) month period if certain "life events" occur, such as changing address of record or adding a Dependent, as set forth in the Plan's administrative procedures.

SECTION 4.7 – COST-SHARING FEATURES OF ALL OPTIONS

Primary Enrollees are responsible for cost-sharing through monthly Contributions. A monthly Contribution is an amount a Primary Enrollee may be required to pay, on a monthly basis, for health care coverage. The amount, as described in the Schedule of Benefits, may vary depending on such items as family size, the Retiree's classification ("Protected" or "General"), and the option elected (e.g., TCN or HMO).

All Enrollees are generally responsible for cost sharing through deductibles, co-insurance, and co-payments. Specific information on cost sharing for a Plan option is included in the Schedule of Benefits or in the applicable insurance policy or contract for the insured portion of the Plan.

SECTION 4.8 – BENEFITS PAYABLE

When an Enrollee incurs a covered expense, benefits are payable (in accordance with the applicable Schedule of Benefits or the applicable insurance policy or contract for the insured portion of the Plan) up to the Allowed Amount after the calendar year deductible has been satisfied. Benefits payable under this Plan shall not exceed any benefit maximum or the lifetime maximums set forth in the applicable Schedule of Benefits or in the applicable insurance policy or contract for the insured portion of the Plan.

Benefits for certain covered services are payable only if approved by the Carrier and/or if furnished by approved Providers, when applicable. If such approval is not obtained, or if such Providers are not utilized, any benefits for such services may be reduced or eliminated. Examples include, but are not limited to, Traditional Care Network option Enrollees' failure to comply with the predetermination requirements for inpatient admissions, Preferred Provider Organization option Enrollees' failure to utilize panel Providers, or Health Maintenance Organization option Enrollees' failure to utilize In-Network Providers.

SECTION 4.9 – DEDUCTIBLE AMOUNT

The Deductible Amount is the amount of covered medical expenses that an Enrollee must pay in any calendar year before the Plan begins to pay benefits. Some covered medical expenses may not be subject to the deductible and some covered medical expenses may be subject to special, specific deductibles, as described in the Schedule of Benefits or in the applicable insurance policy or contract for the insured portion of the Plan.

There are two types of deductibles: Single and Family. The Single Deductible is the amount an Enrollee must pay toward covered medical expenses before the Plan begins to pay benefits for such Enrollee. The Family Deductible applies when a Primary Enrollee is covering one (1) or more Enrollees in addition to him or herself. When a family deductible is applicable, it is not required that one Enrollee satisfy the entire Single Deductible amount. Rather, all Enrollees covered by the Primary Enrollee may contribute toward satisfying the Family Deductible amount, even if no single Enrollee satisfies the Single Deductible amount.

SECTION 4.10 – CO-INSURANCE, CO-PAYMENT, AND OUT-OF-POCKET MAXIMUM

(a) Co-insurance is the designated portion of the contracted charges or Allowed Amount that the Retiree or Dependent receives and for which both the Plan and the Retiree or Dependent pays. Co-insurance is expressed as a percentage of the charges paid by the Plan, as set forth in the Schedule of Benefits or the insurance policies or contracts for the insured portion of the Plan. Both the Plan and the Retiree or the Dependents will pay a certain Co-insurance percentage, as set forth in the applicable Schedule of Benefits, depending on the service and whether the benefits are provided under the TCN, PPO, or HMO benefit program, and whether the services are obtained from In-Network Providers.

(b) A Co-payment is the fixed dollar amount that a Retiree or Dependent must pay for certain services and supplies at the time the service or supply is provided, as set forth in the Schedule of Benefits or the insurance policies or contracts for the insured portion of the Plan. Primary Enrollees are responsible for any required co-payments, regardless of the status of any applicable deductibles or out-of-pocket maximums.

(c) The annual Out-of-Pocket Maximum limits the amount a Retiree or Dependent pays out-of-pocket in a calendar year for the Retiree's or Dependent's share of the deductible and co-insurance amount before the Plan pays for certain covered services and supplies. Some covered charges may not be subject to the Out-of-Pocket Maximum, as described in the applicable Schedule of Benefits or the insurance policies or contracts for the insured portion of the Plan. Separate "in-network" and "out-of-network" out-of-pocket maximums may apply.

Certain expenses may not be applied toward the deductible or out-of-pocket maximum. In addition, some expenses may not be paid at 100% even after the out-of-pocket maximum is satisfied. For additional information, please refer to the Schedule of Benefits or the insurance policies or contracts for the insured portion of the Plan.

SECTION 4.11 – MAXIMUM BENEFIT

The overall annual or lifetime maximum benefit payable under this Plan for all expenses incurred by a Retiree or Dependent due to Injuries or Illnesses is described in the applicable Schedule of Benefits or the insurance policies or contracts for the insured portion of the Plan. Some covered medical expenses are subject to special, specific maximum annual or lifetime benefits as described in the applicable Schedule of Benefits or the insurance policies or contracts for the insured portion of the Plan.

In addition, an Enrollee may incur a sanction, which is an amount of otherwise covered or potentially covered expense that the Plan will not pay as a result of a Primary Enrollee's failure to follow Plan provisions (such as the failure to follow Plan provisions for using Out-of-Network Providers).

SECTION 4.12 – COVERED CHARGES

Covered Charges are found in the Summary Plan Description.

SECTION 4.13 – CONVERSION OF HEALTH COVERAGE

Any former Enrollee who is no longer eligible to continue coverage under the Plan, may be offered an opportunity to obtain other available coverage, on a self-paid basis, from the Carrier with whom enrolled at the time eligibility terminated.

A former Enrollee wishing to exercise this privilege shall make application to the Carrier within thirty (30) days of termination of eligibility under this Plan, or as otherwise required by the Carrier.

SECTION 4.14 – MATERNITY BENEFITS

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

prescribing a length of stay not in excess of 48 hours (or 96 hours). This Plan conforms to HIPAA with regard to the payment of maternity benefits.

The Plan will not restrict benefits for any Hospital length-of-stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a caesarean section. However, this does not prohibit the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). The Plan will not require that a Provider obtain authorization from the Carrier for prescribing a length-of-stay not in excess of 48 hours (or 96 hours).

SECTION 4.15 – WOMEN'S HEALTH AND CANCER RIGHTS ACT

Except as may be required under HIPAA for the insured portion of the Plan, the Plan is voluntarily complying with the Women's Health and Cancer Rights Act. However, if an Enrollee undergoes a mastectomy and if the Plan pays benefits for that surgery, the following services and supplies will also be covered under the Plan:

(a) Reconstruction of the breast on which the mastectomy was performed;

(b) Surgery and reconstruction of the other breast to produce a symmetrical appearance; and

(c) Prostheses and treatment of physical complications, including lymphedemas, at all stages of the mastectomy.

Coverage is subject to the same annual deductibles, co-payments, co-insurance rates, and other limitations that apply to other medical procedures that are covered under the Plan.

SECTION 4.16 – CASE MANAGEMENT

The Plan reserves the right to direct the Enrollee into Case Management as a condition of coverage for certain conditions. If the Enrollee, including those enrolled in Medicare Parts A and B, refuses to participate and/or cooperate in Case Management, the Plan's portion of the financial obligation for all medical services, treatments, situations, prescription drugs, or other services related to the condition will not be covered. For Enrollees enrolled in Parts A and B of Medicare, Medicare will continue to cover its portion of the financial obligation as Case Management is not required by Medicare.

SECTION 4.17 – MEDICARE PART D PRESCRIPTION DRUG COVERAGE

The Medicare Part D Prescription Drug Coverage under the Trust's Plan is prescription drug coverage that has been approved by the Centers for Medicare and Medicaid Services (CMS) and is administered by a private company. The Medicare Part D Prescription Drug Coverage provides Medicare Part D prescription drug benefits and is governed by CMS guidance and other documents related to the Medicare Part D Prescription Drug Coverage under the Trust's Plan, except to the extent superseded by Plan terms.

SECTION 4.18 – MEDICAL SECOND OPINION

The Plan reserves the right to require that an Enrollee obtain a medical second opinion, at an institution or physician of the Plan's choosing, as a condition to receiving initial or ongoing coverage for certain medical or surgical benefits, treatments, procedures, prescription drugs, medical devices or supplies, or other services related to a specific condition. The Plan will offer the Enrollee a choice of one of two institutions or physicians for a second opinion. The Plan will cover the Allowed Amount of charges for covered services associated with obtaining the medical second opinion, such as examinations, x-rays and laboratory work. If the Enrollee refuses to obtain a medical second opinion required by the Plan, the Plan may deny or discontinue coverage of the medical or surgical benefits, treatment, procedures, prescription drugs, medical devices or supplies or other services.

ARTICLE V — HOSPITAL EXPENSE BENEFIT

TRADITIONAL CARE NETWORK (TCN) AND PREFERRED PROVIDER ORGANIZATION (PPO) NETWORK ONLY

SECTION 5.1 – HOSPITAL EXPENSE COVERAGE GENERALLY

Hospital expense coverage includes the items described in this Article. If Enrollees are enrolled in an HMO or a Medicare Advantage plan, this Article does not apply to them. Enrollees in an HMO or a Medicare Advantage plan should consult the applicable insurance policy or contract for information about hospital expense coverage.

SECTION 5.2 – HOSPITAL COVERAGE

Coverage is provided for services and supplies associated with Hospital admissions if they meet the requirements of this Plan. Coverage is only for the period that is Medically Necessary for the proper care and treatment of the patient, subject to the maximum benefit period discussed below, and to other Plan provisions. Whether and to what extent benefits are available depends on whether the Hospital or other facility is Participating or Non-Participating. As a condition of coverage, the Carrier may require predetermination of the admission and written verification of the need for continued services by the Physician in charge of the case. The Enrollee must give notice of coverage to any Hospital at the time of admission. If notice is not given at that time, the Enrollee may be liable for a portion of charges incurred.

The Plan will only cover a hospital admission outside of the United States in these circumstances:

(a) When the Enrollee is seeking care for an Emergency or the care sought is Urgent; or

(b) When Medicare would cover an elective service—

  (1) When the Enrollee lives in the U.S. and the hospital outside of the U.S. is closer to the Enrollee's home than the nearest U.S. hospital that can treat the Enrollee's medical condition; or

  (2) When Enrollee is on board a ship within the territorial waters adjoining the U.S., but never when that ship is more than 6 hours distant from a U.S. port.

SECTION 5.3 – PARTICIPATING HOSPITALS

Treatment at a Participating Hospital will be paid in accordance with the terms set forth in the applicable Schedule of Benefits. The Enrollee should determine which Hospitals participate with the Carrier before Hospital care is needed.

A Hospital in the Carrier's area that: (i) meets the Carrier's qualification requirements to be eligible for full payment of covered expenses; (ii) is approved by the Carrier for such payment; and (iii) agrees to the Carrier's payment as a Participating Hospital for covered expenses shall receive full reimbursement in accordance with the Carrier's payment practices.

SECTION 5.4 – NON-PARTICIPATING HOSPITALS

Treatment at a Non-Participating Hospital may result in a significant financial obligation for the Enrollee. The Enrollee should determine which Hospitals participate with the Carrier before Hospital care is needed.

Coverage at a Non-Participating Hospital will be in accordance with the following rules:

(c) Elective Services

(1) Inpatient

(2) If an elective service performed involves an inpatient admission, the Plan will not provide coverage.

(3) When an Enrollee is enrolled with Medicare, inpatient admission for an elective service is not covered by the Plan.

(4) Outpatient

(A) If an elective service is performed in an outpatient setting, and the Enrollee is not enrolled in Medicare, then the Plan will not provide coverage.

(5) If an elective service is performed in an outpatient setting, and the Enrollee is enrolled in Medicare, then the Plan will not provide coverage.

(6) In no event, will Enrollee's payment for any elective service, inpatient or outpatient, accrue toward Enrollee's cost share.

(d) Emergent Services

(1) Inpatient Admissions

(A) If the Enrollee is not enrolled in Medicare,

(i) The Plan will cover services at the Usual & Customary Rate.

(ii) Costs incurred by the Enrollee do accrue toward the Enrollee's in-network cost share.

(iii) The Plan reserves the right to require the member to transfer to a participating facility when stable (note: the Plan will stop payment if member refuses a transfer to a participating facility).

(iv) Either the Enrollee or the facility admitting the Enrollee must contact the Plan after admission.

(B) If the Enrollee is enrolled in Medicare,

(A) After Medicare payment, the Plan will cover the services up to the Medicare allowed amount.

(B) Where the facility opts out of Medicare, the Plan will pay for services at the Medicare allowed amount.

(C) If the facility does not accept Medicare Assignment, but also does not opt out of Medicare, then the Enrollee will be responsible for the 15% limiting fee as permitted by Medicare.

(D) Costs incurred by Enrollee do accrue toward the Enrollee's in-network cost share.

(E) If the hospital stay becomes prolonged, the Plan reserves the right to transfer the member to a par facility, as long as transfer would not endanger a member's stability.

(F) Either the Enrollee or the facility admitting the Enrollee must contact the Plan after admission.

(2) Emergent, Outpatient Services

(A) If the Enrollee is not enrolled in Medicare,

(i) The Plan will cover services at the Usual & Customary Rate.

(ii) Enrollee responsible only for the Emergency Room copayment. This does not accrue towards the Enrollee's in-network cost share.

(B) If the Enrollee is enrolled in Medicare,

(A) After Medicare payment, the Plan will pay for services up to the Medicare allowed amount.

(B) If the facility opts out of Medicare, the Plan will pay for services at the Medicare allowed amount.

(C) The Enrollee is responsible for both the Emergency Room copayment and, if the facility does not accept Medicare assignment, but also does not opt out of Medicare, the limiting fee (15%).

SECTION 5.5 – TYPES OF COVERED HOSPITAL ADMISSIONS

Benefits are available for admissions occurring on and after the effective date of coverage of the Enrollee, and only when he or she is admitted as a bed patient in accordance with the Hospital's rules and regulations governing admissions as a bed patient, and during such time as the Enrollee is under the constant care and treatment of a licensed Physician. For inpatient Hospital services, days of care must be available under the maximum Hospital benefit period.

(a) Medical Admission. Inpatient services are covered for the treatment of medical conditions necessitating Hospitalization. While the Enrollee need not be acutely ill at the

time of admission, he or she must require active and definite treatment, on an inpatient basis, or require diagnostic procedures that necessitate Hospitalization.

(b) Surgical Admission. Inpatient services are covered for treatment of acute or chronic surgical conditions, including elective procedures, when the procedure or surgical service contemplated requires the Hospitalization of the Enrollee as an inpatient. All necessary prior in-Hospital care to prepare the patient for surgery will be covered, except for defined exclusions (e.g., private duty nurses).

(c) Maternity Admission. Maternity care includes inpatient services for any conditions due to pregnancy or complications thereof.

(d) Psychiatric Admission—Psychiatric Illness. Benefits are payable for inpatient services principally for psychiatric illness (up to forty-five (45) days per benefit period). The condition must require continuing professional care on an inpatient basis. The condition must also meet the definition of covered conditions as discussed in the Mental Health and Substance Abuse Article of this Plan.

(e) Psychiatric Admission—Substance Abuse. Benefits for inpatient psychiatric services are payable for substance abuse addiction if the treatment is for an emotional disorder causing or resulting from the addiction and the disorder requires continuing professional care on an inpatient basis.

(1) Detoxification is a covered service in participating general Hospitals, psychiatric Hospitals, and approved Residential Treatment Facilities. Detoxification is the systematic treatment undertaken when attempting to remove or counteract the acutely threatening physiological or hypersensitive reaction to substance abuse. Benefit utilization in these facilities will be charged against the current 45-day mental health and substance abuse maximum benefit period. Additional benefits may be available in a Participating Residential or outpatient Treatment Facility.

(2) Psychiatric Admission–Splitting Benefits. In psychiatric illness treatment, problems frequently arise involving both organic and psychogenic factors. For example, post-partum psychosis or post-surgical psychosis may necessitate splitting benefits between medical benefits and psychiatric benefits. In such a case, non-psychiatric care benefits that are considered medical care would cover the usual length of Hospitalization for post-partum or post-surgical care; subsequent psychiatric care would then be charged against the psychiatric care inpatient covered services.

(f) Diagnostic Admission. Benefits are payable for diagnostic admissions only when Hospitalization is Medically Necessary. The intent is to provide Hospital services only for those Enrollees with a definite illness or disability that cannot be diagnosed while the Enrollee is cared for in the Enrollee's home, Physician's office, or Hospital outpatient department. Hospital services are not payable for the convenience of the Enrollee or the Physician, or for the saving of time or expense to the patient in the performance of studies and tests. The criteria used are:

(1) Must this Enrollee be Hospitalized for these particular studies; or

(2) Are the studies of such a nature as to require Hospitalization for the Enrollee's safety and effective performance of the test; or

(3) Was the Enrollee sick enough to require Hospitalization apart from the studies (such as severe pain or unconsciousness, etc.); or

(4) Was the treatment administered of such a nature to reasonably require Hospitalization.

The above criteria are to be applied on an individual consideration basis.

SECTION 5.6 – DAYS OF CARE

An Enrollee is entitled to a maximum benefit period of 365 days for each continuous period of covered Hospital confinement or for successive periods of confinement separated by less than sixty (60) days. However, the following limits apply:

(a) The portion of each maximum benefit period available for Hospital care principally for treatment of mental health and substance abuse shall be limited to 45 days. (The 45-day period applies toward the 365-day maximum benefit period.) Each day or night of care used for conditions in an approved day or night care center shall be charged as one-half day of care against the inpatient Hospital days available for mental health or substance abuse care.

(b) An Enrollee is entitled to one hundred (100) days of Skilled Nursing Facility care. Days of care in an approved SNF shall not reduce the days of care available for Hospital confinements. Skilled Nursing Facility (SNF) confinements lasting longer than sixty (60) days will be reviewed and approved by the Carrier for appropriateness and Medical Necessity. See Section 5.13 for a description of the renewal of these days.

(c) An Enrollee is entitled to three (3) Home Health Care visits for each remaining day of the inpatient Hospital benefit period, as long as the care is Medically Necessary. Each visit by a member of the Home Health Care team, each approved outpatient visit to a Hospital or Skilled Nursing Facility, and each Home Health aide visit is considered the equivalent of one (1) Home Health Care visit. A Home Health Care visit will be counted even though the Enrollee is not seen if the visit is made in good faith (e.g., the agency is not notified prior to the visit that the patient is not available). Intravenous infusion therapy visits shall not be counted as Home Health Care visits. The number of Home Health Care visits used will not reduce the number of inpatient Hospital or Skilled Nursing Facility days to which the Enrollee is otherwise entitled. Home Health Care visits exceeding thirty (30) visits will be reviewed and approved by the Carrier for appropriateness and Medical Necessity.

SECTION 5.7 – RENEWAL OF BENEFITS

The benefit periods specified in this Article are within the general benefit period for inpatient Hospital services. There must be a separation of sixty (60) days between periods of Hospitalization for any reason for further benefits to be available. A new maximum benefit period will commence only when there has been a lapse of at least sixty (60) consecutive days between the date of last discharge from a Hospital, night care center, day care center, or SNF,

Hospice, or any other facility to which the sixty (60) day benefit renewal period applies, and the date of next admission, whether or not benefits were provided for the last admission.

For example, if an Enrollee's initial inpatient admission for mental health treatment exhausts the forty-five (45) day maximum, and is separated by sixty (60) days from a second admission for mental health treatment, but the Enrollee had been Hospitalized (for any reason) during the intervening period, the second mental health admission would not be covered.

SECTION 5.8 – INPATIENT HOSPITAL BENEFITS

Upon admission to a Participating Hospital eligible for full payment of covered services, the Enrollee is entitled to receive the Hospital services indicated below, as furnished by a Hospital and as prescribed by the attending Physician.

(a) Semiprivate room, general nursing services, meals, and special diets. Any room charges in excess of the Hospital's standard rate for a semiprivate room are the responsibility of the Enrollee, unless a private room is Medically Necessary and authorized by the Carrier;

(b) Medical/surgical supplies, drugs and medicines used while the Enrollee is in the Hospital;

(c) Use of operating rooms, other surgical treatment rooms, delivery rooms, and recovery rooms;

(d) Anesthesia services;

(e) Blood products and their administration (blood or component preservation and storage for future use are not covered);

(f) Chemotherapy for the treatment of malignant diseases by chemical antineoplastic agents except when treatment is Experimental, Research, and/or Investigational in nature;

(g) Inpatient physical therapy when such service is essential to the treatment of the condition or conditions for which the Enrollee was admitted, and subject to review by the Carrier;

(h) Oxygen and other gas therapy;

(i) Maternity care and routine nursery care of the newborn during the Hospital stay of the mother for maternity care, when the mother is an Enrollee;

(j) X-rays, EKGs, CT scans, ultrasounds, Magnetic Resonance Imaging (MRI), and Magnetic Resonance Angiography (MRA) when billed by the Hospital for diagnostic and not screening or Experimental, Research, and/or Investigational services, and subject to any limitations under this Plan; and

(k) Laboratory and pathology services.

SECTION 5.9 – PREDETERMINATION – PRIOR APPROVAL

The Plan may require the patient, the health care Provider, or the Hospital to obtain a predetermination (prior approval) of all non-emergency, non-maternity Hospitalizations and certain other services.

Predetermination is the process by which the appropriateness of the proposed setting for such service or length of stay is reviewed and approved by the Plan before the performance of such service. Predetermination is required for all inpatient Hospital admissions and Participating Skilled Nursing Facility admissions, except maternity and emergency admissions.

Emergency admissions must be reported to the Carrier within 24 hours after the admission.

The Provider or Hospital is responsible for initiating the predetermination process by calling the Plan. Enrollees may call to initiate the process or to verify that the necessary approvals have been obtained. Requests for predetermination of setting and length of stay for non-emergency, non-maternity admissions are to be made by the Provider or Hospital with sufficient advance notice to permit a decision (and review of an appeal, if necessary) before the admission commences.

The Plan shall provide timely written notification of any actions taken with respect to the predetermination process. Such notification will be mailed to the Provider and the Enrollee. Such notification shall be mailed within 24 hours following receipt by the Plan of oral or written request for predetermination.

The decision of the Plan may be appealed pursuant to the Plan's appeal procedure as detailed in this Plan Document. Decisions resulting from such an appeal will be final and binding on the provider, the Enrollee, and the Plan.

The Carrier will hold the Enrollee harmless for errors of commission or omission involving the predetermination process over which the Enrollee has no control.

The Carrier may monitor and identify Providers who have a pattern of inappropriately prescribing services. The Carrier shall provide selective screening of such identified Providers. The Carrier also shall provide screening for diagnoses identified as being subject to such inappropriate practices.

If the Retiree or Eligible Dependent is notified through the predetermination process that approval for Hospitalization or continued stay has been denied, but the Retiree or Dependent still elects to be hospitalized or remain hospitalized, facility charges and all associated services will not be covered by the Plan. However, if the Hospital or Provider fails to follow the predetermination process, the Enrollee will be held harmless and the Hospital or Provider will not be paid.

The predetermination process determines when and for how long benefits will be payable. The decision about whether to be hospitalized, and for how long, is up to the Retiree or Dependent and their health care Provider, but payment is determined by the Carrier.

SECTION 5.10 – OUTPATIENT FREESTANDING FACILITY COVERAGE

Coverage is provided for most outpatient services, such as treatment of accidental injuries and certain Medical Emergencies, surgery, intravenous infusion therapy, use of assisted breathing devices or similar equipment, and physical therapy (up to sixty (60) treatments per condition per year, which also may be performed in a Freestanding Outpatient Physical Therapy Facility other than a Hospital).

SECTION 5.11 – URGENT CARE FACILITIES

Urgent Care Facilities can provide care for certain medical conditions requiring urgent attention. Urgent Care Facilities are freestanding centers. The charges for covered services at a freestanding Urgent Care Facility, including facility fees, if applicable, will be paid by the Plan, subject to the applicable co-payment.

SECTION 5.12 – EMERGENCY CARE

Benefits for emergency care are provided in the case of certain Accidental Injuries and Medical Emergencies.

A list of conditions/diagnoses that qualify as a medical emergency and accidental injury are maintained by the Carrier.

The Medical Emergency benefit is administered on the basis of signs or symptoms shown by the patient as verified by the Physician at the time of treatment and not on the basis of final diagnosis.

Prompt care must be secured. A Medical Emergency will not be considered to exist if medical treatment is not secured within seventy-two (72) hours after the onset of the condition.

Emergency care may be received outside of the U.S. and be covered by the Plan.

Acute conditions must occur suddenly and unexpectedly. The symptoms must be sufficiently severe to cause a person to seek medical assistance regardless of the hour of the day or night.

If an emergency room patient is placed under observation care, Hospital services are covered when such services are reasonable and necessary to evaluate a patient's condition or determine the need for possible admission to the Hospital. Coverage for such services is generally limited to twenty-four (24) hours, unless the Medical Necessity of additional time is documented in the medical records and approved by the Carrier.

There may be two components of emergency care: Professional (such as those from the treating Physician) and Facility (such as those for use of a Hospital emergency room). Whether the initial treatment is in a Hospital emergency room or not, follow-up care normally can be performed in a Physician office or another setting without a separate facility charge.

(a) Professional Charges – The Plan covers Physician services for the initial examination and treatment of conditions resulting from accidental injuries and other qualifying Medical Emergencies, wherever the services are administered. Follow-up care by the Physician is not covered under the emergency care benefit.

(b) Facility Charges – The Plan covers Hospital emergency room services in Participating and Nonparticipating Hospitals for treatment of covered accidental injuries and Medical Emergencies. Facility charges for follow-up care in a Hospital emergency room are not covered.

A co-payment will apply for emergency room treatment, unless the patient is admitted. The Enrollee will be responsible for only one co-payment should he or she remain under observation

and not be admitted to the Hospital. Emergency admissions must be reported to the Carrier within twenty-four (24) hours.

SECTION 5.13 – SKILLED NURSING FACILITY COVERAGE

(a) Skilled Nursing Facility (SNF) care services are services that can only be safely and effectively performed by or under the supervision of a licensed nurse in a SNF. SNF care is different from residential care, which is not payable. SNF also does not include nursing home care, adult foster care, assisted living, or other Custodial Care (such as helping patients get in and out of bed, bathe, dress, eat, use the toilet, walk, or take drugs or medicines that can be self-administered).

(b) Upon admission to a participating SNF, covered services include the following services when prescribed by the attending Physician and ordinarily furnished by a SNF or by a general Hospital which is affiliated with a participating SNF:

(1) Semi-private room service, including general nursing service, meals, and special diets;

(2) Use of special treatment rooms;

(3) Laboratory examinations;

(4) X-ray and EKG;

(5) Physical, occupational, and speech therapy treatments;

(6) Oxygen and other gas therapy;

(7) Drugs, biologicals and solutions used while the Enrollee is in the SNF;

(8) Gauze, cotton, fabrics, solutions, plaster and other materials used in dressings and casts; and

(9) Durable Medical Equipment to the extent payable under the provisions of this Plan.

(c) Enrollees may only be admitted to a participating SNF on order or recommendation of a Physician and the Physician must, at the time of admission, support with appropriate medical facts in the treatment plan, that the Enrollee requires the type and intensity of continuing skilled nursing care provided by the program and available at a participating SNF. Upon receipt of sufficient medical information to establish eligibility for coverage in the SNF, the Enrollee is provided with an initial verification of thirty (30) days. The admitting Physician, or a licensed Physician designated by the admitting Physician, must assume responsibility for the management of the Enrollee's continuing medical care, including visits to the Enrollee at such intervals as the condition may require, but at a minimum frequency of at least once every two weeks. Less frequent visits will be regarded as evidence that the Enrollee no longer requires the type of skilled nursing care covered by the Plan unless specific orders and progress notes indicate otherwise. The attending Physician must re-verify the Enrollee's continuing need for this type of care at

thirty (30) day intervals, and support, with appropriate medical facts, that the Enrollee's condition continues to require skilled nursing care.

(d) Information concerning the current status of the case must be provided with each re-verification, or when otherwise required by the Carrier. If and when an Enrollee requires only boarding and physical maintenance care, and not definitive medical or skilled nursing care service, the Enrollee will cease to be eligible for payment of benefits. If the Enrollee does not use the 100 allotted SNF days during one admission, any remaining days from the 100 day allotment will continue if there has not been a lapse of at least sixty (60) days between the date of last discharge from a Hospital, SNF, Residential Treatment Facility, mental health facility, night care center, day care center, or extended care facility, and the date of the next admission whether or not Hospital benefits were provided for the last confinement. Continuing institutional care at the Enrollee's (or some other party's or agency's) expense will not be counted toward the sixty (60) day break requirement for benefit continuation. Conversely, the Enrollee who became ineligible for benefits due to requiring principally Custodial Care or Domiciliary Care may resume benefits if a recurrence or exacerbation of a medical condition develops, or a new condition requires such care, provided the Enrollee has benefit days remaining.

(e) Coverage is provided, up to the Allowed Amount, for up to 100 days of Medically Necessary care provided in an approved SNF. An Enrollee who does not have any confinement or inpatient stays for at least sixty (60) consecutive days will be covered for another 100 SNF days. Enrollees will have coverage for a new 100-day benefit a the beginning of a new Plan Year.

(f) A continuation period of any remaining days of the 100 allotted SNF days begins when the Enrollee has not completed at least sixty (60) consecutive days outside of any confinement or inpatient stay.

(g) Treatment at a SNF must meet the following guidelines:

(1) Predetermination may be required for SNF admissions for non-Medicare individuals;

(2) For Medicare patients in an SNF, the Medicare coverage determination is accepted for the period during which Medicare pays claims. Medicare pays a maximum of 100 days for SNF coverage;

(3) The SNF must be a Facility that is Medicare-Approved and is approved by the Carrier:

(4) Patient must be convalescing from an injury or illness that has a favorable prognosis and predictable level of recovery; and

(5) The intensity of care needed by the patient requires a combination of skilled nursing services that are less than those of a general acute care Hospital but are greater than those available in the patient's place of residence.

(h) Skilled Nursing Facility benefits will not be provided for:

(1) Services that are not Medically Necessary and do not require skilled nursing services;

(2) Admissions that are principally Custodial or Domiciliary in nature;

(3) Patients who have reached their maximum level of recovery possible for their particular condition and no longer require treatment other than routine supportive care;

(4) Services provided by non-approved SNFs or SNFs that do not participate with the Carrier;

(5) Primary mental health illness, including drug addiction, chronic brain syndromes and alcoholism without other specific medical conditions of a severity to require care under the Plan, but not including Enrollees with primary mental health illness receiving short-term convalescent care and for whom prognosis for recovery or improvement is deemed favorable; or

(6) Enrollees suffering senile deterioration who do not have a treatable medical condition requiring attention.

SECTION 5.14 – HOME HEALTH CARE COVERAGE

(a) Home Health Care for Medically Necessary services is covered when provided by an approved Home Health Care Agency for skilled, part-time, and intermittent care, including payment for necessary skilled nursing and Home Health Care aides. "Part-time" generally means less than eight hours per day while "intermittent" generally means less than seven days per week. Home Health Care services may also be available for homebound Enrollees, as determined by the Carrier.

(b) The Enrollee may receive Home Health Care benefits for up to three visits for each remaining unused day of the inpatient Hospital benefit period. The maximum number of visits under the Home Health Care benefit is 1,095 (which is 365 Hospital care days times three). Visits in excess of thirty (30) will be reviewed and approved by the Carrier for appropriateness and Medical Necessity.

(c) For example, an Enrollee who receives Home Health Care after spending 100 days in the Hospital can receive Home Health Care benefits for up to 795 visits (365 days – 100 days = 265 days x 3 = 795 Home Health Care visits). A new 1,095-visit period begins when the Enrollee has not been in the Hospital, an SNF, or any other facility or service to which the 60-day benefit period rule applies, for 60 consecutive days.

(d) Each visit by a member of the Home Health Care team, each approved outpatient visit to a Hospital or SNF, and each home health aide visit is considered the equivalent of one Home Health Care visit.

(e) Home Health Care services must be received on or after the Enrollee's effective date of coverage in this Plan. The Home Health Care Agency must meet Plan Standards and be Carrier-approved, and the services received must be prescribed by the Physician in

charge of the case, provided and billed by an approved Provider, and approved by the Carrier.

(f) The following Home Health Care services are covered when provided and billed by a Home Health Care Agency approved by the Carrier:

(1) General nursing services;

(2) Physical therapy and speech therapy (may be provided and billed by a Hospital outpatient department or Freestanding Outpatient Physical Therapy Facility under limited circumstances);

(3) Social service guidance, dietary guidance, and functional occupational therapy; and

(4) Part time health aide service by a home health aide employed by an approved Home Health Care Agency. To be eligible for home health aide service, the Enrollee must be receiving one of the services in (l) or (2) above, and it must be determined by the Home Health Care Agency that the Enrollee could not be treated under this subsection without the home health aide service.

(g) The following services are covered when provided and billed by an approved Provider:

(1) Laboratory tests;

(2) Drugs, biologicals, and solutions; and

(3) Medical supplies which are essential in order to effectively administer in the home the medical regimen ordered by the Physician. Supplies include items such as bandages, dressings, splints, hypodermic needles, catheters, colostomy appliances, and oxygen.

(h) Intravenous (IV) infusion therapy services in the home are covered under Home Health Care coverage. The following provisions will apply to such services:

(1) The “homebound” requirement will be waived with respect to home infusion therapy patients;

(2) Related nursing services will be included;

(3) Applicable prescription drugs will be included;

(4) All services directly related to infusion therapy, including DME, parenteral and enteral methods of hyperalimentation, chemotherapy, and supplies, will be covered under Home Health Care coverage;

(5) The provision that limits Home Health Care benefits to three visits for each remaining inpatient Hospital day will be waived; and

(6) Home IV infusion therapy services will be covered only when delivered by a Provider that is accredited by the Joint Commission on Accreditation of Healthcare Organizations.

SECTION 5.15 – HOSPICE COVERAGE

Hospice care for terminally ill individuals when provided through an approved Hospice program is covered. Benefits for Hospice care are limited to 210 days. The terminally ill individual must have written certification from a Physician that he or she is terminally ill and meets the criteria for life expectancy. Specifically, the order of the Physician must certify that the Enrollee requires the type of care available through the Hospice and that the Enrollee has a life expectancy of six (6) months or less. The individual must file an election statement with the Hospice program agreeing to the terms of Hospice care.

Hospice coverage, as described below, is available to TCN and Preferred Provider Organization option Enrollees. It addresses the needs of terminally ill patients who do not require the continuous level of care provided in a Hospital or Skilled Nursing Facility.

Upon admission to an approved Hospice program, an Enrollee is entitled to receive the following services when rendered as part of the treatment plan:

(a) Nursing care provided by or under the supervision of a registered nurse;

(b) Medical social services provided by a social worker under the direction of a Physician;

(c) Physician services;

(d) Counseling services provided to the patient, family members and/or other persons caring for the patient at home;

(e) General inpatient care provided in a Hospice inpatient unit;

(f) Medical appliances and supplies;

(g) Physical, occupational and speech therapies;

(h) Continuous home care provided during periods of crisis as necessary to maintain the patient at home;

(i) Respite care;

(j) Bereavement counseling;

(k) Care rendered in a nursing home with Hospice support; and

(l) Home health aide services.

SECTION 5.16 – DIAGNOSTIC RADIOLOGY

Radiology services for the diagnosis of disease or injury is covered if the service is approved by the Carrier and the radiology services are performed in an approved Hospital or facility.

Radiology services that are considered Experimental, Research, and/or Investigational are not covered.

Diagnostic radiology services include, but are not limited to, "High Tech" radiology, which includes, but is not limited to, magnetic resonance imaging (MRI), magnetic resonance angiography (MRA), computerized axial tomography (CAT), positron emission tomography (PET), nuclear cardiology, and nuclear bone scans.

For non-urgent cases involving "High Tech" radiology services, Enrollees not enrolled in Parts A and B of Medicare must receive prior authorization from the Plan's delegated entity. If Enrollee proceeds without a prior authorization or is denied an authorization, then the Plan will not cover the radiology service.

Benefits will be payable only when the procedure is performed using approved equipment.

SECTION 5.17 – HUMAN ORGAN TRANSPLANTS

(a) Subject to listed exceptions, each human organ transplant or bone marrow transplant must receive prior authorization approval to determine that such transplant is appropriate and Medically Necessary. The prior authorization review will be based on information provided by the Enrollee's Hospital and Physicians, as well as other professional and scientific sources, including, but not limited to, medical peer-reviewed publications, local and/or national medical opinions and professional association guidelines. Exceptions include:

(1) The transplant is an emergency situation

(2) Skin, cornea, or kidney only transplants

(3) The Enrollee is enrolled in Parts A and B of Medicare

(b) In the case where an Enrollee is enrolled in Parts A and B of Medicare, coverage is limited to transplants approved by Medicare.

(c) All transplants for Enrollees not enrolled in Parts A and B of Medicare must be performed at a Carrier-approved Center of Excellence (e.g., Blue Distinction Centers for Blue Cross Blue Shield).

(d) Enrollment by all Enrollees (including those enrolled in Parts A and B of Medicare) in Case Management is required for all transplants except kidney, cornea, and skin transplants. If the Enrollee refuses to participate and/or cooperate in Case Management, the Plan's portion of the financial obligation for all medical services, treatments, situations, prescription drug, or other services related to the transplant will not be covered. For Enrollees enrolled in Parts A and B of Medicare, Medicare will continue to cover its portion of the financial obligation as Case Management is not required by Medicare.

(e) When the donor or potential donor is a cadaver, all utilization of benefits will be charged against the Enrollee recipient's Plan option, but only in the event that such costs are not covered by an organ procurement agency.

(f) Benefits will be reduced by any amount payable from other sources, such as foundations, grants, governmental agencies or programs, research or educational grants, and charitable organizations. Any portion of the costs of the organ transplant and associated services covered by governmental, foundation, or charitable grant will reduce the coverage by the Plan proportionally.

(g) Any type of human organ or tissue transplant from a donor to a transplant recipient requiring surgical removal of the donated organ and tissue, are covered services, according to the criteria outlined below:

(1) When a Plan Enrollee is the recipient:

(i) The Plan Enrollee's costs are covered.

(ii) The donor's costs are covered if no other insurance or other payor is available or would cover the costs.

(iii) Any cost-sharing associated with the donor will be the responsibility of the Plan Enrollee recipient.

(2) When a Plan Enrollee is the donor:

(i) The Plan Enrollee's costs are covered.

(ii) The recipient's costs are not covered by the Plan.

(3) When a Plan Enrollee is the donor and a Plan Enrollee is the recipient:

(i) The Plan Enrollee donor's costs are covered.

(ii) The Plan Enrollee recipient's costs are covered.

(iii) Cost-sharing associated with the transplant is the ultimate responsibility of the recipient.

(4) When the donor is a cadaver:

(i) The Plan Enrollee recipient's costs are covered, except for any amounts covered by an organ procurement agency.

(ii) Any cost-sharing will be the responsibility of the Plan Enrollee recipient.

(5) Evaluation and procurement costs. Expenses incurred in the evaluation and procurement of organs and tissues are covered when billed by a Hospital. Charges for participation with registries for organ procurement, operating rooms, supplies, use of Hospital equipment and transportation of the tissue or organ to be evaluated are also covered. All such covered expenses will be charged against the Plan Enrollee recipient's coverage to the extent that benefits to the donor or potential donor are not provided under some other health care coverage.

(h) Immunization for post-transplant patients up to 24 months after the transplant

(i) Transplant (Organ and Tissue) Exclusions

(1) Expenses for human organ and/or tissue Transplants that are Experimental, Research, and/or Investigational, including, but not limited to donor screening, acquisition/selection, organ or tissue removal, transportation, Transplantation, postoperative services, drugs/medicines, and all complications thereof.

(2) Expenses related to non-human (Xenografted) organ and/or tissue Transplants or implants, except heart valves.

(3) Expenses for insertion and maintenance of an artificial heart or other organ or related device, including complications thereof, except heart valves, kidney dialysis and a ventricular assist device (VAD) (i.e., a mechanical pump used to assist a damaged or weakened heart in pumping blood) only when used as a bridge to a heart transplant or for support of blood circulation post-cardiotomy (following open-heart surgery), or for destination therapy (permanent mechanical cardiac support only if there is approval from the FDA for that purpose, and the device is used according to the FDA-approved labeling instructions).

(4) Expenses for the cost of an organ or tissue sold rather than donated. Costs associated with the transplant, including the costs of the procedure, are also excluded when the Enrollee knows that the organ was purchased or when the Enrollee intends to sell his or her organ.

SECTION 5.18 – HOME HEMODIALYSIS

Hemodialysis (use of a kidney machine) or peritoneal dialysis is a covered service in the Enrollee's home when the treatment is of a chronic, irreversible kidney disease. Prior Hospitalization is not required for home Hemodialysis to be a covered service. Treatment must be arranged through the Enrollee's attending Physician during the establishment of the treatment program and either the Physician director or a committee of staff Physicians of a Participating Hospital Hemodialysis program that has been approved by the Carrier.

(a) Covered expenses include the following:

(1) The purchase, rental, or lease of a Hemodialysis machine from a Participating Hospital and/or agency and placed in an Enrollee's home, when the Enrollee's home is deemed to be the most convenient and desirable setting for Hemodialysis treatment by the medical authorities indicated above.

(2) Essential installation costs of home Hemodialysis equipment and the subsequent maintenance or repair of such equipment.

(3) The Participating Provider's expenses incurred or resulting from the training of the Enrollee, family members or any other individual who of necessity will be assisting the Enrollee with the operation of the dialyzer in the home.

(4) Related laboratory tests.

(5) Consumable and expendable supplies, such as the dialysis membrane, the dialysis solution, tubing, and drugs required during dialysis, when purchased through and billed by a Participating Hospital.

(6) The full cost of treatment drugs required during dialysis, supplies, solutions, or other consumable and/or expendable items purchased for home Hemodialysis.

(7) The cost of removing the Hemodialysis equipment from the Enrollee's home following discontinuance of the Enrollee's need for Hemodialysis equipment.

(b) Administration

(1) The Physician director or a committee of staff Physicians, in conjunction with the attending Physician will assume full responsibility for appropriate case selection, training of the Enrollee and family members in full detail of the procedure, and the prescribing of a suitable dialysis machine.

(2) The Carrier shall establish an appropriate charging mechanism for participating Hospitals to use in obtaining reimbursement for expenses they incur in the purchase, lease, or rental of dialysis machines to be placed in Enrollees' homes, including installation and maintenance.

(3) Prior to installation of the dialysis machine, the Enrollee's place of residence must have access to electrical power and water supply appropriate for the Hemodialysis equipment. Benefits are payable for attaching the dialyzer to existing power, water and disposal systems but are not payable for the cost of obtaining such systems. The owner of the Enrollee's place of residence must give written permission in advance of installation of such equipment.

(4) A water softening system is a covered supply when used to pre-treat water to be purified by a Reverse Osmosis (RO) unit for home dialysis where:

(A) The manufacturer of the RO unit has set standards for the quality of water entering the RO (e.g., the water to be purified by the RO must be of a certain quality if the unit is to perform as intended).

(B) The patient's water is demonstrated to be of lesser quality than required.

(C) The softener is used only to soften water entering the RO unit, and thus used only for dialysis. (The softener need not actually be built into the RO unit, but must be an integral part of the dialysis system.)

SECTION 5.19 – HOME HEMOPHILIA BENEFIT

The Home Hemophilia benefit provides in-home training to hemophilia patients and provides benefits for the medication and supplies necessary for the treatment of hemophilia in the Enrollee's home, when obtained from a Participating Provider.

The following medications and supplies are covered under the Hemophilia Benefit: Antihemophilic Factor (AHF); Benadryl or other appropriate antihistaminic agents; and syringes, needles and other supplies required to inject the AHF.

Experimental, Research, and/or Investigational drugs and treatment are not covered. The dispensed medications and supplies must be prescribed by a Physician qualified to treat hemophilia patients according to the guidelines established by the Hemophilia Society of each state. Treatment data must be recorded and maintained in the Physician's office for all home hemophilia patients.

Patient selection and training for home hemophilia treatment must be handled by a treatment center that conforms to the qualifying policies and guidelines established by the state Hemophilia Society and approved by the Carrier.

SECTION 5.20 – EXCLUSIONS AND LIMITATIONS

In addition to the exclusions in Article X, Medical Exclusions, benefits are not payable under the following conditions:

(a) When the care received by the Enrollee in the Hospital consists principally of observation or diagnostic evaluation, physical therapy, x-ray examination, laboratory examination, electrocardiograph, basal metabolism test, or reduction of weight by diet control.

(b) When a diagnosis has already been established and the patient is admitted to verify the diagnosis. In such cases, evidence on the Hospital bill and/or Physician service report must clearly establish that specific therapy requiring Hospitalization was administered. However, diagnostic admissions may be covered in the case of an infant, child, or elderly person in a weak or infirm condition as determined by the Carrier. Factors to be considered may include:

(1) Apparent condition and general state of health upon admission (e.g., acutely ill, in severe pain, extreme debilitation);

(2) Onset and duration of illness and severity of symptoms (e.g., sudden, acute onset as opposed to vague complaints);

(3) Findings upon physical examination (e.g., pain, bleeding, increased temperature); or

(4) Specific or definitive treatment rendered which could not be administered on an outpatient basis.

(c) Admissions to prepare for x-rays of the gastrointestinal tract.

(d) Admissions for oral surgery where a concurrent hazardous medical condition, such as a serious blood dyscrasia, unstable diabetes, or a severe cardiovascular condition, do not exist.

(e) Services and supplies for routine dental care.

(f) Abortion admissions, if the service is not legal in the state where it is rendered or not performed in accordance with the Hospital's rules and regulations.

(g) Hospital, SNF, or Residential Treatment Facility services for inpatient admissions which occurred prior to the effective date of the Enrollee;

(h) The purchase of DME or P&O appliances ordered prior to the effective date of the Enrollee;

(i) The rental charges for DME prior to the effective date of the Enrollee;

(j) Products and services provided after the Enrollee's coverage under the Plan is terminated, except for Hospital, SNF, or Residential Treatment Facility services for inpatient admissions which occurred prior to the Enrollee's termination date;

(k) The rental charges for DME for periods after the date the Enrollee's coverage is terminated;

(l) Apprehension on the part of the Enrollee, regardless of age, does not entitle the Enrollee to benefits for inpatient dental treatment;

(m) Inpatient admission is not a covered service for treatment, by any method, of joint or jaw hinge problems, including temporomandibular joint syndrome and craniomandibular disorders, or other conditions of the joint including the jawbone and skull and complex of the muscles, nerves and their tissues related to the temporomandibular joint;

(n) Benefits for Hospital services are available only for the period which is Medically Necessary for the proper care and treatment of the Enrollee;

(o) Hospital coverage does not include facility charges for care received in a freestanding Ambulatory Surgical Facility/Center (unless it is an approved freestanding Ambulatory Surgical Facility/Center).

(p) Home Health Care coverage does not include supplies such as elastic stockings and personal comfort items or equipment and appliances such as Hospital beds, oxygen tents, walkers, wheelchairs, or orthotics. Home Health Care coverage also does not include Physician services, private duty nursing services or housekeeping services.

(q) Hospital and other facility services are subject to all provisions of this Plan and to the Limitations and Exclusions set forth in this Plan.

(r) Hospital and other facility charges are excluded if the charges are related to treatment and services that are not covered services.

(s) Hospital and other facility services received outside the U.S., unless listed under one of the circumstances in 5.2

ARTICLE VI — SURGICAL AND MEDICAL EXPENSE BENEFIT

TRADITIONAL CARE NETWORK (TCN) AND PREFERRED PROVIDER ORGANIZATION (PPO) NETWORK ONLY

SECTION 6.1 – SURGICAL AND MEDICAL EXPENSE COVERAGE GENERALLY

Surgical and medical expenses rendered by Physicians, or Non-Physician Practitioners within the scope of their licensure, for diagnosis or treatment of illness or injury are covered expenses, except where specifically limited or excluded in this Article or elsewhere in the Plan. Such expenses must be Medically Necessary. Certain medical or surgical procedures are excluded under the Plan. This Article does not apply to Enrollees in an HMO or a Medicare Advantage plan. Enrollees in an HMO or a Medicare Advantage plan should consult the applicable insurance policy or contract about surgical and medical benefits. Services received by Enrollees outside the U.S. will only be covered in the following circumstances:

(a) When the Enrollee is seeking care for an urgent or emergent medical condition; or

(b) When Medicare would cover an elective service—

(1) When the Enrollee lives in the U.S. and the hospital outside of the U.S. is closer to the Enrollee's home than the nearest U.S. hospital that can treat the Enrollee's medical condition; or

(2) When Enrollee is on board a ship within the territorial waters adjoining the U.S., but never when that ship is more than 6 hours distant from a U.S. port.

SECTION 6.2 – PAYMENT OF BENEFITS

An Enrollee is eligible for benefits for expenses incurred for surgical and medical covered services only when the following conditions have been met:

(a) Services are received on or after the Enrollee's effective date of coverage in this Plan;

(b) Services are approved by the Carrier; and

(c) Services are received prior to the termination date of the Enrollee's coverage, except that services received during Hospital admissions that commence prior to such termination date will be covered subject to other provisions of this Plan.

The Carrier(s) will make payment according to a fee schedule, capitation schedule, or allowable charges. A Carrier will make the benefit payments directly to the Provider for services performed or materials furnished by such Provider, or directly to the Enrollee if appropriate. A Carrier's determination, made in good faith, of the amount of fees, capitation rates, or allowable charges is conclusive. The Carrier will defend its determination of the fee, capitation rate, or allowable charge if a Provider claims an amount in excess of the Carrier's determination from the

Enrollee and there is no prior written agreement between the patient and the Provider regarding the amount of the Provider's charges.

Certain Hospital based Physician services billed by a Hospital will be paid directly to the Hospital by a Carrier according to the Carrier's agreement with the Hospital.

SECTION 6.3 – COVERED SURGICAL AND MEDICAL EXPENSES

Coverage, up to the Allowed Amount, is provided for Medically Necessary surgical and medical services, including:

(a) Surgery and anesthesia, including pre- and post-operative care (plastic, reconstructive, and dental surgery are subject to limitations and/or exclusions);

(b) In-Hospital consultations;

(c) In-Hospital medical care;

(d) Physician's medical visits, at the rate of two (2) per week, for up to 100 days in an approved Skilled Nursing Facility for general conditions;

(e) Human organ and tissue transplants (some of which have payment limits as set forth in this Plan);

(f) Necessary and appropriate diagnostic imaging, laboratory and pathology services;

(g) MRI, MRA, CT, PET and similar services are part of diagnostic imaging and may be limited to certain diagnoses, use of Carrier-approved facilities, or frequency limits;

(h) Payment for digital mammograms is limited to the Allowed Amount for standard mammograms;

(i) Mastectomy;

(j) Obstetrical delivery, including pre- and post-natal care provided by a Physician or by a nurse mid-wife when received in a Hospital or birthing center affiliated with a Hospital;

(k) Chemotherapy for certain types of malignant conditions. Chemotherapy is covered for the following routes of administration: parenteral, continuous or intermittent infusion, perfusion, and intracavitary, but is not covered for oral administration. Oral chemotherapy medications are covered under the Prescription Drug Benefit.

(l) In the case of an individual who undergoes a mastectomy and who elects breast reconstruction in connection with the mastectomy, coverage is consistent with the provisions of Section 4.15;

(m) Sterilization, but not sterilization reversals;

(n) Surgical services include usual, necessary, and related preoperative and postoperative care performed in or out of the Hospital;

(o) Plastic and reconstructive surgery is limited to the correction of congenital anomalies and conditions resulting from accidental injuries or traumatic scars, to the correction of deformities resulting from cancer surgery or following Medically Necessary mastectomies (including Medically Necessary mastectomies resulting from cancer or fibrocystic disease), and to blepharoplasties when there is secondary visual impairment resulting from conditions such as Bell's Palsy;

(p) Human organ or tissue transplants: For medically recognized human organ or tissue transplants from a living or cadaver donor to a transplant recipient which requires surgical removal of a donated part, benefits for services as listed and limited in this subsection (including laboratory services for evaluation tests to establish a potential donor's compatibility and suitability) will be provided in the same manner as under the Hospital Benefit Article of this Plan Document.

(1) Payments will be reduced by any amount payable from other sources, such as foundations, grants, governmental agencies or programs, research or educational grants and charitable organizations.

(q) Laser surgery is covered if the alternative procedure is covered. The maximum benefit payable for laser surgery is the Allowed Amount for the alternative procedure.

(r) Hemodialysis services are covered only when performed in a facility approved by the Carrier, and pursuant to Section 5.18.

(s) Anesthesia: Services for the administration of anesthetics are covered, when provided by a Physician, other than the operating Physician, and when required by, and performed in conjunction with, another covered service.

(1) Anesthesia services provided by a Physician for covered services are payable in all settings that are appropriate for the covered surgical or diagnostic service being performed, including inpatient Hospital, outpatient Hospital, free-standing Ambulatory Surgical Facility/Center, and Physician’s office.

(2) Anesthesia services include the administration of anesthesia by a Certified Registered Nurse Anesthetist (CRNA) or an Anesthesia Assistant (AA) working under the medical direction of an anesthesiologist who is available for immediate attendance. CRNA services are also covered if performed under the general supervision of a Physician who is not an anesthesiologist and who is available for immediate attendance.

(3) CRNAs must attain specialty certification from the Council on Certification of Nurse Anesthetists and be state licensed. AAs must be graduates of an educational program accredited by the Commission on Accreditation of Allied Health Education Programs, be certified by the National Commission for the Certification of Anesthesiologists Assistants and the National Board of Medical Examiners, and work under the supervision of a licensed MD or DO who is responsible for overall provision of anesthesia to the patient. Anesthesia services performed by CRNAs or AAs are payable in the inpatient Hospital, outpatient Hospital, or freestanding Ambulatory Surgical Facility/Center settings.

(4) Administration of local anesthetics is not covered. Anesthesia services, supplies, gases, and use of equipment provided by a Hospital are covered under the Hospital Benefits Article of this Plan Document.

(t) Technical surgical assistance: Services by a Physician or a Physician Assistant who actively assists the operating Physician are covered when Medically Necessary and when related to covered surgical or maternity services. In order for the services of the assistant surgical Physician or Physician Assistant to be covered, it must be certified that the services of interns, residents, or house officers were not available at the time. In order for technical surgical assistance performed by a Physician Assistant to be covered, the Physician Assistant must be legally qualified and registered, certified and/or licensed, as applicable, to perform these health care services. The Physician Assistant must be approved by the Carrier. Reimbursement for technical surgical assistance services performed by a Physician Assistant will be made to the employer of the Physician Assistant.

(u) Maternity care: Obstetrical services of a Physician or a certified nurse-midwife, including usual prenatal and postnatal care, are covered. For each pregnancy, coverage is also provided for routine prenatal laboratory examinations that are performed in connection with normal maternity care. Covered obstetrical services provided by a certified nurse-midwife are limited to basic ante partum care, normal vaginal deliveries, and postpartum care. For a given uncomplicated pregnancy, reimbursement for such care would be to the Physician or the certified nurse-midwife, but not both. Certified nurse-midwives are reimbursed only for deliveries occurring in the inpatient setting or in a birthing center that is Hospital affiliated, state licensed and accredited and approved by the Carrier. The certified nurse-midwife must be legally qualified and registered, certified and/or licensed, as applicable, to perform these health care services. The nurse-midwife must meet Plan standards and be approved by the Carrier.

The coverage includes the initial Hospital inpatient examination of a newborn child by a Physician other than the delivering Physician, certified nurse-midwife or the Physician administering anesthesia during delivery.

(v) Obstetrical services of a Physician for an abortion are covered only when the abortion is Medically Necessary.

(w) Medical care in Hospitals: Inpatient Hospital medical care by the Physician in charge of the case is covered for conditions, diseases, or injuries (except mental health and substance abuse which is provided for in the Mental Health and Substance Abuse Benefit) for which care is different in kind and nature from that customarily provided and considered to be surgical or obstetrical, provided benefits are available within the benefit period.

(x) Medical care in Skilled Nursing Facilities: Coverage is as set forth in the Article V.

(y) Office/Outpatient Consultations: Coverage is available for office visits and outpatient consultations rendered by an In-Network Provider subject to applicable co-payment requirements.

(z) Emergency treatment: Coverage is provided for the services of one or more Physicians for the initial examination and treatment of conditions resulting from Accidental Injury or Medical Emergencies. If an emergency room patient is placed under observation care, Physician services are covered when such services are reasonable and necessary to evaluate a patient's condition or determine the need for possible admission to the Hospital. Coverage for such services is limited to 24 hours, unless the Medical Necessity of additional time is documented in the medical records and approved by the Carrier. Follow up care is not covered.

A co-payment will apply for emergency room treatment, unless the patient is admitted. The Enrollee will be responsible for only one co-payment should he or she remain under observation and not be admitted to the Hospital.

(aa) Chemotherapy: Coverage for chemotherapy is provided under the Hospital Benefit. Chemotherapy administered in a Physician's office is also covered.

(bb) Extra corporeal shock wave lithotripsy (ESWL): Coverage is provided for services rendered by a provider approved by the Carrier and meeting Plan standards including the treatment of selected conditions/diagnosis.

(cc) Therapeutic radiology: Coverage is provided for **certain** treatment of conditions by external or internal beam radiation, or via radioactive isotope treatments, and includes the cost of materials provided. Some therapeutic radiology services are **only indicated** for treatment of certain conditions and may require prior authorization from the Carrier. Enrollees can contact the Carrier to determine whether a given therapeutic radiology service **requires** prior authorization requirement.

Coverage for Proton Beam Therapy requires prior authorization from the Carrier.

(dd) Diagnostic radiology services: Coverage is provided if approved by the Carrier for diagnosis of any condition, disease, or injury by x-ray, ultrasound, isotope examination, computerized axial tomography (CAT), magnetic resonance imaging (MRI), positron emission tomography (PET), mammography, and other modalities. Benefits will be limited to the Carrier determined rate for the applicable procedure. For non-urgent cases involving "High Tech" radiology services, Enrollees not also enrolled in Parts A and B of Medicare must receive prior authorization from this Plan or this Plan's delegated entity. If Enrollee proceeds without a prior authorization or is denied an authorization, then the Plan will not cover the radiology service. Coverage restrictions include, but are not limited to, the following:

(1) Coverage for diagnostic radiology does not include miniature x-ray plates, screening procedures, whole body scans, or any examination or procedure not directly related and necessary to make a specific diagnosis.

(2) Digital subtraction angiography is a covered procedure if performed on Hospital based equipment and billed by the Hospital.

(3) The maximum benefit payable for digital mammography is the Allowed Amount for the alternative standard film mammogram.

(ee) Diagnostic laboratory, pathology and other services:

(1) Coverage is provided if approved by the Carrier for laboratory and pathological examination for the diagnosis of any condition, disease, or injury. In addition to examinations of blood, tissue, and urine, diagnostic laboratory and pathology include diagnostic procedures such as electrocardiograms, electroencephalograms, and electromyograms.

(2) Coverage is provided for laboratory and pathological services for one (1) routine Papanicolaou (Pap) smear per Enrollee per year to detect cancer of the female genital tract when prescribed by a Physician. More frequent Pap smears will be covered only when specifically prescribed for one of the following conditions: previous surgery for a vaginal, cervical, or uterine malignancy; presence of a suspect lesion in the vaginal, cervical, or uterine areas as established through clinical examination; or a positive Pap smear leading to surgery and requiring a post operative smear.

(3) Proctoscopic examinations with biopsy are covered. Proctoscopic examinations without biopsy are covered once every three (3) calendar years after age 40 is attained.

(4) Two-dimensional echocardiography is a covered procedure if performed by a board certified or board eligible cardiologist.

(5) When a covered diagnostic test requires injection of a drug, biological or solution in order to perform the test, the drug, biological or solution and the injection of it are covered, subject to Carrier billing and reimbursement practices.

(ff) Primary Care Physician Office Visits– TCN Plan: The Plan will pay for up to six physician office visits, one of those being an Annual Exam if the Enrollee is in the TCN plan and not eligible to be enrolled in Medicare.

(1) The Enrollees must see a family practice or general medicine Physician, an internist, an obstetrician-gynecologist, a geriatrician, or a pediatrician or a nurse practitioner, or a physician's assistant in a primary care setting. This benefit does not include office visits to Specialists.

(2) This benefit does not cover associated consultations.

(3) If the Enrollee obtains treatment from a Participating Provider beyond the first six visits, the Enrollee will be responsible for the cost of the visit at 100% copayment (meaning the Enrollee will pay 100% of the cost of services as negotiated by the Plan).

(4) Visits will only be covered if the place of service is the Physician's office.

(gg) Physician Office Visits – PPO option: PPO coverage is open on a limited basis subject to Plan administrative procedures. If an Enrollee is in the Preferred Provider Organization option office visits to Participating Providers are payable subject to the conditions below.

(1) The benefit available for PPO option Enrollees is 50% of the Allowed Amount for Participating Providers.

(2) Coverage includes medical visits by a Physician when rendered in the Physician's office, the home, or the outpatient department of a Hospital, for the examination, diagnosis, and treatment of any condition, disease, or injury.

(3) Office visit coverage does not duplicate or replace benefits available under other areas of coverage, such as mental health, prenatal and postnatal care, immunizations, or substance abuse.

(4) Office visit coverage does not include office visits for:

(A) insurance and employment examinations;

(B) manipulation and/or adjustment of subluxation;

(C) allergy testing; and

(D) injections.

(5) Office visits to a non-Participating Physician, without referral by a Participating Physician, are not covered.

(hh) Well Child Care: Coverage is available for up to six (6) visits to In-Network Providers for children under two (2) years of age.

(ii) Certain immunizations and vaccinations as recommended by the CDC's Advisory Committee on Immunization Practices.

(jj) Screenings: Coverage will be provided for those screenings that receive an A or B recommendation from the U.S. Preventive Services Task Force without cost-sharing when prescribed by a In-Network Physician and administered by an In-Network Provider.

(kk) Contraceptive Services: Medical and surgical coverage for contraceptive services is limited to injections of contraceptive medication (professional fees and medication for injection), implantable contraceptives and their insertion or removal, intrauterine devices and their insertion or removal, cervical caps and their fitting, and diaphragms and their fitting. Coverage under this Section does not include over-the-counter contraceptive devices.

(ll) Expenses for medical or surgical treatment of obesity (bariatric surgery), including drug therapy, gastric restrictive procedures, gastric or intestinal bypass, reversal of a previously performed weight management surgery, skin reduction procedures/treatment, and any complications thereof.

(mm) Expenses are covered for a behavioral-based smoking cessation program approved by the Carrier.

(nn) Expenses are covered for American Diabetes Association (ADA) certified diabetes education classes for Enrollees diagnosed with diabetes.

(oo) Expenses are covered for Phase I and Phase II of cardiac rehabilitation programs, including inpatient evaluation and therapy and outpatient evaluation and individualized prescription by a Physician of graded active exercises designed to rehabilitate or improve damaged heart muscle.

(pp) Expenses for pulmonary rehabilitation are covered.

(qq) Expenses for Advance Care Planning (as defined by Medicare Part B), including the discussion of a plan of treatment and the completion of an advance directive.

(rr) Expenses for surgical and associated medical treatment of gender dysphoria, as defined by the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, so long as the enrollee meets the coverage criteria in the medical policy of the Plan and administered by the Carrier. The medical policy will include any prerequisites for coverage of the services, as well as any ongoing exclusions. Appropriate mental health treatment and prescription drugs are also covered, subject to the restrictions of the Plan, for such an Enrollee.

SECTION 6.4 – SEPARATELY BILLED CHARGES

Separately billed charges for pre-operative and/or post-operative care will be combined with the surgical fee. Total payment for preoperative care will not exceed the amount which would have been otherwise reimbursed had all such charges been billed as an all-inclusive fee. Since these are all-inclusive, no separate reimbursement is applicable.

SECTION 6.5 – MULTIPLE SURGICAL PROCEDURES

Coverage, up to the Allowed Amount, is payable for the total service in the case of multiple surgical procedures.

(a) Multiple surgical procedures during the same operative session performed through the same incision or in the same operative field shall be payable according to the Allowed Amount for the greater procedure.

(b) Multiple surgical procedures during the same operative session performed through separate incisions and in separate operative fields shall be payable according to the Allowed Amount for the total procedure which shall not exceed, in total, the Allowed Amount for the greater procedure and 50% of the Allowed Amount for the lesser procedure(s).

(c) Bilateral procedures during the same operative session performed in separate operative fields shall be payable according to the Allowed Amount for the total procedure which shall not exceed, in total, 150% of the Physician's charge for the unilateral procedure.

SECTION 6.6 – SECOND SURGICAL OPINION BENEFITS

Coverage is provided for a second and third surgical opinion prior to proceeding with surgery. An Enrollee should contact his or her Carrier to determine how second and third opinions are provided. If a second opinion is arranged through the Carrier as required, all services are

covered in full, including the Physician's consultation and any necessary x-ray and laboratory tests. If the second opinion disagrees with the first, a third opinion may be obtained.

SECTION 6.7 – PREVENTIVE SERVICES

The Plan pays for certain preventive services as described in the Schedule of Benefits, which are covered even though they are not provided for treatment of illness or injury. They also are excluded from the annual deductible, co-payment, or co-insurance requirements when received from In-Network Providers.

Preventive services may have sex, age, or frequency limitations, which are set forth in the Schedule of Benefits. If the number of preventive services covered in a time period is limited, such as one (1) per year, the first such service will be considered the preventive one and exempt from cost sharing. Any additional services within the time period, additional diagnostic services, services provided outside the related age windows and services provided by Out-of-Network Providers will be subject to any applicable cost-sharing features (such as the annual deductible, co-payment, or co-insurance requirements) and normal Plan provisions.

SECTION 6.8 – AMBULANCE SERVICES

(a) Coverage is provided, up to the Allowed Amount, for Medically Necessary ambulance transportation (including by ground, air or boat ambulance) to the closest available facility qualified to treat the patient if the following conditions and requirements are met:

(1) Ambulance services must be Medically Necessary. Ambulance services are not Medically Necessary if any other means of transportation could be used without endangering the patient's health.

(2) The ambulance operation providing the service must be licensed.

(3) Ambulance coverage is provided for transportation for purposes of:

(A) Transferring (one way or round trip) a Hospital inpatient, or patient seen in the emergency room, from one Hospital to another local Hospital when lack of needed treatment facilities, equipment or staff Physicians exists at the first Hospital (in the event the required Medically Necessary treatment is not available within the local metropolitan area, transfer will be to the closest Hospital where such treatment is available), or

(B) Transporting (one way or round trip) a Hospital inpatient to a non Hospital facility for a covered CAT scan, MRI or PET examination provided the following conditions are met:

(i) The services are not available in the Hospital in which the Enrollee is confined or in a closer local Hospital, and,

(ii) The facility meets the Carrier's standards for providing such services.

(C) Emergency transportation for:

(i) Transporting a patient one way from the scene of an emergency incident to the nearest available facility qualified to treat the patient; or

(ii) Transporting a patient one-way or round trip from the home to the nearest available facility qualified to treat the patient.

Medical Emergency/ Accidental Injury patients are provided one-way transportation from the home to the facility. Return trip will not be considered Medically Necessary following stabilization. Homebound patients are provided round trip transportation from the home to the facility and back when Medically Necessary (i.e., when other means of transportation could not be used without endangering the patient's health).

A Physician must prescribe the services that necessitate the use of ambulance transportation for services described in sections (3)(A) and (3)(B) above. Ambulance transportation to a facility outside the U.S. is covered if meeting the above criteria and meeting one of the circumstances under Section 5.2 or 6.1.

(b) Coverages

The following services are covered when furnished and billed by an eligible Provider (as determined by the Carrier or preferred provider organization):

(1) Charges for basic life support services. A standard charge per trip inclusive of use of vehicle and equipment, supplies and personnel required to perform services classified as basic life support services. Basic life support consists of services that provide for the initial stabilization and transport of a patient.

(2) Charges for advanced life support services. A standard charge per trip inclusive of use of vehicle and equipment, supplies and personnel required to perform services classified as advanced life support services. Advanced life support is acute emergency treatment procedures with Physician involvement.

(3) Mileage charges. A charge per mile for distances traveled while the Enrollee occupies the ambulance.

(4) Waiting time. A charge for waiting time involved in round trip transport of an Enrollee from a Hospital to another treatment site and return to the same Hospital.

(5) Charges for fixed or rotary wing air ambulance services or boat ambulance services. A standard charge per trip inclusive of use of the air transport or boat transport, supplies and personnel required to perform needed services.

When services are received from an ambulance operation approved by the Carrier, the Carrier will reimburse the Provider for the allowable charges as determined by the Carrier. An approved Provider must agree to accept, as payment in full, the Carrier's determination of the amount payable for covered ambulance services.

When services are received from an eligible, but non-approved provider, the Carrier will pay the Enrollee the allowable charge as determined by the Carrier.

(c) Limitations and Exclusions

(1) The following services are not covered as separate charges; such charges are included in the benefit payment for the standard charge per trip:

(A) Use of specific equipment or devices;

(B) Gases, fluids, medications, dressings, or other supplies;

(C) First aid, splinting, or any emergency medical services or personal service procedures; and

(D) Vehicle operators, attendants, or other personnel.

The charges for these services, while not covered as separate charges, are covered as a component of the charge for the basic or advanced life support services.

(2) Coverage is limited to the Allowed Amount for transporting the patient within a metropolitan area or to the nearest facility qualified to treat the Enrollee, as appropriate under the terms of the Plan.

(3) Coverage does not include the following:

(A) Transportation in a vehicle not qualified as an ambulance;

(B) Transportation for Enrollee, family or Physician convenience;

(C) Service rendered by fire departments, rescue squads or others whose fee is in the form of a voluntary donation;

(D) Transfers not Medically Necessary;

(E) Fees, billed by Physicians or other independent health care Providers, for professional services rendered to Enrollees transported by ambulance;

(F) Services which are payable through an existing arrangement for transfer of patients, where no additional charge is usually made, whether or not such services were immediately available; and

(G) Transportation to a facility outside the U.S. that does not meet one of the circumstances under Sections 5.2 or 6.1.

SECTION 6.9 – OUTPATIENT PHYSICAL THERAPY, FUNCTIONAL OCCUPATIONAL THERAPY AND/OR SPEECH THERAPY

Before receiving outpatient physical, functional occupational or speech therapy, the Enrollee should contact the Carrier to determine if the services will be covered for the condition, and if the outpatient Provider is a Carrier-approved one. Physical, functional occupational or speech therapy benefits will not be paid if received from a Provider that is not Carrier-approved.

Up to sixty (60) combined visits (per qualifying condition) per calendar year are covered for outpatient physical, functional occupational and/or speech therapy provided by a Hospital or by a Carrier-approved Freestanding Outpatient Therapy Facility, Home Health Care Agency, Skilled Nursing Facility or independent Physician or therapist (payable in office setting) participating with and approved by the Carrier. An approved Provider is one who is Medicare-approved and, at the time the patient receives the services, has entered into an agreement with the Carrier, and will accept the Carrier's Allowed Amount as payment in full for covered services. The sixty (60) visit annual limit (per qualifying condition) may be renewed after surgery or a definite aggravation of the condition. Visits beyond thirty (30) will be reviewed and approved by the Carrier for appropriateness and Medical Necessity.

(a) Coverage for physical therapy is available only if it is provided with the expectation that the condition will improve in a reasonable and generally predictable period of time, or improvement is noted on a periodic basis in the patient's record.

(b) Restrictions apply for physical therapy evaluations and re-evaluations.

(c) Multiple therapy treatments occurring on the same day (whether physical, functional occupational or speech) are considered a single visit.

(d) Speech therapy is covered when related to the treatment of an organic medical condition or to the immediate post-operative or convalescent state of the patient's illness. It is not covered for long-standing chronic conditions or inherited speech abnormalities.

(e) Speech therapy for congenital and severe developmental speech disorders is a covered service for children under six (6) years of age, when not available through other public agencies (e.g., state or school), up to sixty (60) visits annually. If a child turns age six (6) while such therapy is in progress, coverage will be continued until the sixty (60) visit maximum for that calendar year is exhausted. In order to be covered, the child must be diagnosed as having a severe communicative deficit.

Limitations and Exclusions

(a) Coverage for physical therapy services is available only if:

    (1) it is provided with the expectation that the condition will improve in a reasonable and generally predictable period of time, or

    (2) improvement is noted on a periodic basis, as documented in the patient's record.

(b) Coverage for physical therapy and functional occupational therapy is excluded for treatment of congenital conditions or when provided solely to maintain musculoskeletal function.

(c) Coverage is not available for inpatient admissions that are principally for physical, functional occupational and speech therapy.

(d) Speech therapy is not covered for the following conditions:

    (1) Educational learning disabilities (e.g., dyslexia);

(2) Deviant swallow or tongue thrust; and

(3) Mild developmental speech or language disorders.

ARTICLE VII — MENTAL HEALTH AND SUBSTANCE ABUSE BENEFIT

TRADITIONAL CARE NETWORK (TCN) AND PREFERRED PROVIDER ORGANIZATION (PPO) NETWORK ONLY

SECTION 7.1 – GENERAL

Mental health and substance abuse coverage is administered by a Behavioral Health Benefits Manager as identified in the Schedule of Benefits through a network of qualified In-Network Providers to promote the delivery of care in the most appropriate settings. If the Enrollee is in an HMO or Medicare Advantage plan option, this Article does not apply and mental health and substance abuse coverage is provided under the applicable insurance policy or contract.

There is a special predetermination or "managed care" process for mental health and substance abuse services. Most services must be approved in advance by the Behavioral Health Benefits Manager to determine the appropriateness of the treatment. The Behavioral Health Benefits Manager evaluates each case and approves treatment, which may include an acute inpatient Hospital or Residential Treatment Facility admission, an appointment for assessment and diagnosis, outpatient mental health services, or a referral to an In-Network Provider (an approved Provider of mental health or substance abuse benefits). The Behavioral Health Benefits Manager can be reached through a toll-free number available 24 hours a day, seven days a week.

If services for treatment of a mental health condition are needed, the Enrollee should first call the Behavioral Health Benefits Manager listed in the Contact Information page of the Schedule of Benefits for treatment authorization. However, if the Enrollee contacts an In-Network Provider before the Behavioral Health Benefits Manager, the In-Network Provider will assess the condition, develop a preliminary treatment plan, and then call the Behavioral Health Benefits Manager for treatment authorization.

If services for treatment of a substance abuse condition are needed, the Enrollee must contact the Behavioral Health Benefits Manager directly for assessment and referral to an In-Network Provider.

The Enrollee must use In-Network Providers to receive full benefits.

SECTION 7.2 – COVERED SERVICES

The Plan provides benefits up to the Allowed Amount for the following Medically Necessary mental health/substance abuse services:

(a) Up to a maximum of forty-five (45) days mental health and/or substance abuse inpatient care within a benefit period at a Hospital or Residential Treatment Facility;

(b) Up to a maximum of thirty-five (35) mental health and/or substance abuse visits per benefit period;

(c) Up to ninety (90) days in a Skilled Nursing Facility for mental health care. Each day of inpatient care for mental health treatment within the benefit period reduces by two the number of available days for Skilled Nursing Facility care. Each two (2) days of medical care for the treatment of mental disorders in a Skilled Nursing Facility reduces by one the number of days of inpatient medical care available for the treatment of mental health related disorders in a Hospital;

(d) Up to ninety (90) days/nights of care in an approved mental health and/or substance abuse Partial Hospitalization Treatment Facility. Each day of inpatient care for mental health treatment within the benefit period reduces the number of partial hospitalization treatment days by two (2). Each two (2) days of medical care for the treatment of mental disorders in a Partial Hospitalization Treatment Facility reduces by one (1) the number of days of inpatient medical care available for the treatment of mental health related disorders in a Hospital;

(e) Psychological testing, when authorized by the Behavioral Health Benefits Manager. If outpatient mental health services are rendered by an Out-of-Network Physician, the first visit will be covered. Any additional visits must be authorized by the Behavioral Health Benefits Manager.

Unauthorized visits to an Out-of-Network Physician will be paid at 50% of the amount that would have been paid to an In-Network Provider. These payments will be made to the Enrollee, not to the Provider.

The Enrollee is responsible for paying the Provider. Mental health services rendered by Out-of-Network, non-Physician Providers (psychologists, social workers, etc.) are not covered under the Plan.

If substance abuse services are rendered by an Out-of-Network Provider, the services are not covered unless an out-of-network authorization is secured from the Behavioral Health Benefits Manager prior to treatment. Services paid may not exceed the amount payable if the services were obtained at an In-Network Provider.

SECTION 7.3 – EXCLUSIONS AND LIMITATIONS

In addition to the exclusions in Article X, Medical Exclusions, mental health and substance abuse services are subject to the following exclusions and limitations.

(a) Coverage is not available for treatment of mental disorders that, according to generally accepted medical standards, are not amenable to favorable modification, except that coverage is available for the period necessary to determine that the disorder is not amenable to favorable modification, or for the period necessary for the evaluation and diagnosis of mental deficiency or retardation.

(b) Coverage for substance abuse treatment does not include professional services such as dispensing methadone, testing urine specimens, or performing physical or x-ray examinations or other diagnostic procedures unless therapy, counseling, or psychological testing are provided on the same day.

(c) Coverage does not include family counseling that is rendered by a Provider other than the Provider for the family member in the course of treatment. Reimbursement will be provided only for services rendered to individuals covered under the Plan.

(d) Coverage does not include diversional or recreation therapy, e.g., an organized program of leisure-based activity programs which, in addition, may include activities that improve or sustain an individual's skills of self care and daily living.

(e) Coverage does not include psychological testing if used as part of, or in connection with, vocational guidance, training, or counseling.

ARTICLE VIII — DURABLE MEDICAL EQUIPMENT AND PROSTHETIC AND ORTHOTIC APPLIANCES BENEFIT

TRADITIONAL CARE NETWORK (TCN) AND PREFERRED PROVIDER ORGANIZATION (PPO) NETWORK ONLY

SECTION 8.1 – GENERAL

Coverage, up to the Allowed Amount, is provided for Medically Necessary Durable Medical Equipment (DME) and Prosthetic and Orthotic (P&O) Appliances prescribed by a Physician, Certified Nurse Practitioner, or Physician Assistant, and under the terms of this Article. If the Enrollee is in an HMO or Medicare Advantage plan option, this Article does not apply and DME and P&O Appliances are available as provided under the applicable insurance policy or contract. DME and P&O appliances must be obtained from an In-Network Provider. If covered items and services are received from Out-of-Network Providers, the Enrollee will be responsible for paying the Provider including additional amounts up to the Provider's full charges for the supply or service.

The Enrollee, his or her Physician, or the DME or P&O Provider may contact the DME Benefit Manager for preauthorization, claims processing, assistance in locating Participating Providers, and for any other questions or concerns.

SECTION 8.2 – CONDITIONS FOR COVERAGE

An Enrollee is eligible for benefits for the rental or purchase of DME and the purchase of P&O appliances only when the following conditions have been met:

(a) Coverage is provided for the basic equipment or appliances plus Medically Necessary special features prescribed by the attending Physician and approved by the Carrier.

(b) The equipment or appliances must be prescribed by a Physician, Certified Nurse Practitioner, or Physician Assistant, and the prescription must include a description of the equipment and the reason for use or the diagnosis.

(c) Coverage is provided for the purchase of DME or P&O appliances ordered on or after the effective date and prior to the termination date of the Enrollee's coverage in this Plan.

(d) Coverage is provided for the rental charges for Durable Medical Equipment for periods on or after the effective date and prior to the termination date of the Enrollee's coverage in this Plan, but rental charges may not exceed the purchase price of the equipment.

(e) The Retiree or Dependent not enrolled in Medicare Parts A and B must receive DME or P&O appliances from an In-Network DME and P&O Provider.

(f) If Retiree or Dependent is enrolled in Medicare Parts A and B, and the Retiree or Dependent receives DME or a P&O appliance that is approved by Medicare for payment, Retiree or Dependent must receive it through a Medicare-approved supplier.

(g) If Retiree or Dependent is enrolled in Medicare Parts A and B and is receiving a Plan-approved, but not Medicare-approved DME or P&O appliance, then the Retiree or Dependent must receive the DME or P&O appliance from an In-Network DME and P&O Provider.

SECTION 8.3 – DME COVERAGE

Unless otherwise indicated below, the equipment must be an item of Durable Medical Equipment that meets Plan standards including being approved for reimbursement under Medicare Part B, and be appropriate for use in the home.

Durable Medical Equipment is covered when used in a Hospital or Skilled Nursing Facility, or when used outside the Hospital or Skilled Nursing Facility and rented or purchased from such Hospital or facility upon discharge.

When the equipment is rented and the rental period extends beyond the expiration of the original prescription, the Physician must recertify by another prescription that the equipment continues to be reasonable and Medically Necessary for the treatment of the illness or injury or to improve the functioning of a malformed body part. If the recertification is not submitted, coverage will cease on the date indicated on the original prescription for duration of need, or thirty (30) days after the date of death, whichever is earlier. Coverage will not be provided for rental charges in excess of the purchase price of the equipment.

When the equipment is purchased, coverage is provided for repairs necessary to restore the equipment to a serviceable condition. Routine periodic maintenance is not covered.

Durable Medical Equipment (DME) coverage includes, but is not necessarily limited to:

(a) Equipment that meets Plan standards, which generally include being approved for reimbursement under Medicare Part B and being appropriate for use in the home;

(b) Repairs necessary to restore the equipment to a serviceable condition when such equipment is purchased (this does not include routine maintenance);

(c) Neuromuscular stimulators;

(d) External electromagnetic bone growth stimulators, in certain approved cases;

(e) Pressure gradient support stockings for certain patients;

(f) Pronged and standard canes (when purchased); and

(g) Continuous Passive Motion Devices (shoulder and elbow): These items will be covered when prescribed by a physician following shoulder or elbow surgery for a period of no more than 21 days total. The total 21 days applies to days that equipment is used in the hospital and home. The DME/P&O Program is responsible for payment of the days of use in the home and the medical surgical program is responsible for inpatient care.

(h) The following items are covered, subject to stated diagnoses and Plan standards;

(1) Alcohol Wipes: There is coverage for alcohol wipes when they are used in conjunction with qualified diabetic testing supplies. Alcohol wipes will not be covered for any other use.

(2) Phototherapy (Bilirubin Light): This item is covered for patients under the age of one having a diagnosis of hyperbilirubinemia.

(3) Cranial Helmets: A cranial helmet will be covered for patients with a diagnosis of Positional Plagiocephaly or Congenital Torticollis.

(4) Special features which are necessary to adapt otherwise covered equipment for use by children.

SECTION 8.4 – PROSTHETIC AND ORTHOTIC APPLIANCES

Unless otherwise indicated below, the appliance must be a prosthetic or orthotic device that meets Plan standards, including being approved for reimbursement under Medicare Part B. Prosthetic and Orthotic (P&O) Appliance coverage includes, but is not necessarily limited to:

(a) P&O appliances that are furnished by an accredited facility and meet Plan standards, which generally include being approved for reimbursement under Medicare Part B, and the replacement, repair, fitting and adjustments of the appliance;

(b) Orthopedic shoes, inserts, arch supports, and shoe modifications when the shoes are part of a covered brace. The coverage for therapeutic shoes prescribed for diabetics not eligible for Medicare shall be limited to the diagnoses established by the Carrier.

(c) Coverage for therapeutic shoes or any style of orthopedic footwear, other than a basic oxford, prescribed for diabetics who are not Medicare eligible shall be limited to the diagnoses and guidelines established by the Plan. Orthopedic shoes, inserts, arch supports, and shoe modifications and braces prescribed for diabetics not eligible for Medicare shall be limited to the diagnoses and guidelines established by the Plan.

The following items are covered, subject to stated conditions of the Plan:

(d) Wigs and appropriate related supplies (stand and tape) are covered for Enrollees who are suffering hair loss from the effects of chemotherapy, radiation or other treatments for cancer. For the first purchase of a wig and necessary related supplies, the maximum benefit is $250. Thereafter, a maximum annual benefit of up to $125 is provided for such purchases.

(e) Appliances or devices that are surgically implanted permanently within the body (except for Experimental, Research, and/or Investigational appliances or devices) or those that are used externally while in the Hospital as part of regular Hospital equipment or when prescribed by a Physician for use outside the Hospital.

(f) Prescription lenses (eyeglasses or contact lenses) only following a cataract operation for any disease of the eye or to replace the organic lens missing because of the congenital absence, or when customarily used during convalescence from eye surgery. However,

prescription lenses not following a cataract operation or to replace the organic lense are covered under the Vision Benefit.

Coverage is provided for appliances furnished by a fully accredited facility or, with Carrier approval, by facilities conditionally accredited by the American Board for Certification in Orthotics and Prosthetics, Inc. as a Provider for the kind of device supplied. The following appliances may be provided by facilities not accredited by the American Board for Certification in Orthotics and Prosthetics: ocular prostheses; prescription lenses; pacemakers; ostomy sets and accessories; catheterization equipment and urinary sets; prefabricated custom fitted orthotic appliances; artificial ears, noses, and larynxes; external breast prostheses; wigs and related supplies and such other appliances as the Carrier may determine.

Coverage for a Prosthetic and Orthotic Appliance includes the replacement, repair, fitting, and adjustments of the appliance.

SECTION 8.5 – EXCLUSIONS AND LIMITATIONS

In addition to the exclusions in Article X, Medical Exclusions, Durable Medical Equipment, and Prosthetic and Orthotic Appliances are subject to the following exclusions and limitations.

(a) Durable Medical Equipment that is not covered includes, but is not limited to:

(1) Deluxe equipment such as motor driven wheelchairs and beds, unless Medically Necessary for the treatment of the Enrollee's condition and required in order for such Enrollee to be able to operate the equipment (for deluxe equipment or features which are not Medically Necessary for the treatment of the Enrollee's condition and required in order for such Enrollee to be able to operate the equipment, benefits are limited to the comparable cost of basic, standard equipment);

(2) Items not medical in nature (which are primarily comfort and convenience items such as bedboards, bathtub lifts, overbed tables, adjust a beds, telephone arms, air conditioners);

(3) Physician's equipment (such as sphygmomanometers and stethoscopes);

(4) Exercise equipment;

(5) Hygienic equipment, such as bidets, toilet seats, and bathtub seats

(6) Self help devices not primarily medical in nature (such as sauna baths and elevators); and

(7) Equipment which has been determined to be Experimental, Research, and/or Investigational equipment.

(8) Pulse oximeters

(9) Wound care

(b) Prosthetic And Orthotic Appliances that are not covered include, but are not limited to:

(1) Dental appliances, hearing aids, eyeglasses, and such non-rigid appliances and supplies as elastic stockings, garter belts, arch supports, corsets, and corrective shoes unless the shoe is attached to a Medically Necessary brace; and

(2) Experimental, Research, and/or Investigational devices.

ARTICLE IX — PRESCRIPTION DRUG EXPENSE BENEFIT

TRADITIONAL CARE NETWORK (TCN) AND PREFERRED PROVIDER ORGANIZATION (PPO) NETWORK ONLY

SECTION 9.1 – PRESCRIPTION DRUG EXPENSE COVERAGE

Prescription drug expense coverage includes items described below.

If an Enrollee is enrolled in an HMO or a Medicare Advantage Prescription Drug (MAPD) Plan Option, this Article may not apply and prescription drug benefits are provided under the applicable insurance policy or contract. If an Enrollee is enrolled in Medicare Part D Drug Coverage under the Trust's Plan, this Article does not apply and prescription drug benefits are provided pursuant to the Medicare Part D Prescription Drug Coverage under the Trust's Plan.

SECTION 9.2 – PRESCRIPTION DRUG COVERED EXPENSES

Covered prescription drugs include:

(a) Federal Legend Drugs: Any medicinal substances that the Federal Food, Drug and Cosmetic Act requires to be labeled, “Caution — Federal Law prohibits dispensing without prescription”;

(b) Compound Drugs: Any drugs that have more than one ingredient and at least one of them is a Federal Legend Drug or a drug that requires a prescription under state law;

(c) Insulin, including syringes and needles dispensed with self-administered insulin; and

(d) Diaphragms.

SECTION 9.3 – PRESCRIPTION DRUG CO-PAYMENTS

The prescription drug co-payment amount for each prescription order or refill will be determined based on various factors, including but not limited to whether the drug is generic or a preferred or non-preferred brand name, and whether the drug is dispensed at a retail, specialty or mail order pharmacy. The Plan has entered into a contract with a Pharmacy Benefit Manager (“PBM”), which has negotiated discounted prices for prescription drugs under the Plan when the prescription is filled at Participating retail and mail order pharmacies. If the discounted price is lower than the co-payment, the Enrollee will be charged the lower amount.

SECTION 9.4 – GENERIC AND BRAND-NAME MEDICATIONS

Many prescription drugs are dispensed under two names: the generic name and the brand name. A generic drug is chemically equivalent to a brand drug for which the patent has expired.

When the Enrollee receives a brand name medication, the Enrollee generally pays more. Generic drugs have a lower co-payment than brand name drugs. When a non-preferred brand-name drug is dispensed instead of its generic version, the Enrollee will pay the third-tier co-payment.

If a Physician has not indicated "Dispense As Written" or DAW, a prescription automatically will be filled with a generic drug.

SECTION 9.5 – RETAIL PHARMACY

For short-term prescription needs, the Enrollee can receive up to a 30-day supply of covered medication for one retail co-payment at a retail pharmacy.

SECTION 9.6 – PARTICIPATING RETAIL PHARMACIES

The Plan provides a national network of Participating retail pharmacies. When the Enrollee purchases covered prescription drugs from a Participating retail pharmacy, he or she should present a prescription order and ID card to the pharmacy and pay the retail co-payment. The Enrollee does not have to submit any paper claims to the PBM when using a Participating retail pharmacy.

SECTION 9.7 – NON-PARTICIPATING RETAIL PHARMACIES

When the Enrollee purchases covered prescription drugs from a non-participating retail pharmacy, the Enrollee must pay the full price (100%) of the prescription and obtain a prescription receipt that the Enrollee can submit to the PBM for reimbursement. The Enrollee will be reimbursed 75% of the Allowed Amount, after deducting the applicable retail co-payment. The Enrollee will be responsible for the difference in cost between the amount charged and the Allowed Amount, plus 25% of the Allowed Amount after deducting the applicable retail co-payment.

If prescription drugs must be purchased from a non-participating pharmacy because the Enrollee is away from home or due to an emergency, the Enrollee will still be required to pay the full charge and file the claim for reimbursement. However, the Enrollee will be reimbursed at 100% of the Allowed Amount for the generic or brand name drug as applicable, after the appropriate co-payment has been deducted.

Claims for prescription drugs purchased at a non-participating retail pharmacy must be submitted within one (1) year of the date dispensed to be eligible for coverage.

SECTION 9.8 – MAIL ORDER PHARMACY

Mail order allows the Enrollee to purchase up to a ninety (90) day supply of maintenance prescription drugs.

All mail order prescriptions are mailed directly to the Enrollees' home at no charge. To use the mail order pharmacy, the Enrollee must complete the PBM's prescription order form and mail it to the PBM along with the Physician's original prescription and the applicable co-payment.

SECTION 9.9 – MAINTENANCE DRUG LIST (MDL)

Maintenance drugs are certain drugs taken on an ongoing basis (three (3) months or more) such as those used to treat high blood pressure or high cholesterol. The Plan has established a list of maintenance drugs that are only covered when filled by mail order after limited initial dispensing.

MDL prescriptions filled at a Participating retail pharmacy will be limited to a thirty (30) day supply. The Plan will cover only the first three (3) prescription drug fills at the Enrollee's retail pharmacy (the initial fill and two (2) refills). On the fourth fill, the Enrollee must have the MDL prescription filled by mail order or pay the full cost of the drug at retail.

When the Enrollee begins taking a prescription drug on the MDL, the PBM will send a letter to the Enrollee describing the mail order process after the second retail fill.

Special rules may apply if the Enrollee resides in a long-term care or assisted living facility.

SECTION 9.10 – SPECIALTY PHARMACY

Specialty medications are injectable, infused, inhaled, or oral biological products with unique handling and or dosing requirements. Many of these medications are not available through the local retail pharmacy and all specialty medications should be available through a designated specialty pharmacy. In most situations, the specialty pharmacy will ship the Enrollee's drug and any required supplies the Enrollee needs for the Enrollee's injection directly to the Enrollee's home for the required co-payment. Specialty medications are limited to a thirty-day supply.

SECTION 9.11 – UTILIZATION MANAGEMENT

To promote safety and clinically appropriate care while maintaining costs, prescription drug coverage will be administered by the PBM. Certain prescriptions may be restricted in quantity or require step therapy/prior authorization. The following limitations and authorization rules will apply.

(a) Quantity Restrictions. Certain drugs have limits based on national standards and current scientific medical literature. These limits ensure the quantity of units supplied for each prescription remain consistent with clinical dosing guidelines and benefit plan design. Below is a brief description of the various quantity restriction programs:

(b) Dose Duration. Provides coverage for specific dosing over a specific period of time. A coverage review may be needed to continue coverage at a specific dose for a greater period of time.

(c) Quantity Duration. Provides coverage for a specific quantity of pills dispensed over a specific period of time.

(d) Dose Optimization/Tablet consolidation. Alerts Physicians and patients to opportunities to simplify dosing regimens, which can decrease the cost of care by reducing the number of dosage units dispensed, while still fully satisfying the therapeutic needs of the member and improving medication compliance. Tablet consolidation means the member takes one tablet of a higher strength tablet daily rather than two tablets of a lower strength (same total daily dose).

(e) Dispensing Quantity. Limits the quantity dispensed per prescription.

(f) Prior Authorization. Requires a review with the Physician to determine if the drug qualifies for coverage under the benefit. If the Enrollee and the Enrollee's Physician request a drug that requires a prior authorization, the Enrollee should contact the PBM.

(g) Step Therapy. Coverage of a specific drug under the benefit may be determined without a coverage review if information is available on the member's profile (claims, diagnosis information, age, sex). If this information is not available, a prior authorization is required to receive the medication.

SECTION 9.12 – EXCLUSIONS AND LIMITATIONS

In addition to the exclusions in Article X, Medical Exclusions, prescription drugs are subject to the following exclusions and limitations.

Prescription drug services, supplies, and medications not covered under the Plan include but are not limited to:

(a) Pharmaceuticals requiring a prescription that have not been approved by the U.S. Food and Drug Administration (FDA) or are not approved by the FDA for the condition, dose, route, and frequency for which they are prescribed (i.e., are used "off-label"), with two exceptions:

(1) Off-label use in accordance with the requirements of Medicare Part D and the definition of "Part D Drug"; and

(2) Off-label use as part of coverage for treatment of gender dysphoria. This exception does not extend to other reasons for drug exclusion, including no coverage for over-the-counter drugs or nutritional supplements.

(b) Drugs available over-the-counter without a prescription (insulin is covered);

(c) Drugs labeled "Caution: Limited by federal law to investigational use";

(d) Any drug being used for cosmetic purposes, even if it contains a Federal Legend Drug;

(e) Medical devices or appliances (needles, syringes, and diaphragms are covered);

(f) Charges for more refills than the Enrollee's Physician specifies or prescriptions filled more than one (1) year from the original date of the prescription;

(g) Diabetic supplies covered under Medicare Part B or the Enrollee's Carrier's Durable Medical Equipment (DME) Benefit (e.g., home blood glucose monitor, test strips);

(h) Drugs used for treatment of erectile dysfunction or inadequacy, except in prior authorized cases of pulmonary arterial hypertension;

(i) Drugs in the Proton Pump Inhibitor (PPI) class of drugs used to treat conditions such as heartburn, acid reflux (GERD), and ulcers; however, PPI drugs used to treat Barrett's Esophagitis and Zollinger-Ellison Syndrome may be covered with prior authorization; and

(j) Expenses other than those determined to be available under the Utilization Management program.

(k) Prescription drugs for smoking cessation are covered only in conjunction with a Carrier-approved smoking cessation program.

ARTICLE X — MEDICAL EXCLUSIONS

SECTION 10.1 – OVERVIEW

The following is a list of services and supplies or expenses not covered by the Plan. General Exclusions are listed first followed by specific medically related Plan exclusions. Enrollees in an HMO or a Medicare Advantage plan should consult the applicable insurance policy or contract about exclusions.

SECTION 10.2 – GENERAL EXCLUSIONS (APPLICABLE TO ALL MEDICAL SERVICES AND SUPPLIES)

(a) Autopsy: Expenses for an autopsy.

(b) Costs of Reports, Bills, etc.: Expenses for preparing medical reports/medical records, bills disability/sick leave claim forms; mailing, shipping or handling expenses; and charges for broken/missed appointments, telephone call, e-mailing charges, prescription refill charges, automotive forms/interest charges, late fees, mileage costs, Provider administration fees concierge/retainer agreement/membership fees and/or photocopying fees.

(c) Educational Services: Even if they are required because of an injury, illness or disability of a Covered Individual, the following expenses are not payable by the Plan: educational services, supplies or equipment, including, but not limited to computers, computer devices/software, printers, books, tutoring or interpreters, visual aids, vision therapy, auditory aids, speech aids/synthesizers, programs to assist with auditory perception or listening/learning skills, vision therapy, auditory or auxiliary aids such as communication boards, listening systems, device/programs/services for behavioral training including intensive intervention programs for behavior change and/or developmental delays or auditory perception or listening/learning skills, programs/services to remedy or enhance concentration, memory, motivation or self-esteem, etc., special education and associated cost in conjunction with sign language education for a patient or family members and implantable medical identification/tracking devices, even if they are required because of an Injury, Illness or Disability of an Enrollee. This exclusion does not apply to approved diabetes, cardiac rehabilitation, or smoking cessation education services.

(d) Employer-Provided Services: Expenses for services rendered through a medical department, clinic or similar facility provided or maintained by an employer, or if benefits are otherwise provided under this Plan or any other plan that an employer contributes to or otherwise sponsors.

(e) Expenses Exceeding Maximum Plan Benefits: Expenses that exceed any Plan benefit, including but not limited to the Annual Maximum Plan Benefits and Lifetime Maximum Plan Benefits, as described in the Medical Benefits Article.

(f) Expenses Exceeding Allowed Amount: Any portion of the expenses for covered medical services or supplies that are determined to exceed the Allowed Amount as defined in the Definitions Article.

(g) Expenses for which a Third Party is Responsible: Expenses for services or supplies for which a third party is required to pay.

(h) Expenses Incurred Before or After Coverage: Expenses for services rendered or supplies provided before the patient became covered under the Plan or after the date the patient's coverage ends.

(i) Experimental, Research, and/or Investigational Services: Expenses for any medical services, supplies, or drugs or medicines that are determined by the Carrier or the Plan to be Experimental, Research, and/or Investigational as defined in the Definitions Article of this document or by the applicable Carrier.

(j) Expenses for services available through other programs: Expenses for services to the extent benefits are payable: under any health care contract under the coordination of benefits provision of this Plan; under Medicare, if the Enrollee was or would have been eligible for Medicare benefits at the time of service had the Enrollee enrolled in Medicare as required by this Plan; and under any health care program supported in whole or in part by funds of the federal government or any state or political subdivision except where by law this Plan is made primary.

(k) Services not related to specific diagnosed illness/injury: Expenses for premarital examinations; pre-employment examinations; or for routine or periodic physical examinations unrelated to the existence of a previously diagnosed specific condition, disease, illness, or injury, except as specifically provided for in this Plan.

(l) Military Service Related Injury/Illness: If an eligible individual under this Plan receives services in a U.S. Department of Veterans Affairs Hospital or other military medical facility on account of a military service-related illness or injury, benefits are not payable by the Plan.

(m) Illegal Act: Expenses incurred by any Enrollee for injuries resulting from or sustained as a result of commission, or attempted commission by the Enrollee, of an illegal act that involves violence or the threat of violence to another person or in which a firearm, explosive or other weapon likely to cause physical harm or death is used by the Enrollee. If the injury or illness is the result of domestic violence or the commission or attempted commission of an assault or felony that is the direct result of an underlying health factor, then the exclusion will not apply.

(n) Medically Unnecessary Services: Physical exams, services, or supplies that are not Medically Necessary as defined in the Definitions Article of this document.

(o) Modifications of Homes or Vehicles: Expenses for construction or modification to a home, residence or vehicle required as a result of an Injury, Illness or Disability of an Enrollee, including, without limitation, construction or modification of ramps, elevators, chair lifts, swimming pools, spas, air conditioning, asbestos removal, air filtration, hand rails, emergency alert system, etc., except as specifically provided for in this Plan.

(p) No-Cost Services: Expenses for services rendered or supplies provided for which an Enrollee is not required to pay or which are obtained without cost, or for which there would be no charge if the person receiving the treatment were not covered under this Plan.

(q) Unreasonable Expenses: Expenses that are determined by the Carrier to be unreasonable.

(r) Expenses for services rendered or supplies provided that are not recommended or prescribed by a Physician, Provider, or other healthcare professional determined acceptable by the Carrier.

(s) Travel and Related Expenses: Expenses for and related to travel or transportation (including lodging and related expenses) of a Health care Provider, Enrollee or family member of an Enrollee, unless those expenses are payable pursuant to coverage for ambulance transportation services as defined in this Plan.

(t) Occupational Illness, Injury or Conditions Subject to Workers' Compensation: All expenses incurred by Enrollees arising out of or in the course of employment (including self-employment) if the Injury, Illness or condition is subject to coverage, in whole or in part, under any workers' compensation or occupational disease or similar law, or for which the employer makes a settlement payment. This applies even if the Enrollee was not covered by workers' compensation insurance, or if the Enrollee's rights under workers' compensation or occupational disease or similar law were waived or qualified.

(u) Personal Comfort Items: Expenses for patient convenience, including, but not limited to, care of family members while the Enrollee is confined to a Hospital or other Health Care Facility or to bed at home, guest meals, television, DVD/Compact disc (CD) and other similar devices, telephone, barber or beautician services, housecleaning or maintenance, shopping, birth announcements, photographs of new babies, etc.

(v) Private Room in a Hospital or Health care Facility: The use of a private room in a Hospital or other Health Care Facility, unless the use of a private room is Medically Necessary. If, for any reason, the Enrollee occupies accommodations that are less expensive than those covered by this Plan, the Enrollee is not entitled to payment of the difference in charges.

(w) Medical Students, Interns: Expenses for the services of a medical student, intern.

(x) Stand-by Physicians or Health Care Practitioners: Expenses for any Physician or other Health Care Provider who did not directly provide or supervise medical services to the patient, even if the Physician or Health Care Practitioner was available on a stand-by basis.

(y) Failure to Comply with Medically Appropriate Treatment: Expenses incurred by an Enrollee as a result of failure to comply with medically appropriate treatment, as determined by the Committee or its delegate.

(z) Leaving a Hospital Contrary to Medical Advice: Expenses incurred by an Enrollee as a result of leaving a Hospital or other health care facility against the medical advice of the attending Physician within 72 hours after admission.

(aa) Travel Contrary to Medical Advice: Expenses incurred by an Enrollee during travel if a Physician or other Health Care Provider has specifically advised against such travel because of the health condition of the Enrollee.

(bb) Telephone Calls: Expenses for any and all telephone calls between a Physician or other Health Care Provider and any patient, other Health Care Provider, Utilization Management company, or any representative of the Plan for any purpose whatsoever, including, without limitation: Communication with any representative of the Plan or its Utilization Management Company for any purpose related to the care or treatment of an Enrollee; consultation with any Health Care Provider regarding medical management or care of a patient; coordinating medical management of a new Health Care Provider regarding medical management or care of a patient; coordinating medical management of a new or established patient; coordinating services of several different health professionals working on different aspects of a patient's care; discussing test results; initiating therapy or a plan of care that can be handled by telephone; providing advice to a new or established patient; providing counseling to anxious or distraught patients or family members.

(cc) Internet/Virtual Office Visit: Expenses related to an online internet consultation with a Physician or other Health Care Practitioner, also called a virtual office visit/consultation, Physician-patient web service or Physician-patient e-mail service, including receipt of advice, treatment plan, prescription drugs, or medical supplies obtained from an online internet Out-of-Network Provider.

(dd) War or Similar Event: Expenses incurred as a result of an Injury or Illness due to any act of war, either declared or undeclared, war-like act, riot, insurrection, terrorist act, rebellion, or invasion, except as required by law.

(ee) Nuclear Energy: Expenses incurred for Injury or Sickness resulting from the release of nuclear energy.

(ff) Foreign Services: Expenses for services received outside the U.S., unless one of the following is true:

(1) Enrollee is seeking care for an urgent or emergent medical condition;

(2) Enrollee lives in the U.S. and the hospital outside of the U.S. is closer to the Enrollee's home than the nearest U.S. hospital that can treat the Enrollee's medical condition; or

(3) Enrollee is on board a ship within the territorial waters adjoining the U.S., but never when that ship is more than 6 hours distant from a U.S. port.

SECTION 10.3 – EXCLUSIONS APPLICABLE TO SPECIFIC MEDICAL SERVICES AND SUPPLIES

(a) Allergy/Alternative/Complementary Health Care Services Exclusions

(1) Allergy testing and treatment.

(2) Expenses for acupuncture and/or acupressure.

(3) Expenses for chelation therapy, except as may be Medically Necessary for treatment of acute arsenic, gold, mercury, or lead poisoning, and for diseases due to clearly demonstrated excess of copper or iron.

(4) Expenses for prayer, religious healing, or spiritual healing.

(5) Expenses for naturopathic, naprapathic, and/or homeopathic services or treatment/supplies.

(6) Expenses for Experimental, Research, and/or Investigational allergy treatments including but not limited to sublingual (under the tongue) drops/oral antigen, rhinophototherapy, repository emulsion therapy (a form of therapy where certain materials are placed inside the body to improve allergies).

(b) Behavioral Health Care Exclusions

For mental health care Providers, the following are Plan exclusions for all Providers in any treatment setting:

(1) Mental health services for mental retardation and mental deficiency. Exception: Certain services are covered when performed for evaluation or diagnosis.

(2) Treatment for mental conditions not classified as emotional or personality disorders.

(3) Services considered Experimental, Research, and/or Investigational in nature.

(4) Services performed for the purpose of research and not generally accepted by the medical profession.

(5) Educational therapy, defined as academic tutoring for children to relieve learning deficits and services intended solely to correct educational deficits, whether developmental or of organic origin. Educational deficits include congenital or developmental learning disturbances such as dyslexia, mathematics and reading defects, word blindness/deafness, and strephosymbolia. They also include speech disturbances, such as stammering, stuttering, cluttering, and lisping.

(6) The following services are considered tutorial in nature: staff training services and services primarily for the advancement of the academic and/or professional education or training of the Enrollee (regardless of the diagnosis or symptoms).

(7) Mental health services for mental disorders and illnesses that, according to generally accepted professional standards, are not amenable to favorable modifications. Exception: Certain services are covered when necessary to determine that such disorders and illness are not amenable to favorable modification.

(8) Psychological and laboratory tests billed when used for routine screening of normal range individuals, who are largely symptom free. Only those tests ordered

by a Physician and authorized by the Plan will be considered for reimbursement. The Physician should selectively order only those services that are determined to be necessary for each patient.

(9) Indirect services, such as supervision conferences that take place between the psychiatrist and primary therapist.

(10) Pre-marital counseling.

(11) Marriage counseling.

(12) Relaxation therapy.

(13) Weight reduction/control.

(14) Didactics (didactics benefits from a structured Intensive Outpatient Program (IOP) are covered).

(15) Services that are not yet generally accepted by the medical profession or for which there is no proven scientific validity.

(16) Treatment or counseling of patients with sexual dysfunction in the absence of an underlying emotional illness. The patient's record is expected to contain a history and physical examination to rule out any physiological cause and clearly establish the causal factor(s) as psychogenic. The partner may participate in treatment, but payment will be made only for the identified patient.

(17) L-Tryptophan – Exception: Treatment of diagnosed and documented nutritional deficiency states.

(18) Vitamins—Exception: Treatment of diagnosed and documented nutritional deficiency states.

(19) Consultation with a mental health professional for purposes of adjudication of marital or child support and custody cases.

(20) Environmental ecological treatments.

(21) Megavitamin or orthomolecular therapy.

(22) Transcendental meditation.

(23) Rolfing.

(24) Z Therapy.

(25) EST (Erhard).

(26) Primal therapy.

(27) Bioenergetic therapy.

(28) Carbon dioxide therapy.

(29) Guided imagery.

(30) Biofeedback.

(31) Sedative action electro stimulation therapy.

(32) Aversion therapy.

(33) Confrontation therapy.

(34) Hypobaric or normobaric oxygen therapy.

(35) Narcotherapy with LSD.

(36) Hemodialysis for schizophrenia.

(37) Training analysis (tutorial, orthodox).

(38) Sensitivity training.

(39) Crystal healing treatment.

(40) Poetry/art/music therapy.

(41) Court ordered treatment.

(42) Missed appointments.

(43) Eye Movement Desensitization Therapy (EMD).

(44) Services provided at non-approved sites.

(45) Services provided in excess of the benefit parameters.

(46) Services not ordered by the Physician.

(47) Services not meeting the Medical Necessity criteria.

(48) Any therapy that is not conducted in a face-to-face setting.

(49) Routine psychological testing of individuals who are largely symptom free.

(50) Gambling addiction.

(c) For substance abuse Providers, the following are Plan exclusions for Providers in any treatment setting:

(1) Services provided at non-approved sites.

(2) Services provided in excess of the benefit parameters.

(3) Treatment for conditions not classified as substance abuse.

(4) Services not ordered by the Physician.

(5) Services not meeting Medical Necessity criteria.

(6) Routine psychological testing of individuals who are largely symptom free.

(7) Any therapy that is not conducted in a face-to-face setting.

(8) Methadone treatment.

(9) Missed Appointments.

(10) Psychological testing only after patient is symptom free from substance abuse for 14 days.

(d) Chiropractic Services

Chiropractic services for spinal manipulation or spinal adjustments are excluded. Chiropractic services are not covered for diagnostic x-rays unrelated to the spine, emergency first aid services unrelated to the spine, Medical Emergency services, office visits, manual manipulation of the spine not performed under general anesthesia, laboratory or pathology services.

(e) Corrective Appliances, Durable Medical Equipment, and Non-durable Supplies Exclusions

(1) Expenses for any items that are not Corrective Appliances, Prosthetic and Orthotic Appliances or Durable Medical Equipment including, but not limited to, air purifiers, swimming pools, spas, saunas, escalators, motorized modes of transportation, pillows, mattresses, water beds and air conditioners.

(2) For these purposes, expenses for replacement of lost, missing, or stolen, duplicate or personalized Corrective Appliances, Prosthetic and Orthotic Appliances or Durable Medical Equipment.

(3) Expenses for Corrective Appliances and Durable Medical Equipment to the extent they exceed the cost of standard models of such appliances or equipment, unless determined to be Medically Necessary.

(4) Expenses for occupational therapy, Orthotic Devices and supplies needed to assist a person in performing activities of daily living, including self-help devices such as feeding utensils, reaching tools and devices to assist in dressing an undressing.

(5) Expenses for Non-durable Supplies, except as payable under Non-durable Supplies in the Schedule of Medical Benefits.

(f) Cosmetic Services Exclusions

(1) Surgery or medical treatment to improve or preserve physical appearance, but not physical function. Cosmetic surgery or treatment includes, but is not limited to removal of tattoos, breast augmentation/breast reduction, elimination of redundant skin of the abdomen, surgery to improve self-esteem or treat psychological symptoms or psychosocial complaints related to one's appearance, treatment of varicose veins or other medical or surgical treatment intended to restore or improve physical appearance. This does not include those services covered under the treatment for gender dysphoria under the policy of this Plan.

(2) Enrollees may be required to use a Pre-certification procedure to determine if a proposed surgery or service will be considered cosmetic surgery or Medically Necessary Reconstructive Services.

(g) Custodial or Domiciliary Care Exclusion

Expenses for Custodial or Domiciliary Care, as defined in this Plan Document, regardless of where they are provided, including, without limitation, domiciliary, custodial, convalescent, nursing home, rest care, adult day care, child day care, services of a homemaker, personal care attendant, sitter/companion service.

(h) Dental Services Exclusions (See Dental Benefit for covered services and supplies.)

(1) Expenses for dental services or dental prosthetics or supplies of any kind, even if they are necessary because of symptoms, congenital anomaly, Illness or Injury affecting the mouth or another part of the body.

(2) Expenses for the diagnosis, treatment or prevention of, or for orthognathic services/surgery for treatment of jaw joint or jaw hinge problems, including related masticatory problems, prognathism, retrognathism, and Temporomandibular Joint (TMJ) Dysfunction or Syndrome.

(3) Expenses for oral surgery to remove teeth including wisdom teeth, gingivectomies, treatment of dental abscesses, and root canal (endodontic) therapy.

(i) Diagnostic Radiology

Diagnostic radiology is not covered if it is not predetermined where required, if it is not performed in an approved Hospital or facility, or if it is determined to be Experimental, Research, and/or Investigational or by the Carrier. Diagnostic imaging procedures are not covered if they are not approved by the Carrier or are not supported as standard diagnostic imaging by the accepted scientific medical literature.

(j) Drugs, Medicines and Nutrition Exclusions (such as are available from the Prescription Drug Benefit)

(1) Pharmaceuticals requiring a prescription that have not been approved by the U.S. Food and Drug Administration (FDA); or are not approved by the FDA for the condition, dose, route and frequency for which they are prescribed (i.e., are used "off-label"), with two exceptions:

(i) Off-label use in accordance with the requirements of Medicare Part D and the definition of "Part D Drug;" and

(ii) Off-label use as part of coverage for treatment of gender dysphoria. This exception does not extend to other reasons for drug exclusion, including no coverage for over-the-counter drugs or nutritional supplements.

(2) Non-prescription (or non-legend or over-the-counter) drugs or medicines, except insulin.

(3) Drugs requiring a prescription by state law, but not by federal law, are not covered.

(4) Foods and nutritional supplements including, but not limited to, home meals, formulas, foods, diets, vitamins, herbs and minerals (whether they can be purchased over-the-counter or require a prescription), except foods and nutritional supplements provided during covered Hospitalization, and except for prenatal vitamins or minerals requiring a prescription and used for treatment or prevention of a documented medical condition.

(5) Naturopathic, naprapathic, or homeopathic services and substances.

(6) Drugs to enhance athletic performance such as anabolic steroids;

(7) Dental products such as fluoride preparations and products for periodontal disease (such may be covered under the Dental Benefit);

(8) Sexual/erectile dysfunction or inadequacy;

(9) Cosmetic skin treatment products (except Retin-A and Accutane, which are payable to age 26 when Medically Necessary);

(10) Vitamins, except prenatal vitamins;

(11) Weight control or anorexiants (e.g., Meridia, Xenical);

(12) Compounded prescriptions in which there is not at least one ingredient that is a legend drug requiring a prescription as defined by federal or state law;

(13) Take-home drugs or medicines provided by a Hospital, emergency room, Ambulatory Surgical Facility/Center, Health Care Practitioner's office or other Health Care Facility;

(14) Vaccinations, immunizations, inoculations or preventative injections, except those provided under adult or pediatric benefits provided under the Plan and those required for treatment of an Injury or exposure to disease or infection (such as anti-rabies, tetanus, anti-venom, or immunoglobulin).

(k) Fertility and Infertility Services Exclusions

(1) Expenses for artificial insemination or in vitro fertilization or similar procedures are excluded for non-Spouse Dependents.

(2) Expenses for surrogate parenting, cryostorage of eggs or sperm, adoption, infertility donor expenses, fetal implants, reversal of sterilization procedures, and fetal reduction services are excluded.

(3) Prenatal services, maternity services and prescription drug services related to a pregnancy incurred by a covered person acting as a surrogate mother (gestational Carrier) are not covered charges. For the purpose of this Plan, the child of a surrogate mother will not be considered a Dependent of the surrogate mother or her spouse, if the mother has entered into a contract or other understanding pursuant to which she relinquishes the child following its birth.

(l) Foot/Hand Care Exclusions

Expenses for routine foot care (including, but not limited to, trimming of toenails, removal or reduction of corns and calluses, removal of thick/cracked skin on heels, foot massage, preventive care with assessment of pulses, skin condition and sensation), or hand care including manicure and skin conditioning. Routine foot care from a podiatrist may be covered for individuals with diabetes or a neurological or vascular insufficiency affecting the feet.

(m) Genetic Counseling Exclusions

Expenses for genetic counseling, except when associated with a covered genetic test.

(n) Hair Exclusions

Expenses for and related to hair removal or hair transplants and other procedures to replace lost hair or to promote the growth of hair, including prescription and non-prescription drugs such as Minoxidil, Propecia, Rogaine, Vaniqa; or expenses for and related to hair replacement including, but not limited to, devices, wigs, toupees and/or hairpieces or hair analysis, except for wigs and related supplies for Enrollees who are suffering hair loss from the effects of chemotherapy, radiation or other treatments for cancer.

(o) Hearing Care Exclusions

(1) Expenses for and related to the purchase, servicing, fitting and/or repair of hearing aid devices, including implantable hearing devices, except for Medically Necessary cochlear implants and as provided under the Plan's Hearing Aid Benefit.

(2) Special education and associated costs in conjunction with sign language education for a patient or family members.

(p) Home Health Care Exclusions

(1) Expenses for any Home Health Care Agency services other than part-time, intermittent Skilled Nursing Services and supplies, except when the services of

home health aides are payable under Home Health Care services under this Plan Document.

(2) Expenses under a Home Health Care Agency program for services that are provided by someone who ordinarily lives in the patient's home or is a parent, spouse, sibling (by birth or marriage, such as a brother-in-law), aunt/uncle, or child of the patient or Retiree or when the patient is not under the continuing care of a Physician.

(3) Expenses for a homemaker, Custodial Care, child care, adult care or personal care attendant, except as provided under the Plan's Hospice coverage, and when Custodial Care is provided by home health aides that are payable under Home Health Care services.

(4) Expenses for transportation to or from a place outside the Enrollee's home to receive a Home Health Care service.

(q) Home Hemodialysis

(1) Services and products not supplied by a Participating Hospital;

(2) Services provided by family members or other individuals trained and assisting in the dialysis procedure;

(3) Training of individuals by other than Participating Providers;

(4) Charges for electricity or water used in the operation or maintenance of the dialysis machine;

(5) Physicians' services for direct patient care;

(6) After the initial installation, any subsequent costs incurred in moving the dialyzer to another location within the Enrollee's place of residence;

(7) Expenses incurred in the installation of a dialysis machine which are not essential to its operation; or

(8) Services provided by an agency or organization providing "back up" assistance in home Hemodialysis, including the services of Hospital personnel sent to the Enrollee's home, or for other persons under contract with the Participating Hospital.

(r) Maternity/Family Planning/Contraceptive Exclusions

(1) Contraception: Expenses for non-prescription contraceptives, such as condoms, are excluded. Expenses are also excluded unless they are obtained through the Prescription Drug Benefit Plan.

(2) Benefits are payable for therapeutic abortions when performed by a Physician on a Hospital inpatient or outpatient basis. Such service must be legal in the state where rendered and provided in an approved Hospital consistent with the

Hospital's rules and regulations. Voluntary (i.e., non-therapeutic) abortions are not covered.

Medically induced abortion by oral ingestion of medication (Mifeprex or Mifepristone) is covered for services rendered in the office location for the termination of an intrauterine pregnancy

(3) Expenses for childbirth education, Lamaze classes, breast feeding classes.

(4) Expenses related to the maternity care and delivery expenses associated with a pregnant Dependent child.

(5) Expenses related to cryostorage of umbilical cord blood or other tissue or organs.

(6) Reversal of voluntary sterilization

(7) Infertility services for non-Spouse Dependents.

(s) Nursing Care Exclusions

Expenses for services of private duty nurses are excluded. Private duty nursing means nursing care that is privately contracted by, or on behalf of, an Enrollee with a nurse, or agency, independent of this Plan.

(t) Professional Services

Professional services of Hospital staff or employees, including but not limited to services of interns, residents, Physicians in training, nursing services, Physician Assistants, and stand-by Physicians.

(u) Prophylactic Surgery or Treatment Exclusions

Expenses for all medical or surgical services or procedures, including prescription drugs and the use of prophylactic surgery when the services, procedures, prescription of drugs or prophylactic surgery is prescribed or performed for the purpose of (1) avoiding the possibility of risk of an Illness, disease, physical or mental disorder or condition based on family history and/or genetic test results; or (2) treating the consequences of chromosomal abnormalities or genetically transmitted characteristics, when there is an absence of objective medical evidence of the presence of disease or physical or mental disorder, except in the case of prophylactic mastectomies, or when the services or procedures are based on the results of amniocentesis, chorionic villus sampling (CVS), or alphafetoprotein (AFP) analysis.

(v) Rehabilitation Therapy Services Exclusions (Inpatient or Outpatient)

(1) Expenses for educational, job training, vocational rehabilitation, and/or special education for sign language.

(2) Expenses for massage therapy, Rolfing, and related services.

(3) Expenses incurred at an inpatient rehabilitation facility for any inpatient Rehabilitation Therapy Services provided to an individual who is unconscious, comatose, or is otherwise incapable of conscious participation in the therapy services and/or unable to learn and/or remember what is taught, including, but not limited to, cognitive rehabilitation, coma stimulation programs and services.

(4) Expenses for Maintenance Rehabilitation.

(5) Expenses for speech therapy for functional purposes including, but not limited to, stuttering, stammering, and conditions believed to be of psychoneurotic origin or for childhood developmental speech delays and disorders.

(6) Expenses for treatment of delays in childhood speech development unless as a direct result of an injury, surgery or the result of a covered treatment.

(7) Expenses for prolotherapy (injection of sclerosing solutions into joints, muscles, or ligaments).

(w) Sexual/Erectile Dysfunction Services Exclusions

Treatment of Sexual/Erectile Dysfunction: Expenses for prescription drugs (e.g., Viagra) for treatment of sexual/erectile dysfunction or inadequacy, except in prior authorized cases of pulmonary arterial hypertension.

(x) Smoking Cessation or Tobacco Withdrawal Exclusions

(1) Expenses for tobacco/smoking cessation products such as nicotine gum or patches, and

(2) Expenses for over-the-counter tobacco/smoking cessation products, even if prescribed by a Physician.

(y) Vision Care Exclusions (See Vision Benefit for covered services and supplies.)

(1) Routine vision care services and supplies.

(2) Expenses for surgical correction of refractive errors and refractive keratoplasty procedures including, but not limited to, Radial Keratotomy (RK) and Automated Lamellar Keratoplasty (ALK), or Laser In Situ Keratomileusis (LASIK), or implantable contact lenses (ICL).

(3) Vision therapy (orthoptics) and supplies.

(z) Wax Removal

Removal of wax from the ear is excluded.

(aa) Weight Management and Physical Fitness Exclusions

(1) Expenses for memberships in or visits to health clubs, exercise programs, gymnasiums and /or any other facility for physical fitness programs, including exercise equipment.

(2) Expenses for medical or surgical treatment of severe underweight, including, but not limited to high calorie and/or high protein food supplements or other food or nutritional supplements, except in conjunction with Medically Necessary treatment of anorexia, bulimia, or acute starvation. Severe underweight means a weight more than 25 percent under normal body weight for the patient's age, sex, height, and body frame based on weight tables generally used by Physicians to determine normal body weight.

ARTICLE XI — COORDINATION OF BENEFITS

SECTION 11.1 – GENERAL

Coordination of Benefits (COB) is a means of apportioning and prioritizing liability for payment of health care claims when more than one health care plan is involved.

This Plan will not pay benefits to or on behalf of an Enrollee if similar or duplicate coverage is available to the Enrollee from, or payable by, other sources (e.g., health plans, comprehensive programs, pre-paid programs, and governmental programs). Such other sources and the Enrollee are liable to this Plan for any sums paid by this Plan for benefits if similar or duplicate benefits are or were available from or payable by the other sources. This Plan has established systems and procedures for coordinating its benefits with benefits from other sources (hereinafter referred to as "COB").

SECTION 11.2 – APPLICABILITY

These COB provisions apply to all benefits provided under this Plan, except where precluded by law.

SECTION 11.3 – ENROLLEE OBLIGATIONS

Primary Enrollees must furnish to this Plan the Social Security Numbers of all Dependents. If the Dependent has not been assigned a Social Security Number at the time of the enrollment, a Social Security Number must be obtained promptly and reported to this Plan. Failure to do so may result in cancellation of coverage for such Enrollee.

Any Enrollee claiming benefits under this Plan must furnish the Carrier any information necessary for the purpose of administering these provisions.

SECTION 11.4 – RELEASE OF INFORMATION

This Plan or Carriers may release to other entities information necessary to administer claims under these provisions. Furthermore, this Plan or Carriers may obtain facts necessary to determine priority under this COB provision without consent of any person and may require information from Enrollees as a condition of payment hereunder.

This Plan or Carriers may participate in organizations that are established to facilitate the COB process and may exchange information relating to Enrollees for such purposes. Such organizations must agree not to release any information obtained, other than for the purpose of effectuating COB.

SECTION 11.5 – ORDER OF BENEFIT PAYMENT

The plan having the first obligation to pay benefits is termed the "primary plan" and the benefits such plan provides are "primary."

The plans or sources that pay benefits after the primary plan are termed the "secondary plan(s)," and the benefits such plans provide are "secondary." The term "other plan" is any other plan or source of payment except this Plan.

(a) When the other plan does not contain a COB provision, that other plan is always primary.

(b) When the other plan contains a COB provision, the following order of benefit determination applies:

(1) The plan covering the Enrollee as an employee or retiree is primary over the plan covering the Enrollee as a dependent.

(2) If the Enrollee is retired or disabled and covered under Medicare and also covered as a dependent of a Spouse who is an active employee, the active employee's health plan is primary.

(3) If one plan covers the Enrollee as an active employee and the other covers the Enrollee as a laid-off or retired employee, the plan covering the Enrollee as an active employee is primary.

(4) When an Enrollee is a dependent child whose parents are not divorced or separated, the plan covering the Enrollee as a dependent of the parent whose birthday occurs earlier in the calendar year is primary over the plan covering the Enrollee as a dependent of the parent whose birthday occurs later in the calendar year. If the two parents' birthdays fall on the same day, the plan that has covered the parent for the longer period of time is primary.

(5) When an Enrollee is a dependent child whose parents are divorced or separated, and there is a court order or custody agreement establishing financial responsibility with respect to health care expenses of the child, the plan that covers the child as a dependent of the parent with such responsibility is primary. If there is no court decree or State agency order, the order of benefit coordination shall be: (1) The plan of the parent with custody; then (2) The plan of the stepparent with custody; then (3) The plan of the parent without custody then (4) The plan of the stepparent without custody. If primary determination cannot be made by Court Order or Custody Agreement, the birth year rule referred to above will apply.

(6) If there is a court decree or State agency order (such as a Qualified Medical Child Support Order) that established financial responsibility for medical expenses, the plan covering the parent who has that legal responsibility shall be primary.

(c) When the above sections do not establish an order of benefit determination, the plan that has covered the Enrollee for the longer period of time is primary. This Plan is effective January 1, 2010, and no coverage under any predecessor plan counts toward coverage under this Plan.

SECTION 11.6 – PAYMENT OF BENEFITS

If this Plan is primary, then the provisions of this Plan determine this Plan's liability regardless of any provisions of the other plan.

If this Plan is primary, it may reimburse a secondary plan for any amounts paid which should have been provided by this Plan.

If this Plan is overpaid by the other plan for any claim involving COB, the other plan shall have the right to recover such overpayment. In the event an Enrollee incurs an overpayment, this Plan may recover such overpayment from benefits for purposes of collecting all or part of the overpayment. The Enrollee's participation in this Plan serves as the participant's deduction authorization.

With regard to any claim for which this Plan has secondary liability, benefits provided under this Plan shall not exceed the amount of benefits payable if this Plan had been primary.

If the other plan provides benefits in the form of services rather than reimbursement, this Plan may recover the reasonable cash value of services from the other plan in connection with the collection of an overpayment by this Plan.

"Benefits paid or payable" under another plan, include the benefits that would have been payable had a claim been made under the primary plan, or which would have been payable by the primary plan but for the Enrollee's failure to comply with the rules of such plan will not be paid by this Plan when this Plan is the secondary plan.

SECTION 11.7 – PLAN IS SECONDARY

Sanctions provided under this Plan (e.g., for failure to obtain predetermination, failure to obtain a required second opinion, failure to obtain services from a panel Provider, etc.) will not apply.

Payment will be made only to the level that would have been paid by this Plan had it been primary, and in no event shall payments be greater than this Plan's Allowed Amount or the allowed amount of the primary plan. Deductibles and co-payments will be included in coordination of benefit calculation.

No payment will be made for services that are not covered under this Plan.

SECTION 11.8 – FACILITY OF PAYMENT

Whenever payments that should have been made under this Plan in accordance with this provision have been made under any other plans, the Plan will have the right to pay over to any organizations making such other payments any amounts it shall determine necessary to satisfy the intent of this provision, and amounts so paid will be deemed to be benefits paid under this Plan and, to the extent of such payments, the Fund will be fully discharged from liability under this Plan.

SECTION 11.9 – RIGHT OF RECOVERY

If the amount of the payments made by this Plan is more than it should have paid under the Coordination of Benefits provision, this Plan may recover the excess from one or more of the persons it has paid or for whom it has paid, including insurance companies, or other plans or organizations. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

SECTION 11.10 – COORDINATION WITH OTHER INSURANCE POLICIES

This Plan will coordinate coverage with other insurance policies, including group or individual automobile, homeowner's or premises insurance, personal injury protection, or no-fault coverage, including medical payments. Other insurance policies will be primary. This Plan will not pay more than this Plan's Allowed Amount. Deductibles and Co-payments will be included in coordination of benefit calculation.

SECTION 11.11 – COORDINATION OF BENEFITS WITH MEDICAID

If the Enrollee is covered by both this Plan and Medicaid, this Plan pays first and Medicaid pays second.

SECTION 11.12 – COORDINATION OF BENEFITS WITH MEDICARE

If an Enrollee is eligible for or enrolled in Medicare, and, if present in the U.S., present lawfully, Medicare will be the primary payer of health care expenses and the Plan will be the secondary payer as described in this Section 11.12 and Section 12.3, "Effect of Medicare." Regardless of whether or not an Enrollee is enrolled in Medicare Part B, benefits will be limited to an amount equal to the secondary balance payment that would have been paid if, on the date of services, the Enrollee was enrolled in Medicare Part B and received services from a Provider that participates in Medicare.

If a Dependent has coverage as an active employee or non-Medicare retiree, the health plan covering the Dependent is the primary payer of eligible health care expenses, and the Plan would be the secondary payer. If a Dependent has Medicare coverage and also has coverage as an active employee, the Dependent's health plan would be the primary payer of eligible health care expenses, Medicare coverage would be the secondary payer, and the Plan would be the third payer.

If a Dependent has Medicare coverage and also has his/her own coverage as a retiree, Medicare would be the primary payer of eligible health care expenses, the Dependent's health plan would be the secondary payer, and the Plan would be the third payer. If a Dependent has Medicare coverage and has no other group health coverage, Medicare will be the primary payer of eligible health care expenses, and the Plan will be the secondary payer.

ARTICLE XII — EFFECT OF MEDICARE

SECTION 12.1 – GENERAL

The benefits payable to an eligible Retiree or Dependent under this Plan will be reduced to the extent necessary so that the sum of the benefits payable under this Plan and the amounts paid under Medicare Part A, Part B, and Part C will not exceed the total Allowed Amount payable. Enrollees who are eligible to enroll in Part A or B of Medicare, whether or not they are enrolled, will have all coverage available under this Plan reduced to the extent payment or benefit is available (or would have been available had the eligible Enrollee been enrolled for Medicare benefits) under Part A or B of Medicare. An Enrollee who is a surviving Spouse or surviving same-sex domestic partner who turns age sixty-five (65) must enroll in Medicare Part B when first eligible or such Enrollee will not be eligible for coverage under the Plan.

SECTION 12.2 – MEDICARE BENEFITS

Medicare is a federal health care program for individuals age 65 or older, and for certain individuals under age 65 who have a severe long-term disability, end-stage renal disease (ESRD), or undergo a kidney transplant.

If the Enrollee is not receiving Social Security already, it is the Enrollee's responsibility to contact the local Social Security Administration office to apply for Medicare when the Enrollee reaches age sixty-five (65). The Social Security Administration suggests that the Enrollee contact them at least three months before the Enrollee reaches age 65. This will allow sufficient time to process the Enrollee's application so that the Enrollee will not miss the Enrollee's initial opportunity for enrollment. If the Enrollee does not enroll for Medicare Part A and Part B when first eligible, a financial penalty will apply, increasing the monthly Medicare Part A and Part B premium the Enrollee pays.

Pursuant to Medicare laws, Medicare will only pay for Medicare services for individuals present in the U.S. that are U.S. citizens or in the U.S. lawfully.

Individuals under age sixty-five (65) who are entitled to disability benefits under the Social Security or Railroad Retirement Acts for at least twenty-four (24) consecutive months also are entitled to Medicare Parts A and B. Coverage begins on the first day of the 25th month of entitlement to disability benefits and terminates at the end of the month following the month in which the Social Security Administration provides notice of termination of disability benefits.

Medicare Advantage (MA) plans are health plan options approved by the Centers for Medicare and Medicaid Services (CMS) and administered by private companies. MA plans provide all Medicare Part A (hospital) and Part B (medical) benefits and cover all services covered under the original Medicare plan and may provide Medicare Part D (prescription drug) benefits. However, MA plans may each include different deductibles, co-payments, and co-insurance. In addition, MA plans may offer benefits not provided under the regular Medicare plan (such as dental, vision and hearing benefits). Most MA plans have Provider networks, so the Enrollee may be required to see specific Physicians and use specific Hospitals. Individuals present in the U.S., but not present lawfully will be disenrolled from any MA plans.

Medicare Part D Prescription Drug Coverage under the Trust's Plan is prescription drug coverage that has been approved by the Centers for Medicare and Medicaid Services (CMS) and is administered by a private company. Medicare Part D Prescription Drug Coverage under the Trust's Plan is governed by CMS guidance and other documents related to the Medicare Part D Prescription Drug Coverage under the Trust's Plan, except to the extent superseded by Plan terms. Individuals present in the U.S., but not present lawfully will be disenrolled from any Medicare Part D plans.

SECTION 12.3 – EFFECT OF MEDICARE

All Enrollees first eligible to enroll in Part A of Medicare after January 1, 2017, must enroll in Part A or he/she will no longer be eligible for enrollment in the Plan. The Hospital coverage under this Plan will be reduced during the additional Medicare sixty (60) day lifetime maximum for inpatient Hospital benefits, to the extent the benefits are available under Medicare whether or not the Enrollee utilizes the lifetime reserve.

Enrollees who are enrolled for benefits under Part B of Medicare will have all coverage available under this Plan reduced to the extent that payment or benefit is available under Part B of Medicare. Enrollees who are eligible to enroll in Part B of Medicare, whether or not they are enrolled, will have all coverage available under this Plan reduced to the extent payment or benefit is available (or would have been available had the eligible Enrollee been enrolled for Medicare benefits) under Part B of Medicare.

Further, except in the case where the Enrollee does not have the ability to control or select a Provider who accepts Medicare assignment, any additional amounts incurred over the Medicare allowed amount will be considered a non-covered expense under the Plan. Such additional amounts will be the Enrollee's responsibility and will not count toward any Enrollee cost-sharing provisions of the Plan.

All benefits furnished under Medicare Part A, or which would have been furnished had the Enrollee been enrolled for Medicare Part A benefits, and all benefits furnished under Medicare Part B will be charged against the maximum benefit periods and maximum benefit amounts under this Plan. Reduction of coverage under this provision or charging of Medicare benefits against the maximum benefit periods and maximum benefit amounts of this Plan will be limited to the benefits provided by Medicare, which would have been provided under this Plan in the absence of this subsection.

The Plan provides outpatient prescription drug coverage to Retirees and Dependents who are eligible for Medicare. The Plan provides Medicare Part D Prescription Drug Coverage to Retirees and Dependents who are eligible for Medicare. If a Medicare-eligible Enrollee opts out of Medicare Part D Prescription Drug Coverage under the Trust's Plan, he will not have any prescription drug coverage under the Plan (unless he has prescription drug coverage under a Medicare Advantage Prescription Drug (MAPD) Plan Option). An Enrollee who is eligible for Part D and elect to enroll in it outside of the Plan will be disenrolled from that Part D coverage, unless he opts out of the Medicare Part D Prescription Drug Coverage under the Trust's Plan.

SECTION 12.4 – MANDATORY MEDICARE ENROLLMENT FOR SURVIVING SPOUSES/SURVIVING SAME-SEX DOMESTIC PARTNERS

An eligible surviving Spouse or surviving same-sex domestic partner who turns age 65 must enroll in Medicare Part A (if first eligible or entitled after January 1, 2017) and Part B when first eligible.

If a Spouse or same-sex domestic partner is age sixty-five (65) or older, and does not have Medicare Part B when the Retiree dies, he or she will not be eligible for coverage under the Plans. When the Spouse or same-sex domestic partner provides evidence of enrollment in Medicare Part B, coverage will be available subject to applicable Contributions and to the terms of Article III of the Plan.

ARTICLE XIII — SUBROGATION

TRADITIONAL CARE NETWORK (TCN) AND PREFERRED PROVIDER ORGANIZATION (PPO) NETWORK ONLY

SECTION 13.1 – PLAN'S RIGHT TO SUBROGATION AND REIMBURSEMENT

If benefits are paid under the Plan and another party's action or inaction was responsible for the Enrollee or the Enrollee's Dependents having incurred the expenses, the Plan is entitled to be subrogated to all of the Enrollee's, the Enrollee's estate's, or the Enrollee's Dependents' rights to recover damages for such benefits (e.g., automobile accidents that cause medical expenses to be incurred). In that way, financial liability remains where it belongs – with the party responsible for incurring the expenses – while the Plan's costs are reduced.

In addition, the Plan has a right of reimbursement from any recovery by judgment, settlement, or otherwise, which the Enrollee, the Enrollee's estate, or the Enrollee's Dependents may receive or be entitled to receive from any source, including but not limited to, liability or other insurance covering the third party, uninsured or underinsured motorist insurance, medical payment or personal injury protection insurance, and no-fault insurance, and direct recoveries from liable parties.

If the Enrollee or the Enrollee's Dependents are involved in such a situation, the Enrollee is required to provide the Plan with whatever assistance is necessary to recover payments made on behalf of the Plan, including providing information regarding the event and cooperating with the Plan. The Plan may require that the Enrollee or the Enrollee's attorney or other representative must execute an agreement to hold any sums collected in a Plan or escrow account pending agreement with the Plan or its agent, or until distribution is ordered by a court of competent jurisdiction. The Enrollee and the Enrollee's attorneys and representatives may not prejudice the Plan's rights.

If the Enrollee or the Enrollee's Dependents receive payment for medical expenses, the Enrollee will be required to reimburse the Plan. The Plan shall have a first priority lien on any recovery from a third party. This lien is binding on any attorney, insurance company, or other party who agrees or is obligated to make payment to the Enrollee or the Enrollee's Dependents as compensation for any damages. The lien exists at the time the Plan pays medical benefits. If the Enrollee or the Enrollee's Dependent files a petition for bankruptcy, the Enrollee or the Enrollee's Dependent agrees that the Plan's lien existed in time prior to the creation of the bankruptcy estate.

The Plan's rights to subrogation and reimbursement shall not be reduced by any reason, including but not limited to the made-whole doctrine, the common fund doctrine, acquiescence, duress, estoppel, frustration of purpose, impossibility, impracticability, laches, unclean hands, unconscionability, undue influence, or waiver. The Plan must be repaid in full regardless of whether the settlement or judgment specifically designates the recovery or a portion of it as including medical expenses. The Plan will not reduce its recovery from any award or settlement for the Enrollee's attorney fees or costs associated with the Enrollee's action or lawsuit without the express written authorization of the Plan.

If the Enrollee fails to repay the Plan, the Plan may offset future benefit payments by withholding payments until the entire amount due is reimbursed.

If the Enrollee is enrolled in an HMO or Medicare Advantage plan, this Article does not apply, and the subrogation and reimbursement rules are provided under the applicable insurance policy or contract.

ARTICLE XIV — CLAIMS AND APPEALS PROCEDURES

SECTION 14.1 – INSURED BENEFIT CLAIMS AND APPEALS

Claims for insured benefits (i.e., claims involving an HMO, Medicare Advantage, or other plan option) will be decided by the applicable Carrier. Claims for Medicare Part D Prescription Drug Coverage will be decided pursuant to guidance issued by the Centers for Medicare and Medicaid Services (CMS) and other documents related to the Medicare Part D Prescription Drug Coverage under the Trust's Plan, except to the extent superseded by this Plan. Claims for Medicare Part D Prescription Drug Coverage under the Trust's Plan may not be submitted for review under the Voluntary Appeal Process described in Section 14.8 of the Plan._To the extent of its responsibility to make determinations on claims for benefits, including the review of adverse benefit determinations, the Carrier has full authority to interpret and apply, in its discretion, the terms of the Plan, including ambiguous terms. The decision of the Carrier is final and binding. Claims and appeals procedures for insured benefits are as set forth in materials provided by the applicable Carrier. The remainder of this Article addresses claims and appeals for self-funded benefits, eligibility determinations, and other special benefit claims.

SECTION 14.2 – SELF-FUNDED BENEFIT CLAIMS, ELIGIBILITY DETERMINATIONS, AND OTHER SPECIAL BENEFIT CLAIMS AND APPEALS – IN GENERAL

(a) Claims for self-funded benefits (i.e., claims for services under the TCN or PPO plan options and the prescription drug benefit), eligibility determinations, and other special benefit claims will be decided by the Committee, the applicable Carrier, or other delegate. To the extent of its responsibility to make determinations on claims for benefits, including the review of adverse benefit determinations or adverse eligibility determinations, the Committee, the applicable Carrier, or other delegate has full authority to interpret and apply, in its discretion, the terms of the Plan, including ambiguous terms. The decision of such body is final and binding.

(b) "Days" Defined: For the purpose of the initial and appeal claims processes, "days" refers to calendar days, not business days.

(c) Determinations made under that discretionary authority will be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

(d) The claims and appeals process shall afford a full, fair, and timely claim review.

(e) The Plan shall take steps to assure that Plan provisions are applied consistently with respect to similarly situated covered persons.

(f) The Committee, the applicable Carrier, or other delegate shall consult with a health care professional with appropriate training and experience when reviewing a denial of benefits or any adverse benefit determination that is based in whole or in part on a medical judgment (such as a determination that a service is not Medically Necessary or is Experimental, Research, and/or Investigational).

SECTION 14.3 – CLAIMS PROCEDURES

The claims procedures in this subsection will apply to claims for any benefit.

(a) Definition of a Claim

(1) A Claim is a request for a Plan benefit, medical or other, or an eligibility determination made by an Enrollee (referred to as a "claimant" in this Article XIV) or that claimant's authorized representative, in accordance with the Plan's reasonable claims procedures.

(2) A Pre-Service Claim is a Claim for a benefit for which the Plan requires approval of the benefit (in whole or in part) before medical care is obtained.

(3) An Urgent Care Claim is any Claim for medical care or treatment with respect to which the application of the time periods for making Pre-Service Claim determinations:

(A) Would seriously jeopardize the claimant's life, health, or ability to regain maximum function if normal pre-service standards were applied; or

(B) Would subject the claimant 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 the claimant's condition.

(4) A Post-Service Claim is a request for health care benefits under the Plan that is not a Pre-Service Claim. Post-Service Claims are requests that involve only the payment or reimbursement of the cost of the care that has already been provided, such as a standard paper claim or electronic bill submitted for payment after services have been provided.

(5) A Concurrent Claim is a Claim that is reconsidered after an initial approval has been made and results in a reduced or terminated benefit. In addition, a Concurrent Claim can pertain to a request for an extension of a previously approved urgent care treatment or service.

(b) Claim Requirements

(1) To trigger the Plan's claims processing procedures, a Claim must:

(A) Be written or be electronically submitted in accordance with the Electronic Data Interchange (EDI) standards of the Health Insurance Portability and Accountability Act (oral communication is acceptable only for Urgent Care Claims);

(B) Be received by the Committee, the applicable Carrier, or other delegate;

(C) Identify a specific claimant/patient;

(D) Identify a specific medical condition or symptom;

(E) Provide a description and date of a specific treatment, service or product for which approval or payment is requested (Post-Service Claims must include an itemized detail of charges);

(F) Identify the Provider's name, address, phone number, professional degree or license and federal tax identification number (TIN); and

(G) Include a copy of another plan's Explanation of Benefits (EOB) statement along with the submitted claim when another plan is the primary payer.

(2) A request is not a Claim if it is:

(A) Not made in accordance with the Plan's benefit claims filing procedures;

(B) Made by someone other than the claimant or the claimant's Authorized Representative;

(C) Made by a person who will not identify himself or herself (anonymous);

(D) A casual inquiry about benefits such as verification of whether a service/item is covered or the estimated allowed cost for a service;

(E) For prior approval where prior approval is not required by the Plan,

(F) An eligibility inquiry that is not a request for benefits; however, if a benefit Claim is denied on the grounds that the claimant lacks eligibility, the Claim is treated as an adverse benefit determination and the claimant will be notified of the decision and allowed to file an appeal; or

(G) A presentation of a prescription to a pharmacy that the pharmacy denies, where the pharmacy/Pharmacy Benefit Manager (PBM) has no discretion to make decisions on claims. After the denial by the pharmacy, a person may file a Claim with the applicable Carrier.

(c) A covered person must file a claim for benefits by the end of the calendar year following the year in which the service was rendered, in the form and manner determined by the Committee, the applicable Carrier, or other delegate. Claims received after such period shall be denied unless the covered person can show that it was not possible to file the claim within the required time period and that the claim was filed as soon as was reasonably possible.

(d) All claims for Medicare enrolled individuals must be submitted to Medicare before being submitted to a Carrier. In many states, a Carrier may have a "crossover" arrangement with the Medicare Carrier, under which Medicare processes the claim and provides information directly to the Carrier, and then the Carrier processes the secondary balance. In such case, claimants will receive a combined Explanation of Benefits (EOB) statement showing how both Medicare and the Plan paid the claim.

SECTION 14.4 – TIME FRAME FOR INITIAL CLAIM DETERMINATION

The Committee (or the applicable Carrier, or other delegate) shall notify a claimant of the Plan's benefit determination as follows:

(a) Pre-Service Claims. The Committee (or the applicable Carrier or other delegate) shall notify the claimant of the Plan's benefit determination within a reasonable period of time appropriate to the medical circumstances, but not later than fifteen (15) days after receipt of the Claim by the Plan. This period may be extended one time by the Plan for up to fifteen (15) days, provided that the Committee (or the applicable Carrier or other delegate) both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the claimant, prior to the expiration of the initial fifteen (15) day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If such an extension is necessary due to a failure of the claimant to submit the information necessary to decide the Claim, the notice of extension shall specifically describe the required information, and the claimant shall be afforded at least forty-five (45) days from receipt of the notice within which to provide the specified information and the period for making the benefit determination shall be tolled from the date on which the notice of extension is sent to the claimant until the date on which the claimant responds to the request for additional information.

(b) Urgent Care Claims. The Committee (or the applicable Carrier or other delegate) shall notify the claimant of the Plan's benefit determination as soon as possible, taking into account the medical exigencies, but not later than seventy-two (72) hours after receipt of the Claim by the Plan, unless the claimant fails to provide sufficient information. In the case of such a failure, the Committee (or the applicable Carrier or other delegate) shall notify the claimant as soon as possible, but not later than twenty-four (24) hours after receipt of the Claim by the Plan, of the specific information necessary to complete the Claim. The claimant shall be afforded a reasonable amount of time, taking into account the circumstances, but not less than forty-eight (48) hours, to provide the specified information. The Committee (or the applicable Carrier or other delegate) shall notify the claimant of the Plan's benefit determination as soon as possible, but in no case later than forty-eight (48) hours after the earlier of: (i) the Plan's receipt of the specified information, or (ii) the end of the period afforded the claimant to provide the specified additional information.

(c) Post-Service Claims. The Committee (or the applicable Carrier or other delegate) shall notify the claimant of the Plan's benefit determination within a reasonable period of time, but not later than thirty (30) days after receipt of the Claim. This period may be extended one time by the Plan for up to fifteen (15) days, provided that the Committee (or the applicable Carrier or other delegate) both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the claimant, prior to the expiration of the initial thirty (30) day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If such an extension is necessary due to a failure of the claimant to submit the information necessary to decide the Claim, the notice of extension shall specifically describe the required information, and the claimant shall be afforded at least forty-five (45) days from receipt of the notice within which to provide the specified information and the period for making the benefit determination shall be tolled from the date on which the notice of extension is

sent to the claimant until the date on which the claimant responds to the request for additional information.

(d) Concurrent Care Decisions. If the Plan has approved an ongoing course of treatment to be provided over a period of time or number of treatments, any request by a claimant to extend the course of treatment beyond the period of time or number of treatments that is a Claim involving urgent care shall be decided as soon as possible, taking into account the medical exigencies, and the Committee (or the applicable Carrier or other delegate) shall notify the claimant of the benefit determination, whether adverse or not, within twenty-four (24) hours after receipt of the Claim by the Plan, provided that any such Claim is made to the Plan at least twenty-four (24) hours prior to the expiration of the prescribed period of time or number of treatments.

SECTION 14.5 – ADVERSE BENEFIT DETERMINATIONS

(a) For the purpose of the initial and appeal claims processes, an adverse benefit determination is defined as:

(1) A denial, reduction or termination of a benefit, a failure to provide or make payment in whole or in part for a benefit or a denial or termination of a claimant's eligibility to participate in this Plan,

(2) A benefit reduction resulting from the application of any Hospital pre-admission review or failure to cover an item or service for which benefits are otherwise provided because it is determined to be Experimental, Research, and/or Investigational or not Medically Necessary or appropriate, or

(3) The Plan's payment of less than the total amount of expenses submitted with regard to a Claim is considered a denial of the Claim or an adverse benefit determination, even where the Plan is paying the portion of the Claim that is covered under the terms of the Plan (e.g., the Plan pays less than 100% due to a claimant who has not yet satisfied the out-of-pocket maximum).

(b) Notice of Denial. If the Claim is denied in whole or in part, the claimant will receive a written notice specifying:

(1) The reasons for the denial;

(2) The Plan provisions on which the denial is based;

(3) Any additional information needed from the claimant in connection with the Claim and the reason such information is needed;

(4) An explanation of the claims review procedure and the applicable time limits, including a statement concerning the claimant's right to bring a civil action under ERISA section 502(a)(1)(B) following an adverse determination on appeal;

(5) A statement regarding any internal rule, guideline, protocol or other criterion that was relied upon in making the adverse determination (a copy of which will be provided free upon request);

(6) If the denial is based on a Medical Necessity or Experimental, Research, and/or Investigational treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment that led to this determination (a copy of which will be provided free upon request); and

(7) If the Claim is an Urgent Care Claim, a description of the expedited review process applicable to such claims. In the case of an Urgent Care Claim, the notice of the benefit determination may be made orally, provided that a written notification is furnished to the claimant not later than three (3) days after the oral notification.

(c) Right to Appeal Denial

(1) The claimant must make a written appeal to the Committee, or other party described in the denial notice, within 180 days of the initial denial of the Claim. If written appeal is not made within such 180-day period, the claimant shall forfeit the right to review. The claimant's written appeal may (but is not required to) include issues, comments, documents, and other records the claimant wants considered in the review. All the information the claimant submits will be taken into account on review, even if it was not reviewed as part of the initial decision. The claimant may ask to examine or receive free copies of all pertinent Plan documents, records, and other information relevant to the Claim by asking the Plan Administrator.

(2) Where an adverse determination is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug or other item is Experimental, Research, and/or Investigational or not Medically Necessary or appropriate, the Plan will consult with a health care professional who has experience in the field of medicine involved in the medical judgment to decide the claimant's appeal. The Committee may, in its discretion, hold one or more hearings. The claimant may, at the claimant's own expense, have an attorney or other representative act on the claimant's behalf, but the Committee requires a written authorization. The Committee reserves the right to delegate its authority to make decisions.

(3) In the case of an Urgent Care Claim, the claimant may provide a request for an expedited appeal of an adverse benefit determination either orally or in writing and all necessary information, including the Plan's benefit determination on appeal, shall be transmitted by telephone, facsimile, or other available similarly expeditious method.

(d) Decision Upon Review. The Committee (or the applicable Carrier or other delegate) shall notify a claimant of the Plan's benefit determination on review as follows:

(1) Post-Service Claims. The Committee (or the applicable Carrier or other delegate) shall notify the claimant of the Plan's benefit determination on review within a reasonable period of time, but no later than sixty (60) days after receipt of the appeal (thirty (30) days if the Plan has two (2) levels of review).

(2) Pre-Service Claims. The Committee (or the applicable Carrier or other delegate) shall notify the claimant of the Plan's benefit determination on review within a reasonable period of time appropriate to the medical circumstances, but no later than thirty (30) days after receipt of the appeal (fifteen (15) days if the Plan has two (2) levels of review).

(3) Urgent Care Claims. The Committee (or the applicable Carrier or other delegate) shall notify the claimant of the Plan's benefit determination on review as soon as possible, taking into account the medical exigencies, but not later than seventy-two (72) hours after receipt by the Plan of the claimant's appeal of the adverse determination.

(4) Concurrent Claims. A Concurrent Claim involving the termination or reduction of a benefit is considered an appeal. Concurrent Claims involving an extension of non-urgent claims will be administered in accordance with the appeals procedures for Pre-Service Claims.

(e) Notice of Denial of Appeal. If the decision on appeal is denied, the claimant will receive a written notice specifying:

(1) The reasons for the denial;

(2) The Plan provisions on which the denial is based;

(3) Any documents, records or other information relevant to the claimant's claim for benefits, which the claimant may ask to examine or receive free copies of by asking the Committee;

(4) A statement explaining any voluntary appeal procedures offered by the Plan and the claimant's right to bring a civil action under ERISA section 502(a)(1)(B);

(5) A statement regarding any internal rule, guideline, protocol or other criterion that was relied upon in making the adverse determination (a copy of which will be provided free upon request); and

(6) If the denial is based on a Medical Necessity or Experimental, Research, and/or Investigational treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment that led to this determination (a copy of which will be provided free upon request). Decisions upon appeal are final.

SECTION 14.6 – AUTHORIZED REPRESENTATIVES

(a) An Authorized Representative is a person who can act on the claimant’s behalf to file a claim, or appeal the denial of a claim under the Plan. The following individuals may be recognized as a claimant’s Authorized Representative:

(1) Health care provider;

(2) Legal Spouse;

(3) Child age eighteen (18) or over;

(4) Parents or adult siblings;

(5) Grandparent;

(6) Court ordered representative, such as an individual with power of attorney for health care purposes or legal guardian or conservator;

(7) Union benefit representative; or

(8) Other adult.

(b) The Plan requires a written statement from the claimant that the individual has designated another person as the claimant's Authorized Representative, along with the representative's name, address, and phone number. Where the claimant is unable to provide a written statement, the Plan must require written proof (e.g., power of attorney for health care purposes, court order of guardian/conservator) that the proposed Authorized Representative has been authorized to act on the claimant's behalf. A health care professional with knowledge of the covered person's medical condition may act as an Authorized Representative in connection with an Urgent Care Claim without the covered person having to complete an authorization form.

(c) Once the claimant names an Authorized Representative, the Plan will provide information to the Authorized Representative and the claimant, and if requested by the claimant, the Plan will route future claims and appeals-related correspondence to the Authorized Representative and not the claimant. The Plan will honor the designation of an Authorized Representative for up to one year, or as mandated by a court order, before requiring a new authorization. The claimant may revoke a designation of an Authorized Representative at any time by submitting a signed statement.

(d) The Plan reserves the right to withhold information from a person who claims to be the Authorized Representative if there is question about the qualifications of the individual claiming to be the Authorized Representative.

SECTION 14.7 – LEGAL PROCEEDINGS

(a) No action at law or in equity or otherwise may be brought on any claim or other matter whatsoever against the Committee, or the applicable Carrier or other delegate, unless all of the required Claim procedures and Claim appeal procedures under this Article XIV of the Plan have been followed and exhausted, nor can such action be brought unless brought within one year from the date of the last decision rendered by the Plan or its Carrier regarding the Claim or within the maximum time permitted under the applicable provisions of ERISA or state law if applicable.

(b) This provision, permitting court action, will not be deemed to extend or reinstitute any Claim or cause of action that has expired under the time limits set forth in the Settlement Agreement, or in any Plan document or any rules of the Plan or under any statute if such time limit has already expired.

SECTION 14.8 – VOLUNTARY APPEAL PROCESS

To afford Enrollees a voluntary alternative means by which they can seek review and possible reconsideration of a disputed health care claim or question of coverage, the Plan provides a voluntary review process. An adverse benefit determination may be submitted for review under this voluntary appeal process only if all of the required Claim procedures and Claim appeal procedures under this Article of the Plan have been followed and exhausted. In connection with this voluntary appeal process, the Plan:

(a) Waives any right to assert that an Enrollee has failed to exhaust administrative remedies because the Enrollee did not elect to submit a benefit dispute to such process; and

(b) Agrees that any statute of limitations or other defense based on timeliness is tolled during the time such review is pending.

Following receipt of a final determination from a Carrier with regard to the appeal of a denial of a claim in full or in part, an Enrollee may request that the Plan Staff Committee for Appeals review the disputed claim.

In accord with Plan policies and procedures, the Staff Committee shall:

(1) Conduct a timely and regular review of such appeal, including member communications, dependent upon whether the particular claim is urgent, concurrent, pre-service, or post-service as described under the terms of this Plan.

(2) Such process will include additional medical and legal review if appropriate under standards established by the Staff Committee.

(3) Such process will include maintaining detailed records of the appeals process and ensure consistency with past decisions.

(4) Appeals will be determined without regard to the financial impact to the Plan of the claims that are decided.

SECTION 14.9 – ELIGIBILITY DETERMINATION APPEAL PROCESS

An appeal of an eligibility determination under the Plan is subject to the rules in this Article.

Notwithstanding the foregoing, any eligibility determination that involves whether a Dependent Child is permanently and totally disabled ("PTD Claim") is subject to the following rules:

(a) A PTD Claim must be filed in the form, time and manner determined by the Plan.

(b) PTD Claims – The Plan will notify the PTD claimant or his or her Authorized Representative of an adverse determination within a reasonable period of time, but not later than forty-five (45) days after receipt of the PTD Claim by the Committee or its delegate. This period may be extended two times by the Plan for up to thirty (30) days, provided that the Committee or its delegate both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the claimant, prior to the expiration of the initial forty-five (45) day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If such an

extension is necessary due to a failure of the claimant to submit the information necessary to decide the Claim, the notice of extension shall specifically describe the required information, and the claimant shall be afforded at least forty-five (45) days from receipt of the notice within which to provide the specified information and the period for making the benefit determination shall be tolled from the date on which the notice of extension is sent to the claimant until the date on which the claimant responds to the request for additional information.

(c) PTD Appeals – The PTD Claimant or his or her Authorized Representative must submit an appeal of an adverse determination of a PTD Claim within 180 days from receipt of the adverse determination. The Plan will notify the PTD Claimant or his or her Authorized Representative within a reasonable period of time, but no later than forty-five (45) days after receipt of the PTD Appeal. The forty-five (45) day period may be extended by the Plan for an additional forty-five (45) days if there are special circumstances.

SECTION 14.10 – ASSIGNMENT OF BENEFITS

Except as expressly authorized by the Plan, or as required to comply with a Qualified Medical Child Support Order under the Omnibus Budget Reconciliation Act of 1993, benefits, claims, coverage or other interests in the Plan may not be assigned, transferred, or alienated by a Primary Enrollee. With the approval of the Plan, however, a Carrier may pay a Provider directly for services rendered, in lieu of payment to a Retiree, surviving Spouse, or Dependent.

SECTION 14.11 – IMPROPER OR FALSE CLAIMS

If a claimant furnishes false information on any material subject to the Plan, or to any of its agents or employees, the Plan will deny all or part of the Claim and will charge the claimant for any expenses incurred relating to the false information. If benefits have already been paid, based on the false information on a material subject, the Plan will recover the benefits from the claimant, plus expenses incurred in such recovery, including attorney's fees, costs and any and all other expenses, and/or will reduce the claimant's future benefits for claims until the Plan has recovered the benefits paid.

The Plan may terminate coverage for any act or omission by a Retiree, surviving Spouse, or Dependent that indicates intent to defraud the Plan, such as the intentional and/or repetitive misuse of the Plan's services or the omission or misrepresentation of a material fact on an application for enrollment, Claim, or other document. Grounds for termination include the submission of any Claim and/or statement containing any materially false information, any information that conceals for the purpose of misleading, and/or any act that could constitute a fraudulent insurance act.

ARTICLE XV — GENERAL PROVISIONS

SECTION 15.1 – PLAN AMENDMENT OR TERMINATION

The Committee may amend or terminate this Plan in accordance with the procedures set forth in the Trust Agreement, which amendment or termination will be reduced to writing and may be effective prospectively or retrospectively, provided, however, no amendment to or termination of the Plan will retroactively reduce benefit entitlement or benefit levels then in effect. All amendments or any termination of the Plan are subject to the limitations of the Trust Agreement and the applicable law and administrative regulations. Retirees and their Dependents of the Plan will be notified in writing of any Plan amendments or termination of the Plan in accordance with requirements of ERISA.

SECTION 15.2 – COMMITTEE AUTHORITY AND INTERPRETATION

The Committee will have the power and authority to increase, decrease, or change benefits, or change eligibility rules, including by adopting Schedules of Benefits, or other provisions of the Plan of benefits as may in their discretion be proper or necessary for the sound and efficient administration of the Plan, provided that such changes are not inconsistent with the law or with the provisions of this Plan or with the provisions of the Trust Agreement.

The Committee and their delegates will have the power to construe this Plan document, the procedures and regulations of the Plan, and other the Plan documents, including ambiguous provisions. The Committee's interpretation will be binding on all involved parties hereto, including but not limited to eligible Retirees and Dependents. The decisions of the Committee will be given judicial deference in any court proceeding regarding benefits of this Plan, unless they are found to be arbitrary or capricious.

SECTION 15.3 – GOVERNING LAW

All questions pertaining to the validity and construction of the Trust Agreement, the Plan, and of the acts and transactions of the Committee or of any matter affecting the Plan will be determined under Federal law where applicable Federal law exists. Where no applicable Federal law exists, the laws of the State of Michigan will apply to the Plan, the laws of the State of New York will apply to the Trust, and any other applicable State law will apply to insured portions of the Plan.

SECTION 15.4 – SEVERABILITY CLAUSE AND CONFORMITY WITH THE LAW

Should any provision of the Plan or this Plan document or any amendment thereto be deemed or held to be unlawful, or unlawful as to any person or instance, such facts will not adversely affect the other provisions herein and therein contained or the application of those 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 Committee will not be held liable for any act done or performed in pursuance of any provisions hereof prior to 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, such provision is hereby amended to conform to such law.

SECTION 15.5 – EXAMINATIONS

The Committee will have the right and opportunity:

(a) To employ a Physician to examine the person whose Injury or Illness is the basis of a claim hereunder when and so often as they may reasonably require during the pendency of a claim hereunder; and

(b) To examine any and all Hospital or medical records relating to a claim under this Plan.

SECTION 15.6 – WORKERS' COMPENSATION NOT AFFECTED

This Plan is not issued in lieu of, nor does it affect any requirement for, coverage by any Workers' Compensation Law, Occupational Disease Law, or similar laws.

SECTION 15.7 – RELEASE OF INFORMATION

To the extent consistent with applicable state and federal law, an Enrollee making application for benefits will be required by the Plan to authorize any Physician, Hospital, employer, government agency or any other person, corporation or organization having relevant health related information, which may be required for a proper determination of the claim by the Plan, to release such information to the Plan. Each Enrollee 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 hereunder, provided, however, no authorization will be required if such authorization would violate applicable state and federal laws. The information will be requested for the purposes of treatment, payment and plan administration and the authorization is intended to comply with all the requirements of the Administrative Simplification rules of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). By making a claim for benefits, an individual will be deemed to have authorized a release of information pursuant to this Article.

Providers of services shall be authorized to permit the Carrier(s) to examine their records with respect to the services and to submit reports of the services in the detail requested by the Carrier(s). All information related to treatment of the Enrollee will remain confidential except for the purpose of determining rights and liabilities arising under this Plan.

A Provider claiming payment from the Carrier must furnish a report to the Carrier, in the prescribed form, within 180 days from the date of the last continuous service listed on the report as having been rendered to the Enrollee. The Provider must certify upon the report that the Provider is entitled to payment under this Plan and that the service was personally rendered or rendered during the Provider's presence and under the Provider's supervision. An Enrollee's request for service is authorization to the provider to make the report.

An Enrollee seeking payment from a Carrier must furnish, or cause the Provider to furnish, a report to the Carrier in the form prescribed by the Carrier. By filing the report, the Enrollee consents that the Carrier may have access to the data disclosed by the records and files of the Provider and of the Hospital or other facility named in this report.

SECTION 15.8 – IDENTIFICATION CARDS

Enrollees shall be furnished identification cards by the Carrier(s). Such cards shall contain telephone numbers for obtaining predetermination information or other required approvals of services. The identification card must be presented when service is requested.

An Enrollee shall not use an identification card to obtain benefits to which such Enrollee is not entitled, nor shall the Enrollee permit another person to obtain benefits to which such person is not entitled.

SECTION 15.9 – RIGHT TO RECOVERY

Whenever the Committee pays benefits that exceed the amount of benefits that should be paid under the terms of this Plan, the Committee shall have the right, to the greatest extent allowed by law, to recover the wrongfully paid benefits from any person, service plan, or any other organization to, or for which the excess payments were made.

If an overpayment of benefits has been made to or on behalf of a Retiree or Dependent, the Plan, at its option, may require immediate repayment in full, set-off the overpayment from current and future benefit payments or institute legal action to collect the overpayment.

To the extent an overpayment is made, any person, or agent for such person, benefiting from the overpayment will be deemed to hold the excess payment or the benefit received as a result of the excess payment in an equitable and constructive trust for the benefit of the Fund.

SECTION 15.10 – LEGAL ACTION BY AN ENROLLEE

No action by an Enrollee for entitlement to benefits under this Plan may be brought more than two (2) years after such claim has accrued; provided, however, no other actions may be brought against the Plan at all more than six (6) months after such claim has accrued.

SECTION 15.11 – SERVICE OF LEGAL PROCESS

Service of legal process may be made upon the Plan Administrator, UAW Retiree Medical Benefits Trust, PO Box 14309, Detroit, Michigan 48214-0309.

SECTION 15.12 – MISREPRESENTATION OR FALSIFICATION

If any individual knowingly misrepresents or falsifies any information or any matters in connection with a claim filed for Plan benefits, the Committee may, in their sole discretion, deny all or part of the benefits that might otherwise be due in connection with the claim. If benefits are paid and it is later determined that they were paid as a result of a misrepresentation or false information then the Committee may, in their sole discretion, withhold future benefits to collect amounts paid in error.

If an overpayment results from misrepresentations made by or on the behalf of the recipient of the benefits, the Plan may also obtain reimbursement of interest, professional fees incurred, and other damages related to that overpayment.

If any individual knowingly misrepresents or falsifies any information or any matters in connection with a claim, eligibility, or in connection with obtaining enrollment under the Plan, the Committee may, in their sole discretion, terminate an individual's coverage, effective at the date the Committee deems appropriate.

If an individual believes that the Plan has terminated his or her coverage in error, that individual can utilize the Appeal Process found in Section 14.9.

SECTION 15.13 – NON-RETALIATION

The Plan will take no action or discriminate against any Retiree or his or her Dependent for reporting or attempting to report a response to an inquiry or a proceeding of a court of appropriate jurisdiction, governmental agency, or member of the Plan.

The Retiree or Dependent must report honestly and in good faith. If the Retiree or Dependent believes that the Plan has violated some law or internal Plan policy, but the Retiree or Dependent does not wish to be known as the source of the complaint, the Retiree or Dependent can call the compliance hotline ("ComplianceLine") at 1-888-250-6617. The Plan will investigate all inquiries.

SECTION 15.14 – GENDER AND NUMBER

Except as the context may specifically require otherwise, use of the masculine gender shall be understood to include both masculine and feminine genders, unless the context requires otherwise. Any reference to the singular may also apply to the plural and vice versa, unless the context requires otherwise or the result would be irreconcilable.

SECTION 15.15 – PAYMENT OF BENEFITS

Benefits are payable to the Retiree whose injury or illness or whose Dependent's injury or illness is the basis for a claim under the Plan, except that:

(a) In the event that an unpaid Hospital bill, Physician's bill, or bill from any other Provider providing medical services or supplies that are covered by this Plan is submitted to the Committee, the applicable Carrier, or other delegate, the payment will be made directly to the Hospital, Physician, or Provider;

(b) No assignment of any present or future right, interest, or benefit under this Plan shall bind the Committee, the applicable Carrier, or other delegate without their written consent thereto;

(c) If any individual is, in the opinion of the Committee, the applicable Carrier, or other delegate, legally incapable of giving a valid receipt for any payment due and no guardian has been appointed for that individual, the Committee the applicable Carrier, or other delegate may, at their option, make such payment to the person or persons who, in the opinion of the Committee, the applicable Carrier, or other delegate, have assumed the care and principal support of such individual. If the individual should die before all amounts due and payable have been paid, the Committee, the applicable Carrier, or other delegate 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 or children, or to any other person or persons who, in the opinion of the Committee, the applicable Carrier, or other delegate, are entitled thereto; and

(d) Any payments made by the Committee, the applicable Carrier, or other delegate in accordance with these provisions shall fully discharge the liability of the Committee, the applicable Carrier, or other delegate to the extent of such payment.

SECTION 15.16 – PAYMENT OF BENEFITS ON PLAN TERMINATION

Retirees are not vested in the benefits provided by this Plan. The Committee may terminate this Plan of Benefits under certain circumstances, and in accord with the applicable terms of the settlement agreements and the Trust Agreement. If it should happen that the Plan is terminated, benefits for covered charges incurred before the termination date fixed by the Committee will be paid 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.

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 Committee in accordance with the provisions of the Trust Agreement. In no event will assets be paid to or recoverable by any employer, association, or labor organization.

SECTION 15.17 – GENERAL EXCLUSIONS AND LIMITATIONS

General and specific benefit exclusions are set forth in this Plan Document, the summary plan description for the Plan, the applicable Schedules of Benefits and in the insurance policies and contracts and other materials prepared by the Carriers for the insured portion of the Plan.

SECTION 15.18 – CHANGES IN LAWS AND/OR REGULATIONS

Notwithstanding any provisions of the Plan Document and Summary Plan Description to the contrary, the Plan shall modify administration, coverages, and other terms and conditions of the Plan Document and Summary Plan Description, as necessary, to comply with applicable federal laws and regulations.

ARTICLE XVI — USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

(a) The Plan will use Protected Health Information (PHI) to the extent and in accordance with the uses and disclosures permitted by the privacy and security regulations under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Specifically, the Plan will use and disclose Protected Health Information for purposes related to health care treatment, payment for health care, and health care operations.

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

(A) Except with regards to "genetic information" as defined by HIPAA, determination of eligibility, coverage, and cost sharing amounts (e.g., cost of a benefit, Plan maximums, and copayments as determined for an individual's claim),

(B) Coordination of benefits,

(C) Adjudication of health benefit claims (including appeals and other payment disputes),

(D) Subrogation of health benefit claims,

(E) Establishing employee contributions,

(F) Risk adjusting amounts due based on Enrollee health status and demographic characteristics,

(G) Billing, collection activities and related health care data processing,

(H) Claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes and responding to participant inquiries about payments,

(I) Obtaining payment under a contract for reinsurance (including stop-loss and excess of loss insurance).

(J) Medical Necessity reviews, or reviews of appropriateness of care or justification of charges,

(K) Utilization review, including precertification, preauthorization, concurrent review and retrospective review,

(L) 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, SSN, payment history,

account number, and name and address of the provider and/or health Plan), and

(M) Reimbursement to the Plan.

(2) "Health Care Operations" include, but are not limited to, the following activities:

(A) Quality Assessment,

(B) Patient safety activities

(C) 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,

(D) Rating provider and Plan performance, including accreditation, certification, licensing, or credentialing activities,

(E) Except with regard to "genetic information" as defined in HIPAA, underwriting, enrollment, 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), but the Plan will not use genetic information for underwriting,

(F) Conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs,

(G) 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, development or improvement of methods of payment or coverage policies,

(H) Business management and general administrative activities of the entity, including, but not limited to:

(i) Management activities relating to implementation of and compliance with the requirements of HIPAA Administrative Simplification,

(ii) Customer service, including the provision of data analyses for policyholders, Plan sponsors, or other customers,

(iii) Resolution of internal grievances, and

(iv) 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.

(I) Compliance with and preparation of all documents as required by the Employee Retirement Income Security Act of 1974 (ERISA), including Form 5500's, SAR's, and other documents.

(J) Management activities relating to implementation and compliance with HIPAA, including disclosure to the Department of Health and Human Services.

(b) The Plan will use and disclose PHI as required by law and as permitted by authorization of the participant or beneficiary.

(c) The Committee is the "Plan Sponsor." The Plan shall disclose PHI to the Plan Sponsor for the purpose of plan administration, but shall only disclose the minimum necessary information. With respect to PHI, the Plan Sponsor agrees to:

(1) Not use or further disclose the information other than as permitted or required by the Plan Document or as required by law,

(2) Ensure that any agents 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,

(3) Not disclose the information for employment-related actions and decisions unless authorized by the individual,

(4) Not use or disclose the information in connection with any other benefit or employee benefit plan unless authorized by the individual,

(5) Report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware,

(6) Make PHI available to the individual in accordance with the access requirements of HIPAA,

(7) Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA,

(8) Make available the information required to provide an accounting of disclosures,

(9) 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 HHS for the purposes of determining compliance by the Plan with HIPAA, and

(10) If feasible, return or destroy all PHI received from the Plan that the 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.

(d) The Committee shall designate to the Plan's workforce the ability to access PHI, in accordance with their specific jobs, for Plan administration functions. The Plan Sponsor

shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

(e) With respect to the HIPAA Security Rule, the Plan Sponsor will:

(1) Implement 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 group health plan,

(2) Ensure that the adequate separation of the Plan's workforce, specific to electronic PHI, is supported by reasonable and appropriate security measures,

(3) Ensure that any agent to whom it provides electronic PHI agrees to implement reasonable and appropriate security measures to protect the electronic PHI, including, where appropriate, executing Business Associate Agreements, and

(4) Report to the Plan any security incident of which it becomes aware concerning electronic PHI.

ARTICLE XVII — HEARING AID BENEFIT

Coverage is described in the applicable Schedule of Benefits.

ARTICLE XVII – DENTAL EXPENSE BENEFIT

SECTION 18.1 – GENERAL

Enrollees and their Dependents have coverage for dental cleanings and procedures. This coverage is subject to certain lifetime and annual maximums. A network of participating dentists and other dental practitioners is maintained by the dental claims administrator. Claims for dental services must be submitted to the dental claims administrator. The dental claims administrator will evaluate and approve claims based on the current Plan design. The dental claims administrator may impose such other benefit limitations as to type of procedure or product covered by the Plan.

SECTION 18.2 – NETWORK

The dental claims administrator may have a multi-tiered network structure. In those cases, the Enrollee can visit a non-participating dentist or dental professional, but the amount of coverage offered will be reduced. The Enrollee may have a choice between two In-Network tiers, with one in a preferred status and with greater coverage. Services by certain dental professionals will not be covered if the dental professionals do not meet certain provider contracting standards of the dental claims administrator. The dental claims administrator maintains the network and network registry.

SECTION 18.3 – COVERED SERVICES

Dental services include the following when determined by the dental claims administrator to be medically necessary:

(a) Dental exams;
(b) Dental cleanings, routine or periodontal twice per year;
(c) Emergency dental services;
(d) X-Rays;
(e) Fillings, non-white or metallic;
(f) Endodontic services;
(g) Periodontic services;
(h) Extractions;
(i) Reline and repair services for dentures, bridges, and implants;
(j) Major restorative (crowns) and other oral surgery;
(k) Prosthodontic services, including bridges and dentures; and
(l) Orthodontic services, if treatment begins before age 19.

ARTICLE XIX – VISION BENEFIT

SECTION 19.1 – GENERAL

Enrollees and their Dependents have coverage for vision exams and certain kinds of corrective lenses. This coverage is subject to certain lifetime and annual limits, as well as limits on the type or kinds of lenses and frames provided. A network of participating providers is maintained by the vision claims administrator. Claims for vision services must be submitted to the vision claims administrator. The vision claims administrator will evaluate and approve claims based on the currently approved Plan design. The Plan sets a dollar limit on each of the covered services in the vision benefit. Expenses beyond that dollar limit or "allowance" are the responsibility of the Enrollee.

SECTION 19.2 – NETWORKS

Enrollees and their Dependents must receive the covered services from an In-Network provider in order to receive vision benefits under the Plan. Enrollees should contact the vision claims administrator in order to determine the network status of any provider.

SECTION 19.3 – COVERED SERVICES AND ITEMS

Vision services include the following when determined by the vision claims administrator to be medically necessary:

a. Annual routine vision exam;
b. Re-examination by an Ophthalmologist within 60 days of an initial Optometrist examination, when medically necessary;
c. Standard lenses (Glass or Plastic);
   (1) Single vision lenses;
   (2) Bifocal and trifocal lenses;
   (3) Special lenses approved by the vision claims administrator, including lenticular and aspheric lenses;
d. Standard frames;
e. Designer frames, subject to certain Plan limits;
f. Contact lens evaluation, fitting, and follow-up care, when covered in place of glasses or when medically necessary; and
g. Contact lenses, when covered in place of glasses or when medically necessary.