NATIONAL IAM
BENEFIT TRUST FUND

# Health and Welfare Plan

Plan A and A+

## Plan Document and Summary Plan Description

Effective January 1, 2026

99 M Street, SE, Suite 600
Washington, DC 20003
Phone: 202-785-8148
Fax: 202-728-0585

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**To All Participants and Eligible Dependents:**

On September 6, 1966, the Executive Council of The International Association of Machinists and Aerospace Workers established a nationwide Trust Fund known as the IAM National Health and Welfare Plan. On October 1, 1979, it became a part of the National IAM Benefit Trust Fund (Plan).

We are pleased to provide you with this Plan Document and Summary Plan Description hereinafter described as the SPD, which describes in detail the benefits available to active and eligible retired employees and their eligible dependents through the National IAM Benefit Trust Fund effective January 2025.

We urge you to read this SPD carefully so that you may fully understand the benefits available to you and your family. We also suggest that you keep this SPD with your important papers so it will be readily available for future reference. Here are some things to keep in mind:

This SPD replaces and supersedes all other SPDs previously published by the Fund. If any changes are made to the Plan's benefits provisions, they will be communicated to you via a notice that will be sent to the last known mailing address the Fund Office has on file for you. **Therefore, it is extremely important that you notify the Fund Office if you change your mailing address.**

The benefits described in the SPD are **not guaranteed** (vested). All benefits may be changed, reduced or eliminated at any time by the Board of Trustees, to the extent allowed by law. The Board reserves the right to set the effective date of any Plan change.

The information set forth in the SPD is effective for the health and welfare benefits provided by the Plan with respect to all claims incurred on or after **January 1, 2026**, unless otherwise stated.

The administration of these benefits and accompanying claims is subject to the terms of any agreements executed between the Trustees and third-party providers of benefits and or services under the terms of the Plan.

The Board solely is authorized to interpret the terms of the Plan and has discretion to decide all questions about the Plan, including questions about your eligibility for benefits, the amount and type of benefits payable to you, and the application of any Plan term or provision. Your Employer or Union Representative does not have the authority to interpret and/or apply the Plan on behalf of the Board or to act as an agent of the Board.

If you have any questions about your benefits, please write or call the Fund Office. Our staff will be pleased to assist you.

Sincerely,

The Board Of Trustees

## Welcome!

Welcome to your Health and Welfare Plan. We know that your benefits are important to you, and that's why we work hard to provide you with the best comprehensive, cost-effective, high-quality coverage we can. A detailed description of your benefits, beginning with your comprehensive medical coverage, is provided in this Summary Plan Description (SPD).

Medical, dental and vision benefits are self-funded, which means that health care claims are paid directly from the National IAM Benefit Trust Fund resources rather than an outside insurance company. Your employer contributes to the Benefit Trust Fund on your behalf, according to the terms of your collective bargaining agreement or other participation agreement. Life and accidental death and dismemberment benefits are insured through a contract with a life insurance company (the Hartford). Summary Plan Descriptions for dental, vision, and short-term disability benefits, and life and accidental death and dismemberment insurance are provided separately if you are eligible for such benefits.

Being self-funded also means that you have a responsibility to be an informed, conscientious health care consumer. Your individual efforts to conserve Fund resources have a direct effect on the cost of health care benefits provided to you and your family, as well as future benefit availability. It's in everyone's best interest to use the savings measures the Trustees have put into place, like using network providers whenever possible, choosing generic medication instead of brand name, and taking advantage of preventive care benefits on a routine basis.

This SPD explains the general provisions of the Health and Welfare Plan. It includes legally required notices, an overview of your coverage, information about eligibility requirements for you and your family, claims and appeals procedures, and a glossary of terms used in this SPD. However, this SPD is only a summary of your Plan's provisions. Full details are contained in the documents that establish the Plan provisions, including the Plan Document. If there is a discrepancy between the wording here and the documents that establish the Plan, the Plan Document language will govern. The Trustees reserve the right to amend, modify or terminate the Plan, and to modify contribution rates at any time and from time to time.

If you have any questions about your Plan, the Trustees have authorized the Fund Office to respond in writing to any written questions you may have. In addition, as a courtesy to you, the Fund Office may respond informally to oral questions. However, oral information and answers are not binding on the Trustees and cannot be relied upon in any dispute concerning your benefits.

**Note:** Neither the Plan, the Board of Trustees, nor any of their designees are engaged in the practice of medicine or dentistry, nor do any of them have any control over any diagnosis, treatment, care or lack thereof, or any health care services provided to you by any doctor, dentist or other provider. Neither the Plan, Trustees, nor any of their designees will have liability whatsoever for any loss or injury caused to you by any doctor, dentist, or provider by reason of negligence, by failure to provide care or treatment, or otherwise.

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# Schedule of Benefits

The Plan provides the following levels of coverage. **Please do not rely on these tables alone to determine your benefits**. Important coverage details, limitations, exclusions and definitions that may affect claims for you, your Spouse, and your Eligible Dependent Children are found later in this SPD.

Coverage under Plan A+ provides the same benefits as Option A with the following additional benefits: a) hearing aids and b) surgical vision correction

## Cost-Sharing Amounts

| Financial | In-Network | Out-of-Network |
|---|---|---|
| **Lifetime Maximum** | No Lifetime Maximum | No Lifetime Maximum |
| **Deductible** (per calendar year – cross accumulates in- and out-of-network – includes 4th quarter carryover) | | |
| **Individual** | $200 | $200 |
| **Family** | $400 | $400 |
| **Out-of-Pocket Limit** (per calendar year – cross accumulate in- and out-of-network – includes deductible, coinsurance and copayments) | | |
| **Individual** | $2,000 | $3,500 |
| **Family** | $4,000 | $7,000 |

## Medical Benefits

The Plan provides the following levels of coverage. Please do not rely on this table alone to determine your benefits. Important coverage details, limitations, exclusions and definitions that may affect claims for you, your Spouse, and your eligible Dependent Children are found later in this SPD.

| Type of Service/Benefit | Plan Pays In-Network | Plan Pays Out-of-Network |
|---|---|---|
| **PHYSICIAN SERVICES** | | |
| **Primary Care Physician Office Visit** | 100% after $20 copay/visit | 70% after deductible |
| **Specialist Office Visit** | 100% after $25 copay/visit | 70% after deductible |
| **Surgical Professional Fees** (inpatient) Surgeon, Assistant Surgeon, Anesthesiologist | 100% after $75 facility copay | 70% after deductible |

| Type of Service/Benefit | Plan Pays In-Network | Plan Pays Out-of-Network |
|---|---|---|
| **Inpatient Hospital Visit** | 100% after $75 facility copay | 70% after deductible |
| **Observation Visit** | 100% after $75 facility copay | 70% after deductible |
| **Urgent Care Physician Visit** | 100% after $25 facility copay | 70% after deductible |
| **Emergency Room Physician Visit** | 100% after $200 facility copay | 100% after $200 facility copay (70% after deductible if not true emergency) |
| **HOSPITAL FACILITY** | | |
| **Inpatient** | 100% after $75 copay/admit | 70% after deductible |
| **Outpatient (except emergency room)** | 100% after $50 copay/visit | 70% after deductible |
| **Emergency Room** | 100% after $200 copay/visit | 100% after $200 copay (70% after deductible if not true emergency) |
| **Urgent Care Facility** | 100% after $35 copay/visit | 70% after deductible |
| **OTHER MEDICAL SERVICES** | | |
| **Allergy Testing and Treatment** (physician's office) | 100% after applicable office visit copay | 70% after deductible |
| **Ambulance Transport** | 90% after deductible | 70% after deductible |
| **Ambulatory Surgical Facility** | 100% after $50 facility copay | 70% after deductible |
| **Bariatric Surgery** If Plan language and Quantum Health's established clinical criteria met | 100% after $75 facility copay | Not covered |
| **Chemotherapy** | 90% after deductible | 70% after deductible |
| **Chiropractic Care** Limit: Maximum of 20 days per calendar year | 100% after $25 copay/visit | 70% after deductible |
| **Diagnostic Lab and X-ray** (Independent Facility) | 90% after deductible | 70% after deductible |

| Type of Service/Benefit | Plan Pays In-Network | Plan Pays Out-of-Network |
|---|---|---|
| **Diagnostic Lab and X-ray** (Physician's Office) | 100% after applicable office visit copay | 70% after deductible |
| **Durable Medical Equipment**<br>Rental coverage limited to purchase price | 90% after deductible | 70% after deductible |
| **Habilitation Services**<br>ABA therapy only | 100% after $25 copay/visit | 70% after deductible |
| **Home Health** | 90% after deductible | 70% after deductible |
| **Hospice Care** | 90% after deductible | 70% after deductible |
| **Infertility Work-up**<br>Diagnostic only-treatment not covered | 90% after deductible | 70% after deductible |
| **Organ Transplant** – Paid like any other illness | See applicable service | 70% after deductible |
| **Podiatry Care**<br>Limit: Maximum of 30 days/calendar year | 100% after $25 copay/visit | 70% after deductible |
| **Prosthetics/Orthotics** | 90% after deductible | 70% after deductible |
| **Radiation Therapy** | 90% after deductible | 70% after deductible |
| **Short-Term Rehabilitative Therapy**<br>Speech, physical, occupational, cardiac, etc.<br>Plan A+ also includes orthoptic therapy<br>Limit: Maximum of 50 days of treatment per calendar year for all covered therapies | 100% after $25 copay/visit | 70% after deductible |
| **Skilled Nursing Facility**<br>Limit: Maximum of 100 days of treatment per calendar year | 90% after deductible | 70% after deductible |
| **Telehealth** | 100% after applicable office visit copay | Not Covered |
| **MENTAL HEALTH CARE** | | |
| Inpatient | 100% after $75 copay/admit | 70% after deductible |
| Outpatient Facility | 100% after $50 copay/visit | 70% after deductible |
| Outpatient Visit | 100% after $20 copay/visit | 70% after deductible |

| Type of Service/Benefit | Plan Pays In-Network | Plan Pays Out-of-Network |
|---|---|---|
| Telehealth | 100% after applicable office visit copay | Not Covered |
| **SUBSTANCE USE DISORDER TREATMENT** | | |
| Inpatient Hospital | 100% after $75 copay/admit | 70% after deductible |
| Outpatient Facility | 100% after $50 copay/visit | 70% after deductible |
| Outpatient Visit | 100% after $20 copay/visit | 70% after deductible |
| **PLAN A+ ONLY** | | |
| Surgical Vision Correction<br>Limit: Maximum of $1,000 per eye and $2,000 per lifetime | 90% after deductible | 70% after deductible |
| Hearing aid<br>Includes testing and fitting of hearing aid devices and replacement batteries | 90% after deductible | 70% after deductible |

| Preventive/Wellness | Plan Pays In-Network | Plan Pays Out-of-Network |
|---|---|---|
| **The following "PREVENTIVE/WELLNESS" services are not subject to the deductible** | | |
| **Routine Examinations**<br>Annual physician exam, annual gynecologic exam; routine well child visits | 100% | 70% |
| **Routine Immunizations**<br>Physicians recommended immunizations, annual flu shot (excludes travel vaccines) | 100% | 70% |
| **Routine Lab and X-ray**<br>Ordered or performed in conjunction with routine exam, including annual pap & PSA | 100% | 70% |
| **Routine Colonoscopy**<br>Covered once every three (3) years from age 50; or if high risk of colon cancer, per doctor, covered every two (2) years | 100% | 70% |

| | | |
|---|---|---|
| **Routine Mammography**<br>One (1) baseline mammogram age 35-39<br>One (1) mammogram per year from age 40 | 100% | 70% |

## Prescription Drugs[1]

| | 34-day Supply<br>All Participating Pharmacies | 90-day Supply<br>All Participating Pharmacies | Specialty Drugs<br>Specialty pharmacy use and pre-authorization required, quantities vary |
|---|---|---|---|
| Copayment - Applies for each covered prescription, unless noted, until out-of-pocket limit is met | | | |
| **Generic** | You pay $15 Retail | You pay $30 Mail | You pay $60 |
| **Preferred** | You pay $25 Retail | You pay $50 Mail | You pay $60 |
| **Non-Preferred** | You pay $40 Retail | You pay $75 Mail | You pay $60 |
| **Deductible -** $0 - the medical deductible does not apply to prescription drugs | | | |
| **Out-of-Pocket Limit -** Applies per calendar year for all copayments – the prescription drug out-of-pocket limit is separate from the medical out-of-pocket | | | |
| **Individual** | $2,000 | | |
| **Family** | $4,000 | | |

Plan includes generic step therapy and prior authorization requirement for brand name drugs, compound drugs over $300, male androgens, and specialty medications. No copayment required for certain female contraceptives.

[1] Note that under the medical plan, the schedule reflects what the plan will pay. However, under prescription drugs, the schedule reflects what you will pay per prescription fill for all plan options.

# Eligibility Provisions

## Eligibility for Active Employees

You are eligible for coverage if you are an active Employee of an Employer that is participating in the Plan, you are working in a position for which coverage is provided under the terms of the applicable collective bargaining agreement and/or participation agreement, and your Employer is making the required monthly contributions to the Plan on your behalf.

## Limitations on Eligibility

Eligibility under the Plan also is subject to any further requirements and limitations in the applicable collective bargaining agreement or other participation agreement. Whenever the coverage language in the applicable collective bargaining agreement or other participation agreement is inconsistent with the language in this document, the language in this "Eligibility Provisions" section of this document will prevail.

## Temporary Extension of Coverage While Totally Disabled

If your medical coverage under the Plan terminates while you are totally disabled, coverage will be extended, only for treatment of that total disability, for three (3) months while you remain totally disabled. In addition, medical coverage for hospital confinement for the disabling condition will be extended until the end of a confinement that begins within three months after your coverage terminated.

You must submit evidence of total disability to be reviewed by the Fund. The Fund will accept records from the Social Security Administration indicating that you or your dependent is totally disabled.

This extension also applies to your dependent who is totally disabled on the date their coverage terminates.

Extension of benefits for total disability will end on the earlier of the following dates:

- The date the total disability ends;
- The date the person becomes covered under Medicare or any group plan that provides medical benefits; or
- Three months from the date the person's medical coverage terminated.

If any applicable extension does not provide uninterrupted coverage to you, you will be notified by the Fund Office that you will be eligible to select COBRA Continuation Coverage under the Plan and make self-payments to continue your coverage. Once you are no longer totally disabled, if you lose coverage, you will be required to satisfy the eligibility rules of the Plan to regain eligibility for benefits. Refer to the Glossary for the Plan's definition of total disability and totally disabled.

## Eligibility During Family Medical Leave (FMLA)

Your eligibility for coverage while on FMLA will be determined by your contributing employer. However, you are eligible for leave under the FMLA if you:

- Have worked for a covered employer for at least 12 months;
- Have worked at least 1,250 hours over the previous 12 months; and
- Work at a location where at least 50 employees are employed by the employer within 75-mile radius.

The Fund Office will maintain your prior eligibility until the end of the leave, provided your contributing employer properly grants the leave under federal law, notifies the Fund, and continues to make monthly contributions on your behalf while you are on approved leave.

If you and your employer have a dispute over your eligibility under FMLA, your benefits will be suspended pending resolution of the dispute, in the absence of the required contribution. The Board of Trustees will have no direct role in resolving the dispute. Coverage under this Plan will continue during the FMLA leave on the same basis as other similarly situated employees.

Call your employer to determine if you are eligible for FMLA leave. Then, contact the Fund Office if you are planning to take FMLA leave so that the Fund is aware of your employer's responsibility to make contributions during your absence. The Board of Trustees cannot enforce collection of contributions from your employer while you are out on leave; however, federal authorities may assist you regarding your continued coverage.

## Eligibility for Coverage During Leave Under USERRA (Military Leave)

If you enter qualified military service (such as active or inactive duty training or active duty in the United States armed forces or National Guard), and you have sufficient hours in previous work periods to continue eligibility for one or more months following the month you enter the Uniformed Services, you have the option of continuing your eligibility in the Plan under the Plan's Continuation of Eligibility rules or freezing your eligibility as of the end of the month in which you enter the Uniformed Services, or as of the date you enter the Uniformed Services if you enter on the first of the month. In addition, you may elect Coverage for yourself and eligible dependent(s) under COBRA Continuation Coverage. However, in accordance with the Uniformed Services Employment and Reemployment Rights Act (USERRA), you must return to work or seek re-employment with an employer following a discharge, under not less than honorable conditions, within the minimum time period allowed.

If you do not return to work in Covered Employment or seek re-employment in Covered Employment within the minimum time period allowed, you will forfeit your continued eligibility rights under the Plan. In order to ensure protection of your rights under the USERRA, you must notify the Fund Office as soon as you are called up for qualified military service.

If you are covered under the Plan at the time your qualified military service leave begins, your health coverage will be continued by the Fund for your first 30 days of military service providing monthly contributions are made by your Contributing Employer. If you are on uniformed services for more than 30 days, you will be permitted to continue health coverage for yourself[1] and your eligible dependents under the options set forth herein:

[1] See option to elect coverage for yourself (not your Spouse or eligible dependents) discussed in the SPD.

- **Coverage Options for your Eligible dependent(s):** Coverage for your eligible dependents may be elected under COBRA Continuation Coverage. You will be required to self-pay for this coverage. In the alternative, coverage may be provided through the military.
- **Coverage Options for yourself:** you may elect coverage under the Plan's continuation of coverage benefit[1], and continue coverage for yourself for up to 24 months. However, the right to elect this continuation coverage is available only to you, not your dependents.

If you freeze your eligibility at the beginning of your qualified military leave (effective after your automatic 30-day coverage) you may reclaim this eligibility when you return to work for an Employer under the criteria set forth in USERRA. You must notify the Fund Office of your selection, i.e., whether you will freeze your eligibility; elect continuation of coverage for yourself; or elect COBRA coverage for yourself, and/or your Spouse and Eligible Dependent Children. If you do not notify the Fund Office, your eligibility will be automatically extended until it is exhausted.

If you are honorably discharged from the Uniformed Services, Plan coverage for you, your Spouse and your Eligible Dependent Child will be reinstated on the day you begin work with an Employer participating in the Plan, provided that you comply with the notice on return-to-work requirements of USERRA. These requirements and additional information on USERRA can be found at the DOL's website at: http://www.dol.gov/vets/programs/userra/userra_fs.htm.

Your right to maintain and reinstate coverage by reason of qualified military service will be administered and interpreted by the Plan in accordance with the requirements of USERRA, employer contributions, if any, credited to you will be kept on the Plan's records during the qualified military service leave of absence, and your coverage, as well as coverage for your Spouse, and your Eligible Dependent Child will be reinstated, provided you return to work in Covered Employment or seek re-employment with an employer within the time period protected under USERRA.

## Benefits Upon Your Death—Eligibility of Your Surviving Spouse

Surviving Spouse coverage is available for existing contributing employers only if the collective bargaining agreement and/or participation agreement provide for Surviving Spouse coverage, and the Employee or Retiree meets any required age and/or years of service rules specified in such agreements at the time of death.

To be eligible for Surviving Spouse coverage where provided, the death of an Employee or Retiree must occur while eligible for benefits under the applicable Plan, and the Contributing Employer must continue to make the required monthly contributions to the Plan.

There is otherwise no coverage for surviving Spouses under this Plan. However, your covered surviving Spouse and surviving Dependent Children may have rights under this Plan to make payments for continuation of coverage under COBRA as described later in this SPD.

In addition, please check your applicable collective bargaining agreement and/or other participation agreement and all information provided to you by your employer for more details on whether or not a surviving spouse benefit is available under the terms of the applicable Plan.

[1] This coverage is similar to, but is not COBRA Continuation Coverage.

## Eligibility for Your Spouse and Eligible Dependent Children

Your eligible dependents include:

- Your Spouse[1] to whom you are legally married pursuant to federal law and with whom you can file an income tax return, until the last day of month in which a divorce, dissolution of marriage, annulment or legal separation is obtained.
- Your biological children, foster children, children placed for adoption, adopted children, stepchildren, and/or children for whom you or your covered Spouse are; a) legal guardian, or b) required to provide medical coverage under a Qualified Medical Child Support Order (QMCSO), until the last day of the month in which the child reaches age 26.
- Unmarried children of any age provided they are incapable of self-sustaining employment because of a physical or mental disability that occurred when they were covered by this Plan and turned age 26 with such disability present.

A dependent must qualify as a dependent as set forth either in the Affordable Care Act (ACA) or the Internal Revenue Code (Code), and the contributing Employer must make contributions to the Plan for such coverage, where required. All eligible dependents must complete the enrollment process to ensure coverage.

Employees are required to submit a completed eligible dependent certification (EDC) form for any child whose last name differs from the Employee's last name, for stepchildren, or for other covered children. Adoption and/or placement papers are required for coverage of legally adopted children and children placed for adoption. Coverage of Stepchildren requires submission of the child's birth certificate and proof of the Employee's marriage to the child's biological or adoptive parent. Coverage of other dependents requires submission of guardianship papers or other papers confirming the legal relationship between the Employee and child. Employees must provide a marriage certificate to enroll a Spouse. The Fund Office also may ask you for other related information it needs to evaluate the terms of your relationship with a dependent and may periodically request verification of the covered dependent's status on an ongoing basis.

### *Eligibility for Disabled Dependent*

If a dependent child, age 26 or older, is incapable of self-sustaining employment because of mental or physical disability, and the child relies on you for more than one-half of his or her financial support and maintenance, and maintains a permanent residence with you during more than one-half of the calendar year, the child's coverage may be continued under this Plan if his or her disability began when the child was covered by this Plan, and he or she turned age 26 with the disability.

Proof of the child's Disability must be submitted before the child turns 26 and may be required periodically thereafter.

### *Important Rules for Dependent's Eligibility*

The Fund will <u>not</u> provide coverage for other relatives living in your household (e.g., mother, father, siblings, etc.) regardless of whether they are dependent upon you financially, or for non-biological children living in your household for whom you are not legally responsible.

[1] The term Dependent does not include a Spouse who is on active duty in any armed forces.

Also note:

- If your eligible dependent child is employed and becomes covered under a group health plan connected to his or her employment, the plan under which he or she is an employee will be considered the primary plan for coverage. This Plan will be secondary.
- In order for adopted children, children placed with you for adoption, or foster children to be considered eligible dependents, you must provide the Fund Office with appropriate legal documentation, satisfactory to the Plan in its sole discretion, such as adoption papers or a court order appointing you as the legal guardian for the child.
- In order for a stepchild to be considered an eligible dependent, the Fund requires that the employee provide a copy of the child's birth certificate and proof of the employee's marriage to the child's biological or adoptive parent. The Fund may also require any and all documentation, including paternity papers, court order, state order and/or divorce decree setting forth the relationship with the child.
- If a dependent Spouse is eligible for benefits under this Plan as an active participant, benefits will be payable for the Spouse first as a participant, then as a dependent. In no event will benefits exceed 100% of covered Charges incurred.
- If a dependent child loses eligibility status, the child may regain eligibility only by satisfying all of the requirements included in the Plan's definition of an eligible dependent and these dependent Eligibility Requirements.

The Fund Office will require all participants to provide documentation substantiating an individual's right to status as an eligible dependent. Documentation required by the Fund Office may include:

- A marriage certificate (in the English language);
- Birth certificate of biological child showing both parents' names;
- Court (legal) documents showing legal guardianship or adoption;
- Acknowledgement of paternity;
- Receipt of a Qualified Medical Child Support Order pursuant to terms of the Fund; or
- Notarized affidavits.

The date a person becomes a dependent means:

- With respect to a newborn child, the date of birth;
- With respect to a stepchild, the date of your marriage to your stepchild's parent;
- With respect to a foster child, the date the child is placed with you for foster care;
- With respect to a child named in a QMCSO, the later of the date specified in the court order or the date it is qualified;
- With respect to an adopted child, the date of adoption or placement for adoption; or
- With respect to a Spouse, the date of the marriage;
- With respect to a child for whom you are legal guardian, the date the guardianship papers are signed by the Court.

### *Effective Date of Coverage for Active Employees*

Your coverage will become effective on the first day of the month in which you become an eligible Employee, you enroll in the Plan, and your Employer contributes to the Fund on your behalf.

### *Effective Date of Coverage for Eligible Dependents*

On the day you become eligible for coverage under the Plan, your eligible dependents also become eligible, provided they are enrolled in the Plan within 60 days of your eligibility effective date, and meet all the requirements for coverage.

If you marry after the date you initially become covered under the Plan, your Spouse becomes covered on the day of marriage provided you give the Fund Office timely notice of the marriage, complete the required paperwork within the permissible time period as set forth under the subsection “Special Enrollment During Mid-Coverage Period.”

If, after the date you initially become covered under the Plan, you have a newborn biological child, an adopted child, a stepchild, a child placed with you for adoption, or a foster child such child will become covered on the date of their birth (for a newborn biological child) or on the date the child is adopted or placed in your home (for step, adopted, or foster children).

To ensure a new dependent receives coverage, you must notify the Fund Office within 60 calendar days of the date you acquire a new dependent through marriage, birth, foster placement, or adoption. You must also submit all required paperwork, and your Employer must make the required contribution for dependent coverage (e.g. Employee plus Spouse, Employee plus children, family).

## Determination of Eligibility for Coverage

Your eligibility for coverage under this Plan is determined each month, based on the contributions received from your employer. After the initial determination of your eligibility, your eligibility and coverage will terminate on the last day of any month in which you no longer qualify as an Employee, and your employer does not remit the required contribution for your coverage.

If your coverage terminates because of your death, your dependents will continue coverage as if you had remained a participant until the end of month of your death. After that, your dependents are eligible to elect COBRA Continuation Coverage.

## Eligibility for Retiree Coverage

To be eligible for Retiree coverage where provided, you must retire from active employment with a participating Employer while you are eligible for benefits under this Plan, and your Employer must continue to make the required monthly contributions to the Plan. Retiree coverage is only available where the collective bargaining agreement and/or participation agreement provide for Retiree health care coverage, and the covered Employee meets the eligibility rules for Retiree coverage under the terms of such agreements.

Please be sure that you and your Medicare-eligible dependents are enrolled for Medicare before your retirement, or as soon as you become entitled to Medicare after retirement. This Plan has a Medicare enrollment provision for Retirees (and certain disabled persons) which requires that you enroll for Medicare when you become entitled. If a participant could enroll for Medicare but neglects to do so, the

Plan will administer benefits as the secondary payer, i.e., Medicare as primary, and will reduce medical benefit payments by the amount Medicare would have paid if the person had enrolled (See Coordination of Benefits).

## Eligibility Pursuant to a Qualified Medical Child Support Orders

The Plan is required to recognize Qualified Medical Child Support Orders (QMCSOs). QMCSOs require health plans to recognize state court orders that the Plan finds to be Qualified Medical Child Support Orders, as defined in the Social Security Act, directing a participant to provide health care coverage for dependent children, even if the participant does not have custody of the children. The Plan will honor any medical child support order, which it finds to be a Qualified Medical Child Support Order (QMCSO) under the procedures set forth under the Plan, and as set forth in ERISA.

Under federal law, a QMCSO is a child support order of a court or state administrative agency that has been received by the Fund Office, and that:

- Designates one parent to pay for a child's health plan coverage;
- Indicates the name and last known address of the parent required to pay for the coverage and the name and mailing address of each child covered by QMCSO;
- Contains a reasonable description of the type of coverage to be provided under the designated parent's health care plan or the manner in which such type of coverage is determined; and
- States the period for which the QMCSO applies.

An order is not a QMCSO if it requires the Plan to provide any type or form of benefit or any option that the Plan does not otherwise provide. For a state administrative agency order to be a QMCSO state law must provide that such an order will have the force and effect of law, and the order must be issued through an administrative process established by state law.

If a court or state administrative agency has issued an order with respect to health care coverage for any of your dependent children, the Plan Administrator will determine if that order is a QMCSO as defined by ERISA, and under the terms of the Plan. The Plan Administrator's determination will be binding on you, the other parent, the child and any other party acting on behalf on the child. If an order is determined to be a QMCSO, the Plan Administrator will notify the parents of each child, and advise them of the Fund's procedures that must be followed to provide coverage to the dependent children.

Coverage of the dependent children will be subject to all terms and provisions of the Plan, including any limits on the selection of providers, and requirement for authorization of services, insofar as is permitted by applicable law.

No coverage will be provided for any dependent child under a QMCSO unless all of the Plan's requirements for coverage of that dependent child have been satisfied. Coverage of a dependent child under a QMCSO will terminate when your coverage terminates for any reason, subject to the dependent child's right to elect COBRA Continuation Coverage (if that right applies).

You may obtain a copy of the Plan's procedures governing QMCSOs without charge from the Fund Office. If you have any questions about QMCSOs contact the Fund Office.

## How to Enroll in Coverage Under the Plan

You must apply for coverage for yourself and your dependents by completing an enrollment form and providing the completed form to your Employer. Your Employer will process the form and initiate any necessary payroll deduction, indicate the effective date of coverage, and provide the form to the Fund Office. Coverage for you, your Spouse, and/or Eligible Dependent Children will not be effective until the Fund Office receives and processes the form. Enrollment forms should be received by the Fund Office prior to your initial effective date for coverage. If submission prior to your effective date is not possible, your form must be received by the Fund Office before the end of the initial coverage month.

If you acquire a new dependent, you should notify your Employer and enroll the new dependent within 60 days to ensure coverage for your dependent. If you do not enroll your dependent within 60 calendar days, unless you experience a special enrollment event, enrollment for coverage will be delayed until your Employer's next Open Enrollment period..

If you fraudulently enroll someone who is not eligible for coverage, **that person's coverage will be terminated immediately**. The Fund has a right to be reimbursed of any claims that were paid based on the fraudulent enrollment. You also may be subject to criminal penalties.

## Special Enrollment During Mid-Coverage Period

If you, your Spouse, or your Eligible Dependent Children are declining coverage because of other health insurance coverage, in the future you may be able to enroll yourself, your spouse, or your dependents in this Plan, provided you request enrollment within 60 calendar days after coverage under the other plan ends. The dependent's loss of coverage must be due to exhaustion of continuation coverage under another plan, termination resulting from the loss of eligibility under the other plan, termination as a result of increase in cost of coverage under the other plan, or termination because Employer contributions under the other plan were reduced or terminated.

Loss of coverage for this purpose does not include a loss due to the individual or participant's failure to make payments on a timely basis under the applicable terms, or termination of coverage for cause.

If you have a new dependent as a result of marriage, birth, or placement for adoption, you may enroll yourself, and your new dependent(s), provided that you request enrollment within 60 days after the marriage, birth, adoption, or placement for adoption. If you fail to enroll within the Special Enrollment window, you may enroll yourself and/or your new dependent(s) during your Employer's next Open Enrollment period.

A child will be considered placed for adoption when you become legally obligated to support that child, totally or partially, prior to that child's adoption. If a child placed for adoption is not adopted, all health coverage ceases when the placement ends, and will not be continued.

Please contact the Fund Office if you have any questions about Special Enrollment.

# Termination and Continuation of Health Coverage

## Termination of Coverage for Employees

Your coverage under this Plan will terminate on the earliest of the following dates:

- The date your Employer ceases to be a contributing Employer;
- The date this Plan is discontinued or the National IAM Benefit Trust Fund is terminated;
- The last day of the month for which you made a contribution for coverage, if it is required, or for which contributions were made on your behalf by your Employer; or
- The last day of the month during which your employment terminates. Your employment will terminate if you are not actively engaged in work in a covered position for your Employer. However, if you are no longer actively engaged in work in a covered position due to any of the following reasons your employment will be deemed to continue provided your Employer does not terminate you, and continues to make the required payments for your coverage:
  - Paid vacation;
  - Retirement, but only if the participation agreement provides for Retiree coverage;
  - Disability due to accident or illness (applies to medical benefits only); but only if the participation agreement provides for such coverage, and limited to no more than 12 months unless otherwise approved by the Board; or
  - Layoff (applies to medical benefits only); but only if the participation agreement provides for such coverage, and limited to no more than 12 months unless otherwise approved by the Board.

## Termination of Coverage for Dependent Children

The coverage for children will terminate on the earlier of the following dates:

- The date your coverage terminates;
- The last day of the month in which the person no longer qualifies as a dependent;
- The last day of the month for which contributions were made for dependent coverage; or
- The last day of the month during which you die.

## Termination of Coverage for your Spouse

The coverage for your Spouse will terminate on the earlier of the following dates, as applicable:

- The date your coverage terminates;
- The last day of the month during which you divorce or legally separate from your Spouse; or
- The last day of the month during which you die.

You must provide proof satisfactory to the Fund Office of your divorce or legal separation.

## Termination of Coverage for Surviving Spouse

Survivor benefits, if allowed, will terminate on the earliest of the following:

- The date your surviving spouse dies;
- The last day of the month in which your surviving Spouse remarries;
- The last day of the month in which a monthly contribution is received for coverage; or
- The expiration of the applicable Continuation of Coverage period under the Plan, including COBRA Continuation Coverage.

## Options Under Which Your Coverage Can Be Extended

### *Coverage During Family and Medical Leave*

The Family and Medical Leave Act (FMLA) of 1993, (as amended), allows you to take up to 12 weeks of unpaid leave during any 12-month period due to any of the events listed below, and you have performed at least 1,250 hours over the previous 12-month period. In addition, you must work at a location where at least 50 employees are employed by the employer within a 75-mile radius.

Eligibility for leave under FMLA will be determined by your contributing employer. In determining your continued eligibility for medical coverage benefits during a FMLA leave of absence, the Plan will comply in all respects with the Act. The FMLA allows an Employee to FMLA leave of absence due to:

- The birth, adoption, or placement with you for adoption or foster care of a child;
- You need to care for a seriously ill Spouse, child, or parent;
- Your serious illness;
- A qualifying exigency, or urgent need to for leave because your Spouse, son, daughter or parent is on active duty in the armed services (including the National Guard or Reserves) in support of a military operation.
- In addition, you may be able to take up to 26 weeks of unpaid leave during any 12-month period to care for a service member. The service member must be:
  - Your Spouse, son, daughter, parent, or next of kin;
  - Undergoing medical treatment, recuperation or therapy for a serious illness or injury incurred in the line of duty while in the armed forces; and
  - As an outpatient or on the temporary disability retired list of the armed services.

Covered service members include veterans who were members of the Armed Forces (including the National Guard or Reserves) at any time during the 5 years preceding the date on which the medical treatment, recuperation or therapy began.

The Fund will maintain your prior eligibility status until the end of the leave, provided the contributing Employer properly grants the leave under FMLA, notifies the Fund, and continues to make the required contribution to the Fund.

If you and your employer have a dispute over your eligibility under the FMLA, your benefits will be suspended pending resolution of the dispute, in the absence of the required contribution. The Board of Trustees will have no direct role in resolving the dispute. Coverage under the Plan will continue during FMLA leave on the same basis as other similarly situated employees.

Call your employer to determine if you are eligible for FMLA leave. Then contact the Fund Office if you are planning to take FMLA leave so that the Fund is aware of your employer's responsibility to make contributions during your absence. The Board of Trustees cannot enforce collection of contributions from your employer while you are out on leave. However, you may seek guidance regarding your continued coverage from the Department of Labor (DOL), EBSA division.

### *Coverage During Qualified Military Service*

If you enter qualified military service (such as active or inactive duty training or active duty in the United States armed forces or national guard), under the Uniformed Services Employment and Reemployment Rights Act (USERRA), your eligibility for coverage under the Plan may be protected during the qualified military service leave of absence. If you have sufficient hours in previous work periods to continue eligibility for one or more months following the month you enter the Uniformed Services, you have the option of continuing your eligibility in the Plan under the Plan's Continuation of Eligibility rules or freezing your eligibility as of the end of the month in which you enter the Uniformed Services or as of the date you enter the Uniformed Services if you enter on the first of the month. If you freeze your eligibility, you may reclaim this eligibility when you return to work for an Employer under the criteria set forth in USERRA. You must notify the Fund Office of which option you select. If you do not notify the Fund Office, your eligibility will be automatically extended until it is exhausted.

If you are covered under the Plan at the time your qualified military service leave of absence begins, your health coverage will be continued by the Fund during your first 30 calendar days of military service. If you are on qualified military leave for more than 30 calendar days, you will be permitted to continue benefits for yourself, or you may opt to freeze your eligibility (as set forth above). The Plan may require you to continued coverage, at your own expense, in premium amounts permitted under COBRA for up to 24 months. If you elect continuation of coverage under USERRA, **this coverage is available only to you**, not your Spouse and/or Eligible Dependent Children. Coverage may be available through the military for you, your Spouse, and your Eligible Dependent Children.

In order to preserve your eligibility under the Plan, in accordance with USERRA, you must return to work or seek re-employment with an employer following a discharge, under not less than honorable conditions, within the minimum time period allowed. If you do not return to work in Covered Employment or seek re-employment in Covered Employment within the required time period, you will forfeit your continued eligibility rights. In order to ensure protection of your rights under USERRA, you must notify the Fund Office as soon as you are called up for qualified military service and set forth the option you have elected to exercise.

Your right to maintain and reinstate coverage by reason of qualified military service will be administered and interpreted by the Plan in accordance with the requirements of USERRA. The contributions, if any, credited to you will be kept on the Plan's records during the qualified military service leave of absence, and your coverage and coverage for your Spouse and your Eligible Dependent Children will be reinstated, provided you return to work in Covered Employment or seek re-employment with an employer within the time period protected under USERRA.

If you are honorably discharged from the Uniformed Services, Plan coverage for you, your Spouse, and Eligible Dependent Child will be reinstated on the day you begin work with an Employer participating in the Plan, provided that you comply with the notice on return-to-work requirements of USERRA. These requirements and additional information on USERRA can be found at the Department of Labor website at: http://www.dol.gov/vets/programs/userra/userra_fs.htm.

### *Extension of Coverage under COBRA Continuation Coverage (COBRA)*

The right to COBRA Continuation Coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA Continuation Coverage can become available to you when you otherwise lose your group health coverage. It also can become available to your Spouse and Eligible Dependent Child who are covered under the Plan at the time they would otherwise lose their coverage. This continuation of coverage under the Plan is a temporary extension of coverage, with a period of coverage that is determined by the type of event (qualifying event) that would otherwise trigger your loss of coverage (or loss of coverage for your Spouse and/or Eligible Dependent Child). This continuation of coverage is provided in addition to the Plan Provided Continuation of Coverage Benefit noted on the next page.

To be enrolled in the Plan under COBRA Continuation Coverage, you, your Spouse or Eligible Dependent Child must elect to continue coverage, complete the election form, and submit the completed form to the Fund Office within the applicable time period. In addition, the monthly premiums must be paid on a timely basis and sent directly to the Fund Office. See Section on COBRA Continuation Coverage below for more details on this benefit.

# Continuation Coverage (Self-Pay)

## Plan Provided Continuation of Coverage Benefit

If an active employee loses eligibility because of the termination or reduction in hours of employment, eligibility to participate in health care coverage may be continued by making self-payments (ACH or check), payable to the Fund, for a period of up to six (6) months. This benefit is available to eligible Participants in addition to COBRA continuation coverage, **except where such addition would result in more than 36-months of total continuation coverage**.

**Note:** Upon termination or reduction is hours, the employee will have until the **later of:** (a) 60 days from the date of notification of the option to elect this benefit, or (b) 60 days from the date eligibility is lost, to notify the Fund Office of his or her election to continue eligibility by making self-payments.

## COBRA Continuation Coverage Benefit

COBRA Continuation Coverage is a continuation of your health care coverage under the Plan when coverage for you, your Spouse, Eligible Dependent Children, would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed below.

After a qualifying event, COBRA Continuation Coverage must be offered to each person who is a "qualified beneficiary." you, your Spouse, and your Eligible Dependent Children could become Qualified Beneficiaries if coverage under the Plan is lost because of the qualifying event, and you, your Spouse, or Eligible Dependent Children were enrolled in coverage under the Plan at the time the Qualifying Event occurred. Qualified Beneficiaries who elect COBRA Continuation Coverage must make monthly self-payments for coverage, on or before the due date.

**You, as the participant/employee** will become a "Qualified Beneficiary" if you lose your coverage under the Plan because any of the following Qualifying Events occur:

- A reduction in your work hours which causes a loss of eligibility under the Plan; or
- Your employment ends for any reason other than your gross misconduct;
- You lose retiree coverage due to becoming entitled to Medicare (Part A, Part B, or both if the retiree terminates retiree coverage after electing Medicare.

**Your Spouse** will become a "Qualified Beneficiary" if coverage under the Plan is lost because any of the following Qualifying Events:

- Your death;
- You experience a reduction in work hours, which causes a loss of eligibility under the Plan;
- Your employment ends for any reason other than your gross misconduct;
- You lose retiree coverage due to becoming entitled to Medicare (Part A, Part B, or both); or
- You become divorced or legally separated from your Spouse.

**Your Eligible Dependents** will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events:

- Your death;
- You experience a reduction in work hours, which causes a loss of eligibility under this Plan;
- Your employment ends for any reason other than your gross misconduct;
- You lose retiree coverage due becoming entitled to Medicare benefits (Part A, Part B, or both);
- You and your Spouse become divorced or legally separated; or
- Your dependent child no longer meets the eligibility requirements under the Plan. For example, the dependent child reaches age 26 and no longer meets the eligibility definition as of the end of the month of his or her 26th birthday.

## Who Is a Qualified Beneficiary?

A "Qualified Beneficiary" under COBRA is any participant or eligible dependent who, on the day before the Qualifying Event, has coverage under the Plan, who would otherwise lose such coverage due to the Qualifying Event, and timely elects to receive COBRA Continuation Coverage. The term Qualified Beneficiary includes any eligible dependent who is born to, or placed for adoption with, you during the period of COBRA Continuation Coverage. Adding a dependent to your coverage may cause an increase in your COBRA premiums.

If a Qualified Beneficiary with COBRA Continuation Coverage acquires an eligible dependent, the eligible dependent may be added to the coverage for the remainder of the COBRA Continuation coverage period. If a Qualified Beneficiary has a dependent who was eligible, but not enrolled in the Plan at the time the Qualified Beneficiary enrolled for COBRA continuation coverage because the dependent had other group health coverage at that time, and the dependent loses the coverage under the other group health plan due to exhaustion of COBRA continuation coverage, you may add the dependent to your coverage for the remainder of the COBRA continuation coverage period. The addition must be completed within 30 calendar days after the dependent's loss of the other coverage.

## Who Must Give Notice of the Qualifying Event?

### *Employer's Responsibility*

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Fund Office has determined, or been notified, that a Qualifying Event has occurred. Your contributing employer must notify the Fund Office if:

- You experience a reduction in work hours that causes a loss of eligibility under the Plan;
- Your employment ends for any reason other than your gross misconduct;
- You die; or
- You become entitled to Medicare benefits (Part A, Part B or both).

### *Your Responsibility*

You are responsible for providing the Fund Office with timely notice of the following Qualifying Events:

- You and your Spouse are divorced or are legally separated;
- An eligible dependent has ceased to meet the eligibility requirements;

- If there is an occurrence of a "second qualifying event" experienced by you or any other qualified beneficiary after you, or the other qualified beneficiary who previously became entitled to COBRA with a maximum duration of 24 (or 35) calendar months. This second qualifying event could include your death, you becoming entitled to Medicare, your divorce or legal separation, or your dependent losing eligibility status under the Plan. (More information about second qualifying events is provided later in this section.);
- If a qualified beneficiary entitled to receive COBRA continuation coverage with a maximum of 24 calendar months has been determined by the Social Security Administration to be disabled. If this determination is made at any time that an individual is disabled during the first 60 calendar days of COBRA continuation coverage, the qualified beneficiary may be eligible for an 11-calendar month extension of the original 24-calendar month maximum coverage period, for a total of 35 calendar months of COBRA continuation coverage; and
- If the Social Security Administration determines that a qualified beneficiary is no longer disabled.

Failure to provide the proper notice within the required timeframes, as set forth below, may prevent you from obtaining or extending COBRA continuation coverage.

The Fund Office will determine whether a qualifying event has occurred for purposes of COBRA Continuation Coverage. However, you should promptly notify the Fund Office of any of these qualifying events listed herein. This will allow the Fund Office to process your election for continuation of coverage more efficiently, with little or no interruption in your coverage and the handling of your claims.

## Procedures for Notifying the Plan of a Qualifying Event

To notify the Fund Office of any of the qualifying events listed above, a "qualified beneficiary" can send a notice via U.S. First Class mail, fax or email to request continued coverage under the Plan within the later of 60 calendar days from the date of the qualifying event *or* the date coverage was lost under the Plan due to the qualifying event. The notice must be in a form that documents the date sent (*e.g.*, if sent by mail, the request must be postmarked no later than 60 calendar days after the date described above). In the event of divorce or legal separation, you must also submit a copy of the divorce decree or written proof of the legal separation.

In the event of a Social Security Administration determination of disability, you must submit a copy of the Social Security disability determination. If you are providing notice of a Social Security Administration determination of disability, the notice must be postmarked no later than 60 calendar days after the latest of:

- The date of the disability determination by the Social Security Administration;
- The date on which the qualifying event occurs; or
- The date on which the qualified beneficiary loses (or would lose) coverage under the plan as a result of the qualifying event.

Notice of a Social Security disability determination must be submitted to the Fund Office *before* the end of the first 18 calendar months of the COBRA continuation coverage.

If you are providing notice of a Social Security Administration determination that a qualified beneficiary is no longer disabled, the notice must be postmarked no later than 30 calendar days after the date of

the final determination by the Social Security Administration that the qualified beneficiary is no longer disabled.

Notice may be provided by the participant or qualified beneficiary with respect to the qualifying event, or any representative acting on behalf of the participant or qualified beneficiary. Notice from one individual will satisfy the notice requirement for all related qualified beneficiaries affected by the same qualifying event.

**Address to Notify Plan Administrator of Qualifying Event**
National IAM Benefit Trust Fund
99 M Street, SE, Suite 600
Washington, DC 20003

## Determining the Duration of COBRA Continuation Coverage

Once the Fund Office determines or receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Participants may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

Generally under COBRA, an Employee may elect to continue coverage by making timely self-payments for up to 18 months for COBRA qualifying events. However, under this Plan, except where otherwise noted below, coverage may be continued by making timely self-payments for up to 24 months if the loss of coverage is for any termination of employment or loss of hours in employment covered by the Plan. Consequently, continuation of coverage with respect to termination of employment or loss of hours in employment will be collectively referred to as continuation of coverage.

In the case where the qualifying event is your death, you become entitled to Medicare benefits (under Part A, Part B, or both), you and your Spouse divorce or are legally separated, or your covered dependent is losing eligibility under the Plan, the length of COBRA continuation coverage may be in effect up to a total of 36 calendar months for each qualified beneficiary.

In the case where the qualifying event is termination of your employment or reduction of your hours of employment to result in failure to meet eligibility under the Plan, or you become entitled to Medicare benefits less than 18 calendar months before the loss of coverage due to a qualifying event, the length of COBRA continuation coverage may be for a period of up to 36 calendar months for each qualified beneficiary, except for your coverage, starting after the date you became entitled to Medicare coverage (Part A or B, or both).

For example, if you become entitled to Medicare eight months before the date on which your employment terminates or you experience a reduction in your hours of employment that result in loss of eligibility to participate in health coverage under the Plan, the period of COBRA continuation coverage for your Spouse and covered dependents may be elected for a period up to 36 calendar months beginning after the date of your Medicare entitlement, and is equal to 28 calendar months after the date of the qualifying event (36 calendar months minus eight months).

In the case when the qualifying event is the termination of your employment or reduction of your hours of employment to result in failure to meet the eligibility requirements under the Plan, the COBRA continuation coverage period generally will last up to a total of 24 calendar months (see above).

However, this 24-calendar month period of COBRA continuation coverage may be extended in the following two instances:

- Extension of 24-calendar Month Period of Continuation Coverage Due to Disability

  If you, your Spouse or your Eligible Dependent Child covered under the Plan is determined by the Social Security Administration to be disabled, and you notify the Fund Office in a timely fashion, you and your covered dependents may be entitled to receive up to an additional 11 calendar months of COBRA continuation coverage at an increased premium of up to 150% (for a total maximum of 35 months). The disability must be determined some time before the 60$^{th}$ day of COBRA continuation coverage and must last at least until the end of the 24-calendar month of the original period of continuation coverage.

- Extension of 24-calendar month period of continuation coverage Due to a Second **Qualifying Event**

  If you, your Spouse or Eligible Dependent Child covered by the COBRA Continuation Coverage experiences another qualifying event (a "second qualifying event") while covered under an 24-calendar month Continuation Coverage that includes the six-month continuation coverage period provided under the Plan plus the eighteen-month period under COBRA (or a 35-calendar month period of coverage if disabled), you and your covered qualified beneficiaries may be eligible for additional months of COBRA Continuation Coverage for a maximum period of COBRA Continuation Coverage of up to 36 calendar months. Timely notice of the second qualifying event must be given to the Fund Office.

  This extension may be available to any eligible dependents (if they are qualified beneficiaries) receiving continuation coverage if the participant or former participant dies, becomes entitled to Medicare benefits (under Part A, Part B or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as an eligible dependent child.

In no event will any Spouse, or Eligible Dependent Child be eligible for more than 36 total months of continuation coverage.

This extended period of continuation coverage is not available to anyone who became your Spouse after the termination of employment or reduction in hours. However, this extended period of continuation coverage is available to any child born to, adopted by, or placed for adoption with you (the active Employee) during the 24-month period of continuation coverage.

In no case are you entitled to Continuation Coverage for more than a total of 24 months if your employment is terminated or you have a reduction in hours (unless you are entitled to an additional continuation coverage period on account of disability). Therefore, if you experience a reduction in hours followed by termination of employment, the termination of employment is not treated as a second qualifying event and continuation coverage may not be extended beyond 24 months from the initial, qualifying event.

## COBRA Continuation Coverage and Disability

If you are a covered Employee and you lose coverage due to termination of employment as the result of your disability, you may elect to enroll in COBRA Continuation coverage. As in the case of all COBRA Continuation Coverage, you must self-pay for the premiums during the coverage period. Your coverage will continue until the earliest of:

- The date you cease to be disabled or return to active work;
- The date you attain age 65; or
- The expiration of the applicable COBRA Continuation Coverage period.

## Application of COBRA Continuation Coverage to Retirees

Some contributing Employers of the National IAM Benefit Trust Fund provide Retiree coverage for qualified Retirees and their dependents. Refer to the applicable collective bargaining agreement or other participation agreement for information on whether such coverage may be available, and for specific rules about how long such coverage is provided. Other contributing employers have no specific Retiree coverage. If there is a loss of coverage in either case, the Plan offers continuation coverage on a self-pay basis.

If you are a covered Employee and you lose coverage due to your termination of employment at retirement, or if you are a covered Retiree and you lose Retiree coverage for any reason, you may elect continuation coverage by making timely self-payments until the earliest of:

- The date you return to active work;
- The date you attain age 65 or become eligible for Medicare coverage; or
- The occurrence of another qualifying event within the otherwise applicable COBRA Continuation of Coverage period

If you are a retired Employee and should lose Retiree coverage due to the bankruptcy of your last contributing Employer, you have the right to choose continuation of health coverage for an indefinite period of time, but not beyond the occurrence of other applicable termination events described in the COBRA Continuation Coverage section.

## Summary of Periods of Continuation Coverage

| Qualifying Event Resulting in Loss of Coverage | Qualified Beneficiary | Maximum Continuation Coverage Period |
|---|---|---|
| 1. Termination of participant (for reasons other than gross misconduct | Employee, Spouse, and Dependent Children | 24 months after the date of the qualifying event[1] |
| 2. Participant reduction in work hours (making the participant ineligible for the coverage in place prior to reduction) | Employee, Spouse, and covered Dependent(s) | 24 months after the date of the qualifying event[1] |
| 3. Death of Employee | Surviving Spouse and Eligible Dependent Children | 36 months after the date of the qualifying event |
| 4. Divorce or legal separation of participant | Spouse or Dependent Children | 36 months after the date of the qualifying event |
| 5. Dependent child ceases to qualify for benefits under the Plan | Child aging out of eligibility | 36 months after the date of the qualifying event |
| 6. Disability as certified by Social Security Administration of any COBRA covered qualified beneficiary | Participant, Spouse or Dependent Child with the disability | 35 months after the date of the qualifying event[1] or longer in certain circumstances[2] |
| 7. Termination of employment due to retirement | Employee, Spouse and Dependent Children | 24 months after the date of the qualifying event[1] or longer in certain circumstances[3] |

## Benefits While on COBRA Continuation Coverage

If you choose to elect COBRA Continuation Coverage, the Plan will provide an extension of your health care coverage that was in effect the day before the qualifying event occurred and that is identical to similarly situated participants under the Plan.

**Note:** Benefits under life and accidental death and dismemberment insurance and short-term disability are not subject to COBRA. Therefore, these benefits are not continued under the terms and conditions of the Plan, although there may be conversion options under the applicable life insurance policy.

Following receipt of a notice or after a participant's loss of eligibility due to a termination of employment or reduction in hours of employment, the Plan will notify the participant, Spouse and their Eligible Dependent Child of their rights to purchase COBRA Continuation Coverage and the cost of such coverage that you will self-pay.

[1] This 24-month maximum period includes the 18-month statutory COBRA period plus an additional 6 months self-pay, as provided under the Plan.
[2] Refer to above section concerning COBRA Continuation Coverage and Disability
[3] The length of the COBRA Continuation Coverage will depend on whether the participant applies for Medicare before or after beginning COBRA Continuation Coverage.

## Making the Election for COBRA Continuation Coverage

When the Fund Office receives information concerning the loss of health care coverage due to a qualifying event, the participant or eligible family member will be sent a notice explaining their right to elect COBRA Continuation Coverage. The notice provides you (or eligible family member) with information regarding your coverage options and the cost to you associated with each option. The Notice also will include an election form you must complete and return to the Fund Office within the applicable time in order to activate your coverage under COBRA. The completed election form must be submitted to the Fund Office, within 60 days after the later of; (1) the date coverage would otherwise end, or (2) the date the qualified beneficiary receives the notice of the right to elect Continuation Coverage.

Each qualified beneficiary who elects Continuation Coverage must be named on the election form, or a separate election form must be submitted for any person not named on the form. If, for any reason, the Fund Office does not receive a completed election form within the 60-day period for any particular qualified beneficiary, the eligibility period for that qualified beneficiary to elect COBRA Continuation Coverage will expire and his or her health benefits will terminate as of the date on which he or she first became a qualified beneficiary (i.e., when coverage under the Plan terminated).

Neither the Fund Office nor the Plan will be responsible if a parent or guardian, acting on behalf of a minor qualified beneficiary, does not inform the minor qualified beneficiary of his or her right to elect COBRA Continuation Coverage within the 60-day period.

## Cost of COBRA Continuation Coverage

The cost of coverage under COBRA is paid totally by you or the other qualified beneficiary covered under the Plan. The monthly rates you will self-pay reflect the cost of medical benefits under the Plan, plus a 2% administration fee as allowed under COBRA. In the event that your coverage is based on a Social Security Administration or Railroad Retirement Board disability award, your monthly premium may include a surcharge. Also, the rate for COBRA coverage may change due to changes in the benefits offered by the Plan and, in certain circumstances, to reflect changes in the cost of the Plan's benefits. Absent these restrictions or conditions, your COBRA rate generally will remain in effect for a period of 12-months.

Under the law, you are required to pay the full cost for this coverage. More details are included in the individual COBRA election notice you will receive. The initial payment must be received by the Plan within 45 days after the date of your election for COBRA Continuation Coverage. The initial premium must be paid to cover the period of coverage from the date of the election, retroactive to the date of the loss of coverage due to the Qualifying Event. Subsequent premiums amounts will be due on the first day of each calendar month for the duration of the applicable period of coverage.

It is the responsibility of each qualified beneficiary or person acting on behalf of a qualified beneficiary, to ensure that the Fund Office receives the correct payment on a timely basis. Neither the Plan or the Fund Office is responsible if the qualified beneficiary causes himself or herself to lose Continuation Coverage through a failure to submit the correct payment in a timely fashion.

## Termination of COBRA Continuation Coverage

Continuation Coverage will terminate as noted above, or the earliest of:

- The date of death for the covered individual;
- The last day of the applicable maximum continuation period;
- The last day of the month for which you made a timely self-payment for COBRA Continuation Coverage;
- The date you (as a Spouse) remarry or marry and obtain coverage under another group health plan;
- The date you obtain coverage as an employee under another employer-sponsored group health plan;
- The date you become eligible for coverage under Medicare unless other rules apply as noted above;
- The date the Social Security Administration or Railroad Retirement Board makes a determination that you are no longer disabled;
- The date the Plan terminates; or
- The date your employer ceases to be a Contributing Employer, except as noted below.

If your Employer stops participating in the National IAM Benefit Trust Fund, the Fund will continue to carry the COBRA Continuation Coverage benefits for you, your Spouse, and your Eligible Dependent Children only if the Employer does not substitute another plan. If the Employer establishes one or more group health plans, or starts contributing to another multi-employer group health plan, the plan established by the Employer or the other multi-employer plan must make COBRA Continuation Coverage available to you, your Spouse and/or your Eligible Dependent Child, who:

- Was receiving coverage under the Plan (including Retiree coverage) immediately before the Employer's cessation of participation; and
- Is, or whose qualifying event occurred in connection with, a covered Employee or Retiree whose last coverage before the qualifying event was through the applicable Employer.

## Continuation Coverage or Extension of Coverage Other Than COBRA

Some contributing Employers of the National IAM Benefit Trust Fund provide a temporary extension of healthcare coverage if the Employee is terminated or is totally disabled or hospitalized, and/or the Employer terminates participation in the Fund. Refer to your applicable participation agreement for information on whether such an extension may be available to you.

The policy of the Trustees is that any such extension of coverage will be made available to you first, followed by COBRA Continuation Coverage so that you, your Spouse, and/or your Eligible Dependent Children will receive the maximum uninterrupted coverage period that can be provided under the Plan and the terms of your employment.

# Comprehensive Medical Coverage

The Plan will pay medical benefits as set forth in this SPD for covered medical charges incurred by you, your Spouse, or your Eligible Dependent Children while eligible for medical benefits under the Plan.

## Medical Benefit

A **Medical Benefit** is the amount, if any, the Plan will pay for covered medical charges incurred by you, your Spouse, or your Eligible Dependent Child. The amount of a medical benefit is the amount the Claims Administrator calculates in the steps shown below:

- The charges for which a claim is submitted to the Claims Administrator are tested against the covered medical charge definition. The submitted charges that meet all of the tests are the covered medical charges under the Plan.
- Any copayment amount that applies to the charges is subtracted from the amount of covered medical charges.
- If any part of the remaining amount exceeds an applicable benefit maximum, then that part is subtracted and the remainder is the amount of the medical benefit.

## Medically Necessary Charges

Plan benefits are payable for charges incurred only to the extent the charges are for services, supplies and treatments that are Medically Necessary as defined under the terms of the Plan, and only up to the applicable maximum allowed for such benefits, services, or supplies under the terms of the Plan. Certain services are not subject to the Medically Necessary definition, as noted in the SPD.

## Deductible

The deductible shown in the Schedule of Benefits:

- Applies to all covered medical charges unless otherwise stated;
- Applies separately to each participant during each calendar year; and
- Must be accumulated during the applicable calendar year.

No charge will be subject to more than one deductible amount. Only those charges to which a deductible applies will be applied to satisfy the applicable deductible.

When a covered individual's cumulative deductible in a calendar year reaches the individual deductible maximum amount as shown in the Schedule of Benefits, the deductible will be considered met in full, and no further deductible amounts will be applied to any charges incurred by the applicable participating individual in the applicable calendar year.

## Family Deductible Maximum

When eligible covered individuals in your family have accumulated their individual deductible amounts in any calendar year that, when combined, reach the family deductible maximum amount as shown in the Schedule of Benefits, the family deductible will be considered met in full, and no further deductible

amounts will be applied to any charges incurred in the applicable calendar year by any of the applicable covered individuals in your family.

The result of this rule is that some covered individuals in your family may fully satisfy their individual deductible amount before receiving benefits under the Plan (except for Preventive Services with no applicable deductible amount and no cost sharing), while other covered individuals may end up having to satisfy only a portion of their applicable individual deductible amount because collectively between those members the entire family deductible amount is met in full.

For this purpose, family includes you and all eligible members of your family, including your Spouse and Eligible Dependent Child that are covered under the Plan.

## Deductible Carry-Over

If a covered individual incurs charges during the last three months of a calendar year that are applied toward satisfaction of the deductible, those charges will also be applied toward the individual's deductible for the next calendar year.

## Copayment

A **Copayment** is the amount a participant must pay to his or her provider of service before benefits are payable by the Plan. The copayment shown in the Schedule of Benefits:

- Applies to all covered medical charges unless otherwise stated;
- Applies separately to each participant; and
- Applies separately for each visit, stay, procedure or item unless otherwise stated.

No charge will be subject to more than one copayment amount.

## Coinsurance

The coinsurance referenced in the Schedule of Benefits is the patient percentage of Covered Medical Charges for which you are responsible after the Plan's payment (e.g. if the Plan pays 90% of a covered service, your coinsurance is the remaining 10%). Your coinsurance:

- Is generally payable when your provider bills you after submitting your claim to the Plan;
- Does not include expenses not covered by the Plan; and
- Does not include your deductible or copayments (although these are included in your out-of-pocket limit explained later).

## Common Accident

If you, your Spouse, and any of your Eligible Dependent Children incur covered medical charges as a result of injuries suffered in a common accident, only one deductible will be applied during each calendar year to those charges. If greater medical benefits would be paid in the absence of this provision, then this provision will not apply.

## Payment Percentage

The Payment Percentage and the covered medical charges to which such Payment Percentage applies are shown in the detailed Schedule of Benefits. The Payment Percentage applies after any applicable deductible amount has been met, and it is applied separately to each covered individual.

## Out-of-Pocket Limit

The individual and family out-of-pocket limits are shown in the Schedule of Benefits. A separate out-of-pocket limit for the Prescription Drug Coverage applies for benefits under the Plan. The out-of-pocket limit is the maximum amount a covered individual will have to pay for covered charges during a calendar year. The out-of-pocket limit includes the deductible.

When a covered individual's cumulative out-of-pocket expenses in any calendar year reaches the applicable out-of-pocket limit shown in the Schedule of Benefits, all covered charges for the covered individual will be paid by the Plan at 100% for the remaining months of that calendar year.

When your covered family members have accumulated individual out-of-pocket amounts in any calendar year that, when combined, equals or exceeds the amount of the family out-of-pocket limit shown in the Schedule of Benefits, all further covered charges for all covered family members will be paid by the Plan at 100% for the remaining months of that calendar year.

For this purpose, the term family includes you, your Spouse, and your Eligible Dependent Children who are covered under the Plan.

The above provisions do not apply to charges that exceed Usual, Customary and Reasonable (UCR) charges, charges that exceed Plan benefit limitations, or charges for services that are excluded under the terms of the Plan.

## Accumulation of Deductible and Out-of-Pocket Limits for In-Network and Out-of-Network Purposes

Covered expenses incurred either in-network or out-of-network will cross accumulate to satisfy deductible amounts and maximum out-of-pocket limits. However, note that separate out-of-pocket limits apply to in-network and out-of-network covered medical charges and Prescription Drug Coverage.

## Lifetime Maximum

The Plan does not impose an overall lifetime dollar maximum. However, there are limits that may apply for some types of visits, and/or a limit on the number of days permitted for the benefit under the terms of the Plan. In addition, there may be dollar limits applicable to certain benefits as described in this SPD.

# No Surprises Act

The No Surprises Act (the "Act") was signed into law in December 2020. The Act protects patients who receive emergency services at a hospital, at an independent freestanding emergency department, and from air ambulances. In addition, the law protects patients who receive emergency services from a Non-PPO Provider at an in-network facility. Effective January 1, 2022, beneficiaries receiving these services will only be responsible for paying their in-network cost sharing and cannot be billed for the balance by the provider or emergency services facility.

Effective January 1, 2022, the Plan is implementing improvements to comply with the No Surprises Act.

**Emergency Services** Emergency Services are covered:

- Without the need for a prior authorization determination, even if the services are provided out-of-network;
- Without regard to whether the health care provider furnishing the Emergency Services is a PPO Provider or a PPO emergency facility, as applicable, with respect to the services;
- Without imposing any administrative requirements or limitations on out-of-network Emergency Services that are more restrictive than the requirements or limitations that apply to Emergency Services received from PPO Providers and PPO emergency facilities;
- Without imposing cost sharing requirements on out-of-network Emergency Services that are greater than the requirements that would apply if the services were provided by a PPO Provider or a PPO emergency facility;
- By calculating the cost sharing requirement for out-of-network Emergency Services as if the total amount that would have been charged for the services were equal to the Recognized Amount for the services; and
- By counting any cost sharing payments made by the participant or beneficiary with respect to the Emergency Services toward any in-network deductible or in-network out-of-pocket maximums applied under the Plan (and the in-network deductible and in-network out-of-pocket maximums are applied) in the same manner as if the cost sharing payments were made with respect to Emergency Services furnished by a PPO Provider or a PPO emergency facility.

Your cost sharing amount for Emergency Services from Non-PPO Providers will be based on the lesser of billed charges from the provider or the Qualified Payment Amount ("QPA").

**Non-Emergency Items or Services from a Non-PPO Provider at a PPO Facility**

With regard to non-emergency items or services that are otherwise covered by the Plan, if the covered non-emergency items or services are performed by a Non-PPO Provider at a PPO facility, the items or services are covered by the Plan:

- With a cost sharing requirement that is no greater than the cost sharing requirement that would apply if a PPO Provider had furnished the items or services.
- By calculating the cost sharing requirements as if the total amount that would have been charged for the items and services by such PPO Provider were equal to the Recognized Amount for the items and services.

- By counting any cost sharing payments made by the participant or beneficiary toward any in-network deductible and in-network out-of-pocket maximums applied under the Plan (and the in-network deductible and out-of-pocket maximums must be applied) in the same manner as if such cost sharing payments were made with respect to items and services furnished by a PPO Provider.
- Non-emergency items or services performed by a Non-PPO Provider at a PPO facility will be covered based on your out-of-network coverage if:

– At least 72 hours before the day of the appointment (or three (3) hours in advance of services rendered in the case of a same-day appointment), the participant or dependent is supplied with a written notice, as required by federal law, that the provider is a Non-PPO Provider with respect to the Plan, of the estimated charges for your treatment and any advance limitations that the Plan may put on your treatment, of the names of any PPO Providers at the facility who are able to treat you, and that you may elect to be referred to one of the PPO Providers listed; and

– The participant or dependent gives informed consent to continued treatment by the Non-PPO Provider, acknowledging that the participant or beneficiary understands that continued treatment by the Non-PPO Provider may result in greater cost to the participant or beneficiary.

• The notice and consent exception does not apply to Ancillary Services and items, or services furnished as a result of unforeseen, urgent medical needs that arise at the time an item or service is furnished, regardless of whether the Non-PPO Provider satisfied the notice and consent criteria, and therefore these services will be covered:

– With a cost sharing requirement that is no greater than the cost sharing requirement that would apply if a PPO Provider had furnished the items or services,

– With cost sharing requirements calculated as if the total amount charged for the items and services were equal to the recognized amount for the items and services, and

– With cost sharing counted toward any in-network deductible and in-network out-of-pocket maximums, as if such cost sharing payments were with respect to items and services furnished by a PPO Provider.

Your cost sharing amount for Non-Emergency Services at PPO Facilities by Non-PPO Providers will be based on the lesser of billed charges from the provider or the QPA.

**Air Ambulance Services** If you receive Air Ambulance Services that are otherwise covered by the Plan from a Non-PPO Provider, the Plan will cover those services as follows:

- The Air Ambulance Services received from a Non-PPO Provider will be covered with a cost sharing requirement that is no greater than the cost sharing requirement that would apply if a PPO Provider had furnished the services.
- In general, you cannot be balance billed for these items or services. Your cost sharing will be calculated as if the total amount that would have been charged for the services by a PPO Provider of Air Ambulance Services were equal to the lesser of the QPA or the billed amount for the services.
- Any cost sharing payments you make with respect to covered Air Ambulance Services will count toward your Network (PPO) deductible and Network (PPO) out-of-pocket maximum in the same manner as those received from a PPO Provider.

**Payments to Non-PPO Providers and Facilities**

The Plan will make an initial payment or notice of denial of payment for Emergency Services, Non-Emergency Services at PPO Facilities by Non-PPO Providers, and Air Ambulance Services, within thirty (30) calendar days of receiving a Clean Claim from the Non-PPO Provider. The 30-day calendar period begins on the date the Plan receives the information necessary to decide a claim for payment for the services. If a claim is subject to the No Surprises Act, the participant cannot be required to pay more than the cost sharing under the Plan, and the provider or facility cannot bill the participant or dependent more than the required cost sharing. The Plan will pay a total plan payment directly to the Non-PPO Provider that is equal to the amount by which the Out-of-Network Rate for the services exceeds the cost sharing amount for the services, less than any initial payment amount.

**External Review**

In addition to the two (2) reasons for External Review listed in the Medical SPD, External Review is also available for a claim denial that is related to an Emergency Service, Non-Emergency Service provided by a Non-PPO Provider at a PPO facility, and/or Air Ambulance Service, as covered under the federal No Surprises Act. Please see the External Review Procedures in the Medical SPD for further information.

**Continuity of Coverage**

If you are a Continuing Care Patient, and the contract with your Network provider or facility terminates, or your benefits under a group health plan are terminated because of a change in terms of the providers' and/or facilities' participation in the Plan:

1. You will be notified in a timely manner of the contract termination and of your right to elect continued transitional care from the provider or facility; and
2. You will be allowed up to ninety (90) days from the date of notification of continued coverage at Network cost sharing to allow for a transition of care to a Network provider.

**Incorrect PPO Provider Information**

A list of PPO Providers is available to you without charge by visiting the CareFirst Administrators website or by calling the phone number on your ID card. The network consists of providers, including hospitals, of varied specialties as well as general practice, who are contracted with the Plan or an organization contracting on its behalf. If you obtain and rely upon incorrect information about whether a provider is a PPO Provider from the Plan or its administrators, the Plan will apply PPO cost sharing to your claim, even if the provider was a Non-PPO Provider.

**Complaint Process**

If you believe you have been wrongly billed, please contact Quantum Customer Service at 1-866-871-0839 for assistance or the Employee Benefits Security Administration ("EBSA") toll-free number at 1-866-444-3272.

**Repeal of Emergency Room Payment Rules**

The Plan provision concerning payment for Emergency Room Services, as required by the Affordable Care Act, is repealed for services provided on or after January 1, 2022, and replaced with the No Surprises Act requirements.

# Preferred Provider Organization

The Plan contracts with CareFirst Administrators or access to a nationwide preferred provider network (PPO). If you utilize services provided by physicians, other health care professionals, hospitals, or other health care facilities in the CareFirst Administrators network this will result in less cost to you and the Plan.

When you select a CareFirst Administrators participating provider for your medical services, you will have, in general, a higher percentage benefit payment and a lower out-of-pocket cost than if you select to receive those services from a non-participating provider. CareFirst Administrators participating providers have agreed, by contract, to accept payments from the Plan for services and benefits at discounted levels negotiated by CareFirst Administrators.

When you are seeking services from a provider, please present your medical ID card at each visit. The card identifies you as a CareFirst Administrators network participant and gives the participating provider necessary billing information for purposes of submitting your claims.

Note: you are not required to use a CareFirst Administrators provider. It is your choice. However, both you and the Plan will experience savings if you choose to utilize an in-network provider for your medical needs.

Participating providers in the CareFirst Administrators network include physicians, hospitals, other health care professionals, and other health care facilities. To find participating providers in the CareFirst Administrators network, please access the Plan's website at www.iambtf.org or the www.cfablue.com member portal. You also may get CareFirst Administrators network provider information by calling Quantum Health at the toll-free number shown on the back of your identification card, 866-871-0839. We recommend that you confirm a provider's *current* participation in the CareFirst Administrators network by calling CareFirst Administrators directly **before** treatment. If you would like a paper directory of providers, please contact CareFirst Administrators at the number on your medical identification card to request a copy for your zip code area.

If you need assistance, please contact Quantum Health at 866-871-0839.

## Applicability of In-Network Benefits

You must utilize a CareFirst Administrators network provider to obtain in-network benefits with the accompanying financial advantages. The following are exceptions to this rule:

### *Emergency Medical Care*

Whenever possible, you should request treatment from CareFirst Administrators providers. However, benefits will be provided at the in-network level for all Medically Necessary Emergency Services associated with true medical Emergencies that are received in the Emergency Room of both in-network and out-of-network hospitals.

### *If You're Not Able to Access an In-Network Provider*

Except where benefits are specifically limited to in-network providers, if there are no CareFirst Administrators providers within a 25-mile radius of your home, benefits will be provided at the in-network level for any covered provider that is located in the 25-mile radius, regardless of network participation

of the provider. Outside the 25-mile radius surrounding your home, the Plan's normal network provider coverage applies.

### *Hospital Assigned Services*

Whenever possible, you should advise your hospital and your attending physician of your need to use CareFirst Administrators providers for all referral services. However, if you receive services from a CareFirst Administrators participating hospital, and the hospital makes a referral to a non-participating provider, benefits for covered services will be provided at the in-network level. This standard will apply when your participating hospital assigns you a non-participating anesthesiologist or Emergency Room Physician or refers your lab tests or x-rays to a non-participating pathologist or radiologist for interpretation. This standard also will apply if your participating surgeon selects a non-participating assistant surgeon, or if your participating physician asks a non-participating physician or Specialist to see you at the hospital.

## *Travel Employees (Applies to IAM&AW Grand Lodge Active Employees covered under Plan A+ only)*

If you, as an Employee of the Grand Lodge of the IAM&AW, are identified by the Employer as a "Travel Employee", regardless of the time-period of the travel assignment, benefits will be provided at the "In-Network" level for any covered provider, regardless of network participation. This feature is not available to any family member other than to the Employee identified as a "Travel Employee" by the Grand Lodge, or to Employees of any other contributing Employer.

However, if you wish to incur the lowest possible out-of-pocket expenses, you should always consider seeking out an CareFirst Administrators network provider, even when you are away from home on business for the Employer, by calling Quantum Health's toll-free care line, 1-866-871-0839, for assistance in finding a participating provider, or by using the cfablue.com website or telephone app.

## Opportunity to Select a Primary Care Physician

Under the terms of the Plan, you are not required to select a Primary Care Physician (PCP), but may do so if you wish. You may use CareFirst Administrators network to select a Primary Care Physician for yourself, your Spouse, and/or your Eligible Dependent Child. The role of the PCP is to provide or arrange for medical care. Whether you select a PCP or not, you, your Spouse, and/or your Eligible Dependent child may exercise their choice of other health care providers without authorization from the PCP to provide the covered services they need, including Specialists. Each individual covered under the Plan has the right to select a PCP from CareFirst Administrator's list, and such PCP may be different for each covered individual.

## Quantum Health's Toll-Free Care Line

Quantum Health's toll-free care line allows you to talk to a health professional between 8:30am and 10:00pm, Monday - Friday, by calling the toll-free number shown on the back of your identification card at 1-866-871-0839. The staff at Quantum Health's toll-free care line can provide you with names of Quantum Health participating providers. You, your Spouse, and/or your Eligible Dependent Child may call Quantum Health's toll-free number if you need medical care. The staff will assist you with the available options.

## Access to CareFirst Administrators Participating Providers While on Travel

If you, your Spouse, or your Eligible Dependent Children need medical care while away from home, including travel outside the U.S., you have access to a national network of participating providers through the Blue Cross Blue Shield Global Core® Program. Call 800-810-BLUE (2583) toll-free or 804-673-1177, 24 hours a day, 7 days a week for information on doctors, hospitals, other health care professionals or to receive medical assistance services. A medical assistance coordinator, in conjunction with a medical professional, will make an appointment with a doctor or arrange hospitalization if necessary.

## If you Have a Complaint about CareFirst Administrators

If you have any type of complaint about CareFirst Administrators, you may contact CareFirst Administrators member services. You should contact CareFirst Administrators member services if you have any concerns regarding a CareFirst Administrators employee, the quality of care provided by CareFirst Administrators participating providers, or the processing of your claims (including claims for your covered family members). The toll-free number for member services is 866-871-0839 as shown on the back of your CareFirst Administrators identification card. You also will be able to find the CareFirst Administrators number on any copy of your Explanation of Benefits (EOB) CareFirst Administrators provides to you. You also have the option to express your concerns to CareFirst Administrators in writing.

CareFirst Administrators will make every effort to resolve the concerns you raise on your initial contact. However, CareFirst Administrators may need more time to address your concerns. In this case, someone will get back to you as soon as possible, but no more than 30 days after your initial contact.

The Fund Office also is available to you should you have any complaints about CareFirst Administrators or any aspect of the administration of the Plan. You may contact the Fund Office at 202-785-8148 or toll free at 800-457-3481.

Contacting CareFirst Administrators' member services or the Fund Office to make a complaint does not replace the requirement that you file a written appeal if you are not satisfied with the results of a decision by CareFirst Administrators on a claim you have submitted for benefits or services received under the Plan. If you do not agree with CareFirst Administrator's decision on any claim, you may contact CareFirst Administrators member services or the Fund Office about your concerns. In addition, you must make a written request as set forth under the section governing appeals and as explained in the section "Claims and Appeals Procedures" included in this SPD.

# Quantum Health Care Coordination Program

To best assist you with navigation of the healthcare system, the Plan includes a "Care Coordination Program" provided by Quantum Health. The Care Coordination Program is intended to help you better understand your available health and welfare benefits, obtain quality healthcare and services in the most appropriate setting, reduce unnecessary medical costs, and allow early identification of complex medical conditions using "Care Coordinators," "Medical Management Standards" and "Care Management." The Care Coordinators are available to you and your providers for information, help, and guidance, and can be reached toll-free by calling Quantum Health's **Care Coordinators at 1-866-871-0839.**

## The Care Coordinators

Quantum Health provides a single point of contact through "Care Coordinators" or "Patient Service Representatives" for you and your providers to help with your navigation through your individual healthcare journey, including, but not limited to:

- Answering questions about eligibility, Plan benefits and coverage levels,
- Locating providers based on network status and your needs,
- Outreaching to you and educating you about the benefits of using in-network providers and other resources available under the Plan,
- Identifying and educating you about availability of community resources,
- Initiating and coordinating referrals,
- Identifying those who may benefit from Care Management,
- Facilitating Prior Authorization determinations as "Pre-service" and "Concurrent" Claims in accordance with the Plan's Claim and Appeal Procedures*,
- Advising on Claim and appeal status, how to understand explanations of benefits ("EOBs") and health care bills, and
- Other general customer service functions on behalf of the Plan.

## Your Role in Care Coordination

You play a vital role in the Care Coordination process. To maximize benefits available under the Plan, you should familiarize yourself with and follow the Care Coordination processes outlined below and any other applicable Plan provisions. **Note:** failure to comply with requirements under the Plan can result in significant benefit reductions, which may include penalties, higher co-payments and cost-sharing, balance billing or denials of coverage for certain services. When in doubt, contact the Care Coordinators at 1-866-871-0839.

1. **Use In-Network Providers where Possible to Reduce Your Out-of-Pocket Costs.**

The Plan offers a broad network of providers and the benefits under the Plan are more generous when a Member receives services from a participating provider (aka, "in-network"). **To find in-network providers, please visit the Plan's website at www.myNIAMbenefits.com or call the Care Coordinators at 1-866-871-0839**. The Schedule of Benefits provided in this SPD and in the Summary

of Benefits and Coverage ("SBC") provided by the Plan identifies the coverage differences between services provided in-network and out-of-network. Generally, receiving services from out-of-network providers will result in increased financial responsibility and could result in balance billing by the provider for many non-emergency services as otherwise explained in this SPD.

2. **Designate an In-Network Primary Care Provider.**

While not required, to maximize benefits under the Plan and streamline the coordination of care, you are strongly encouraged to designate an in-network Primary Care Provider (PCP). A successful healthcare journey generally begins with a PCP who maintains a relationship with you, coordinates with the Plan and other providers and supplies ongoing general healthcare evaluation, guidance, and care management.

You are encouraged to begin all healthcare events or inquiries with a call or visit to your designated PCP. Because the PCP takes part in Care Coordination, they will help with submission of Prior Authorization requests and may receive updates from the Plan to enable the PCP to supply ongoing healthcare guidance.

If you have trouble finding a PCP, the Care Coordinators can supply a list of in-network PCPs based on your individual needs.

3. **Understand what Services Require Prior Authorization.**

| Medical/Surgical Services | Mental Health/Substance Use Disorder Services |
|---|---|
| • Inpatient Hospital Admissions (Inpatient)<br>• Skilled Nursing Facility Admissions (Inpatient)<br>• Hospice Care (Inpatient and Outpatient)<br>• Organ, Tissue, and Bone Marrow Transplants (Inpatient)<br>• Outpatient Surgeries provided in a Hospital Setting (Outpatient)<br>• Home Health (Outpatient)<br>• Diagnostics MRI/MRA/PET (Outpatient)<br>• Genetic Testing (Outpatient)<br>• Oncology Services – Chemotherapy, Radiation, and Clinical Trials (Outpatient)<br>• Dialysis (Outpatient)<br>• Durable Medical Equipment over $1,500 and all Rentals | • Inpatient Hospital Admissions (Inpatient)<br>• Residential Treatment Facility Admissions (Inpatient)<br>• Partial Hospitalization (Outpatient)<br>• Intensive Outpatient Services (Outpatient) |

To provide Care Coordination and to maximize benefits payable under the Plan, the care, services, and procedures listed above must be authorized before they are provided ("Prior Authorization or Pre-certification") under the Plan's Medical Management Standards (also commonly referred to as utilization review).

4. **Understand the Prior Authorization Process.**

A. **Timing of Request.**

Prior Authorization requests should be made to the Care Coordinators at least **three business days** before a scheduled service, treatment, procedure, inpatient admission or any other service requiring Prior Authorization except in the following circumstances:

- For an "emergency" hospital admission or outpatient procedure, notification to the Care Coordinators should be made on or before the next business day after the admission or procedure. For the purposes of this subsection only, "emergency" is defined as a procedure that has not been previously scheduled and cannot be delayed without harming your health.
- Notification should be made upon your identification as a potential organ or tissue transplant recipient.
- Maternity admission notifications should be submitted thirty (30) days before the expected delivery date.

B. **Submission of a Request.**

**You are ultimately responsible for ensuring that all Prior Authorizations are approved and on file prior to the provision of service to maximize benefits under the Plan.** Most Prior Authorization requests are submitted to the Care Coordinators by a designated PCP, other PCP, or other healthcare provider via the Plan's provider portal, facsimile or by calling the **Care Coordinators: 1-866-871-0839** as listed on the back of your identification card.

C. **Evaluation of the Request**

Submitted Prior Authorization requests considered Pre-service Claims are reviewed to determine if the requested service is: (a) specifically covered or excluded under the terms of the Plan or (b) considered experimental or investigative and (c) medically necessary under the Plan's Medical Management Standards discussed below. Depending on the request, the Care Coordinators may contact the requesting provider and/or treating provider to obtain additional clinical information to support the request and will suspend the claim for 45 days to allow the provider to send the information. At the end of the 45-day period, the claim will be denied as an administrative denial if the information is not provided.

D. **Ongoing Courses of Treatment.**

Quantum Health will regularly monitor inpatient hospital stays, other institutional admissions, or ongoing courses of treatment if you are receiving ongoing care and will examine the use of alternative levels of care or facilities, if necessary, under the appropriate Medical Management Standards. Quantum Health will communicate regularly with attending providers, discharge planners of facilities, and you and/or your family to monitor your progress and expect and initiate planning for discharge needs.

If Quantum Health reduces or terminates an already approved courses of treatment or is reviewing an ongoing course of treatment in a Claim involving urgent care, the Claim will be treated as a Concurrent care Claim under the Plan's Claim and Appeal Procedures. Otherwise, it will be treated as a Pre-service or Post-service Claim as applicable.

5. **Understand the Impact of Failure to Request Prior Authorization.**

Failure to timely submit a Prior Authorization request may result in a reduction of benefits, a denial of coverage, or assessment of penalties as reflected in in the Plan's Schedule of Benefits and/or SBC. Any penalty charges assessed during Claim processing are not applied toward the Member's satisfaction of the Deductible, Co-insurance amounts, or Out-of-Pocket limits under the Plan.

However, you will not be penalized for failure to obtain Prior Authorization if a prudent layperson, who has an average knowledge of health and medicine, could reasonably expect that the absence of immediate medical attention would jeopardize the life or long-term health of the individual. Those who receive care on this basis should contact the Care Coordinators no later than two (2) business days after receiving care or a hospital admittance.

6. **Understand that Participation in the Program Is Not a Guarantee of Benefits.**

Quantum Health strives to supply accurate and up-to-date information about provider network status, benefit estimates and Plan coverage through the Program. However, engagement with the Care Coordinators for any reason, including Pre-determinations, is not a guarantee of benefits. You are still responsible for educating yourself on the benefits available to you (under the Plan and as otherwise provided by the Plan Sponsor or community resources).

Further, Prior Authorization approvals issued by Quantum Health mean that the medical condition, services, and care settings meet the Medical Management Standards adopted by the Plan. The approvals do not guarantee that the service will be a covered benefit at the time the Claim is submitted for processing as a Post-Service Claim, that you are eligible for such benefits, that other benefit conditions such as Co-payments, Deductibles, Co-insurance, or Out-of-Pocket limits have been satisfied or that you will not be subject to balance billing where services are provided by an out-of-network provider. Final determinations of coverage and eligibility for benefits are made by the Plan when the Claim is submitted for payment.

## The Plan's Medical Management Standards

Determinations involving medical judgment (i.e., experimental/investigative and medical necessity) that require interpretation of clinical information are reviewed by a clinician under the terms of the Plan and the clinical review criteria approved by the Plan Administrator. If the clinician is not able to justify coverage based on the established criteria or no applicable criteria is available, it is referred to a medical director for review using the general clinical review criteria or medical director criteria or is referred to a "Peer Reviewer." A Peer Reviewer is a staff medical director or an independent reviewer but will be a Doctor of Medicine or a Doctor of Osteopathic Medicine or in the same licensure category as the ordering provider.

If an initial adverse determination is pending or issued by Quantum Health based on medical judgment, the ordering provider may request a peer-to-peer conversation with the Peer Reviewer to discuss the determination and supply more information that may support coverage. The peer-to-peer must be requested by the ordering provider prior to the Member (or Authorized Representative) filing an appeal under the Plan's Claim and Appeal procedures.

## Compliance with the Mental Health Parity and Addiction Equity Act

The Mental Health Parity and Addiction Equity Act and regulations issued thereunder ("MHPAEA") generally require that the Plan may not impose a financial requirement or treatment limitation on any mental health/substance use disorder benefits offered under the Plan unless the requirement or treatment limitation meets certain requirements, as documented by a comparative analysis.

Certain components of the Care Coordination Program, including the Prior Authorization and Concurrent review requirements and the use of other "Medical Management Standards" (medical experimental or investigative treatment to make benefit determinations) are generally considered Non-Quantitative Treatment Limitations (NQTLs) under MHPAEA.

The Care Coordination Program is intended to be compliant with the MHPAEA in its design and application because:

- The Plan's Prior Authorization and Concurrent review and Medical Management Standards are reasonably designed to detect or prevent fraud, waste and abuse.

- The processes, strategies, evidentiary standards and other factors used to design the Prior Authorization, Concurrent review and Medical Management Standards requirements for mental health or substance use disorder benefits in each classification are comparable to and no more restrictive than those processes, strategies, evidentiary standards, or other factors used to design the Prior Authorization, Concurrent review and Medical Management Standards to substantially all of the medical and surgical benefits in the same classification as reflected above.

- The clinical criteria applied by the Plan under the Medical Management Standards as written and in operation for medical/surgical and mental health/substance use disorder benefits are generally recognized independent professional medical or clinical standards (generally, InterQual, the TPA's medical criteria and Quantum Health medical director criteria consistent with generally accepted standards of care).

The Plan's Prior Authorization, Concurrent review and Medical Management Standards, as written and in operation, are not applied to mental health or substance use disorder benefits in any classification more restrictively or more stringently than and are impartially applied comparably to the Prior Authorization, Concurrent review and Medical Management Standards applied to substantially all medical/surgical benefits in the same classification.

# Case Management

Case management is a service that assists covered individuals with treatment needs that extend beyond the acute care setting. The goal of case management is to ensure that patients receive appropriate care in the most effective setting possible, whether at home, as an outpatient, or as an Inpatient in a hospital. If there is a need for case management, a case management professional will work closely with the patient, the family members, and the attending physician to determine appropriate treatment options that would best meet the patient's needs, while maintaining manageable costs to the Plan.

Case managers will help coordinate the treatment program and arrange for the necessary resources. In addition, case managers will answer questions and provide ongoing support for the family members during a medical crisis. While case managers, who are trained Registered Nurses and other credentialed health care professionals, may recommend alternate treatment programs and coordinate resources, your attending physician remains in charge of, and responsible for, your actual medical care.

Participation in case management programs is recommended for patients who need post-hospitalization services, or who have difficulty in managing or dealing with a costly illness. Quantum Health, may on occasion, contact you or your attending physician if they believe that case management might be helpful in your case. However, it is important to remember that participation in the case management program is voluntary. You should discuss the option of case management with your attending physician and contact Quantum Health for more information. You, your Spouse, your Eligible Dependent Child(ren), and/or your attending physician may request case management services by calling Quantum Health at the toll-free number on your identification card.

# Personal Care Guide Management

Quantum Health utilizes a primary nurse model for chronic condition as well as acute condition management. This enhanced approach provides one nurse to address clinical needs for all chronic and acute issues. The Personal Care Guide (PCG) nurse will consult with the covered member, their family (if requested), the attending physician, and other members of the covered person's treatment team to assist in facilitating/implementing proactive plans of care. The Personal Care Guide nurse can assist with benefits, incidental health care issues, becoming healthier, finding resources or an unexpected healthcare journey.

During outreach, the Personal Care Guide will touch on the covered member's treatment and perform a physical assessment, perform a medication reconciliation to ensure there are no duplications or interactions, perform a depression screening with subsequent referrals to EAP or in-network providers, as well as focus on the physical and emotional needs of the covered member.

The Personal Care Guide will look at the covered member's psychosocial needs and social determinants of health. In addition to the depression screening, they will evaluate the covered member's financial issues, knowledge deficits, as well as any cultural barriers that may exist. Conversations with the covered member could occur at least monthly, if not more frequently, and continue until the covered member's health goals and needs are met.

The primary Personal Care Guide nurse will align with the covered member and be the single point of contact for them, and their family and caregivers, and providers. The primary Personal Care Guide nurse will:

- Provide comprehensive benefit education/utilization support
- Drive PCP designation and steerage to Network Providers
- Encourage provider involvement
- Perform pre-admission, pre-discharge, and post-discharge engagement
- Coordinate with utilization review team for discharge planning needs
- Identify gaps in care and alleviate clinical, financial, and humanistic barriers
- Coordinate second opinions, drive utilization to other third-party vendor tools, and introduce community resources
- Perform behavioral health screening
- The primary nurse model has three foundational drivers for the changes:
    - Humanistic: to help members with acute and chronic needs by assigning a single nurse to the covered member and their family as well as a heightened attention to psychosocial issues that can negatively affect health, quality of life and financial outcomes.
    - Clinical: identify and prioritize members in need of clinical outreach. Improve adherence to quality measures for preventive health and management of chronic conditions.
    - Financial: identify and outreach to members at risk for future high costs while encouraging preventive care and chronic condition management to improve health and reduce costs.

**Note:** Information and/or recommendations received in connection with the disease management program do not imply that you are eligible for the coverage under the Plan. You should contact Quantum Health, or the Fund Office directly, to confirm whether you, your Spouse, and/or your Eligible Dependent Child have coverage under the terms of the Plan for any recommended services, or to get answers to any questions about the coverage provided by the Plan.

You can contact Quantum Health directly by calling 866-871-0839. You, your Spouse, and your Eligible Dependent Child may also contact the Fund Office with any questions at 202-785-8148 or toll-free at 800-457-3481.

# Covered Medical Charges List

Subject to the Schedule of Benefits, the Covered Charge Limits, the Areas of Limited Coverage provisions, and any applicable Exclusions and Limitations, the following sets forth a list of medical charges as provided under the terms of the Plan.

**Note: Precertification is required by the Plan for all inpatient and many outpatient services**. See the precertification requirements section earlier in this SPD and contact Quantum Health directly, before services are scheduled, to determine if precertification is needed for any proposed services.

## Facility Charges

These charges are classified as Facility Charges:

- Room and board charges of an Acute Care Hospital for each day of a participant's inpatient stay. Unless other contractual limits apply, such charges shall not be more than:
  - **Routine care unit:** The hospital's average semi-private room rate
  - **Intensive care unit:** Up to 300% of the hospital's average semi-private room rate.
  - **Special care unit** (other than intensive care unit): The hospital's average semi-private room rate.
- Charges of an Acute Care Hospital, other than room and board charges, for medical services and supplies furnished to a participant during his or her inpatient stay
- Charges of a hospital for emergency services.
- Charges of an Acute Care Hospital for medical services and supplies furnished on an outpatient basis.
- Charges of an Ambulatory Surgical Facility for an outpatient surgery done in the facility.
- Charges of a skilled nursing facility for the confinement of a participant as an inpatient, but only if the confinement: (a) follows a stay of at least five days as an inpatient in an Acute Care Hospital; and (b) starts within seven (7) days after the participant is discharged from that hospital stay. Unless other contractual limits apply, the covered medical charge for all services provided on each day of confinement will not be more than 50% of the prior Acute Care Hospital average semi-private room rate. The inpatient maximum stay for a skilled nursing facility is 100 days per calendar year.
- Charges for medical services and supplies furnished by a specialized facility. Unless other contractual limits apply, the covered medical charge for room and board for each day of the participant's inpatient stay shall be no more than the average semi-private room rate.

## Practitioner Charges

These charges are classified as Practitioner Charges:

- Charges of a physician for the following professional services:
  - Office visits, visits to an Acute Care Hospital, at the patient's home, or at any other covered medical facility, including urgent care facilities.
  - Surgery, subject to the surgery guidelines shown below.
  - Radiation therapy, chemotherapy, and dialysis treatment.

- Anesthesiology, subject to the surgery guidelines shown below.

  **Surgery Guidelines:** (a) If two or more surgical procedures are performed at the same time, the covered medical charges will be limited to those incurred for the major procedure plus 50% of those incurred for each lesser procedure that adds significant time or complexity; (b) the covered medical charges for performing surgery includes normal follow-up care and the administration of any local, digital block, or topical anesthesia; and (c) reduced benefits may be paid for the administration of other anesthetics if done by the operating or assisting surgeon.

- Charges of a physician for a diagnostic laboratory test or x-ray examination. Laboratory charges are also covered as part of a wellness program. Obesity screening is covered when completed by a physician, or as part of a wellness program.
- Pathology and radiology interpretation.
- Charges of a physician for casts, splints, surgical dressings, and other medical supplies.
- Charges for the professional services of a Nurse for private duty nursing, but only during a period for which there is a physician's certification that is validated by the Claims Administrator.
  - Private duty nursing services must be Medically Necessary under the terms of the Plan; and
  - Outpatient private duty nursing charges are covered only when the participant would otherwise need to be an inpatient at an Acute Care Hospital.

## Medical Support Charges

These charges are classified as medical support charges. They are subject to any applicable limit shown in the section that covers "Areas of Limited Coverage."

1. Charges from a professional ambulance service for transportation to or from a local Acute Care hospital or skilled nursing facility where the covered individual receives (or received) treatment.
2. Charges for non-experimental and Medically Necessary internal prosthetics and/or medical appliances that provide permanent or temporary internal functional support for nonfunctional body parts. Medically Necessary repair, maintenance or replacement of a covered internal appliance is also covered.
3. Charges for the initial purchase and fitting of non-experimental, Medically Necessary external prosthetic and orthotic appliances or devices, but only if ordered or prescribed by a physician when necessary for the alleviation or correction of an illness, injury, or congenital defect. This includes prostheses/prosthetic appliances and devices, orthoses/orthotic devices, braces and splints. **Prostheses/prosthetic devices** are defined as fabricated replacements for missing body parts, and include, but are not limited to, basic limb prostheses, terminal devices such as a hand or hook, and speech prostheses. **Orthoses/orthotic devices** are defined as orthopedic appliances and apparatus used to support, align, prevent or correct deformities. After a reasonable period of time, payment for replacement or repair of the prosthetic device may be authorized if determined to be Medically Necessary. **Note:** Repair and replacement that result from a person's misuse are not covered. See the Podiatry Care benefit below for information about coverage for foot related orthotics.
4. Charges made for the purchase or rental of Durable Medical Equipment that is ordered or prescribed by a physician up to the purchase price of standard equipment (Durable Medical Equipment may be purchased if less expensive than rental, if accompanied by documentation from the physician

regarding the estimated period for the use of the equipment.) Coverage of Durable Medical Equipment is limited to the lowest cost reasonable alternative. After a reasonable period of time, payment for replacement or repair of Durable Medical Equipment may be authorized if such repair or replacement is determined to be Medically Necessary. **Note:** Repair and/or replacement that resulted from a person's misuse are not covered.

5. CareFirst Administrator's network includes some national contracts with providers of Durable Medical Equipment that will work in partnership with your physician to make sure you have Medically Necessary equipment. In some cases, they even deliver items directly to your home. You are encouraged, but not required, to use vendors in CareFirst Administrator's network.
6. **Note**: The rental or purchase of Durable Medical Equipment requires precertification.
7. Charges for oxygen, blood, blood products, anesthetics, or other medical supplies that can be lawfully obtained only with the prescription of a physician.
8. Charges for glucose testing devices when ordered by your physician. The Plan also will cover charges for insulin needles and syringes, and lancets and test strips for use with glucose testing devices, but only when purchased from a medical supply company. When purchased at a pharmacy such items are covered by the Prescription Drug Coverage. The Prescription Drug Coverage will provide a glucose testing device at no cost to you or the covered family member when obtained under a special program through CVS Caremark.
9. Charges for a drug or medicine that can be lawfully obtained only with the written prescription of a physician, an Allied Health Professional, or a dentist, if it cannot be obtained under the terms of the Prescription Drug Coverage, and it is not an excluded benefit under the terms of the Prescription Drug Coverage, or any exclusion or limitation under the terms of the Plan.
10. **For Employers selecting Plan A+**, charges for the purchase of a hearing aid device ordered by your physician.

# Areas of Limited Coverage

**Note:** These services and benefits **are not** included in the A+ coverage option.

## Acupuncture

Charges for acupuncture treatments are covered medical charges, when performed by a physician, but only when performed for a pain diagnosis. The Plan does **not** cover acupuncture treatments performed for any other reason, including conditions like allergy and sinus problems, cold and flu symptoms, etc.

## Allergy Testing and Treatment

Charges for allergy testing and treatment of allergies are covered medical charges but are limited to the charges of a physician for diagnostic allergy testing and allergy serums dispensed by the physician, including allergy injections administered in the provider's office.

## Bariatric Surgery

The Plan provides in-network coverage for Medically Necessary bariatric surgery that meets with CareFirst Administrator's clinical criteria for Medical Necessity and the recommended procedural guidelines. **There is no out-of-network coverage for bariatric surgery**. Precertification is required.

### *Guidelines for Coverage for Bariatric Surgery*

The guidelines set forth below provide an overview of the requirements for Medically Necessary bariatric surgery. These guidelines are subject to periodic change without notice and should be reviewed with CareFirst Administrators well in advance when bariatric surgery is being considered. We recommend that you and/or your physician contact CareFirst Administrators in advance of this procedure.

- The individual should be at least 18 years of age or should have reached full expected skeletal growth;
- Body Mass Index (BMI) of 40 or greater; or
- BMI of at least 35 with at least one clinically significant comorbidity, including but not limited to, cardiovascular disease, Type 2 diabetes, hypertension, coronary artery disease, or pulmonary hypertension;
- Failure of medical management, including evidence of active participation within the last two years in a weight-management program that is supervised either by a physician or a registered dietician for a minimum of six months without significant gaps. The program must include monthly documentation of ALL of the following components:
  - Weight;
  - Current dietary program; and
  - Physical activity (e.g., exercise program).

    Programs such as Virta's weight management program are acceptable alternatives if done in conjunction with the supervision of a physician or a registered dietician, and detailed documentation of participation is available for review. For individuals with long-standing morbid obesity, participation in a program within the last five years is sufficient if reasonable attendance in the weight-management program over an extended period of time of at least six months can

be demonstrated. **Note:** Physician-supervised programs consisting exclusively of pharmacological management are not sufficient to meet this requirement.

- A thorough multidisciplinary evaluation within the previous 12-months that includes:
  - An evaluation by a bariatric surgeon who is recommending surgical treatment, including a description of the proposed procedure(s) and all associated current procedure codes;
  - A separate medical evaluation, from a physician other than the surgeon who is recommending surgery, that includes a medical clearance for bariatric surgery;
  - Unequivocal clearance for bariatric surgery by a mental health provider;
  - A nutritional evaluation by a physician or registered dietician.

**Note**: The procedures set forth herein do not preclude nutritional counseling where the covered individual has a BMI of more than 30, as covered by the Preventive Services benefit.

### *Coverage Information*

Charges for bariatric surgery are subject to all limitations as set forth in the Schedule of Benefits and the section on Covered Charge Limits.

Coverage for these services is **limited to in-network benefits** for contracted Hospitals and facilities designated as Centers of Excellence for Bariatric Surgery, and their affiliated contracted providers. Any CareFirst contracted facility may be used when a center of excellence is not available.

- There is no out-of-network coverage for bariatric surgery.
- Coverage is available only for certain bariatric surgery procedures that Quantum Health determines are medically appropriate. Coverage is excluded for bariatric surgery procedures that are considered experimental, investigational, or unproven. Please contact a hospital or facility that is designated as a CareFirst Center of Excellence for Bariatric Surgery to determine whether the Plan covers a proposed bariatric surgery procedure.
- Services required to establish Medical Necessity of bariatric surgery are not automatically included in this benefit. The Plan provides coverage for some required services (e.g., evaluation by a bariatric surgeon) but does not necessarily provide coverage for all required services (e.g., weight management programs). Each service must be considered independently for purposes of determining whether the service is covered under the terms of the Plan. Please examine the details set forth in this SPD and/or speak to a Quantum Health representative to determine which pre-surgical services are covered under the Plan.

Covered and excluded bariatric surgery procedures and clinical guidelines are subject to change without notice, as appropriate, in accordance with advances in treatment and changes in industry standards as Quantum Health determines.

**Please ask your physician to contact Quantum Health well in advance of any proposed bariatric surgery.**

## Chiropractic Care

Charges for chiropractic services are covered medical charges provided that: (a) the services are Medically Necessary treatment of musculoskeletal disease or injury, and (b) the services are restorative in nature, designed to restore levels of function that had previously existed but that have been lost due

to injury or illness. Restorative therapy services do not include therapy designed to acquire levels of function that had not been previously achieved prior to the injury or illness.

The Plan will not pay for any type of: (a) maintenance or preventive treatment, (b) services that are considered custodial, training, developmental or educational in nature, (c) vitamin therapy, (d) massage therapy, or (e) for medical equipment and supplies provided in connection with chiropractic services.

**Days Limitation:** Chiropractic Care benefits are limited to 20 days per calendar year.

## Clinical Trials

Charges made for routine patient costs associated with approved clinical trials are covered medical charges under the terms of the Plan. An approved clinical trial is a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition. An individual will qualify for participation in an approved clinical trial based on a referral from a physician participating in the trial, or by providing medical and scientific information establishing that participation would be appropriate.

Routine patient costs include all items and services consistent with the coverage provided under the Plan for a person not enrolled in a clinical trial.

Routine patient costs do **not** include, and reimbursement will not be provided for:

- The investigational item, device or service;
- Services or supplies listed as Exclusions;
- Services or supplies related to data collection for the clinical trial (i.e., protocol-induced costs);
- Services that are clearly inconsistent with widely accepted and established standards of care for a particular diagnosis; or
- Services or supplies, which in the absence of private health care coverage, are provided by a clinical trial sponsor or other party (e.g., device, drug, item or service supplied by manufacturer and not, yet FDA approved) without charge to the trial participant.

## Erectile Dysfunction

Charges for the treatment of erectile dysfunction are covered medical charges. Benefits are limited to physician charges for diagnostic services to determine the cause of the erectile dysfunction, and charges for internal penile implants or external devices for an erectile dysfunction that is clearly caused by an established medical condition, such as postoperative prostatectomy or diabetes. Penile implants and external devices are not covered to treat psychogenic erectile dysfunction. Refer to the terms of Prescription Drug Coverage for more information on coverage of, and limitations on male androgens used to treat erectile dysfunction.

## Genetic Testing

Charges for genetic testing that uses a proven testing method for the identification of a genetically linked inheritable illness are covered medical charges, but only if one of the following requirements is met:

- The covered individual has symptoms or signs of a genetically linked inheritable illness;

- It has been determined that the covered individual is at risk for carrier status as supported by existing peer-reviewed, evidence-based, scientific literature for the development of a genetically linked inheritable illness when the results will impact clinical outcome; or
- The therapeutic purpose is to identify specific genetic mutation that has been demonstrated in the existing peer-reviewed, evidence-based, scientific literature to directly impact treatment options.

## Home Health Care

The following charges for Home Health Care services are covered medical charges. The Plan will **not** pay for Home Health Care unless:

- A plan of Home Health Care is drawn up, or approved, by the covered individual's physician; and
- The physician certifies that:
  - Home Health Care is Medically Necessary; and
  - In the absence of Home Health Care, the covered individual would be an inpatient at an Acute Care Hospital; or
- A Quantum Health case manager recommends Home Health Care services as being the most appropriate treatment in the most effective setting possible for the patient's medical condition.

Home Health Care charges include:

- Charges for the services of a home health aide on a part-time or intermittent basis. Services under this benefit are limited to 40 visits in a calendar year. Note: The Plan will not pay for visits that exceed the 40-visit limit. One home health aide visit is limited to four hours or less.
- Charges for nutrition counseling.
- Charges for psychiatric treatment by a licensed social worker who is practicing within the scope of the license.
- Practitioner charges and medical support charges.

## Hospice Care

Charges for Hospice Care by a Hospice Care Program or other qualified Hospice Care provider as listed below are covered medical charges under the terms of the Plan. Charges that are incurred only: (a) during a period (no longer than 6 months) for which the Claims Administrator validates a physician's certification that the participant is a terminally ill patient, and (b) during the bereavement period, will be covered under the terms of the Plan.

Covered Hospice Care charges include the following, if provided by a Hospice Care Program:

- Confinement of the terminally ill participant as an inpatient in a Hospice Care facility.
- Home Health Care furnished to the terminally ill participant in his or her home. Such Home Health Care may include, as part of Hospice Care:
  - Services of a home health aide.
  - Professional services of a Nurse.
  - Physical therapy or other therapy furnished by an Allied Health Professional.

  - Charges for nutrition counseling and special meals.
  - Medical Support Charges.
- Charges for medical social services furnished to the terminally ill participant or to the participant's family unit.
- Charges for bereavement counseling furnished to the terminally ill participant's family unit during the bereavement period, up to three (3) individual or family sessions for all members of the terminally ill participant's family unit.
- Inpatient Respite Care is limited to eight (8) days per lifetime.

For Hospice Care only, the terms of the medical coverage are modified as set forth below to enable Hospice Care charges to meet the definition of covered medical charges:

- The exclusion for Custodial Care does not apply.
- The definition of Medically Necessary is:
  - Deemed to include medical social services and bereavement counseling; and
  - Changed as follows: (i) test A is changed to include palliative care, as well as treatment or diagnosis; and (ii) test D is changed to allow inpatient respite care.

In addition, the following special definitions apply to Hospice Care:

- **Bereavement Counseling** is counseling performed by a licensed or certified social worker or licensed pastoral counselor to assist members of the family unit in coping with the death of the terminally ill participant.
- **Bereavement Period** is the 12-month period that begins on the date of the death of the terminally ill participant.
- **Family Unit** consists of each member of the terminally ill participant's family.
- **Medical Social Services** include counseling furnished to the terminally ill participant or to the members of the participant's family unit to assist each family member in coping with the dying process of the terminally ill participant. The counseling may be furnished by a social worker or a pastoral counselor, but **only if** such person is licensed and practicing within the scope of the license.
- **Palliative Care** is care that is provided to relieve the symptoms or effects of an illness without curing the illness.
- **Respite Care** is care that is given to a terminally ill participant so that members of the family unit may have relief from the stress of caring for the terminally ill participant.
- A **Terminally Ill Patient** is a participant of the Plan whose physician has certified that the participant is: (a) terminally ill, and (b) expected to live six (6) months or less.

## Laparoscopic Treatment of GERD

The Plan provides in-network coverage for treatment of gastroesophageal reflux disease (GERD) using a laparoscopically implanted magnetic esophageal ring. **There is no out-of-network coverage for this benefit.**

### *Guidelines for Coverage of Laparoscopically Implanted Magnetic Esophageal Ring*

The guidelines set forth below provide an overview of the requirements for Medically Necessary treatment of GERD using a laparoscopically implanted magnetic esophageal ring. These guidelines are subject to periodic change without notice, and prior authorization should be obtained through Quantum Health well in advance when this treatment option is being considered.

- The individual has been diagnosed with severe GERD, as documented by endoscopy. If endoscopy is normal, objective evidence of reflux should include at least one of the following:
  - 24-hour ambulatory esophageal pH monitoring; or
  - Barium swallow study; and
- The individual continues to have chronic GERD symptoms that have been resistant to conservative medical treatment and unresponsive to two or more of the following lifestyle modifications:
  - Weight loss for overweight or obese patients; or
  - Avoidance of late meals and/or specific foods that cause heartburn (spicy foods, citrus, fatty foods, chocolate, caffeine, carbonated drinks, alcohol, etc.); or
  - Elevation of the head of the bed for patients who develop heartburn or regurgitation when lying down; or
  - Avoidance of recumbent position within 2-3 hours after a meal; and
- Laparoscopic implantation of a magnetic esophageal ring is intended solely as a minimally invasive alternative to surgical treatment.
- The individual does not have evidence of:
  - Barrett's Esophagus
  - Esophageal cancer
  - Motility and/or swallowing issues
  - Previous bariatric or esophageal surgery
  - Morbid obesity with a body mass index > 35 kg/m2 at the time of surgery
  - Significant hiatal hernia > 3 cm as defined by manometry, upper GI (barium swallow), or endoscopy (one of these measurements should be 3-cm or less)
  - Allergy to titanium, stainless steel, nickel or iron materials; and

Coverage is available for the implantation, replacement, and/or removal of the device, and for the device itself, when the above criteria are met.

### *Coverage Information*

Charges for treatment of GERD with a laparoscopically implanted magnetic esophageal ring are subject to all limitations as set forth in the Schedule of Benefits and the section on Covered Charge Limits.

- Coverage for these services is limited to in-network benefits only.
- **There is no out-of-network coverage** for implantation/removal of a laparoscopically implanted magnetic esophageal ring or for the device itself.

- Coverage is available only for use of a laparoscopically implanted magnetic esophageal ring where it is medically appropriate as outlined above.

Covered and excluded procedures as well as clinical guidelines are subject to change without notice, as appropriate, in accordance with advances in treatment and changes in industry standards as determined by the Plan or the Claims Administrator.

**Note: Prior authorization review and approval is required. Please ask your physician to contact Quantum Health well in advance of any proposed procedure to implant or remove a laparoscopically implanted magnetic esophageal ring.**

## Mental Health Services

The Facility, Practitioner, and Medical Support Charges incurred for the treatment of mental health conditions are covered medical charges under the terms of the Plan, provided the charges meet Mental Health Services definition. No other charges outside this definition incurred for treatment of mental health conditions are covered medical charges under the terms of the Plan.

Benefits for Mental Health Services will be eligible for payment **only if** the treatment is provided by a Hospital or a Mental Health Residential Treatment Center, or by a physician or a psychologist holding a Master or Doctorate in Psychology, or another similarly degreed practitioner legally licensed to provide Mental Health Services or practice psychotherapy by the state in which he or she practices.

Coverage is provided for both inpatient and outpatient Mental Health Services, including, but not limited to, treatment of conditions such as anxiety or depression which interfere with daily functioning; emotional adjustment or concerns related to chronic conditions, such as psychosis or depression; emotional reactions associated with marital problems or divorce; child/adolescent problems of conduct or poor impulse control; affective disorders; suicidal or homicidal threats or acts; eating disorders; or acute exacerbation of chronic mental health conditions (crisis intervention and relapse prevention), and outpatient testing and assessment. Covered services also may include inpatient care at a Mental Health Residential Treatment Center, Partial Hospitalization, and Intensive Outpatient Therapy programs.

Except for Applied Behavioral Analysis (ABA) therapy for the treatment of autism spectrum disorder, the Plan does not cover diagnoses such as learning, behavioral and developmental disorders under this benefit or under any other benefit. Neither does the Plan cover therapies such as art, music, drama, physical, speech, recreational, occupational, and adjunctive under this benefit or any other benefit.

## Nutritional Evaluation

Charges for nutritional evaluation and counseling are covered medical charges under the terms of the Plan when ordered by a physician, but **only when** diet is part of the medical management of a diagnosed and documented organic illness.

## Organ Transplant

Charges in connection with Medically Necessary, non-experimental, human organ and tissue transplant, including services that include solid organ and bone marrow/stem cell procedures, are covered medical charges under the terms of the Plan as provided below:

Transplant services include the covered recipient's medical, surgical and Hospital services; inpatient immunosuppressive medications; and costs for organ or bone marrow/stem cell procurement. Transplant services are covered **only if** they are required to perform any of the following human to human organ or tissue transplants; allogeneic bone marrow/stem cell, autologous bone marrow/stem cell, cornea, heart, heart/lung, kidney, kidney/pancreas, liver, lung, pancreas or intestinal which includes small bowel, liver or multivisceral.

All covered transplant services that are provided by non-participating providers will be payable at the out-of-network level under the terms of the Plan.

Coverage for organ procurement costs are limited to costs directly related to the procurement of an organ from a cadaver or a live donor. Organ procurement costs shall consist of surgery necessary for organ removal and organ transportation. Charges for transportation and hospitalization of a live donor are covered **only if** both the donor and the recipient are covered Plan participants. Donor compatibility testing undertaken before procurement, and costs related to the search for, and identification of, a bone marrow or stem cell donor for an allogeneic transplant are also covered, **but only if** both the potential donor and the recipient are covered Plan participants.

## Podiatry Care

The charges for podiatry care that are covered medical charges include Medically Necessary services of a podiatrist acting within the scope of his or her license. For example, podiatry care includes charges for the diagnosis and treatment of chronic foot pain; instability or imbalance of the feet; foot deformities; and toenail infections. Podiatry care also includes the charge for custom molded orthotics, but does not include the charge for shoes or prefabricated shoe inserts. The podiatry care benefit does **not** cover routine foot care such as paring and removal of corns and calluses or trimming of toenails. However, services associated with foot care for diabetes and peripheral vascular disease are covered medical charges when Medically Necessary under the terms of the Plan.

Podiatry care is limited to 30-days maximum per calendar year, regardless of the service provider. Benefits for Medically Necessary surgery are not subject to the 30-days limitation but are payable on the same basis as benefits for any other covered surgery.

## Preventive and Wellness Services

The Plan provides the following preventive and wellness services for all covered participants in keeping with prevailing medical standards, including frequency and age recommendations, as appropriate for the type of service. The requirement that benefits be paid only for charges that are Medically Necessary does **not** apply to these routine services.

**Preventive Services are required by the Affordable Care Act (ACA).** If coverage is provided ***in-network,*** there is no cost sharing (for example, no deductibles, coinsurance, or copayments) for the following preventive services:

- Services described in the United States Preventive Services Task Force (USPSTF) A and B recommendations;
- Services described in guidelines issued by the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC); and

- Health Resources and Services Administration (HRSA) guidelines including the American Academy of Pediatrics Bright Futures guidelines and HRSA guidelines relating to services for women.

In some cases, federal guidelines are unclear about which preventive benefits must be covered under the ACA. In those cases, the Claims Administrator will determine whether a particular benefit is covered under this preventive services benefit.

The following benefits are available under the Plan's preventive services benefit with no cost sharing, pursuant to the applicable USPSTF, ACIP, and HRSA preventive services recommendations and guidelines effective January 1, 2025. Where medications or vitamins are noted, a prescription is required and the benefit is provided through the Prescription Drug coverage.

### *Covered Preventive Services for Adults*

- Abdominal aortic aneurysm one-time screening for men of specified ages who have ever smoked;
- Anxiety disorders screening for adults 64 years or younger, including pregnant and postpartum persons;
- Asymptomatic bacteriuria: screening for asymptomatic bacteriuria using culture in pregnant persons;
- Behavioral counseling interventions for adults with cardiovascular disease risk factors.
- Behavioral counseling interventions for health weight gain in pregnancy.
- Blood pressure screening for all adults age 18 and older. Blood pressure screening is not payable as a separate claim, as it is included in the payment for a physician visit;
- Cholesterol screening for men aged 35 and older and women aged 45 and older, men aged 20 to 35 if they are at increased risk for coronary heart disease, and women aged 20 to 45 if they are at increased risk for coronary heart disease;
- Colorectal cancer screening using fecal occult blood testing, sigmoidoscopy or colonoscopy, in adults beginning at age 45 and continuing until age 75. The test methodology must be medically appropriate for the patient. The Plan will not impose cost sharing with respect to a polyp removal during a colonoscopy performed as a screening procedure. The plan will not impose cost-sharing with respect to the following services when these services are provided in connection with a screening colonoscopy and the attending provider determines the service is medically appropriate; anesthesia services; a pre-procedure specialist consultation; or a pathology exam on a polyp biopsy;
- Depression and suicide risk screening for adults;
- Type two (2) diabetes screening for asymptomatic adults aged 35 to 70 years who are overweight or have obesity; ;
- Diet counseling for adults at higher risk for chronic disease;
- Exercise interventions to prevent falls in community-dwelling adults 65 years or older who are at increased risk for falls.
- HIV screening for all adolescents and adults ages 15 to 65 and for younger and older individuals at increased risk;

- Preexposure prophylaxis using effective antiretroviral therapy to persons who are at increased risk of HIV acquisition to decrease the risk of acquiring HIV;
- Weight loss to prevent obesity-related morbidity and mortality screening and intensive counseling and behavioral interventions to promote sustained weight loss for obese adults. Screening includes measurement of BMI by the clinician with the purpose of assessing and addressing body weight in the clinical setting;
- Sexually Transmitted Infection (STI) prevention counseling for adults at higher risk;
- Tobacco use screening for all adults and cessation interventions for tobacco users;
- Syphilis screening for all adults at higher risk;
- Counseling for young adults to age 24 about minimizing their exposure to ultraviolet radiation to reduce risk for skin cancer;
- Exercise or physical therapy to prevent falls in community-dwelling adults age 65 years and older who are at increased risk for falls;
- Vitamin D supplementation to prevent falls in community-dwelling adults age 65 years and older who are at increased risk for falls;
- Screening for Hepatitis C virus (HCV) infection in persons at high risk for infection and a one-time screening for HCV infection in adults born between 1945 and 1965;
- Screening for Latent Tuberculosis Infection (LTBI) in populations at increased risk
- Annual screening for lung cancer with low-dose computed tomography in adults ages 55 to 80 years who have a 30 pack/year smoking history and currently smoke or have quit within the past 15 years; and
- Screening for Hepatitis B virus infection in adults at high risk for infection;
- Screening for Hepatitis C virus infection in adults aged 18 to 79 years;
- Screening for hypertension in adults 18 years or older with office blood pressure measurement (OBPM)
- Screening for unhealthy alcohol use in primary care settings in adults 18 years and older, including pregnant women, and providing persons engaged in risking and hazardous behavioral counseling interventions to reduce unhealth alcohol use;
- Screening by asking questions about unhealthy drug use in adults age 18 years or older. Screening should be implemented when services for accurate diagnosis, effective treatment, and appropriate care can be offered or referred. (Screening refers to asking questions about unhealthy drug use, not testing biological specimens.);
- Statin for the primary prevention of CVD for adults aged 40 to 75 years who have 1 or more CVD risk factors (i.e. dyslipidemia, diabetes, hypertension, or smoking) and an estimated 10-year risk of a cardiovascular event of 10% or greater.

### *Covered Preventive Services for Women, Including Pregnant Women*

- Well woman office visits for women for the delivery of required preventive services (includes prenatal visits);

- Anemia screening on a routine basis for pregnant women;
- Anxiety disorders screening in adolescent and adult women, including those who are pregnant or postpartum;
- BRCA counseling about genetic testing for women at higher risk. Women whose family history is associated with an increased risk for deleterious mutations in BRCA 1 or BRCA 2 genes will receive referral for counseling. The Plan will also cover BRCA 1 or 2 genetic tests without cost-sharing, if appropriate as determined by the woman's health care provider, including for a woman who has previously been diagnosed with cancer, as long as she is not currently symptomatic or receiving active treatment for breast, ovarian, tubal or peritoneal cancer;
- For women at increased risk for breast cancer aged 35 years or older, risk-reducing medications, such as tamoxifen, raloxifene, or aromatase inhibitors, to women who are at increased risk for breast cancer and at low risk for adverse medication effects.
- Breast cancer screening mammography for women with or without clinical breast examination and with or without diagnosis, every 1 to 2 years for women aged 40 to 74 years;
- Breast cancer chemoprevention counseling for women at higher risk. The Plan will pay for counseling by physicians with women at high risk for breast cancer and at low risk for adverse effects of chemoprevention, to discuss the risks and benefits of chemoprevention. The Plan will also pay for risk-reducing medications for women at increased risk for breast cancer and at low risk for adverse medication effects;
- Interventions or referrals, during pregnancy and after birth, to support breastfeeding;
- Low-dose aspirin after 12 weeks of gestation for women who are at high risk for preeclampsia;
- Comprehensive lactation support and counseling by a trained provider during pregnancy and/or in the postpartum period, and costs for renting breastfeeding equipment. The Plan may pay for purchase of lactation equipment instead of rental, if deemed appropriate by the Plan;
- Cervical cancer screening for women ages 21 to 65 with Pap smear every three years;
- Human papillomavirus testing for women ages 30 and older with normal Pap smear results, once every three years as part of a well woman visit;
- Chlamydia and gonorrhea infection screening for all sexually active women aged 24 and younger, and in woman 25 years or older who are at increased risk of infection;
- For all pregnant women aged 24 and younger, and for older pregnant women at increased risk, chlamydia infection screening is covered as part of the prenatal visit;
- For women of reproductive capacity, the Plan will cover at least one form of contraception in each of the FDA-approved contraceptive methods (including barrier and hormonal methods and implanted devices) as well as patient education and counseling, when prescribed by a health care provider. Services related to follow-up and management of side effects, counseling for continued adherence, and device removal are also covered without cost sharing. The FDA-approved contraception methods for women include:
  - Sterilization surgery (tubal ligation)
  - Surgical sterilization implant for women Implantable rod
  - Intrauterine device (IUD) copper

- IUD with progestin
- Shot/injection
- Oral contraceptives (combined pill)
- Oral contraceptives (progestin pill)
- Oral contraceptives (extended/continuous use)
- Patch
- Vaginal contraceptive ring
- Software application for contraception
- Male condom
- Diaphragm
- Sponge with spermicide
- Cervical cap with spermicide
- Female condom
- Anti-sperm vaginal contraceptives, including spermicides and other anti-sperm agents
- Emergency Contraception (Plan B/Plan B One Step/Next Choice)
- Emergency Contraception (Ella)

- Generic birth control prescriptions and brand name birth control prescriptions for which there is no generic equivalent;
- The Plan may cover a generic drug without cost sharing but charge cost sharing for an equivalent branded drug. The Plan will accommodate any individual for whom the generic would be medically inappropriate, as determined by the individual's health care provider and the Prescription Drug Coverage prior authorization process;
- Folic acid supplements for women who are planning or capable of pregnancy, containing 0.4 to 0.8 mg of folic acid;
- Interventions for pregnant and postpartum persons who are at increased risk of perinatal depression;.
- Gonorrhea screening for all sexually active women, including those who are pregnant, if they are at increased risk for infection (i.e., young or have other individual or population risk factors), provided as part of a well woman visit;
- Counseling for sexually transmitted infections, once per year as part of a well woman visit;
- Counseling and screening for HIV, once per year as part of a well woman visit, and for pregnant women, including those who present in labor who are untested and whose HIV status is not known;
- Hepatitis B screening for pregnant women at their first prenatal visit;
- Screening for hypertensive disorders in pregnant persons with blood pressure measurements throughout pregnancy;
- Obesity prevention counseling midlife women aged 40 to 60 years with normal or overweight body mass index (BMI) (18.5-29.9 kg/m2) to maintain weight or limit weight gain to prevent obesity;

- Osteoporosis screening for women. Women aged 65 and older will be eligible for routine screening for osteoporosis. Younger women will be eligible for screening if their risk of fracture is equal to or greater than that of a 65-year-old woman. The Plan will pay for the most cost-effective test methodology only;
- Rh incompatibility screening for all pregnant women during their first visit for pregnancy related care, and follow-up testing for all unsensitized Rh (D) negative women at 24-28 weeks' gestation, unless the biological father is known to be Rh (D) negative;
- Screening for gestational diabetes in asymptomatic pregnant women between 24 and 28 weeks' gestation and at the first prenatal visit for pregnant women identified to be at risk for diabetes;
- Screening for type 2 diabetes in women with a history of gestational diabetes mellitus (GDM) who are not currently pregnant and who have not previously been diagnosed with type 2 diabetes;
- Screening women for urinary incontinence annually;
- Tobacco use screening and interventions for all women, as part of a well woman visit, and expanded counseling for pregnant tobacco users as set forth under the tobacco use program prescribed under ACA;
- Syphilis screening for all pregnant women or other women at increased risk, as part of a well woman visit;
- Screening and counseling for interpersonal and domestic violence, as part of a well woman visit; and
- Effective for plan years beginning on or after February 1, 2017, depression screening for pregnant and post-partum women.

### *Covered Preventive Services for Children*

- Well baby and well child visits from newborn through age 21, as recommended for pediatric preventive health care by "Bright Futures/American Academy of Pediatrics." Visits will include the following age-appropriate screenings and assessments:
- Anxiety disorder screening in children and adolescents aged 8 to 18 years;
- Developmental screening for children under age three, and surveillance throughout childhood;
- Behavioral assessments for children of all ages;
- Medical history;
- Blood pressure screening;
- Depression and suicide risk screening for adolescents ages 12-18;
- Vision screening at least once in all children aged 3 to 5 years to detect amblyopia or its risk factors;
- Hearing screening;
- Height, weight and body mass index measurements for children;
- Autism screening for children at 18 and 24 months;
- Alcohol and drug use assessments for adolescent

- Critical congenital heart defect screening in newborns;
- Hematocrit or Hemoglobin screening for children;
- Comprehensive, intensive behavioral interventions for high body mass index (≥95th percentile for age and sex) children and adolescents 6 years or older;
- Lead screening for children at risk of exposure;
- Tuberculin testing for children at higher risk of tuberculosis;
- Dyslipidemia screening for children at higher risk of lipid disorders;
- Sexually transmitted infection (STI) screening and counseling for sexually active adolescents;
- Cervical dysplasia screening at age 21; and
- Oral health risk assessment;
- Newborn screening tests recommended by the Advisory Committee on Heritable Disorders in Newborns and Children (such as hypothyroidism screening for newborns and sickle cell screening for newborns);
- Prophylactic ocular topical medication for all newborns for the prevention of gonorrhea;
- Fluoride varnish to the primary teeth of all infants and children starting at the age of primary tooth eruption
- Oral fluoride supplementation at currently recommended doses (based on local water supplies) to preschool children older than six months of age whose primary water source is deficient in fluoride. A prescription must be submitted in accordance with Plan rules;
- Iron supplementation for asymptomatic children aged six to 12 months who are at increased risk for iron deficiency anemia;
- Obesity screening for children aged six years and older, and counseling or referral to comprehensive, intensive behavioral interventions to promote improvement in weight status;
- HIV screening for adolescents ages 15 and older and for younger adolescents at increased risk of infection;
- Counseling for children, adolescents, and young adults ages 10 to 24 years, , and parents of young children , about minimizing their exposure to ultraviolet radiation to reduce risk for skin cancer;
- Screening for Hepatitis B virus infection in adolescents at high risk for infection;
- Interventions, including education or brief counseling, to prevent initiation of tobacco use among school-aged children and adolescents; and
- Application of fluoride varnish to the primary teeth of all infants and children up to age 5 starting at the age of primary tooth eruption, in primary care practices.

### *Immunizations*

- Routine adult immunizations are covered for you, your spouse, and dependent children who meet the age and gender requirements, and who meet the CDC medical criteria for recommendation. Immunizations administered for travel are excluded.

- Immunization vaccines for adults — doses, recommended ages and recommended populations must be satisfied:
  - COVID-19
  - Diphtheria/tetanus/pertussis;
  - Measles/mumps/rubella (MMR);
  - Inactivated poliovirus;
  - Influenza;
  - Human papillomavirus (HPV);
  - Pneumococcal (polysaccharide);
  - Zoster;
  - Hepatitis A;
  - Hepatitis B;
  - Meningococcal
  - Mpox; and
  - Varicella;
- Immunization vaccines for children from birth to age 18 — doses, recommended ages and recommended populations must be satisfied:
  - Respiratory syncytial virus;
  - Hepatitis B;
  - Rotavirus;
  - Diphtheria/tetanus/pertussis;
  - Haemophilus influenzae type b;
  - Pneumococcal;
  - Inactivated poliovirus;
  - COVID-19;
  - Influenza;
  - Measles/mumps/rubella;
  - Varicella;
  - Hepatitis A;
  - Meningococcal;
  - Dengue;
  - Mpox; and
  - Human papillomavirus (HPV).

### *Office Visit Coverage*

Preventive services are paid based on the Plan's payment schedules for the individual services. However, there are situations in which an office visit may not be payable under the preventive services benefit. If the primary purpose of the office visit is not for a preventive item or service, then the Plan will impose cost sharing with respect to the office visit. The following conditions apply to payment for in-network office visits under the Preventive Service benefit.

- If a preventive item or service is billed separately from an office visit, then the Plan will impose cost sharing with respect to the office visit.
- If the preventive item or service is not billed separately from the office visit, and the primary purpose of the office visit is the delivery of such preventive item or service, then the Plan will pay 100 percent for the office visit.
- If the preventive item or service is not billed separately from the office visit, and the primary purpose of the office visit is not the delivery of such preventive item or service, then the Plan will impose cost sharing with respect to the office visit.

For example, if a covered individual schedules an in-network office visit to discuss recurring abdominal pain, and during the office visit the individual has a blood pressure screening, the office visit will be covered subject to the Plan's cost sharing requirements, e.g., the deductible, if not already satisfied, and coinsurance, or copayment, because the blood pressure screening was provided as part of an office visit, for which the primary purpose was not to deliver recommended preventive items or services.

**Note:** Services performed as the result of medical symptoms or due to a known or suspected medical condition are not covered under this benefit. Such services would be considered under the related medical benefit where appropriate, subject to the deductible and applicable Payment Percentage for the service provided.

Well child annual physical exams recommended in the Bright Futures Recommendations (for children from birth through age 21) are treated as preventive services and paid at 100% when received from an in-network provider.

**Note:** Covered preventive services and items that are required by federal law are not subject to the deductible and will be paid at 100% when received from an in-network provider. Covered preventive services received from an out-of-network provider are not subject to the deductible, but the out-of-network Payment Percentage will apply.

Please contact Quantum at if you have any questions about what preventive services are covered, or if you need help finding an in-network provider.

### *Routine Examinations*

The following charges for routine examinations are covered medical benefits under the terms of the Plan.

- Charges for annual complete physical exam.
- Charges for annual gynecological exam for female participants.
- Charges for routine well-child visits for children, including developmental assessment and anticipatory guidance.

### *Routine Immunizations*

The following charges for routine immunizations are covered medical benefits under the terms of the Plan.

- Charges for an annual flu shot.
- Charges for other medically appropriate routine childhood and adult immunizations when recommended or provided by a physician, excluding immunizations solely for travel.

### *Routine Lab and X-ray Screening*

The following charges for routine lab and X-ray screening are covered medical benefits under the terms of the Plan.

- Charges for routine laboratory, electrocardiogram, and x-ray screening services ordered or performed by a physician in connection with a covered routine examination or wellness program.
- Charges for an annual Papanicolaou (PAP) screening for female participants.
- Charges for an annual prostate specific antigen (PSA) screening for male participants.

### *Routine Colonoscopy Screening*

This benefit applies to all covered individuals once every three (3) years beginning at age 50 or, if there is a high risk of colon cancer indicated by a physician, once every two (2) years regardless of age.

The following charges for routine colonoscopy screening are covered medical benefits under the terms of the Plan.

- Charges for a surgeon and an anesthesiologist who perform the procedure.
- Charges for outpatient facility use at a Hospital or other approved surgical facility.
- Charges for related professional interpretation services required as a result of surgery.

Removal of polyps that are found during the routine screening are included.

### *Routine Mammography Screening*

Charges for routine screening for breast cancer by low-dose mammography that are listed below are covered medical charges if ordered by a physician.

Mammography screening charges include only:

- Charges for a baseline mammogram for a covered individual age 35 but less than age 40.
- Charges for a mammogram performed once every year for a covered individual age 40 and over.

The term low-dose mammography means the x-ray examination of the breast using equipment dedicated specifically for mammography, including, but not limited to, the x-ray tube, filter, compression device, screens, films and cassettes, with an average radiation exposure delivery of less than one rad mid-breast, with two views for each breast.

### *Family Planning*

Charges for family planning related services including medical history, physical exam, related laboratory tests, medical supervision in accordance with generally accepted medical practices, counseling on contraception, implanted or injected contraceptives, medical services connected with surgical therapies including tubal ligation or vasectomy, are covered medical benefits (oral contraceptives are covered under the Prescription Drug Coverage) under the terms of the Plan.

Other limitations that apply to preventive services will also apply to family planning services.

### *Women's Preventive Care*

Routine annual gynecological exam, annual Papanicolaou (PAP) screening, and routine mammography screening are provided by the Plan as specified above. The Plan also provides coverage for female participants as follows:

- **Gestational Diabetes Screening:** Covered for women who are 24 to 28 weeks pregnant, and those at high risk of developing gestational diabetes.
- **HPV DNA Testing**: Covered every three (3) years for women age 30 and over, regardless of Pap smear results.
- **STI Counseling**: Covered annually for sexually active women. An **STI** is a sexually transmitted infection.
- **HIV Screening and Counseling:** Covered annually for sexually active women.
- **Contraception and Contraceptive Counseling:** All FDA approved contraceptive methods, sterilization procedures, patient education and counseling. Oral contraceptives are covered under the Prescription Drug Coverage
- **Breastfeeding Support, Supplies, and Counseling**: Pregnant and postpartum women are covered for lactation support and counseling, and breastfeeding equipment. Breastfeeding equipment is limited to the rental of one breast pump per birth as ordered or prescribed by a physician and related supplies.
- **Interpersonal and Domestic Violence Screening and Counseling:** Adolescent and adult women are covered for screening and counseling for interpersonal and domestic violence.

The Plan covers the above services in accordance with applicable federal guidelines. Covered services received from an in-network provider are not subject to the deductible and will be paid at 100%. Covered services received from an out-of-network provider are not subject to the deductible, but the out-of-network Payment Percentage will apply.

## Routine Newborn Care

The charges that are listed below for routine care of a newborn at the time of delivery are covered medical benefits under the terms of the Plan and are payable on the same basis as an illness.

- Charges of an Acute Care Hospital for routine nursery care furnished to a newborn well baby at the time of birth.
- Charges of a physician for one routine examination of a newborn well baby performed each day before the child is released from nursery care.

## Second Surgical Opinion

Charges for a second surgical opinion are paid on the same basis as charges for an illness. Charges for a third surgical opinion also will be covered if the first and second opinions do not confirm that the surgery is Medically Necessary.

## Short-Term Rehabilitative Therapy

Short-term rehabilitative therapy that is part of a rehabilitation program, including physical, speech, occupational, cognitive, osteopathic manipulative, cardiac rehabilitation, and pulmonary rehabilitation therapy is covered subject to the following limitations:

- To be covered all therapy services must be restorative in nature. Restorative therapy services are services that are designed to restore levels of function that had previously existed but that have been lost as a result of injury or illness. Restorative therapy services do **not** include therapy designed to acquire levels of function that had not been previously achieved prior to the injury or illness.
- Services are not covered if they are custodial, training, educational or developmental in nature.
- Occupational therapy is provided only for purposes of enabling persons to perform the activities of daily living after an illness, injury, or sickness.
- Vision therapy is also covered.

Short-term rehabilitative therapy services that are **not** covered include, but are not limited to:

- Sensory integration therapy, group therapy; treatment of dyslexia, behavior modification or myofunctional therapy for dysfluency, such as stuttering or other involuntary acted conditions without evidence of an underlying medical condition or neurological disorder;
- Treatment for functional articulation disorder such as correction of tongue thrust, lisp, verbal apraxia or swallowing dysfunction that is not based on an underlying diagnosed medical condition or injury; and
- Maintenance or preventive treatment consisting of routine, long term or non-Medically Necessary care provided to prevent recurrence, or to maintain the current status of the individual.

If multiple outpatient services are provided on the same day, the visits will be treated as a single visit.

Chiropractic treatment is not covered under the rehabilitative therapy benefits. See the section on Chiropractic Care for information about Chiropractic treatment and limits.

The Plan does **not** cover physical, speech, occupational, cognitive, osteopathic manipulative, cardiac rehabilitation, pulmonary rehabilitation, or vision therapy except for the short-term treatment of an acute condition. There are no such benefits for chronic conditions, developmental problems, health club memberships, recreational or exercise programs, even when recommended by a physician.

***Limit on Number of Days***: The Plan will **not** pay more than 50 days of short-term rehabilitative therapy for all combined types of therapy in any one calendar year.

## Substance Use Disorder Treatment

The Facility, Practitioner, and Medical Support Charges that are incurred for the treatment of alcoholism, drug or chemical dependence are covered medical charges under the terms of the Plan, provided each element meets all the requirements of the definition of covered medical charge, as well as the Substance Use Disorder Treatment Services definition. No charges, other than those listed above, for treatment of alcoholism, drug, or chemical dependence are covered medical charges under this Plan.

Charges for Substance Use Disorder Treatment Services will be covered **only if** the treatment of the covered individual is provided by a Hospital, a Substance Use Disorder Residential Treatment Center, a physician, a psychologist holding a Master or Doctorate in Psychology, or another similarly degreed practitioner legally licensed to provide Use Disorder Treatment by the state in which he or she practices.

Coverage of these services is provided under the Plan for both inpatient and outpatient Use Disorder Treatment Services, including both detoxification and rehabilitation. Covered services also may include inpatient care at a Use Disorder Residential Treatment Center, Partial Hospitalization and Intensive Outpatient Therapy programs.

The Plan does **not** cover diagnoses such as learning, behavioral and developmental disorders under this benefit or any other benefit. Neither does the Plan cover therapies such as art, music, drama, and recreational under this benefit.

## Surgical Vision Correction

**For Plan A+ participants**, the charges for surgical vision correction that meet all the requirements of the definition of covered medical charge are covered under the terms of the Plan. The requirement that charges are paid only for a benefit that is Medically Necessary does **not** apply to this benefit.

Allowable charges for this benefit include all related charges for exam, surgery, pre- and post-operative testing, and facility, as well as corrective lenses to be implanted during cataract surgery. The Plan will pay no more than $1,000 per eye, and $2,000 maximum for both eyes, for all related services incurred during the lifetime of the participant. There is no other benefit under the terms of the Plan for services in connection with surgical vision correction.

Telehealth

Telehealth is the delivery of health-related services and information via telecommunications

technologies, including telephones, smartphones and personal computers, for virtual consultations. CareFirst Administrators Telehealth Connection is a telemedicine program providing access to certain telehealth services as part of your medical plan through CareFirst Administrators. It includes live appointments with board- certified doctors, via secure video or phone, who may diagnose and prescribe, when appropriate.

Telehealth is not intended to replace your Primary Care Physician (PCP). Telehealth is designed to handle minor, non-emergency medical issues for eligible employees and their covered dependents enrolled in a medical plan through CareFirst Administrators. This program is accessible, 365 days a year, from most locations in the United States with an internet connection, or a US-based phone number that can receive a call back.

Covered employees and eligible dependents may access telehealth services from either a designated provider or Closeknit.

CareFirst Administrators
Phone: 855.677.9722

Closeknit
Through the web: portal.closeknit.com
Phone: 866.233.6925

Telehealth services are subject to In-Network copayments for PCP Office Visits. CareFirst Administrators are only available for medical visits. For covered services related to mental health and substance use disorder, employees have access to the CareFirst Administrators network of providers.

## TMJ Treatment

TMJ stands for temporomandibular joint. The term TMJ disorder means a disorder, disease, or dysfunction of the TMJ, regardless of the diagnosis. Charges for Medically Necessary surgical and non-surgical treatment of a TMJ disorder that are not covered by a dental plan are payable on the same basis as charges for an illness, except that benefits are limited to $600 per calendar year.

# Exclusions

The Plan does **not** cover charges or treatments of all Injuries or illness or pay expenses for all medications. Excluded benefits and services include, but are not limited to, the following:

1. Treatment of an illness for which benefits are payable under any Workers' Compensation law, or treatment of an injury which arises out of, or in the course of, employment.
2. Treatment of an illness or injury that results from, or arises out of, any past or present employment or occupation for compensation or profit.
3. Injury or illness that results from an act of declared or undeclared war, the participant's commission of a crime, or non-therapeutic release of nuclear energy.
4. A charge, or part of a charge, that the participant is not obligated to pay, or for which you would not have been billed except for the fact that the individual was covered under the Plan.
5. Services, supplies, or treatments provided by: (a) a person who ordinarily lives in the participant's home, or (b) a spouse, child, parent, or sibling of the participant or of the participant's spouse.
6. Experimental, investigational, or unproven services, treatments, or devices, unless provided during an approved clinical trial as set forth in the SPD. Experimental, investigational, and unproven services, treatments, or devices are health care technologies, supplies, treatments, procedures, drug therapies, or devices that are not demonstrated through existing peer-reviewed, evidence based, scientific literature to be safe and effective for treating and diagnosing the condition or sickness for which its use is proposed, or is not approved by the FDA or other appropriate regulatory agency to be lawfully marketed for the proposed use.
7. Charges for services, supplies, or treatments that are furnished, paid for, or otherwise provided as a result of past or present service in the armed forces of a government, except as otherwise provided by law.
8. Charges for services, supplies, or treatments that are furnished, paid for, or otherwise provided by any local, state, or federal government agency, program, or institutions, unless otherwise provided by law.
9. Services, supplies, or treatments that are not Medically Necessary.
10. Services, supplies, or treatments that are not ordered by a physician or by an Allied Health Professional who is practicing within the scope of his or her license.
11. Charges that are not necessary for the treatment of an illness or injury except as otherwise provided in the SPD.
12. Custodial Care.
13. Services primarily for rest, domiciliary care, or convalescent care.
14. Charges that exceed the Usual, Customary, and Reasonable charge amount.
15. Expenses for any services, supplies, or treatments that are unreasonably priced, or are not reasonably necessary for the illness or injury being treated.
16. Charges incurred for reversal of sterilization (benefits are payable for sterilization).
17. Charges incurred for treatment of infertility, including infertility drugs, surgical or medical treatment programs, impregnation techniques, such as artificial insemination, in vitro fertilization and

development of an embryo, implantation of an embryo developed in vitro, and variations of these procedures. Cryopreservation of donor sperm and eggs are also excluded from coverage.

18. Services, supplies or procedures related to treatment of obesity or weight reduction, except as specifically provided under the terms of the Plan, and as set forth in the SPD in the sections on Areas of Limited Coverage and Preventive and Wellness Services.
19. Charges incurred for treatment of complications from excluded procedures.
20. Charges for services obtained on a date when the individual was not eligible to participate in the Plan, except where eligibility is provided under the extension of benefits for total disability under the terms of the Plan, and as set forth in the SPD.
21. Drugs labeled: "Caution - limited by federal law to investigational use", or experimental drugs, unless provided in connection with an approved clinical trial under the terms of the Plan, and as set forth in the SPD.
22. Over the counter medicines and supplies, unless otherwise covered as required under federal law
23. Routine eye examinations, refractions, glasses, contact lenses, or the fitting of glasses or contact lenses; except for the first pair of glasses or the first pair of lenses for use after cataract surgery.
24. Dental work or dental treatment; unless it is rendered for: (a) surgical removal of impacted teeth; (b) treatment of tumors; (c) treatment of ectodermal dysplasia (except orthodontia); or (d) repair of damage to sound natural teeth if damage is sustained in an accident and the charges are incurred within one year from the date of the accident. The term "sound natural tooth" means a tooth that: (a) is organic and formed by the natural development of the body (not manufactured); (b) has not been extensively restored; and (c) has not become extensively decayed or involved in periodontal disease.
25. Cosmetic surgery and therapies, unless resulting from an injury or illness occurring while covered under the Plan or as required by federal law. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem, or to treat psychological symptomatology or psychosocial complaints related to one's appearance. The Plan covers charges made for reconstructive surgery or therapy to repair or correct severe physical deformity or disfigurement which is accompanied by functional deficit (other than abnormalities of the jaw or conditions related to TMJ disorder which is covered under another benefit under the terms of the Plan) provided that: (a) the surgery or therapy restores or improves function; (b) reconstruction is required as a result of Medically Necessary, non-cosmetic surgery; or (c) the surgery or therapy is performed prior to age 19 and is required as a result of the congenital absence or agenesis (lack of formation or development) of a body part. Repeat or subsequent surgeries for the same condition are covered **only** when there is the probability of significant additional improvement as determined by the utilization review process.
26. Anti-wrinkle agents.
27. Hair growth stimulants.
28. Exercise equipment, tanning booths, whirlpools, swimming pools, saunas, spas, or health club and gym memberships.
29. Charges for prescription drug plan copayments.
30. Transsexual surgery including medical or psychological counseling and hormonal therapy in preparation for, or subsequent to, any such surgery.

31. Coverage for the children of your children, unless such children are otherwise determined to be your qualified eligible dependents within the meaning of Section 152 of the Internal Revenue Code and legal documentation is provided to the Fund as required during the enrollment process.
32. Vitamins or nutritional supplements, except for infant formula needed for the treatment of inborn errors of metabolism, and vitamins as required under the ACA.
33. Massage therapy.
34. Fees associated with the donation of blood.
35. Cosmetics, dietary supplements, and health and beauty aids.
36. Court ordered treatment or hospitalization, unless such treatment is determined to be medically necessary under the Plan or is otherwise covered by the Plan."
37. Treatment of erectile dysfunction, except for penile implants and external devices for a medical condition under the terms of the Plan, and as set forth in the SPD, and male androgens as provided under the Prescription Drug Coverage.
38. Non-medical counseling or ancillary services, including, but not limited to, custodial services, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, employment counseling, back to school, return to work services, driving safety and training, educational therapy or other non-medical ancillary services for learning disabilities, developmental delays, or mental retardation.
39. Therapy or treatment intended primarily to improve general physical condition or for the purpose of enhancing job, school, athletic, or recreational performance, including, but not limited to, routine, long term or maintenance care which is provided after the resolution of an acute medical problem and when significant therapeutic improvement is not expected.
40. Personal items or comfort items such as personal care kits provided on admission to the Hospital, television, telephone, complimentary meals, newborn infant photographs, birth announcements, or other items which are not for specific treatment of an injury or illness.
41. Artificial aids including, but not limited to, corrective orthopedic shoes, pre-fabricated arch supports, elastic stockings, garter belts, corsets, dentures, and wigs (except as required under the Women's Health and Cancer Rights Act).
42. Aids or devices that assist with nonverbal communications, including, but not limited to, communication boards, prerecorded speech devices, laptop computers, desktop computers, personal digital assistants, Braille typewriters, visual alert systems for the deaf, and memory books.
43. Medical treatment where payment of claims has been denied by the primary plan because the treatment was received from a non-participating provider, or because of failure to follow the primary plan's rules for coverage, unless the primary plan Explanation of Benefits ("EOB") statement shows that the patient is liable for payment.
44. Claims that are received more than one year after the date of service, unless shorter filing limits are required under an in-network provider's contract with the Preferred Provider Organization.
45. Any services, supplies, or treatments not identified as a covered benefit under the terms of the Plan and as set forth in the SPD.
46. Gene therapy, including treatments, drugs, and related services, such as pre-therapy professional fees, and inpatient hospital, facility, and associated travel costs.
47. Gene therapy medications

48. Dermatological medical devices, for the treatment of skin diseases and throat conditions. Topical products may be in the form of creams, emulsions, gels, solutions, and aerosol foams, among others. Products for treatment of throat conditions may include artificial saliva products and saliva substitutes.

# Prescription Drug Coverage—CVS Caremark / Virta

The Plan will pay for certain drugs that are prescribed by your physician, after you pay the applicable copayment. If you, your Spouse, or Eligible Dependent Child get a covered prescription filled or refilled at a participating pharmacy that has an agreement with the pharmacy benefit manager (CVS Caremark), the Plan pays the total cost of the prescription minus your copayment. You will be supplied with a CVS Caremark Prescription Drug Card, which you must present at the participating pharmacy when you get a prescription filled.

CVS Caremark Specialty Pharmacy Services include a program called ACSF, which means Advanced Control Specialty Formulary. With ACSF, in addition to the required Medical Necessity review, Specialty Medications will also be reviewed to determine whether a preferred alternative exists that should be tried first. If an alternative is available, it will be discussed with your physician and the script changed. This is part of the prior authorization process which will be transparent to you.

The prescription copayment shown in the Schedule of Benefits is your out-of-pocket expense for each covered prescription that is filled. Under the terms of the Plan, different copayment levels apply for generic drugs, preferred brand name drugs, and non-preferred brand name drugs. If you use generic drugs whenever possible you will incur the lowest out-of-pocket expense to you and to the Plan. To determine the applicable copayment for any particular drug, go to the CVS Caremark website at www.caremark.com, and register to obtain specific benefit information. In addition, you may call the CVS Caremark Customer Care line at 866-282-8503.

Note: Prescription drug copayments are **not** reimbursable under this benefit or any other provision of the Plan.

The Plan limits the amount of a drug you can get at any one time under the prescription drug benefit. You have the following options to obtain your prescription:

- **Mail Order** will provide up to a 90-day supply of covered maintenance medication.
- **CVS Retail Pharmacies** will provide up to a 90-day supply of covered maintenance medication.
- **Other Retail Pharmacies** will provide up to a 34-day supply of any covered medication.
- **CVS Specialty** will provide up to a 34-day supply of specialty medication, or as appropriate based on dosing, therapy, and handling limitations.

## Out-of-Pocket Limit

The Plan includes an out-of-pocket limit on the prescription drug program administered by CVS Caremark. The out-of-pocket limit is shown in the Schedule of Benefits. When a participant's cumulative out-of-pocket expenses in a calendar year reach the applicable out-of-pocket limit shown in the Schedule of Benefits, prescription drug copayments will be waived for that participant for the rest of the applicable calendar year.

When covered participants in your family have accumulated individual out-of-pocket amounts in the applicable calendar year that, when combined, equals or exceeds the family out-of-pocket limit shown in the Schedule of Benefits, copayments for prescription drugs will be waived for all covered participants in your family for the remaining months of the applicable calendar year.

## Covered Charges (Formulary)

Covered charges include only the reasonable and customary charges for drugs and medications, which, in accordance with federal or state laws, may not be dispensed without the written prescription issued by a physician. The CVS Caremark covered drug list (formulary) includes coverage for most prescription drugs; however, some products are excluded from the formulary in favor of therapeutic equivalents. A therapeutic equivalent is a drug that has essentially the same effect in the treatment of a disease or condition as one or more other drugs; or more simply, a drug that controls a symptom or condition in the exact same way as another.

CVS Caremark may make changes to the formulary from time to time. To determine whether a particular drug is covered, you can go to the CVS Caremark website at www.caremark.com, and register to obtain specific benefit information. Also, you can call the CVS Caremark Customer Care line at 800-282-8503. In addition, if your physician feels there is a clinical reason why you, your Spouse, or your Eligible Dependent Child cannot, or should not, use any of the available therapeutic equivalent alternatives in place of an excluded product, CVS Caremark will provide a review option. Your physician can call CVS Caremark toll-free at 855-240-0536 to initiate such a review.

## Diabetic Testing Equipment

The formulary limits glucose monitors and related test strips to OneTouch devices. OneTouch blood glucose meters will be provided at no charge, by the manufacturer, to the covered individuals who are using a meter other than OneTouch. For more information on how to obtain a blood glucose meter, and any limitations that apply to the program, call 866-871-0839.

## Generic Step Therapy

The Plan includes a generic step therapy program that requires participants to try one or more generic equivalent alternatives in most drug classes before the Plan will provide coverage for a brand name medication. If a brand name medication is required, it must be specifically ordered, and the physician will be required to verify that the drug is Medically Necessary using the CVS Caremark prior authorization process. If you have not tried a generic alternative, and do not have prior authorization approval of Medical Necessity, you will be responsible for full payment of the brand name medication even if the prescription is marked “dispense as written.”

To avoid any confusion at the pharmacy, we suggest that you inform your physician about the Generic Step Therapy program and ask them to call CVS Caremark at 800-294-5979 before accepting a prescription for a brand name drug. CVS Caremark will inform your provider regarding whether the Plan covers the brand name drug, what alternatives are available, and will initiate the Medical Necessity review process where appropriate. If you have not tried a generic or generic equivalent to the brand name drug, your physician will be offered generic alternative options and will be required to select one. Your brand name prescription will be changed to the generic alternative chosen by your physician.

## Exceptions to Generic Alternatives

Your physician can provide CVS Caremark with historic information about alternatives you have tried, if applicable, and request approval for coverage of a brand name drug. Your physician should provide a statement of Medical Necessity that explains the clinical reasons why the brand name drug is required. The brand name drug will be allowed if CVS Caremark confirms Medical Necessity. Your provider also

can call CVS Caremark directly at 800-294-5979 to request prior approval for coverage of a brand name drug, or to start the authorization process.

## Obtaining your Prescription

CVS Caremark has a large nationwide network of participating pharmacies. To locate a participating pharmacy, you can check the website noted above, or you can contact the Fund Office for assistance. When you fill your prescription at a participating pharmacy, you should present your CVS Caremark Prescription Drug Card to the pharmacist and pay the applicable copayment. The pharmacy will submit an electronic claim to CVS Caremark for direct reimbursement of the amount that exceeds your copayment. You are not responsible for any paperwork after you make your copayment.

Using a CVS Caremark participating pharmacy is the easiest way to fill your prescriptions; however, there are a few pharmacies that do not belong to the CVS Caremark network. If you use a pharmacy that does not accept your CVS Caremark Prescription Drug Card to have your prescription filled, you must pay the pharmacist for the prescription and then seek reimbursement from CVS Caremark by filing a paper claim. CVS Caremark will reimburse you for the allowable cost of the prescription, less the applicable copayment provided that the drug is covered under the terms of the Plan. Paper claim forms can be obtained from the Fund Office.

If you have any questions or problems in connection with your prescription drug purchase, please contact the Fund Office at 202-785-8148 or Quantum Health at 866-871-0839 for assistance.

## Mail Order Program

The Prescription Drug Coverage also includes a convenient mail order option that is an excellent alternative, especially in the case of prescription drugs that are used on an on-going basis. Under the mail order program, the CVS Caremark Mail Service Pharmacy will send your prescription drugs directly to the location of your choice, and standard shipping is free. You also have the ability to speak to a registered pharmacist 24 hours a day, seven days a week, and can order refills from CVS Caremark by telephone or through the internet at www.caremark.com.

Contact the CVS Caremark mail order department at 800-824-6349 to obtain information about this program or go to the CVS Caremark website at www.caremark.com and register to obtain more information or to complete mail order forms. You also can contact the Fund Office for further information about the Mail Order Program by telephone at 202-785-8148 or 800-457-3481.

## Specialty Medications

CVS Caremark Specialty Pharmacy Services (CVS Specialty) is the exclusive provider for Specialty Medications under the Prescription Drug Coverage. Specialty Medications include select injectable and oral medications that target and treat specific chronic and/or genetic conditions. They are bioengineered proteins, blood derived products, and complex molecules that generally require special handling and dispensing. Prescriptions for these medications are not filled at a retail pharmacy using your CVS Caremark Prescription Drug Card. Instead, you must obtain Specialty Medications through the Specialty Pharmacy Program.

The Plan participates in the CVS Caremark Specialty Guideline Management Program, which is designed to promote the appropriate use of Specialty Medications. The Program starts with a **review and approval process** overseen by clinical specialists at CVS Specialty. When Specialty Medications

are prescribed, CVS Specialty will contact your physician directly to obtain the necessary clinical information that will enable them to make approval decisions based on drug-specific guidelines. CVS Specialty must approve the use of all Specialty Medications and will discuss alternatives with your physician if any proposed medication does not meet with the applicable guidelines. Following approval, Specialty Medications may be obtained only through CVS Specialty.

A list of covered Specialty Medications can be obtained by calling CaremarkConnect® toll-free at 800-237-2767. If you are prescribed a drug that is on the list, or if your pharmacist tells you that an item you are requesting is a Specialty Medication, you should call CVS Specialty at the toll-free number shown above and identify yourself as a participant of the National IAM Benefit Trust Fund. CVS Specialty will contact your physician directly and take care of all paperwork. In addition, they will provide confidential and convenient delivery of your medication to the location of your choice (i.e., home, work, doctor's office, vacation spot, etc.)

CVS Specialty's pharmacist-led CareTeam also will provide condition-specific education, drug administration instruction, and expert advice to help you manage your therapy. The program includes access to pharmacists and other health experts who can provide condition-specific materials. The CareTeam also will perform follow-up calls to remind you when it's time to refill your prescription, check on your therapy progress, and answer any questions.

If you have questions, please call the toll-free CaremarkConnect® number, 800-237-2767. If you have a hearing impairment and need telecommunications device (TDD) assistance, please call CaremarkConnect® toll-free at 800-231-4403. In addition, you can always contact the Fund Office at 202-785-8148 or Quantum Health at 866-871-0839.

**PrudentRx Copay Program for Specialty Medications**

The Plan participates in the CVS PrudentRx Copay Program ("PrudentRx Copay Program") for certain specialty medications, Participant enrollment in the PrudentRx Copay Program becomes effective after the participant has met the enrollment requirements, outlined below.

The PrudentRx Copay Program helps participants who enroll in manufacturer copay assistance programs. Medications in the specialty tier are subject to a 30% co-insurance. Participants enrolled in the PrudentRx Copay Program who get a copay card for their specialty medication (if applicable), will have a $0 out-of-pocket responsibility for their covered prescriptions under the PrudentRx Copay Program.

Copay assistance is a process in which drug manufacturers provide financial support to patients by covering all or most of the patient cost share for select medications, particularly specialty medications. The PrudentRx Copay Program will assist members in obtaining copay assistance from drug manufacturers to reduce a participant's cost share for eligible medications, thereby reducing out-of-pocket expenses. Participation in the program requires certain data to be shared with the administrators of these copay assistance programs. Any data sharing is done in compliance with HIPAA.

If you or a covered family member are not currently taking but will start a new medication covered under the PrudentRx Copay Program, you can contact PrudentRx, or they will proactively contact you to enroll. PrudentRx can be reached at 1-800-578-4403 to address any questions regarding the PrudentRx Copay Program.

The Plan may periodically update the PrudentRx Copay Program Drug List.

Copayments for these medications, whether made by you, your plan, or a manufacturer's copay assistance program, will not count toward your plan deductible.

Because certain specialty medications do not qualify as "essential health benefits" under the Affordable Care Act, member cost share payments for these medications, whether made by you or a manufacturer copayment assistance program, do not count towards the Plan's out-of-pocket maximum. A list of specialty medications that are not considered to be "essential health benefits" is available. An exception process is available for determining whether a medication that is not an essential health benefit is Medically Necessary for a particular individual.

**Enrollment**

If you currently take one or more medications included in the PrudentRx Copay Program Drug List, you will receive a welcome letter and phone call from PrudentRx that provides specific information about the program as it pertains to your medication. All eligible participants are enrolled in the PrudentRx Copay Program via an easy two-step process: 1) The first step of enrollment is already complete as your member information is on file with PrudentRx; 2) You need to call PrudentRx at 1-800-578-4403 within five (5) days of receipt of the letter to register for any copay assistance available from drug manufacturers.

Some manufacturers require you to sign up to take advantage of the copay assistance that they provide for their medications — in that case, you must speak to someone at PrudentRx at 1-800- 578-4403 to provide any additional information needed to enroll in the copay program. PrudentRx will also contact you if you are required to enroll in the copay assistance for any medication that you take. If you do not return their call, choose to opt out of the program, or if you do not affirmatively enroll in any copay assistance as required by a manufacturer you will be responsible for the full amount of the 30% co-insurance on specialty medications that are eligible for the PrudentRx program.

**Opting Out of the PrudentRx Copay Program**

You can choose to opt out of the PrudentRx Copay Program, by calling 1-800-578-4403.

As noted above, if you opt out, you will be responsible for the 30% co-insurance on specialty medications.

**PrudentRx Contact**

PrudentRx can be reached at 1-800-578-4403 to address any questions regarding the PrudentRx Copay Program.

## Virta Responsible Prescriber Program

National IAM Benefit Trust Fund has partnered with Virta Health, a virtual clinic specializing in sustainable weight loss and diabetes care for those 18 years or older. In partnership with CVS Health, the Fund is enhancing support for member's health goals. This program involves new clinical requirements for coverage of certain medications, specifically GLP-1 medications for weight loss. Through Virta, members will have access to a dedicated care team, digital health tools, and personalized support all at no cost to the member.

To get started, visit **go.virta.com/niamcot** and select "Join Now" or "Check Eligibility" or call 844-847-8216 to begin the enrollment process. This process includes a video appointment with a Virta provider and can take one to three weeks.

## Contraception

The Plan covers certain prescribed contraceptives and contraceptive devices for eligible female participants with no copayment, coinsurance or deductible. In all cases the drug or other contraceptive item must be prescribed by a physician. Prescribed generics and single source brands will be covered with no cost-sharing. Standard time limits for dispensing of such items apply. Please contact CVS Caremark directly at 866-282-8503 if you have questions about what prescribed items are covered.

## Male Androgens

The Plan provides coverage for medical treatment of erectile dysfunction when caused by an established medical condition. This includes coverage for prescribed male androgens (testosterone and erectile dysfunction drugs). Prior authorization and Medical Necessity are required for coverage.

Your physician can call CVS Caremark directly at their toll-free number 855-240-0536 to request approval. They will be required to provide supporting clinical information, which CVS Caremark will review to determine whether the Medical Necessity standard has been met.

If Medical Necessity is confirmed, the Plan will allow covered prescriptions, subject to a 10-pill per month limit for on demand products, or a 30-pill per month limit for daily use Cialis 2.5 mg or 5 mg. If CVS Caremark determines that the use of a male androgen is not Medically Necessary, coverage of the prescribed drug will be denied.

## Compounded Medications

A compounded medication is a medication that is made by combining, mixing or altering ingredients, in response to a prescription, to create a customized medication that is not otherwise commercially available. Any medication classified as a compounded medication that costs more than $300 will require prior authorization before it is covered under the terms of the Plan. Bulk powders and high-cost proprietary bases are not covered under the Plan. One fill of a compound medication is allowed in a 34-day period. If your physician prescribes a compound medication for you, your Spouse, or your Eligible Dependent Children, you should ask him or her to call CVS Caremark at 800-294-5979 to request prior authorization before the prescription is filled.

## GLP-1s

Except where a participant has a history of diabetes, the Plan requires prior authorization for the use of GLP-1 and GLP-1 combination drugs for diabetes treatment (e.g., Ozempic, Trulicity, and Mounjaro), A participant is considered to have a history of diabetes for this purpose if the participant is currently using, or has in the past used, a drug other than a GLP-1 drug for the treatment of diabetes. GLP-1 drugs for the treatment of weight loss (e.g., Wegovy, Saxenda, and Zepbound) must be prescribed by Virta Health.

## Federally Required Coverage

Federal law requires that some prescription drugs and over the counter drugs with a prescription be covered at 100%. CVS Caremark regularly updates the list of these drugs to reflect required changes. For current information on what is included on the list, please call the CVS Caremark Customer Care line at 800-282-8503.

## Prescription Drugs Excluded from Coverage

No charges will be paid for any Prescription Drug that is listed as a Medical Exclusion, or for any items in the list that follows:

1. Physician charges for administration or injection of any drug or medicine.
2. Biological serums, blood products, and allergy serums.
3. Cosmetic products including, but not limited to, anti-wrinkle agents; Botox Cosmetic, hair growth stimulants and hair removal agents; and similar items. However, retinoid medications are covered for treatment of acne for participants through age 25.
4. Devices and supplies of any type including, but not limited to, elastic bandages and supports; ostomy and irrigation supplies; hypodermic needles and syringes; nebulizers; and similar items. Note: The Plan covers insulin needles and syringes; and lancets and test strips for use with glucose testing devices described in the Diabetic Testing Equipment paragraph noted earlier in this section.
5. Drugs or medicines prescribed to be taken by, or administered to, the covered individual, in whole or in part, when the covered individual is a patient in an acute care hospital.
6. Male Androgens that are not approved as Medically Necessary by CVS Caremark.
7. Medications approved as Medically Necessary for the treatment of erectile dysfunction that exceed a 10-pill per month limit for on demand products, or a 30-pill per month limit for daily use of Cialis 2.5 mg or 5 mg.
8. Drugs for treatment of infertility.
9. Experimental drugs or drugs that are labeled: “Caution – limited by federal law to investigational use”.
10. Medications lawfully obtainable over-the-counter, medications not requiring a prescription from a physician, and any medication that is equivalent to an over-the-counter medication (except where federal law requires that certain over-the-counter medications be covered when prescribed).
11. Non-legend drugs other than insulin (except where required by federal law).
12. Refills that are in excess of the number prescribed by the physician, or that are dispensed more than one year after the health care provider’s order.
13. Specialty Medications that are not approved for coverage under the guidelines for the CVS Caremark Specialty Guideline Management program.
14. Prescription drugs that are not included for coverage on the CVS Caremark formulary on the date the prescription is filled, or that are excluded from the formulary in favor of therapeutic equivalents (unless approved under the CVS Caremark review option).

## Benefits after Termination of Coverage

The Prescription Drug Coverage will cease upon termination from the Plan, and no prescription drug benefits are available after termination, even if you are on an extension of medical benefits. If you anticipate your coverage will be ending, you should fill any needed prescriptions before your termination date, or you will be asked to reimburse the Plan for any medication filled after your termination. If you use the mail order program, be sure to order refills so they are received before your termination date.

## Medicare Part D

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) added a new prescription benefit for individuals that are eligible for Medicare coverage called Medicare Part D. The Trustees have determined, with the assistance of an actuary, that the Plan's prescription drug coverage for Medicare eligible participants is actuarially equivalent to Medicare Part D. This means, on average, the Fund's benefits are equal to or better than the standard Medicare Part D drug plan, and therefore the Fund offers Creditable Coverage.

As required by MMA, each plan participant who is Medicare eligible will periodically receive a notice, called a Notice of Creditable Coverage, advising the individual whether the Plan's prescription drug benefit continues to be actuarially equivalent to Medicare Part D. An eligible participant also may receive a Notice of Creditable Coverage upon request to the Fund Office.

Medicare eligible participants, active or retired, are not required to sign up for Medicare Part D and may still obtain their prescription benefits coverage through the Plan. If you do enroll in Medicare Part D, your coverage and the coverage for your Spouse and your Eligible Dependent Child under the Plan will be terminated. In such a case, there is no adjustment to the cost of the coverage under the Plan. If you choose not to enroll in Medicare Part D, your prescription drug coverage under the Plan will continue for you, your Spouse, and your Eligible Dependent Child.

# Coordination of Benefits

The benefits provided by this Plan are coordinated with any benefits payable to you, your Spouse, or your Eligible Dependent Child for the same expenses paid from other group health plans or insurance plans. Coordination means that benefits from the Plan described in this SPD and from other benefit plans and insurance plans cannot exceed 100% of the allowable expense for each covered individual in each calendar year. Coordination is intended to permit up to the full payment of actual allowable expenses without duplication of benefits.

Please Note: There is no Coordination of Benefits under the Prescription Drug Coverage, and prescription drug copayments are not reimbursable under the medical Plan benefits.

There are several circumstances that may result if you, your Spouse, and/or your Eligible Dependent Child are reimbursed for your medical expenses from this Plan and from another source. If any of the possible sources of payment for health benefits, as listed below, apply in the case of you, your Spouse, or Eligible Dependent Child, you must let this Plan know about *all* such plans under which you have coverage.

The application of the COB provisions can occur if you, your Spouse, and/or an Eligible Dependent Child also is covered by:

- Medicare or some other government program;
- Another group health care plan;
- Motor vehicle no-fault coverage for medical expenses;
- Workers' Compensation; or
- If a spouse is employed and covered by a high deductible health plan with a Health Savings Account (HSA), that spouse cannot be covered by another group health plan.

## Effect of Coordination Benefits

When a covered individual is entitled to medical benefits or services under more than one plan, the rules shown in the order as set forth below will be used to decide which plan is the Primary plan. If the Plan described herein:

1. If the Primary Plan among all plans that cover the participant, then its benefits will be determined without taking into account the benefits or services of any other plan.
2. If not the Principal plan, then its benefits may be reduced. The benefits will be reduced so that the benefits provided by all plans will not be more than 100% of the allowable expenses incurred by the applicable participant. The benefits provided under a Plan include the benefits that would have been provided if a claim had been duly made.

The benefits from this Plan will never be greater than those that would be paid in the absence of other coverage.

## How Much the Plan Pays When it is Secondary

When the Plan described in this SPD pays second, it will pay the same benefits that it would have paid had it paid first, **less** whatever payments were made by the plan (or plans) that was required to pay first. In addition, when this Plan pays second, it will never pay more in benefits than it would have paid had it paid the claim as the primary plan. Deductibles, coinsurance, and exclusions of this Plan still apply. As a result, when this Plan pays second, you may not receive 100% of the total cost of the covered health care services.

**Plan.** The term plan for Coordination of Benefits purposes means a plan that provides benefits or services for medical care by or through any:

- Group health plan, including group insurance and a self-insured group health plan;
- Group practice or prepayment coverage;
- Group service plan;
- Method of coverage for persons in a group other than as shown in items 1, 2, and 3; or
- Coverage that is required or provided by law.

The term plan shall also include no-fault motor vehicle insurance.

## Understanding Coordination of Benefits

**Primary Plan.** If a plan is considered primary, that plan is responsible for paying first, in accordance with its benefits schedule, all claims for a covered person.

**Secondary Plan.** If a plan is considered secondary, that plan is responsible for paying benefits, if any remain, after the primary plan has paid its share.

**Pre-Paid Plans.** Pre-Paid plans (HMOs, EPOs, etc.) that require use of specific providers and pay benefits to only those providers will always be primary for dependents whose coverage by the Pre-Paid plan is because they are, or were, an employee. In such cases, this Plan will reimburse only copayments or expenses that remain on covered charges after the Pre-Paid plan has paid benefits.

**Allowable Expense.** Allowable Expense means any necessary, reasonable, and customary item or expense, at least a part of which is a covered expense under any of the plans that cover the person for whom the claim is made. When the benefits from a plan are in the form of services, not payments, the service is considered to be both an Allowable Expense and a benefit paid.

**Claim Determination Period.** Claim Determination Period means a calendar year.

## Coordination of Benefits with Medicare and Other Government Programs

**Medicare.** Generally, anyone age 65 or older is entitled to Medicare coverage. Anyone under age 65 who is entitled to Social Security Disability Income Benefits is also entitled to Medicare coverage after a waiting period.

Medicare has two parts: Hospital Insurance (Part A) and Medical Insurance (Part B). Part A covers inpatient Hospital care and generally is available to all individuals over age 65 at no cost. Part B covers

doctor's services, outpatient Hospital services and other medical supplies and is optional. You must pay a monthly premium for Medicare Part B.

Although you are eligible for Medicare Part A once you reach age 65, if you are an active participant, Part A coverage under Medicare is not automatic unless you have applied for Social Security benefits. Since Part A coverage is not automatic, you and your Spouse can register with Social Security for Part A when you reach age 65. You do not have to apply for Social Security payments (that is, actually retire), but you must apply and establish your entitlement to such benefits in order to be covered by Medicare.

If you, your Spouse, or your Eligible Dependent Child are covered by the Plan and by Medicare, and you remain actively employed, your employer-sponsored group health plan will continue to provide the same benefits and the Plan will pay first (Primary) and Medicare will pay second (Secondary). If you are not actively employed, Medicare will be the Primary plan for any individual that is eligible for Medicare.

Where Medicare is the Primary Plan, its benefits will be taken into account in determining any benefits to be paid under this Plan. **The benefits of Medicare Parts A and B will be taken into account whether or not the participant has enrolled.** This means that the benefits of Medicare Parts A and B will be estimated and benefits under this Plan will be reduced to the extent that benefits would have been paid had you enrolled in Medicare.

In addition, if Medicare is the primary plan, and you elect to use a provider who does not participate in Medicare, the benefits of Medicare Parts A and B will be estimated and the benefits under this Plan will be reduced to the extent that benefits would have been paid had your provider been a Medicare participating provider.

The Plan's benefit payment will coordinate with Medicare's payment. For covered expenses, the Plan will figure its benefit based on the total expense and then subtract the Medicare benefit and consider the balance as payable under the provisions of this Plan. For these expenses, the Plan carves out Medicare's payment. However, federal law limits the amount a provider (Hospital, physician, etc.) can charge above the Medicare payment. The Fund cannot pay the provider more than the amount that Medicare shows as the patient liability for Medicare covered services, and the provider cannot legally bill for more than that amount.

When Medicare is primary, claims should be submitted to Medicare first. After Medicare pays the claim, submit a copy of the claim, along with the Medicare explanation of benefits, to CareFirst Administrators.

If you remain actively employed and you or any of your eligible Dependents become entitled to Medicare solely because of end-stage renal disease (ESRD), this Plan pays first (Primary) and Medicare pays second (Secondary) for 30 months starting the **earlier** of:

- The month in which Medicare ESRD coverage begins; or
- The first month in which the individual receives a kidney transplant.

Then, starting with the 31$^{st}$ month, Medicare pays first (Primary) and this Plan pays second (Secondary).

For the first 30 months, as stated above, any Covered Medical Charges incurred by such disabled individual should be submitted to this Plan for payment with any unpaid balance submitted to Medicare.

## Medicare Advantage Programs

If you are a retiree who is covered under a Medicare Advantage program through another employer, your coverage under this Plan will terminate.

## Medicaid

If a covered individual, active or retired, is covered by both the Plan described in the SPD and Medicaid, this Plan pays first (Primary) and Medicaid pays second (Secondary).

## Military Insurance Coverage

The Plan does not cover dependent Spouses who are on active duty in any armed forces. However, if any covered individual is covered by both this Plan and Military coverage only, this Plan pays first (Primary) and the Military coverage pays second (Secondary).

## Veterans Affairs Facility Services

If a covered individual receives services in a U.S. Department of Veterans Affairs hospital or facility on account of a military service-related illness or injury, benefits related to the illness or injury are not payable by the Plan.

If a covered individual receives services in a U.S. Department of Veterans Affairs hospital or facility on account of any other condition that is not a military service-related illness or injury, benefits are payable by the Plan to the extent those services are Medically Necessary, and the charges are reasonable and customary.

## Motor Vehicle No-Fault Coverage Required by Law

If you, your Spouse, or your Eligible Dependent Child are involved in a motor vehicle accident and you have, or are required by state law to have, basic reparation coverage, your insurance carrier will be primarily liable for lost wages, medical, surgical, hospital, and related charges.

Regardless of whether the Plan described in this SPD is Primary or Secondary, you, your Spouse, or your Eligible Dependent Child (if an adult) may be required to sign a Reimbursement Agreement and Consent to Lien before any claims relating to the accident will be paid by the Plan. The Reimbursement Agreement permits the Fund to receive reimbursement for expenses paid by the Fund that you recover through litigation or settlement with another party or insurance company.

## Rules to Determine Payment

Group plans determine which plan pays first by applying Uniform Order of Benefit Determination rules in a specific sequence. This Plan uses the Order of Benefit Determination rules established by the National Association of Insurance Commissioners (NAIC), and which are commonly used by insured and self-insured plans. Any group plan that does not use these rules will be deemed by this Fund to be the Primary plan.

Under the rules set forth below, if the first rule does not establish a sequence or order of benefits, the next rule is applied and so on, until an order of benefits is established. The rules are:

**Rule 1: No Coordination of Benefit Provision**

If your other plan does not have a Coordination of Benefits provision which coordinates Benefits, the Plan will always be the Primary Plan.

**Rule 2: Coverage as a Subscriber and as a Dependent**

If you are covered under one plan as a subscriber and under the other plan as a dependent, the plan which covers you as a subscriber will be Primary.

**Rule 3: Dependent Child Covered Under More Than One Plan**

If you are covered as a dependent under two plans, then the rules are as follows:

- The coverage of the parents whose birthday is first in the year will be primary and the parent whose birthday is later in the year will be secondary. The word **birthday** refers only to the month and day in a calendar year; not the year in which the person was born.
- If both parents have the same birthday, the benefits of the plan in effect longer will be primary;
- If the other plan does not have this rule, instead has a rule based upon the parents' gender; and if as a result, the plans do not agree on the order of benefits, then the rule in the other plan will determine the order of payment for the claimed benefits.

**Rule 4: For a Child of Separated or Divorced Parents**

- If the terms of a court decree specify which parent is responsible for the health care coverage and expenses of the child, and that parent's plan has actual knowledge of the Court Order, then that parent's plan shall be primary.
- If no such court decree exists, or if the plan of the parent designated under such a court decree as responsible for the child's health care coverage and expenses does not have actual knowledge of the court decree, benefits for the child are determined in the following order:
  - First, the plan of the parent with custody of the child;
  - Then, the plan of the Spouse of the parent with custody of the child;
  - Finally, the plan of the parent not having custody of the child.

**Rule 5: Coverage of Active Employee and/or Employee's Dependent**

A plan which covers you as an active employee or the dependent is primary. A plan which covers you as a laid-off or retiree employee (or that employee's dependent) is secondary. If the other plan does not have this rule and if, as a result, the plans do not agree on which plan is primary, this Rule 5 is ignored.

**Rule 6: Longer/Shorter Length of Coverage**

If none of the above rules determines the order of benefits, the plan that covered you longer is primary.

The length of time a person is covered under a plan is measured from the date the person was first covered under that plan, and does **not** start over as the result of a change:

- In the amount or scope of a plan's benefits;
- In the entity that pays, provides or administers the plan; or

- From one type of plan to another (such as from a single employer plan to a Multiemployer plan).

## Administering Coordination of Benefits

To administer COB, the Plan reserves the right to:

- Exchange information with other plans involved in paying claims;
- Require that you or your health care provider furnish any necessary information;
- Reimburse any plan that made payments this Plan should have made; or
- Recover any overpayment from your hospital, physician, other health care provider, other insurance company, you, your Spouse, or your adult Dependent Child.

If this Plan should have paid benefits that were paid by any other plan, this Plan may pay the party that made the other payments in the amount that the Fund Office, or its designee, determines to be proper under this provision. Any amounts so paid will be considered to be covered benefits under this Plan, and this Plan will be fully discharged from any liability it may have to the extent of such payment.

To obtain all the benefits available to the covered individual, a claim should be filed under each plan that covers the person for the medical expenses that were incurred. However, any person who claims benefits under this Plan must provide all the information this Plan will need to apply COB requirements.

# Third-Party Liability and Right of Recovery

## Payment Prior to Determination of Responsibility of a Third Party

The Plan does not cover, nor is it liable for, any charges or expenses incurred by a participant, his or her parent(s) and eligible dependent(s) or a representative, guardian or trustee of the participant, parent(s) or eligible dependent(s) (hereinafter, collectively "claimant") as a result of an accident or injury for which one or more third parties (any person or entity) are, or may be, liable. However, subject to the terms and conditions of this Section, the Board of Trustees or their designee, at their discretion, may advance payment for some or all of a claimant's medical expenses after receipt of a properly executed Reimbursement Agreement and Consent to Lien. In addition, acknowledgement of the Agreement must be provided to the Fund Office Claims Administrator, or designee by the claimant's attorney. The reimbursement agreement and consent to lien, and Acknowledgement must be executed without alteration or any other condition.

Where the Plan has made payments for an injury, irrespective of any signed written agreement, the Plan will have the right to recover from the participant the full amount of benefits paid without deductions or adjustments of any kind if the claimant obtains any settlement, judgment, arbitration or recovery from a third party or from any insurance provider or other source. In such event, the Plan will have a first lien on any such recovery and must be promptly reimbursed in full within 30 calendar days, or the claimant will have additional liability for interest and all costs of collection, including reasonable attorney's fees. The claimant will first reimburse the Fund out of any recovery before the claimant is entitled to any portion of the recovery and without regard to the extent of the recovery that has been, or may be, provided to the claimant.

As noted above, the Plan has the right to recover the full amount of benefits paid by the Plan, without deductions or adjustments of any kind. For example, there is no deduction or adjustment for attorney's fees incurred by the claimant in obtaining the settlement, judgment, arbitration or recovery. The Plan's lien is **not** reduced by any such attorney's fees. Regardless of the sufficiency of any recovery, the Plan is **not** subject to any state law doctrines, including but not limited to, the common fund doctrine, which would purport to require the Plan to reduce its recovery by any portion of a claimant's attorney's fees and costs. The Plan is also **not** subject to the make whole doctrine or other similar doctrines which purport to subject the Plan's recovery to the claimant's full compensation for all of his Injuries.

In the event the claimant fails to reimburse the Fund from proceeds received from a third party, the Fund will also have the right to withhold future benefits equal to the amount otherwise due the Fund, plus interest and the costs of collection including attorneys' fees incurred by the Fund.

## Reimbursement and Consent to Lien

Every claimant, on whose behalf an advance may be payable, must execute and deliver to the Fund a reimbursement agreement and consent to lien in the form provided without alteration. Claimants must do whatever is necessary to protect the Fund in obtaining reimbursement and/or its subrogation rights. Each such claimant must promptly notify the Fund Office if he or she makes a claim or brings an action against a third party or if he or she obtains any settlement, judgment, or other recovery from any source.

If a claimant does not execute a reimbursement agreement or consent to lien for any reason, it will **not** waive, compromise, diminish, release or otherwise prejudice any of the Fund's reimbursement rights if

the Fund, at its discretion, makes an advance and inadvertently pays benefits in the absence of a reimbursement agreement.

The Fund's standard administrative procedure will be used to determine whether a third party might potentially be held liable in connection with an accident or injury. Claims will **not** be paid until this determination is made. If it is determined that the claim may be the result of a third party's negligence or other misconduct, the Fund will not process any claims without a properly signed Reimbursement Agreement and Consent to Lien along with acknowledgement by the claimant's attorney, both executed without alteration or other conditions.

## Sources of Payment

The Plan's sources of payment through subrogation or reimbursement are as follows:

- Money from a responsible party or third party that you, your family members, your guardian, or other representatives or beneficiaries receive or are entitled to receive;
- Any constructive trust that is imposed on the proceeds of any settlement, verdict or other amount that you, your family members, your guardian, or other representatives or beneficiaries receive;
- Any liability or other insurance (for example, uninsured motorist, underinsured motorist, medical payments, no-fault, school, homeowners, or excess or umbrella coverage) that is paid or payable.

## Cooperation with the Plan by All Covered Persons

By accepting an advance for related claim payment, every claimant agrees to do nothing that will waive, compromise, diminish, release or otherwise prejudice the Fund's reimbursement rights.

By accepting an advance payment for related claims to an injury, every claimant agrees to notify and consult with the Board of Trustees, its Fund Office or designee before:

- Starting any legal action or administrative proceeding against a third party based on any alleged negligent, intentional or otherwise wrongful action that may have caused or contributed to the claimant's injury that resulted in the Fund's advance payment of claims; or
- Entering into any settlement agreement with that third party or that third party's insurer that may be related to any actions by that third party that may have caused or contributed to the claimant's injury that resulted in the Fund's advance for claims related to such injury.

By accepting an advance in claim payments, every claimant agrees to keep the Board of Trustees, its Fund Office or designee informed of all material developments with respect to all such claims, actions, or proceedings.

## Your Responsibilities

You have the duty to cooperate fully with the Plan and any party designated by the Plan Administrator if the Plan's rights of subrogation or reimbursement are asserted, including executing and delivering any documents the Plan may require or appearing in court for a deposition or testimony, if necessary. You must do nothing to prejudice the Plan's rights of subrogation and reimbursement.

When making or filing a claim, you or your legal representative must give the Plan written notice about whether or not you were injured by a third party. You also must provide the following information in a timely manner:

- The name, address and telephone number of:
  - The third party who in any way caused the injury, as well as the attorney representing the third party;
  - The third party's insurer; and
  - The attorney who represents you with respect to the third party's act or omission.
- Before any meeting, the date, time and location of the meeting between the third party or his or her attorney and yourself or your attorney;
- All terms of any settlement offer made by the third party or his or her insurer;
- All information you or your attorney discovered concerning the third party's insurance coverage;
- The amount and location of any funds you recover from the third party or his or her insurer, and the dates on which such funds were received;
- All information related to any oral or written settlement agreement between you and the third party or his or her insurer;
- All information regarding any legal action that has been brought on your behalf against the third party or his or her insurer;
- All other information the Plan may request.

## All Recovered Proceeds Are to Be Applied to Reimbursement of the Fund

By accepting an advance payment of claims for an injury, every claimant agrees to reimburse the Fund for all such advances by applying any and all amounts paid or payable to them by any third party or that third party's insurer by way of settlement, judgment, arbitration or recovery, or in satisfaction of any judgment or agreement, regardless of whether those proceeds are characterized as being paid on account of the medical expenses for which any advance has been made by the Fund. The Fund will have the right to recover from the claimant the full amount of benefits paid without deductions or adjustments of any kind including attorney's fees. In such event, the Fund must be fully reimbursed within 30 calendar days of the date proceeds are received by the claimant or his attorney, or the claimant will have additional liability for interest and all costs of collection, including reasonable attorney's fees. The Fund may offset future claims/benefits in order to receive the full amount of benefits paid if full reimbursement is not made.

**Furthermore, once the claim is settled and further liability is closed, the Fund is not liable for, and will not pay, future benefits for claims related to that injury or accident.**

**Note:** This Fund is a self-insured employee welfare benefit plan and, therefore, ERISA preempts any state law purporting to restrict the Fund's right under this provision. Furthermore, any state law directed at insurance companies will not apply to the Fund since it is self-insured.

## No-Fault Insurance Coverage

Where the participant or eligible dependent is involved in a motor vehicle accident covered by a no-fault insurance policy, whether or not required by state insurance law, the automobile no-fault insurance carrier will initially be liable for lost wages, medical, surgical, hospital and related charges and expenses up to the greater of:

- The maximum amount of basic reparation benefit required by applicable law; or
- The maximum amount of the applicable no-fault insurance coverage in effect.

The Plan will thereafter consider any excess charges and expenses under the applicable provisions of the respective Plan in which you are provided health coverage. Before related claims will be paid through the Fund, the participant or his/her eligible dependent will be required to sign a Reimbursement Agreement and Consent to Lien.

If the participant or his/her eligible dependent fails to secure no-fault insurance as required by state law, the participant or eligible dependent is considered as being self-insured and must pay the amount of the basic medical reparation expenses for himself and/or his eligible dependents arising out of the accident.

## Refund of Overpayment of Benefits — Right of Recovery

If the Fund pays benefits for expenses incurred on account of you or your Eligible Dependent, you or any other person or organization that was paid must make a refund to the Fund if:

- All or some of the expenses were not paid or did not legally have to be paid by you or your eligible dependents;
- All or some of the payment made by the Fund exceeds the benefits under the Plan; or
- All or some of the expenses were recovered from or paid by a source other than this Plan including another plan to which this Plan has secondary liability under the Coordination of Benefits provisions. This may include payments made as a result of claims against a third party for negligence, wrongful acts or omissions.

The refund will equal the amount the Fund paid in excess of the amount it should have paid under the Plan. In the case of recovery from or payment by a source other than this Plan, the refund equals the amount of the recovery or payment up to the amount the Fund paid.

If you or any person or organization that was paid does not promptly refund the full amount, the Fund may reduce the amount of any future benefits that are payable under the Plan. The reductions will equal the amount of the required repayment, plus interest. The Fund may have other rights in addition to the right to reduce future benefits.

# Claims Filing and Appeal Procedures

This Section of the SPD describes the procedures for filing claims and benefits as provided under the terms of the National IAM Benefit Trust Fund. It also describes the procedures for you to follow if your claim is denied in whole or in part and you wish to appeal the decision.

The Plan's internal claims and appeal procedures are designed to provide you with full, fair, and fast claim review and so that Plan provisions are applied consistently with respect to you and other similarly situated participants. In addition, the Plan must consult with a health care professional with appropriate training and experience when reviewing an 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 appropriate or is Experimental or Investigational).

The internal claims process pertains to determinations made by the appropriate Claims Administrator about whether a request for benefits (known as a "claim") is payable. If the appropriate Claims Administrator denies your claim for benefits (known as an "adverse benefit determination"), you have the right to appeal the denied claim under the Plan's internal appeals process.

For health benefits, you may be able to seek an external review with an Independent Review Organization (IRO) that conducts reviews of adverse benefit determinations either (i) after the Plan's internal appeals process has been exhausted, or (ii) under limited circumstances before the Plan's internal claims and appeals process have been exhausted.

| Appropriate Claims Administrator | Types of Claims Processed |
|---|---|
| CareFirst Administrators<br>P.O. Box 14115<br>Lexington, KY 40512-4115<br>Phone: 1-866-871-0839<br>www.cfablue.com | • Post-Service Medical Claims<br>• First Level Appeals:<br>  • Pre-Service and Concurrent Care Medical Claims denied based on Medical Necessity<br>  • All Post-Service Medical Claims |
| Quantum Health<br>Appeals Department<br>5240 Blazer Parkway<br>Dublin, OH 43017<br>1-800-257-2038<br>Fax: (877)-498-3681<br>www.quantum-health.com | Pre-Service and Concurrent Care Medical Claims denied for reasons other than Medical Necessity |
| CVS Caremark, Inc.<br>9501 East Shea Blvd.<br>Scottsdale, AZ 85260-6719<br>Phone: 888-727-5575<br>www.cvscaremark.com | • Prescription Drug Claims |

| | |
|---|---|
| National IAM Benefit Trust Fund<br>99 M Street, SE, Suite 600<br>Washington, DC 20003<br>Phone: 202-785-8148<br>Fax: 202-728-0585<br>www.iambtf.org | • Eligibility Determinations<br>• Second-Level Appeal |

## Right to an Authorized Representative

In making a claim or appeal, you may be represented by any authorized representative. If your representative is not an attorney, parent, or court appointed guardian, you must designate the representative by a signed written statement. For this purpose, an authorized representative also includes a health care professional. An "authorized representative" means a person you authorize, in writing, to act on your behalf, such as your Spouse. The Plan will also recognize a court order giving a person authority to submit claims on your behalf, except that in the case of a claim involving urgent care, a health care professional with knowledge of your condition may always act as your authorized representative. A form can be obtained from the Fund Office to designate an authorized representative.

The Plan requires you to provide a written statement declaring your designation of an authorized representative along with the representative's name, address, phone number, and email address. To designate an authorized representative, you must submit a completed authorized representative form (available from the Fund Office). The Plan will honor the designated authorized representative until the designation is revoked, or as mandated by a court order. You may revoke a designated authorized representative status by submitting a completed change of authorized representative form available from and to be returned to the appropriate Claims Administrator or the Fund Office.

The Plan reserves the right to withhold information from a person who claims to be your authorized representative if there is suspicion about the qualifications of that individual

## Adverse Benefit Determination

An adverse benefit determination, for the purpose of the internal claims and appeal process, means:

- A denial, reduction, or termination of, or a failure to provide or make payment in whole or in part for a benefit, including a determination of an individual's eligibility to participate in the Plan or a determination that a benefit is not a covered benefit;
- A reduction of a benefit resulting from the application of any utilization review decision, source-of-injury exclusion, network exclusion, or other limitation on an otherwise covered benefit or failure to cover an item or service for which benefits are otherwise provided because it is determined to be not Medically Necessary or appropriate, or Experimental or Investigational; or
- A rescission of coverage, whether or not there is an adverse effect on any particular benefit.

## Health Care Professional

A health care professional, for the purposes of the claims and appeals provisions, means a physician or other health care professional licensed, accredited or certified to perform specified health services consistent with state law.

## Definition of a Claim

A claim is a request for a Plan benefit made by you, your Spouse, or your covered Dependent Child (also referred to as "claimant") or your authorized representative in accordance with the Plan's reasonable claims procedures.

Casual inquiries about benefits or the circumstances under which benefits might be paid according to the terms of the Plan are **not** considered claims. Nor is a request for a determination of whether an individual is eligible for benefits under the Plan considered to be a claim. However, if a claimant files a claim for specific benefits and the claim is denied because the individual is not eligible for benefits under the Plan, the coverage determination is considered a claim.

A request for prior approval of a benefit that does not require prior approval by the Plan is not considered a claim. However, requests for prior approval of a benefit where the Plan does require prior approval (e.g., hospital pre-admission certification, etc.) are considered claims and should be submitted as pre-service claims (or urgent claims, if applicable), as described in the following procedures.

## Types of Claims

Health benefit claims can be filed for medical, mental health, substance use disorder, and prescription drug, benefits. There are four categories of health claims as described below:

**Pre-Service Claim** means a claim for a benefit for which the Plan requires approval before health care is obtained, or approval is required in order to receive the maximum benefit provided by the Plan.

**Urgent Claim** means a claim for health care or treatment that if normal pre-service standards were applied, would seriously jeopardize the life or health of the Covered Person or the ability of the Covered Person to regain maximum function or, in the opinion of a physician with knowledge of the covered person's medical condition, subject the covered person to severe pain that could not be adequately managed without the care or treatment that is the subject of the claim. However, the Plan will not deny benefits for these procedures or services if it is not possible for the claimant to obtain the pre-approval, or the pre-approval process would jeopardize the claimant's life or health.

**Concurrent Claim** means a claim that is reconsidered after an initial approval is made, resulting in a reduction, termination or extension of a benefit. (An example of this type of claim would be an inpatient hospital stay originally certified for five days that is reviewed at three days to determine if the full five calendar days stay is still appropriate. In this situation, a decision to reduce, terminate or extend the hospital stay is made concurrently with the period of hospitalization.)

**Post-Service Claim** means a claim for benefits that is not a pre-service, concurrent or urgent claim. Specifically, a claim submitted for payment *after* health services or treatment have been obtained.

## Claim Elements

A claim must include the following elements to trigger the Plan's internal claims process:

- Be written or electronically submitted (oral communication is acceptable for authorization of services only for Urgent Care Claims);
- Be received by the Plan Administrator or Claims Administrator (as applicable);

- Name a specific individual participant and his/her Social Security Number or other assigned unique identification number;
- Name a specific claimant and his/her date of birth;
- Name a specific medical condition or symptom;
- Provide a description and date of a specific treatment, service or product for which approval or payment is requested (must include an itemized detail of charges and applicable service codes);
- Identify the provider's name, address, phone number, professional degree or license, and federal tax identification number (TIN); and
- When another plan is primary payer, include a copy of the other Plan's Explanation of Benefits (EOB) statement along with the submitted claim.

A request is *not* a claim if it is:

- Not made in accordance with the Plan's benefit claims filing procedures described in this section;
- Made by someone other than you, your covered dependent, or your (or your covered dependent's) authorized representative;
- Made by a person who will not identify himself or herself (anonymous);
- A casual inquiry about benefits such as verification of whether a service/item is a covered benefit or the estimated allowed cost for a service;
- A request for prior approval where prior approval is not required by the Plan;
- An eligibility inquiry that does not request benefits. However, if a benefit claim is denied on the grounds of lack of eligibility, it is treated as an adverse benefit determination and the individual will be notified of the decision and allowed to file an appeal;
- The presentation of a prescription to a retail pharmacy or mail order pharmacy that the pharmacy denies at the point of sale. After the denial by the pharmacy, you may file a claim with the Plan.

If you submit a claim that is not complete or lacks required supporting documents, the Plan Administrator or Claims Administrator, as applicable, will notify you about what information is necessary to complete the claim. This does not apply to simple inquiries about the Plan's provisions that are unrelated to any specific benefit claim or which relate to proposed or anticipated treatment or services that do not require prior approval.

## How to File a Claim

Please make sure that you present your benefit identification card to each provider before you are given any services so that the provider will know that you participate in a CareFirst Administrators Preferred Provider Organization. Non-Preferred Providers may require that you pay them first and that you seek reimbursement by filing your own claim with CareFirst Administrators.

### *Network Benefits*

If you use CareFirst Administrators network providers, your claim for benefits will go directly from the network health care provider (hospital, physician, laboratory, etc.), through an automated electronic

system, or through the mail, to the Claims Administrator for processing. Generally, you are **not** required to file a claim form for in-network benefits.

### *Out-of-Network Benefits*

If you use out-of-network providers not affiliated with the CareFirst Administrators network, you may be required to submit your own completed claim form and follow the claims procedures outlined in this Section, as applicable.

You may obtain claim forms from the Fund Office, CareFirst Administrators, or by going online at www.iambtf.org. To expedite the processing of your medical claim, please be sure to complete the form thoroughly, including information about Medicare eligibility and any other group benefits that may be payable on your behalf. Your written claim must be mailed to CareFirst Administrators as soon as reasonably possible after the expense is incurred, but in no event more than one year after the expense is incurred.

**Note:** Any claims CareFirst Administrators receives more than one year after the expense is incurred will be denied as untimely. CareFirst Administrators may also have shorter filing limits for their network providers. You will not be responsible for payment of charges CareFirst Administrators denies for untimely filing if a CareFirst Administrators contracted provider fails to file your claim in accordance with CareFirst Administrator's contractual requirements.

The following information must be completed on the claim form in order for your request for benefits to be considered a claim, and in order for the Plan to be able to process your claim.

You complete the Employee portion of the claim form, providing the following:

- Participant name;
- Patient name;
- Participant member id and account number
- Patient date of birth; and

**Note:** Your member ID is the ID shown on your benefit identification card.

Your physician (or other provider) may **either**:

- Complete the following items, as applicable, on the Attending Physician's Statement section of the claim form:
  - Date of Service;
  - CPT-4 (the code for physician services and other health care services found in the Current Procedural Terminology, Fourth Edition, as maintained and distributed by the American Medical Association);
  - ICD-10 (the diagnosis code found in the International Classification of Diseases, 10th Edition, Clinical Modification as maintained and distributed by the U.S. Department of Health and Human Services);
  - Billed charge;
  - Number of units (for anesthesia and certain other claims);

- Federal taxpayer identification number (TIN) of the provider;
- Billing name and address; and
- If treatment is due to accident, accident details.

**Or**

- Attach all itemized bills or doctor's statements that describe in full the services rendered.

**Warning:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit may be guilty of a crime and may be subject to fines and confinement in prison.

## Filing a Claim

You may file claims for health benefits and appeal adverse claim decisions yourself or have an authorized representative do it for you. Often, the provider will make the claim on your behalf directly to the Claims Administrator. If your claim is denied, in whole or in part, you will receive a written notice of the denial from the Claims Administrator. The notice will explain the reason for the denial and the review procedures, including any applicable statute of limitation within which the claimant may file a claim in a court of law.

An "authorized representative" means a person you authorize, in writing, to act on your behalf, such as your Spouse. The Plan will also recognize a court order giving a person authority to submit claims on your behalf, except that in the case of a claim involving urgent care, a health care professional with knowledge of your condition may always act as your authorized representative. A form can be obtained from the Fund Office to designate an authorized representative.

### *Urgent Care Claims*

If the Plan requires advance approval of a service, supply or procedure before a benefit will be payable, and if the Plan or your physician determines that it is an urgent care claim, you will be notified of the decision not later than 72 hours (shorter depending on medical urgency of the case) after the claim is received. The decision will be made by Quantum Health unless the decision relates to your eligibility to participate, in which case it will be made by the Fund Office, acting on behalf of the Board of Trustees.

If there is not sufficient information to decide the claim, you will be notified of the information necessary to complete the claim as soon as possible, but not later than 24 hours after receipt of the claim. You will be given a reasonable additional amount of time, but not less than 48 hours, after the end of that additional time period (of after receipt of the information, if earlier).

### *Other Health Claims (Pre-Service and Post-Service)*

If the Plan requires you to obtain advance approval of a service, supply or procedure before a benefit will be payable, a request for advance approval is considered a pre-service claim and should be filed with Quantum Health. You will be notified of the decision by Quantum Health not later than 15 calendar days after receipt of the pre-service claim.

For other claims (post-service claims), you will be notified by CareFirst Administrators of the decision not later than 30 calendar days after receipt of the claim. For either a pre-service or a post-service claim, these time periods may be extended up to an additional 15 calendar days due to circumstances outside

the Plan's control. In that case, you will be notified of the extension before the end of the initial 15- or 30-calendar day period.

The time period may be extended because you have not submitted sufficient information, in which case you will be notified of the specific information necessary and given an additional period of at least 45 calendar days after receiving the notice to furnish that information. You will be notified of the Plan's claim decision no later than 15 calendar days after the end of that additional period (or after receipt of the information, if earlier).

For pre-service claims which name a specific claimant, medical condition and service or supply for which approval is requested, and which are submitted to a Plan representative responsible for handling benefit matters, but which otherwise fail to follow the Plan's procedures for filing pre-service claims, you will be notified of the failure within five calendar days (within 24 hours in the case of an urgent care claim) and of the proper procedures to be followed. The notice may be oral unless you request written notification.

**Note:** Any claim CareFirst Administrators receives more than one year after the expense is incurred will be denied as untimely. CareFirst Administrators may also have shorter filing limits for some network providers. You will not be responsible for payment of charges CareFirst Administrators denies for untimely filing if a CareFirst Administrators contracted provider fails to file your claim in accordance with CareFirst Administrator's contractual requirements.

## Ongoing Course of Treatment

If you have received precertification for an ongoing course of treatment, you will be notified in advance if the Plan intends to terminate or reduce benefits for the previously authorized course of treatment so that you will have an opportunity to appeal the decision and receive a decision on that appeal before the termination or reduction takes effect. If the course of treatment involves urgent care, and you request an extension of the course of treatment at least 24 hours before its expiration, you will be notified of the decision within 24 hours after receipt of the request.

## Notice of Decision

If your claim is denied, you will be provided with written notice of denial of the claim (whether denied, in whole or in part). This notice generally will be provided by CareFirst Administrators, except in some cases, by the Fund Office on behalf of the Trustees. For example, if the decision relates to Plan eligibility. This notice will state:

- The claim involved.
- The specific reason(s) for the determination.
- The Plan standard that was used, if any.
- The specific Plan provision(s) on which the determination is based.
- A description of any additional material or information necessary to perfect or decide the claim, and an explanation of why the material or information is necessary.
- A description of the appeal procedures (including the external appeal opportunity) and applicable time limits for pursuing the appeal or filing a legal claim.

- A statement of your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review.
- If an internal rule, guideline or protocol was relied upon in deciding your claim, you will receive either a copy of the rule, or a statement that such a rule was relied upon in deciding the claim and that a copy will be provided to you upon request at no charge.
- If the determination was based on the absence of Medical Necessity, or because the treatment was experimental or investigational, or other similar exclusion, you will receive an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to your claim, or a statement that it is available upon request at no charge.
- If the adverse benefit determination involves urgent care, a statement of the expedited review process applicable to such claims. An adverse determination involving urgent care may be provided orally, provided written notification is provided not later than three calendar days after the oral notification.

If a Pre-Service claim is approved, you will receive written (or electronic, as applicable) notice within fifteen (15) days of the appropriate Claims Administrator's receipt of the claim. Notice of Approval of an Urgent Care Claim will be provided in writing (or electronically, as applicable) to you and your health care professional within the applicable timeframe after the Claims Administrator's receipt of the claim.

## Internal Appeals for Health Claims

### *A. First Level Appeal*

- Medical Benefits Appeal
  - Pre-Service Claims

    If you disagree with Quantum Health or CareFirst Administrator's decision on any of your Pre-Service Claims for medical benefits, you may submit an appeal to the appropriate Claims Administrator as stated in the notice of adverse benefit determination. Your request for appeal review must be made in writing within 180 days of receipt of your denial notice and should be submitted to the appropriate Claims Administrator noted above. You should state the reason why you feel your appeal should be approved and include any information supporting your appeal. Your appeal will be reviewed by someone not involved in the initial decision. **Note: You must first file your internal appeal with the appropriate Claims Administrator as you initiate the Appeals process.** First level appeals received more than 180 days after receipt of the notice of the denial or adverse determination of the claim will be denied as untimely.

    The Claims Administrator will respond in writing to your appeal no later than 15 calendar days (for pre-service claims) or 30 calendar days (for post-service claims) after the appeal is received. In ruling on such first level appeals, the applicable Claims Administrator, CareFirst Administrators, or Quantum Health serves in the capacity of a named fiduciary under ERISA.
- Eligibility Appeal
- If you are appealing an adverse determination relating to eligibility, your appeal must be made to the Board of Trustees in writing within 180 days after receipt of the determination notice. Appeals received more than 180 days after receipt of the notice will be denied as untimely.

- If you file an appeal with the Board of Trustees, you will be deemed to authorize the Fund to obtain information relevant to your claim. Mail your written appeal directly to the Board of Trustees, National IAM Benefit Trust Fund, 99 M Street, SE, Suite 600, Washington, D.C. 20003.

  If you are appealing an adverse determination relating to eligibility to the Board of Trustees, the Board of Trustees will make a determination at the next scheduled meeting of the Board of Trustees following the Plan's receipt of a request for review, unless the request for review is filed within 30 calendar days preceding the date of such meeting. In such case, a benefit determination may be made no later than the date of the second meeting following the Plan's receipt of a request for review.

  If special circumstances require a further extension of time, a determination will be rendered not later than the third meeting of the Board of Trustees following the Plan's receipt of the request for review. If such an extension of time for review is required because of special circumstances, the Board of Trustees will notify the claimant in writing of the extension, describing the special circumstances and the date as of which the benefit determination will be made, prior to the commencement of the extension. Notice of the benefit determination and review by the Board of Trustees will be made as soon as possible, but not later than five calendar days after the benefit determination is made.

  You may submit written comments, documents, records and other information relating to your claim. You may also request that the Plan provide you, free of charge, copies of all documents, records and other information relevant to the claim.

- Expedited Appeal Process

  **If your claim involves urgent care,** an expedited appeal may be initiated by a telephone call to Member Services located on the back of your member identification card). You or your authorized representative may appeal urgent care claim denials either orally or in writing. All necessary information, including the appeal decision, will be communicated between you or your authorized representative and the Plan by telephone, fax or other similar method. You will be notified of the decision not later than 36 hours after the urgent care appeal is received.

- Right to Second Level Appeal

  If you are dissatisfied with the Claim Administrator's first level appeal decision, you may request a second level review of your appeal. Your request for second level appeal review must be made in writing to the Board of Trustees and be submitted to the office of the National IAM Benefit Trust Fund within 180 days of your receipt of CareFirst Administrator's denial notice on the first level appeal review. Your second level appeal should include a copy of the first level appeal denial, and any information supporting your appeal. Second level appeals received more than 90 days after receipt of the denial of the first level appeal will be denied as untimely.

### *B. Filing a Second Level Appeal*

On second level, the Board of Trustees will review your claim and make a decision on the date of the first meeting of the Board that immediately follows the Plan's receipt of a request for review, unless the request for review is filed within 30 days preceding the date of such meeting. In such case, a benefit determination may be made on the date of the second meeting following the Plan's receipt of the request for review. If special circumstances require a further extension of time for processing, a determination will be made no later than the third meeting following the initial receipt of the appeal. If an extension

is required, you will be notified of the extension and the reasons for it prior to the commencement of the extension.

In deciding an appeal of a benefit determination that was based, in whole or in part, on a medical judgment (including determinations about whether a particular treatment, drug, or other item is experimental, investigational, or not Medically Necessary or appropriate), the reviewer will consult with a health care professional who has appropriate training and expertise in the particular field of medicine, and who was not consulted in connection with the original determination. You will also be provided, upon request, with the identity of any medical or vocational experts whose advice was obtained at any level of the claims and appeals process, without regard to whether that advice was relied on.

If you submit an appeal with the Board of Trustee, any applicable statute of limitations will be delayed while the appeal is pending. The filing of a claim will have no effect on your rights to any other benefits under the Plan. No fees or costs are imposed upon you as part of the appeal to the Board of Trustees. The decision to submit an appeal to the Board of Trustees will have no effect upon your rights to any other benefits under the Plan.

If you choose to appeal to the Board of Trustees following an adverse determination at the first level of appeal, you must do so in writing, and you should send the following information:

- The specific reason(s) for the appeal;
- Copies of all past correspondence with the Fund, including any Explanation of Benefits (EOB's);
- Copies of the first level adverse appeal determination made by the Claims Administrator; and
- Any applicable information that you have not yet sent to the Fund Office.
- If you file an appeal with the Board of Trustees, you will be deemed to authorize the Fund to obtain information relevant to your claim. Mail your written appeal directly to:

Board of Trustees
National IAM Benefit Trust Fund
99 M Street, SE, Suite 600
Washington, DC 20003

The Board of Trustees will review your appeal. They will evaluate your claim within the timeframes described above. You will be notified of the Board of Trustees decision on your appeal within 15 calendar days after the date your appeal is reviewed.

## Prescription Drug Benefit Claims

There are separate procedures for making claims for the Prescription Drug Benefit, including a special procedure to fill prescriptions for Specialty Medications. You do **not** have to complete a written claim form if you have a CVS Caremark prescription card and use a participating pharmacy. If any claim for a prescription drug benefit is denied, you have the right to appeal by following the procedures explained below.

You may get your general prescriptions filled at any participating pharmacy by presenting your CVS Caremark prescription card to the pharmacist. However, if you use a non-participating pharmacy that does not accept your CVS Caremark card, you must first pay the pharmacist and then seek reimbursement by filing a written claim with CVS Caremark.

CVS Caremark will treat the claim as a Post-Service Claim set forth in the medical benefit claims provisions above. Any prescription drug claim CVS Caremark receives more than one year after the date of purchase will be denied as untimely.

### *Specialty Medications*

Specialty Medications can be filled by using only CVS Caremark Specialty Pharmacy Services. Claims for Specialty Medications are treated as Pre-Service Claims because you must get prior authorization as a condition of coverage.

If you are prescribed a Specialty Medication, or if your pharmacist tells you that an item you are requesting is a Specialty Medication, you must call CaremarkConnect® toll-free at 800-237-2767. When notified, CVS Caremark will contact your physician directly to obtain clinical information needed to perform a prior authorization review, and you will not have to complete a written claim form.

CVS Caremark Specialty Pharmacy Services include a program called ACSF, which means Advanced Control Specialty Formulary. With ACSF, in addition to the required Medical Necessity review, Specialty Medications will also be reviewed to determine whether a preferred alternative exists that should be tried first. If an alternative is available, it will be discussed with your physician and the script changed. This is part of the prior authorization process which will be transparent to you.

CVS Caremark will notify you in writing of its determination on your claim for coverage of a Specialty Medication within a reasonable period of time, but no later than 15 calendar days after it receives notification of the claim. This period may be extended by one 15-day period, if special circumstances beyond CVS Caremark's control require that additional time is needed to process your claim.

If an extension is needed, CVS Caremark will notify you in writing before the expiration of the initial 15-day period of the circumstances requiring an extension and the date by which it expects to reach a decision. If the extension is required because additional information is needed from you to decide the claim, the notice of extension will specifically describe the information that is needed from you, and you will be given at least 45 days from your receipt of the notice within which to provide the information.

If your claim for a Specialty Medication is an Urgent Claim, you will be notified of CVS Caremark's determination more quickly. The definition of an Urgent Claim is as set forth in the health benefit claims section above. For Urgent Claims for Specialty Medication, CVS Caremark will notify you of its determination as soon as possible, taking into account the medical exigencies, but no later than 72 hours after you first call CVS Caremark about the prescription for the Specialty Medication, unless you or your physician fail to provide sufficient information to make the determination, in which case you will be notified within 24 hours of the information that is needed. The determination will then be made no more than 24 hours after CVS Caremark receives the information.

### *Appeals of Prescription Drug Claims Denied by CVS Caremark*

A. First Level Appeal

If you disagree with a determination made by CVS Caremark on any prescription drug claim, you must first submit a request for appeal by contacting CVS Caremark customer care at 800-282-8503 within 180 days of receipt of your denial notice. You should state the reason why you believe your appeal should be approved and include any information supporting your appeal. First level appeals received more than 180 days after receipt of the denial or adverse determination of the claim will be denied as untimely.

**Non-Specialty Drugs:** For appeals of denied claims that do **not** involve Specialty Drugs, CVS Caremark will notify you of a decision within 30 days of receipt of your request for review.

**Specialty Drugs:** For appeals not involving Urgent Claims, CVS Caremark will notify you of its decision within a reasonable period of time appropriate to the medical circumstances, but in no event will CVS Caremark take more than 15 days to notify you of its decision.

**Urgent Claim:** If the Specialty Medication appeal involves a denied Urgent Claim, CVS Caremark will decide the appeal as soon as possible, taking into account the medical exigencies, but no later than 72 hours after receipt of the appeal.

If CVS Caremark denies your appeal, you have the right to request a second level appeal with the Board of Trustees of the National IAM Benefit Trust Fund.

B. Second Level Appeal

If CVS Caremark denies your appeal, you have the right to request a second level appeal with the Board of Trustees of the National IAM Benefit Trust Fund. You should submit your second level appeal to the Fund Office after you receive the first level appeal denial, but within 90 days of receipt of CVS Caremark's denial notice on the first level appeal review. Your second level appeal should include a copy of the first level appeal denial, and any information supporting your appeal. Second level appeals received more than 90 days after receipt of the notice of denial of the first level appeal will be denied as untimely.

The Board of Trustees will review your appeal on the date of the first Board meeting that immediately follows the Plan's receipt of your request for review, unless the request for review is filed within 30 days preceding the date of such meeting. In such case, a benefit determination may be made on the date of the second meeting following the Plan's receipt of the request for review.

If special circumstances require a further extension of time for processing, a determination will be made no later than the third meeting following the initial receipt of the appeal. If an extension is required, you will be notified of the extension and the reasons for it prior to the commencement of the extension.

If the Specialty Medication appeal is related to a denied Urgent Claim, the final decision on the appeal will be made as soon as possible, taking into account the medical exigencies, but no later than 72 hours after receipt of the appeal by the Fund Office.

## External Review of Adverse Benefit Determination after Internal Appeal

Generally, health benefit claims are handled directly by CareFirst Administrators if you use a provider in the CareFirst Administrators network. After you have exhausted the Plan's internal claims and appeals process, you may exercise your option to seek an external review with an Independent Review Organization (IRO) that conducts reviews of adverse benefit determinations.

This External Review process is intended to comply with the Affordable Care Act's external review requirements. If you are not literate in English, depending on the county in which you reside, you may be eligible for assistance in the non-English language in which you are literate. Call the Fund Office at 202-785-8148 or toll-free at 800-457-3481 for more information.

### *The External Review Process Works as Follows:*

If your appeal of a claim is denied, whether it's a pre-service, post-service, or urgent care claim, you may request further review by an Independent Review Organization (IRO) as described below. You may only request external review after you have exhausted the internal review and appeals process described above.

**NOTE:** External review is only available for the following types of claim denials**:**

- A denial that involves medical judgment, including, but not limited to, those based on the Plan's requirements for Medical Necessity, appropriateness, health care setting, level of care or effectiveness of a covered benefit, or a determination that a treatment is experimental or investigational. The IRO will determine whether a denial involves a medical judgment; and
- A denial due to a rescission of coverage (retroactive elimination of coverage), regardless of whether the rescission has any effect on any particular benefit at that time.

External review is not available for any other types of denials, including if your claim was denied due to your failure to meet the requirements for eligibility under the terms of the Plan.

Under limited circumstances, you may be able to seek external review before the internal claims and appeals process has been completed:

- If the Plan waives the requirement that you complete its internal claims and appeals process first.
- In an urgent care situation (see "Expedited External Review of Claims"). Generally, an urgent care situation is one in which your health may be in serious jeopardy, or, in the opinion of your health care professional, you may experience pain that cannot be adequately controlled while you wait for a decision on your internal appeal.
- If the Plan has not followed its own internal claims and appeals process and the failure was more than a minor error. In this situation, the internal claims and appeal is "deemed exhausted," and you may proceed to external review. If you think that this situation exists, and the Plan disagrees, you may request that the Plan explain in writing why you are not entitled to seek external review at this time.

Your request for external review of a denial must be made, in writing, within four (4) calendar months of the date that you receive the denial. Because the Plan's internal review and appeals process generally must be exhausted before external review is available, typically external review of claims will only be available for denials of appeals (and not initial claim denials).

1. Preliminary Review

    a. Within five (5) business days of the Plan's receipt of your external review request for a claim, the Plan will complete a preliminary review of the request to determine whether:
        - You are/were covered under the Plan at the time the health care item or service is/was requested or, in the case of a retrospective review, were covered under the Plan at the time the health care item or service was provided;
        - The denial does not relate to your failure to meet the requirements for eligibility under the terms of the Plan;
        - You have exhausted the Plan's internal claims and appeals process (except, in limited, exceptional circumstances); and

- You have provided all of the information and forms required to process an external review.

b. Within one business day of completing its preliminary review, the Plan will notify you in writing as to whether your request meets the threshold requirements for external review. If applicable, this notification will inform you:
   - If your request is complete and eligible for external review, or
   - If your request is complete but not eligible for external review, in which case the notice will include the reasons for its ineligibility, and contact information for the Employee Benefits Security Administration (toll-free number (866) 444-EBSA (3272)), or
   - If your request is not complete, in which case the notice will describe the information or materials needed to make the request complete, and allow you to perfect the request for external review within the four-month filing period, or within a 48-hour period following receipt of the notification, whichever is later.

2. Review by Independent Review Organization

If the request is complete and eligible, the Plan will assign the request to an Independent Review Organization or "IRO." The IRO is not eligible for any financial incentive or payment based on the likelihood that the IRO would support the denial of benefits. The Plan has contracted with more than one IRO and generally rotates assignment of external reviews among the IROs with which it contracts.

Once the claim is assigned to an IRO, the following procedure will apply:

- The assigned IRO will timely notify you in writing of the request's eligibility and acceptance for external review, including directions about how you may submit additional information regarding your claim (generally, such information must be submitted within ten (10) business days).
- Within five (5) business days after the assignment to the IRO, the Plan will provide the IRO with the documents and information it considered in making its denial determination.
- If you submit additional information related to your claim, the assigned IRO must within one business day forward that information to the Plan. Upon receipt of any such information, the Plan may reconsider its denial that is the subject of the external review. Reconsideration by the Plan will not delay the external review. However, if upon reconsideration, the Plan reverses its denial, it will provide written notice of its decision to you and the IRO within one business day after making that decision. Upon receipt of such notice, the IRO will terminate its external review.
- The IRO will review all of the information and documents timely received. In reaching a decision, the IRO will review the claim de novo (as if it is new) and will not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. However, the IRO will be bound to observe the terms of the Plan to ensure that the IRO decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law. The IRO also must observe the Plan's requirements for benefits, including the Plan's standards for clinical review criteria, Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit. In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and appropriate, may consider additional information, including information from your medical records, any recommendations or other information from your treating health care providers, any other information from you or the Plan, reports from appropriate health care professionals, appropriate practice guidelines, the Plan's applicable clinical review criteria and/or the opinion of the IRO's clinical reviewer(s), unless such requirements are inconsistent with applicable law.

- The assigned IRO will provide written notice of its final external review decision to you and the Plan within 45 calendar days after the IRO receives the request for the external review.
- The assigned IRO's decision notice will contain the following information, unless such information is inconsistent with applicable current law:
  - A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning, and the reason for the previous denial);
  - The date that the IRO received the assignment to conduct the external review and the date of the IRO decision;
  - References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;
  - A discussion of the principal reason(s) for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;
  - A statement that the determination is binding except to the extent that other remedies may be available to you or the Plan under applicable state or federal law;
  - A statement that judicial review may be available to you; and
  - Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under the Public Health Services Act to assist with external review processes.

### Expedited External Review of Claims

You may request an expedited external review if:

- You receive an initial claim denial that involves a medical condition for which the timeframe for completion of a non-expedited internal appeal would seriously jeopardize your life or health, or would jeopardize your ability to regain maximum function, and you have filed a request for an expedited internal appeal; or
- You receive a denial from an appeal that involves a medical condition for which the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function; or, you receive a denial from an appeal that concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but you have not yet been discharged from a facility.

### Preliminary Review

Immediately upon receipt of the request for expedited external review, the Plan will complete a preliminary review of the request to determine whether the requirements for preliminary review set forth above, in Section 1(a), are met. The Plan will immediately notify you as to whether your request for review meets the preliminary review requirements, and if not, will provide or seek the information described above in Section 1(b).

### Review by Independent Review Organization

Upon determination that a request is eligible for expedited external review following the preliminary review, the Plan will assign an IRO. The Plan will expeditiously provide or transmit to the assigned IRO all necessary documents and information that it considered in denying the claim.

The assigned IRO, to the extent the information or documents are available, and the IRO considers them appropriate, must consider the information or documents described in the procedures for standard review, previously. In reaching a decision, the assigned IRO must review the claim de novo (as if it is new) and is not bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. However, the IRO will be bound to observe the terms of the Plan to ensure that the IRO decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law. The IRO also must observe the Plan's requirements for benefits, including the Plan's standards for clinical review criteria, Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit, unless such requirements are inconsistent with applicable law.

The IRO will provide notice of the final external review decision, in accordance with the requirements set forth in this Section, as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the IRO must provide written confirmation of the decision to you and the Plan.

## After External Review

If, upon external review, the IRO reverses the Plan's denial, upon the Plan's receipt of notice of such reversal, the Plan will immediately provide coverage or payment for the reviewed claim. However, even after providing coverage or payment for the claim, the Plan may, in its sole discretion, seek judicial remedy to reverse or modify the IRO's decision. If the final external review upholds the Plan's denial, the Plan will continue not to provide coverage or payment for the reviewed claim. If you are dissatisfied with the external review determination, you may seek judicial review as permitted under ERISA Section 502(a).

## Elimination of Conflict of Interest

To ensure that the persons involved with adjudicating claims and appeals (such as claim processors and medical experts) act independently and impartially, decisions related to those persons' employment status (such as decisions related to hiring, compensation, promotion, termination or retention), will not be made on the basis of whether that person is likely to support a denial of benefits.

## Facility of Payment

If the Board of Trustees or its designee determines that you cannot submit a claim or prove that you or your covered Dependent paid any or all of the charges for health care services that are covered by the Plan because you are incompetent or incapacitated, the Plan may, at its discretion, pay Plan benefits directly to the health care professional(s) who provided the health care services or supplies, or to any other individual who is providing for your care and support. Any such payment of Plan benefits will completely discharge the Plan's obligations to the extent of that payment. Neither the Plan, Board of Trustees, appropriate Claims Administrator nor any other designee of the Plan will be required to see to the application of the money so paid.

## Board of Trustee and IRO Decisions Are Final and Binding

The decision of the Board of Trustees and the IRO are final and binding on all parties, including anyone claiming a benefit on your behalf.

Only as limited by the IRO, the Board of Trustees of the National IAM Benefit Trust Fund has full discretion and authority to determine all matters relating to the benefits provided under this Plan including, but not limited to, all questions of coverage, eligibility, and methods of providing or arranging for benefits, as well as full discretion and authority over the standard of proof required for any claim and over the application and interpretation of the Plan. The Fund Office maintains records of determinations on appeals and Plan interpretations so that those determinations and interpretations may be referred to in future cases with similar circumstances to maintain consistency.

## Right to Judicial Review

ERISA, Section 502(a) establishes your right to seek judicial review of your adverse determination of your benefit claim after you have exhausted your internal review and appeal procedures except where the plan (or plan sponsor) has violated a specific ERISA standard of conduct.

If the Board of Trustees or the IRO deny your appeal in whole or in part and you decide to seek judicial review, the decisions made by the Trustees or the IRO are subject to limited judicial review to determine only whether the decision was arbitrary and capricious. No evidence may be used in court unless it was first submitted to the Board of Trustees or to the IRO.

# Miscellaneous Provisions and Cost Savings Advice

## Misrepresentation and Fraud

In the event you, your Spouse, or your Eligible Dependent Children receives benefits as a result of misleading representation or any type of false information or other fraudulent representations to the Fund, you, your Spouse, or your Eligible Dependent Child will be liable to repay all amounts paid by the Fund.

Fraud includes a person's failure to disclose any other group health coverage in which such person is entitled to receive reimbursement of a claim submitted to the Fund for payment or reimbursement from a third party (See the Section on Third Party Liability for more information). You, your Spouse, or your adult dependent children will be prosecuted for fraud and held liable for all costs of collection, including interest, court, and attorney's fees. In addition, you may be subject to criminal penalties.

## Overpayments and Erroneous Payments

If a claim payment is made to a participant or assigned to a provider and it is later determined that the payment is an overpayment or an erroneous payment, the Board of Trustees may offset future claim payments or take any other action it deems appropriate in order to recover the overpayment or erroneous payment.

## Notices Sent to Addresses of Participants

The Board of Trustees and/or the Fund Office will give notice by mail to participants of actions taken with respect to eligibility, claims, and other important matters.

All such notices will be sent to your address, as it appears in the Fund's records. To protect yourself and your rights, you must be sure the Fund Office always has your current address. If you fail to notify the Fund Office of your current address, you may miss receiving an important notice and might lose valuable rights or benefits. You may even lose coverage.

Any notice sent to you at the address in the Fund's records will be deemed to have been received by you. The time in which you must reply to such a notice will **not** be extended, because you did not give the Fund Office your current address.

## Cost Savings Advice

### *Physician's Fees and Treatment Plans*

Whenever possible, you should use an in-network physician, hospital, laboratory or imaging provider. If you use an out-of-network provider, you should ask your physician about his/her treatment and medical fees, as it is important to know whether the Fund will recognize these fees as "reasonable and customary, Medically Necessary, or covered charges."

Remember that coverage under the Plan for out-of-network services is limited and subject to out-of-network deductibles and coinsurance. You are liable for charges billed by a physician or other provider that are in excess of the allowable covered charges under the Plan, and such amounts will not count towards your annual out-of-pocket maximum. You do not have this risk of being billed above the allowance recognized by the Fund if you utilize a provider from the CareFirst Administrators network.

### *Bills and Unnecessary Services*

Review any out-of-network medical bills, if any, and your Explanation of Benefit (EOBs) forms for in-network claims thoroughly to assure correct charges and payments. When deciding upon the methods for treatment, avoid requesting unnecessary services. For example, you may reduce your expenses by:

- Avoiding weekend hospital admissions;
- Getting a second surgical opinion;
- Taking advantage of outpatient surgery;
- Contacting the Fund's Utilization Review Program; and
- Using generic drugs, whenever available.

By adhering to these suggestions, you may utilize your benefit to its fullest, while simultaneously cutting medical costs.

### *Reliance on Coverage Advice*

If you contact CVS Caremark, Quantum Health, CareFirst Administrators or the Fund Office to determine if a particular service, procedure or medication is a covered expense, including eligibility and other advice, unless you receive written confirmation, the Plan is not necessarily responsible for these representations. If there is any question about eligibility for coverage of a specific service, procedure, or prescription drug, you should not rely on any verbal representation from Quantum Health, CareFirst Administrators, or the Fund Office, but request confirmation in writing to assure that there will be no misunderstandings.

## Use and Disclosure of Protected Health Information

The Plan maintains a "Privacy Notice" pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and regulations thereunder describing how your medical information may be used or disclosed, as well as how you may gain access to your medical information and your other rights regarding that information. The Plan's Privacy Notice is reproduced here for your careful review:

## Privacy Notice

## Section 1: Purpose of This Notice and Effective Date

**This Notice Describes How Medical Information About You May Be Used and Disclosed and How You Can Get Access To This Information. Please Review It Carefully.**

**Effective date.** The effective date of this Notice is April 14, 2003.

**This Notice is required by law.** The National IAM Benefit Trust Fund (the "Fund") is required by law to take reasonable steps to ensure the privacy of your personally identifiable health information and to inform you about:

- The Fund's uses and disclosures of Protected Health Information (PHI),
- Your rights to privacy with respect to your PHI,
- The Fund's duties with respect to your PHI,

- Your right to file a complaint with the Fund and with the Secretary of the United States Department of Health and Human Services (HHS), and
- The person or office you should contact for further information about the Fund's privacy practices.

## Section 2: Your Protected Health Information

### *Protected Health Information (PHI) Defined*

The term "Protected Health Information" (PHI) includes all individually identifiable health information relating to your past, present or future physical or mental health condition or to payment for health care. PHI includes information maintained by the Fund in oral, written, or electronic form.

### *When the Fund May Disclose your PHI*

Under the law, the Fund may disclose your PHI without your consent or authorization, and without providing you an opportunity to agree or object, in the following cases:

*At your request.* If you request it, the Fund is required to give you access to certain PHI in order to allow you to inspect and/or copy it. You have additional rights explained in Section 3.

*As required by HHS.* The Secretary of the United States Department of Health and Human Services may require the disclosure of your PHI to investigate or determine the Fund's compliance with the privacy regulations.

*For treatment, payment or health care operations.* The Fund and its business associates will use PHI in order to carry out:

- Treatment,
- Payment, or
- Health care operations.

Treatment is the provision, coordination, or management of health care and related services. It also includes but is not limited to consultations and referrals between one or more of your providers.

For example, the Fund may disclose to a treating orthodontist the name of your treating dentist so that the orthodontist may ask for your dental x-rays from the treating dentist.

Payment includes, but is not limited to, actions to make coverage determinations and payment (including billing, claims management, subrogation, Fund reimbursement, reviews for Medical Necessity and appropriateness of care, utilization review and preauthorization).

For example, the Fund may tell a doctor whether you are eligible for coverage or what percentage of the bill will be paid by the Plan. If we contract with third parties to help us with payment operations, such as a physician that reviews medical claims, we will also disclose information to them. These third parties are known as "business associates."

Health care operations includes, but is not limited to, quality assessment and improvement, reviewing competence or qualifications of health care professionals, underwriting, premium rating and other insurance activities relating to creating or renewing insurance contracts. It also includes disease management, case management, conducting or arranging for medical review, legal services, and

auditing functions including fraud and abuse compliance programs, business planning and development, business management and general administrative activities.

For example, the Fund may use information about your claims to refer you into a disease management program, a well-pregnancy program, project future benefit costs or audit the accuracy of its claims processing functions.

**Disclosure to the Fund's Trustees.** The Fund will also disclose PHI to the Plan Sponsor, the Board of Trustees of the National IAM Benefit Trust Fund, for purposes related to treatment, payment, and health care operations, and have amended the Trust Agreement to permit this use and disclosure as required by federal law. For example, we may disclose information to the Board of Trustees to allow them to decide an appeal or review a subrogation claim.

### *When the Disclosure of your PHI Requires your Written Authorization*

Although the Fund does not routinely obtain psychotherapy notes, it must generally obtain your written authorization before the Fund will use or disclose psychotherapy notes about you. However, the Fund may use and disclose such notes when needed by the Fund to defend itself against litigation filed by you.

**Psychotherapy notes** are separately filed notes about your conversations with your mental health professional during a counseling session. They do not include summary information about your mental health treatment.

**Disclosure to Other Benefit Plans.** On certain occasions, it may be necessary to receive information from the Health Fund in order to process life insurance benefits, Weekly Disability Income Benefits or benefits from the Pension Fund. In those cases, we will require you to complete and submit the Fund's authorization formto release such information in order to continue processing your benefits.

### *Use or Disclosure of your PHI That Requires You Be Given an Opportunity to Agree or Disagree Before the Use or Release*

Disclosure of your PHI to family members, other relatives and your close personal friends is allowed under federal law if:

- The information is directly relevant to the family or friend's involvement with your care or payment for that care, and
- You have either agreed to the disclosure or have been given an opportunity to object and have not objected. You should note that under certain circumstances described below, federal law allows the use and disclosure of your PHI without your consent, authorization or opportunity to object to such use or disclosure.

### *Use or Disclosure of your PHI for Which Consent, Authorization or Opportunity to Object Is Not Required*

The Fund is allowed under federal law to use and disclose your PHI without your consent or authorization under the following circumstances:

- When required by applicable law.

- **Public health purposes.** To an authorized public health authority if required by law or for public health and safety purposes. PHI may also be used or disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease or condition, if authorized by law.
- **Domestic violence or abuse situations.** When authorized by law to report information about abuse, neglect or domestic violence to public authorities, if a reasonable belief exists that you may be a victim of abuse, neglect or domestic violence. In such case, the Fund will promptly inform you that such a disclosure has been or will be made unless that notice would cause a risk of serious harm.
- **Health oversight activities.** To a health oversight agency for oversight activities authorized by law. These activities include civil, administrative or criminal investigations, inspections, licensure or disciplinary actions (for example, to investigate complaints against health care providers) and other activities necessary for appropriate oversight of government benefit programs (for example, to the Department of Labor).
- **Legal proceedings.** When required for judicial or administrative proceedings. For example, your PHI may be disclosed in response to a subpoena or discovery request that is accompanied by a court order.
- **Law enforcement health purposes.** When required for law enforcement purposes (for example, to report certain types of wounds).
- **Law enforcement emergency purposes.** For certain law enforcement purposes, including:
  - Identifying or locating a suspect, fugitive, material witness or missing person, and
  - Disclosing information about an individual who is or is suspected to be a victim of a crime.
- **Determining cause of death and organ donation.** We may give PHI to a coroner or medical examiner to identify a deceased person, determine a cause of death or other authorized duties. We may also disclose PHI for cadaveric organ, eye or tissue donation purposes.
- **Funeral purposes.** We may give PHI to funeral directors to carry out their duties with respect to the decedent.
- **Research.** For research, subject to certain conditions.
- **Health or safety threats.** When, consistent with applicable law and standards of ethical conduct, the Fund in good faith believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat, including the target of the threat.
- **Workers' compensation programs.** When authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.

Except as otherwise indicated in this notice, uses and disclosures will be made only with your written authorization subject to your right to revoke your authorization.

### *Other Uses or Disclosures*

The Fund may disclose protected health information to the plan sponsor of the Fund for reviewing your appeal of a benefit claim or for other reasons regarding the administration of this Plan. The "plan sponsor" of this Fund is the Board of Trustees of the National IAM Benefit Trust Fund.

## Section 3: Your Individual Privacy Rights

Following is a description of your individual privacy rights. It is important to note that while all requests should be directed to the Health Fund, the Fund contracts with numerous vendors, also called "business associates," who provide services to the Fund and services and benefits to you on the Fund's behalf. Once the Fund is notified that you choose to invoke any of the individual rights listed below, it will notify the appropriate vendor on your behalf. Because some of your PHI is maintained and used by these business associates to provide or process your benefits, the Fund requires that they administer certain aspects of the individual privacy rights. You may contact the Privacy Official at the address and phone number listed below:

Yolanda D. Montgomery, Executive Director & Counsel, Privacy Official
National IAM Benefit Trust Fund
99 M Street, SE, Suite 600
Washington, DC 20003
Phone: 202-785-2658
Fax: 202-728-0585
www.iambtf.org

### *You May Request Restrictions on PHI Uses and Disclosures*

You may request the Fund to:

- Restrict the uses and disclosures of your PHI to carry out treatment, payment or health care operations, or
- Restrict uses and disclosures to family members, relatives, friends or other persons identified by you who are involved in your care.

The Fund, however, is not required to agree to your request.

You must contact the Fund to receive an application to make a request to restrict the use or disclosure of PHI. You may contact the Privacy Official at the address and phone number listed above.

### *You May Request Confidential Communications*

The Fund will accommodate an individual's reasonable request to receive communications of PHI by alternative means or at alternative locations where the request includes a statement that disclosure could endanger the individual.

You or your personal representative will be required to complete a form to request alternative means and/or locations for communication of PHI. You may contact the Privacy Official at the address and phone number listed above.

### *You May Inspect and Copy PHI*

You have a right to inspect and obtain a copy of your PHI contained in a "designated record set," as long as the Fund maintains the PHI. However, you do not have a right to inspect or copy psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and PHI that is subject to law(s) that otherwise prohibits access to PHI.

The Fund must provide the requested information within 30 days if the information is maintained on site or within 60 days if the information is maintained offsite. A single 30-day extension is allowed if the Fund is unable to comply with the deadline.

You or your personal representative will be required to complete a form to request access to the PHI in your designated record set. A reasonable fee may be charged. You may contact the Privacy Official at the address and phone number listed above.

Under limited circumstances, access may be denied. If access is denied, you will be provided with a written denial setting forth the basis for the denial, a description of how you may exercise your review rights and a description of how you may complain to the Fund and HHS.

**Designated Record Set:** Includes your medical records and billing records that are maintained by or for a covered health care provider. Records include enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for a Health Fund or other information used in whole or in part by or for the covered entity to make decisions about you. Information used for quality control or peer review analyses and not used to make decisions about you is not included.

### *You Have the Right to Amend your PHI*

You have the right to request that the Fund amend your PHI or a record about you in a designated record set for as long as the PHI is maintained in the designated record set, subject to certain exceptions. See the Fund's Right to Amend Policy for a list of exceptions.

The Fund has 60 days after receiving your request to act on it. The Fund is allowed a single 30-day extension if the Fund is unable to comply with the 60-day deadline. If the Fund denies your request in whole or part, the Fund must provide you with a written denial that explains the basis for the decision. You may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of that PHI.

You may contact the Privacy Official at the address and phone number listed above. You or your personal representative will be required to complete a form to request amendment of the PHI.

### *You Have the Right to Receive an Accounting of the Fund's PHI Disclosures*

At your request, the Fund will also provide you with an accounting of certain disclosures by the Fund of your PHI. We do not have to provide you with an accounting of disclosures related to treatment, payment, or health care operations, or disclosures made to you or authorized by you in writing. See the Fund's Accounting for Disclosure Policy for the complete list of disclosures for which an accounting is not required.

The Fund has 60 days to provide the accounting. The Fund is allowed a single 30-day extension if the Fund gives you a written statement of the reasons for the delay and the date by which the accounting will be provided.

If you request more than one accounting within a 12-month period, the Fund may charge a reasonable, cost-based fee for each subsequent accounting.

### *Your Personal Representative*

You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of authority to act on your behalf before the personal representative will be given access to your PHI or be allowed to take any action for you. Proof of such authority will be a completed, signed and approved Appointment of Personal Representative form. You may obtain this form by calling the Fund Office.

The Fund retains discretion to deny access to your PHI to a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect.

The Fund will recognize certain individuals as personal representatives without you having to complete an Appointment of Personal Representative form. For example, absent notice of restrictions under the Fund's Right to Request Restrictions on the Use and Disclosure Policy and Procedures, the Fund will automatically consider a Spouse to be the personal representative of an individual covered by the plan.

In addition, the Fund will consider a parent, guardian *or other person acting* in loco parentis as the personal representative of an unemancipated minor unless applicable law requires otherwise. A Spouse or a parent may act on an individual's behalf, including requesting access to their PHI. Spouses and unemancipated minors may, however, request that the Fund restrict access of PHI to family members as described above at the beginning of Section 3 of this Notice.

You should also review the Fund's Policy and Procedure for the Recognition of Personal Representatives for a more complete description of the circumstances where the Fund will automatically consider an individual to be a personal representative.

## Section 4: The Fund's Duties

### *Maintaining your Privacy*

The Fund is required by law to maintain the privacy of your PHI and to provide you and your eligible dependents with notice of its legal duties and privacy practices.

This notice is effective beginning on April 14, 2003, and the Fund is required to comply with the terms of this notice. However, the Fund reserves the right to change its privacy practices and to apply the changes to any PHI received or maintained by the Fund prior to that date. If a privacy practice is changed, a revised version of this notice will be provided to you and to all past and present participants and beneficiaries for whom the Fund still maintains PHI. A Privacy Notice will be sent by U.S. Mail.

Any revised version of this notice will be distributed within 60 days of the effective date of any material change to:

- The uses or disclosures of PHI,
- Your individual rights,
- The duties of the Plan, or
- Other privacy practices stated in this notice.

### *Disclosing Only the Minimum Necessary Protected Health Information*

When using or disclosing PHI or when requesting PHI from another covered entity, the Fund will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations.

However, the minimum necessary standard will not apply in the following situations:

- Disclosures to or requests by a health care provider for treatment,
- Uses or disclosures made to you,
- Uses or disclosures made pursuant to your authorization,
- Disclosures made to the Secretary of the United States Department of Health and Human Services pursuant to its enforcement activities under HIPAA,
- Uses or disclosures required by law, and
- Uses or disclosures required for the Fund's compliance with the HIPAA privacy regulations.

This notice does not apply to information that has been de-identified. De-identified information is information that:

- Does not identify you, and
- With respect to which there is no reasonable basis to believe that the information can be used to identify you.

In addition, the Fund may use or disclose "summary health information" to the Fund Sponsor for purposes of obtaining premium bids or modifying, amending or terminating the group health plan. Summary information summarizes the claims history, claims expenses or type of claims experienced by individuals for whom a Fund Sponsor has provided health benefits under a group health plan. Identifying information will be deleted from summary health information, in accordance with HIPAA.

## Section 5: Your Right to File a Complaint with the Fund or the HHS Secretary

If you believe that your privacy rights have been violated, you may file a complaint with the Fund in care of the following official:

Yolanda D. Montgomery, Executive Director & Counsel, Privacy Officer
ymontgomery@iamnpf.org
National IAM Benefit Trust Fund
99 M Street, SE, Suite 600
Washington, DC 20003
Phone: 202-785-2658
www.iambtf.org

You may also file a complaint with:

Secretary of the U.S. Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue S.W.

Washington, D.C. 20201

The Fund will not retaliate against you for filing a complaint.

## Section 6: All Other Uses & Disclosures of your PHI

All other uses or disclosures of your PHI will only be made with your authorization or the authorization of a duly appointed personal representative pursuant to the Fund's Recognition of Personal Representative Policy and Procedures.

## Section 7: If You Need More Information

If you have any questions regarding this notice or the subjects addressed in it, you may contact the Privacy Official at the address and phone number listed above.

## Section 8: Conclusion

PHI use and disclosure by the Fund is regulated by the federal Health Insurance Portability and Accountability Act, known as HIPAA. You may find these rules at 45 *Code of Federal Regulations* Parts 160 and 164. This notice attempts to summarize the regulations. The regulations will supersede this notice if there is any discrepancy between the information in this notice and the regulations.

# General Benefit Provisions

## Statement Regarding Newborns and Mothers Health Protection Act

The Plan will pay benefits for Pregnancy on the same basis as an illness or injury. Under federal law, group health plans may not restrict benefits for any Hospital stay in connection with childbirth for the mother or newborn child to less than 48 hours following vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the Plan may pay for a shorter stay if the attending provider (e.g., physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, the Plan may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain pre-certification.

## Statement Regarding Women's Health and Cancer Rights Act (WHCRA)

In the case of any participant receiving benefits under the Plan in connection with a mastectomy and who elects breast reconstruction, coverage will be provided under the Plan for:

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

As with other benefits under the Plan, applicable deductibles and cost sharing amounts apply to the above coverage.

# General Information

## Plan Name

This Plan is known as the National I.A.M. Benefit Trust Fund (Plan).

## Type of Plan

This Plan is a multi-employer health and welfare plan. It also is a group health plan.

## Plan Identification Numbers

The employer identification number (EIN) is: 36-6562520

The Plan number is: 501

## Plan Sponsor and Administration

The Board of Trustees is both the legal Plan Sponsor and the legal Plan Administrator under the Employee Retirement Income Security Act. The Board of Trustees consists of Employer and Union Representatives, selected in accordance with the Trust Agreement. If you wish to contact the Board of Trustees, you may do so at the Fund Office's address above. The Board of Trustees has designated an Executive Director to supervise the daily functions of the Plan. As the legal Plan Administrator, the Trustees have the authority to allocate or delegate their responsibilities for the administration of the Plan to others and employ others to carry out or give advice with respect to their responsibilities under the Plan.

## Agent for Service

The Board of Trustees has designated the Executive Director as Agent for Service of legal process. The address at which the process may be served is the Fund Office, as indicated below. Service of legal process also may be made upon any individual Trustee.

## Fund Office Administration

The day-to-day administration of the Plan is handled by the Fund Office. Claims for medical benefits are not handled by the Fund Office. Inquiries about eligibility and the Plan in general should be directed to:

National IAM Benefit Trust Fund
99 M Street, SE, Suite 600
Washington, DC 20003
Phone: 202-785-8148
Fax: 202-728-0585
www.iambtf.org

The Fund Office performs the following:

- Receives Employer contributions.
- Keeps eligibility records.

- Provides information about the Plan.

## Claims Administrator

Claims for medical benefits are processed by the Claims Administrator, which is CareFirst Administrators. Medical claims should be sent to the address on the back of your benefits identification card and inquiries should be made to the phone number on the back of your benefits identification card.

The rules and regulations described in this SPD apply to claims incurred on or after January 1, 206. Your claims prior to this date will be processed and reimbursed based on the rules and regulations of the benefits under the Plan in force when the claim was incurred.

## Selection of Preferred Providers

The Board of Trustees may, from time to time, in its sole discretion, enter into written agreements with Preferred Provider Organizations. The use of such Preferred Provider Organizations is solely at your option. The existence of any Preferred Provider agreement does not, in any manner, imply an endorsement of any specific provider, nor does it constitute any guarantee of the services rendered.

The Board of Trustees currently has a contract with the following organization for a Preferred Provider network:

CareFirst Administrators
P.O. Box 14115
Lexington, KY 40512-4115
Phone: 1-866-871-0839
www.cfablue.com

The use of Preferred Providers is solely at your option. However, you should note that use of the Preferred Provider network will result in the lowest out-of-pocket expense for you. The existence of a Preferred Provider network does not, in any manner, imply an endorsement of any specific provider, nor does it constitute any guarantee of payment for the services rendered.

## Prescription Drug Benefits Administration

The Board of Trustees has contracted with CVS Caremark for the prescription drug benefit, as part of the Fund's participation in the Health Care Cost Containment Corporation (HCCCC):

CVS Caremark, Inc.
9501 East Shea Blvd.
Scottsdale, AZ 85260-6719
Phone: 888-727-5575

## Trust Fund

The assets of the National IAM Benefit Trust Fund are held in trust by the Board of Trustees.

## Identity of Source of Benefits

All of the types of benefits provided by the Plan are set forth in this SPD. The Trust Fund is the source of the benefits of this Plan.

## Plan Year

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

## Collective Bargaining Agreements

This Plan is maintained pursuant to one or more collective bargaining agreements, or other type of agreement. A copy of any such agreement may be obtained upon written request to the Fund Office and is available for examination at the Fund Office. Upon written request, the Fund Office will tell you if an Employer is contributing to the National IAM Benefit Trust Fund on behalf of its Employees or will supply you with a list of such Employers.

## Workers' Compensation

The Plan is not in place of and does not affect any requirement for coverage by workers' compensation insurance. Benefits are not paid under this Plan for diseases, for which benefits are payable under any workers' compensation law or for accidental bodily injuries which arise out of or in the course of employment.

## Action of the Trustees

The Trustees have full discretion and authority over the standard of proof required for any inquiry, claim, or appeal and over the application and interpretation of the Plan. No legal proceedings may be filed in any court or before any administrative agency against the Trustees, the Fund, or the Plan unless all review procedures have been exhausted. No legal action may be commenced or maintained more than three years after all remedies have been exhausted. Any action concerning a claim for benefits must be brought in the federal district court for the District of Columbia.

## Exclusive Rights

No individual shall have any right to any benefits except as specified in this SPD. The National IAM Benefit Trust Fund will not be bound by any oral representations that are inconsistent with the contents of this SPD, and you should not rely on any oral representations that are inconsistent with the terms of this Plan. None of the benefits provided under this Plan are vested.

## No Fund Liability

The use of services of any Hospital, physician or other provider of health care, whether designated by the Plan or otherwise, is your voluntary act. Nothing in this SPD is meant to be a recommendation or instruction to use any provider. You should select a provider or course of treatment based on all appropriate factors, only one of which is coverage by the Plan. Providers are independent contractors, not employees of the Fund. The Trustees make no representation regarding the quality of service or treatment of any provider and are not responsible for any acts of commission or omission of any provider in connection with Plan coverage. The provider is solely responsible for the services and treatments rendered.

The Fund, the Board of Trustees, or any of their designees are not engaged in the practice of medicine, nor do any of them have any control over any diagnosis, treatment, care or lack thereof, or over any health care services provided or delivered to anyone by any health care provider. Neither the Fund, the Board of Trustees, nor any of their designees have any liability whatsoever for any loss or injury caused

to anyone by any health care provider by reason of negligence, by failure to provide care or treatment, or otherwise.

## Right to Amend

The Board of Trustees has complete discretion to amend or modify this Plan or the Trust Agreement or any of the provisions of this Plan or the Trust Agreement in whole or in part at any time. This means that the Trustees can reduce, eliminate, or modify benefits, as well as improve benefits. The Trustees may also modify the length of or eliminate coverage for Employees, dependents, and/or Retirees, and the Trustees may also modify any eligibility requirements for coverage. The benefits under the Plan are not guaranteed and are provided only from assets of the Benefit Trust Fund collected and available for such purposes.

## Erroneous Benefit Payments

Every effort will be made to ensure accuracy in the payment of your benefits. If an error is discovered, however, and it is determined that the Fund has paid any benefits that you are not entitled to, the Trustees have the right to seek repayment from you, including the right to reduce future benefit payments by the amount of the erroneous payment.

## No Assignment of Benefits

You may not assign your benefits under this Plan except that you may direct that benefits payable to you be paid directly to an institution or provider of medical care. However, the Fund is not legally obligated to accept such a direction from you, and no payment by the Fund to a provider can be considered a recognition by the Fund that it has a legal duty to pay the provider, except to the extent that it chooses to do so. Direct payment to an institution or provider of medical care does not waive the anti-assignment clause under the Plan.

## Plan Termination

The Trustees may terminate the Fund through a written document. The Fund may be terminated if, in the opinion of the Trustees, the Trust Fund is not adequate to meet the payments due or which may become due. The Fund may also be terminated if there are no longer any collective bargaining agreements requiring contributions to the Fund. The Trustees have complete discretion to determine when and if the Fund should be terminated.

If the Fund is terminated, the Trustees will: (a) pay the expenses of the Fund incurred up to the date of termination and the expenses in connection with the termination; (b) arrange for a final audit of the Fund; (c) give any notice and prepare and file any reports which may be required by law; and (d) apply the assets of the Fund in accordance with the Plan including amendments adopted as part of the termination until the assets of the Fund are distributed.

No part of the assets or income of the Fund will be used for purposes other than for the exclusive benefit of the Employees and dependents or the Fund’s administrative expenses. Under no circumstances will any portion of the Fund revert or inure to the benefit of any contributing Employer or the union, either directly or indirectly.

## Savings Clause

If any provision of this Plan is held to be unlawful, or unlawful as to a particular person or circumstance, such findings shall not adversely affect the application of the other provisions of the Plan as they are described in this SPD, unless the illegality makes the continued operation of the Plan impossible.

## Source of Plan Funding

The benefits under the Plan are funded by monthly contribution payments by the Employers. There also are circumstances in which Employees self-pay to the Fund. In addition, the Trustees have purchased stop loss insurance to cover losses to the Fund in the event of large claims. The stop loss insurance is provided by Amalgamated Life Insurance Company:

Amalgamated Life Insurance Company
333 Westchester Avenue
White Plains, NY 10604
914-367-5000

The continuation of this insurance arrangement is at the discretion of the Trustees.

Benefits are provided only to the extent permitted by the contributions. If contributions are not sufficient to maintain benefits, the Board of Trustees (Board) reserves the right to change the eligibility rules, reduce or change the benefits, or eliminate the Plan, in whole or in part.

The amount of contributions and the Employees on whose behalf contributions are made are determined by the provisions of the collective bargaining agreements or other agreements, as approved by the Trustees. The Employer must make the required payments for a month for coverage to be provided for the period. The Trustees reserve the right to terminate the participation of any Employer at any time for any reason.

All contributions and income from earnings are used exclusively for providing benefits to eligible Employees and their dependents, and for paying expenses incurred with respect to the operation of the Fund.

## Erroneous Contributions

Once contributions are made to the Fund, they may be returned to an Employer, at the Trustees' discretion, only upon the Employer's written request and only if the Employer conclusively demonstrates that the contributions were made in error and the result would not be an impermissible rescission. Employers may not unilaterally take a credit against a future payment. In determining whether the contributions were made in error and whether a refund will be made, the Trustees will consider all circumstances, including the period of time that has elapsed since the contributions were made.

Federal law provides that coverage by group health plans may not be rescinded (cancelled) retroactively (except to the extent attributable to a failure to pay timely monthly contributions towards coverage), unless there is fraud or an individual makes an intentional misrepresentation of material fact. In determining whether a refund of contributions will be made, the Trustees will consider whether the requested refund will result in an impermissible rescission of coverage under federal law or applicable regulations. If so, the contributions will not be refunded.

Any costs the Fund incurred in correcting the Employer's error, including administrative and computer costs and benefits paid in reliance on the Employer's erroneous contributions, including amounts paid after discovery of the error during a review period (including external review) as required by federal law, may be deducted from any amounts refunded. Interest will not be paid to the Employer on the erroneous contributions.

It is very important that Employers carefully review contributions and reports to the Fund to avoid erroneous payments. The Fund relies on the accuracy of Employer reports to credit Employees for eligibility. Any errors must be reported to the Fund promptly.

# Glossary

**Accident** means an unexpected and unintentional event occurring through external means, not necessarily involving another person. Injuries caused by normal activities of daily living (such as walking, bending, stretching, etc.) are not considered to be accidents.

**Acute Care Hospital** or **Hospital** means only an institution that meets all of the following tests:

- It mainly provides medical treatment to inpatients.
- It maintains facilities for diagnosis.
- It provides treatment only by or under a staff of physicians.
- It provides care by Registered Nurses 24 hours per day.
- It maintains permanent facilities for surgery.
- It maintains a daily medical record for each patient.
- It complies with all licensing and other legal requirements.
- It is not a Skilled Nursing Facility or a Specialized Facility.
- It is not, other than incidentally, (1) a place for Custodial Care; (2) a place for the aged; (3) a place for the care of a person addicted to or dependent on a drug or chemical including alcohol; (4) a place for the care of persons with mental, nervous, or emotional disorders or conditions; (5) a place of rest; or (6) a nursing home, hotel, or a similar institution.

**Air Ambulance** means medical transport by a rotary-wing air ambulance, as defined in 42 CFR 414.605, or fixed-wing air ambulance, as defined in 42 CFR 414.605, for patients.

**Ambulatory Surgical Facility** means a facility that meets Professionally Recognized Standards and all of the following tests:

- It provides a setting for outpatient surgeries.
- It does not provide services or accommodations for overnight stays.
- It has at least two operating rooms and one recovery room; all the medical equipment needed to support the surgery performed; x-ray and laboratory diagnostic facilities; and Emergency equipment, trays, and supplies for use in life threatening events.
- It has a medical staff that is supervised full time by a physician and that includes a registered Nurse at all times when patients are in the facility.
- It maintains a medical record for each patient.
- It has a written agreement with a local Acute Care Hospital and a local ambulance company for the immediate transfer of patients who require greater care than can be furnished at the facility.
- It complies with all licensing and other legal requirements.
- It is not the office or clinic of one or more physicians.

- For purposes of determining a medical benefit, a surgical procedure performed in an Ambulatory Surgical Facility that, as determined by the Claims Administrator, is commonly performed in a physician's office shall be deemed to have been performed in a physician's office.

**Ancillary Services** are, with respect to a PPO health care facility:

- Items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether provided by a physician or non-physician practitioner,
- Items and services provided by assistant surgeons, hospitalists, and critical care doctors;
- Diagnostic services, including radiology and laboratory services and subject to exceptions specified by the Secretary; and
- Items and services provided by a Non-PPO Provider if there is no PPO Provider who can furnish such item or service at such facility.

**Average Semi-Private Room Rate** means the rate a Hospital normally charges for semi-private room accommodations for the condition being treated, as identified by the Hospital. However, if a Hospital's contract provides a negotiated rate that is based on a per diem or case rate rather than billed charges, the negotiated contract rate will supersede individual room and board limits. On the other hand, if the Hospital's contract provides a discount off billed charges, the individual room and board limits will apply.

**Birth Center** means a facility that meets Professionally Recognized Standards and all of the following tests:

- It mainly provides an outpatient setting for childbirth following a normal, uncomplicated Pregnancy.
- It has: (1) at least two birthing rooms; (2) all the medical equipment needed to support the services furnished by the facility; (3) laboratory diagnostic facilities; and (4) Emergency equipment, trays, and supplies for use in life threatening events.
- It has a medical staff that: (1) is supervised full time by a physician, and (2) includes a registered Nurse at all times when patients are in the facility
- It has written agreements with a local Acute Care Hospital and a local ambulance company for the immediate transfer of patients who require greater care than can be furnished at the facility.
- It admits only patients who: (1) have undergone an educational program to prepare them for the birth, and (2) have records of adequate prenatal care.
- It schedules stays of not more than 24 hours for a birth.
- It maintains a medical record for each patient.
- It complies with all licensing and other legal requirements that apply.
- It is not: (1) the office or clinic of one or more physicians; (2) an Acute Care Hospital; (3) a Specialized Facility other than a Birth Center.

**Child** means your biological child, legally adopted child, legal stepchild, child placed with you for adoption and any other child under your legal guardianship, all of whom are below age 26.

**Chiropractic Care** means the conservative management of acute neuromusculoskeletal conditions through manipulation and ancillary physiological treatment rendered to specific joints to restore motion, reduce pain, and improve function.

**Claims Administrator** means the entity that processes medical claims.

**Clean Claim** means a medical claim that has no defects or special circumstances, including incomplete documentation that delays timely payment.

**Complication of Pregnancy** means: (1) an unscheduled cesarean section; (2) spontaneous termination of Pregnancy that occurs during a period of gestation in which a viable birth is not possible; (3) a condition, that requires Hospital confinement (when the Pregnancy is not terminated), whose diagnosis is distinct from Pregnancy but is caused or adversely affected by Pregnancy, such as: acute nephritis, nephrosis; cardiac decompensation; missed abortion; and similar medical and surgical conditions of comparable severity.

The term **does not** include: false labor; occasional spotting; physician prescribed rest during a Pregnancy; morning sickness; pre-eclampsia; or similar conditions that are associated with a difficult Pregnancy but do not constitute classifiably distinct Complications of Pregnancy. Pregnancy Benefits are payable on the same basis as benefits for treatment of an illness.

**Continuing Care Patient** means an individual who, with respect to a provider or facility —

3. is undergoing a course of treatment for a serious and complex condition from the provider or facility;
4. is undergoing a course of institutional or inpatient care from the provider or facility;
5. is scheduled to undergo non-elective surgery from the provider, including receipt of postoperative care from such provider or facility with respect to such a surgery;
6. is pregnant and undergoing a course of treatment for the pregnancy from the provider or facility; or
7. is or was determined to be terminally ill (as determined under section 1861(dd)(3)(A) of the Social Security Act) and is receiving treatment for such illness from such provider or facility.

**Covered Charge Limits** mean (a) the usual charge for the service or supply; (b) the customary charge for the service or supply; (c) any limit specified in the Covered Charges List, the Schedule of Benefits, or the Areas of Limited Coverage section.

**Covered Medical Charge** means a charge that: (1) is made for a Medically Necessary service or supply that is furnished to a participant; and (2) meets all of the following tests:

- It is shown in the covered medical charges list or is otherwise listed as a covered medical charge in this SPD.
- It is incurred by a participant while the participant is eligible for medical benefits. A charge is deemed to be incurred at the time the service is rendered or the supply is furnished for which the charge is made.
- It is not listed as a Plan exclusion.
- It does not exceed the smallest of the Covered Charge Limits that apply to the service or supply for which the charge is made. The part of a charge that does not exceed the smallest of the Covered Charge Limits shall be considered a covered medical charge if it meets the above tests.

**Custodial Care** means care that consists of services and supplies that are given mainly to help a person to meet the activities of daily living, whether or not the person is disabled, and that are not rendered mainly for their therapeutic value in the treatment of an injury or illness. Custodial Care includes, but is not limited to, care such as:

- Care mainly to provide room and board;
- Preparation of special diets;
- Supervision of the administration of medications that can normally be self-administered; and
- Personal care such as helping the person to walk, get in or out of bed, bathe, dress, eat, or use the toilet.

**Deductible** means the amount of covered medical charges a participant must pay to his or her provider of service before benefits are payable by the Plan, as shown in the Schedule of Benefits.

**Dependent** means your Spouse, child under age 26, and your disabled dependent. The term dependent does not include a Spouse who is on active duty in any armed forces.

**Disability** or **Disabled** means the inability to perform substantially all the duties of the person's occupation because of a physical or mental illness or injury. For your children, it means they are prevented by illness or injury from engaging in their normal daily activities.

**Disabled Dependent** means a child, who is incapable of self-sustaining employment because of a physical or mental disability that occurred before the dependent child turned age 26, and who is chiefly dependent on you for financial support. Proof of the disability must be submitted before age 26 and may be required periodically thereafter.

**Durable Medical Equipment** means equipment that is: (1) designed for repeated use; (2) mainly and customarily used for medical purposes; (3) not generally of use to a person in the absence of an illness or injury; and (4) not disposable. Durable Medical Equipment includes, but is not limited to, such items as: crutches; Hospital beds; wheelchairs; oxygen concentrators; CPAP machines; and TENS units.

The following items are examples of some, but not all, types of equipment that are not considered to be Durable Medical Equipment: air conditioners; air purifiers; bed and bath items; fixtures to real property; heat lamps; heating pads; bed boards; orthopedic shoes; corrective devices for use in shoes; gravity traction devices; exercise bicycles; weight lifting equipment; and specially equipped vans.

**Emergency Medical Condition** means a medical condition manifested by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in serious impairment to bodily functions, serious dysfunction of any bodily organ or part, or placing the health of a woman or her unborn child in serious jeopardy.

**Emergency Services** means the following:

8. An appropriate medical screening examination that is within the capability of the emergency department of a hospital or of an independent freestanding emergency department, as applicable, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and

9. Within the capabilities of the staff and facilities available at the hospital or the independent freestanding emergency department, as applicable, such further medical examination and treatment as are required to stabilize the patient (regardless of the department of the hospital in which such further examination or treatment is furnished).

Emergency Services furnished by a Non-PPO Provider or Non-PPO emergency facility (regardless of the department of the hospital in which such items or services are furnished) also include post-stabilization services (services after the patient is stabilized) and as part of outpatient observation or an inpatient or outpatient stay related to the emergency medical condition, until:

- • The provider or facility determines that the participant or beneficiary can travel using non-medical transportation or non-emergency medical transportation; or
- • The participant or beneficiary is supplied with a written notice, as required by federal law, that the provider is a Non-PPO Provider with respect to the Plan, of the estimated charges for your treatment and any advance limitations that the Plan may put on your treatment, of the names of any PPO Providers at the facility who are able to treat you, and that you may elect to be referred to one of the PPO Providers listed; and
- • The participant or beneficiary gives informed consent to continued treatment by the Non-PPO Provider, acknowledging that the participant or beneficiary understands that continued treatment by the Non-PPO Provider may result in greater cost to the participant or beneficiary.

**Employee** means a person who is actively working for an Employer in a covered position and on whose behalf the Employer makes the required contributions to Plan. An unincorporated sole proprietor or partner in a partnership cannot be treated as an Employee under the Plan.

**Employer** means any Employer obligated under a collective bargaining agreement or other signed agreement to make contributions to the Plan on its Employees' behalf.

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

**Extended Care Facility** means an institution that is approved as such under Medicare.

**Health Care Facility** (for Non-Emergency Services) is each of the following:

10. A hospital (as defined in section 1861(e) of the Social Security Act); 6
11. A hospital outpatient department;
12. A critical access hospital (as defined in section 1861(mm)(1) of the Social Security Act); and
13. An ambulatory surgical center described in section 1833(i)(1)(A) of the Social Security Act.

**Home Health Care** is medical care that is furnished by or through a Home Health Agency to a participant in the participant's home.

**Home Health Agency** means an agency that provides Home Health Care services that (1) meets any legal licensing required by the state or other locality in which it is located; or (2) qualifies as a participating Home Health Agency under Medicare.

**Hospice Care** is care that:

- Is furnished or arranged by a Hospice Care Program;

- Is provided as part of a coordinated plan of home and inpatient care designed to meet the special needs of the terminally ill patient and the family unit due to the terminal illness;
- May include medical care, palliative care, respite care, and medical social services for the terminally ill patient; and
- May include medical social services and bereavement counseling for the family unit.

**Hospice Care Program** means an agency, facility, or organization that provides care for terminally ill patients and meets established standards, including certification by the National Hospice Organization, Medicare, and any legal licensing required by the state or other locality in which it is located.

**Illness** means a disease or disorder resulting in an unsound condition of the mind or body.

**Independent Freestanding Emergency Department** is a health care facility (not limited to those described in the definition of health care facility) that is geographically separate and distinct from a hospital under applicable State law and provides Emergency Services.

**Injury** means a wound or damage to the body sustained by accident or through external force.

**Inpatient** and **Outpatient** refer either to the setting in which medical care is given or to a person who is receiving care in that setting.

- When these terms describe the setting in which medical care is given:
  - Inpatient means that the care is furnished to a person while the person is confined in a facility as a registered bed patient and is being charged a fee for inpatient room and board; and
  - Outpatient means that the care is furnished to a person while the person is not so confined.
- When these terms refer to a person who is receiving medical care:
  - Inpatient means a person who is confined in a facility as a registered bed patient and is being charged a fee for inpatient room and board; and
  - Outpatient means a person who is not so confined.

**Intensive Care Unit** means only a separate, clearly designated service section that is part of an Acute Care Hospital and that meets all of the following tests:

- It is solely for treatment of patients who are in a critical condition;
- It provides constant special nursing care and observation not available in the other sections of the hospital;
- It contains special life-saving equipment that is ready for immediate use;
- It contains at least two beds for critically ill patients;
- It has, at all times, at least one registered Nurse who is in constant attendance; and
- It meets the standards set for an Intensive Care Unit by the Joint Commission on Accreditation of Healthcare Organizations.

The term Intensive Care Unit shall include a burn unit or a cardiac care unit that meets all of the above tests. The term shall not include a unit for intensive alcoholism, drug or chemical dependence, or psychiatric treatment.

**Intensive Outpatient Therapy** means distinct levels or phases of treatment that are provided by a certified/licensed Mental Health or Substance Use Disorder Treatment program. Intensive Outpatient Therapy programs typically provide a combination of individual, family, and/or group therapy in a day, totaling nine (9) or more hours in a week.

**Medically Necessary/Medical Necessity** with respect to each service or supply means that the service or supply meets all of the following tests:

- It is rendered for the treatment or diagnosis of an injury or illness, including premature birth, congenital defects, and birth defects;
- It is appropriate for the symptoms, consistent with the diagnosis, and is otherwise in accordance with generally accepted medical practice and Professionally Recognized Standards;
- It is not mainly for the convenience of the participant or the participant's physician or other provider;
- It is the most appropriate supply or level of service needed to provide safe and adequate care. When applied to confinement in a hospital or other facility, this test means that the participant needs to be confined as an inpatient due to the nature of the services rendered or due to the participant's condition and that the participant cannot receive safe and adequate care through Outpatient treatment.

**Medicare** means the health insurance benefits provided under Title XVIII of the Social Security Act, as amended in 1965.

**Mental Health Services** are the services that are required to treat a disorder that impairs behavior, emotional reaction, or thought processes, but not including substance use disorder, and not including learning, behavioral, and developmental disorders except for ABA therapy for the treatment of autism spectrum disorder. In determining benefits payable, charges made for the treatment of any physiological conditions related to mental health will not be considered to be charges made for the treatment of mental health.

**Mental Health Residential Treatment Center** means a facility that meets all of the tests of the Acute Care Hospital definition or that is licensed in accordance with the laws of the appropriate legally authorized agency as a residential treatment center for Mental Health Services.

**No Surprises Act** means the federal No Surprises Act (Public Law 116-260, Division BB).

**Non-PPO emergency facility** means an emergency department of a hospital, or an independent freestanding emergency department (or a hospital, with respect to Emergency Services as defined), that does not have a contractual relationship directly or indirectly with a group health plan or group health insurance coverage offered by a health insurance issuer, with respect to the furnishing of an item or service under the plan or coverage respectively.

**Non-PPO Provider** means a health care provider who does not have a contractual relationship directly or indirectly with the Plan with respect to the furnishing of an item or service under the Plan.

**Out-of-Network Rate** with respect to items and services furnished by a Non-PPO Provider, Non-Network emergency facility, or Non-PPO Provider of ambulance services, means one of the following:

- the amount the parties negotiate;
- the amount approved under the independent dispute resolution ("IDR") process; or

- if the state has an All-Payer Model Agreement, the amount that the state approves under that system.

**Nurse** means only a person who is a registered Nurse (R.N.), a licensed vocational Nurse (L.V.N.), or a licensed practical Nurse (L.P.N.).

**Partial Hospitalization Care** means only continuous treatment of substance use disorder or of a mental, nervous or emotional disorder or condition for at least 4 hours, but not more than 12 hours, in any 24-hour period.

**Participant** means a person who is eligible for benefits under the Plan.

**Participation Agreement** means the agreement providing for coverage under the Plan.

**Payment Percentage** the percentage the Plan pays of a covered medical charge after any applicable deductible is satisfied.

**Physician** means a doctor of medicine or a doctor of osteopathy who is licensed by his jurisdiction and acting within the scope of his license to practice medicine or to perform surgery.

**Plan** means the National IAM Benefit Trust Fund.

**Preferred Provider Organization** means an organization that negotiates discounted rates with medical providers in an effort to provide benefits to participants.

**Preferred Provider** means a provider that enters into an agreement with the Preferred Provider Organization to provide services at negotiated discount rates.

**Pregnancy** means any Pregnancy, a complication thereof, or the termination of a Pregnancy. Pregnancy benefits are payable on the same basis as benefits for treatment of an illness.

**Professionally Recognized Standards** means professionally recognized standards of quality, as determined by the Trustees, or their delegates. To determine such standards, the Fund Office may use such groups as: The American Medical Association; The American Dental Association; their affiliates and successors; peer review groups; professional review groups; and similar groups.

**Qualifying Payment Amount** means the amount calculated using the methodology described in 29 CFR 716-6(c).

**Recognized Amount** means (in order of priority) one of the following:

1. An amount determined by an applicable All-Payer Model Agreement under section 1115A of the Social Security Act;

2. An amount determined by a specified state law; or

3. The lesser of the amount billed by the provider or facility or the Qualifying Payment Amount.

4. For air ambulance services furnished by Non-PPO Providers, the **Recognized Amount** is the lesser of the amount billed by the provider or facility or the Qualifying Payment Amount.

**Retiree** means a person who formerly qualified as an Employee, who has retired from active employment while covered by this Plan, and on whose behalf the Employer continues to make the required contributions to the Plan, but only if the particular collective bargaining agreement or participation agreement allows for Retiree coverage.

**Serious and Complex Condition** mean with respect to a participant, beneficiary, or enrollee under the Plan, one of the following:

1. in the case of an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent disability; or

2. in the case of a chronic illness or condition, a condition that is — a. is life-threatening, degenerative, potentially disabling, or congenital; and b. requires specialized medical care over a prolonged period.

**Skilled Nursing Facility** and **Rehabilitation Hospital** each mean only an institution that meets all of the following tests:

- It mainly provides skilled nursing care or rehabilitation care to registered inpatients;
- It provides care that is supervised, 24 hours per day, by a physician or registered Nurse;
- It is available at all times a physician who is a staff member of an Acute Care Hospital;
- It has a registered Nurse, licensed vocational Nurse, or licensed practical Nurse on duty 24 hours per day and has a registered Nurse on duty at least eight hours per day;
- It maintains a daily medical record for each patient;
- It complies with all licensing and other legal requirements;
- It is not a Specialized Facility; and
- It is not, other than incidentally: (1) a place for Custodial Care; (2) a place for the aged; (3) a place for the care of persons addicted to or dependent on a drug or chemical, including alcohol; (4) a place for the care of persons with mental, nervous, or emotional disorders or conditions; (5) a place of rest; or (6) a nursing home, a hotel, or a similar institution.

**Specialists** mean a physician who provides specialized services, and is not engaged in general practice, family practice, internal medicine, obstetrics/gynecology or pediatrics.

**Specialized Facility** means only an Ambulatory Surgical Facility, a Birth Center, a Mental Health Residential Treatment Center, and a Substance Use Disorder Residential Treatment Center, whether physically or legally a part of another facility.

**Spouse** means the person to whom an Employee is legally married, as determined by both state law and with whom the employee can file a joint income tax return pursuant to the U.S. Tax Code.

**Substance Use Disorder Residential Treatment Center** means a facility that is licensed in accordance with the laws of the appropriate legally authorized agency as a residential treatment center for alcoholism, drug or chemical dependence.

**Substance Use Disorder Treatment Services** are services that are required to treat psychological or physical dependence on alcohol or other mind-altering drugs that requires diagnosis, care, and

treatment. In determining benefits payable, charges made for the treatment of any physiological conditions related to rehabilitation services for alcohol or drug abuse or addiction will not be considered to be charges for treatment of substance use disorder.

**Termination** includes, with respect to the Continuation of Care benefit, the expiration or nonrenewal of the contract, but does not include a termination of the contract for failure to meet applicable quality standards or for fraud.

**Total Disability** or **Totally Disabled** means that you or your Spouse are prevented by illness or injury from engaging in any duty of your occupation for wages or profit. For your dependent children, it means they are prevented by illness or injury from engaging in their normal daily activities.

**Usual, Customary and Reasonable Charges** or **UC&R Charges** (sometimes referred to as Maximum Reimbursable Charge or MRC) means charges for Medically Necessary services or supplies that are determined to be the lowest of:

- The 90$^{th}$ percentile of the usual charge by the health care provider for the same or similar service or supply;
- The prevailing charge of most other health care providers in the same or similar geographic area for the same or similar health care service or supply;
- With respect to a Preferred Provider, the charge set forth in the agreement between the Preferred Provider and the Preferred Provider Organization or the Plan; or
- The health care provider's actual charge.

**You and your** means the employee/participant who is eligible for coverage under the terms of the plan and who can enroll his or her Spouse and/or eligible dependent children.

# Statement of ERISA Rights

This statement of your rights under ERISA is required by federal law and regulation.

As a participant in the National IAM Benefit Trust Fund Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants are entitled to the following rights:

## Receive Information about your Plan and Benefits

You have the right to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator's office, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator's office may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

## Continue Group Health Plan Coverage

You have the right to continue group health coverage for yourself, Spouse or Eligible Dependent Child if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

## Prudent Actions by Plan Fiduciaries

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

## Enforce your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to

$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

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

However, in all cases including those described in the above paragraph, you must first exhaust your administrative remedies under the Plan (by following the claims and appeals procedures described in the SPD) before you may file suit in any court.

## Assistance with Questions

If you have any questions about your Plan (for example, any questions about the processing of your claims, or allowances considered by the Plan, covered expenses, or questions regarding your eligibility), you should contact the Plan Administrator.

This SPD contains a summary in English of your plan rights and benefits under the Plan. If you have difficulty understanding any part of this booklet, you should contact the Plan Administrator .

If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or write to the EBSA's Office of Assistance:

Office of Participant Assistance
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue, NW, Suite N-5625
Washington, DC 20210

You may also obtain certain publications about your rights and responsibilities under ERISA by calling EBSA's Toll-Free Employee & Employer Hotline at (866) 444-EBSA (3272) or visit the EBSA website at www.dol.gov/dol/ebsa.

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BENEFIT TRUST FUND

**99 M Street, SE, Suite 600, Washington, DC  20003**

**202-785-8148**
**800-457-3481**
**www.iambtf.org**