



**DISTRICT COUNCIL 37, LOCAL 95 HEAD START EMPLOYEES  
WELFARE FUND**

P. O. Box 816  
New York, NY 10108

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**YOUR**

**HEALTH**

**AND**

**WELFARE**

**BENEFITS**



## DISTRICT COUNCIL 37, LOCAL 95 HEAD START EMPLOYEES WELFARE FUND

P. O. Box 816  
New York, NY 10108

Phone: (212) 343-1660

*We Care We Count • HEAD START EMPLOYEES*

Fax: (212) 965-1073

Dear Participant:

The Board of Trustees is pleased to present you with this book that summarizes the benefit coverage provided by the District Council 37, Local 95 Head Start Employees Welfare Fund effective January 2025. The information in this booklet replaces and supersedes any prior materials previously distributed. This Summary Plan Description (SPD) is designed to provide you with a non-technical explanation of the features of the Plan and will help you understand and use the benefits provided by the Local 95 Head Start Employees Welfare Fund (“the Fund”). We urge you to read this SPD carefully so that you will understand the Plan as it applies to you. You should keep this SPD in a safe place for future reference and share it with any family Participants that are covered by the Fund.

Please understand that no general explanation can adequately provide all of the details of the Plan. Therefore, this SPD does not change or otherwise interpret the terms of the official Fund documents, such as the Trust Agreement, or Collective Bargaining Agreements relating to the Fund. The Plan is administered by the joint labor-management Board of Trustees that are selected either by the Union or the contributing employers and serve without pay. Only the Board of Trustees has the authority to interpret the Fund's benefit program or official Fund documents or to make any promises to you about them.

In most cases, the benefits provided by the Fund will be your primary source for health care coverage. However, in cases where other coverage is available to you, the Fund will be the secondary payer. This is described elsewhere in the SPD. Not every expense you incur for health care is covered by the Plan.

We believe that the Fund provides an excellent array of benefits which will meet most of your health care expenses for illness and injuries. It is our hope to provide the best affordable health care available. As you are aware, in recent years, the cost of medical services and supplies has rapidly increased. The prudent use of benefits for which you and your dependent's are eligible will help us to continue to provide you with a comprehensive program.

This Summary Plan Description for the Medical Plan will also serve as the Fund's Plan Document.

Sincerely,

THE BOARD OF TRUSTEES



# DISTRICT COUNCIL 37, LOCAL 95 HEAD START EMPLOYEES WELFARE FUND

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## INTRODUCTION

### **To All Plan Participants:**

*The Trustees of your Welfare Fund are pleased to provide you with this new, updated Plan Document and Summary Plan Description (SPD) booklet. Be sure to read this booklet carefully and keep it with your other important papers for future reference.*

*Sincerely,*

**Board of Trustees**

**About This Book** – This book is intended to serve as the Plan Document and Summary Plan Description. This document (“the Plan”) describes the rules, regulations, benefits, and limitations of the payment of health benefits by the Fund. Only the full Board of Trustees, or Individuals or Committees designated may interpret and apply the Plan described in this book. The Trustees’ (or their designee’s) interpretation and application of the Plan will be final and binding on all persons dealing with the Plan or claiming a benefit from the Plan. If a decision of the Trustees is challenged in court, it is the intention of the parties that such decision is to be upheld unless it is determined to be arbitrary or capricious. No agent, representative, officer or other person from the Union or an Employer has the authority to speak for the Trustees or to act contrary to the written terms of the governing Plan documents. If you have questions about eligibility or claims, only the Welfare Fund Office is authorized to answer the questions for the Trustees. Matters that are not clear, or which need interpretation, will be referred to the Trustees or their designees.

**No Vesting of Benefit Rights** – Plan Participants and their Dependents do not have a vested right to benefits provided by the Plan or to coverage under the Plan. The Board of Trustees has full authority to increase, reduce or eliminate benefits and to change the eligibility rules or other provisions of the Plan at any time. The Plan is maintained for the exclusive benefit of the Plan Participants and Beneficiaries.

### **IMPORTANT NOTICE**

In the event there appears to be a conflict between any description of a Plan provision in this Summary Plan Description (SPD) and any other information you may have received, either written or orally, the language contained in this SPD is the official and governing language.

This SPD shall function as the Plan Document. The Trustees have **SOLE AND ABSOLUTE DISCRETION** with regard to the Plan and its interpretation and/or application. As the Plan is amended from time to time, you will be sent information in the form of a Summary of Material Modification (SMM) explaining the changes. If those SMM notices describe a benefit or procedure that is different from what is described here, you should rely on the SMM information.

## PLAN INFORMATION

This Summary Plan Description (SPD) sets forth the benefits for Participants who are eligible to participate in this Welfare Fund.

### COLLECTIVE BARGAINING AGREEMENTS

The Plan is maintained pursuant to the Collective Bargaining Agreements (CBA) between your employer and the union. A copy of any such agreement may be obtained by Participants or their beneficiaries upon written request to the Welfare Fund office and is available for examination at the fund office.

Some union Participants who are employed by non-delegate Head Start agencies that have a Participation Agreement with the District Council 37, Local 95 may be eligible for benefits. For more information and to find out if you are eligible, please contact the Fund Office at (212) 343-1660.

### NAME AND ADDRESS OF PLAN SPONSOR

<b>Plan Sponsor:</b>	District Council 37 Local 95 Head Start Employees Welfare Fund 420 West 45 <sup>th</sup> St., 3 <sup>rd</sup> Floor New York, N.Y. 10036 Telephone (212) 343-1660
<b>Name of Plan:</b>	District Council 37 Local 95 Head Start Employees Welfare Fund
<b>Type of Plan:</b>	Multiemployer Welfare Fund governed by a Joint Board of Trustees
<b>Plan Administrator:</b>	Board of Trustees or its designee District Council 37 Local 95 Head Start Employees Welfare Fund 420 West 45 <sup>th</sup> St., 3 <sup>rd</sup> Floor New York, N.Y. 10036
<b>Address of Plan:</b>	District Council 37 Local 95 Head Start Employees Welfare Fund 420 West 45 <sup>th</sup> St., 3 <sup>rd</sup> Floor New York, N.Y. 10036
<b>Plan Number:</b>	501
<b>Employer Identification Number:</b>	13-3819669
<b>Plan Fiscal Year Ends:</b>	December 31 <sup>st</sup> .
<b>Benefit Plan Year:</b>	January 1 <sup>st</sup> through December 31 <sup>st</sup>
<b>Service of legal process should be made upon the Plan Trustees to:</b>	District Council 37 Local 95 Head Start Employees Welfare Fund 420 West 45 <sup>th</sup> Street, 3 <sup>rd</sup> Floor New York, N.Y. 10036 Telephone (212) 343-1660
<b>Plan Type:</b>	Hospital, Medical/Surgical, Major Medical, Prescription, Dental

## CONTACT INFORMATION

### WELFARE FUND OFFICE

Contact the Welfare Fund office to discuss all questions regarding the benefits available under the Plan.

District Council 37 Local 95 Head Start Employees

Welfare Fund

420 West 45<sup>th</sup> St., 3<sup>rd</sup> Floor

New York, N.Y. 10036

(212) 343-1660

<b><u>To Find Out About:</u></b>	<b><u>Contact:</u></b>	<b><u>Telephone Number:</u></b>	<b><u>Website:</u></b>
<b>ENROLLMENT DEPARTMENT</b>	Fund Office	212-343-1660	<a href="http://www.dc1707195wf.net">www.dc1707195wf.net</a>
<b>HOSPITAL &amp; MEDICAL SURGICAL BENEFITS</b>	Insurance Design Administrators	800-255-1345	<a href="http://www.idatpa.com">www.idatpa.com</a>
<b>PROVIDER LOCATOR</b>	MagnaCare PPO For Physicians Providers Only	800-255-1345	<a href="http://www.idatpa.com">www.idatpa.com</a> or <a href="http://www.magnacare.com">www.magnacare.com</a>
<b>PRE-CERTIFICATION</b>	MedWatch	866-255-0793	<a href="http://www.urmedwatch.com">www.urmedwatch.com</a>
<b>PATHWAYS CONCIERGE SERVICES</b>	MedWatch	888-538-0981	<a href="http://www.urmedwatch.com/pathways">www.urmedwatch.com/pathways</a>
<b>DURABLE MEDICAL EQUIP</b>	Navitus Rx	866-333-2757	<a href="http://www.navitus.com">www.navitus.com</a>
<b>PRESCRIPTION</b>	Navitus Rx	866-333-2757	<a href="http://www.navitus.com">www.navitus.com</a>
<b>MAINTENANCE DRUGS</b>	Navitus RX	866-333-2757	<a href="http://www.navitus.com">www.navitus.com</a>
<b>DENTAL</b>	HealthPlex	(800) 469-0466	<a href="http://www.Healthplex.com">www.Healthplex.com</a>

## **PLAN SPONSORSHIP AND ADMINISTRATION**

The Plan is sponsored and administered by a joint labor-management Board of Trustees.

The Board of Trustees is divided equally between Trustees appointed by the Union and Trustees appointed by Employers contributing to the Fund. The legal address of the Board of Trustees is set forth above and the names of the individual trustees are listed in this booklet. The Board of Trustees is assisted in its administration by the Fund Administrator and Welfare Fund Office staff who are responsible for maintaining eligibility records, paying claims and initial denial of claims (when necessary).

## **FINANCING OF THE PLAN**

The benefits provided by this Plan are funded through Employer and Employee contributions as required by the Collective Bargaining Agreements between the Union and the Contributing Employers. The contributions are received and held in Trust by the Board of Trustees for the payment of benefits and administration of the Plan. The amount of the contributions are determined by the terms of the Collective Bargaining Agreements. If applicable, contributions are determined by the terms of Participation Agreement(s) between the Trustees and the Contributing Employer.

The Board of Trustees is responsible for the funding policy of the Fund. A copy of the Collective Bargaining Agreement and a list of contributing employers is available upon written request to the Fund Manager.

All of the assets are held in trust by the Board of Trustees of the Fund for the exclusive benefit of Participants and Beneficiaries of the Plan. The Board of Trustees has the ultimate responsibility for the management of monies and may from time to time utilize the services of investment managers to invest Plan assets.

Benefits under the Plan shall not in any manner be assignable or transferable by the Participant, including, but not limited to, assigning to a provider a participant or beneficiary's right to sue the plan and plan fiduciaries.

The Fund only accepts contributions directly from Participants who have elected COBRA coverage.

## **WELFARE FUND PRIVACY OFFICER**

If you believe that your HIPAA privacy rights have been violated, you may file a complaint with the Fund in care of the Privacy Officer at the following address:

Randy S. Paul, Privacy Officer  
District Council 37 Local 95 Head Start Employees  
Welfare Fund  
420 West 45<sup>th</sup> St., 3<sup>rd</sup> Floor  
New York, N.Y. 10036  
Telephone (212) 343-1660

**You may also file a  
complaint with:**

**Secretary of the U.S. Department of  
Health and Human Services  
Hubert H. Humphrey Building  
200 Independence Ave. S.W.  
Washington, D.C. 20201**

**IMPORTANT:** This Summary Plan Description and the personnel at the Fund Office are the only authorized sources of Fund information for you. The Trustees of the Fund have not empowered anyone else to speak for them with regard to the District Council 37 Local 95 Head Start Employees Welfare Fund. No Employer, Union representative, supervisor or shop steward is in a position, or authorized to, discuss your rights with authority.

## DEFINITIONS

These are some of the terms used in your booklet. Some other terms are described as they are used. PLEASE READ THEM CAREFULLY. It can help you to better understand what your benefits are.

**Adverse Determination** means a determination by the Fund or its agents that an admission, extension of stay, or other health care service has been reviewed and based on the information provided, is not medically necessary, experimental or investigational in nature and therefore not covered. The scope of an Adverse Determination includes a Rescission of Coverage (whether or not the rescission has an adverse effect on any particular benefit at the time).

**Maximum Allowable Charges** means the charges for services and supplies as covered medical expenses under the Plan, which are Medically Necessary for the care and treatment of Illness or Injury, but only to the extent that such fees are within the Maximum Allowable Charge. Examples of the determination that a charge is within the Maximum Allowable Charge include, but are not limited to, the following guidelines:

- **Errors, Unbundled and/or Unsubstantiated Charges.** Maximum Allowable Charge will not include the following amounts:
  - (a) Charges identified as improperly coded, duplicated, unbundled and/or for services not performed;
  - (b) Charges for treating injuries sustained or illnesses contracted, including infections and complications, which, in the opinion of the Plan Administrator, can be attributed to medical errors by the Provider;
  - (c) Charges that cannot be identified or understood; and
  - (d) Charges that cannot be verified from audits of medical records.

**Ambulatory Surgical Facility (or Ambulatory Surgical Center)** means a health care facility in which surgery is performed on patients on an outpatient basis.

**Amendment** means a document that modifies a plan's content and generally adds or excludes coverage or amends the terms of existing coverage.

**Annual Maximum** means the maximum accumulated payments the Fund will make for covered services rendered to a covered person during a calendar year, or the maximum number of covered days/visits available to a covered person for a particular service or services during a calendar year. Essential Benefits do not have an annual maximum accumulated payment threshold.

**Appeal** is a request for the Plan to review a decision. Please refer to the section on Appeal Procedures.

**Balance-of-Charges** means Non-Network Providers have not agreed to accept the Allowed Charge as payment in full. When you receive out-of-network services, you are responsible for any provider charges that exceed the Fund's allowance if any, in addition to any cost-sharing provisions, e.g., copayment, deductible and coinsurance amounts, that apply to your benefits for the services covered. For example, if the provider charges \$50 for a given service and the Fund allows \$30, then you are responsible for the \$20 difference. In this example, the balance-of-charges would be \$20. With an EPO program, balance-of-charges may apply to services received in a network hospital or network facility performed by non-participating providers, such as: an anesthesiologist, radiologist, an assistant surgeon or emergency room physician.

**Beneficiary** means the person entitled to receive benefits under the terms of the Plan following the death of an active Employee Participant.

**Board of Trustees** are the individuals with whom Fund property is legally committed in trust. The Board has the legal obligation of managing Fund assets on behalf of the Participants in the Fund.

**Case Managers** are professionals hired by the Plan for clinical review, support and assistance in determining medical necessity.

**Child** - For purposes of this definition, "Child" (and its plural form "Children") means:

- Your natural child provided you submit satisfactory proof of your parenthood (birth certificate, voluntary acknowledgement of paternity, etc.);
- Any child legally adopted by you or any child placed in your home for the purpose of adoption;
- A stepchild (meaning any child of your current Spouse who was born to your Spouse or who was legally adopted by your Spouse before your marriage to that Spouse);
- A foster child, meaning a child who is placed with you pursuant to legal guardianship of the child or other court order, provided that no state or private social service agency pays any support or compensation to you or any Participant of your household for the support or maintenance of the child;
- Any child determined by the Trustees to be an "alternate recipient" under the terms of a Qualified Medical Child Support Order. You can obtain, without charge, a copy of the Plan's procedures governing Qualified Medical Child Support Order determinations by calling or writing the Welfare Fund Office.

The Fund Office will require proof of a Child's status with the Subscriber. Such proof may be in the form of copies of certified marriage or birth certificates, court orders, or other documents. These documents should be kept readily available to submit to the Fund Office when they are requested.

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

**Co-Insurance** means the percentage of the Fund's allowance payable by you for covered services. Expenses credited toward your deductible, copayments, charges for services that are not covered, and charges in excess of the Fund's allowances and benefit limitations are also payable by you but are not considered to be coinsurance.

**Copayment (copay charge)** Copayments are dollar amounts that the Plan Participant must pay before this Plan pays. A copayment is the amount of money that is paid each time a particular service is used. Typically, there may be copayments on some services and other services will not have any copayments. Copayment(s) for In-Network services accrue toward the 100% Maximum Out-of-Pocket amount(s).

**Collective Bargaining Agreements (CBA)** were established between Employers and the District Council 37, Local 95 ("Union") and have been maintained through succeeding agreements under which Employer contributions to the Plan are required.

**Contributing Employer** is an employer required to contribute to the Fund pursuant to the terms of a Collective Bargaining Agreement or other written agreement.

**Cost-Sharing** is a comprehensive term for the deductible, copayment and coinsurance provisions.

**Covered Employment** means work for which your employer must contribute to the Fund on your behalf.

**Covered Expenses or Covered Medical Expenses** means the Reasonable and Customary expenses incurred by a Participant that are eligible to be considered for payment under the Plan, subject to the provisions, limitations and exclusions of the Plan.

**Custodial Care** is care that is designed primarily to assist an individual in meeting the activities of daily living, regardless of what the care is called, including any care intended primarily to help a disabled person meet basic personal needs when there is no plan of active medical treatment to reduce the disability, or the plan of active medical treatment cannot reasonably be expected to reduce the disability.

**Deductible** is the portion of eligible expenses that an individual or family must pay during a Calendar Year before the Fund begins to pay benefits for covered services.

**Dependent** is an individual other than the subscriber who is eligible to receive health care services under the subscriber's coverage. Generally, dependents are limited to the subscriber's spouse and dependent children or domestic partner.

**Durable Medical Equipment** is medically necessary equipment and supplies ordered by a health care provider for everyday or extended use.

**Eligible Employee** is an Employee who has met the eligibility requirements established by the Trustees and is entitled to receive benefits under this Plan.

**Eligible Expense** means the total dollar amount allowed by the Fund for a particular service or procedure.

**Emergency** means care for a medical or behavioral condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: 1) Placing the health of the person afflicted with such condition (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, or in the case of a behavioral condition placing the health of such person or others in serious jeopardy; 2) Serious impairment to such person's bodily functions, 3) Serious dysfunction of any bodily organ or impair of such person; or 4) Serious disfigurement of such person.

**Employee or Employee Participant or Participant** means an individual who is the Employee of an Employer who is covered under the terms of a Collective Bargaining Agreement. The Trustees shall have the sole and absolute discretion to verify whether an individual is an Employee of an Employer.

**Employer** means an employer required to contribute to the Plan on behalf of Employees pursuant to a Collective Bargaining Agreement or other written agreement.

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

**Essential Benefits** means ambulatory care, emergency services; hospitalization, maternity and newborn care, mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative care; laboratory services; preventive and wellness services and chronic disease management; pediatric services including oral and vision care; and any other services described as Essential Benefits pursuant to the Patient Protection and Affordable Care Act. There are no annual or lifetime maximum payment thresholds on Essential Benefits. Your plan may or may not cover all Essential Benefits. Refer to this SPD for a complete description of covered services.

**Excluded Services** are health care services that are not covered by this Plan.

**Experimental** means any treatment procedure, facility, drug, device, or supply not yet recognized as acceptable medical practice and any such items requiring Federal or government agency approval for which such approval has not been granted at the time services are provided. The Trustees have the authority to determine whether a treatment, service or supply is Experimental. The fact that a Physician has prescribed, ordered, recommended, or approved the treatment, service or supply does not in itself make it an acceptable medical practice.

**Fund Office** means the office maintained by the Trustees of District Council 37 Local 95 Head Start Employees Welfare Fund, where the business of said Fund is conducted. It is located at: 420 West 45<sup>th</sup> St., 3<sup>rd</sup> Floor, New York, N.Y. 10036. The telephone number is: (212) 343-1660.

**HIPAA** means the Health Insurance Portability and Accountability Act.

**Hospice** is a public agency or private organization (or a part of either), primarily engaged in providing a coordinated set of services at home or in outpatient or institutional settings to persons suffering from a terminal medical condition. The agency or organization (1) must be eligible to participate in Medicare; (2) must be appropriately licensed by the state in which it operates; (3) must have an interdisciplinary group of personnel that includes the services of at least one Doctor and one Registered Nurse (R.N.); (4) must maintain clerical records on all patients; (5) must meet the standards of the National Hospice Organization; and (6) must provide, either directly or under other arrangements, the services and supplies listed as Covered Expenses under the Hospice Benefit.

**Home Health Agency** is a public agency or private organization, or a subdivision that meets all of the following requirements: (1) It is primarily engaged in providing skilled nursing services and other therapeutic services in the homes of its patients; (2) It has established policies governing the services that it provides; its services are supervised by a Doctor or a registered nurse (R.N.); (3) It maintains records on all of its patients; (4) It is licensed according to the applicable laws of the state in which the patient receiving the treatment lives and of the locality in which it is located or in which it provides services; and (5) It is eligible to participate in Medicare.

**Hospital** refers to an institution that has medical and surgical facilities for the care and treatment of the sick. It must be a short-term acute care general hospital. A short-term acute care general hospital is an institution engaged primarily in providing inpatient diagnostic and therapeutic facilities for surgical and medical diagnoses, treatment, and care of sick and injured persons. The hospital must provide 24-hour nursing service by registered graduate nurses who are present and on duty. The hospital must be supervised by a staff of physicians. A hospital is not one of the following:

- An old age, rest, or nursing home
- A convalescent home or similar institution
- A sanitarium
- A camp, school, college, or university infirmary
- A facility primarily for the treatment of mental problems, tuberculosis, drug abuse, or alcoholism
- A weight loss or fitness center
- A skilled nursing center or facility
- An institution utilized primarily for custodial care or as a domicile
- A health resort or spa
- A place for hospice care treatment
- A rehabilitation facility

**Investigational** means any service, supply, drug, or other treatment that does not meet all of the following criteria:

- The service, supply, drug, or treatment has received final approval from the appropriate governmental regulatory bodies;
- Scientific evidence permits conclusions concerning the effect of the service, supply, drug, or treatment on health outcomes; and
- The service, supply, drug, or treatment is generally accepted as standard medical treatment of the condition being treated.

**Lifetime Maximum** means the maximum accumulated payments the Fund will make for covered services rendered to a covered person per lifetime, or the maximum number of days/visits available to a covered person per lifetime for a particular service or services. Essential Benefits do not have a lifetime maximum.

**Medically Necessary** means necessary care that is rendered by a hospital or a licensed or certified provider and is determined by the Fund to meet all of the criteria listed below:

- It is provided for the diagnosis, direct care, or treatment of the condition, illness, disease, injury, or ailment.
- It is consistent with the symptoms or proper diagnosis and treatment of the medical condition, disease, injury, or ailment.
- It is in accordance with accepted standards of good medical practice in the community.
- It is furnished in a setting commensurate with the Participant's medical needs and condition.
- It cannot be omitted under the standards referenced above.
- It is not in excess of the care indicated by generally accepted standards of good medical practice in the community.
- It is not furnished primarily for the convenience of the Participant, the Participant's family, or the provider.
- In the case of a hospitalization, the care cannot be rendered safely or adequately on an outpatient basis and, therefore, requires that the Participant receive acute care as a bed patient.

The fact that a provider has prescribed a service or supplies does not automatically mean that the service or supplies will qualify for reimbursement under the Fund. To be eligible for reimbursement by the Fund, all covered services must meet the medical necessity criteria described above.

**Medicare** means the medical benefits provided by Title XVIII of the Federal Social Security Act, as amended from time to time.

**Medical Review Organization** means the professional medical organization whose staff reviews specified services and supplies to ensure that they are Medically Necessary and appropriate for the treatment of the Participant's condition.

**Mental or Nervous Disorder** means neurosis, psychopathy, psychoneurosis, psychosis or mental or emotional disease or disorder of any kind, regardless of any physiological or traumatic cause or origin of such condition.

**Motor Vehicle** means a "motorized vehicle," which is not limited to an automobile, truck, or van. It includes motorcycle, moped, all-terrain vehicle, snowmobile, and other recreational vehicles.

**Network** is a group of providers that are under a contract with the Plan to provide health care services to our eligible Participants under pre-determined prices.

**Network Provider** also known as a "Participating Provider," a Network Provider is any doctor or other provider who has agreed with us to accept our Schedule of Allowances or negotiated rate(s) as payment in full for covered services and who participates in the network that applies to your program. Visit [www.magnacare.com](http://www.magnacare.com) for the names of Network Providers. This Plan is a plan which contracts a Preferred Provider Network for In-Network Physician and Non-Facility Providers Access Only.

**Non-Network Provider** also known as "Non-Participating Provider," a Non-Network Provider does not have an agreement with the Funds network to accept its rates as payment in full. Services obtained or rendered by Non-Participating Providers are generally not covered under an EPO benefit Program except for emergency care situations.

**Network rate** means the scheduled allowance(s) or negotiated rate(s) a Network Provider has agreed to accept as payment in full for covered services rendered to Fund Participants. The Network rates usually represent a reduction to the provider's regular fee. In some cases, we will have a negotiated rate with a Network Provider. The negotiated rates will vary, depending upon the terms agreed upon between us and the Network Provider.

**Non-Participating Provider** means a Non-Network Provider.

**Out-of-Pocket Maximum** is the maximum dollar amount per calendar year of coinsurance expenses payable by you for covered medical, hospital & prescription services.

The Plan will pay the percentage of Covered Charges designated until the following amounts of out-of-pocket payments are reached, at which time the Plan will pay 100% of the remainder of Covered Charges for the rest of the Calendar Year unless stated otherwise.

The Medical Plan's In-Network Maximum Out-of-Pocket amount(s) plus the Standalone Prescription Drug Plan copayment(s) will not exceed the Maximum Out-of-Pocket amount(s) stipulated in accordance with the guidelines set forth by the Affordable Care Act (ACA).

The Standalone Prescription Drug Plan through Navitus has its own prescription drug Maximum Out-of-Pocket amount(s).

**Participant, Eligible Participant, Plan Participant, Covered Person or Covered Individual** or Member means an individual satisfying the Eligibility provisions of this Plan for coverage as an Eligible Employee, Retiree or Dependent.

**Participating Provider** means a Network Provider.

**Physician or Doctor** means, a duly licensed Doctor of Medicine authorized to perform a particular medical or surgical service within the lawful scope of his/her practice, and shall also include Doctor of Osteopathy, Doctor of Chiropractic, Doctor of Podiatric Medicine, a Certified Social Worker, or a Doctor of Psychology with regard to Major Medical Mental Health Benefits and Hospice Care, and a licensed Rehabilitative Therapist. No other providers are recognized.

**Plan** means the District Council 37, Local 95 Head Start Employees Welfare Fund.

**Plan Administrator** means the Board of Trustees.

**Plan Trustees** means the Board of Trustees of the Plan.

**Pre-certification** means certain covered services must be pre-certified by contacting the Funds vendor for approval prior to treatment. Failure to obtain prior approval for these services may result in a rejection of benefits payments.

**Preventive Service Benefits** is care that helps you stay healthy. For a complete list of services considered to be Preventive Services Benefits, go to [www.healthcare.gov](http://www.healthcare.gov). These include certain physicals and immunizations.

**Provider** means a medical practitioner or covered facility recognized by the Fund for reimbursement purposes. A provider may be any of the following, subject to the conditions listed in this paragraph:

- A doctor of medicine
- A doctor of osteopathy
- A dentist (see dental plan)
- A chiropractor
- A doctor of podiatric medicine
- A physical therapist
- A nurse midwife
- A certified and registered psychologist
- A certified and qualified social worker
- An ophthalmologist
- A nurse anesthetist
- A speech therapist
- An audiologist
- A clinical laboratory
- A general hospital

A provider must be licensed or certified to render the covered service. The covered service must be within the scope of the provider's license or certification. Please note that not all services rendered by a specific class of providers listed above are reimbursable. In order for the treatment to be reimbursable, the service rendered to you must be covered under the Fund and must be medically necessary. In addition, the practitioner or facility rendering the service must be listed as a provider who is recognized by the Fund to render the covered service.

**Reasonable and Customary (R&C) Charge** is an amount determined by comparing a particular charge with the charges made for similar services and supplies in the locality concerned to individuals of similar age, sex, circumstances, and medical condition. The result of this comparison will determine the amount that is the maximum Allowed Amount to be considered a Covered Expense under the Plan.

**Reference Based Pricing** Reference-based pricing (RBP) is an alternative to traditional healthcare pricing where reimbursement rates for medical services are based on a specific reference point rather than on a provider's billed charge.

**Rescission of Coverage** is a cancellation or discontinuance of coverage that has retroactive effect. The Plan may not rescind coverage with respect to an individual (including a group to which the individual belongs or family coverage in which the individual is included) once the individual is covered under the Plan, unless the individual (or a person seeking coverage on behalf of the individual) performs an act, practice, or omission that constitutes fraud, or unless the individual makes an intentional misrepresentation of material fact, as prohibited by the terms of the Plan. The Plan will provide at least 30 days advance written notice to each participant who would be affected before coverage may be rescinded. A cancellation or discontinuance of coverage is not a rescission if –

- (i) The cancellation or discontinuance of coverage has only a prospective effect;
- (ii) The cancellation or discontinuance of coverage is effective retroactively, to the extent it is attributable to a failure to timely pay required premiums or contributions (including COBRA premiums) towards the cost of coverage.

**Skilled Nursing Facility** is an institution, or a distinct part of an institution, that complies with all licensing and legal requirements and that meets all of the following criteria:

1. It is primarily engaged in providing inpatient skilled nursing care, physical restoration services and related services for patients who are convalescing from injury or sickness and who require medical or nursing care to assist them to reach a degree of body functioning to permit self-care in essential daily living activities.
2. It provides 24-hour-a-day supervision by one or more Doctors or one or more Registered Nurses (R.N)
3. It provides 24-hour-a-day nursing services under the supervision of an R.N., and it has an R.N. on duty at least 8 hours a day.
4. Every patient is under the supervision of a Doctor, and it has available at all times the services of a Doctor who is a staff Participant of a general hospital.
5. It maintains daily medical records on all patients, and it provides appropriate methods and procedures for the dispensing and administering of drugs and biologicals.
6. It has a utilization review plan.
7. It has a transfer agreement with one or more Hospitals.
8. It is eligible to participate under Medicare.
9. It is not, other than incidentally, a place for rest, for Custodial Care, for the aged, for drug addicts, for alcoholics, a hotel, a place for the care and treatment of mental diseases or tuberculosis, or a similar institution.

**Spouse** means a person who is legally married to the Employee Participant, including all legally married same-sex or opposite-sex spouses, regardless of state of residence.

**Substance Use** or Chemical Dependency means the abuse, addiction to or dependency on the use of drugs, narcotics, alcohol or any other chemical (except for nicotine).

**Sudden & Serious** means symptoms of such severity and pain that a prudent layperson could reasonably expect that the absence of immediate medical attention would result in serious medical or behavioral health jeopardy; cause serious bodily function impairment or dysfunction of any organ; or cause disfigurement.

**Treatment Facility for Chemical Dependency** is a rehabilitation facility for the treatment of persons suffering from alcoholism and/or drug abuse or drug addiction. To be considered an approved treatment facility for the purposes of this Plan, the facility must be accredited by the Joint Commission on Accreditation of Healthcare Organizations or meet certain requirements specified by the Trustees.

**Trust** means all cash, securities and other property that at the time of reference has been deposited in the trust account established pursuant to the Trust Agreement.

**Trustee(s)** means the individual Union Trustees, the individual Employer Trustees and, when acting as Trustees, their alternates and successors.

**Trust Agreement** means the Agreement and Declaration of Trust, as amended from time to time, which establishes the funding vehicle for the Plan and sets forth the respective rights, obligations and responsibilities of the Administrator, the Board and the Trustees.

**Union** means the District Council 37, Local 95 CSAEU – AFSCME.

**Utilization Review** means a review to determine whether covered services that have been provided or are proposed to be provided to you, whether undertaken prior to, concurrent with, or subsequent to the delivery of such services, are medically necessary, experimental, or investigational in nature. A Utilization Review also means a review to determine whether the individual (or a person seeking coverage on behalf of the individual) performs an act, practice, or omission that constitutes fraud or intentional misrepresentation of material fact as prohibited by the terms of the Plan.

**Utilization Review Agent** means any agent performing utilization review on our behalf.

**Utilization Review Appeal** means the process by which you or your representative may request review of a denied service (for lack of medical necessity) based upon an Adverse Determination made or a Utilization Review agent acting on our behalf. An Adverse Determination is a denial by the Fund of coverage for services considered not medically necessary or experimental or investigational in nature.

**You or Your** when used in this document refers to the Employee who is covered by the Plan. **Those terms do not refer to any Dependent.**

<p><b>Note:</b> Whenever a personal pronoun in the masculine gender is used, it will be deemed to include the feminine unless the context clearly indicates the contrary.</p>
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# ELIGIBILITY

## INITIAL ELIGIBILITY

**You are eligible for Fund coverage if you are an employee of a New York City Head Start delegate agency covered under the Collective Bargaining Agreement or a Participation Agreement between District Council 37 Local 95 Community and Social Agency Employees Union ("CSAEU") and the New York City Head Start Sponsoring Board Council, and contributions to the Fund are being made on your behalf. Your coverage begins on the first day of the month following the completion of 30 days of employment; or the first day of the month following the completion of 30 days of employment in which the Fund receives the completed Fund enrollment form, if later. In no event will coverage begin after 90 days from the date of your eligibility.**

**Management or other non-union employees of a New York City Head Start delegate agency with a Collective Bargaining Agreement with the Union are eligible for Hospital, Medical and Prescription benefits administered through this Fund.**

**VERIFICATION OF ELIGIBILITY: 1.800.225.1345.**

**Call this number to verify eligibility for Plan Benefits before the charge is incurred.**

## CONTINUATION OF ELIGIBILITY

Once eligible for benefits, an Employee will continue to remain eligible until the end of the month that his or her employer has ceased to make the required Contributions on his/her behalf.

## DEPENDENT ELIGIBILITY

**Generally, coverage for your Dependents begins at the same time your coverage begins, provided that family coverage has been elected and contributions to the Fund are being made on their behalf.**

- Your Child(ren), until the end of the month in which they reach age 26;
  - Group benefits are available to Eligible Dependents until the end of the month the dependent reaches age 26, regardless of their student status, financial dependency, residency, employment or any combination of those factors.
  - A dependent student may be Eligible for continued coverage under Michelle's Law. Please see that Section of this SPD for details.
  - Your Child's spouse and your Child's children (your grandchildren) are not eligible for coverage.
- Your unmarried Children, regardless of age, who are unable to support themselves because of a physical or mental disability (all as defined under the New York Mental Hygiene Law), provided the disability started before age 26;
- Your adopted Children from the moment of birth, provided that you take custody of the infant as soon as the infant is released from the hospital after birth and an adoption petition is filed with New York State within 30 days of the infant's birth, even if the adoption is not yet final. However, adopted newborns will not be covered from the moment of birth if: (1) the health insurance of the Child's natural parents covers the newborn's initial hospital stay; (2) a notice revoking the adoption has been filed; or (3) one of the natural parents revokes their consent to the adoption.

**NOTE: Your foster children and grandchildren are not eligible for coverage. Additionally, your Spouse or Domestic Partner are not eligible for coverage under this Plan**

**For purposes of eligibility, your dependent children include your stepchildren and the children of your domestic partner.**

## **DOCUMENTATION REQUIREMENTS FOR DEPENDENTS**

Certain documents must be submitted to establish that the Dependent is eligible for coverage. Other types of documentation are required when there is or may be other group coverage available.

Be sure to include your (the Employee's) name and Social Security number on any documents you send. The documents will be kept on file, and you do not have to resubmit copies with each subsequent claim for that Dependent. The following are examples of the documentation that must be submitted to the Welfare Fund Office:

### **For natural and adopted Children of the marriage:**

- Certified birth certificate issued by the county in which the birth took place. Hospital certificates are **NOT** acceptable.
- If the Child is over age 26 and totally disabled, proper medical documentation supporting the disability.
- If the Child is adopted, the adoption decree.

### **For all other Children, including stepchildren:**

- All of the documentation applicable to natural Children (see above).
- Divorce decrees, support agreements, paternity decrees, and other court orders and a notarized affidavit that indicate the Child's relationship to you and who has the responsibility for providing medical coverage for the Child.
- Legal guardianship documents.

Depending on the circumstances, other types of documents may also be requested.

## **ENROLLMENT**

### **OPEN ENROLLMENT**

Each year you have the opportunity to review your current health benefits and make changes to these benefits for the upcoming plan year. This Open Enrollment period will take place annually and your elections will be effective the first day of the new benefit period.

If you are enrolled in the plan and do not want to make changes to your coverage, no action is necessary. Your coverage will continue in the benefit plan into the new benefit period.

If you decline to be enrolled in the plan and wish to enroll or make changes to your health coverage, you must complete and submit a new enrollment form to the Fund Office by the end of the open enrollment period.

If your enrollment is not completed within the open enrollment period, you will have to wait until next year's open enrollment period to apply for coverage unless you experience a Special Enrollment event that makes you eligible for the plan.

### **WAIVE ENROLLMENT**

You may decide not to enroll in the Plan and waive your right to coverage under the Plan if you are enrolled in another health plan. To do so, you must provide the Plan a completed Enrollment Waiver Form. The form must be signed by you, your agency's Director, and returned to the Fund office for processing. Your disenrollment in the Fund and its benefits will become effective the first day of the new benefit period, provided that the Fund receives the Enrollment Waiver form within the required deadline.

Should you elect not to enroll or waive out of the Welfare Fund's coverage you will not be able to join the health plan until the next Open Enrollment period, unless you experience a Special Enrollment Event that would allow you the opportunity to enroll.

## **SPECIAL ENROLLMENT**

If you waive coverage for yourself or a dependent, under the Health Insurance Portability and Accountability Act (HIPAA), eligible employees and eligible dependents have the right to enroll for coverage in this Plan outside of Open Enrollment under certain circumstances. Special Enrollment is available in the following three situations.

### **1. Loss of Eligibility for Other Coverage**

If you declined enrollment for you or your Dependents Child(ren) in the Plan, and you signed the Plan's Enrollment Waiver form, you may be able to enroll your Dependent child(ren) and you in this Plan if you or your Dependent Child(ren) subsequently lose eligibility for that other coverage (or if the employer stops contributing toward your or your Dependents' other coverage). You must request Special Enrollment within 60 days of the loss of eligibility.

A completed Enrollment Waiver Form must be signed by you and your agency's Director and returned to the Fund office for processing.

### **2. Marriage, Birth, Adoption or Placement for Adoption**

If you are a participant in the Plan, and your new Dependent child(ren) are permitted to specially enroll because of marriage, birth, adoption, or placement for adoption. You must request enrollment within 60 days of marriage and 60 days for birth, adoption, or placement for adoption. See Changes in Family Status below for more on these deadlines.

### **3. Eligibility for or Loss of State Assistance**

A special enrollment right also arises for you and your Dependents Child(ren) who lose coverage under a State Children's Health Insurance Program (CHIP) or Medicaid, or who are eligible to receive premium assistance under those programs. You or your Dependent Child(ren) must request enrollment within 60 days of the loss of coverage or the determination of eligibility for premium assistance.

To request a special enrollment or obtain more information, contact the Fund Office at telephone 212-343-1660.

## **CHANGES IN COVERAGE (Adding or Removing Dependents & Cancelling Coverage)**

The Plan follows the IRS rules for the plan that your employer sponsors. Provided that the employer-sponsored plan has adopted these Permitted Election Changes, under these plan rules, you may be permitted to change your coverage elections (including cancellation of coverage or adding dependents) outside of Open Enrollment if you experience any of the following events.

### **1. Special Enrollment Event**

A plan may permit an employee to revoke an election for coverage under a group health plan during a period of coverage and make a new election that corresponds with the special enrollment rights listed above.

### **2. Change in Status Event**

Qualifying changes in status include these situations:

- Events that change Your legal marital status, including marriage; death of spouse; divorce; legal separation; and annulment.
- Events that change the number of Your dependents, including birth; death; adoption; and placement for adoption.
- Any of the following events that change the employment status of You, or Your Dependent Child(ren): termination or commencement of employment; a strike or lockout; a commencement of or return from an unpaid leave of absence; a change in worksite; or any other change in employment status with the consequence that You, Your Spouse, or Your Dependent becomes (or ceases to be) eligible under the Plan.
- Events that cause Your Dependent to satisfy or cease to satisfy eligibility requirements for coverage on account of attainment of age, student status, or any similar circumstance.
- A change in the place of residence of You, Your Spouse, or Your Dependent.

3. Judgment, Decree, or Order

If a court has ordered you to cover a spouse or minor children, you must add the spouse and minor children as directed in the court order.

4. Entitlement to Medicare or Medicaid

If You or Your Dependent Child(ren) who is enrolled in this Plan becomes entitled to Medicare or Medicaid, a cafeteria plan may permit the employee to make a prospective election change to cancel or reduce coverage for the same individual under the Plan. In addition, if You or Your Dependent who has been entitled to such coverage under Medicare or Medicaid loses eligibility for such coverage, the cafeteria plan may permit You to make a prospective election to commence or increase coverage for the same individual under the Plan. This Plan is not a cafeteria plan as that term is defined by the Internal Revenue Code.

5. Significant Cost or Coverage Changes

A change in cost means:

A significant increase or decrease in your cost for an option offered under the Plan that occurs during the year. Changes that may be made include commencing participation in the Plan for the option with a decrease in cost, or, in the case of an increase in cost, revoking an election for that coverage and, in lieu thereof, either receiving on a prospective basis coverage under another benefit package option providing similar coverage or dropping coverage if no other benefit package option providing similar coverage is available.

Change in coverage means:

- The addition of a new benefit option, the elimination of an existing benefit option or a significant change in an existing benefit under the Plan.
- A change in Your coverage or that of your Dependent Child through a Spouse or Dependent Child's employment, including those changes resulting from your Spouse or Dependent's election during an annual enrollment period for his or her employer-sponsored plan(s).

6. Additional Permitted Election Changes:

- You request to cancel coverage because you were in an employment status under which you were reasonably expected to average at least 30 hours of service per week and you have a change in that employment status where you will be reasonably expected to average less than 30 hours of service per week after the change, even if this reduction does not result in you ceasing to be eligible under the Plan
- You request to cancel coverage because you are eligible for a Special Enrollment Period to enroll in a Qualified Health Plan through your spouse or domestic partner, if applicable. You will have to certify that you are enrolled in minimal essential coverage.

For the employment status change you will be required to attest that you and any qualified dependents have enrolled or intend to enroll in another plan that provides minimum essential coverage. The new coverage must be effective on the first day of the month following one full calendar month after the date the original coverage is revoked.

## CHANGES IN FAMILY STATUS

If you have single coverage at the time the newborn or proposed adopted newborn is born, you must notify the Fund and submit an enrollment form for the newborn within 60 days from the date of birth for coverage. If you do not enroll within 60 days, you may enroll for coverage during the first year after the birth, which will be effective on the date the Fund receives the completed enrollment. If you do not switch coverage and enroll the newborn; the newborn or proposed adopted newborn will not be covered.

If you have family coverage, the newborn child or proposed adopted child will automatically be covered from the date of birth. Please note that you must submit an enrollment form for the newborn or proposed adopted newborn within 60 days of birth. If you submit an enrollment form for the newborn or proposed adopted newborn more than 60 days after the date of

birth, any claims received after 60 days will not be processed until the enrollment form is received, with coverage retroactive to the date of birth.

If you have single coverage and you get married and transfer to family coverage within 30 days after the date of marriage, you will receive full continuity of coverage from your individual coverage.

### **PROOF OF ELIGIBILITY**

When applying for Special Enrollment or a Change in Coverage, you are responsible for providing proof of eligibility for such enrollment or coverage changes. For example, if you request to cancel your coverage outside of the Open Enrollment period because you became entitled to Medicare or Medicaid, you must provide proof of your entitlement to Medicare or Medicaid before cancellation can occur. Generally, the documentation listed under the “Documentation Requirements for Dependents” section will satisfy the proof requirements when applicable. For example, marriage or birth certificates will prove you are entitled to add a Spouse or Child. With respect to the above-referenced Additional Permitted Election Changes, you must complete and sign an Attestation Form that must be provided to the Plan. Contact the Plan Administrator for a copy of the Attestation Form, the Enrollment Waiver Form, and any other forms necessary to effectuate a change in your coverage.

## **TERMINATION OF COVERAGE**

**Benefits will end on the last day of the month in which you were last on the payroll at the Head Start agency. For example, if your last day on payroll is May 15th, your coverage would end on May 31st. When benefits end for you, they are automatically terminated at the same time for your eligible dependents.**

**Your benefits provided by this Fund may terminate for any of the following reasons:**

- You or your Employer fails to pay any required premiums/contributions;
- The Fund terminates the Plan;
- Either you or your covered dependents no longer meet the Fund’s eligibility requirements;
- You or your covered dependents have made a false statement on either an application for coverage or a health insurance claim form, or have otherwise engaged in fraud with respect to obtaining coverage;
- Under certain circumstances you may have the right to continue your group coverage. For information on your right to continue your coverage under COBRA, please refer to COBRA Section of this Plan.

## CONTINUATION OF COVERAGE

### COBRA

When eligibility in the Health Plan terminates, a Participant can continue coverage by electing continuation of health coverage under the terms of the Consolidated Omnibus Budget and Reconciliation Act (known as COBRA).

Participants who elect COBRA coverage are typically allowed coverage up to 18 months. The eligibility and rules for COBRA coverage are detailed in the COBRA Section of this SPD.

### FMLA

In accordance with the Family Medical Leave Act of 1993 (“FMLA”), health benefits provided by the Fund are continued during an FMLA leave of absence. Employees on authorized disability leave due to illness, accident or complications of pregnancy are eligible for coverage for three (3) months beyond the last day of the month in which they were last on payroll at a Head Start agency. Please refer to the Family Medical Leave Act Section of this SPD for details of this Act.

**EXAMPLE: An employee becomes disabled on the 15th day of the current month. In this example, the employee would continue his or her group coverage until the end of the current month plus an additional three (3) months or until he or she returns to work, whichever occurs first. If, at the end of the three (3) month extension, the employee has not returned to work, the employee will be eligible to elect continuation of benefits under a federal law called the Consolidated Omnibus Budget Reconciliation Act (“COBRA”). For more information, please refer to the COBRA Section of this SPD.**

**Employees entering or returning from military service will have the right to continuation of coverage as mandated by the Uniformed Services Employment and Reemployment Rights Act (“USERRA”). For more information about your rights under USERRA, please see page 115.**

### MILITARY SERVICE

If you are inducted into the armed forces of the United States or if you enlist in military service your eligibility and the eligibility of your Dependents will terminate. However, coverage for you and your Dependents may be continued. If you are called into active service for up to 31 days, your coverage during that leave period will be continued at no cost to you. If you are called into active service for more than 31 days, you can continue your coverage for up to 24 months. See the COBRA Section in this SPD for more information.

Upon discharge from the armed forces, eligibility for you and your eligible Dependents will be reinstated on the date you return to work in Covered Employment, providing such return to work is within 90 days from the date of your discharge, or such shorter or longer period required by law if you serve less than 180 days.

## PRE-EXISTING CONDITIONS

There is no waiting period for coverage of pre-existing conditions for all eligible Head Start employees and their eligible Dependents.

## HIGHLIGHTS OF BENEFITS INCLUDED IN THE PLAN

The health plan offers you and your eligible dependents coverage for a wide range of health care services. In order to be eligible for reimbursement, all services rendered to you must be covered and must be medically necessary and received thru an in-network provider.

### VERIFICATION OF ELIGIBILITY 1.800.225.1345

Call this number to verify eligibility for Plan benefits **before** the charge is incurred.

### MEDICAL BENEFITS

All benefits described in this Schedule are subject to the exclusions and limitations described more fully herein including, but not limited to, the Plan Administrator's determination that: care and treatment is Medically Necessary; that charges are Usual and Reasonable; that services, supplies and care are not Experimental and/or Investigational. The meanings of these capitalized terms are in the Defined Terms section of this document.

This document is intended to describe the benefits provided under this Plan but, due to the number and wide variety of different medical procedures and rapid changes in treatment standards, it is impossible to describe all covered benefits and/or exclusions with specificity. Please contact the Plan Administrator if you have questions about specific supplies, treatments, or procedures.

This Plan is a plan which contains a referenced base pricing program for Hospitals/Facilities.

This Plan is a plan which also contains a Preferred Provider Network for In-Network Physician and Non- Facility Providers Access Only.

PPO Name: MagnaCare PPO for Providers Only  
Website: [www.magnacare.com](http://www.magnacare.com)

Hospital/Facilities: [www.ida-mac.com/local95](http://www.ida-mac.com/local95)

This Plan has entered into an agreement with certain Hospitals, Physicians, and other health care providers, which are called Participating Providers. Because these Participating Providers have agreed to charge reduced fees to persons covered under this Plan, this Plan can afford to reimburse a higher percentage of their fees.

Therefore, when a Participant uses a Participating Provider, that Plan Participant will receive better benefits from this Plan.

Under the following circumstances, the higher In-Network payment will be made for certain Non-Participating services:

If a Participant has no choice of Participating Providers in the specialty that the Participant is seeking within the EPO service area.

If a Participant is out of the EPO service area and has a Medical Emergency requiring immediate care.

If a Participant receives Physician or anesthesia services by a Non-Participating Provider at an In-Network facility.

If a Plan Participant is referred to a Non-Participating Provider by a Participating Provider.

This Plan includes a claim review and auditing program in order to identify charges billed in error, charges for excessive or unreasonable fees and charges for services which are not medically necessary or appropriate. Benefits for claims which are selected for review and auditing may be reduced for any charges that are determined to be in excess of the Maximum Allowable Charge.

Upon request, Hospital/ Facilities/Providers will be given a fully detailed explanation of any charges that are found to be in excess of Maximum Allowable Charge. Providers may file an appeal of the determination if they agree not to bill the Participant for excluded charges based on the results of the claim review and audit. This will in no way affect the rights of the Participant to file an appeal.

**Any Plan member who receives a balance-due billing from a medical care Hospital/Facility or Provider for these charges should contact the Claims Administrator for assistance.**

“Maximum Allowable Charge” means the charges for services and supplies as covered medical expenses under the Plan, which are Medically Necessary for the care and treatment of Illness or Injury, but only to the extent that such fees are within the Maximum Allowable Charge. Examples of the determination that a charge is within the Maximum Allowable Charge include, but are not limited to, the following guidelines:

**Errors, Unbundled and/or Unsubstantiated Charges.** Maximum Allowable Charge will not include the following amounts:

- (1) Charges identified as improperly coded, duplicated, unbundled and/or for services not performed;
- (2) Charges for treating injuries sustained or illnesses contracted, including infections and complications, which, in the opinion of the Plan Administrator, can be attributed to medical errors by the Provider;
- (3) Charges that cannot be identified or understood; and
- (4) Charges that cannot be verified from audits of medical records.

**GUIDELINES.** The following guidelines will be used when determining Maximum Allowable Charge:

Maximum Allowable Charge means the amount of Covered Expenses that are eligible for reimbursement prior to application of any point of purchase cost sharing (e.g., deductibles, copayments, coinsurance, etc.) The Maximum Allowable Charge is the negotiated rate – if one exists. Where no negotiated rate exists, the Maximum Allowable Charge will be determined in relation to Medicare reimbursement rates as would be applied by the Centers for Medicare and Medicaid Services (“CMS”). Where no Medicare reimbursement rate exists, the Plan Administrator will establish and update a Schedule of Benefits or adopt by reference other standards and/or schedules. Maximum Allowable Charge, as of **February 1<sup>st</sup>, 2024**, means:

- (1) Where there is a Network Provider or a Directly Contracted Provider, the negotiated, agreed upon rate,
- (2) For prescription drugs, a specific drug will be designated as the reference product for each therapeutic class;
- (3) For all other Providers, services, and products:
  - Where a Medicare Allowable amount can be determined,
    - (a) **150 %** of the Medicare Allowable amount for inpatient hospital expenses, using the Medicare Diagnosis Related Group (“DRG”) scheduled dollar conversion amounts based upon the CMS weighted values,
    - (b) **150%** of the Medicare reimbursement rate for outpatient hospital expenses, using the CMS Ambulatory Payment Classification (APC) based upon the CMS weighted values, or the current Medicare allowable fee for the appropriate area,
    - (c) **150%** of the current Medicare allowable fee for the appropriate area for Ambulatory Surgical Centers (ASC);
    - (d) **120%** of the current Medicare allowable fee for the appropriate area for physicians and other eligible Providers.
    - (e) **100%** of the current Medicare allowable fee for dialysis.
  - Where a Medicare Allowable amount cannot be determined, the 75<sup>th</sup> Percentile determination of Usual, Customary and Reasonable database of Context4 Healthcare.

The Plan will use the actual charge billed where it is less than the Maximum Allowable Charge.

- (1) **Insufficient Information to Determine Maximum Allowable Charge.** In the event that insufficient information is available to determine Maximum Allowable Charge for specific services or supplies using the guidelines listed above, the Plan will apply the following guidelines:
  - (a) **General Medical and/or Surgical Services.** The Maximum Allowable Charge for any covered services may be calculated based upon resources including, but not limited to, published and publicly available fee and cost lists and comparisons, or any combination of such resources that in the opinion of the Plan Administrator results in the determination of a reasonable expense under the Plan.
  - (b) **Pharmaceuticals.**
    - (i) The Maximum Allowable Charge for pharmacy charges by a Facility may be determined to be **150%** of the current Medicare allowable fee.
    - (ii) The Maximum Allowable Charge for pharmacy charges by a Provider may be determined to be **120%** of the current Medicare allowable fee.
  - (c) **Medical and Surgical Supplies, Implants, Devices.** The Maximum Allowable Charge for charges for medical and surgical supplies made by a Provider may be based upon the invoice price (cost) to the Provider, plus an additional 10%. The documentation used as the resource for this determination will include, but not be limited to, invoices, receipts, cost lists or other documentation as deemed appropriate by the Plan Administrator.
  - (d) **Physician Medical and Surgical Care, Laboratory, X-ray, and Therapy.** The Maximum Allowable Charge for these services may be determined based upon **120%** of Medicare.

#### **CERTAIN COPAYMENTS ARE PAYABLE BY PLAN PARTICIPANTS.**

Copayments are dollar amounts that the Plan Participant must pay before this Plan pays.

A copayment is the amount of money that is paid each time a particular service is used. Typically, there may be copayments on some services and other services will not have any copayments.

Copayment(s) for In-Network services accrue toward the 100% Maximum Out-of-Pocket amount(s).

#### **DEDUCTIBLES ARE PAYABLE BY PLAN PARTICIPANTS**

A deductible, if applicable to this Plan, is an amount of money that is paid once a Calendar Year per Covered Person. Typically, there is one (1) deductible amount per Plan and it must be paid before any money is paid by this Plan for any Covered Charges. On the first day of each Calendar Year a new deductible amount is required.

For Family Coverage, the deductible can be met by any combination of Covered Person(s) in the Family Unit (*cumulative*) for the family deductible to be satisfied before any money is paid by the/this Plan for any Covered Charges. The Plan will begin to pay the covered charges on an individual family member who has met the individual deductible, even before the family deductible has been met. (*No one (1) Covered Person in the Family Unit will exceed the required individual per Covered Person deductible.*)

## **MAXIMUM OUT-OF-POCKET PAYMENTS, PER CALENDAR YEAR**

The Plan will pay the percentage of Covered Charges designated until the following amounts of out-of-pocket payments are reached, at which time the Plan will pay 100% of the remainder of Covered Charges for the rest of the Calendar Year unless stated otherwise.

The Maximum Out-of-Pocket amount(s) satisfaction does not cross accumulate between In-Network and Out-of-Network.

The Medical Plan's In-Network Maximum Out-of-Pocket amount(s) plus the Standalone Prescription Drug Plan copayment(s) will not exceed the Maximum Out-of-Pocket amount(s) stipulated in accordance with the guidelines set forth by the Affordable Care Act (ACA).

The Standalone Prescription Drug Plan through Navitus has its own prescription drug Maximum Out-of- Pocket amount(s).

## EPO PLAN A SCHEDULE OF MEDICAL BENEFITS

DC 37 LOCAL 95 HEAD START EMPLOYEES WELFARE FUND EPO PLAN A SCHEDULE OF MEDICAL BENEFITS			
BENEFIT PROVISIONS	NETWORK PROVIDERS (Based on negotiated rates)	OUT-OF-NETWORK PROVIDERS	REQUIREMENTS MAXIMUM BENEFITS, LIMITATIONS OR EXCLUSIONS
<b>MAXIMUM AMOUNTS</b>			
<b>MAXIMUM LIFETIME BENEFIT AMOUNT</b>	Unlimited per Covered Participant Lifetime (Combined In-Network Maximum; and Includes all other Maximums noted under this Plan, unless otherwise stated.)		
<b>DEDUCTIBLE, PER CALENDAR YEAR</b>			
Per Covered Participant	\$1,000	NOT COVERED	<b>Note:</b> Deductible applies to all services other than Preventive Care, unless otherwise noted.
Per Family Unit (Cumulative)	\$2,000	NOT COVERED	<b>Note:</b> Deductible applies to all services other than Preventive Care, unless otherwise noted.
<p><b>Also refer to Deductible information</b>  <b>*Note:</b> Deductible(s) refer to the Calendar Year Deductible(s). The Deductible applies once to each Covered Person per Calendar Year. Once the Covered Person satisfies the Calendar Year Deductible, this Plan will consider the Calendar Year Deductible satisfied for the Covered Person for the rest of that Calendar Year. Once Covered Persons in the Family Unit incur eligible expenses that satisfy the Family Unit Calendar Year Deductible, this Plan will consider the Family Calendar Year Deductible satisfied for all Covered Persons in the Family Unit for the remainder of that Calendar Year. Other Covered Persons in the Family Unit are not required to satisfy a Deductible for the rest of that Calendar Year. A new Deductible will apply on the first day of the next Calendar Year.</p> <p>If as a result of the same accident, covered medical expenses for two (2) or more Covered Persons are incurred, only one (1) Deductible amount will be applied against those expenses incurred by all such persons during the Calendar Year in which the accident occurs.</p>			
<b>COPAYMENT, PER CONFINEMENT/ADMISSION</b>			
Hospital (Inpatient Facility)	\$100 Copayment per Inpatient Confinement	NOT COVERED	Copayment applies per Inpatient Confinement, unless otherwise noted differently under the Plan provision.
<b>COPAYMENT</b>			
Hospital (Outpatient Hospital Facility, Ambulatory Surgical Center)	\$200 Copayment	NOT COVERED	Copayment applies per Outpatient Hospital Facility Visit, including Outpatient Same Day Surgical Facility.
Physician Office Visits	\$30 Copayment per Visit	NOT COVERED	<b>Note:</b> Copayment does not apply to Routine Care.
Specialist Office Visits	\$30 Copayment per Visit	NOT COVERED	
Initial OB/GYN Visit (Non-Routine)	\$30 Copayment Initial Visit Only	NOT COVERED	

**DC 37 LOCAL 95 HEAD START EMPLOYEES WELFARE FUND**

**EPO PLAN A**

**SCHEDULE OF MEDICAL BENEFITS**

<b>BENEFIT PROVISIONS</b>	<b>NETWORK PROVIDERS</b> (Based on negotiated rates)	<b>OUT-OF-NETWORK PROVIDERS</b>	<b>REQUIREMENTS MAXIMUM BENEFITS, LIMITATIONS OR EXCLUSIONS</b>
<b>COPAYMENT (continued)</b>			
Chiropractic/Spinal Manipulation	\$20 Copayment per Visit	NOT COVERED	
Emergency Room Visit (Facility)	\$300 Copayment per Visit	\$300 Copayment per Visit	<i>Copayment is waived if admitted</i>
Urgent Care (Non-Hospital Setting)	\$50 Copayment	NOT COVERED	Services rendered not in the Emergency Room but in an Office Setting or Urgent Care Facility. In-Network Benefits will apply for a true emergency when performed by an Out-of-Network Provider.
Allergy Diagnostic Testing and Treatment (Office Setting)	\$30 Copayment per Visit	NOT COVERED	
Allergy Diagnostic Testing and Treatment (Outpatient Facility)	\$200 Copayment per Visit	NOT COVERED	
Diagnostic Laboratory (Office Setting / Freestanding Lab Same Day)	\$30 Copayment per Visit	NOT COVERED	
Diagnostic Laboratory (Outpatient Facility)	\$200 Copayment per Visit	NOT COVERED	
Diagnostic Testing and Radiology (X-ray) (Office Setting / Freestanding Facility)	\$30 Copayment per Visit	NOT COVERED	
Diagnostic Testing and Radiology (X-ray) (Outpatient Facility)	\$200 Copayment per Visit	NOT COVERED	
Advanced Radiology (CT Scan, CTA, PET Scan, MRI, MRA) (Outpatient Hospital/Facility)	\$200 Copayment per Visit	NOT COVERED	
Outpatient Mental Disorders (Biologically based)	\$30 Copayment per Visit	NOT COVERED	
Outpatient Mental Disorders (Non-biologically based)	\$30 Copayment per Visit	NOT COVERED	
Outpatient Substance Use Disorders (Alcohol Related)	\$30 Copayment per Visit	NOT COVERED	
Inpatient Physical Rehabilitation Facility (Inpatient Services)	\$100 Copayment	NOT COVERED	

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<b>BENEFIT PROVISIONS</b>	<b>NETWORK PROVIDERS</b> <i>(Based on negotiated rates)</i>	<b>OUT-OF-NETWORK PROVIDERS</b>	<b>REQUIREMENTS MAXIMUM BENEFITS, LIMITATIONS OR EXCLUSIONS</b>
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**COPAYMENT *(continued)***

Outpatient Therapy Services such as Pulmonary, Cardiac, Radiation, Chemotherapy, Infusion <i>(Outpatient Facility)</i>	\$200 Copayment per Visit	NOT COVERED	
Outpatient Physical, Speech & Occupational Therapy <i>(Outpatient Facility)</i>	\$200 Copayment per Visit	NOT COVERED	
Outpatient Physical, Speech & Occupational Therapy <i>(Office Setting)</i>	\$30 Copayment per Visit	NOT COVERED	
Dialysis <i>(Outpatient/Home Services)</i>	\$200 Copayment per Visit	NOT COVERED	
Diabetic Education <i>(Office Setting)</i>	\$30 Copayment per Visit	NOT COVERED	
Podiatry Service <i>(Performed in the Physician's Office)</i>	\$30 Copayment per Visit	NOT COVERED	<i>Copayment applies to the Physician's Office Visit Charge only</i>
Podiatry Service <i>(Outpatient Facility)</i>	\$200 Copayment per Visit	NOT COVERED	

**COINSURANCE**

Plan's Percentage Payable	100%; 80%	NOT COVERED	
Plan Participant's Percentage Payable	0%; 20%	NOT COVERED	

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<b>MAXIMUM OUT-OF-POCKET AMOUNT, PER CALENDAR YEAR</b>			
Per Plan Participant	\$ 5,000**	NOT COVERED	See Note Below*/**
Per Family Unit	\$10,000**	NOT COVERED	See Note Below*/**
<p><b>*Note:</b> The In-Network Maximum Out-of-Pocket amount(s) include In-Network Deductible(s), Copayment(s), and the Coinsurance amount(s), if any. The In-Network Maximum amount(s) do not include Precertification Non-Compliance Penalty, Non-Covered Charge(s), or any amount(s) that exceed(s) the Maximum Allowable Charge or those that Usual and Reasonable Charges.</p> <p><b>**Note:</b> Once a Covered Person attains the Calendar Year's In-Network Maximum Out-of-Pocket amount under this Plan, this Plan will pay 100% of all eligible Covered Charges for that Covered Person for the remainder of that Plan Year. Once any number of Covered Persons in the Family Unit attains the In-Network Maximum Out-of-Pocket amount under this Plan, this Plan will pay 100% for all eligible Covered Charges for all Covered Persons in the Family Unit for the remainder of that Calendar Year</p> <p><b>*/**Note:</b> Also, for purposes of reaching the Calendar Year Maximum Out-of-Pocket amount, no one (1) Plan Participant under a Family Unit will be able to contribute more than \$5,000 in eligible covered services toward the In-Network Maximum Out-of-Pocket amount</p> <p><b>Note:</b> The Standalone Prescription Drug Plan has its own Maximum Out-of-Pocket amount(s). The Prescription Drug Copayment(s) will apply to the Prescription Drug Maximum Out-of-Pocket (Refer to the Prescriptions Drug Benefit).</p> <p>The Medical Plan's In-Network Maximum Out-of-Pocket amount(s) plus the Standalone Prescription Drug Plan's Maximum Out-of-Pocket amount(s) will not exceed the Maximum Out-of-Pocket amount(s) stipulated in accordance with the guidelines set forth by the Affordable Care Act (ACA).</p>			
This Plan will pay the designated percentage of Covered Charges until the Maximum Out-of-Pocket amount(s) are reached, at which time, this Plan will pay 100% of the remainder of Covered Charges for the rest of the Calendar Year unless stated otherwise.			
The following charges do not apply toward the Out-of-Pocket Maximum(s) and are never paid at 100%.			
Cost Management Penalties		Amounts over Usual & Reasonable Charges or the Maximum Allowable Charge	

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**PRECERTIFICATION**

<b>PRECERTIFICATION PAYMENT REDUCTION</b> for failure to pre-certify services ( <i>Refer to list of services for the appropriate payment reduction</i> )	100% Reduction in Benefits Payable	The Plan Participant is responsible for making sure that all non-emergency services, which require pre-certification, have been approved prior to having services performed. Pre-certification can be verified by contacting Customer Service.	
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Some services/procedures require prior authorization. Contact the Plan's Utilization Management team at 1.866.255.0793 for services requiring precertification as noted below:

- All Hospital Confinements, Elective and Emergent, including
  - Surgical Admissions
  - Medical Admissions
  - Hospice Admission
- All Skilled Nursing Facility (SNF) Confinements
- All Rehabilitation Facility Confinements
- All Sub-Acute Confinements
- Mental Disorders and Substance Use Disorders Confinements (*including Residential and Partial Hospitalizations.*)
- Inpatient /Outpatient Surgery, including but not limited to: cosmetic, reconstructive, nasal, varicose vein surgery.
- Outpatient Diagnostic Radiology, MRIs, MRAs, CAT Scans, PET Scans, including Nuclear Medicine/Nuclear Cardiology
  - Home Health Care
- Hospice Care
  - Renal Dialysis
  - Home IV Infusion
- Chemotherapy
  - Hyperbaric oxygen treatment MUST be precertified and Medically Necessary
  - Physical, Speech & Occupational Therapy, ABA Therapy
  - Infertility Procedures
  - Gene Testing (*Only as required under the ACA and Pre-natal*)
  - Pain Management Services
  - Durable Medical Equipment (*Cost over \$2,000 per item*)
  - Prosthetics Appliances (*Cost over \$2,000 per item*)
  - Air Ambulance
  - Specialty Pharmaceuticals under the Medical Plan
  - Human Organ Transplants
  - Notification of Maternity Care should be provided as soon as the pregnancy is known and again upon hospitalization.

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**SPECIAL PROVISIONS FOR COVERED SERVICES**

**Preferred Provider versus Non-Participating Provider Benefit Level**

Covered services rendered by a Participating Provider will be paid at the Participating Provider benefit level. Covered services rendered by a Non-Participating Provider will not be covered with the exception of a medical emergency due to an Accidental Injury or a true Medical Emergency condition. Under the following circumstances, the Participating Provider benefit payment will be made for certain Out-of-Network services:

If a Plan Participant has a Medical Emergency requiring immediate care.

If a Plan Participant received services by a Non-Participating Provider (Out-of-Network Provider) (for example, an anesthesiologist, radiologist, or pathologist, etc.) while admitted to a Participating Facility (an In-Network Facility) and while attended by a Participating Surgeon, such charges are payable at the In-Network Benefit level. However, all other limitations, requirements, and provisions of this Plan will apply. This exception does not apply in the event of any consultations and situations in which the Plan Participant (and/or the Provider selected), had the opportunity to select a Participating Provider and exercised the right to receive services from a Non-Participating Provider. Referrals by a Participating Provider to a Non-Participating Provider will not be covered unless such a service has been pre-approved in advance.

**Experimental and Investigational Treatments**

This Plan does not cover treatment that is considered experimental or investigational. Charges in connection with such a service or supply are also not covered. A service or supply will be considered experimental or investigational if it is determined that one (1) or more of the following are true:

- The service or supply is under study or in a clinical trial to evaluate its toxicity, safety, or efficacy for a particular diagnosis or setoff indications. Clinical trials include, but are not limited to, phase I, II, and III clinical trials, with the exception of approved cancer trials.
- The prevailing opinion within the appropriate specialty of the United States medical profession that the service or supply needs further evaluation for a particular diagnosis or set of indications before it is used outside clinical trials or other research settings. This determination will be based on:
  - Published reports in authoritative medical literature; and
  - Regulations, reports, publications, and evaluations issued by US government agencies such as the Agency for Health Care Research and Quality, the National Institutes of Health, and the federal Food and Drug Administration (FDA).
- The provider's institutional review board acknowledges that the use of the service or supply is experimental or investigational and subject to the board's approval.
- The providers institutional review board requires that the patient, parent, or guardian give an informed consent stating that the service or supply is experimental or investigational, part of a research project or study, or federal law requires such consent.
- Research protocols indicate that the service or supply is experimental or investigational. This item applies for protocols used by the Plan Participant/patient's provider as well as for protocols used by other providers studying substantially the same service or supply.
- The service or supply is not recognized by the prevailing opinion within the appropriate medical specialty as an effective treatment for the particular diagnosis or set of indications.
- Additionally, it is a drug, device or other supply that is subject to FDA approval. It will be considered experimental and investigational if it:
  - Does not have FDA approval for sale or use in the United States; or
  - Has FDA approval only under the Treatment Investigational New Drug regulation or similar regulation; or
  - Has FDA approval but is being used for an indication or at a dosage that is not an acceptable off-label use based on published reports in peer reviewed, authoritative medical literature and entries in the American Medical Association Drug Evaluations, the American Hospital Formulary Service Drug Information, and the United States Pharmacopeia Dispensing Information.

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<b>Preventive Care</b>			
<b>Routine Well Adult Care</b>			
Routine Well Adult Care Includes: Office Visits; Routine Gynecological Examination; Routine Physical Examination, related Diagnostic Services such as X-rays, Laboratory Blood Tests, and Immunizations/ Vaccinations.	100% of the pre- negotiated contracted rate; Calendar Year Calendar Year Deductible Waived.  Maximum Benefit Applies*  <i>(Refer to Preventive Care                      Schedule)</i>	NOT COVERED	Refer to list of Preventive Services that follows, which is subject to change in accordance with The American College of Physicians, the US Preventive Services Task Force, and the American Cancer Society.  Maximum Benefit applies In- Network. * <i>(See Above)</i>
Routine Gynecological Examination & Pap Smear	100% of the pre- negotiated contracted rate; Calendar Year Deductible Waived.  Maximum Benefit Applies*  <i>(Refer to Preventive Care                      Schedule)</i>	NOT COVERED	Limited - One (1) per Calendar Year. *  Maximum Benefit applies In- Network. *
Routine Mammography	100% of the pre- negotiated contracted rate; Calendar Year Deductible Waived.  Maximum Benefit Applies*  <i>(Refer to Preventive Care                      Schedule)</i>	NOT COVERED	One (1) baseline between ages thirty-five (35) and forty (40); one (1) per Calendar Year forty (40) and over, or more frequently if recommend by a Physician. *  Maximum Benefit applies In- Network. *
Osteoporosis Testing <i>(Bone Mineral Density                      Testing)</i>	100% of the pre- negotiated contracted rate; Calendar Year Deductible Waived.  Maximum Benefit Applies*	NOT COVERED	One (1) screening every two (2) Calendar Years beginning at age sixty-five (65). *  Maximum Benefit applies In- Network. *

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BENEFIT PROVISIONS	NETWORK PROVIDERS (Based on negotiated rates)	OUT-OF-NETWORK PROVIDERS	REQUIREMENTS MAXIMUM BENEFITS, LIMITATIONS OR EXCLUSIONS
<b>Preventive Care</b>			
<b>Routine Well Adult Care (continued)</b>			
Colorectal Cancer Screening**	100% of the pre-negotiated contracted rate; Calendar Year Deductible Waived.  Maximum Benefit Applies*  <i>(Refer to Preventive Care Schedule)</i>	NOT COVERED	Fecal Occult Blood Test - One (1) test per Calendar Year beginning at age forty (40). *  Maximum Benefit applies In-Network.*
Routine Colorectal Cancer Screening**	100% of the pre-negotiated contracted rate; Calendar Year Deductible Waived.  Maximum Benefit Applies*  <i>(Refer to Preventive Care Schedule)</i>	NOT COVERED	Limited to: Colorectal cancer screening rendered at regular intervals for (a) Plan Participant age forty-five (45) or over; and (b) age forty (45) or sooner for Plan Participants of any age who are deemed to be at average to high risk for this type of cancer or such services are prescribed by a Physician. * <i>(Refer to Note below)</i>  Maximum Benefit applies both In-Network. *
<p><b>**Note: In-Network</b> – Covered tests include: a screening fecal occult blood test; flexible sigmoidoscopy; colonoscopy; barium enema; any combination of these tests; or the most reliable, medically recognized screening test available. For the purposes of this part, “high risk for colorectal cancer” means that a Plan Participant has: (a) a family history of; familial adenomatous polyposis; hereditary non-polyposis colon cancer; or breast, ovarian, endometrial, or colon cancer or polyps; (b) Chronic inflammatory bowel disease; or (c) a background, ethnicity, or lifestyle that the Plan Participant’s Physician believes puts the Plan Participant at elevated risk for colorectal cancer.</p> <p><b>The method and frequency of screening shall be:</b> (a) in accordance with the most recent published guidelines of the American Cancer Society; and (b) as deemed to be medically necessary and appropriate by the Plan Participant’s Physician, in consultation with the Plan Participant.</p>			
Routine Prostate Diagnostic Screening Exam** <i>(includes digital rectal examination and prostate specific antigen test)</i>	100% of the pre-negotiated contracted rate; Calendar Year Deductible Waived.  Maximum Benefit Applies*  <i>(Refer to Preventive Care Schedule)</i>	NOT COVERED	Routine Prostate Screening - One (1) test per Calendar Year beginning at age fifty (50); beginning at age forty (40) for men with a family history of prostate cancer or other prostate cancer risk factors. *  The Maximum Benefit applies In-Network. *
<p><b>**Note: In-Network</b> – Benefits are provided for an annual medically recognized diagnostic exam, including, but not limited to: (a) a digital rectal exam; and (b) a prostate-specific antigen test, for male Plan Participants age fifty (50) or over who are asymptomatic; and male Plan Participants age forty (40) and over with a family history of prostate cancer or other prostate cancer risk factors.</p>			

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<b>Preventive Care</b>			
<b>Routine Well Adult Care (continued)</b>			
Routine Prostate Diagnostic Screening Exam** (includes digital rectal examination and prostate specific antigen test)	100% of the pre-negotiated contracted rate; Calendar Year Deductible Waived.  Maximum Benefit Applies*  (Refer to Preventive Care Schedule)	NOT COVERED	Routine Prostate Screening - One (1) test per Calendar Year beginning at age fifty (50); beginning at age forty (40) for men with a family history of prostate cancer or other prostate cancer risk factors. *  The Maximum Benefit applies In-Network. *
<b>**Note: In-Network</b> – Benefits are provided for an annual medically recognized diagnostic exam, including, but not limited to: (a) a digital rectal exam; and (b) a prostate-specific antigen test, for male Plan Participants age fifty (50) or over who are asymptomatic; and male Plan Participants age forty (40) and over with a family history of prostate cancer or other prostate cancer risk factors.			
Routine Vision Screening (Dependent Child under the guidelines of the ACA)	100% of the pre-negotiated contracted rate; Calendar Year Deductible Waived.	NOT COVERED	This is a non-refractive Vision Exam under the Medical Plan for a Dependent Child under the guidelines of the ACA.
Routine Glaucoma Screening	100% of the pre-negotiated contracted rate; Calendar Year Deductible Waived.  Maximum Benefit Applies*	NOT COVERED	Routine Screening for Glaucoma - One (1) test every five (5) Calendar Years beginning at age thirty-five (35). *  The Maximum Benefit applies In-Network. *

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**Preventive Care**

**Routine Child Care**

<p>Routine Baby Care** <i>(Birth through one (1) year of age)</i></p> <p>Includes: Office Visits, Routine Physical Examination, Laboratory Blood Tests and X-rays.</p>	<p>100% of the pre-negotiated contracted rate; Calendar Year Deductible Waived.</p> <p>Maximum Benefit Applies*</p> <p><i>(Refer to Preventive Care Schedule)</i></p>	NOT COVERED	<p>Refer to list of Preventive Services that follows, which is subject to change in accordance with the American Academy of Pediatrics, The American College of Physicians, the US Preventive Services Task Force.</p> <p>Unlimited In-Network or In-Network but age and frequency limits may apply. *</p>
<p>Routine Child Care** <i>(One (1) year of age and older)</i></p> <p>Includes: Office Visits, Routine Physical Examination, Laboratory Blood Tests and X-rays.</p>	<p>100% of the pre-negotiated contracted rate; Calendar Year Deductible Waived.</p> <p>Maximum Benefit Applies*</p> <p><i>(Refer to Preventive Care Schedule)</i></p>	NOT COVERED	<p>Refer to list of Preventive Services that follows, which is subject to change in accordance with the American Academy of Pediatrics, The American College of Physicians, the US Preventive Services Task Force.</p> <p>Unlimited In-Network or In-Network but age and frequency limits may apply. *</p>

**\*\*Note: In-Network** - Third party requests for physical examinations, diagnostic services, and immunizations in connection with: (a) obtaining insurance coverage; (b) foreign travel; (c) research studies; (d) education or experimentation; mandatory consultations required by Hospital regulations are not covered under this Plan.

<p>Pediatric Immunizations and Vaccinations**</p>	<p>100% of the pre-negotiated contracted rate; Calendar Year Deductible Waived.</p> <p>Maximum Benefit Applies*</p> <p><i>(Refer to Preventive Care Schedule)</i></p>	NOT COVERED	<p>Benefits limited to Plan Participants in accordance with the ACA Preventive Care guidelines. *</p>
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**\*\*Note: In-Network** - Childhood immunizations recommended by and approved by the Advisory Committee on Immunization Practices (<http://www.cdc.gov/vaccines/acip>), the American Academy of Pediatrics (<http://www.aap.org>), the American Academy of Family Physicians (<http://www.aafp.org>), and the American College of Obstetricians and Gynecologists (<http://www.acog.org>).

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<b>Preventive Care</b>			
<b>Routine Well Child Care (continued)</b>			
Lead Poisoning Screening and Treatment**	100% of the pre-negotiated contracted rate; Calendar Year Deductible Waived.	NOT COVERED	
* <b>Note: In-Network</b> - Screening by blood lead measurement for lead poisoning for children, including confirmatory blood test must be conducted as specified by the Department of Health. Medical evaluation and any necessary follow-up and treatment for lead-poisoning children are also covered.			
Newborn & Infant Screening for Hearing Loss – In or Outpatient Hospital**	100% of the pre-negotiated contracted rate; Calendar Year Deductible Waived.	NOT COVERED	Newborn Hearing Screening – Electrophysiological Screening Measures for an infant twenty-nine (29) to thirty-six (36) months old; or newborn from birth to twenty-eight (28) days old. *
Newborn & Infant Screening for Hearing Loss – Physician/ Specialist Office**	100% of the pre-negotiated contracted rate; Calendar Year Deductible Waived.	NOT COVERED	Newborn Hearing Screening – Electrophysiological Screening Measures for an infant twenty-nine (29) to thirty-six (36) months old; or newborn from birth to twenty-eight (28) days old. *
** <b>Note: In-Network</b> – Benefits are provided for newborn screening. Electrophysiological screening measures” means the electrical result of the application of physiologic agents. This includes but is not limited to: (a) the procedures currently known as Auditory Brainstem Response testing (ABR); and Otoacoustic Emissions testing (OAE); and (b) any other procedure adopted.			
Routine Vision Screening (Dependent Child)	100% of the pre-negotiated contracted rate; Calendar Year Deductible Waived.	NOT COVERED	This is a non-refractive Vision Exam under the Medical Plan. Refer to the Vision Benefit for vision provisions.

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**PREVENTIVE CARE SERVICES**

This list of Preventive Services that follows is subject to change in accordance with The American College of Physicians, the US Preventive Services Task Force, the American Cancer Society and the recommended Preventive Services under the Patient Protection and Affordable Care Act.

**Schedule of Preventive Care**

- Routine Child Care including Well Baby Visits – Routine Pediatric Care and Pediatric Immunizations in accordance with the American Academy of Pediatrics. Unlimited coverage is provided for a Dependent child from birth through age twelve (12) years of age; Unlimited, but in accordance with the frequency schedule, for all through to adulthood, including immunizations.
- Lead Poisoning Screening & Testing.
- Newborn & Infant Screening for Hearing Loss – In or Outpatient Hospital, or Physician’s Office - Newborn Hearing Screening – Electrophysiological Screening Measures for an infant twenty-nine (29) days to thirty-six (36) months old; or newborn from birth to twenty-eight (28) days old. “Electrophysiologic screening measures” means the electrical result of the application of physiologic agents. This includes but is not limited to: (a) the procedures currently known as Auditory Brainstem Response testing (ABR); and Otoacoustic Emissions testing (OAE); and (b) any other procedure adopted.
- Routine Gynecological Examination – One (1) per Calendar Year.
- Routine Pap Smear – One (1) per Calendar Year.
- Routine Mammography - One (1) baseline mammography for women thirty-five (35) years of age or older; All women forty (40) years of age or older a mammography annually, or at any age for women at risk, when recommended by a Physician.
- Routine Adult Physical Examination - Limited for Plan Participant to One (1) Routine Physical Examination per Calendar Year Preventive Care services include related X-ray, Laboratory and Diagnostic Tests.
- Health Wellness Tests - One (1) Exam annually beginning at age twenty (20) to include, but not limited to: Routine Urinalysis & Routine Blood Test - annual tests to determine blood hemoglobin, blood pressure, blood glucose level, and blood cholesterol or alternatively, low density lipoprotein (LDL) level and blood high-density (HDL) level.
- Recommended Adult Immunizations and Vaccines are covered.
- Routine Vision Screening – Refer to the Vision Benefit Provisions for services that are considered refractive in nature.
- Routine Screening for Glaucoma - One (1) test every five (5) Years beginning at age thirty-five (35) years of age or older.
- Stool Exam – Plan Participants forty (40) years of age or older and annual stool examination for the presence of blood.
- Routine Colon Exam /Colorectal Screening/Colonoscopy – Colorectal cancer screening & other diagnostic services such as a colonoscopy rendered at regular intervals for (a) Plan Participants age forty-five (45) or over with average risk and no personal or family history of colorectal cancer; and (b) Plan Participant age forty-five (45) or sooner for a Plan Participant of any age who is deemed to be at average to high risk for this type of cancer or such services are prescribed by a Physician. (Refer to specific preventive benefit)
- Routine Prostate Screening - Annual digital examination and prostate antigen test beginning at age forty (40) with family history of prostate cancer; age fifty (50) and over who are asymptomatic.
- All Plan Participants twenty (20) years of age and older - Consultations with a Physician to discuss lifestyle behaviors that promote health and well-being, such as, but not limited to: coronary artery disease, heart failure management, smoking control, nutrition and diet recommendations for diabetes, exercise plans, lower back protection, weight control, immunization practices, breast self-examination and testicular self-examination and seat belt usage in motor vehicles.

**Note:** Other preventive care /wellness tests and frequency schedules will be covered upon the recommendation of a Physician.

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**Pre-Admission X-ray & Laboratory Services**

Pre-Admission and Pre-Surgical Testing, within seven (7) days of a scheduled Inpatient Hospital Admission ( <i>Outpatient Facility</i> )	\$200 Copayment; then 80% of the pre-negotiated contracted rate after the Calendar Year Deductible.	NOT COVERED	
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**Hospital Services, Specialized Treatment Facilities and Services**

Hospital Room and Board; Intensive Care Unit ICU, CCU, BCU, NCU Room & Board and Hospital Ancillary Services including General Nursing Care, Medications, Operating Room & Related Services, Oxygen Services, Diagnostic Laboratory & X-ray Services, and any other services performed while confined Inpatient. ** ( <i>Facility</i> )	\$100 Inpatient per Confinement Copayment; then 80% of the pre-negotiated contracted rate after the Calendar Year Deductible.  Maximum Benefits Apply*	NOT COVERED	Limited to semi-private room rate*  Precertification Required - This Plan's payment may be reduced if the requirements under the Cost Management Section of this Plan are not followed. ( <i>Refer to this section for additional information</i> )  This payment reduction does not apply to the satisfaction of the Out-of-Pocket Maximum.  Three hundred sixty-five (365) Day/Visit In-Network Maximum Benefit per Calendar Year. *
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**\*\*Note: In-Network** – This Plan will cover a private room charge if a Plan Participant is required to be confined to a private room due to a highly contagious condition or is at a greater risk of contracting an infectious disease because of the Plan Participant's medical condition. If a Plan Participant, otherwise, elects a private room, the Plan Participant will be responsible for paying the difference between the semi-privates and private room rates in addition to any Copayment or Coinsurance (if any).

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**SCHEDULE OF MEDICAL BENEFITS**

BENEFIT PROVISIONS	NETWORK PROVIDERS (Based on negotiated rates)	OUT-OF-NETWORK PROVIDERS	REQUIREMENTS MAXIMUM BENEFITS, LIMITATIONS OR EXCLUSIONS
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**Hospital Services, Specialized Treatment Facilities and Services (continued)**

Inpatient Newborn Care	\$100 Inpatient per Confinement Copayment; then 80% of the pre-negotiated contracted rate after the Calendar Year Deductible.	NOT COVERED	<i>(Refer to Inpatient Hospital Provisions)</i>
Inpatient Maternity  Maternity/Pregnancy for a Dependent child is not covered. <i>(Refer to Inpatient Maternity)</i>	\$100 Inpatient per Confinement Copayment; then 80% of the pre-negotiated contracted rate after the Calendar Year Deductible.	NOT COVERED	Inpatient Maternity Care provided for a minimum of forty-eight (48) hours following a vaginal delivery; a minimum of ninety-six (96) hours for a cesarean delivery. This applies to both mother and child.  Prior notification / Pre-certification Required within forty-eight (48) hours of or next business day after admission.  This Plan's payment may be reduced if the requirements under the Cost Management Section of this Plan are not followed. <i>(Refer to this section for additional information)</i>  This payment reduction does not apply to the satisfaction of the Out-of-Pocket Maximum.

**\*\*Note: In-Network** - Coverage is provided for a minimum inpatient stay of forty-eight (48) hours following a vaginal delivery and ninety-six (96) hours following a cesarean delivery for both the covered mother and the newly born child or children. During the initial Hospital stay, services and supplies provided to the mother and newborn child will be covered as part of the obstetrical care benefits. However, if the child's care is given by a different Physician from the one who provided the mother's obstetrical care, the child's care will be covered separately.

Maternity care includes parent education, assistance, and training in breast or bottle feeding and the performance of any necessary maternal and newborn clinical assessments. If the covered mother decides to leave the Hospital early, one (1) home visit will be provided. The visit must be requested within forty-eight (48) hours of a vaginal birth or within ninety-six (96) hours of a cesarean birth. The visit must occur within twenty-four (24) hours of the later of: (a) the mother's request; or (b) discharge from the Hospital.

A home visit consists of a visit by a professional RN to provide the following post-delivery care: (a) assessment of the mother and child(ren); (b) instruction on breast feeding; (c) cleaning and care for the child(ren); and (d) any required blood tests ordered by the Plan Participant's (mother or child(ren)) Physician.

Maternity related Diagnostic Tests, such as ultrasounds fetal screenings and fetal monitor procedures for genetic and/or chromosomal status of the fetus are covered. Coverage is provided for one (1) genetic test.

Benefits for a covered Dependent child for obstetrical care (pregnancy) are not covered. Interruption of a Dependent child's pregnancy is not covered.

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<b>BENEFIT PROVISIONS</b>	<b>NETWORK PROVIDERS</b> (Based on negotiated rates)	<b>OUT-OF-NETWORK PROVIDERS</b>	<b>REQUIREMENTS MAXIMUM BENEFITS, LIMITATIONS OR EXCLUSIONS</b>
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**Hospital Services, Specialized Treatment Facilities and Services (continued)**

<p>Birthing Center (Facility)</p> <p><i>(Refer to Inpatient Maternity)</i></p> <p>Maternity/Pregnancy for a Dependent child is not covered. <i>(Refer to Inpatient Maternity)</i></p>	<p>\$100 Inpatient per Confinement Copayment; then 80% of the pre-negotiated contracted rate after the Calendar Year Deductible.</p>	<p>NOT COVERED</p>	<p>Precertification Required</p> <p>Prior notification / Pre-certification Required within forty-eight (48) hours of or next business day after admission.</p> <p>This Plan's payment may be reduced if the requirements under the Cost Management Section of this Plan are not followed. <i>(Refer to this section for additional information)</i></p> <p>This payment reduction does not apply to the satisfaction of the Out-of-Pocket Maximum.</p>
<p>Skilled Nursing Facility, Extended Care Facility and Rehabilitation Facility**</p>	<p>80% of the pre-negotiated contracted rate after the Calendar Year Deductible</p> <p>Maximum Benefits Apply*</p>	<p>NOT COVERED</p>	<p>Precertification Required.</p> <p>This Plan's payment may be reduced if the requirements under the Cost Management Section of this Plan are not followed. <i>(Refer to this section for additional information)</i></p> <p>This payment reduction does not apply to the satisfaction of the Out-of-Pocket Maximum.</p> <p>One hundred (100) Day Maximum Benefit In-Network; per Calendar Year. *</p>

**\*\*Note: In-Network** - Room and Board limited to Facility's semi-private room rate (or an allowance equal to this rate that may be applied to the cost of private accommodations).

A Skilled Nursing Facility is a place other than a Hospital that can provide permanent full-time care for resident patients, has a Physician available at all times or on full-time duty in charge of patient care, has one (1) or more RNs or LPNs on duty at all times, and keeps daily medical records for each patient. The facility is not meant for custodial care that is provided for the primary purpose of assisting an individual in meeting the basic activities of daily living.

The following is not covered: Private or special duty nursing; custodial care, convalescent care, domiciliary care, long-term care, maintenance care, adult day care or rest cures. Room and board, nursing care, or personal care is not covered when the Plan Participant has reached the maximum level of physical or mental function possible and will not make any further significant clinical improvement. Rehabilitative services and physical therapy on a long-term basis is not covered.

This Plan covers Inpatient treatment in a Physical Rehabilitation Center. Inpatient treatment will include the same services and supplies available to any other Facility Inpatient.

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<b>BENEFIT PROVISIONS</b>	<b>NETWORK PROVIDERS</b> (Based on negotiated rates)	<b>OUT-OF-NETWORK PROVIDERS</b>	<b>REQUIREMENTS MAXIMUM BENEFITS, LIMITATIONS OR EXCLUSIONS</b>
<b>Outpatient Hospital</b>			
Outpatient Hospital <i>(All Services performed in the Outpatient Hospital Facility and billed by the Hospital) (Facility)</i>	\$200 Outpatient Copayment; then 80% of the pre-negotiated contracted rate after the Calendar Year Deductible.	NOT COVERED	
Ambulatory Surgical Center <i>(Outpatient Hospital or Freestanding Independent Surgical Center)</i>	\$200 Outpatient Copayment; then 80% of the pre-negotiated contracted rate after the Calendar Year Deductible.	NOT COVERED	<p>Precertification Required</p> <p>This Plan's payment may be reduced if the requirements under the Cost Management Section of this Plan are not followed. <i>(Refer to this section for additional information)</i></p> <p>This payment reduction does not apply to the satisfaction of the Out-of-Pocket Maximum.</p>
<b>Outpatient Hospital &amp; Emergency Care</b>			
Hospital Emergency Room** <i>(Facility &amp; Professional Services)</i>	\$300 Copayment, then 80% after the Calendar Year Deductible for a true emergency.  <i>Refer to Plan Provisions if admitted</i>	\$300 Copayment, then 80% after the Calendar Year Deductible for a true emergency; otherwise not covered.	<p>Precertification Required if Admitted</p> <p>Use of the Emergency Room for services that are necessary due to an Accidental Injury or serious Medical Condition <i>(A life-or-limb-threatening condition)</i>. **</p>
<p><b>**Note: In-Network</b> - A Medical Emergency is as follows: A medical condition manifesting itself by acute symptoms of sufficient severity, including but not limited to: severe pain, psychiatric disturbance, and/or symptoms of substance abuse that absence of immediate attention could reasonably be expected to result in: (a) placing the health of the Plan Participant in serious jeopardy. (In the case of a pregnancy, the health of the mother or unborn child.); (b) serious impairment to bodily functions; (c) serious dysfunction of a bodily organ or part; or (d) serious disfigurement of the Plan Participant. Medical Emergencies include but are not limited to severe chest pains; severe shortness of breath; severe or multiple injuries, excessive bleeding; broken bones; serious burns; poisoning; unconsciousness; convulsions or choking. <i>Copayment, if any, waived if admitted.</i></p>			
Hospital Emergency Room <i>(Facility &amp; Professional Services - Non-emergency)</i>	NOT COVERED	NOT COVERED	Use of the Emergency Room for services that are NOT an Accidental Injury or serious Medical Condition

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<b>Emergency Care</b>			
Urgent Care** <i>(Non-Hospital Urgent Care Facility or Outpatient Facility)</i>	\$50 Copayment; then 80% of the pre-negotiated contracted rate after the Calendar Year Deductible.	NOT COVERED	Urgent Care is Medically Necessary Services including a Medical Evaluation in order to treat a Medical Condition or an Accidental Injury that requires care within twenty-four (24) hours and is considered a true emergency.
<p><b>**Note: In-Network</b> - Urgent care refers to medical care for an Accidental Injury or a serious Medical Condition that needs immediate attention to minimize severity and prevent complications. If an Urgent Care visit results in a Hospital admission, refer to the Inpatient Hospital provisions. If Urgent Care is considered a true emergency, then covered eligible expenses provided by an Out-of-Network provider will be considered payable under the In-Network benefit provisions. <i>Copayment, if any, waived if admitted.</i></p>			
<b>Ambulance Service</b>			
Ambulance Service** <i>(When Medically Necessary)</i>  <i>(Services provided and billed by the Hospital or Independent Provider)</i>	80% of the pre-negotiated contracted rate after the Calendar Year Deductible	NOT COVERED	Professional land (ground) or pre-approved air transportation or non-emergency transportation to a Facility for medical intervention or stabilization when Medically Necessary treatment is required due to a non-serious or non-life-threatening Medical Condition.
Ambulance Service** <i>(When Medically Necessary and due to a true emergency)</i>  <i>(Services provided and billed by the Hospital or Independent Provider)</i>	80% of the pre-negotiated contracted rate after the Calendar Year Deductible	NOT COVERED	Professional land (ground) or pre-approved air transportation or non-emergency transportation to a Facility for medical intervention or stabilization when Medically Necessary treatment is required due to a serious or life-threatening Medical Condition.
<p><b>**Note: In-Network</b> - This Plan provides coverage for transporting a Plan Participant to: (a) a local Hospital, if it can provide the needed care and treatment; (b) the nearest Hospital that can furnish the needed care and treatment, if: (1) a local Hospital cannot provide the care; and (2) the Plan Participant is admitted as an Inpatient; or (c) another Inpatient Facility when Medically Necessary and appropriate. Note, prior approval is required for air ambulance transportation or non-emergency transportation.</p>			
<p>This Plan does not cover chartered air flights, non-emergency air ambulance, invalid coach, transportation services, or other travel, lodging, or communication expenses of a patient, a family member, provider, or nurse.</p>			
<b>Diagnostic Testing, X-rays, Laboratory &amp; Pathology Services (Services performed in the Outpatient Hospital)</b>			
Outpatient Diagnostic Testing, X-ray, Laboratory & Pathology <i>(Outpatient Hospital Facility)</i>	\$200 Outpatient Copayment; then 80% of the pre-negotiated contracted rate after the Calendar Year Deductible.	NOT COVERED	

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<b>Diagnostic Testing, Radiology (X-rays), Laboratory &amp; Pathology Services (Services performed at an Independent Freestanding Facility or Physician's Office)</b>			
Outpatient Diagnostic Testing, X-ray, Laboratory & Pathology <i>(Independent Facility)</i>	\$30 Copayment; after the Deductible; pre-negotiated contracted rates apply; Coinsurance Waived.	NOT COVERED	
Outpatient Diagnostic Testing, X-ray, Laboratory & Pathology <i>(Physician's Office)</i>	\$30 Copayment; after the Deductible; pre-negotiated contracted rates apply; Coinsurance Waived.	NOT COVERED	
<b>Diagnostic, Therapeutic &amp; Nuclear Radiology Services (Services performed in the Inpatient or Outpatient Hospital, an Independent Facility or Physician's Office &amp; related Professional Services)</b>			
Diagnostic Radiation, Radiology & Therapeutic X-ray <i>(Inpatient,)</i>	80% of the pre-negotiated contracted rate after the Calendar Year Deductible	NOT COVERED	Inpatient Copayment applies to the Inpatient Confinement
Diagnostic Radiation, Radiology & Therapeutic X-ray <i>(Outpatient Facility / Professional Services)</i>	\$200 Outpatient Copayment; then 80% of the pre-negotiated contracted rates after the Calendar Year Deductible.	NOT COVERED	
Diagnostic Radiation, Radiology & Therapeutic X-ray <i>(Physician's Office)</i>	\$30 Copayment; after the Deductible; pre-negotiated contracted rates apply; Coinsurance Waived.	NOT COVERED	
Advanced Radiology & Imaging: MRIs, MRAs, CAT Scans PET Scans & Nuclear Testing <i>(Inpatient)</i>	80% of the pre-negotiated contracted rate after the Calendar Year Deductible	NOT COVERED	
Advanced Radiology & Imaging: MRIs, MRAs, CAT Scans PET Scans & Nuclear Testing <i>Outpatient Facility, &amp; Professional Services)</i>	\$200 Outpatient Copayment; then 80% of the pre-negotiated contracted rate after the Calendar Year Deductible	NOT COVERED	
Advanced Radiology & Imaging: MRIs, MRAs, CAT Scans PET Scans & Nuclear Testing <i>(Physician's Office)</i>	\$30 Copayment; after the Deductible; pre-negotiated contracted rates apply; Coinsurance Waived.	NOT COVERED	

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<b>Outpatient Therapy Services (Services performed in the Outpatient Hospital/Facility)</b>			
Chemotherapy (Outpatient Hospital/Facility)	\$200 Outpatient Copayment; then 80% of the pre-negotiated contracted rate after the Calendar Year Deductible	NOT COVERED	
Inhalation Therapy (Outpatient Hospital/Facility)	\$200 Outpatient Copayment; then 80% of the pre-negotiated contracted rate after the Calendar Year Deductible	NOT COVERED	
Infusion Therapy** (Outpatient Hospital/Facility)	\$200 Outpatient Copayment; then 80% of the pre-negotiated contracted rate after the Calendar Year Deductible	NOT COVERED	
<p><b>**Note: In-Network</b> – Infusion Therapy is the administration of antibiotic, nutrient, or other therapeutic agents by direct infusion into the vein, and parenteral administration of medication and nutrients. Infusion services also include enteral nutrition, which is the delivery of nutrients by tube into the gastrointestinal tract. These services include the coverage of all medications administered intravenously and/or parenterally.</p>			
<b>Physician Professional Services</b>			
Inpatient Physician Visits/Consultations	80% of the pre-negotiated contracted rate after the Calendar Year Deductible	NOT COVERED	
Inpatient Physician Professional Services	80% of the pre-negotiated contracted rate after the Calendar Year Deductible	NOT COVERED	
Inpatient or Outpatient Surgery** (Includes Surgeon and Anesthesiologist) (Outpatient Copayment applies to the Facility Charge)	80% of the pre-negotiated contracted rate after the Calendar Year Deductible	NOT COVERED	<p>Precertification Required</p> <p>This Plan’s payment may be reduced if the requirements under the Cost Management Section of this Plan are not followed. (Refer to this section for additional information)</p> <p>This payment reduction does not apply to the satisfaction of the Out-of-Pocket Maximum.</p>

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<b>Physician Professional Services (continued)</b>			
Inpatient or Outpatient Assistant Surgeon**	80% of the pre-negotiated contracted rate after the Calendar Year Deductible	NOT COVERED	
**Note: In-Network – The maximum amount payable will be limited to charges made by an Assistant Surgeon that do not exceed twenty (20) percent of the Surgeon’s allowable charge. (For purposes of this limitation, allowable charge means the amount payable to the Surgeon prior to any reductions due to coinsurance or deductible amounts).			
Physician Office Visit	\$30 Copayment; after the Deductible; pre-negotiated contracted rates apply; Coinsurance Waived.	NOT COVERED	
Specialist Office Visit	\$30 Copayment; after the Deductible; pre-negotiated contracted rates apply; Coinsurance Waived.	NOT COVERED	
Allergy Consultation	\$30 Copayment; after the Deductible; pre-negotiated contracted rates apply; Coinsurance Waived.	NOT COVERED	
Allergy Testing (Services performed by a Network Laboratory or in the Physician’s Office)	\$30 Copayment; after the Deductible; pre-negotiated contracted rates apply; Coinsurance Waived.	NOT COVERED	
Allergy Testing (Services performed-Outpatient Facility)	\$200 Outpatient Copayment; then 80% of the pre-negotiated contracted rate after the Calendar Year Deductible.	NOT COVERED	
Allergy Treatment/Injections	\$30 Copayment; after the Deductible; pre-negotiated contracted rates apply; Coinsurance Waived.	NOT COVERED	
Surgery (Performed in the Physician’s or Specialist’s Office)	\$30 Copayment; after the Deductible; pre-negotiated contracted rates apply; Coinsurance Waived.	NOT COVERED	
Surgery (Performed in an Outpatient Facility) (Outpatient Copayment applies to the Facility Charge)	80% of the pre-negotiated contracted rate after the Calendar Year Deductible	NOT COVERED	

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BENEFIT PROVISIONS	NETWORK PROVIDERS (Based on negotiated rates)	OUT-OF-NETWORK PROVIDERS	REQUIREMENTS MAXIMUM BENEFITS, LIMITATIONS OR EXCLUSIONS
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**Physician Professional Services (continued)**

Physician Services via Telemedicine	\$30 Copayment; after the Deductible; pre-negotiated contracted rates apply; Coinsurance Waived.	NOT COVERED	<b>You've got Teladoc Health Talk to a doctor anytime, anywhere by phone or video.</b> Visit Teladoc.com Call 1-800-TELADOC (800-835-2362) Right click below to register <a href="https://www.teladochealth.com">https://www.teladochealth.com</a>
Maternity/Pregnancy OB/GYN ( <i>Non-Routine Services</i> )  <i>Maternity/Pregnancy for a Dependent child is not covered.</i>	\$30 Copayment; after the Deductible; pre-negotiated contracted rates apply; Coinsurance Waived.	NOT COVERED	
Maternity/Pregnancy Professional Services** ( <i>Pre-Natal, Post-Natal, Delivery and Follow-up Care</i> )  <i>Maternity/Pregnancy for a Dependent child is not covered.</i>	80% of the pre-negotiated contracted rate after the Calendar Year Deductible	NOT COVERED	Maternity related Diagnostic Tests, such as ultrasounds, fetal screening, and fetal monitor procedures for genetic and/or chromosomal status of the fetus are covered.

**\*\*Note: In-Network** - Coverage is provided for a minimum inpatient stay of forty-eight (48) hours following a vaginal delivery and ninety-six (96) hours following a cesarean delivery for both the covered mother and the newly born child or children. During the initial Hospital stay, services and supplies provided to the mother and newborn child will be covered as part of the obstetrical care benefits. However, if the child's care is given by a different Physician from the one who provided the mother's obstetrical care, the child's care will be covered separately.

Maternity care includes parent education, assistance, and training in breast or bottle feeding and the performance of any necessary maternal and newborn clinical assessments. If the covered mother decides to leave the Hospital early, one (1) home visit will be provided. The visit must be requested within forty-eight (48) hours of a vaginal birth or within ninety-six (96) hours of a cesarean birth. The visit must occur within twenty-four (24) hours of the later of: (a) the mother's request; or (b) discharge from the Hospital.

A home visit consists of a visit by a professional RN to provide the following post-delivery care: (a) assessment of the mother and child(ren); (b) instruction on breast feeding; (c) cleaning and care for the child(ren); and (d) any required blood tests ordered by the Plan Participant's (mother or child(ren)) Physician.

Coverage is provided for one (1) genetic test during the prenatal care.

Benefits for a Dependent child for pregnancy and maternity services are not covered under this Plan.

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**Réhabilitation / Rehabilitative Services versus Habilitation / Habilitative Services.**

**Rehabilitation / Rehabilitative Services**

Rehabilitation refers to skilled health care services that help a Plan Participant keep, restore, or improve skills and functioning for daily living and skills related to communication that have been lost or impaired because a person was sick, injured or disabled. These services include physical therapy, occupational therapy, speech-language pathology, and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

Rehabilitative services, including devices, are provided to help a Plan Participant regain, maintain, or prevent deterioration of a *skill or function that has been acquired but then lost or impaired* due to an illness, injury or disabling condition.

**Habilitation / Habilitative Services**

Habilitation refers to skilled health care services that help a Plan Participant acquire, keep, or improve, partially or fully, and at different points of life, skills related to communication and activities of daily living. These services address the competencies and abilities needed for optimal functioning in interaction with their environments. Examples include therapy for a child who isn't walking or talking at the expected age. Adults, particularly those with intellectual disabilities or disorders such as cerebral palsy, can also benefit from habilitation services. Habilitative services include physical therapy, occupational therapy, speech-language pathology, audiology and other services people with disabilities in a variety of inpatient and/or outpatient settings. Habilitative services are skilled when all of the following are true: (a) the services are part of a prescribed plan of treatment or maintenance program that is Medically Necessary to maintain the Plan Participant's current condition or prevent or slow further decline. (b) It is not delivered for the purpose of assisting in activities of daily living, such as dressing, feeding, bathing, or transferring from a bed to a chair. (c) It is not Custodial Care. Therapies provided for the purpose of general well-being or a condition in the absence of a disabling condition is not considered habilitative services.

Habilitative services, including devices, are provided for a Plan Participant to attain, maintain, or prevent deterioration of a *skill or function never learned or acquired* due to a disabling condition.

A rehabilitative or habilitative covered service or item is Medically Necessary, if it will do, or is reasonably expected to do one or more of the following: (a) arrive at a correct diagnosis; (b) prevent the onset or deterioration of an illness, injury, condition, secondary conditions comorbidities, disability, or participation restriction. (c) reduce correct, or ameliorate the physical, mental, developmental, or behavioral effects of an illness, injury, condition, or disability; (d) assist the Plan Participant to achieve sufficient functional capacity through rehabilitation or habilitation to perform appropriate daily activities and communicate effectively; (e) assist care givers through training and support to achieve the aforementioned objectives.

The determination of Medical Necessity should take in consideration regarding health, functional performance and the Plan Participant's interaction with their environment as provided by the following: (a) the Plan Participant (as appropriate to his or her age and communicative abilities); (b) the Plan Participant's family; (c) the primary care Physician, and consultants with appropriate specialty training, as well as other providers, programs, multidisciplinary teams, educational institutions or agencies that have evaluated the Plan Participant.

The determination of Medical Necessity should be made on an individual basis and should consider: (a) the functional capacity of the Plan Participant and those capacities that are appropriate for persons of the same age or developmental level; (b) the long term cost to the Plan Participant, the Plan Participant's family, and the community that may result from not providing such service or item; (c) available research finding regarding the effectiveness, evidenced based practice, health care practice guidelines, and standards issued by professionally recognized organizations or government agencies.

The determination of Medical Necessity may include consideration of whether there is an equally effective and safe, but less costly, alternative to the recommended treatment.

Medically Necessary services may be delivered in a setting that is appropriate to the specific health, rehabilitation and habilitation needs of the Plan Participant.

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<b>Outpatient Short Term Rehabilitation - Includes Cardiac Rehab, Physical Therapy, Speech Therapy, Occupational Therapy, Pulmonary Therapy &amp; Chiropractic Therapy</b>			
Alternative Care – Chiropractic Therapy - Spinal Manipulation** <i>(Chiropractic)</i>  <i>Considered Outpatient Short-Term Rehabilitative Therapy</i>	\$30 Copayment after the Deductible; pre-negotiated contracted rates apply, Coinsurance Waived. Maximum Benefits Applies*	NOT COVERED	Must be Medically Necessary & Treatment is limited to conditions that are subject to significant improvement within the treatment period noted above.  A Medical Review performed on a regular basis is to determine Medical Necessity and Appropriateness of Care.  Twenty (20) Visit Maximum Benefit In-Network per Calendar Year*
<b>**Note: In-Network</b> - Services include manipulation of the spine and other joints (manual medical intervention) and associated evaluation/management services, application of manual traction and soft tissue manipulation such as massage and myofascial release.			
Cardiac Rehabilitation Therapy** <i>(Outpatient Facility)</i>  <i>Considered Short-Term Rehabilitative Therapy Outpatient Facility</i>	\$200 Outpatient Copayment; then 80% of the pre-negotiated contracted rate after the Calendar Year Deductible.	NOT COVERED	Benefits are provided for these Covered Services for acute conditions when it is determined that significant improvement is expected.
Cardiac Rehabilitation Therapy** <i>(Office Setting)</i>  <i>Considered Short-Term Rehabilitative Therapy in an office Setting</i>	\$30 Copayment after the Deductible; pre-negotiated contracted rates apply, Coinsurance Waived.	NOT COVERED	A Medical Review performed on a regular basis is to determine Medical Necessity and Appropriateness of Care.
<b>**Note: In-Network</b> - Cardiac Rehabilitation is covered when in connection with myocardial infarction, coronary occlusion or coronary bypass surgery, or any other cardiac condition requiring rehabilitation. Outpatient cardiac rehabilitation is covered if a Plan Participant has: (a) an acute myocardial infarction within the preceding twelve (12) months; (b) chronic angina; or (c) had coronary bypass within the preceding six (6) months. Treatment must commence within twelve (12) weeks following cessation of other treatment for the Medical Condition.			
Rehabilitation services or therapy on a long-term basis is not covered. Therapy is not covered once a Plan Participant has reached the maximum level of physical function possible and will not make further significant clinical improvement.			
<i>Inpatient Physical Rehabilitation (Includes Physical, Speech and Occupational Therapies, Cardiac Rehabilitation, Pulmonary Rehabilitation)</i>  <i>Copayment applies to the Inpatient Confinement</i>	\$100 Inpatient per Confinement Copayment; then 80% of the pre-negotiated contracted rate after the Calendar Year Deductible	NOT COVERED	Must be Medically Necessary & Treatment is limited to conditions that are subject to significant improvement within the treatment period noted above.  A Medical Review performed on a regular basis is to determine Medical Necessity and Appropriateness of Care.

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**SCHEDULE OF MEDICAL BENEFITS**

<b>BENEFIT PROVISIONS</b>	<b>NETWORK PROVIDERS</b> (Based on negotiated rates)	<b>OUT-OF-NETWORK PROVIDERS</b>	<b>REQUIREMENTS MAXIMUM BENEFITS, LIMITATIONS OR EXCLUSIONS</b>
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**Outpatient Short Term Rehabilitation (continued)**

Occupational Therapy** (Outpatient Facility)  <i>Considered Short-Term Rehabilitative Therapy for Mental Health Disorders, Substance Use Disorders, Developmental Disabilities and includes ABA Therapy if applicable.</i>	\$200 Outpatient Copayment; then 80% of the pre-negotiated contracted rate after the Calendar Year Deductible.	NOT COVERED	Benefits are provided for these Covered Services for acute conditions when it is determined that significant improvement is expected.  A Medical Review performed on a regular basis is to determine Medical Necessity and Appropriateness of Care.
Occupational Therapy** (Office Setting)  <i>Considered Outpatient Short-Term Rehabilitative Therapy for Mental Health Disorders, Substance Use Disorders, Developmental Disabilities and includes ABA Therapy if applicable.</i>	\$30 Copayment after the Deductible; pre-negotiated contracted rates apply, Coinsurance Waived.	NOT COVERED	
Occupational Therapy** (Outpatient Facility)  <i>Considered Short-Term Rehabilitative Therapy</i>	\$200 Outpatient Copayment; then 80% of the pre-negotiated contracted rate after the Calendar Year Deductible. Maximum Benefits Apply*	NOT COVERED	Benefits are provided for these Covered Services for acute conditions when it is determined that significant improvement is expected.  A Medical Review performed on a regular basis is to determine Medical Necessity and Appropriateness of Care.  Thirty (30) Visit Maximum Benefit In-Network per Calendar Year*
Occupational Therapy** (Office Setting)  <i>Considered Short-Term Rehabilitative Therapy</i>	\$30 Copayment after the Deductible; pre-negotiated contracted rates apply, Coinsurance Waived Maximum Benefits Apply*	NOT COVERED	

**\*\*Note: In-Network** Therapy prescribed by a Physician and performed by a registered Occupational Therapist is covered. Covered expenses do not include recreational programs, maintenance therapy, or supplies used in Occupational Therapy.

Occupational Therapy is a program of care that focuses on the physical, cognitive, and perceptual disabilities that influence the Plan Participant's ability to perform functional tasks. The therapist evaluates fine motor skills, perceptual skills, cognitive function, and eye-hand coordination. A therapy session may involve physical movement exercises and functional tasks. Therapy intended to primarily address vocational rehabilitation issues, such as work skills, will not be considered covered services under this Plan.

To be covered, therapy services must be restorative in nature and designed to restore levels of function that has previously existed, but that have been lost as a result of Injury or Sickness. Therapy services also include therapy designed to acquire levels of function that has not been previously acquired due to a disabling condition.

Rehabilitative services, including devices, are provided to help a Plan Participant regain, maintain, or prevent deterioration of a *skill or function that has been acquired but then lost or impaired* due to an Illness, Injury or disabling condition.

Habilitative services, including devices, are provided for a Plan Participant to attain, maintain, or prevent deterioration of a *skill or function never learned or acquired* due to a disabling condition.

The Short-Term Rehabilitative Services Maximum Benefit, if any, does not apply to Autism or specific developmental disabilities.

Services are not covered if they are custodial, educational, or vocational in nature are not covered.

Refer to Rehabilitation and Habilitation Services in this Plan for additional information.

**DC 37 LOCAL 95 HEAD START EMPLOYEES WELFARE FUND**

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**SCHEDULE OF MEDICAL BENEFITS**

<b>BENEFIT PROVISIONS</b>	<b>NETWORK PROVIDERS</b> (Based on negotiated rates)	<b>OUT-OF-NETWORK PROVIDERS</b>	<b>REQUIREMENTS MAXIMUM BENEFITS, LIMITATIONS OR EXCLUSIONS</b>
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**Outpatient Short Term Rehabilitation (continued)**

Physical Therapy ** (Outpatient Facility)  <i>Considered Short-Term Rehabilitative Therapy for Mental Health Disorders, Substance Use Disorders, Developmental Disabilities and includes ABA Therapy if applicable.</i>	\$200 Outpatient Copayment; then 80% of the pre-negotiated contracted rate after the Calendar Year Deductible.	NOT COVERED	Benefits are provided for these Covered Services for acute conditions when it is determined that significant improvement is expected.  A Medical Review performed on a regular basis is to determine Medical Necessity and Appropriateness of Care.
Physical Therapy ** (Office Setting)  <i>Considered Short-Term Rehabilitative Therapy for Mental Health Disorders, Substance Use Disorders, Developmental Disabilities and includes ABA Therapy if applicable.</i>	\$30 Copayment after the Deductible; pre-negotiated contracted rates apply, Coinsurance Waived.	NOT COVERED	
Physical Therapy ** (Outpatient Facility)  <i>Considered Short-Term Rehabilitative Therapy</i>	\$200 Outpatient Copayment; then 80% of the pre-negotiated contracted rate after the Calendar Year Deductible. Maximum Benefits Apply*	NOT COVERED	
Physical Therapy ** (Office Setting)  <i>Considered Short-Term Rehabilitative Therapy</i>	\$30 Copayment after the Deductible; pre-negotiated contracted rates apply, Coinsurance Waived Maximum Benefits Apply*	NOT COVERED	

**\*\*Note: In-Network** – Physical Therapy prescribed by a Physician and performed by a registered Physical Therapist or Physiotherapist is covered under this Plan. Services covered are therapeutic exercises, testing and soft tissue mobilization; physical modalities utilizing heat, cold, water, light, air, electricity, sound, massage, mobilization, and mechanical stimulations; reconditioning, including work reconditioning.

Physical Therapy is the treatment of physical disabilities or impairments resulting from Sickness, Injury, congenital anomaly, or prior therapeutic intervention by the use of therapeutic exercise and other interventions that focus on improving posture, locomotion, strength, endurance, balance, coordination, joint mobility, flexibility, and the functional activities of daily living.

To be covered, therapy services must be restorative in nature and designed to restore levels of function that has previously existed, but that have been lost as a result of Injury or Sickness. Therapy services also include therapy designed to acquire levels of function that has not been previously acquired due to a disabling condition.

Rehabilitative services, including devices, are provided to help a Plan Participant regain, maintain, or prevent deterioration of a skill or function that has been acquired but then lost or impaired due to an Illness, Injury or disabling condition.

Habilitative services, including devices, are provided for a Plan Participant to attain, maintain, or prevent deterioration of a skill or function never learned or acquired due to a disabling condition.

The Short-Term Rehabilitative Services Maximum Benefit, if any, does not apply to Autism or specific developmental disabilities.

Services are not covered if they are custodial, educational, or vocational in nature are not covered.

Refer to Rehabilitation and Habilitation Services in this Plan for additional information.

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<b>BENEFIT PROVISIONS</b>	<b>NETWORK PROVIDERS</b> (Based on negotiated rates)	<b>OUT-OF-NETWORK PROVIDERS</b>	<b>REQUIREMENTS MAXIMUM BENEFITS, LIMITATIONS OR EXCLUSIONS</b>
<b>Outpatient Short Term Rehabilitation (continued)</b>			
Speech Therapy** Speech-Language Pathology Services** (Outpatient Facility) <i>Considered Short-Term Rehabilitative Therapy for Mental Health Disorders, Substance Use Disorders, Developmental Disabilities and includes ABA Therapy if applicable.</i>	\$200 Outpatient Copayment; then 80% of the pre-negotiated contracted rate after the Calendar Year Deductible.	NOT COVERED	Benefits are provided for these Covered Services for acute conditions when it is determined that significant improvement is expected.  A Medical Review performed on a regular basis is to determine Medical Necessity and Appropriateness of Care.
Speech Therapy** Speech-Language Pathology Services** (Outpatient Facility) <i>Considered Short-Term Rehabilitative Therapy for Mental Health Disorders, Substance Use Disorders, Developmental Disabilities and includes ABA Therapy if applicable.</i>	\$30 Copayment after the Deductible; pre-negotiated contracted rates apply, Coinsurance Waived.	NOT COVERED	
Speech Therapy** Speech-Language Pathology Services** (Office Setting)  <i>Considered Outpatient Short-Term Rehabilitative Therapy</i>	\$200 Outpatient Copayment; then 80% of the pre-negotiated contracted rate after the Calendar Year Deductible. Maximum Benefits Apply*	NOT COVERED	Benefits are provided for these Covered Services for acute conditions when it is determined that significant improvement is expected.  A Medical Review performed on a regular basis is to determine Medical Necessity and Appropriateness of Care.
Speech Therapy** Speech-Language Pathology Services** (Office Setting)  <i>Considered Outpatient Short-Term Rehabilitative Therapy</i>	\$30 Copayment after the Deductible; pre-negotiated contracted rates apply, Coinsurance Waived. Maximum Benefits Apply*	NOT COVERED	Benefits are provided for these Covered Services for acute conditions when it is determined that significant improvement is expected.  A Medical Review performed on a regular basis is to determine Medical Necessity and Appropriateness of Care.  Thirty (30) Visit Maximum Benefit In-Network per Calendar Year*
<p><b>**Note: In-Network</b> – Speech Therapy services are covered for the treatment of a speech impairment which results from a Sickness, surgery, Injury, congenital anatomical anomaly, or prior medical treatment and are provided by a Physician, a qualified Speech Therapist, or licensed Speech Language Pathologist.</p> <p>To be covered, therapy services must be restorative in nature and designed to restore levels of function that has previously existed, but that have been lost as a result of Injury or Sickness. Therapy services also include therapy designed to acquire levels of function that has not been previously acquired due to a disabling condition.</p> <p>Rehabilitative services, including devices, are provided to help a Plan Participant regain, maintain, or prevent deterioration of a skill or function that has been acquired but then lost or impaired due to an Illness, Injury or disabling condition.</p> <p>Habilitative services, including devices, are provided for a Plan Participant to attain, maintain, or prevent deterioration of a skill or function never learned or acquired due to a disabling condition.</p> <p>There must be an expectation that: (a) the Plan Participant’s condition will improve significantly in a reasonable period, or (b) the services must be necessary for the establishment of a safe and effective maintenance program required in connection with a specific condition.</p> <p>The Short-Term Rehabilitative Services Maximum Benefit, if any, does not apply to Autism or specific developmental disabilities.</p> <p>Services are not covered if they are custodial, educational, or vocational in nature are not covered.</p> <p>Refer to Rehabilitation and Habilitation Services in this Plan for additional information.</p>			

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<b>BENEFIT PROVISIONS</b>	<b>NETWORK PROVIDERS</b> (Based on negotiated rates)	<b>OUT-OF-NETWORK PROVIDERS</b>	<b>REQUIREMENTS MAXIMUM BENEFITS, LIMITATIONS OR EXCLUSIONS</b>
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**Outpatient Short Term Rehabilitation (continued)**

Outpatient Pulmonary Therapy** <i>(Outpatient Facility)</i> <i>Considered Short-Term Rehabilitative Therapy</i>	\$200 Outpatient Copayment; then 80% of the pre-negotiated contracted rate after the Calendar Year Deductible	NOT COVERED	Benefits are provided for these Covered Services for acute conditions when it is determined that significant improvement is expected.  A Medical Review performed on a regular basis is to determine Medical Necessity and Appropriateness of Care.
Outpatient Pulmonary Therapy** <i>(Office Setting)</i> <i>Considered Short-Term Rehabilitative Therapy</i>	\$30 Copayment after the Deductible; pre-negotiated contracted rates apply, Coinsurance Waived.	NOT COVERED	Benefits are provided for these Covered Services for acute conditions when it is determined that significant improvement is expected.  A Medical Review performed on a regular basis is to determine Medical Necessity and Appropriateness of Care.

**\*\*Note: In-Network** – Pulmonary Rehabilitation is multi-disciplinary treatment, which combines Physical Therapy with an educational process, directed at stabilizing pulmonary diseases and improving functional status.

Outpatient Pulmonary Rehabilitation is covered for severe symptomatic and chronic respiratory impairment. Respiratory impairment is a loss or abnormality of physiologic, psychological, or anatomic structure or function, which is the result of respiratory disease. Therapy will be covered if it contains all of the following components: (a) exercise training consisting of upper and lower extremity training, ventilator muscle training, and breathing exercises; (b) patient education; (c) psychological and behavioral interventions and (d) outcome assessment.

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<b>BENEFIT PROVISIONS</b>	<b>NETWORK PROVIDERS</b> <small>(Based on negotiated rates)</small>	<b>OUT-OF-NETWORK PROVIDERS</b>	<b>REQUIREMENTS MAXIMUM BENEFITS, LIMITATIONS OR EXCLUSIONS</b>
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**Developmental Disorders and Autism**

This Plan provides coverage for a Plan Participant for expenses incurred for the screening and diagnosing of autism or other developmental disabilities. When the primary diagnosis is autism or another developmental disability, this Plan shall provide coverage for the expenses incurred for Medically Necessary behavioral interventions based on the principles of applied behavioral analysis and related behavioral programs, occupational therapy, physical therapy, and speech therapy, as prescribed through a treatment plan. Any such treatment will not be denied on the basis that the treatment is not restorative.

The treatment plan required shall include all elements necessary for this Plan to determine the appropriate benefits, including, but not limited to: diagnosis; proposed treatment by type, frequency, and duration; the anticipated outcomes stated as goals; the frequency by which the treatment plan will be updated; and the attending Physician's prescription and written review and approval. An updated treatment plan may be requested every six (6) months from the attending Physician to review the Medical Necessity, unless a more frequent review is necessary due to emerging clinical circumstances.

The above benefit provision may be subject to utilization review, including periodic review, to determine continued Medical Necessity and Appropriateness of care for specific therapies and interventions.

**Mental Health/Disorders**

<p>Inpatient Mental Health Disorders** <i>(Biologically based &amp; Non-biologically based)</i></p> <p><i>(Inpatient Facility)</i></p> <p><i>(Coverage is also provided for Mental Health Residential Treatment)</i></p> <p><i>(Treated the same as any other Medical Condition.)</i></p>	<p>\$100 Inpatient per Confinement Copayment; then 80% of the pre-negotiated contracted rate after the Calendar Year Deductible.</p>	<p align="center">NOT COVERED</p>	<p>Precertification Required</p> <p>This Plan's payment may be reduced if the requirements under the Cost Management Section of this Plan are not followed. <i>(Refer to this section for additional information)</i></p> <p>This payment reduction does not apply to the satisfaction of the Out-of-Pocket Maximum.</p>
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**\*\*Note: In-Network** - A biologically based mental disorder is a condition that is caused by a biological disorder of the brain and results in a clinically significant, or psychological syndrome, or pattern that substantially limits the functioning of the Plan Participant with the Sickness, including but not limited to: schizophrenia; schizo-affective disorder; major depression disorder; bipolar disorder; paranoia and other psychotic disorders; obsessive-compulsive disorder; panic disorder; and pervasive developmental disorder or autism.

Inpatient Mental Health Disorder Services include Partial Hospitalization sessions and Residential Treatment Services. Partial Hospitalization sessions when services are provided for not less than four (4) hours and not more than twelve (12) hours in a twenty-four (24) hour period are covered and exchangeable as follows, two (2) Partial Hospitalization sessions are equal to one (1) day of inpatient care.

<p>Inpatient Mental Health Disorders <i>(Biologically &amp; Non-biologically based)</i></p> <p><i>(Physician Services)</i></p> <p><i>(Treated the same as any other Medical Condition.)</i></p>	<p>80% of the pre-negotiated contracted rate after the Calendar Year Deductible</p>	<p align="center">NOT COVERED</p>	<p>Precertification Required <i>(Refer to Inpatient Service)</i></p>
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<b>BENEFIT PROVISIONS</b>	<b>NETWORK PROVIDERS</b> (Based on negotiated rates)	<b>OUT-OF-NETWORK PROVIDERS</b>	<b>REQUIREMENTS MAXIMUM BENEFITS, LIMITATIONS OR EXCLUSIONS</b>
<b>Mental Health Disorders (continued)</b>			
Outpatient Mental Health Disorders <i>(Biologically &amp; Non-biologically based)</i>  <i>(Services rendered in an Outpatient Facility or for partial hospitalization days)</i>  <i>(Treated the same as any other Medical Condition.)</i>	\$200 Outpatient Copayment; then 80% of the pre-negotiated rate after the Calendar Year Deductible.	NOT COVERED	
Outpatient Mental Health Disorders <i>(Biologically &amp; Non-biologically based)</i>  <i>(Services rendered in an Office Setting)</i>  <i>(Treated the same as any other Medical Condition.)</i>	\$30 Copayment after the Deductible; pre-negotiated contracted rates apply, Coinsurance Waived.	NOT COVERED	
<b>Substance Use Disorders (Alcohol and/or Drug Related)</b>			
Inpatient Substance Use Disorders <i>(Alcohol and/or Drug Related)</i>  <i>(Inpatient Facility)</i>  <i>(Coverage is also provided for Substance Use Disorder Residential Treatment Center – Refer to Sub-Acute Facilities for provisions)</i>  <i>(Treated the same as any other Medical Condition.)</i>	\$100 Inpatient per Confinement Copayment; then 80% of the pre-negotiated contracted rate after the Calendar Year Deductible.	NOT COVERED	Precertification Required  This Plan’s payment may be reduced if the requirements under the Cost Management Section of this Plan are not followed. <i>(Refer to this section for additional information)</i>  This payment reduction does not apply to the satisfaction of the Out-of-Pocket Maximum.
Inpatient Substance Use Disorders <i>(Alcohol and/or Drug Related)</i>  <i>(Physician Services)</i>	80% of the pre-negotiated contracted rate after the Calendar Year Deductible	NOT COVERED	Precertification Required <i>(Refer to Inpatient Service)</i>

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**Substance Abuse (Alcohol and/or Drug Related) (continued)**

Outpatient Substance Use Disorders <i>(Alcohol and/or Drug Related)</i>  <i>(Services rendered in an Outpatient Facility or for partial hospitalization days)</i>  <i>(Treated the same as any other Medical Condition.)</i>	\$200 Outpatient Copayment; then 80% of the pre-negotiated rate after the Calendar Year Deductible.	NOT COVERED	
Outpatient Substance Use Disorders <i>(Alcohol and/or Drug Related)</i>  <i>(Physician's Office)</i>  <i>(Treated the same as any other Medical Condition.)</i>	\$30 Copayment after the Deductible; pre-negotiated contracted rates apply, Coinsurance Waived.	NOT COVERED	

**Mental Health Disorders and Substance Use Disorders (Alcohol or Drug Related) Residential Treatment Center & Services**

Residential Treatment Center and Services Inpatient Mental Health Disorders & Substance Use Disorders** <i>(Alcohol and/or Drug Related)</i>  <i>(Treated the same as any other Medical Condition.)</i>	\$100 Inpatient per Confinement Copayment; then 80% of the pre-negotiated contracted rate after the Calendar Year Deductible.	NOT COVERED	Precertification Required  This Plan's payment may be reduced if the requirements under the Cost Management Section of this Plan are not followed. <i>(Refer to this section for additional information)</i>  This payment reduction does not apply to the satisfaction of the Out-of-Pocket Maximum.
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**\*\*Note: In-Network** – Benefits are provided for confinement in a Mental Health Residential Treatment Center or a Substance Use Disorder Treatment Center when the Plan Participant is a registered bed patient.

A Residential Treatment Center means an institution which (a) specializes in the treatment of psychological and social disturbances that are the result of a Mental Health condition or disorder, or that are the result of Substance Use *(Alcohol or Drug Related)*; (b) provides a sub-acute, structured, psychotherapeutic treatment program, under the supervision of Physicians; (c) provides twenty-four (24) hour care, in which a Plan Participant lives in an open setting; and (d) is licensed in accordance with the laws of the appropriate legally authorized agency as a residential treatment center.

Mental Health or Substance Use Residential Treatment Services are services provided by a Hospital for the evaluation and treatment of the psychological and social functional disturbances that are a result of sub-acute Mental Health conditions or disorders, or as a result of sub-acute Substance Use Disorder *(Alcohol or Drug Related)* conditions.

Mental Health Disorder and/or Substance Use Disorder Residential Treatment services are exchanged with Inpatient Mental Health Disorder or Substance Use Disorder services at a rate of two (2) days of Mental Health Disorder Treatment or Substance Use Disorder Treatment being equal to one (1) day of Inpatient Mental Health Disorder or Substance Use Disorder Treatment.

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<b>Other Services &amp; Treatment</b>			
Acupuncture Therapy** (Outpatient Facility)	\$200 Outpatient Copayment; then 80% of the pre-negotiated rate after the Calendar Year Deductible.	NOT COVERED	
Acupuncture Therapy** (Office Setting)	\$30 Copayment after the Deductible; pre-negotiated contracted rates apply, Coinsurance Waived.	NOT COVERED	
<b>**Note: In-Network</b> – Acupuncture services rendered by a certified acupuncturist, which are deemed Medically Necessary, to relieve pain or is used as a form of anesthesia are covered under this Plan.			
Dental Services** (Inpatient Facility)	\$100 Inpatient per Confinement Copayment; then 80% of the pre-negotiated contracted rate after the Calendar Year Deductible.	NOT COVERED	Precertification Required for Hospitalization. (Refer to Inpatient Hospital Benefit if admitted) Services limited to Medically Necessary General Anesthesia & Hospitalization for Dental Services.
Dental Services** (Physician Services Inpatient or Outpatient)	80% of the pre-negotiated contracted rate after the Calendar Year Deductible	NOT COVERED	
Dental Care & Treatment & Oral Surgery** (Performed in an Outpatient Facility)	\$200 Outpatient Copayment; then 80% of the pre-negotiated rate after the Calendar Year Deductible.	NOT COVERED	
Dental Care & Treatment & Oral Surgery** (Performed in an Office Setting)	\$30 Copayment after the Deductible; pre-negotiated contracted rates apply, Coinsurance Waived.	NOT COVERED	
<b>**Note: In-Network</b> - Benefits are provided for the following: (a) excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof, and floor of the mouth; (Cysts related to teeth are not covered); (b) emergency repair due to an Accidental Injury to sound natural teeth or approved treatment within twelve (12) months of the Accidental Injury. This time may be extended if treatment cannot be reasonably completed within the twelve (12) months; (c) surgery to correct an Accidental Injury to the jaws, cheeks, lips, tongue, floor or roof of the mouth; (d) excision of benign bony growths of the jaw and hard palate; (e) oral surgical procedures required for the correction of a non-dental physiological condition which results in a severe functional impairment; (f) incision of sensory sinuses, salivary glands or ducts; (g) removal of impacted wisdom teeth when coverage is not provided through a dental plan; (h) surgical and non-surgical medical procedures for temporomandibular joint (TMJ) disorders and orthognathic surgery.			
This Plan does not cover charges for (a) orthodontia, crowns, or bridgework; (b) shortening or lengthening of a mandible or maxillae for cosmetic purposes; (c) medications for the treatment of periodontal disease; (d) treatment of natural teeth due to disease; (e) biting or chewing related injuries; (f) restorative services and supplies necessary to promptly repair, remove, or replace sound natural teeth. Dental implants are also not covered under this Medical Plan.			

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**Other Services & Treatment (continued)**

Diabetic Care** (Office Setting)	\$30 Copayment after the Deductible; pre-negotiated contracted rates apply, Coinsurance Waived.	NOT COVERED	When part of the PPACA services refer to Preventive Care Benefits and the Copayment per Visit does not apply.
Diabetic Education & Training** (Office Setting)	\$30 Copayment after the Deductible; pre-negotiated contracted rates apply, Coinsurance Waived.	NOT COVERED	When part of the PPACA services refer to Preventive Care Benefits and the Copayment per Visit does not apply.
Diabetic Education & Training** (Office Setting)	100% of the pre-negotiated contracted rates apply, Deductible & Coinsurance Waived. Maximum Benefits Apply*	NOT COVERED	When part of the Health Care Reform no cost sharing will apply for up to four (4) Visits for education and up to six (6) Visits for nutritional counseling per Calendar Year.*

**\*\*Note: In-Network** - Diabetic services will also include benefits for Inpatient and Outpatient self-management education and education relating to diet shall be limited to visits that are Medically Necessary and Appropriate upon: (a) upon the initial diagnosis of diabetes; or (b) the diagnosis by a Physician or Nurse Provider or Clinical Nurse Specialist of a significant change in the Plan Participant's symptoms or conditions which requires changes in the Plan Participant's self-management; and (c) determination by a the Physician or Nurse Provider or Clinical Nurse Specialist decides that a re-education or refresher course is necessary. Covered training will include nutrition therapy by a licensed, certified dietician or nutritionist and must be supervised and certified as completed successfully by a Physician.

Diabetic self-management education is covered when rendered by: (a) a Dietician registered by a nationally recognized professional association of Dieticians; (b) a health care professional recognized as a Certified Diabetes Educator by the American Association of Diabetes Educators; or (c) registered Pharmacist in that specific state qualified with regard to management education for diabetes by any institution recognized by the Board of Pharmacy in that specific state.

Diabetic Services & Supplies**	80% of the pre-negotiated contracted rate after the Calendar Year Deductible	NOT COVERED	
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**\*\*Note: In-Network** – Diabetic equipment and related supplies are covered under this Medical Plan when they are not covered under the Standalone Prescription Drug Plan. Examples of covered items under the Medical Plan are: (a) blood glucose monitors and glucose monitors for the legally blind; (b) test strips for glucose monitors and visual reading and urine testing strips; (c) insulin; (d); injection aids; (e) cartridges for legally blind; (f) lancets, syringes and hypodermic needles and syringes; (g) insulin pumps and appurtenances to them; (h) infusion devices; (i) oral agents for controlling blood sugar; (j) additional supplies as designated by regulation as appropriate for the treatment of diabetes.

Please verify what is covered under the Standalone Prescription Drug Plan first before purchase and submitting claims under this Medical Plan.

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**Other Services & Treatment (continued)**

Audiology Services** (Exam)	\$30 Copayment after the Deductible; pre-negotiated contracted rates apply, Coinsurance Waived.	NOT COVERED	A Medical Review performed on a regular basis is to determine Medical Necessity and Appropriateness of Care.
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**\*\*Note: In-Network** – Audiology Services are covered when rendered by a Physician or a licensed Audiologist and such services are determined to be Medically Necessary and at the Appropriate level of care. There must be an expectation that: (a) the Plan Participant’s condition will improve significantly in a reasonable period, or (b) the services must be necessary for the establishment of a safe and effective maintenance program required in connection with a specific condition.

Hearing Testing (Non-Routine)	80% of the pre-negotiated contracted rate after the Calendar Year Deductible	NOT COVERED	
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Hearing Aids**	80% of the pre-negotiated contracted rate after the Calendar Year Deductible	NOT COVERED	
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**\*\*Note: In-Network** – The Plan provides benefits for expenses incurred or in connection with the purchase of bone anchored (i.e., cochlear implants) when they are Medically Necessary to correct a hearing impairment when (a). craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid; or (b) hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.

Coverage is provided for one (1) hearing aid per ear during the entire period that a plan participant I enrolled for coverage. Coverage is provided for repair and or replacement of a bone anchored hearing aid only for malfunctions.

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<b>Other Services &amp; Treatment (continued)</b>			
Autologous Blood Drawing, Storage & Transfusion**	80% of the pre-negotiated contracted rate after the Calendar Year Deductible	NOT COVERED	Covered Services are in conjunction with a planned episode of care which requires transfusion including, but not limited to, a surgical procedure. Storage provided until the date of the scheduled care or procedure.
<p><b>**Note: In-Network</b> – Coverage is provided only when they being provided in connection with a scheduled covered inpatient procedure for the treatment of a Disease or Injury. Services for the treatment of cancer by dose-intensive chemotherapy, autologous bone marrow transplants, and peripheral blood stem cell transplants are covered when performed by a Provider that is approved by the National Cancer Institute or performed pursuant to the protocols consistent with the guidelines of the American Society of Clinical Oncologists.</p> <p>Coverage is provided for the storage fees for a reasonable period that is appropriate for having the blood available when it is needed.</p>			
Blood & Blood Plasma	80% of the pre-negotiated contracted rate after the Calendar Year Deductible	NOT COVERED	Coverage provided for blood and blood plasma that has not been donated or replaced.
Hemophilia**	80% of the pre-negotiated contracted rate after the Calendar Year Deductible	NOT COVERED	Services include home treatment for bleeding episodes, services in a Hospital Outpatient Clinical Laboratory or Regional Care Center.
<p><b>**Note: In-Network</b> - Coverage is provided for blood infusion equipment, (including syringes and needles, if not available through the Standalone Prescription Drug Plan), as required for the home treatment of routine bleeding episodes related with hemophilia. The home treatment program must be under the supervisions of a state-approved hemophilia treatment center.</p>			
Dialysis Services & Treatment ** (Outpatient Hospital or Freestanding Dialysis Facility)	\$200 Outpatient Copayment; then 80% of the pre-negotiated rate after the Calendar Year Deductible.	NOT COVERED	Services provided in the Outpatient Hospital Facility or Freestanding Dialysis Facility.
Dialysis Services & Treatment** (Home)	80% of the pre-negotiated contracted rate after the Calendar Year Deductible	NOT COVERED	Home Dialysis will include equipment, training, and medical supplies.
<p><b>**Note: In-Network</b> – Dialysis treatment is the treatment for an acute renal failure or chronic irreversible renal insufficiency by removing waste products from the body. This includes hemodialysis and peritoneal dialysis</p>			

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<b>Other Services &amp; Treatment (continued)</b>			
Pain Management** (Outpatient Facility)	\$200 Outpatient Copayment; then 80% of the pre-negotiated rate after the Calendar Year Deductible.	NOT COVERED	
Pain Management** (Physician Services Inpatient)	80% of the pre-negotiated contracted rate after the Calendar Year Deductible	NOT COVERED	Copayment applies to Office Visit charge only
Pain Management** (Physician's Office)	\$30 Copayment after the Deductible; pre-negotiated contracted rates apply, Coinsurance Waived.	NOT COVERED	Copayment applies to Office Visit charge only
<p><b>**Note: In-Network</b> – Pain Management services are covered subject to medical guidelines. Pain Management therapy must be supported by a comprehensive evaluation of the Plan Participant/patient, the rationale for treatment must be well documented, and treatment must include a comprehensive program that is multifaceted and may include therapeutic exercises, activity modification, physical therapy, occupational therapy, pharmacological interventions, mental health and behavioral interventions, therapeutic and injection interventions, and surgical interventions, if necessary.</p> <p>Treatment will not always achieve complete elimination of a Plan Participant/patient's pain. In such cases, an increase in a Plan Participant/patient's level of function and teaching the Plan Participant/patient strategies to cope with residual pain will be the aim. If treatment reaches a point at which no appreciable improvement in the Plan Participant/patient's condition is anticipated, services will be considered maintenance and/or supportive and will not be eligible for reimbursement under this Plan.</p>			
Sleep Disorders** (Includes Sleep Apnea, Nocturnal Seizures & Narcolepsy) (Outpatient Facility & Physician's Office)	NOT COVERED	NOT COVERED	
<b>**Note: In-Network</b> – Sleeping disorder treatment & care is not covered under this Plan. Non-medical counseling for Sleep Therapy is not covered under this Plan.			
Smoking Cessation Treatment** (Preventive Care Program)	100% of the pre-negotiated contracted rate; Deductible Waived.	NOT COVERED	Service are provided in accordance with the guideline for Preventive Care under the ACA.
<b>**Note: In-Network</b> - Smoking Cessation treatment, care, or programs (provided they are not covered under a Standalone Prescription Drug Plan) are covered under this Plan when prescribed under a Preventive Care Program or when Medically Necessary due to a severe active lung disease, such as emphysema or asthma.			

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**Other Services & Treatment (continued)**

Nutritional Counseling** (Physician's Office)	\$30 Copayment after the Deductible; pre-negotiated contracted rates apply, Coinsurance Waived.  Maximum Benefit Applies*	NOT COVERED	Limited to six (6) visits per Calendar Year when related to diabetic education .*
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**\*\*Note: In-Network** – Nutritional counseling and education for the evaluation and counseling when diet is a part of the medical management of documented organic disease, such as diabetes, will be covered under this Plan.

Obesity** (Physician Services Inpatient for Morbid Obesity)	80% of the pre-negotiated rate after the Calendar Year Deductible.	NOT COVERED	Surgical procedures such as a gastric bypass or lap band surgeries re limited to one (1) procedure Lifetime.*
Obesity** (Physician Services Outpatient for Morbid Obesity)	\$200 Outpatient Copayment; then 80% of the pre-negotiated rate after the Calendar Year Deductible.	NOT COVERED	
Obesity Care & Treatment** (Physician's Office for Morbid Obesity)	\$30 Copayment after the Deductible; pre-negotiated contracted rates apply, Coinsurance Waived.	NOT COVERED	

**\*\*Note: In-Network** - Charges incurred for obesity screening services and counseling are covered services under this benefit provision. Charges incurred for bariatric surgery such as a gastric bypass or lap band surgery are covered under this when deemed medically necessary and are limited to one (1) surgery lifetime. Charges incurred for weight or dietary control, such as weight loss programs, special foods, or dietary supplements, whether prescribed or recommended by a Physician or under medical supervision, are not covered under this Plan. Services and treatment only provided when the diagnosis is Morbid Obesity.

Inherited Metabolic Disease Medical Foods and Low Protein Modified Food Products**  Specialized Non-Standard Infant Formulas	80% of the pre-negotiated contracted rate after the Calendar Year Deductible	NOT COVERED	
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**\*\*Note: In-Network** – Included is therapeutic treatment, purchase of Medical Food (Enteral Formula) & Low Protein Modified Food Products determined as Medically Necessary.

“Inherited Metabolic Disease,” means a disease caused by an inherited abnormality of body chemistry for which testing is required.

“Medical Food” means food that is intended for the dietary treatment of a disease or condition for which nutritional requirements are established by medical evaluation and is formulated to be consumed or administered enterally under the direction of a Professional Provider/Physician.

“Low Protein Modified Food Product” means a food product that is specially formulated to have less than one (1) gram of protein per serving and is intended to be used under the direction of a Professional Provider/ Physician for the dietary treatment of an inherited metabolic disease but does not include a natural food that is naturally low in protein.

“Specialized Non-Standard Infant Formulas” are covered under this Plan when the following conditions are met: (a) the Plan Participant’s (infant) Physician has diagnosed him or her as having multiple food protein intolerance; (b) the Physician has determined that the formula is Medically Necessary and Appropriate; and (c) the infant has not responded to trials of standard non-cow milk based formulas including soybean and goat milk.

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**Other Services & Treatment (continued)**

Podiatric Care** (Outpatient Facility & Professional Fee)  (Refer to Physician Services and other Services for Benefit provisions)	\$200 Outpatient Copayment; then 80% of the pre-negotiated rate after the Calendar Year Deductible.	NOT COVERED	
Podiatric Care** (Physician's Office)	\$30 Copayment after the Deductible; pre-negotiated contracted rates apply, Coinsurance Waive.	NOT COVERED	

**\*\*Note: In-Network -** Routine foot care including (a) paring and removing of corns and calluses; (b) trimming of nails; (c) flat feet; (d) fallen arches; (e) weak feet; (f) chronic foot strain; or symptomatic complaints of the feet; (g) subluxation of the feet; (h) support devices, arch supports, foot inserts, orthopedic and corrective shoes that are not part of a leg brace and fitting, casting and other services related to devices of the feet are not covered under this Plan. The only exception is as may be Medically Necessary and Appropriate for the treatment of certain Sicknesses such as diabetes and peripheral vascular disease. Charges for open cutting operations are covered.

Foot Orthotics**	80% of the pre-negotiated contracted rate after the Calendar Year Deductible	NOT COVERED	Foot Orthotics is not covered except for the condition of Diabetes and Peripheral Artery Disease. Limited to two(2) inserts Maximum Benefit per foot. Orthopedic shoe inserts covered but limited to two (2) per Calendar Year*
Internal Prosthetic Devices/ Medical Appliances**	80% of the pre-negotiated contracted rate after the Calendar Year Deductible	NOT COVERED	

**\*\*Note: In-Network –** This Plan provides coverage for internal prosthetic/medical appliances that provide permanent or temporary internal functional support for nonfunctional body parts. Medically Necessary repair, maintenance or replacement of a covered appliance is also covered.

External Prosthetic Appliances and Devices**	80% of the pre-negotiated contracted rate after the Calendar Year Deductible	NOT COVERED	(Copayment would apply to an In-network Office Visit Charge)
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**\*\*Note: In-Network –** This Plan provides coverage for the initial purchase and fitting of external prosthetic appliances and devices available only by prescription and Medically Necessary for the alleviation or correction of an Injury, Sickness, or congenital defect or for the treatment of Diabetes.. External prosthetic appliances and devices shall include prostheses/prosthetic appliances and devices, orthoses, and orthotic devices; braces and splints. **Payment is subject to the greater of: (a) the reimbursement rate for the device in the federal Medicare reimbursement schedule; and (b) the amount that the Provider has agreed to accept for the device. If there is no such agreement the Medical reimbursement rate will prevail.**

**Prostheses/Prosthetic Appliances and Devices** are defined as fabricated replacements for missing body parts, and they include, but are not limited to (a) basic limb prostheses; (b) terminal devices such as hands or hooks; and (c) speech prostheses.

**Orthoses and Orthotic Devices** are defined as orthopedic appliances or apparatuses used to support, align, prevent, or correct deformities. Coverage is provided for custom foot orthoses and other orthoses as follows:

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**Other Services & Treatment** *(continued)*

**External Prosthetic Appliances and Devices\*\*** *(continued)*

**Non-foot Orthoses** – Only the following non-foot orthoses are covered: (a) rigid and semi-rigid custom fabricated orthoses; (b) semi-rigid prefabricated and flexible orthoses; and (c) rigid prefabricated orthoses including the preparation, filling, and basic additions, such as bars and joints.

**Custom Foot Orthoses** – Custom foot orthoses are only covered as follows: (a) for a Plan Participant with impaired peripheral sensation and/or altered peripheral circulation (e.g. diabetic neuropathy and peripheral vascular disease); (b) when the foot orthoses is an integral part of a leg brace and it is Medically Necessary for the proper functioning of the brace; (c) when the foot orthosis is for use as a replacement or substitute for missing parts of the foot (e.g. amputated toes) and is Medically Necessary for the alleviation or correction of an Injury, Sickness or congenital defect; and (d) for a Plan Participant with neurologic or neuromuscular condition (e.g. cerebral palsy, hemiplegia or spina bifida) producing spasticity, malalignment, or pathological position of the foot and there is reasonable expectation of improvement; ((e) or a custom foot brace or support prescribed by a Physician and has deemed the orthotic as Medically Necessary.

**Braces** – A brace is defined as an orthosis or orthopedic appliance that supports or holds in correct position any movable part of the body and that allows for motion of that part.

**Splints** – A splint is defined as an appliance for preventing movement of a joint or for the fixation of displaced or movable parts.

**Excluded Orthoses and Orthotic Devices:** (a) fabric and elastic supports; (b) corsets; (c) arch supports; (d) trusses; (e) elastic hose; (f) canes; (g) crutches; (h) cervical collars; or dental appliances or other similar devices carried in stock and sold by drug stores, department stores, corset shops or surgical supply facilities.

Scalp Prosthesis/Hair Loss <i>(Following Chemotherapy or Radiation Therapy and for the diagnosis of Alopecia)</i>	80% of the pre-negotiated contracted rate after the Calendar Year Deductible	NOT COVERED	
Breast Reconstruction & Prosthesis**	80% of the pre-negotiated contracted rate after the Calendar Year Deductible	NOT COVERED	
<p><b>**Note: In-Network</b> – Services provided following a mastectomy on one (1) or both breasts: (a) reconstruction of the breast on which the mastectomy has been performed; (b) surgery and reconstruction of the other breast to produce symmetrical appearance; and (d) prostheses and physical complications in all stages of a mastectomy, including lymphedemas.</p>			
Medical & Surgical Supplies	80% of the pre-negotiated contracted rate after the Calendar Year Deductible	NOT COVERED	
Oxygen and Its Administration	80% of the pre-negotiated contracted rate after the Calendar Year Deductible	NOT COVERED	

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**Other Services & Treatment** *(continued)*

Durable Medical Equipment**	80% of the pre-negotiated contracted rate after the Calendar Year Deductible	NOT COVERED	<p>Precertification Required for DME in excess of \$2,000.</p> <p>This Plan's payment may be reduced if the requirements under the Cost Management Section of this Plan are not followed. <i>(Refer to this section for additional information)</i></p> <p>This payment reduction does not apply to the satisfaction of the Out-of-Pocket Maximum.</p>
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**\*\*Note: In-Network** – Benefits are provided for the rental (but not to exceed the total allowance of purchase) or purchase when approved by the Plan Administrator. Benefits are provided for Durable Medical Equipment (DME) that meets the following tests: (a) it is durable and intended for repeated use; (b) it is medical equipment that is primarily and customarily used for medical purposes and is not generally useful in the absence of a Sickness or Injury; (c) it is generally not useful to a person without a Sickness or Injury; (d) it is appropriate for home use. Such equipment includes, but is not limited to, crutches, hospital beds, respirators, wheel chairs and dialysis machines.

This Plan does cover: (a) replacements or repairs; and (b) duplicate equipment when required due to anatomical change and/or reasonable wear and tear. All maintenance and repairs due to a Plan Participant's misuse are the Plan Participant's responsibility.

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

- Nebulizers;
- Hospital type beds;
- Wheelchairs;
- Traction Equipment;
- Walkers and Crutches.

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

- **Bed Related Items:** Bed trays, over the bed tables, bed wedges, pillows, custom bedroom equipment, mattresses, including non-power mattresses, custom mattresses and posturepedic mattresses.
- **Bath Related Items:** Bath lifts, non-portable whirlpools, bathtub rails, toilet rails, raised toilet seats, bath benches, bath stools, hand held showers, paraffin baths, bath mats and spas.
- **Chair, Lifts and Standing Devices:** Computerized or gyroscopic mobility systems, roll about chairs, geriatric chairs, hip chairs, seat lifts (mechanical or motorized), patient lifts (mechanical or motorized – manual hydraulic lifts are covered if the Plan Participant is a two (2) person transfer, and auto ramps.
- **Fixtures to Real Property:** Ceiling Lifts and wheelchair ramps.
- **Car/Van Modifications.**
- **Air Quality Items:** Room humidifiers, vaporizers, air purifiers and electrostatic machines.

**Other Equipment:** Heat lamps, heating pads, cryounits, cryotherapy machines, electronic-controlled therapy units, ultraviolet cabinets, sheepskin pads and boots, postural drainage board, AC/DC adaptors, enuresis alarms, magnetic equipment, scales (baby and adult), stair gliders, elevators, saunas, any exercise equipment, and diathermy machines.

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<b>Other Services &amp; Treatment (continued)</b>			
Genetic Testing & Counseling**		NOT COVERED	
<p><b>**Note: In-Network</b> – Genetic testing is only covered if: (a) a Plan Participant has symptoms or signs of a genetically-linked inheritable disease; (b) it has been determined that a Plan Participant is at risk for carrier status as supported by existing peer-reviewed, evidence-based. Scientific literature for the development of a genetically linked inheritable disease when the results will impact clinical outcome; or (c) 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.</p> <p>Genetic counseling is covered if a Plan Participant is undergoing approved genetic testing, or if a Plan Participant has an inherited disease and is a potential candidate for genetic testing.</p>			
Elective Sterilization**	80% of the pre-negotiated contracted rate after the Calendar Year Deductible	NOT COVERED	Reversals of elective sterilizations are not covered.
<p><b>**Note: In-Network</b> - Vasectomies and tubal ligations are covered under this Medical Plan. Sterilization reversals are not covered under this Plan except where stated as covered under the ACA.</p>			
Family Planning** (Physician's Office)	\$30 Copayment after the Deductible; pre-negotiated contracted rates apply, Coinsurance Waive.	NOT COVERED	
<p><b>**Note: In-Network</b> - Covered family planning services consist of counseling on the use of contraceptives and related topics. The costs related to the contraceptive devices (e.g., Depo-Provera, Intrauterine Devices (IUDs) and Diaphragms, the measuring and fitting when applicable) are covered if the services are performed in the Physician's office. Birth control pills, implantable or injectable contraceptive drugs, condoms, foams, contraceptive jellies, and ointments, even if prescribed by a Physician or recommended for a medical condition other than birth control are not covered under this Medical Plan when covered under a Standalone Prescription Drug Plan. Refer to the Standalone Prescription Drug Plan for prescription drug coverage.</p>			
Diagnostic Infertility Services** (Outpatient Hospital Facility or Physician Services)	\$200 Outpatient Copayment; then 80% of the pre-negotiated rate after the Calendar Year Deductible.	NOT COVERED	
Abortions Therapeutic Abortion & Non- Elective Abortions for the Termination of Pregnancy)	80% of the pre-negotiated contracted rate after the Calendar Year Deductible	NOT COVERED	Elective Abortions are not covered under this Plan.

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**Other Services & Treatment (continued)**

Infertility** <i>Refer to Note which follows</i>	80% of the pre-negotiated contracted rate after the Calendar Year Deductible	NOT COVERED	Precertification Required – This Plan’s payment may be reduced if the requirements under the Cost Management Section of this Plan are not followed. (Refer to this section for additional information)  This payment reduction does not apply to the satisfaction of the Out-of-Pocket Maximum.
Infertility** (Office Setting) Refer to Note which follows	\$30 Copayment after the Deductible; pre-negotiated contracted rates apply, Coinsurance Waive.	NOT COVERED	Copayment applies to Office Visit.
Diagnostic Infertility Services** (Outpatient Hospital Facility or Physician Services)	\$200 Outpatient Copayment; then 80% of the pre-negotiated rate after the Calendar Year Deductible.	NOT COVERED	

**\*\*Note: In-Network** – Benefits are provided for Inpatient and Outpatient services for expenses incurred in the diagnosis and treatment of infertility. Covered infertility services include, but are not limited to the following services performed at facilities that conform to the standards established by the American Society of Reproductive Medicine or the American College of Obstetricians & Gynecologists:

**Basic Infertility Services include:**

- Initial evaluation;
- Diagnosis & diagnostic tests;
- Semen analysis;
- Evaluation of ovulatory function;
- Postcoital test;
- Endometrial biopsy;
- Pelvic ultrasound;
- Hysterosalpingogram;
- Sono-hystogram;
- Testis biopsy;
- Blood tests; and
- Medically appropriate treatment of ovulatory dysfunction.
- Surgery, including microsurgical sperm aspiration;
- Fresh and frozen embryo transfer;
- Medications, including injectable Infertility medications;

**Comprehensive Infertility Services include:**

- Ovulation induction and monitoring;
- Pelvic ultrasound;
- Artificial insemination with no limit as to the number of cycles;
- Hysteroscopy;
- Laparoscopy;
- Laparotomy.

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**Other Services & Treatment (continued)**

*Infertility Services (continued)*

**Advanced Infertility Services include:**

- Intracytoplasmic sperm injection;
- In vitro fertilization (IVF) - Limited to three (3) cycles per lifetime;
- Cryopreservation and storage of sperm, ova, and embryos in connection with in-vitro fertilization.
- Zygote intrafallopian transfer (ZIFT) - Limited to three (3) cycles per lifetime only if in vitro fertilization has been exhausted.
- Gamete intrafallopian transfer (GIFT) - Limited to three (3) cycles per lifetime only if in vitro fertilization has been exhausted.
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Coverage for GIFT/ZIFT tube transfers do not count towards the in vitro fertilization benefit limit.

A “cycle” is all treatment that starts when: preparatory medications are administered for ovarian stimulation for oocyte retrieval with the intent of undergoing in-vitro fertilization using a fresh embryo transfer, or medications are administered for endometrial preparation with the intent of undergoing in vitro fertilization using a frozen embryo transfer.

**Fertility Preservation Services.** Standard fertility preservation services are covered when a medical treatment will directly or indirectly lead to iatrogenic infertility. Standard fertility preservation services include the collecting, preserving, and storing of ova and sperm. “Iatrogenic infertility” means impairment of a Plan Participant’s fertility by surgery, radiation, chemotherapy, or other medical treatment affecting reproductive organs or processes.

**Exclusions and Limitations:**

- Costs associated with an ovum or sperm donor, including the donor’s medical expenses;
- Ovulation predictor kits;
- Reversal of tubal ligations;
- Reversal of vasectomies;
- Costs for and relating to surrogate motherhood (maternity services are covered for the Plan Participant acting as a surrogate mother);
- Cloning; or
- Medical and surgical procedures that are experimental or investigational unless the denial is overturned by an External Appeal Process.

All services must be provided by Providers who are qualified to provide such services in accordance with the guidelines established and adopted by the American Society for Reproductive Medicine. The Plan does not discriminate based on a Plan Participants’ expected length of life, present or predicted disability, degree of medical dependency, perceived quality of life, other health conditions, or based on personal characteristics including age, sex, sexual orientation, marital status, or gender identity, when determining coverage under this benefit.

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Home Health Care**	80% of the pre-negotiated contracted rate after the Calendar Year Deductible  Maximum Benefit Applies*	NOT COVERED	Limited to a Maximum Benefit of two hundred (200) Visits In-Network per Calendar Year.*
<p><b>**Note: In-Network</b> - Covered services for Home Health Care are covered when specified as part of a Physician’s written plan established within fourteen (14) days of the beginning of the Home Health Care and is without or in lieu of a Hospital confinement or Skilled Nursing Facility confinement. Home Health Care includes: (a) part-time or intermittent nursing care (except when twenty-four (24) hour services are needed on a short-time basis) by or under the supervision of a registered professional nurse (RN); (b) part-time or intermittent services of a home health aide; (c) physical, occupational and speech therapy provided by the Home Health Agency are not subject to such provisions day limitations; (d) medical supplies, appliances and equipment, medications and drugs prescribed by a Physician; (e) medical social work; nutritional counseling and laboratory services by or on behalf of the Home Health Agency to the extent such services would have been covered had the Plan Participant been hospitalized or confined in a Skilled Nursing Facility.</p> <p>Home Health Care visit is considered a periodic visit by a therapist, home health aide or home health team. Services must be Medically Necessary and reviewed by a Physician on a periodic basis.</p> <p>This Plan does not cover: (a) services furnished to family members other than the Plan Participant/patient; (b) services provided by a companion; (c) services and supplies not included in the home health care plan; (d) a period when a Plan Participant/patient is not under the continuing care of a Physician or when therapy is in considered maintenance; (e) food and home delivered meals; (f) nursing home care or care that is maintenance care, supportive care, care to treat deficiencies that are developmental in nature or primarily custodial care in nature.</p>			
Private Duty Nursing Services** (Outpatient)	80% of the pre-negotiated contracted rate after the Calendar Year Deductible  Maximum Benefit Applies*	NOT COVERED	Refer to Home Health Care Benefits. Such services are only covered through the Home Health Care Benefits. Maximum Benefit limits apply*
<p><b>**Note: In-Network</b> – This Plan covers the services of Nurse for Private Duty Nursing care. These conditions apply: (a) The care must be ordered by the Physician. (b) The care must be furnished while: (1) intensive skilled nursing is required in the treatment of an acute illness or during the acute period after an Accidental Injury; and (2) the patient is not in a Facility that provides nursing care.</p> <p>Requirements for (b) (1) will not be deemed to be met if the care actually furnished is mainly Custodial Care or maintenance. Also, no benefits will be provided for the services of a Nurse who: (a) ordinarily resides in the Plan Participant/patient’s home; or (b) is a member of the Plan Participant/patient’s immediate family.</p>			

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<b>Other Services &amp; Treatment (continued)</b>			
Hospice Care** (Inpatient Services)	80% of the pre-negotiated contracted rate after the Calendar Year Deductible  Maximum Benefit Applies*	NOT COVERED	Limited to a Maximum Benefit of two hundred ten (210) Days Lifetime*
Hospice Care** (Outpatient Services)	80% of the pre-negotiated contracted rate after the Calendar Year Deductible  Maximum Benefit Applies*	NOT COVERED	
Bereavement Counseling (Supportive Care)	80% of the pre-negotiated contracted rate after the Calendar Year Deductible  Maximum Benefit Applies*	NOT COVERED	Limited to five (5) Visits for supportive care and guidance for the purpose of helping a Plan Participant and his or her immediate family cope with the emotional and social issues related to the Plan Participant's death either before or after the Plan Participant's death.*

**\*\*Note: In-Network** - Hospice benefits are provided to a Plan Participant when the attending Physician certifies that the Plan Participant has a terminal Sickness with a medical prognosis of twelve (12) months or less, and that the care is provided in accordance with a Physician's prescribed course of treatment. Hospice Care is primarily comfort care, including pain relief, physical care, counseling, and other services that will help the Plan Participant cope with the terminal Sickness rather than cure it.

Hospice Care services when provided under a Hospice Care Program include the following: (a) inpatient room and board and general nursing services for the related conditions, including also inpatient acute care in a Hospice Care Facility; (b) services provided by a Hospice Care Facility rendered on an outpatient basis; (c) part-time professional nursing care; (d) home health aide services provided under the supervision of an R.N.; (e) medical care rendered by a Hospice Care Program Physician; (f) therapy services (including speech, physical and occupational therapies); (g) medical and surgical supplies; (h) durable medical equipment; (i) prescribed medications; (j) oxygen and its administration; (k) medical social services; (l) psychological support services to the terminally ill Plan Participant/patient; (m) bereavement counseling and family counseling related to the Plan Participant's terminal condition; and (n) dietician services. A Hospice Care Facility must be established and operated in accordance with the applicable laws in the jurisdiction in which it is located, and where licensing is required, be licensed, and approved by the regulatory authority having responsibility for licensing under law.

Hospice Care services not covered are as follows: (a) services of a person who is a member of the Plan Participant's family or the covered Dependent's family; (b) any period when a Plan Participant is not under the care of a Physician; (c) services or supplies not listed in the Hospice Care Plan or Program; (d) for any curative or life prolonging procedures; (e) volunteer services or services provided by others without charge (f) pastoral services; (g) services and supplies that are primarily to aid a Plan Participant in daily living, such as, (1) homemaker or caretaker services; and (2) food or home delivered meals; (h) non-authorized private duty nursing services; (i) funeral services and arrangements; (j) services and expenses incurred in regard to the Plan Participant's personal, legal and financial affairs (such as preparation and execution of a will or other dispositions of personal and real property).

**DC 37 LOCAL 95 HEAD START EMPLOYEES WELFARE FUND**

**EPO PLAN A**

**SCHEDULE OF MEDICAL BENEFITS**

<b>BENEFIT PROVISIONS</b>	<b>NETWORK PROVIDERS</b> (Based on negotiated rates)	<b>OUT-OF-NETWORK PROVIDERS</b>	<b>REQUIREMENTS MAXIMUM BENEFITS, LIMITATIONS OR EXCLUSIONS</b>
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**Other Services & Treatment (continued)**

Human Organ Transplants**  <i>Confinement Copayment applies to Inpatient Facility Charge</i>  <i>All Transplants must be performed and approved at designated Facilities</i>	\$100 Inpatient per Confinement Copayment; then 80% of the pre-negotiated contracted rate after the Calendar Year Deductible.	NOT COVERED	Precertification Required  This Plan's payment may be reduced if the requirements under the Cost Management Section of this Plan are not followed. (Refer to this section for additional information)  This payment reduction does not apply to the satisfaction of the Out-of-Pocket Maximum.
Human Organ Transplants** (Surgical Services)  <i>All Transplants must be performed and approved at designated Facilities</i>	80% of the pre-negotiated contracted rate after the Calendar Year Deductible	NOT COVERED	

**\*\*Note: In-Network** – Coverage is provided only for those transplants determined to be non-experimental and non-investigational.

Charges for services related to Medically Necessary human organ and tissue transplant which include but not limited to: kidney, corneal, liver, heart, pancreas, and lung transplants; solid organ and bone marrow/stem cell procedures for aplastic anemia, leukemia, severe combined immunodeficiency disease and Wiskott-Aldrich Syndrome are covered under this Plan. Transplant services include the recipient's (a) medical; (b) surgical; and (c) Hospital services; (d) inpatient immunosuppressive medications; and (e) costs for the organ or bone marrow/stem cell procurement.

Approval must be requested for Human Leukocyte Antigen HLA testing, donor searches and/or harvest and storage of stem cells prior to the final decision as to what transplant procedure will be needed. In these cases, the HLA testing and donor search charges will be covered as routine diagnostic tests. The harvest and storage request will be reviewed for Medical Necessity and may be approved. However, such an approval of HLA testing, donor search and/or harvest and storage is NOT approval for the later transplant. A separate Medical Necessity decision will be needed for the transplant.

All transplants must be prescribed by a Specialist and performed in a hospital/Facility that has been specifically approved and designated to perform these procedures.

Coverage is provided for Hospital and medical expenses, including donor search fees of the Plan Participant as the recipient. The Plan covers transplant services required by a Plan Participant as an organ donor only if the recipient is also covered under the Plan as a Plan Participant. This Plan does not cover the medical expenses of a donor if the donor has coverage under another Health Plan.

If the donor does not have health coverage that would cover the costs associated with his or her role as the donor this Plan covers the following services required for a live donor due to a covered transplant procedure: (a) the search for a donor; (b) typing (immunologic); (c) the harvesting of the organ tissue and related services; (d) the processing of the tissue.

**Note:** This Plan will cover these services only if: (a) the recipient of the transplant is a Covered Person under this Plan; and (b) benefits are not paid or payable for the services by reason of the donor's own coverage under any health coverage. No benefits are available when the Covered Person is a donor unless the recipient is a family member covered under this Plan.

This plan does not cover (a) travel expense; (b) lodging, (c) meals, or other accommodations for donors or guests; (d) donor fees in connection with the organ transplant surgery; (e) routine harvesting and storage of stem cells for newborn cord blood.

**DC 37 LOCAL 95 HEAD START EMPLOYEES WELFARE FUND**

**EPO PLAN A**

**SCHEDULE OF MEDICAL BENEFITS**

<b>BENEFIT PROVISIONS</b>	<b>NETWORK PROVIDERS</b> (Based on negotiated rates)	<b>OUT-OF-NETWORK PROVIDERS</b>	<b>REQUIREMENTS MAXIMUM BENEFITS, LIMITATIONS OR EXCLUSIONS</b>
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**Other Services & Treatment (continued)**

Clinical Trials**	<i>REFER TO ACTUAL SERVICES BEING PROVIDED</i>	NOT COVERED	Coverage is not provided for services related to clinical trials that are considered investigations treatment, drugs, or devices.
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**\*\*Note: In-Network** - This Plan provides coverage for charges made for routine patient services associated with cancer clinical trials approved and sponsored by the federal government. The following criteria must be met:

- The cancer trial is listed as being sponsored by the federal government;
- The trial investigates a treatment for terminal cancer and (a) the Plan Participant has failed standard therapies for the disease; (b) cannot tolerate standard therapies for the disease; or (c) no effective non-experimental treatment for the disease exists;
- The Plan Participant meets all the inclusion criteria for the clinical trial and is not treated: off protocol”;
- The trial is approved by the Institutional Review Board of the institution administering the treatment.

Routine services do not include, and reimbursement will not be provided for:

- The investigation services or supply itself;
- Service or supplies listed here as exclusions;
- Services or supplies related to data collection for the clinical trial (i.e., protocol costs);
- Services or supplies which, in the absence of private health care coverage, are provided by a clinical trial sponsor or other party (i.e., device, drug, item or service supplies by a manufacturer and not yet FDA approved) without charge to the trial participant/Plan Participant.

Prescription Drugs under this Medical Plan	<p><b>Refer to Standalone Prescription Drug Card Plan for Prescription Coverage</b></p> <p>Prescription medications are eligible under this Plan when dispensed and administered by a licensed Physician/Provider in an approved environment. 80% of the pre-negotiated contracted rate after the Calendar Year Deductible</p>	NOT COVERED	<p><b>Refer to Standalone Prescription Drug Card Plan for Prescription Coverage</b></p> <p>Medically Necessary to treat a Medical Condition.</p> <p>A Standalone Prescription Drug Card Plan Copayment is <b>NOT</b> eligible for reimbursement under this Medical Plan.</p>
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# COST MANAGEMENT SERVICES

## COST MANAGEMENT SERVICES PHONE NUMBER

Please refer to the Employee ID card for the Cost Management Services phone number.

The Plan Participant/patient or family member must call this number to receive certification of certain Cost Management Services. This call must be made in advance of services being rendered as noted under this provision, or in advance of an inpatient admission or within forty-eight (48) hours or two (2) business days after an emergency admission.

Any and all services that require precertification that are not precertified will be subject to a non-compliance penalty of a 20% reduction in benefits payable.

**Any costs incurred because of reduced reimbursement due to failure to follow cost management procedures will not accrue toward the 100% maximum out-of-pocket payment.**

## UTILIZATION REVIEW

Utilization review is a program designed to help insure that all Plan Participants receive necessary and appropriate health care while avoiding unnecessary expenses.

**These review services incorporate precertification, concurrent, and retrospective review of care, as well as discharge planning services. Inpatient admissions, medical procedures, treatment and care, services and/or supplies, shown in the Schedule of Benefits and/or Benefits Summary, and as summarized below require precertification and/or authorization.**

The program consists of:

- (1) Precertification of the Medical Necessity for the following non-emergency services before Medical and/or Surgical services are provided:
- (2) Retrospective review of the Medical Necessity of the listed services provided on an emergency basis;
- (3) Concurrent review, based on the admitting diagnosis, of the listed services requested by the attending Physician; and
- (4) Certification of services and planning for discharge from a Medical Care Facility or cessation of medical treatment.

## OVERVIEW

The purpose of the program is to determine what charges may be eligible for payment by this Plan. This program is not designed to be the practice of medicine or to be a substitute for the medical judgment of the attending Physician or another health care provider.

If a particular course of treatment or medical service is not certified, it means that either this Plan will not pay for the charges or this Plan will not consider that course of treatment as appropriate for the maximum reimbursement under this Plan. The Plan Participant/patient is urged to find out why there is a discrepancy between what was requested and what was certified before incurring charges.

The attending Physician does not have to obtain precertification from this Plan for prescribing a maternity length of stay that is forty-eight (48) hours or less for a vaginal delivery or ninety-six (96) hours or less for a cesarean delivery.

In order to maximize Plan reimbursements, please read the following provisions carefully. **Here's how the program works.**

**Precertification.** Before a Plan Participant enters a Medical Care Facility on a non-emergency basis or receives other listed medical services, the utilization review administrator will in conjunction with the attending Physician, certify the care as appropriate for Plan reimbursement. A non-emergency stay in a Medical Care Facility is one that can be scheduled in advance.

The utilization review program is set in motion by a telephone call from the Plan Participant. Contact the utilization review administrator at the telephone number on your ID card **at least five (5) days before** services are scheduled to be rendered with the following information:

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

If there is an **emergency** admission to the Medical Care Facility, the patient, patient's family member, Medical Care Facility or attending Physician must contact the utilization review administrator **within forty-eight (48) hours or two (2) next business days** after the admission.

The utilization review administrator will determine the number of days of Medical Care Facility confinement or use of other listed medical services authorized for payment. **Failure to follow this procedure may reduce reimbursement received from this Plan.**

If the Plan Participant does not receive authorization as explained in this section, the benefit payment will be reduced by 100% for non-compliance.

**Concurrent review, discharge planning.** Concurrent review of a course of treatment and discharge planning from a Medical Care Facility are parts of the utilization review program. The utilization review administrator will monitor the Plan Participant's Medical Care Facility stay or use of other medical services and coordinate with the attending Physician, Medical Care Facilities and Plan Participant either the scheduled release or an extension of the Medical Care Facility stay or extension or cessation of the use of other medical services.

If the attending Physician feels that it is Medically Necessary for a Plan Participant to receive additional services or to stay in the Medical Care Facility for a greater length of time than has been precertified, the attending Physician must request the additional services or days.

## PRECERTIFICATION SERVICES

Non-compliance Payment Reduction for failure to precertify will result in a 50% reduction in benefits payable for the following:

### Inpatient Care, including

- Hospital Inpatient Admissions
- Emergency Admissions within two (2) business days
- Inpatient Elective Surgery and Nonsurgical Procedures
- Inpatient Mental Disorder (*Biologically & Non-biologically based*)
- Inpatient Substance Use Disorders (*Alcohol & Drug Related*) (*Detoxification & Rehabilitation*)
- All Rehabilitation Facility Confinements or Long Term Acute Care (LTAC) Facility Admissions
- Skilled Nursing Facility Admissions
- Hospice (*Inpatient Care*)

### Ancillary Services

- Non-emergency Ambulance Services (Land/Air/Sea)
- Home Health Care Services, includes Private Duty Nursing
- Home Infusion Therapy
- Hospice Care Services

### Transplant Services

Notification of **Inpatient** Transplant Services must be provided as soon as the need for an organ or tissue transplant is known.

### Maternity Care – *Notification only*

Notification of Maternity Care should be provided as soon as the pregnancy is known and again upon hospitalization. Reduction in benefits for non-notification will not apply for the first forty-eight (48) hours of hospitalization for a vaginal delivery, or ninety-six (96) hours for a cesarean section.

### Infertility Services

Medical Review is required for these services.

- Artificial insemination
- In vitro fertilization
- Gamete intrafallopian transfer
- Gamete intrafallopian transfer
- Zygote intrafallopian transfer

### Interventional Pain Management Services

- Epidural Injection Procedures and Diagnostic Selective Nerve Root Blocks
- Paravertebral Facet Injection/Nerve Block/Neurolysis
- Regional Sympathetic Nerve Block
- Sacroiliac Joint Injections
- Implanted Spinal Cord Stimulators

## **Surgical Procedures**

*Contact the Utilization Management Services for an elective surgical procedure (refer to list below) that is being performed Inpatient or on an Outpatient Hospital basis, in an Ambulatory Surgical Center or in a Physician's Surgical Suite. The Utilization Management will determine its Medical Necessity and Appropriateness of Care and whether precertification is required. Precertification is not required for surgery performed in the Physician's Office.*

- An Inpatient or Outpatient Surgical Procedures (*Only exceptions are diagnostic surgical procedures & surgical procedures performed in the Physician's office do not require precertification.*)
- Cochlear Implant Surgery and associated Supplies/ Bone-anchored (Osseo integrated) Hearing Aids, Implantable Bone Conduction Hearing Aids
- Carticel (ACI), Osteochondral Allograft, and Autograft Transplantation
- Pain Management Services that include injections and blocks: epidural, facet, and/or trigger point
- Obesity Surgery, including but not limited to:
  - Gastroplasty
  - Gastric Bypass
  - Bariatric Procedures
- Spinal/vertebral surgery including but not limited to:
  - Percutaneous Laser Discectomy
  - Nucleoplasty
  - Spinal Fusion
- Uvulopalatopharyngoplasty (UPPP), Including laser-assisted
- Any potential cosmetic or reconstructive procedure (*Refer to potential cosmetic reconstructive procedure listing*)
- **Potential cosmetic/reconstructive procedures**  
*Surgical procedures that are potentially cosmetic and/or reconstructive in nature and require precertification include, but are not limited to, the following:*

- Arthroplasty
- Blepharoplasty / Blepharoptosis Repair
- Bone Graft, Genioplasty and Mentoplasty
- Breast Reconstruction
- Breast Augmentation (augmentation mammoplasty)
- Breast Implants (insertion, reinsertion, removal)
- Breast Lift or Shaping (Mastopexy)
- Breast Reduction
- Gynecomastia, excision
- Canthopexy / Canthoplasty
- Cervicoplasty
- Chemical peels
- Dermabrasion
- Excision of Excessive Skin and/or Subcutaneous Tissue
- Genetically and Bio-engineered Skin Substitutes for Wound Care
- Hair Transplants
- Injectable Dermal Fillers, such as Botox injections
- Joint Replacement Surgery
- Keloid removal
- Lipectomy, Liposuction or any other excess fat removal procedures (such as Panniculectomy and Abdominoplasty)
- Nasal Surgery (Rhinoplasty, Septoplasty, Turbinectomy)
- Otoplasty
- Rhytidectomy
- Scar Revision
- Skin Closures including:
  - Skin Grafts
  - Skin Flaps
  - Tissue Grafts
- Sex Reassignment Surgery
- Surgery for Varicose Veins, Ligation, Stripping, including Perforators and Sclerotherapy
- Any other potentially cosmetic procedure

**Any procedure, device or service that may be considered experimental or investigational including:**

New emerging technology / procedures, as well as existing technology and procedures applied for new uses and treatments.

**Therapy & Other Restorative Services**

Medical Review may be required for these services to determine Medical Necessity and Appropriateness of Care.

Outpatient Therapies, including therapies for Autism Spectrum Disorder

- Physical Therapy
- Speech Therapy
- Occupational Therapy
- ABA Therapy

**Prosthesis/Orthotics (Exceeding \$2,000)**

Precertification and/ or Medical Review of Prosthesis or Orthoses, examples such as:

- Custom Ankle-Foot Orthosis
- Custom Knee-Ankle-Foot Orthoses
- Custom Knee Braces
- Custom Limb Prosthetics (*including accessories / components*)

**Durable Medical Equipment (DME)**

Medical Review required for Durable Medical Equipment over \$2,000. Also, all DME rentals over thirty (30) days must be pre-approved. Samples described below.

- Bone Growth Stimulators
- Bone-Anchored Hearing Aids
- Continuous Positive Airway Pressure (CPAP) Devices, Bi-Level (BI-PAP) Devices and all Supplies.
- Dynamic Adjustable and Static Progressive Stretching Devices (*excludes CPMs*)
- Electric, Power and Motorized Wheelchairs (*including custom accessories*)
- External Defibrillator (*and associated accessories*)
- High Frequency Chest Wall Oscillation Generator System
- Manual Wheelchairs
- Negative Pressure Wound Therapy
- Neuromuscular Stimulators
- Power Operated Vehicles (POV)
- Pressure Reducing Support Surfaces
- Air Fluidized Bed
- Non powered Advanced Pressure Reducing Mattress
- Powered Air Flotation Bed (*Low Air Loss Therapy*)
- Powered Pressure Reducing Mattress
- Push Rim Activated Power Assist Devices
- Repair or Replacement of DME items, and Orthoses and Prosthetics that require Precertification
- Speech Generating Devices

**Specialty Drugs**

Call to confirm the Medical Appropriateness of specialty drugs administered in an outpatient facility or in a professional Provider's Office setting.

**Genetic and Genomic Tests Requiring Precertification**

The following list is a guide to the types of genetic and genomic tests that require precertification. Due to the volume of tests, it is not possible to list each test separately.

## **SECOND AND/OR THIRD OPINION VOLUNTARY PROGRAM**

Certain surgical procedures are performed either inappropriately or unnecessarily. In some cases, surgery is only one (1) of several treatment options. In other cases, surgery will not help the condition.

In order to prevent unnecessary or potentially harmful surgical treatments, the second and/or third opinion program fulfills the dual purpose of protecting the health of this Plan's Plan Participants and protecting the financial integrity of this Plan.

Benefits will be provided for a second (and third, if necessary) opinion consultation to determine the Medical Necessity of an elective surgical procedure. An elective surgical procedure is one that can be scheduled in advance; that is, it is not an emergency or of a life-threatening nature. Benefits for the second (and third, if necessary) opinion will be paid as stated in the Schedule of Benefits.

These additional consultations must be performed by Physicians who are:

- (1) Board Certified Specialists in the area in which the operation is concerned; and
- (2) not financially associated with either the surgeon originally recommending surgery or, in the case of a third opinion, with each other.

If the second opinion does not confirm the need for surgery, a third opinion is required to obtain the scheduled benefits for the surgery. Even if the third opinion does not confirm the need for surgery, full Plan benefits will be paid if the Plan Participant desires the procedure. All such consultations will be paid at the rate of shown in the Schedule of Benefits.

## **PREADMISSION TESTING SERVICE**

The Medical Benefits percentage payable will be for diagnostic lab tests and x-ray exams when:

- (1) performed on an outpatient basis within seven (7) days before a Hospital confinement;
- (2) related to the condition which causes the confinement; and
- (3) performed in place of tests while Hospital confined.

Covered charges for this testing will be payable as shown in the Schedule of Benefits. In-network benefits will be paid at the percentage of the pre-negotiated contracted rate and Out-of-network benefits will be paid at the percentage of eligible charges after the deductible, where applicable. These tests are covered even if the tests show the condition requires medical treatment prior to Hospital confinement or the Hospital confinement is not required.

## **PREDETERMINATION OF BENEFITS**

A predetermination for any services may be obtained in writing in advance of services being rendered. The written request should be sent to the Claims Supervisor, and will need to include the provider's name, address, and telephone number, the diagnosis, a description of the services to be rendered, and the anticipated charges. If the actual services rendered differ from those described in the written request, the predetermination will have no effect. A predetermination is valid for one (1) year from the date issued. All written requests for a predetermination must include all the necessary medical documentation and must be provided prior to services being rendered.

## CASE MANAGEMENT

**Case Management.** This Plan may elect, in its sole discretion, when acting on a basis that precludes individual selection, to provide alternative benefits that are otherwise excluded under this Plan. The alternative benefits, called "Case Management," shall be determined on a case-by-case basis, and this Plan's determination to provide the benefits in one instance shall not obligate this Plan to provide the same or similar alternative benefits for the same or any other Plan Participant, nor shall it be deemed to waive the right of this Plan to strictly enforce the provisions of this Plan.

A case manager consults with the patient, the family, and the attending Physician in order to develop a plan of care for approval by the patient's attending Physician and the patient. This plan of care may include some or all of the following:

- personal support to the Plan Participant/patient;
- contacting the family to offer assistance and support;
- monitoring Hospital or Skilled Nursing Facility;
- determining alternative care options; and
- assisting in obtaining any necessary equipment and services.

Case Management occurs when this alternate benefit will be beneficial to both the patient and this Plan.

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

Once agreement has been reached, the Plan Administrator will direct this Plan to reimburse for Medically Necessary expenses as stated in the treatment plan, even if these expenses normally would not be paid by this Plan.

**Note: Case Management is a confidential and voluntary service. There are no reductions of benefits or penalties if the patient and family choose not to participate.**

**Each treatment plan is individually tailored to a specific patient and should not be seen as appropriate or recommended for any other patient, even one with the same diagnosis.**

**Coverage for Emergency Care** You are covered for emergency care provided and billed for by a hospital emergency room, whether it is in-network or out-of-network provided it meets the Plan's definition of Sudden and Serious.

If you require emergency care, as defined in the definitions section of this SPD above, visit the Emergency Room of any general acute care hospital. The Plan requires copayment for each emergency room visit. If you are admitted to the hospital immediately from the emergency room, the Plan will waive any applicable emergency room copayment.

Precertification is never required in connection with outpatient emergency care or emergency hospital admissions. However, the Plan requires pre-certification of elective hospital admissions, you or the hospital should notify the Utilization Review Department of your admission within two (2) business days following an emergency admission or as soon as you are reasonably able to do so.

**Chemical Dependency / Mental Health (CD/MH)** The Plan offers outpatient benefits for chemical dependency, inpatient treatment for chemical dependency, inpatient mental health care, and/or outpatient mental health care.

**Prescription drugs** Your coverage includes prescription drugs. The Fund provides reimbursement based on discounted prices of each drug. Please note that your program does not provide coverage if you use an out-of-network pharmacy. Network Pharmacies have agreed to accept these discounted rates as payment in full for covered prescription drugs, subject to applicable cost-sharing provisions.

The Fund has contracted with a third party, Navitus Health Solutions ("Navitus") to provide coverage for Retail and Home delivery prescription drugs. These benefits include:

- Retail prescriptions, which can be filled for acute medications - generally a short-term supply, which cannot exceed a 90 consecutive day supply of the drug - at a Network Pharmacy.
- Home delivery prescriptions, which can be filled for longer-term supplies of medications, up to 90 days.

## EMERGENCY ROOM TREATMENT

**An emergency is defined as a medical or behavioral condition, the onset of which is sudden. It manifests itself by symptoms of such severity, including severe pain that a prudent layperson with an average knowledge of medicine and health could reasonably expect that the absence of immediate medical attention would result in one or more of the following:**

- Placing the health of the afflicted person in serious jeopardy;
- Placing the health of an individual with a behavioral health condition or others in serious jeopardy;
- Causing serious impairment to the individual's bodily functions;
- Causing serious dysfunction of any bodily organ or part;
- Causing serious disfigurement of the afflicted individual;
- Causing significant pain.

Your benefits cover the visit for treatment of an emergency condition delivered in a hospital's emergency or operating room. Emergency room care is covered as follows:

1. Emergency hospital service during the first visit for treatment of an accidental injury within 24 hours following such injury, or
2. Emergency hospital care during the first visit for treatment within 24 hours of the onset of sudden and serious illness will be reimbursed. The Fund reserves the right to determine if the visit was a sudden and serious illness under accepted medical standards and prudent layperson definitions. The Trustees reserve the right to request any and all emergency room notes records and/or charts prior to any benefits being paid.
3. There will be no payment for emergency hospital service if the patient is admitted and the Fund makes payment for hospital confinement for that day.

**To prevent your payment of unnecessary charges, and at the same time to get the care you need when you need it, just follow the simple instructions below:**

1. If you have questions about a health situation and/or emergency call your personal physician for advice or seek care in an urgent care setting unless you believe you meet the conditions as an emergency. Your personal physician will direct you to the appropriate location for the care you need.
2. If you cannot call your personal physician in advance or utilize an urgent care center, go directly to an emergency room. If possible, go to the emergency room of the hospital where your personal physician is affiliated.
3. If you have a medical emergency while you are away from home and outside the local service area, follow Steps 1 and 2 above.
4. If you must go to an emergency room, show your Participant ID card at the hospital.
5. **Emergency Room care is the most expensive way to treat a routine ailment. The Fund will cover emergency room care only when a prudent layperson would assume that the absence of emergency care would result in placing the health or bodily functions of the afflicted person or, in the case of a behavioral health care emergency of others in serious jeopardy.** They are there to help you in case of accident, injury, or a life threatening illness. Use them wisely. Examples of types of illness where you or an eligible dependent might need to use an emergency room are as follows:
  - Acute appendicitis attack;
  - Asthmatic attack;
  - Convulsions;
  - Acute abdominal pains;
  - Heart failure or heart disease;
  - Food poisoning.

## PRESCRIPTION DRUG PROGRAM

The Fund's program covers all "Legend Drugs." "Legend Drugs" are defined as all medications which require a prescription by Federal Law and are prescribed by a licensed practitioner. Our program also covers medications which require a prescription under applicable State Law. Additionally, the use of the prescription must be Medically Necessary.

Over-the-counter medications are **not** covered regardless of whether a Physician prescribes them (except certain preventive medications as specified by the Affordable Care Act). The prescription drug benefits are handled by a third party administrative service.

When your coverage starts, you will be issued an identification card and an information package which may be used at participating pharmacies in the network. How your prescription expenses are covered under the Program depends on how and where you get them filled.

### YOUR PREFERRED FORMULARY

The Prescription Drug administrator has established a formulary intended to be beneficial for most patients. Their clinical staff has looked closely at the formulary drugs to ensure availability of drugs within each therapeutic class. In doing this they have established the best cost saving options for your needs. Your formulary is broken down into 3 tier levels. Tier 1: Generic, Tier 2: Preferred Brand, Tier 3: Non-Preferred Brand. The list of approved prescription medications under your plan has been chosen to help keep prescription drug costs down. You have been provided with a formulary list to share with your doctor when deciding which medication is right for you. You can also access the preferred formulary list on the Funds' [www.dc1707195wf.net](http://www.dc1707195wf.net) website or by requesting one from the Fund office.

### PRESCRIPTION CARD PROGRAM

To use the Drug Card Program, simply take each prescription or refill of a covered prescription drug (up to a 34-day supply) to a participating pharmacy and your co-pays will be as follows:

Type of Drug	Your Co-Pay
Tier I Generic	\$10 (but not more than cost of drug)
Tier II Formulary brand	\$25 or 25% of the cost whichever the greater
Tier III Non-preferred brand (not on formulary)	\$50 or 25% of the cost whichever the greater

### MAIL SERVICE PROGRAM

To use the Mail Service Program, simply contact the Mail order service provider and they will provide you with a full explanation of the home delivery program, including instructions on how to order refills and new prescriptions (up to a 90 day supply). Your co-pay will be as follows:

Type of Drug	Your Co-Pay
Tier I Generic	\$30
Tier II Formulary brand	\$75 or 25% of the cost whichever the greater
Tier III Non-preferred brand (not on formulary)	\$150 or 25% of the cost whichever the greater

### GENERIC DRUGS

Generic drugs are drugs which are identified by their "official" (or chemical) name rather than a brand name. All drugs (whether generic or not) **must** meet the same governmental standards for safety and effectiveness.

Many companies market the same drugs under a more expensive brand name, so you end up paying more for the same quality. Therefore, it makes sense to ask your doctor to prescribe a generic drug whenever possible. This is to afford Participants the most coverage possible and will help keep the Plan costs down.

## MAINTENANCE DRUGS

A maintenance medication is a drug that you will be taking on a regular basis over a period of time. The Fund has made provisions for those Participants on maintenance prescription drugs to receive a 90-day supply of these drugs through a Central Fill Pharmacy. Please contact the Fund Office or review the accompanying material provided with this Summary Plan Description for information and instructions on how to participate in the maintenance drug program.

Should you have any questions, please feel free to contact the Fund Office at (212) 343-1660.

## BIRTH CONTROL

The Plan covers birth control under the guidelines established by the Affordable Care Act. All reimbursable birth control requires a prescription from a Physician.

If a particular drug (generic or brand name) would be medically inappropriate, as determined by your health care provider, you are entitled to seek an exception by contacting the Plan and submitting supporting documentation from Your health care provider.

## SPECIALTY PHARMACY

The Funds Prescription Drug provider partners with a nationwide clinical pharmacy that has expertise in managing complex therapies and specialty medication distribution.

As one of the nation's leading specialty pharmacies, Specialty Pharmacy provides comprehensive therapy-management programs as well as injectable pharmaceutical treatments for multiple medical conditions.

With convenient online access you can place your order and have your drugs shipped directly to you or your doctor depending on your needs. Contact the Fund office for the Specialty Pharmacy.

## EXCLUSIONS

The prescription Drug Benefit does not cover the following:

- Medications purchased while a person was not covered under the Plan.
- Vitamins, whether prescribed or not. (Exception: Pre-Natal Vitamins and items covered as Preventive under the ACA)
- Non-prescription items such as over-the-counter drugs, bandages, heating pads, aspirins, etc., even though a doctor may order them on a prescription blank.
- Drugs for cosmetic purposes, such as Retin- A and including, but not limited to, treatment for baldness.
- Drugs or medications that are considered “Step 2” medications except as allowed under the Step Therapy Program.
- Food substitutes and supplements.
- Drugs that are excluded under this Section or which are stated as excluded in “What the Plan Doesn’t Cover”.
- Abortifacient Drugs or male contraceptives (e.g., condoms)
- Rogaine or similar drugs and preparations, even with a doctor’s prescription.
- Any medications available over the counter, unless specified by the Plan.

**IMPORTANT:** If you are not personally presenting a prescription for dispensing, please make sure that the individual picking up the medication is able to state the age of the patient and his/her relationship to the cardholder.

**When your eligibility ceases, your benefits cease. You will be held responsible for all prescriptions filled after your eligibility terminates.**

## **PRESCRIPTION DRUG BENEFITS FOR ACTIVES AND DEPENDENTS WHO ARE MEDICARE ELIGIBLE**

If you and/or your Dependent(s) are enrolled in either Part A or B of Medicare, you are eligible for Medicare Part D (Medicare's Prescription Drug Plan).

Medicare covers prescription drug benefits under Part D. For Active Participants and/or their Dependents who are Medicare-eligible, this Plan offers "Creditable Coverage." This means that the Plan's prescription drug coverage is expected to pay out, on average, as much or more as the standard Medicare prescription drug benefit will pay. Since this Plan's coverage is as good as Medicare, you do not need to enroll in a Medicare Prescription Drug Plan while you have this Plan's prescription drug coverage.

When you lose this coverage, you may enroll in a Medicare Prescription Drug Plan either during a special enrollment period or during Medicare's annual enrollment period (November 15<sup>th</sup> - December 31<sup>st</sup> of each year) by calling 1-800-MEDICARE. If you would rather elect Medicare's coverage, you can enroll in the Medicare Part D plan no sooner than 3 months prior to, through 3 months after, your 65<sup>th</sup> birthday; otherwise, you may incur a premium penalty. For more information about creditable coverage see Plan's Notice of Creditable Coverage that will be mailed to you from the Plan once a year. You may request another copy of this Notice by calling the Fund Office and asking for one.

## **DENTAL BENEFITS**

An eligible dues paying Participant of District Council 37, Local 95 is entitled to dental benefits under the Dental Plan, through a separate Summary Plan Description.

The Fund has contracted with a third party to design and administers a dental benefit plan that provide access to a wide range of dental services. The Dental Plan provides allowances for most of the services you will need. This Plan works to prevent major dental problems and their high cost by assuring that highly qualified care is available to you and your eligible dependents on an "as needed" basis.

Details of the Dental benefit are included with this Summary Plan Description through a separate benefit description. To obtain an additional copy please contact the Fund office.

# DC 37 LOCAL 95 HEAD START WELFARE FUND EXCLUSIONS AND LIMITATIONS

## GENERAL RULES

Charges must be medically necessary. The Fund is intended to make reimbursement for medically necessary charges for the care of covered Participants as the result of an injury, pregnancy, or sickness (unless otherwise indicated). Any service not prescribed by a physician as medically necessary will not be considered for reimbursement. The Fund reserves the right to request all medical records.

Charges must be incurred while covered. The Fund will not reimburse any expenses incurred by a person while such a person is not eligible under the Fund.

Health care expenses for Maternity are covered for the Participant and spouse only. Maternity benefits are not Eligible Expenses for dependent children.

The Fund may apply any or all of the following five (5) criteria when determining whether technology is experimental, investigational, obsolete, or ineffective:

- Any medical device, drug or biological product must have received final approval to market by the U.S. Food and Drug Administration (FDA) for the particular diagnosis or condition. (Once FDA grants approval for a particular diagnosis or condition, use of the medical device, drug or biological product for another diagnosis or condition may require that any or all of these five criteria be met);
- Conclusive evidence (from the published peer-viewed medical literature) must exist that the technology has a definite positive effect on health outcomes;
- Demonstrated evidence (as reflected in the published peer-viewed medical literature) must exist that over time the technology leads to improving health outcomes (i.e., the beneficial effects outweigh any harmful effects);
- Proof (as reflected in the published peer-viewed medical literature) must exist that the technology is either effective in improving the health outcome of usable in appropriate clinical contexts in which established technology is not employable;
- Proof (as reflected in the published peer-viewed medical literature) must exist that improvement in health outcomes (as defined above) is possible in standard conditions of medical practice, outside clinical investigatory settings.

**NOTE:** The above exclusion does not apply to the treatment of Cancer or Cancer-related conditions: (See the attached "Women's Cancer Rights Act" memorandum)

No coverage is available under this Plan for the following:

- (1) **Alternative Therapies/Complimentary Medicine.** Charges for alternative therapies and complementary medicine, including, but not limited to: music therapy; dance therapy, equestrian therapy or hippo-therapy; homeopathy; primal therapy; rolfing; psychodrama therapy; vitamin or other dietary supplements (except for the medical foods or formula noted under this Plan or the Prescription Drug Plan); naturopathy; hypnotherapy; bio-energetic therapy; Qi Gong; ayurvedic therapy; aroma-therapy; massage therapy; therapeutic touch therapy; wilderness therapy; educational therapy are not covered under this Plan.
- (2) **Aviation.** We do not Cover services arising out of aviation, other than as a fare-paying passenger on a scheduled or charter flight operated by a scheduled airline, or air ambulance when determined medically necessary.
- (3) **Blood.** Blood or blood plasma which has been donated or replaced.
- (4) **Broken appointments.** Charges incurred due to broken or missed appointments.

- (5) **Complications of non-covered treatments.** Care, services, or treatment required as a result of complications from a treatment not covered under this Plan are not covered.
- (6) **Completion of forms.** Charges for completing forms, or medical records, any third-party questionnaires and other administrative duties not related to the care and treatment of the patient.
- (7) **Convalescent and Custodial Care.** Charges for services related to rest cures, custodial care, or transportation. “Custodial care” means help in transferring, eating, dressing, bathing, toileting, and other such related activities. Custodial care does not include Covered Services determined to be Medically Necessary.
- (8) **Conversion Therapy.** Charges for conversion therapy. Conversion therapy is any practice by a mental health professional that seeks to change the sexual orientation or gender identity of a member under eighteen (18) years of age, including efforts to change behaviors, gender expressions, or to eliminate or reduce sexual or romantic attractions or feelings toward individuals of the same sex. Conversion therapy does not include counseling or therapy for an individual who is seeking to undergo a gender transition or who is in the process of undergoing a gender transition, that provides acceptance, support, and understanding of an individual or the facilitation of an individual’s coping, social support, and identity exploration and development, including sexual orientation-neutral interventions to prevent or address unlawful conduct or unsafe sexual practices, provided that the counseling or therapy does not seek to change sexual orientation or gender identity.
- (9) **Cosmetic Services.** Charges for procedures or treatment are not covered for cosmetic services, Prescription Drugs, or surgery, unless otherwise specified, except that cosmetic surgery shall not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered Child which has resulted in a functional defect. Charges for services in connection with reconstructive surgery following a mastectomy, as provided elsewhere in this Booklet. Cosmetic surgery does not include surgery determined to be Medically Necessary. If a claim for a procedure listed in 11 NYCRR 56 (e.g., certain plastic surgery and dermatology procedures) is submitted retrospectively and without medical information, any denial will not be subject to the Utilization Review process in the Utilization Review and External Review sections of this Plan unless medical information is submitted.
- (10) **Counseling.** Charges incurred for employment and career counseling.
- (11) **Court order services.** Charges related to court ordered services unless the court order qualifies as a “qualified medical child support order” under ERISA section 609 and the ordered services are otherwise covered under this Plan.
- (12) **Coverage Outside of the United States, Canada, or Mexico.** Coverage is not provided for care or treatment provided outside of the United States, its possessions, Canada or Mexico except for Emergency Services, Urgent Care, Pre-Hospital Emergency Medical Services, and ambulance services to treat an Emergency Condition.
- (13) **Dental Services.** Charges for dental services are not covered except for care or treatment due to accidental injury to sound natural teeth within twelve (12) months of the accident; dental care or treatment necessary due to congenital disease or anomaly; or dental care or treatment specifically stated in the stated in this Plan.
- (14) **Dependent’s Pregnancy.** All services and supplies related to the Pregnancy of a dependent child’s newborn are not covered under this Plan.
- (15) **Diversional Therapy.** Charges for diversional/recreational therapy or activity.
- (16) **Drugs That Do Not Need a Prescription.** This Plan does not cover Drugs that do not need a prescription by federal law (including Drugs that need a prescription by state law, but not by federal law), except for injectable insulin or other Drugs provided in the Diabetic Equipment, Supplies and Self-Management Education as described in this Plan.

**Excess charges.** The part of an expense for care and treatment of an Injury or Sickness that is in excess of the eligible charges as defined by this Plan’s specifically designated fee schedule as specifically designated by this Plan, or the Usual and Reasonable Charge or pre-negotiated contracted rate for services, treatment or supplies in the locality where rendered or furnished

- (17) **Experimental or not Medically Necessary.** Care and treatment that is either Experimental/Investigational or not Medically Necessary. This exclusion shall not apply to the extent that the charge is for routine patient care of costs a Qualified Individual who is a participant in an approved clinical trial. Charges will be covered only to the extent specifically set forth in the "Covered Charges" section.
- (18) **Eye care.** Charges for (a) eye surgery such as radial keratotomy, to correct myopia (nearsightedness), hyperopia (farsightedness), or astigmatism (blurring) whether performed for cosmetic or work related purposes; (b) routine eye examinations, including refractions, eyeglasses, contact lenses, or any type of external appliances used to improve visual acuity and their fittings, unless specifically stated as covered under this Plan.
- This Plan will cover the (a) first pair of eyeglasses which a Physician prescribes after cataract surgery; (b) initial replacement lenses for loss of natural lens; (c) services for aphakic patients and soft lenses or sclera shells intended for use as corneal bandages. Such expenses will be considered a covered expense to the extent of the least expensive service, supply or procedure which will correct the condition.
- (19) **Felony Participation.** Charges are not covered for any illness, treatment, or medical condition due to a Plan Participant's participation in a felony, riot, or insurrection. This exclusion does not apply to Coverage for services involving injuries suffered by a victim of an act of domestic violence or for services as a result of a medical condition (including both physical and mental health conditions).
- (20) **Foot Care.** Charges for routine foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the fee are not covered by This Plan. However, coverage is provided for foot care when have a specific medical condition or disease resulting in circulatory deficits or areas of decreased sensation in Your legs or feet.
- (21) **Fraud, Waste, Abuse, and Other Inappropriate Billing.** Charges are not covered for services from a Provider that are determined to be not payable as a result fraud, waste, abuse, or inappropriate billing activities. This includes a Provider's failure to submit medical records required to determine the appropriateness of a claim.
- (22) **Government Facility.** This Plan does not cover care or treatment provided in a Hospital that is owned or operated by any federal, state, or other governmental entity, except as otherwise required by law unless the Plan Participant is taken to the Hospital because it is close to the place where the injured occurred or became ill and Emergency Services are provided to treat the Emergency Condition.
- (23) **Hearing Aids.** Hearing aids or exams to prescribe or fit hearing aids, including bone-anchored hearing aids, unless listed as covered in this Plan. This Exclusion does not apply to cochlear implants.
- (24) **Herbal medicine.** Charges incurred for services or supplies related to herbal medicine.
- (25) **Hospital Employees.** Professional services billed by a Physician who is a resident or intern or a nurse who is an Employee of a Hospital or Skilled Nursing Facility/Extended Care Facility and paid by the Hospital or Facility for the service.
- (26) **Illegal acts.** Charges for services received as a result of Injury or Sickness caused by or contributed to by engaging in an illegal act or occupation; by committing or attempting to commit any crime, criminal act, assault, or other felonious behavior; or by participating in a riot or public disturbance. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including physical and mental health) condition.
- (27) **Interruption of Dependent child Pregnancy.** All services and supplies related to the interruption of a Dependent child, are not covered.
- (28) **Medically Necessary.** In general, this Plan does not cover any health care service, procedure, treatment, test, device, or Prescription Drug that We determine is not Medically Necessary.

- (29) **Medicare or Other Governmental Program.** This Plan does not cover services if benefits are provided for such services under the federal Medicare program or other governmental program (except Medicaid). When a Plan Participant is eligible for Medicare, the Plan will reduce the benefits by the amount Medicare would have paid for the Covered Services. Except as otherwise required by law, this reduction is made even if the Plan Participant fails to enroll in Medicare or does not pay the appropriate Medicare premium. Benefits for Covered Services will not be reduced if the Plan is required by federal law to pay first or if not eligible for premium-free Medicare Part A.
- (30) **Military Service.** This Plan does not cover Illness, treatment, or a medical condition due to service in the Armed Forces or auxiliary units.
- (31) **Music therapy.** Charges incurred for music therapy.
- (32) **No charge.** Care and treatment for which there would not have been a charge if no coverage had been in force.
- (33) **No-Fault Automobile Insurance.** This Plan does not cover any benefits to the extent provided for any loss or portion thereof for which mandatory automobile no-fault benefits are recovered or recoverable. This exclusion applies even if Plan Participant do not make a proper or timely claim for the benefits available under a mandatory no-fault policy.
- (34) **No medical value.** Charges for services, supplies or treatment not recognized by the appropriate medical or dental association in the United States as generally accepted and Medically Necessary for the diagnosis and/or treatment of an Injury or Sickness; or charges for procedures, surgical or otherwise, which are specifically recognized by the appropriate medical or dental association in the United States as having no medical value.
- (35) **No obligation to pay.** Charges incurred for which this Plan has no legal obligation to pay.
- (36) **No Physician recommendation.** Care, treatment, services or supplies not recommended and approved by a Physician; or treatment, services or supplies when the Covered Person is not under the regular care of a Physician. Regular care means ongoing medical supervision or treatment which is appropriate care for the Injury or Sickness.
- (37) **No show charges.** Charges related to missed appointments.
- (38) **Non-emergency Hospital admissions.** Care and treatment billed by a Hospital for non-Medical Emergency admissions on a Friday, or Saturday unless the Attending Physician certifies in writing that such admittance was an emergency Hospital admittance and Medically Necessary. This does not apply if surgery is performed within twenty-four (24) hours of admission.
- (39) **Not licensed or certified.** Charges incurred for facility charges, operating rooms or general anesthesia billed by a facility not licensed or certified by the state or Medicare approved.
- (40) **Occupational.** Care and treatment of an Injury, Sickness or disease that is occupational – that is, arises from work for wage or profit including self-employment, and/or is covered by reason of its relation to work by any workers' compensation law, occupational disease laws or similar laws. This is true regardless of where the law is in effect; regardless of whether the Covered Person actually claims compensation or receives benefits under those laws and regardless whether or not the Covered Person has any recovery from a third party for damages resulting from such a condition, Sickness, or Injury.
- (41) **Outside U.S.** Charges incurred outside the United States if the Covered Person traveled to the locale for the purposes of obtaining medical services, drugs, or supplies.
- (42) **Personal comfort items and other medical supplies.** Personal comfort items or other equipment, such as, but not limited to, air conditioners, air-purification units, humidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, thermometers, ovulation kits, early pregnancy or home pregnancy testing kits, elastic bandages or stockings, non-prescription drugs and medicines, first-aid supplies and non-hospital adjustable beds, waterbeds, water purifiers, air purifiers, hypo-allergenic pillows, hot tubs, swimming pools and exercise equipment.

- (43) **Screening, research, and other services.** Service provided for screening, research studies or experimentation, mandatory consultation required by Hospital regulations, routine pre-operative consultations and stand-by services are not covered under this Plan.
- (44) **Services before or after coverage.** Care, treatment or supplies for which a charge was incurred before a person was covered under this Plan or after coverage ceased under this Plan.
- (45) **Services Not Listed.** This Plan does not cover services that are not listed in this Plan as being Covered.
- (46) **Services Provided by a Family Member.** This Plan does not cover services performed by a member of the Plan Participant's immediate family. "Immediate family" shall mean a child, spouse, mother, father, sister, or brother whether the relationship is by blood or exists in law.
- (47) **Services Separately Billed by Hospital Employees.** This Plan does not cover services rendered and separately billed by employees of Hospitals, laboratories, or other institutions.
- (48) **Stand-by services.** Charges for stand-by services required by a Provider.
- (49) **Surgical sterilization reversal.** Care and treatment for reversal of surgical sterilization for men and/or women.
- (50) **Travel or accommodations.** Charges for travel or accommodations, whether or not recommended by a Physician, except for ambulance charges as defined as a covered expense under this Plan.
- (51) **Vision Services.** This Plan does not cover the examination or fitting of eyeglasses or contact lenses.
- (52) **War.** This Plan does not cover an illness, treatment, or medical condition due to war, declared or undeclared.
- (53) **Weight loss.** Care and treatment of obesity, weight loss or dietary control whether or not it is, in any case, a part of the treatment plan for another Sickness. Medically Necessary charges for Morbid Obesity will be covered.

## CLAIMS AND REIMBURSEMENT

Claims must be filed within 12 months following the date the charges were incurred. Claims filed later than 12 months after treatment begins, or hospital confinement started will be denied.

**Note:** No plan benefits will be paid for any claim not submitted within 12 months.

If you or a Dependent incurs expenses for treatment of a sickness or injury, you must notify the Fund within 90 days of the date that the sickness started, or the injury occurred. Your written proof of loss, claim form, and any other necessary documentation must be submitted within 12 months after the charges are incurred. If the Fund requires additional information from you to process your claim, you have 60 days from the date of the letter requesting the information. If you do not abide by this timetable, the Fund will deny the claim.

### WHERE TO FILE CLAIMS

Your claim will be considered to have been filed as soon as it is received by the appropriate organization that is responsible for

**TIP:** Whenever you interact with insurance provider, keep a copy of anything you send in the mail. Keep track of dates you call and the names of employees you speak with.

determining the initial determination of the claim.

In order for the Plan to pay benefits, a claim must be filed with the Plan. A claim can be filed by you, your eligible Dependent, or by someone authorized to act on behalf of you or your Dependent. The person who has incurred the claim is called the “Claimant” except that, if the claim is incurred by a Dependent Child, then the adult who files the claim or is legally authorized to act on behalf of the Child is the Claimant. In these Procedures, “you” means the Claimant.

1. A claim for a benefit is considered to have been filed on the date it is received by the Plan or its representative. Even if a claim is incomplete – for example, the Fund Office or its representative has received a medical bill but has not received a claim form – the claim is considered to have been filed on the date it is first received.
  - a. When you file a claim for benefits, be sure to follow the proper claim filing procedures (see How to File a Claim section).
  - b. If you incur a medical expense and ask the Plan to pay benefits, that is considered a claim. A claim includes the failure of the Plan to provide or make a payment (in whole or in part) for a benefit, including any such denial, reduction, termination or failure to provide or make a payment that is based on a determination of an individual’s eligibility for coverage, a denial of part of the claim due to the terms of the Plan regarding Co-Payments, Deductibles or other cost sharing requirements. A claim also includes a termination of coverage regardless of whether there has been any medical expenses incurred. This paragraph does not apply to “pre-service” claims (defined below).
  - c. Claims must be submitted within 12 months after the date the loss occurred.
  - d. If the Plan requires additional information from you to process your claim, you have 60 days from the date on which you receive the written request for information to respond to the Fund.
2. You may designate another person as your authorized representative for the purpose of filing a claim. Except in the case of an “urgent care” claim (defined below), such designations must be in writing.
  - a. Unless your (the Claimant’s) authorization states otherwise, all notices regarding your claim will be sent to your authorized representative and not to you. Where such authorization is received from a provider, it shall not be considered valid until you have filed a written authorization form confirming your understanding of the consequences of the authorization.
  - b. A routine assignment of benefits to a medical provider, so that the Plan will make payment directly to the provider, is not considered to be a designation of the provider as your authorized representative.
3. You (the Claimant) may not assign your rights as a Plan Participant to a provider or other third party or in any way alienate your claim for benefits. Any attempt to assign those rights or in any way alienate a claim for benefits will be void and will

not be recognized by the Fund for that purpose. The Fund will treat any document attempting to assign your rights as a Plan Participant or to alienate a claim for benefits to a provider, to be only an authorization for direct payment by the Fund to the provider. For example, the Fund will NOT allow Claimants to assign to their provider any rights as a Participant in the Plan, including, but not limited to, the right to appeal a claim denial or the right to receive documentation concerning claims. In the event that the Fund does receive a document claiming to be an assignment of benefits, the Fund will send payments for the claims to the provider, but will send all claim documentation, such as an Explanation of Benefits, and appeal procedures directly to the Claimant. If the Fund should deny any claim, only the Claimant will have the right to appeal. (However, Claimants may, in accordance with the applicable Plan rules, designate their provider as their authorized representatives to file a claim or appeal on their behalf and/or receive notices on their behalf.)

4. The Fund will pay claims only when covered under the terms of the Plan. If the Fund pays a claim that it is not required to pay, it may recover and collect payments from the Claimant or any other entity or organization that was required to make the payment. Recovery of such payments may be made but is not limited to offset or reduction of future benefits from the Claimant or the Claimant's covered family Participants.
5. The Claimant will be provided, free of charge, any new or additional evidence considered, relied upon, or generated in connection with the claim review, as well as any new or additional rationale for a denial at the appeals stage, and a reasonable opportunity for the Claimant to respond to such new evidence or rationale.
6. Conflicts of interest: The Fund's decisions with respect to hiring, compensation termination, promotion or other similar matters with respect to an employee or contractor, such as a claims adjudicator or medical expert, will not be based upon the likelihood that the individual will support the denial of benefits.

## TIME PERIODS FOR PROCESSING CLAIMS

The amount of time that the Plan can take to process a claim depends on the type of claim. There are three categories:

### 1. Post-Service Claims

2.
  - a. Most medical claims are of this type. A claim is "post-service" if
    - The Claimant has already received the treatment or service, and the claim consists of asking the Plan for payment;
    - The treatment or service has not yet been provided but the Plan does not require the Claimant to obtain approval before receiving the treatment or service; or
    - Any other claim that is not a "pre-service" claim or a disability claim (defined below)
  - b. Approval or denial of a post-service claim will normally be made within 30 days of the date the claim is received by the Plan. If additional time is required, there are two types of extensions that may apply: a "Plan extension" or a "Claimant extension".
    - A "Claimant extension" occurs when you have not provided the Plan with all information or documents needed to process your claim.
    - A "Plan extension" occurs when there are circumstances beyond the control of the Plan that cause the Plan to need an extension of time, other than where the Claimant has not provided the Plan with all information or documents needed to process the claim. If the Plan needs information or materials from your Physician or medical provider, that is considered a "Claimant extension", even though the materials will come from your medical provider and not from you. As a convenience to you, the Plan may request necessary materials or information directly from your medical provider, but you are responsible for providing the Plan with that material.
  - c. In the case of a "Plan extension", the Plan can extend the 30-day claim processing period by 15 days. Before the end of the original 30-day period, you will be notified in writing of the circumstances requiring an extension of time and of the circumstances requiring an extension of time and of the date by which the Plan expects to make a final decision on the claim.
  - d. When there is a "Claimant extension", the Plan will request the necessary information or material in writing. If the request goes to your medical provider, you will receive a copy of the request. You will then have 45 days to submit, or have your medical provider submit, the information the Plan needs to process your claim. When a "Claimant extension" is in effect, the time for the Plan to decide your claim is extended by the time it takes you or your medical provider to

supply the requested information. Once the Plan has received a response to its request, the ordinary time limits (the 30-day period or the 15-day extension) will start to run again. If the Plan does not receive a response to its request within 60 days, the Plan will decide your claim without that information, which may result in the denial of your claim.

### 3. Pre-Service Claims

- a. A claim is “pre-service” only if the Plan specifies that benefits will not be paid unless the claim is approved before care is provided. In addition to normal pre-service claims, there are two special types of pre-service claims, that is, “urgent care” claims and “concurrent care” claims.
  - “Urgent care” claims. If applying the time limits for a non-urgent pre-service claim (see below) could jeopardize the life or health of the patient or subject the patient to severe pain that could be managed with care or treatment, the claim is considered to be an “urgent care” claim.
  - “Concurrent care” claims. If the Plan requires preapproval for an ongoing course of treatment, then the claim is not only “pre-service”, but also a “concurrent care” claim.
- b. Approval or denial of a normal pre-service claim (that is, a pre-service claim that is not an “urgent care” or a “concurrent care” claim) will ordinarily be made within 15 days of the date the claim is received by the Plan.
  - If a “Plan extension” is necessary, the Plan can extend the 15-day time period by another 15 days. (The same “Plan extension” and “Claimant extension” rules that apply to “post-service claims”, explained above, also apply to “pre-service claims”.) Before the end of the original 15-day period, you will be notified in writing of the circumstances requiring a “Plan extension” and the date by which the Plan expects to make a final decision on the claim.
  - When the Plan needs additional material or information from you or your medical provider, that is a “Claimant extension”. (The same “Plan extension” and “Claimant extension” rules that apply to “post-service claims”, explained above, also apply to “pre-service claims”.) Once the Plan has received a response to its request, the original time limit (the 15-day period or, with the extension, 30 days) will start to run again. If the Plan does not receive a response to its request within 60 days, the Plan will decide your claim without that information, which may result in the denial of your claim.
- c. The following time limits apply to “urgent care” claims:
  - As soon as possible, considering the medical exigencies, but not later than 72 hours – after the Plan’s receipt of an “urgent care” claim, the Plan (or its representative) will advise you whether or not the treatment or service is approved. This notice may be given by telephone or in writing but, if the notice is by telephone, a written confirmation will follow within 3 days. If the Plan cannot process the claim without additional material or information from you or your medical provider, that will cause a “Claimant extension” and the Plan will request the necessary material within 24 hours of receipt of the claim. You will be given no less than 48 hours to provide the needed information. Once the Plan has received a response to its request, the Plan will decide on your claim within 48 hours of the time the additional information is received or, if no information is provided, within 48 hours of the expiration of the time period within which a response was to be made.
  - For “urgent care” claims, a medical professional with knowledge of your medical condition can act as your authorized representative. The Plan will not require the medical professional to show that you have designated him/her as your authorized representative.

- d. “Concurrent care” claims are processed within the same time limits that apply to normal pre-service claims unless the “concurrent care” claim is also an “urgent care” claim. The following additional rules apply to “concurrent care” claims.
- If the Plan has approved coverage for a specified period of treatment and you request an extension of that period, the request for an extension is treated as a new “pre-service” claim. However, if the extension request is an “urgent care” claim, the Plan will notify you of its decision within 24 hours of the Plan’s receipt of the request, provided that the request for an extension is received more than 24 hours before the end of the originally approved period of treatment. Otherwise, the time periods for processing an “urgent care” claim will apply.
  - If you have a “concurrent care” claim and the Plan terminates or reduces a previously approved period of treatment, you will have the right to appeal that termination or reduction. (The rules governing appeals are explained below.) The Plan will give you 10 days’ advance notice of such a termination or reduction. If you appeal the termination or reduction within the 10-day period, the Plan will not implement the termination or reduction before you are given notice of the outcome of the appeal. This rule, allowing the course of treatment to continue pending an appeal, does not apply if your benefits terminate because you have lost eligibility under the Plan or if the termination or reduction of benefits is the result of a Plan amendment.

## **HOW TO FILE A CLAIM**

Using an In-Network Provider makes obtaining benefits simple. You show your Participant ID card and pay any applicable copayment, deductible or coinsurance. Your hospital, doctor or other provider then files the claim for you.

If you use a non-participating provider, please ask your Provider to submit the claim to the address on your ID card. You may be requested to pay the Provider's full charge, but ask that Provider to submit the claim and any payment due by you will be provided upon payment by the Plan if there is any balance due such as as copayment, deductible or coinsurance. In an emergency situation, please ask the Provider to submit the claim to the address on the ID card. If you receive emergency care services from a Non-Network Provider, please ask the Provider to submit the claim to the address on the ID card. You can also submit a claim form to Insurance Design Administrators for processing, but this is not recommended.

Most clean claims are processed and mailed within 10 to 15 business days from the date the claim is received from you or your provider. To save time, we suggest you request the provider complete the claim form at the time of your visit so that you can mail the claim right away to the address on the ID card.

In order to prevent a denial of coverage due to failure to file a claim in a timely manner, you must file your claim within 12 months after the date upon which the service was provided. The Health Insurance Claim Form is used for most services.

## **YOUR EXPLANATION OF BENEFITS ("EOB"):**

You will usually receive an Explanation of Benefits ("EOB") when a claim is processed submitted for processing and payment.

The EOB statement will tell you the services you received, the dates they were performed, the network rate for each covered service, and any copayment, deductible or coinsurance amounts applied. A check will generally be sent to the provider.

If you use a Non-Network Provider for medical services, you may be responsible for paying any Non-Network Provider up front except for emergency care. Such services rendered should be filed by the Provider for consideration and payment. You will receive an EOB statement which will explain to you the services you received, the dates they were performed, Plan allowances for covered services and any deductible or coinsurance amounts applied that would be your responsibility. You can expect to receive a bill from the provider for your responsibility.

Hospital services will usually be billed directly. After the claim is processed, you and the hospital will receive an EOB explaining how the claim was settled. A payment by check or electronic payment, if appropriate, will be sent directly to the hospital. Hospital services rendered by a hospital or facility that has agreed to the Maximum Allowable Charge, will advise you of any amount(s) that are your responsibility.

If you obtain covered services from a Non- par network provider, unless it is for emergency care, you are responsible for paying the provider up front. If you received services from a Non-Network Provider for emergency care, the Plan will pay the allowed emergent charge for your eligible charges. If the provider charges more than the allowance, you will have to pay the difference between the allowance and the provider's charge, in addition to any applicable copay, deductible and coinsurance amount(s).

When you obtain covered services from providers, you may be responsible for any or all of the following types of charges:

- **Deductible** - A portion of eligible expenses that an individual or family must pay during a calendar year before the Plan will pay benefits for covered services.
- **Coinsurance** - A percentage of the Plan's allowance(s) payable by you for covered services. Expenses credited toward your deductible, copayments, charges for services that are not covered, and charges in excess of Plan allowances and benefit limitations are also payable by you but are not considered coinsurance.
- **Copayment** - The fixed dollar amount Participants must pay for certain covered services. It is usually paid to a provider at the time the service is rendered.
- **Balance of Charges** - Non-par Providers have not agreed to accept the Plan's allowed charge as payment in full. When you receive out-of-network services, usually emergency services, you are responsible for any provider charges that exceed Plan allowances in addition to any cost-sharing provisions, e.g., copayment, deductible, coinsurance amounts that apply to your benefits, usually emergency services. For example, if the provider charges \$50 for a service and the Plan allows \$30, then you are responsible for the \$20 difference ( $\$50 - \$30 = \$20$ ). In this example, the balance-of-charges would be \$20.

## **WHAT THE PLAN PAYS**

**Network Providers** – The Plan provides benefits for covered hospital and medical services given by participating Network Providers based on negotiated rates or Schedule(s) of Allowances. Network Providers have agreed to accept negotiated rates or allowances as payment in full for covered services, subject to applicable cost-sharing provisions.

**Non-Participating Providers** – The Plan does not, except for emergency care, offer the option of seeing a Non-Participating Provider. Your coverage will provide benefits only for covered services rendered by an In-Network Provider.

**Non-Covered services** – The Plan will not pay for any services that are not listed as covered or are specifically excluded under your program. You will be responsible for the provider's full charges for such services.

**Transfers among providers** – If during the course of treatment, you transfer from one provider to another, the Plan's allowance for the covered services may be pro-rated between the providers. Normally, the Plan will not pay more than its maximum allowance had payment been made to only one provider.

## **WHAT YOU PAY**

You will maximize your benefits and minimize out-of-pocket expenses by utilizing In-network providers.

Your financial responsibility is limited to the following categories:

**Cost-sharing.** The specific cost-sharing provisions for this Plan are detailed in this SPD. The following information is included here to help you more easily understand the information.

When you use Network Providers, many services are covered in full but may require a copayment. The copayment is usually paid to the provider at the time service is rendered. For example, you may have a copayment for a doctor office visit. Some services that require a copayment include:

- **Physician Medical Services** (also referred to as a doctor office visit)
  - Office Visit
  - Specialist Office Visit
  - Chiropractic Care
  - Physical Therapy
  - Speech Therapy
  - Diagnostic Lab Copayment

Certain benefits may also require you to satisfy a deductible and/or pay coinsurance, even if you receive covered services In-Network or a Provider who has agreed to the Maximum Allowable Charge or an agreed upon amount for the services rendered. Some services that require a coinsurance payment include the following Inpatient Hospital Services:

- Hospital Admission and Hospital Coverage
- Medical Rehabilitation

- Physician Surgical Services or Skilled Nursing Care
- Inpatient Mental Health Care
- Inpatient Chemical Dependency Care

Outpatient Hospital Services include:

- Ambulatory Surgery
- Physician Surgical Services
- Diagnostic Lab Tests
- Diagnostic Radiology Tests

There can be instances where a Physician's office visit, which requires a copayment, may also include the Plan's deductible and a coinsurance payment. This typically happens when a Participant goes for an office visit and the doctor performs a service in the office that requires a coinsurance payment.

Examples of services performed in a Physician's office that may include a coinsurance payment in addition to the office visit copayment are:

- Biopsy
- Incision
- Excision
- Excision by needle
- Endoscopy
- Esophagoscopy
- Dilation of esophagus
- Colonoscopy (if not done as a preventive service)
- Peritoneocentesis
- Abdominal paracentesis
- Peritoneal lavage
- Bladder instillation of anticarcinogenic
- Cystourethroscopy
- Vasectomy
- Conization of cervix
- Dilation and curettage

This is not a comprehensive list of services that will require a coinsurance payment in addition to the office visit copayment. If you have questions about your particular service that may be performed in the doctor's office, please consult your physician. The information included here is to help you more easily understand your coverage.

When you obtain covered services from Non- participating providers, not including emergency services, you are responsible for the following type of charge:

- Balance of Charges – Non par providers have not agreed to accept the Allowed Charge as payment in full. When you receive out-of-network services, you are responsible for any provider charges that exceed the Plan's allowance in addition to any cost-sharing provisions, e.g., copayment, deductible, and/or coinsurance amounts that apply to your benefits for covered services.

## DENIAL OF CLAIMS

If your claim is denied in whole or in part, the Plan will send you a written notice stating the specific reason or reasons for the denial, referring to pertinent Plan provisions and standards on which the denial was based. Specifically, the denial will include sufficient information to identify the claim involved, including the date of service, the healthcare provider, the claim amount (if applicable), and any denial codes and their meanings. The notice will be provided in a culturally and linguistically appropriate manner consistent with the requirements of the Affordable Care Act. The notice of claim denial will also include:

1. If applicable, a description of any additional material or information necessary to process your claim along with an explanation of why such material or information is necessary;
2. If applicable, a statement that, upon written request, will be furnished with a copy of any internal rule, guideline or policy that the Plan relied on in processing your claim;
3. If applicable, a statement that, upon written request, you will be furnished with an explanation of any scientific or clinical judgment used by the Plan in denying your claim if the Plan found that the treatment was Experimental or not Medically necessary;
4. A statement that Section 502(a) of the Employee Retirement Income Security Act of 1974, as amended (“ERISA”), provides that a participant or beneficiary of an employee benefit plan may file suit to recover benefits due under the terms of the Plan, to enforce the terms of the Plan or to clarify the person’s right to future benefits under the Plan;
5. The deadline for filing an appeal of the denied claim;
6. A statement describing the appeal process and the external review process, including information on how to initiate the appeal.
7. A statement that, upon request to the Fund Office, you have the right to receive the diagnosis and/or treatment codes and their meanings for the treatment at issue; and
8. A statement disclosing the availability of, and contact information for, an applicable office of health insurance consumer assistance or ombudsman established under ACA.

**TIP:** If you disagree with the way your claim was paid or with an eligibility ruling, you can inquire informally by calling or writing the Fund Office. If you still disagree, there is a formal process to follow to have your claim reconsidered.

## NEW YORK STATE SURCHARGE

New York State imposes a surcharge on health care given by certain types of providers. This surcharge applies to payments made by the Fund and to the out-of-pocket expenses that you, the patient, are often responsible for. Out-of-pocket expenses include deductibles, copayments and coinsurance. The Plan will pay the surcharge attributable to payments actually made by the Fund and the surcharge attributable to copayments. Patients must pay the surcharge attributable to any copayment, deductibles and coinsurance if the providers separately bill you for this amount.

The surcharge only applies to services given by the following types of providers: general hospitals, hospital-based extension clinics, comprehensive diagnostic and treatment centers, diagnostic and treatment center extension clinics, diagnostic and treatment centers that provide ambulatory surgical services, and clinical laboratories.

## CLAIM APPEAL PROCEDURE

This section describes the procedure for you to follow if your claim is denied in whole or in part and you wish to appeal the decision.

### APPEALING THE DENIAL OF A CLAIM

If your claim has been denied in whole or in part, you may request a full and fair review (referred to in these Procedures as an “appeal”) by filing a written notice of appeal with the Plan.

1. A notice of appeal must be received at the offices of the Plan or its representative not more than 180 days after receipt by the Claimant of the written notice of denial of the claim. Your appeal is considered to have been filed on the date the written notice of appeal is received.
2. If you wish, another person may represent you in connection with an appeal. If another person claims to be representing you in your appeal, the Trustees have the right to require that you give the Plan a signed statement, advising the Trustees that you have authorized that person to act on your behalf regarding your appeal. Any representation by another person will be at your own expense.
3. Prohibition Against Assignment to Providers – A Claimant may not assign any right under the Plan or statutory right under applicable law to a provider of services or supplies. The prohibition against assignment of such rights includes, but not limited to, the right:
  - a. to receive benefits;
  - b. to claim benefits in accordance with Plan procedures and/or Federal law;
  - c. to commence legal action against the Trustees, Plan/Fund, its agents or employees;
  - d. to request Plan documents or other instruments under which the Plan is established or operated;
  - e. to request any other information that a Participant or Dependent as defined by Section 102 of ERISA may be entitled to receive upon written request to a plan administrator;
  - f. any and all other rights afforded a person covered under the Plan, Restated Trust Agreement federal law and state law.

This subsection shall not have the effect of prohibiting the Administrator or Trustees from paying benefits under the Plan directly to a provider of services or supplies in an amount determined by the claims adjuster, the Administrator, the Trustees, or the Trustees’ Appeals Committee.

4. In connection with your appeal, you or your authorized representative may review pertinent documents and may submit issues and comments in writing.
  - a. Upon written request, the Plan will provide reasonable access to, and copies of, all documents, records or other information relevant to your claim.
  - b. If the Plan obtained an opinion from a medical or vocational expert in connection with your claim, the Plan will, on written request, provide you with the name of that expert.
  - c. The Plan will not charge you for copies of documents you request in connection with an appeal.
5. Appeals of post-service claims will be decided by the Board of Trustees or representatives of the Board of Trustees authorized to act on their behalf. Appeals of pre-service claims may be decided by a Plan fiduciary selected by the Board of Trustees. The person or persons who decide the appeal will not be the same person, or a subordinate of the person who made the original claim denial. **You (and your authorized representative, if any) are not entitled to appear before the persons deciding your appeal and no hearing will be held on the appeal.** However, in its sole discretion, the persons deciding the appeal may invite you (and your authorized representative, if any) to appear before them for an informal hearing on your appeal, for example, if they determine they need information you may be able to provide in order to decide your appeal.
6. In deciding your appeal, the persons deciding the appeal will consider all written comments and documents that you submit, regardless of whether that information was available at the time of the original claim denial.
  - a. In deciding your appeal, the persons deciding the appeal will not presume that the original denial was correct and will consider the issues with no deference to the original decision.
  - b. If an appeal involves a medical judgment, such as whether treatment is Medically Necessary, the persons deciding the appeal will consult with a medical professional who is qualified to offer an opinion on the issue. If a medical professional was consulted in connection with the original claim denial, the persons deciding the appeal will not consult with the same medical professional (or a subordinate of that person) for purposes of the appeal.

**TIP:** Before bringing legal action against the Plan, you must follow the Claim and Appeal procedures completely.

## **CLAIMS AND APPEALS WHERE THE BOARD DOES NOT MEET QUARTERLY**

### **Post-Service Claims**

1. An appeal will be decided no later than 60 days after it was filed, unless special circumstances require an extension of time for processing, in which case the Participant will be advised in writing before the end of the 60-day period of why the extension of time was needed and when the appeal will be decided. In no case will such an extension exceed a period of 60 days from the end of the initial 60-day period.
2. When the Trustees deciding the appeal determine, in their sole discretion, that they can decide an appeal sooner than the time limits stated above, they will do so.
3. The Plan will mail the Participant a written notice of a review decision within five business days after the decision has been made.

### **Pre-Service Claims**

1. For a pre-service claim that is not an “urgent care” claim, the Plan will notify you of the decision on appeal within 30 days of the Plan’s receipt of the appeal.
2. For an “urgent care” claim, the Plan will notify you of the decision on appeal within 72 hours of the Plan’s receipt of the appeal. Also, for appeals of “urgent care” claims, the notice of appeal can be oral instead of in writing, and the Plan may notify you of its decision by telephone or facsimile (“fax”).
3. If a Claimant whose pre-service claim was denied obtains the service or treatment that had been denied, the claim is no longer a pre-service claim and any appeal of the denial of the pre-service claim will be handled under the rules that apply to post-service claims.

## **DECISIONS ON APPEAL**

1. The notice explaining the decision on your appeal will state the specific reason or reasons for the decision, referring to pertinent Plan provisions or standards on which the decision was based. The notice will also include sufficient information to identify the claim involved, including the date of service, the healthcare provider, the claim amount (if applicable), and any denial codes and their meanings. The notice will be provided in a culturally and linguistically appropriate manner consistent with the requirements of the Affordable Care Act. If applicable, the notice will also include:
  - a. A statement that, upon written request, you will be furnished with a copy of any internal rule, guideline or policy that the Plan relied on in processing your claim;
  - b. A statement that, upon written request, you will be furnished with an explanation of any scientific or clinical judgment used by the Plan in denying your claim if the Plan found that the treatment was Experimental or not Medically Necessary.
  - c. A statement that, upon request to the Fund Office, you have the right to receive the diagnosis and/or treatment codes and their meanings for the treatment at issue.
  - d. If the appeal is denied, a statement that you will have the right to file suit, under the authority of the Employee Retirement Income Security Act of 1974, as amended (“ERISA”) and that you are entitled to receive, upon written request and at no cost, copies of documents and information that the Plan relied on in denying your claim.
  - e. A statement describing the external review process.
2. If your appeal is approved in full, the Plan will not be required to send you a letter meeting the requirements of this section unless otherwise required by law.
3. A Claimant may not file a suit against the Plan until the Claimant has exhausted all of the procedures described in these Claim and Appeal Procedures. However, this rule is subject to the following:
  - a. If the Plan does not issue a decision on a claim within the time limits stated in these Procedures, the Claimant shall have the immediate right to file an appeal under these Procedures.
  - b. If a decision on an appeal is not furnished within the time limits stated in these Procedures, this requirement to exhaust Plan remedies will not apply.
  - c. Under no circumstances can the Claimant file suit against the Plan more than three years after the date on which the Participant received notice from the Plan that the claim was denied or, if the Participant appealed the claim denial, the date on which the Participant received notice from the Plan that the appeal was denied.

Appeals need to be submitted in writing to the appropriate organization within *180 days* after you receive notice of denial.

**Note:** Appeals involving **Urgent Care Claims** may be made orally to the health organization that administers the particular Benefit you are requesting.

Effective as required by federal law, the Plan's claims and appeals procedures have changed to comply with the Affordable Care Act. If your claim involves an issue dealing with medical judgment or retroactive termination of coverage and your claim for benefits is denied after you exhaust the Plan's internal appeal procedures, you may request an external review by an independent review organization (IRO) within four months of the receipt of notice of the final internal denial decision. Your Explanation of Benefits and internal appeal decisions will inform you of your right to request an external review appeal, your external review rights and your right to file a suit in federal court under the Employee Retirement Income Security Act of 1974.

## **EXTERNAL REVIEW PROCEDURE**

This section sets forth procedures for an external review for health claims and coverage terminations.

1. Request for external review. A Claimant may file a request for an external review with the Plan if the request is filed within four months after the date of receipt of a notice of a final internal adverse benefit determination (i.e., an appeal denial). **The request for external review must be for a claim involving medical judgment (excluding those that involve only contractual or legal interpretation without any use of medical judgment) or termination of coverage.** (Please note that external review is only available for an adverse benefit determination (i.e., a claim denial) without first exhausting the internal appeal process when the adverse benefit determination meets the requirements for expedited review as described below).
2. Preliminary review. Within five business days following the date of receipt of the external review request, the Plan will complete a preliminary review of the request to determine whether:
  - a. The Claimant was eligible at the time services were provided;
  - b. The adverse benefit determination or the final adverse benefit determination does not relate to the Claimant's failure to meet the requirements for eligibility under the terms of the group health plan;
  - c. The Claimant exhausted the Plan's internal appeal process;
  - d. The Claimant has provided all the information and forms required to process an external review.

Within one business day after completion of the preliminary review, the Plan will issue a notification in writing to the Claimant. If the request is complete but not eligible for external review, such notification will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration. If the request is not complete, such notification will describe the information or materials needed to make the request complete and the Plan will allow you to perfect the request for external review within the four-month filing period or within the 48-hour period following the receipt of the notification, whichever is later.

3. Referral to Independent Review Organization. The Plan or its agent will assign an independent review organization (IRO) that is accredited by URAC or by similar nationally recognized accrediting organization to conduct the external review. The Plan will utilize at least two (2) IROs for assignments under the Plan and rotate claims assignments among them (or incorporate other independent, unbiased methods for selection of IRO's, such as random selection). The IRO will not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits.

The assigned IRO will utilize legal experts where appropriate to make coverage determinations under the Plan.

The assigned IRO will timely notify the Claimant in writing of the request's eligibility and acceptance for external review. This notice will include a statement that the Claimant may submit, in writing to the assigned IRO within ten business days following the date of receipt of the notice, additional information that the IRO must consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted after ten business days.

Within five business days after the date of assignment of the IRO, the Plan will provide to the assigned IRO the documents and any information considered in making the final internal adverse benefit determination. Failure by the plan to timely provide the documents and information will not delay the conduct of the external review. If the Plan fails to timely provide the documents and information, the assigned IRO may terminate the external review and decide to reverse the final internal adverse benefit determination. Within one business day after making the decision, the IRO will notify the Claimant and the Plan.

Upon receipt of any information submitted by the Claimant, the assigned IRO will, within one business day, forward the information to the Plan. Upon receipt of any such information, the Plan may reconsider its final internal adverse benefit determination that is the subject of the external review. Reconsideration by the Plan will not delay the external review. The external review may be terminated as a result of the reconsideration only if the Plan decides, upon completion of its

reconsideration, to reverse its final internal adverse benefit determination and provide coverage or payment. Within one business day after making such a decision, the Plan will provide written notice of its decision to the Claimant and the assigned IRO and the assigned IRO will terminate the external review

The IRO will review all of the information and documents timely received. In reaching a decision, the assigned IRO will review the claim from the beginning and not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process under paragraph (b) of the interim final regulations under section 2719 of the PHS Act. In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:

1. The Claimant's medical records;
2. The attending health care professional's recommendation;
3. Reports from appropriate health care professionals and other documents submitted by the Plan, Claimant, or the Claimant's treating provider;
4. The terms of the Claimant's Plan to ensure that the IRO's decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law;
5. Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations;
6. Any applicable clinical review criteria developed and used by the Plan, unless the criteria are inconsistent with the terms of the Plan or with applicable law;
7. The opinion of the IRO's clinical reviewer or reviewers after considering information described in this notice to the extent the information or documents are available, and the clinical reviewer or reviewers consider appropriate.

The assigned IRO will provide a written notice of the final external review decision within 45 days after the IRO receives the request for the external review. The IRO will deliver the notice of final external review decision to the Claimant and the Plan.

The assigned IRO's decision notice will contain:

1. 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, the treatment code and its corresponding meaning, and the reason);
2. The date the IRO received the assignment to conduct the external review;
3. References to the evidence or documentation, including the specific coverage provisions and evidence-based standards that were relied on in making its decision;
4. A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;
5. A statement that determination is binding except to the extent that other remedies may be available under State or Federal law to either the group health plan or to the Claimant;
6. A statement that judicial review may be available to the Claimant;
7. Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793.

**Expedited Review:** The Claimant will be entitled to make a request for an expedited review if the Claimant receives:

1. An adverse benefit determination (i.e., a claim denial) involving a medical condition of the Claimant for which the timeframe for completion of an expedited internal appeal (e.g., appeals for urgent care claims) would seriously jeopardize the life or health of the Claimant or would jeopardize the Claimant's ability to regain maximum function and the claimant has filed a request for an expedited internal appeal; or
2. A final adverse benefit determination, if the Claimant has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the Claimant or would jeopardize the Claimant's ability to regain maximum function, or if the final internal adverse benefit determination concerns an admission, availability of care, continued stay or health care item or service for which the Claimant received emergency services, but has not been discharged from a facility.

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

eligible for external review following the preliminary review, the Plan will assign an IRO to review the matter. The Plan will provide or transmit all necessary documents and information considered in making the adverse benefit determination or final internal adverse benefit determination to the assigned IRO electronically or by telephone or fax or any other available expeditious method.

The assigned IRO, to the extent the information or documents are available, and the IRO considers them appropriate, will consider the information or documents described above under the procedures for standard review. In reaching a decision, the assigned IRO must review the claim from the beginning and is not bound by any decisions or conclusions reached during the plan's internal claims and appeals process. The assigned IRO must provide notice of the final external review decision, in accordance with the requirements set forth in above for standard reviews, as expeditiously as the Claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO must provide written confirmation of the decision to the Claimant and the Plan.

After a final external review decision, the IRO must maintain records of all claims and notices associated with the external review process for six years. An IRO must make such records available for examination by the Claimant, Plan, or State or Federal oversight agency upon request, except where such disclosure would violate State or Federal privacy laws.

Reversal of Plan's decision: Upon receipt of a notice of a final external review decision reversing the adverse benefit determination or final internal adverse benefit determination, the Plan immediately must provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

**MEDICARE BENEFITS**  
**COORDINATION OF BENEFITS PROVIDED FOR ELIGIBLE**  
**PARTICIPANTS WHO ARE ELIGIBLE FOR MEDICARE**

Under the Tax Equity and Fiscal Responsibility Act of 1982 (“TEFRA”) and the Deficit Reduction Act of 1984 (“DEFRA”), Employees who continue to work after age 65 for a Contributing Employer who has 20 or more employees after you become age 65 and eligible for Medicare, you are entitled to the same benefits as employees under age 65 as long as you meet the regular eligibility rules.

**Under the Omnibus Budget Reconciliation Act of 1986 (“OBRA”), if the Fund covers 100 or more people, you (as an active employee) or your covered dependents who become entitled to Medicare disability may choose the Fund’s coverage as the primary coverage by notifying the Fund Office.**

You can decline coverage under this Plan. If you do, Medicare will be your only health care coverage. Understand that you are not permitted to receive any payment by your employer for any Medicare premiums or receive additional compensation to drop your coverage from this Plan in order to enroll in Medicare. If you prefer Medicare as your only health care coverage when you are age 65, contact the Fund Administrator. Unless you make such a choice, this Plan will continue to pay primary benefits for you as long as you remain eligible.

For Participants who are under 65 and entitled to Medicare because of End Stage Renal Disease, this Plan will be primary for the person's first 30 months of Medicare coverage and Medicare will be secondary. After the first 30 months, this Plan's coverage will be secondary for as long as the person remains eligible. In all other cases, this Plan will pay secondary to Medicare when it is allowed to do so by law.

You are responsible for enrolling in Medicare Part A and Part B when eligible to do so. Part A provides Hospital benefits, while Part B covers such items as Doctors' services.

**NOTE:** Medicare will contact you three (3) months before you turn age 65.

**IMPORTANT NOTE ABOUT MEDICARE**

To maintain maximum health benefits coverage, you must join Medicare by calling your local Social Security office as soon as you are eligible. To enroll in Medicare Part A (Hospital) and Part B (Medical), contact the Social Security office three months before your 65th birthday.

## COORDINATION OF BENEFITS (“C.O.B”)

Benefits are coordinated when both you and your Spouse and/or your Dependent Child(ren) are covered by this Plan as well as by another group health plan. Coordination allows benefits to be paid by two or more plans, up to, but not to exceed, 100% of the allowable expenses on the claim.

### GENERAL C.O.B. INFORMATION

- Benefits are coordinated on all Covered Individuals' claims for payment or reimbursement. C.O.B. applies to medical, prescription, vision and dental claims.
- Benefits are coordinated with other group plans, including group insurance plans.
- You must file a claim for any benefits to which you are entitled from any other source. Whether or not you file a claim with these other sources, your Plan payments will be calculated as though you have received any benefits to which you are entitled.
- Benefits are paid in C.O.B. for "Allowable Expenses," which are expenses that are eligible to be considered for reimbursement.
- A plan that pays "primary" benefits is the plan that is required to pay its benefits first. The plan that pays "secondary" benefits is the plan that pays its benefits after the other plan has paid its benefits.
- If an eligible Dependent elects to participate in a Health Maintenance Organization (HMO) as an employee of another employer, benefits under this Plan are limited to Co-Payment and/or Deductibles not covered under the HMO and Covered Expenses that are specifically excluded under the HMO. There will be no coverage under this Plan for any item not covered by the HMO because the Dependent chose not to avail himself or herself of the HMO participating provider.

### ORDER OF BENEFIT PAYMENTS WHEN TWO OR MORE PLANS ARE INVOLVED

When both you and your Spouse are covered under group health plans as employees and someone in your family has a claim, you should each file the claim with your own plan. The plans will pay as follows:

- If the other plan does not have C.O.B. rules, that plan will pay its benefits first and this Plan will pay second.
- When the other plan does have C.O.B. rules, the plan covering the person for whom the claim is filed as an employee will pay first and the plan covering the person other than as an employee will pay second.
- If you elect to make self-payments for COBRA Coverage under this Plan while you are also covered by another plan, the other plan will pay first, and this Plan's COBRA Coverage will pay second.
- If you and your Spouse are both covered as Employees under this Plan and one of you has a claim, the Plan will pay primary benefits on the claim as the claim of an Employee and then pay secondary benefits on the claim as the claim of a Dependent.
- On claims for Dependent Children:
  - If one of your Dependent Children is covered under another plan as an employee, the Child's plan will pay first and this Plan will pay second.
  - When the natural parents are married (and not separated or divorced), or when they are not married but living together, the plan covering the parent whose birthday comes first in the year will pay first and the plan covering the parent whose birthday comes later in the year will pay second (the "birthday rule").
  - When the natural parents are legally separated or divorced, or are not married and not living together, benefits are payable according to any existing court decree (i.e., the plan of the parent who is identified as financially responsible for the health care of the Child is primary). If there is not a court decree stating who is financially responsible for a Child's health care (or the decree provides that both parents have financial responsibility for the Child's health care), the plan covering the parent with custody pays first and the plan covering the parent without custody pays second. If the parent with custody has remarried, that parent's plan pays first, the stepparent's plan pays second and the plan covering the parent without custody pays third.
  - If you and your Spouse are both covered as Employees under this Plan, benefits for claims for your Dependent Children will be coordinated, subject to the above rules, up to 100% of the Allowable Expense.

If the above rules still do not clearly show which plan should pay first, the plan that has covered the person (for whom the claim is filed) the longest period of time will pay first, the plan that has covered the person for the next longest period of time will pay second, and so on.

No benefits will be payable under this Plan to, or on behalf of, a Dependent who has health coverage of any kind under another group health plan unless that plan provides the same maximum benefits to that Dependent as it does to other participants in that plan (without regard to any benefits the Dependent may have under this Plan).

## **SUBROGATION**

### **(Claims involving Third-Party Liability)**

This provision applies to all Participants with respect to all of the benefits provided under this Plan. For the purpose of this provision, the terms “*you*” and “*your*” refer to all Participants and covered Dependents.

### **GENERAL**

Occasionally, a third party may be liable for your medical expenses. This may occur when a third party is responsible for causing your Illness or Injury or is otherwise responsible for your medical bills. The rules in this section govern how this Fund pays all benefits in such situations.

These rules have two (2) purposes. First, the rules ensure that your benefits will be paid promptly. Often, where there are questions of third-party liability, many months pass before the third party actually pays. These rules permit this Fund to pay your covered expenses and provide any other benefits to which you are entitled until your dispute with the third party is resolved.

Second, the rules protect this Fund from bearing the full expense in situations where a third party is liable. Under these rules, once it is determined that a third party is liable, in any way, for the injuries giving rise to these expenses, or that third party settles the claim which gave rise to the injuries without an admission of guilt, this Plan must be reimbursed for the relevant benefits it has advanced to you out of any recovery, whatsoever, that you receive that is, in any way, related to the event which caused you to incur the medical expenses. This is true whether or not the settlement is itemized.

### **RIGHTS OF SUBROGATION AND REIMBURSEMENT**

If you incur covered expenses for which a third party may be liable, or if you become entitled to other benefits as a result of the same events which caused you to incur the covered expenses, you are required to advise the Plan of the fact. By law, the Plan automatically acquires any and all rights which you may have against the third party.

In addition to its subrogation rights, the Fund has the right to be reimbursed for payments made to you or on your behalf, under these circumstances. The Plan must be reimbursed in full from any settlement, judgment, or other payment that you obtain from the liable third party. Other expenses, including attorneys' fees, cannot be taken out of the payment.

### **ASSIGNMENT OF CLAIM**

The Trustees, in their sole discretion, may require you to assign your entire claim against the third party to this Fund. If this Fund recovers from the third party any amount in excess of the benefits paid to you, plus the expenses incurred in making the recovery, then the excess will be paid to you.

### **FAILURE TO DISCLOSE AND/OR COOPERATE**

If you fail to tell this Fund that you have a claim against a third party; if you fail to assign your claim against the third party to this Fund when required to do so (and to cooperate with the Fund's subsequent recovery efforts); if you fail to require any attorney you subsequently retain to sign the Fund's Reimbursement Agreement and forms; if you and/or your attorneys fail to reimburse this Fund out of any payment you obtain from the third party; and/or if you fail to fully reimburse the Fund (out of any settlement you receive, or otherwise, even if the Fund reduces the amount of its lien or otherwise limits its rights); then you

are personally liable to this Fund for the reimbursement owed to this Fund by the third party. The Fund may offset the amount you owe from any future benefit claims, or if necessary, take legal action against you.

If any Participant files a claim for medical expenses or Loss of Time Benefits and a third party is legally responsible for paying those expenses, the Fund will not pay benefits on the claim unless the requirements of the Subrogation Rules stated below are met. A "third party" is any person or corporation (or any insurance company obligated to pay claims resulting from the acts of such a person or corporation) or any other entity which is or may be found legally responsible to pay your medical expenses. The Plan's subrogation rules will not apply to any amount paid under the Participant's own insurance policy, except that the rules WILL apply to payments made under the Uninsured Motorist and Underinsured Motorist provisions of the Participant's automobile insurance coverage. Also, these Subrogation Rules do not apply to benefits you recover under another employer-sponsored group health plan if that coverage is subject to Coordination of Benefits.

## **SUBROGATION RULES**

If a third party is responsible for paying expenses for which the Participant files a claim, the Fund will only pay benefits on the claim under the following conditions:

- The Participant must sign the Fund's Reimbursement Agreement that includes, but is not limited to, the following provisions:
  - The Participant agrees that the Participant will repay the Fund the amount of benefits which the Fund pays on the claim out of any recovery of expenses you receive, regardless of whether the recovery is sufficient to fully reimburse the loss;
  - The Participant agrees that the Fund is entitled to a first priority lien on the proceeds of any recovery, to the extent of the full amount of benefits paid, regardless of whether the Participant is made whole by the recovery;
  - The Participant agrees that, if the third party does not voluntarily pay the Participant for the incurred expenses and the Participant does not sue the third party for recovery of the expenses, the Fund has the right to sue the third party in the Participant's name to recover the amount it paid. In such a case, if there is a recovery or settlement, the Participant agrees that the Fund's expenses, costs and incurred attorney's fees will also be paid out of the recovery or settlement;
  - The Participant agrees not to assign to another person the Participant's right to recover money from another source, and the Participant agrees that he or she will obtain the Fund's consent before releasing another person or entity from liability for any injury.
  - The Participant's attorney also must sign the agreement if: (1) the Participant enters into a contingent fee arrangement with the attorney to pursue the Participant's claim against a third party or (2) the claim is based on work-related injuries.
- If the Participant who is injured by a third party is an adult Dependent, the injured adult Dependent must sign the Reimbursement Agreement along with the Eligible Employee or Retiree. If the Participant who is injured by a third party is a minor Dependent Child, the Eligible Employee or Retiree, or any other adult authorized to act on behalf of the Child, must sign the Reimbursement Agreement on behalf of the Child.
- The Fund will be entitled to reimbursement out of any recovery. A recovery shall include all payments from another source the Participant receives or to which the Participant is entitled (including, but not limited to, any amounts allocated to a trust set up for the Participant or on the Participant's behalf). In the case of a minor Dependent Child, the minor Dependent Child, such Child's legal representative, and the Eligible Employee are obligated to reimburse the Fund out of any recovery received by or on behalf of the Dependent Child, Child's legal representative or the Eligible Employee.
- If the Participant obtains a recovery of incurred expenses and does not repay the Fund as the Participant agreed to do when the Participant signed the Reimbursement Agreement, the Fund may file suit against the Participant to recover expenses it paid on the Participant's claim and the attorney's fees and expenses incurred in filing such a suit. The Fund also has the right to reduce any future benefits to which the Participant may be entitled on claims for the Participant and the other eligible Participants of the Participant's family until the proper amount has been recovered by the Fund.
- The Fund will not expect repayment of more than the benefits it pays on the claim or more than the amount of the Participant's gross recovery.
- The Fund will not be responsible for legal fees and expenses incurred by the Participant in obtaining a recovery except that, at the discretion of the Trustees, the Fund may agree to pay for a reasonable share of those fees and expenses actually incurred by the Participant in connection with the proof of and recoupment of the payments made by the Fund.

- Once a Participant has obtained a recovery, no further benefits are payable from the Fund for any claims related to the injury at issue, until the total of Covered Expenses arising out of the injury equals the gross amount of the recovery paid to or on behalf of the Participant. The Fund will then consider only the amount of claims that exceeds the amount of the gross recovery, except that in the event of a recovery insufficient to repay in full the benefits the Fund has paid on the claim, the Fund will continue to pay benefits for future claims related to the injury at issue until additional recovery sufficient to reimburse the Fund in full is obtained.
- The Participant must inform the Fund of the progress of any claim, settlement or legal action against the third party responsible for the Participant's injury and must respond to any inquiries made by the Fund as to such progress. The Participant must also inform the Fund of any attempts to settle, release, dismiss or discharge any claim, settlement or legal action against the third party.
- The Participant must furnish the Fund upon demand with all papers, documents or other information in his or her possession necessary for the proper recovery upon any claim, settlement or legal action against the third party.
- In the event that the Participant does not sign a Reimbursement Agreement, and the Fund pays benefits on claims for which a third party is legally responsible, the Fund is entitled to a first priority lien on any recovery obtained by the Participant in the same manner as if the Participant had signed the Reimbursement Agreement.
- If the Participant suffers a work-related injury, the Fund will not pay benefits until (1) it receives a Reimbursement Agreement signed by the Participant and the Participant's attorney, (2) it receives confirmation in writing that the employer, or the employer's worker's compensation liability insurer, has denied responsibility for the injury and (3) the Participant demonstrates that he or she is pursuing a claim against the employer and/or the employer's worker's compensation insurer, unless the Trustees determine, in their discretion, that such a claim is not viable based on the facts and circumstances surrounding the injury.
- In the event that the Fund agrees to accept less than the full amount of the lien, the Participant and his or her attorney must sign a release consistent with this section. If the Participant and/or attorney fail to submit a signed release to the Fund when requested to do so, the Fund may demand payment of the balance owed to the Fund and/or deny future claims until the balance owed is recouped.

## RESTORATION OF RECOVERED BENEFITS

If a person has a claim which is subject to subrogation and the Plan pays benefits on the claim, the benefits paid by the Plan apply toward all applicable maximum benefit limitations, the same as benefits which are paid for non-subrogation claims. If the Plan pays benefits under the subrogation rules and recovers some or all of the benefits it paid through subrogation, the amount of benefits recovered may be restored to certain maximum benefits. The following rules apply to restoration of recovered benefits:

- Recovered benefits will not be restored to benefit maximums that pertain to a specific accident or injury.
- Recovered benefits will be restored only to Major Medical lifetime maximum.
- A restoration will be effective on the date the recovery is received by the Plan.
- Any increase in a maximum benefit due to a restoration will apply only to claims incurred on and after the date the subrogation recovery is received by the Plan.

**TIP:** If the Fund receives a claim that may have been caused by an accident or another party (such as an auto accident), the Fund Office will send you a “subrogation form”. The Fund will not pay for a claim until this form is returned. You have 60 days to respond.

## TRUSTEE AUTHORIZED DENIAL OR LOSS OF BENEFITS

The Trustees or their representatives are authorized to deny benefits. The following list outlines some circumstances or reasons that all or part of a person's claim may be denied by the Fund that would cause a person to lose benefits or to receive reduced benefits.

1. The person on whose behalf you filed the claim was not eligible for benefits on the date the expenses were incurred (see the "Eligibility" section), or, in the case of a Dependent, the person does not meet the Plan's definition of a "Dependent".
2. You did not file the claim within the Plan filing time limits (18 months from the date the claim was incurred) or you failed to furnish, when requested, information or documents available to you that were necessary to complete the claim within 60 days of such request.
3. The expenses that were denied are not considered Covered Expenses under the Plan, or the expenses for which you filed the claim were not actually incurred.
4. The person for whom the claim was filed had already received the maximum benefit allowed for that type of expense.
5. Some other plan was primarily responsible for paying benefits on the expenses.
6. No payment, or a reduced payment, was made because some or all of the expenses were applied against a Deductible.
7. A third party, such as the driver of a car that caused an accident for which medical expenses were incurred, was responsible for paying the expenses and you and/or your attorney did not sign the required Reimbursement Agreement which would permit the Plan to pay your claim and recover payment from the third party or his/her insurance company.
8. The Plan of Benefits was terminated.
9. The Trustees amended the Plan's eligibility rules or decreased Plan benefits.
10. The Trustees reduced or temporarily suspended future benefit payments to a Covered Person in order to recover an overpayment of benefits previously made on that person's behalf.
11. Benefits were reduced due to the fact that a noncompliance Deductible was applied because the procedures of the Medical Review Program were not followed.
12. A non-participating hospital or provider was used and benefits were denied.

The list specified above is not an all-inclusive listing of the circumstances that may result in a claim denial or loss of benefits. It is truly representative of the types of circumstances, in addition to failure to meet the requirements for eligibility under the Plan that may result in denial of claims or loss of benefits.

## PLAN CHANGE OR TERMINATION

It is anticipated that the Plan will remain in effect indefinitely. However, the Trustees reserve the right to change or discontinue (1) the types and amounts of benefits under the Plan and (2) the eligibility rules.

This booklet includes information concerning the benefits provided by the Trustees to Participants and their Dependents and the circumstances which may result in disqualification, ineligibility, denial, loss, forfeiture or suspension of benefits that a participant or dependent might otherwise reasonably expect a Plan to provide. The benefits and eligibility rules applicable to Participants and their Dependents have been established by the Trustees. The right to terminate, amend or modify the eligibility rules and plan of benefits for Participants and Dependents is reserved by the Trustees in accordance with the Agreement and Declaration of Trust. The continuance of benefits for Participants and their Dependents and the eligibility rules relating to qualification therefore are subject to modification and revision by the Trustees in accordance with their authority contained in the Agreement and Declaration of Trust.

No Employee, Retiree, Dependent or Beneficiary has a vested right to future coverage under the Plan or to the continuation of any given benefits provided for Participants and their Dependents. In addition to the right to terminate any benefits of Participants and/or their Dependents at any time, the Trustees also reserve the right in their sole and absolute discretion to terminate the Plan and Trust at any time, and there shall not be any vested right by any Participant or Dependent or Beneficiary nor any contractual rights thereafter. If the Trust is terminated, the Agreement and Declaration of Trust provides that any remaining assets of the Fund, after payment of the Fund's obligations, will be used to provide benefits for Employees who are covered at the time of termination. At their discretion, the Trustees may also transfer remaining funds to another trust fund that covered Employees who were covered under this Fund prior to its termination. Under no circumstances will any surplus assets revert to the Employers.

Plan benefits and eligibility rules for active, retired or disabled Participants are provided under the Plan and:

- Are not guaranteed;
- May be changed, amended or discontinued by the Board of Trustees at any time or eliminated entirely;
- Are subject to the Trust Agreement which establishes and governs the Fund's operations;
- Are payable only to the extent that, in the judgment of the Trustees, funds are available considering the desirability of maintaining other benefits.
- Are subject to the provisions of any group insurance policy purchased by the Trustees.

The nature and amount of Plan benefits are always subject to the actual terms of the Plan as it exists at the time the claim occurs.

The Funds' Trustees have the power to interpret and apply the terms of this Plan and also the Fund's Trust Agreement.

# CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985 (COBRA)

A Federal Law called the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires most employers sponsoring group health plans to offer employees and their families (*if eligible*) the opportunity for a temporary extension of health coverage at group rates in certain instances where coverage would otherwise end (called “qualifying events”). This section outlines your rights and obligations with respect to continuation of the health benefits provided under the Plan.

To be eligible to continue coverage under COBRA, you must be enrolled in the Plan when your coverage ends because of a qualifying event.

## COBRA ELIGIBILITY

### *Qualifying Events for You*

COBRA coverage is available to you if coverage would otherwise end if:

- Your regularly scheduled hours are reduced so that you are no longer eligible to participate in the Fund's welfare benefits program.
- You voluntarily or involuntarily terminate your employment for any reason (including retirement) other than gross misconduct.

### *Qualifying Events for Your Dependents*

COBRA coverage is available to your eligible Dependents if coverage would otherwise end if:

- Your regularly scheduled hours are reduced so that you are no longer eligible to participate in the Fund's welfare benefits program.
- You (the active Employee) voluntarily or involuntarily terminate employment for any reason (including retirement) other than gross misconduct.
- You (the active Employee) retire.
- You (the active Employee) die, become divorced, legally separated or become entitled to Medicare.
- Your Dependent Child ceases to be eligible for Fund coverage. For example, he or she reaches the maximum age limit for coverage.

## HOW COBRA COVERAGE WORKS

In order to have the opportunity to elect COBRA Continuation Coverage after a divorce, legal separation, or a child ceasing to be a “Dependent Child” under the Plan, you and/or a family Participant must notify the Fund Office in writing of that event no later than 60 days after that event occurs. Notice should be sent to:

District Council 37, Local 95 Head Start Employees Welfare Fund  
420 West 45<sup>th</sup> Street, 3<sup>rd</sup> Floor  
New York, NY. 10036

The Fund Office will send you information about COBRA coverage.

You should notify the Fund Office promptly and in writing of termination of employment, reduction in hours, retirement, divorce, legal separation or entitlement to Medicare. Your family Participants must notify the Fund Office promptly and in writing in the event of your death.

**Under Federal Law your employer is required to notify the Fund on your behalf under these circumstances:**

Your voluntary/involuntary termination	30 days
Your reduction of hours	30 days
Your death	30 days
Employer’s bankruptcy	30 days
Your eligibility for Medicare	14 days of its learning of the event*
Your divorce or legal separation	14 days of its learning of the event*

\* You must notify your employer within 60 days of the event.

## HOW TO ELECT COBRA CONTINUATION COVERAGE

When your employment terminates or your hours are reduced so that you are no longer entitled to coverage under the Plan, or when the Fund Office is notified on a timely basis that you died, divorced, or that a Dependent Child loses Dependent status, the Fund Office will provide you and your COBRA eligible dependents notice of the date that your coverage under the group ends and your rights to elect continuation of coverage under COBRA can begin. Under the law you and or your eligible dependents will have the later of 60 days from the qualifying event or the date that the notice is sent by the Fund office to elect continuation of coverage. If the Fund does not receive election prior to the 60-day period, you will forfeit your rights for continuation.

Each qualified beneficiary has a right to elect continuation coverage. For example, the Employee's Dependent may elect continuation coverage even if the Employee does not. Continuation coverage may be elected for only one, several, or for all Dependent children who are qualified beneficiaries. A parent may elect to continue coverage on behalf of any Dependent Children. The Employee or the Employee's Dependent can elect continuation coverage on behalf of all of the qualified beneficiaries.

In considering whether to elect continuation coverage, you should consider that a failure to continue your group health coverage will affect your future rights under federal law. You should consider that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your Spouse's employer) within 30 days after your group health coverage ends because of the qualifying event listed above. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

## THE COBRA CONTINUATION COVERAGE THAT WILL BE PROVIDED

If you choose COBRA Continuation Coverage, you will be entitled to the same health coverage that you had when the event occurred that caused your health coverage under the Plan to end, but you must pay for it. See the section on the Cost of COBRA Coverage for information about how much COBRA will cost you and about grace periods for payment of those amounts. If there is a change in the health coverage provided by the Plan to similarly situate active Employees and their families, that same change will be made in your COBRA Continuation Coverage.

## COST OF COBRA COVERAGE

Individuals who continue full coverage under COBRA pay 102% of the Plan's cost, on an after-tax basis, except in cases of disability. See the section below entitled COBRA Coverage in Cases of Social Security Disability for details.

## PAYING FOR COBRA COVERAGE

The amount you, your covered Dependent Child(ren) must pay for COBRA coverage will be payable monthly. The Plan is permitted to charge the full cost of coverage for similarly situated active Employees and families, plus an additional 2% (for a total charge of 102%). The COBRA Continuation Coverage charge is different in cases of extended coverage due to Social Security disability. See that section for further information.

The Fund Office will notify you of the cost of the coverage at the time you receive your notice of entitlement to COBRA coverage, and of any monthly COBRA premium amount changes. The cost of COBRA Continuation Coverage may be subject to future increases during the period it remains in effect.

There will be an initial grace period of 45 days to pay the first amounts due starting with the date COBRA coverage was elected. If this payment is not made when due, COBRA Continuation Coverage will not take effect. After that, payments are due on the first day of each month.

**If payment is not received by the end of the applicable grace period, your COBRA coverage will terminate retroactively to the date in which the last payment was due but not paid. For example, if payment is due on January 1<sup>st</sup> and you don't make a payment before January 31<sup>st</sup>, then Your coverage will terminate retroactive to January 1<sup>st</sup>. Once coverage has been terminated, you will lose your right to continuation coverage.**

## COBRA AT-A-GLANCE

COBRA Coverage May Continue For:	If the Following Event Occurs and Coverage is Lost:	Maximum Length of COBRA Coverage:
<b>You and Your Eligible Dependents</b>	<ul style="list-style-type: none"> <li>Your employment ends (for example, you resign) for any reason except gross misconduct</li> <li>Your regularly scheduled hours are reduced so that you are no longer eligible to participate in the Fund's welfare benefits program</li> </ul>	18 months from the date of loss of coverage (29 months if you or your eligible Dependent is Social Security disabled*).
<b>Your Eligible Dependents Only</b>	<ul style="list-style-type: none"> <li>You die</li> <li>You are divorced or legally separated</li> <li>Your Child(ren) no longer qualifies as an eligible Dependent under the Plan</li> </ul>	36 months from the date of loss of coverage

\* See COBRA Coverage in Cases of Social Security Disability for more details.

### DURATION OF COBRA COVERAGE

Your COBRA coverage can continue for up to 18, 24, 29, or 36 months depending on the qualifying event.

The Continuation Coverage period begins on the date you and/or your Dependents lose coverage (rather than on the date of the qualifying event).

#### 18 Months

COBRA health coverage can continue for up to 18 months if you lose Fund health coverage because of:

- Your reduction in hours caused by, for example, disability, strike, or leave of absence other than leave under the Family and Medical Leave Act.
- Your termination.

#### 24 Months

COBRA health coverage can continue for up to a total of 24 months if you and/or your eligible Dependent(s) elect coverage while you are performing Military Service in accordance with the USERRA Section of this SPD.

#### 29 Months

COBRA health coverage can continue for up to a total of 29 months if you or an eligible Dependent becomes permanently disabled (as determined by the Social Security Administration), before the 60<sup>th</sup> day of COBRA coverage, the disability continues the entire 18-month period of CPBRA coverage and you or your Dependent notifies the Fund Office of the determination no later than 60 days after it was received.

#### 36 Months

COBRA health coverage for your Dependents may continue for up to a total of 36 months if any one of the following qualifying events occurs:

- Your death.
- Your divorce.
- Your Dependent is no longer eligible for Fund coverage.
- You become entitled to Medicare.

## **OTHER COBRA INFORMATION**

### **COBRA Coverage in Cases of Social Security Disability**

If you or any of your covered Dependent Child(ren) are entitled to COBRA coverage for an 18-month period, that period can be extended for the Covered Person who is determined to be entitled to Social Security Disability Income benefits, and for any other covered family Participants, for up to 11 additional months (for a total of 29 months) if all of the following conditions are satisfied:

- The disability occurred on or before the start of COBRA coverage, or within the first 60 days of COBRA coverage.
- The disabled Covered Person receives a determination of entitlement to Social Security Disability Income benefits from the Social Security Administration.
- The Plan must be notified in writing by you or by the disabled Covered Person or another family Participant that the determination was received:
  - No later than 60 days after it was received; and
  - Before the 18-month COBRA continuation period ends.

This extended period of COBRA coverage will end at the **earlier** of:

- The last day of the month, 30 days after Social Security has determined that you and/or your Dependent(s) are no longer disabled.
- The end of 29 months from the date of the COBRA qualifying event.
- The date the disabled individual becomes entitled to Medicare.

You must notify the Plan when you are no longer disabled.

### **Cost of COBRA Coverage in Cases of Social Security Disability**

If the 18-month period of COBRA Continuation Coverage is extended because of disability, the Plan will charge Employees and their families 150% of the cost of coverage for the COBRA family unit that includes the disabled person for the 11-month period following the 18th month of COBRA Continuation Coverage. Any family units that do not include the disabled person will be charged 102% of the cost of coverage.

### **Acquiring a New Dependent(s) while Covered by COBRA or Other Health Insurance Coverage**

If you acquire a new Dependent through marriage, birth, or placement for adoption while you are enrolled in COBRA Continuation Coverage, you may add that Dependent to your coverage for the balance of your COBRA coverage period.

To enroll your new Dependent for COBRA coverage, you must notify the Fund Office in writing. There may be a change in your COBRA premium amount in order to cover the new Dependent.

If COBRA coverage ceases for you before the end of the maximum 18-, 29-, or 36-months COBRA coverage period, COBRA coverage also will end for your newly added Spouse. However, COBRA coverage can continue for your newly added newborn child, adopted child or child placed with you for adoption until the end of the maximum COBRA coverage period if the required premiums are paid on time. Check with the Fund for more details on how long COBRA coverage can last.

### **Loss of Other Group Health Plan Coverage or Other Health Insurance Coverage**

If, while you (the Participant) are enrolled in COBRA Continuation Coverage, your eligible Dependents lose their coverage under another group health plan, you may enroll them in your COBRA for the remainder of the period of continuation of coverage. However, adding Dependent child may cause an increase in the amount you must pay for COBRA Continuation Coverage.

The loss of other coverage must be due to exhaustion of COBRA Continuation Coverage under another plan, termination as a result of loss of eligibility for the coverage, or termination as a result of employer contributions toward the other coverage being terminated. Loss of eligibility does not include a loss due to failure to pay premiums on a timely basis or termination of coverage for cause.

## **Notice of Unavailability of COBRA Coverage**

In the event the Plan is notified of a qualifying event but determines that an individual is not entitled to the requested COBRA coverage, the individual will be sent, by the Fund office, an explanation indicating why COBRA coverage is not available. This notice of the unavailability of COBRA coverage will be sent according to the same timeframe as a COBRA election notice.

## **Multiple Qualifying Events while Covered by COBRA**

If, during an 18-month period of COBRA Continuation Coverage resulting from loss of coverage because of your termination of employment or reduction in hours, you die, become divorced or legally separated, or if a covered child ceases to be a Dependent Child under the Plan, the maximum COBRA Continuation period for the affected dependent child is extended to 36 months from the date of your termination of employment or reduction in hours.

For example, assume you lose your job (the first COBRA-qualifying event), and you enroll yourself and your covered Spouse for COBRA coverage. Three months after your COBRA coverage begins, you and your Spouse divorce and your Spouse is no longer eligible for Plan coverage. Your Spouse can continue COBRA coverage for an additional 33 months, for a total of 36 months of COBRA coverage.

This extended period of COBRA 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 COBRA Continuation Coverage is available to any child(ren) born to, adopted by, or placed for adoption with you (the active Employee) during the 18-month period of COBRA Continuation Coverage.

In no case are you entitled to COBRA Continuation Coverage for more than a total of 18 months if your employment is terminated or you have a reduction in hours (unless you are entitled to an additional COBRA Continuation Coverage period on account of Social Security disability). As a result, 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 COBRA may not be extended beyond 18 months from the initial qualifying event.

## **TERMINATION OF COBRA COVERAGE**

### **When COBRA Coverage May Be TERMINATED**

Once COBRA coverage has been elected, it may be terminated on the occurrence of any of the following events:

- The first day of the time period for which you don't pay the COBRA premiums within the required time period.
- The date on which the Plan is terminated.
- The date, after the date of the COBRA election, on which you or your eligible Dependent(s) first become covered by another group health plan and that plan does not contain any legally applicable exclusion or limitation with respect to a preexisting condition that the Covered Person may have.
- The date, after the date of the COBRA election, on which you or your eligible Dependent(s) first become entitled to Medicare (usually age 65).
- When active Employee coverage would be terminated for cause (for example, you submit fraudulent claims to the Fund).
- When the Employer that employed you prior to the qualifying event has stopped contributing to the Plan and (1) the Employer establishes one or more group health plans covering a significant number of the Employer's Employees formerly covered under this Plan, or (2) the Employer starts contributing to another multi-employer plan that is a group health plan.

### **Notice of Early Termination of COBRA Continuation Coverage**

The Plan will notify a qualified beneficiary if COBRA coverage terminates earlier than the end of the maximum period of coverage applicable to the qualifying event that entitled the individual to COBRA coverage. This written notice will explain the reason COBRA terminated earlier than the maximum period, the date COBRA coverage terminated and any rights the qualified beneficiary may have under the Plan to elect alternate or conversion coverage. The notice will be provided as soon as practicable after the Fund Office determines that COBRA coverage will terminate early.

### **When COBRA Coverage Ends**

Your COBRA coverage ends on the earliest of the date that:

- Any of the above-listed events occurs.
- The COBRA period (18, 29, or 36 months) ends.

**IMPORTANT NOTE: YOU MUST PAY THE FUND OFFICE MONTHLY!**

The Fund is not required to issue payment notices. Late payment will cause rejection of direct pay benefits. If you have any questions about COBRA continuation coverage, please contact the Fund Office.

**Note: You should contact the Fund Office regarding any subsidy rules, which may be in effect when you lose your coverage.**

## **CHILDREN'S HEALTH INSURANCE PROGRAM REAUTHORIZATION ACT OF 2009 (CHIPRA)**

The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) permits you and your dependent(s) who are eligible, but not enrolled, for coverage through the Fund, to enroll outside of the Fund's normal enrollment period under the following circumstances:

- If your coverage or your dependent's coverage under Medicaid or the Children's Health Insurance Plan ("CHIP") terminates as a result of loss of eligibility for either program. If this circumstance occurs, you must request coverage from the Fund within sixty (60) days after the termination of Medicaid or CHIP coverage.
- If you or your dependent(s) become eligible for a Medicaid or CHIP premium assistance subsidy. If this circumstance occurs, you must request coverage from the Fund within sixty (60) days after eligibility for the Medicaid or CHIP subsidy was determined.

Please contact the Fund Office at (212) 343-1660 for more information.

## **FAMILY AND MEDICAL LEAVE ACT OF 1993 ("FMLA")**

The FMLA provides an entitlement of up to 12 weeks of job-protected, unpaid leave during any 12-month period for the following reasons:

- Birth and care of the employee's child, or placement for adoption or foster care of a child with the employee;
- Care of an immediate family Participant (Spouse, child, parent) who has a serious health condition; or
- Care of the employee's own serious health condition.

The emergency leave benefit (of up to 12 weeks) now will be available to family Participants of active-duty service Participants in the Armed Forces who are deployed to a foreign country.

In addition, under the Act, the caregiver leave benefit (of up to 26 weeks) now includes leave to take care of a child, Spouse, parent or next of kin who (1) is a veteran, (2) is undergoing medical treatment, recuperation or therapy for serious injury or illness, and (3) was a Participant of the Armed Forces (including a Participant of the National Guard or Reserves) at any time during the five years preceding the date of treatment. The medical treatment must be related to a serious injury or illness incurred while in the line of duty on active duty in the Armed Forces or which existed before the beginning of military service, and which was aggravated by service in the line of duty while on active duty.

If an employee was receiving group health benefits when leave began, an employer must maintain them at the same level and in the same manner during periods of FMLA leave as if the employee had continued to work. Usually, an employee may elect (or the employer may require) the use of any accrued paid leave (vacation, sick, personnel, etc.) for periods of unpaid FMLA leave.

Employees may take FMLA leave in blocks of time less than the full 12 weeks on an intermittent or reduced leave basis when medically necessary. Taking intermittent leave for the placement, adoption, or foster care of a child is subject to the employer's approval. Intermittent leave taken for the birth and care of a child is also subject to the employer's approval except for pregnancy-related leave that would be leave for a serious health condition.

When the need for leave is foreseeable, an employee must give the employer at least 30 days' notice, or as much notice as is practicable. When the leave is not foreseeable, the employee must provide such notice as soon as possible.

An employer may require medical certification of a serious health condition from the employee's health care provider. An employer may also require periodic reports during the period of leave of the employee's status and intent to return to work, as well as "fitness-for-duty" certification upon return to work in appropriate situations.

An employee who returns from FMLA leave is entitled to be restored to the same or an equivalent job (defined as one with equivalent pay, benefits, responsibilities, etc.). The employee is not entitled to accrue benefits during periods of unpaid FMLA

leave, but the employer must return him or her to employment with the same benefits at the same levels as existed when leave began.

Employers are required to post a notice for employees outlining the basic provisions of FMLA and are subject to a \$100 civil money penalty per offense for willfully failing to post such notice. Employers are prohibited from discriminating against or interfering with employees who take FMLA leave.

## **EMPLOYEE RIGHTS**

The FMLA provides that eligible employees of covered employers have a right to take up to 12 weeks of job-protected leave in any 12-month period for qualifying events without interference or restraint from their employers. The FMLA also gives employees the right to file a complaint with the Wage and Hour Division of the Department of Labor's Employment Standards Administration, file a private lawsuit under the Act (or cause a complaint or lawsuit to be filed), and testify or cooperate in other ways with an investigation or lawsuit without being fired or discriminated against in any other manner.

## **COMPLIANCE ASSISTANCE AVAILABLE**

The Wage and Hour Division of the Employment Standards Administration administers FMLA. More detailed information, including copies of explanatory brochures, may be obtained by contacting your local [Wage and Hour Division office](#). In addition, the Wage and Hour Division has developed the *elaws* [Family and Medical Leave Act Advisor](#), which is an online resource that answers a variety of commonly asked questions about FMLA, including employee eligibility, valid reasons for leave, notification responsibilities of employers and employees, and rights and benefits of employees. Compliance assistance information is also available from the [Wage and Hour Division's Web site](#). For additional assistance, contact the Wage and Hour Division at 1-866-4USWAGE.

## **GENETIC INFORMATION NONDISCRIMINATION ACT OF 2008 (GINA)**

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits discrimination in group health plan coverage based on genetic information.

GINA expands the genetic information protections included in the Health Insurance Portability and Accountability Act of 1996 (HIPAA). HIPAA prevents a plan or issuer from imposing a pre-existing condition exclusion provision based solely on genetic information, and prohibits discrimination in individual eligibility, benefits, or premiums based on any health factor (including genetic information).

GINA provides that group health plans and health insurance issuers cannot base premiums for an employer or a group of similarly situated individuals on genetic information. (However, premiums may be increased for the group based upon the manifestation of a disease or disorder of an individual enrolled in the plan).

GINA also generally prohibits plans and issuers from requesting or requiring an individual to undergo a genetic test. However, a health care professional providing health care services to an individual is permitted to request a genetic test. Additionally, genetic testing information may be requested to determine payment of a claim for benefits, although the regulations make clear that the plan or issuer may request only the minimum amount of information necessary in order to determine payment. There is also a research exception that permits a plan or issuer to request (but not require) that a participant or beneficiary undergo a genetic test.

# HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY

## ACT OF 1996 (HIPAA)

HIPAA amended the Employee Retirement Income Security Act (ERISA), to provide new rights and protections for participants and beneficiaries in group health plans. Understanding this amendment is important to your decisions about future health coverage. HIPAA contains protections for health coverage offered in connection with this Plan.

If you find a new job that offers health coverage, or if you are eligible for coverage under a family Participant's employment-based plan, HIPAA includes protections for coverage under group health plans that:

- Limit exclusions for preexisting conditions;
- Prohibit discrimination against employees and dependents based on their health status;
- Allow a special opportunity to enroll in a new plan to individuals in certain circumstances;
- If you choose to apply for an individual policy for yourself or your family, HIPAA includes protections for individual policies that:
  - Guarantee access to individual policies for people who qualify;
  - Guarantee renewability of individual policies.

### WHAT IS A PREEXISTING CONDITION?

A preexisting condition is a medical condition present before your enrollment date in any new group health plan.

The Affordable Care Act prohibits any exclusion of coverage based on a preexisting condition.

## MENTAL HEALTH PARITY

The Mental Health Parity Act (MHPA), signed into law on September 26, 1996, requires that annual or lifetime dollar limits on mental health benefits be no lower than any such dollar limits for medical and surgical benefits offered by a group health plan or health insurance issuer offering coverage in connection with a group health plan.

The law:

- Generally requires parity of mental health benefits with medical/surgical benefits with respect to the application of aggregate lifetime and annual dollar limits under a group health plan
- Provides that plan sponsors retain discretion regarding the extent and scope of mental health benefits offered to workers and their families (including cost sharing, limits on numbers of visits or days of coverage, and requirements relating to medical necessity).

The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) supplements prior provisions under the MHPA.

Under the MHPAEA, group health plans and health insurance issuers are required to:

- Ensure that financial requirements (such as co-pays, deductibles) and treatment limitations (such as visit limits) applicable to mental health or substance use disorder (MH/SUD) benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical/surgical benefits. Non-quantitative treatment limitations (such as precertification requirements) must also be no more restrictive than the predominant requirements or limitations applied substantially to all medical/surgical benefits.

## **MILITARY SERVICE RULES**

If an active Employee terminates covered employment due to military service covered by the Uniformed Services Employment and Reemployment Rights Act (“USERRA”) and is subsequently reemployed by an Employer, he or she will immediately resume coverage under the Plan as if he or she had never left.

When you are discharged (not less than honorably) from the uniformed services, your full eligibility will be reinstated on the day you return to work with an Employer, provided that you return to employment:

1. Within ninety (90) days from the date of discharge, if the period of service was more than one hundred eighty (180) days; or
2. Within fourteen (14) days from the date of discharge, if the period of service was more than thirty (30) days but less than one hundred eighty (180) days; or
3. At the beginning of the first full regularly scheduled working period on the first calendar day following discharge (plus travel time and an additional eight hours) if the period of service was less than thirty (30) days.

If you are hospitalized or recovering from an injury caused by active duty, these time limits are extended up to two years.

If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents for up to 24 months while in the military (see COBRA Section of this SPD for details).

If an active Employee terminates covered employment due to military service beyond the period allowed under USERRA and is subsequently reemployed by an Employer, Plan coverage is not immediately reinstated upon return to work. The formerly active Employee will be treated as a new Employee for purposes of determining eligibility for Plan coverage or benefits, and must satisfy the eligibility requirements summarized in this booklet or in the Collective Bargaining Agreement.

If you have any questions about taking a leave, please speak directly with your Employer. If you have any questions about how a leave affects your benefits, please contact the Fund Office.

## **THE NEWBORNS’ AND MOTHERS’ HEALTH PROTECTION ACT (NMHPA)**

The Newborns' and Mothers' Health Protection Act of 1996 (NMHPA) affects the amount of time you and your newborn child are covered for a hospital stay following childbirth. This law applies both to the mother and the newborn covered by this Plan. In general, this plan may NOT restrict benefits for a hospital stay in connection with childbirth to less than 48 hours following a vaginal delivery or 96 hours following a delivery by cesarean section.

If you deliver in the hospital, the 48-hour (or 96-hour) period starts at the time of delivery. If you deliver outside the hospital and you are later admitted to the hospital in connection with childbirth, the period begins at the time of the admission.

Although the NMHPA prohibits this Plan from restricting the length of a hospital stay in connection with childbirth, this Plan does not have to cover the full 48 or 96 hours in all cases. If an attending provider, after speaking with you, determines that either you or your child can be discharged before the 48-hour (or 96-hour) period, this Plan does not have to continue covering the stay for whichever one of you is ready for discharge. An attending provider is an individual, licensed under State law, who is directly responsible for providing maternity or pediatric care to you or your newborn child. In addition to physicians, an individual such as a nurse midwife, physician assistant, or nurse practitioner may be an attending provider. This Plan, Hospital, insurance company, or HMO would NOT be an attending provider.

The Plan benefits relating to this Act are found in the benefits section of this SPD. Your health coverage provided by this Fund complies with NMHPA standards.

# STATEMENT OF PRIVACY PRACTICES

This section describes how medical information about you may be used and disclosed, and how you can get access to this information. Please review it carefully.

The Trustees and the Fund office have always made the protection of your personal information a very important priority. We want you to have a clear understanding of how we use and safeguard your information.

This section describes how the Welfare Fund may use and disclose your Protected Health Information (“PHI”), defined below, in order to carry out treatment, payment and health care operations and for other purposes permitted or required by law. It also describes your rights to access and control your PHI.

Federal legislation known as the Health Insurance Portability and Accountability Act (“HIPAA”) requires the Fund to establish a formal policy and procedures for maintaining the privacy of your PHI.

This section is effective beginning in April 2003, and the Welfare Fund is required to comply with its terms. However, the Welfare Fund reserves the right to change its privacy practices and this section and to apply the changes to any PHI received or maintained by the Welfare Fund prior to that date. If a privacy practice is materially changed, a revised version of this section will be provided to Employees via first class mail, and to all other persons upon request. Any revised version of this section will be distributed within 60 days of the effective date of any material change to the Welfare Fund’s policies.

## PROTECTED HEALTH INFORMATION

The term “Protected Health Information” includes all individually identifiable health information related to an individual’s past, present or future physical or mental health condition or to payment for health care. PHI includes information maintained by the Welfare Fund in oral, written, or electronic form.

## USES AND DISCLOSURES OF HEALTH INFORMATION

### Disclosure of Your PHI Generally Requires Your Written Authorization.

Except as provided in this section, any use and disclosure of PHI will be made only with your written authorization. Once you give the Fund authorization to release your PHI, the Fund cannot guarantee that the person or organization to whom the information is provided will not disclose such information. You may revoke your authorization at any time in writing, except if the Fund has already acted based on your authorization.

There are circumstances in which the Welfare Fund will disclose your PHI in the absence of a written authorization. Under the law, the Welfare Fund may disclose your PHI without your authorization or without giving you the opportunity to agree or object, in the following cases:

- At your request. If you request it, the Welfare Fund is required to give you access to certain of your PHI in order to allow you to inspect and/or copy it. Your right to this information is detailed later in this section.
- For treatment, payment or health care operations. The Welfare Fund and its business associates may use PHI in order to carry out treatment, payment or health care operations.
- “Treatment” is defined as the provision, coordination, or management of health care and related services. For example, the Welfare Fund may disclose PHI to providers to provide information about alternative treatments.
- “Payment” includes but is not limited to actions to make coverage determinations and payment for services and items you receive. For example, the Welfare Fund may disclose to a doctor whether you are eligible for coverage or the amount that the Welfare Fund will reimburse a provider for certain services. If the Welfare Fund contracts with third parties to help us with payment operations, such as a physician who reviews medical claims, we will also disclose information to them. These third parties are known as “business associates.”
- “Health care operations” are the operations of the Welfare Fund relating to such things as underwriting and quality assessment and other insurance activities relating to creating or renewing insurance contracts. They also include auditing functions, including fraud compliance programs, business planning and development, business management and general administrative activities. For example, the Welfare Fund may use PHI to audit the accuracy of its claims processing functions.
- Disclosure to Trustees. The Welfare Fund may also disclose PHI to the Trustees as Plan sponsor, for plan administrative functions. For example, the Welfare Fund may disclose information to the Trustees to allow them to decide an appeal or review a subrogation claim.
- In addition, the Welfare Fund may disclose “summary health information” to the Trustees for obtaining premium bids or modifying, amending or terminating the Welfare Fund’s group health plan. Summary information summarizes the claims

history, claims expenses or type of claims experienced by individuals for whom a plan sponsor such as the Trustees has provided health benefits under a group health plan. Identifying information will be deleted from summary health information, in accordance with federal privacy rules.

- Disclosure to Family and Friends. The Welfare Fund may release PHI to friends or family Participants that you have identified who participate in caring for you or involved in paying for your care unless you notify the Welfare Fund's Privacy Officer in writing (contact information below) that you object. The Welfare Fund will disclose only PHI that is directly relevant to that person's involvement. In an emergency or if you become incapacitated, the Welfare Fund may also disclose your PHI to other family Participants, relatives or close friends under certain circumstances as permitted in the Welfare Fund's procedures, unless you have previously notified the Welfare Fund's Privacy Officer in writing that you do not want your information shared under those circumstances.
- If you want the Welfare Fund to disclose your PHI routinely to specific persons, then you must complete an authorization form designating that person as authorized to receive your PHI. Authorization forms are available from the Privacy Officer at the Welfare Fund office.
- Additional Disclosures. In addition to the above permitted uses and disclosures, the Welfare Fund may also use and disclose your PHI under the following unique circumstances:
  - When required by applicable law.
  - As required by HHS. Disclosure of your PHI may be required by the U.S. Department of Health and Human Services to investigate the Welfare Fund's compliance with the privacy regulations.
  - For public health purposes. Disclosure of your PHI to an authorized public health authority may be necessary 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.
  - In the event of domestic violence or abuse. Your PHI may be disclosed 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 a case, the Welfare Fund will promptly inform you that such a disclosure has been or will be made unless so informing you would cause a risk of serious harm.
  - Health oversight activities. Your PHI may be disclosed 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. Your PHI may be disclosed when required for judicial or administrative proceedings. For example, your PHI may be disclosed in response to a subpoena or court ordered discovery request. In the case of subpoenas and discovery requests which are not court ordered, the Welfare Fund will disclose your PHI only if certain conditions are met.
  - Law enforcement purposes. Your PHI may be disclosed for certain law enforcement purposes, such as identification or location of a suspect, fugitive, material witness or missing person, and reporting a crime.
  - To a coroner, medical examiner, or funeral director related to information about a deceased individual.
  - For organ, eye, or tissue donation purposes.
  - Research. Your PHI may be disclosed for research, subject to certain conditions.
  - Health or safety threats. Your PHI may be disclosed when, consistent with applicable law and standards of ethical conduct, the Welfare Fund in good faith believes the use or disclosure of PHI is necessary to prevent a serious and imminent threat to the health or safety of a person or the public. Under these circumstances, the Welfare Fund will limit the disclosure to a person reasonably able to prevent or lessen the threat, including the target of the threat.
  - Government Functions. Your PHI may be disclosed in connection with certain government functions, such as military service or national security.
  - Correctional/Law Enforcement. Your PHI may be disclosed to correctional institutions or law enforcement officials if you are an inmate of a correctional institution or under the custody of a law enforcement official, but only if necessary for the institution to provide you with health care; to protect your health and safety or the health and safety of others; or for the safety and security of the correctional institution.
  - Business Associates. The Welfare Fund may disclose your PHI to business associates of the Fund that perform functions or services on the Fund's behalf. The business associates are under contract with the Fund to protect your PHI and are not allowed to use such information other than as specified in the contract.
  - Data breach notifications. The Fund may use your contact information to provide legally required notices of unauthorized acquisition, access, or disclosure of your PHI.

- Workers' Compensation Programs. Your PHI may be disclosed to the extent necessary to comply with Workers' Compensation or other similar programs established by law.
- Marketing. The Fund will not disclose PHI to any other company for their use in marketing their products to you and will not sell your PHI, unless the Fund first obtains your written authorization.
- Genetic Information. The Fund will not use or disclose your genetic information that falls under the definition of PHI for underwriting purposes.

## **BREACH NOTIFICATION**

In the event that the Fund discloses PHI, and such disclosure is not permitted by this policy or the HIPAA Privacy Rule, the Fund is required to notify you of the breach unless certain exceptions apply. The disclosure of "secured" PHI (i.e., PHI that is encrypted) is not subject to this requirement.

## **YOUR INDIVIDUAL PRIVACY RIGHTS**

You have a right to inspect and obtain a copy of your PHI contained in a "designated record set," defined below, for as long as the Welfare Fund (Fund) maintains the PHI. You or your personal representative will be required to request access to the PHI in your designated record set in writing. A reasonable fee for copying may be charged. Requests for access to PHI should be made to the Fund's Privacy Officer.

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

If access is denied, you or your personal representative 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 Welfare and HHS.

A "designated record set" includes your medical or billing records that are maintained by the Fund. Records include enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by the Fund or other information used in whole or in part by or for the Fund 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.

The Fund is also required to provide you with access to electronically stored PHI (electronic PHI) maintained in a designated record set in the electronic form and format you request, if it is readily producible and, if not, in the form and format agreed to by you and the Fund. Additionally, you may request in writing that the Fund transmit your electronic PHI directly to another person designated by you. The Fund must provide the requested electronic PHI in the same manner and time frame as it is required to provide all other PHI.

If you feel that any PHI kept by the Fund is incorrect or incomplete, you may request that the Fund amend it subject to certain exceptions. PHI is not subject to amendment if it was not created by the Fund, is not part of the designated record set you are permitted to inspect and copy, or if it is not kept by the Fund. 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 denied your request in whole or part, the Fund must provide you with a written denial that explains the basis for the decision. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of that PHI. You should make your request to amend PHI to the Fund's Privacy Officer, in writing, at the address below.

At your request, the Fund will also provide you with a list of certain disclosures by the Fund of your PHI made after April 14, 2003. This accounting is not required to include disclosures related to treatment, payment for treatment, or health care operations, or disclosures made to you or authorized by you in writing. The Fund has 60 days to provide the accounting. The Fund is allowed an additional 30 days if the Fund gives you a written statement of the reasons for the delay and the date by which the accounting will be provided. The first accounting you request in a 12-month period will be provided free of charge. If you request more than one accounting within a 12-month period, the Fund will charge a reasonable cost-based fee for each subsequent accounting. You or your personal representative must submit your request for restrictions on uses and disclosures of your PHI in writing to the Fund's Privacy Officer at the address below.

You may request that the Fund restrict the uses and disclosures of your PHI to conduct treatment, payment or health care operations. In addition, you may restrict uses and disclosures to family Participants, relatives, friends or other persons identified by you who are involved in your care.

The Fund is not required to agree to your request. You or your personal representative must submit your request for restrictions on uses and disclosures of your PHI in writing to the Fund's Privacy Officer at the address below.

You may also request to receive communications of PHI confidentially by alternative means or solely at an alternative location (for example, mailing information somewhere other than your home address) if it is feasible and reasonable. Make such requests to the attention of the Fund's Privacy Officer at the address below. Please note that the Plan must grant this request only if the individual states he or she would be in danger. You or your personal representative may request confidential communications of your PHI orally or in writing. However, requests to modify or cancel a previous confidential communication request must be made in writing.

You may exercise your rights through a personal representative. Except as provided below in connection with parents of unemancipated minor children, 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. 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 completion of an Appointment of Personal Representative form. For example, the Fund will consider a parent or guardian as the personal representative of an unemancipated minor unless applicable state law requires otherwise. Unemancipated minors may, however, request that the Fund restrict information that goes to family Participants if permitted by applicable state laws. Other documentation that may substitute for this form would include other official legal documentation that demonstrates that under relevant state law the representative is authorized to make health care decisions for you (for example, appointment as a legal guardian, or a health care power of attorney).

## **THE WELFARE FUND'S DUTIES**

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

If you believe that your privacy rights have been violated, you may file a complaint with the Welfare Fund in care of the Privacy Officer at the following address:

Randy S. Paul, Privacy Officer  
District Council 37, Local 95 Head Start Employees Welfare Fund  
420 West 45<sup>th</sup> Street, 3<sup>rd</sup> Floor  
New York, NY 10036

You may also file a complaint with:

Secretary of the U.S. Department of Health & Human Services  
Hubert H. Humphrey Building  
200 Independence Ave. S.W.  
Washington, D.C. 20201

The Welfare Fund will not retaliate against you for filing a complaint.

If you have any questions regarding this section or the subjects addressed in it, you may contact the Privacy Officer at the Welfare Fund office.

## **QUALIFIED MEDICAL CHILD SUPPORT ORDER PROCEDURES**

A Qualified Medical Child Support Order (“QMCSO”) is a judgment, decree or order usually issued as part of a settlement agreement or divorce decree by a court of competent jurisdiction (or through an administrative process established under state law) that provides for child support or health care coverage for the child of a Plan participant. As long as a QMCSO conforms to statutory requirements, a child named in the QMCSO will be eligible for coverage.

If the Fund receives a court order requiring the Plan to provide health coverage to a child, the Fund will follow the order only if it is determined that the order is a QMCSO. When the Fund receives a medical child support order from a court, the Fund will promptly notify, in writing, the Participant and each of the children named in the order that the Fund received the order, and will deliver a copy of the Plan’s procedures for determining whether the order is a QMCSO to them at the addresses listed on the order. The Fund will also notify each child named in the order of his or her right to designate a representative to receive copies of all notices regarding the order.

Within a reasonable period of time, the Fund will determine whether the order is a QMCSO and notify the participant and each child named in the order of the determination in writing. If claims are submitted to the Plan on behalf of the child or children named in the order while the Fund is determining whether the order is a QMCSO, the Plan will suspend payment of any benefits that are due until the order is determined to be a QMCSO. If the order is determined to be a QMCSO, children covered by the QMCSO will become covered Dependents of the participant named in the QMCSO as of the first date to which the QMCSO applies, as if the participant enrolled them in the Plan and paid any required payments as of that date.

For a free copy of the Plan’s QMCSO procedures, contact the Welfare Fund office.

## **THE WOMEN’S HEALTH AND CANCER RIGHTS ACT**

The Women’s Health and Cancer Rights Act of 1998 (WHCRA) requires group health plans and insurance companies that provide coverage for mastectomies to provide certain mastectomy-related benefits or services to plan participants and beneficiaries. The Plan provides the benefits required under the WHCRA, and makes these benefits available to eligible Participants.

Under the WHCRA, a group health plan Participant who is receiving benefits in connection with a mastectomy, and who elects breast reconstruction in connection with the mastectomy is entitled to coverage for the following:

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

Coverage for these benefits or services will be provided in a manner determined in consultation with the participant’s or beneficiary’s attending Physician.

If you are a participant in the Plan, and are currently receiving, or in the future receive benefits under the Plan in connection with a mastectomy, you are entitled to coverage for the benefits and services described above in the event that you elect breast reconstruction. Your eligible Dependents are also entitled to coverage for these benefits or services on the same terms. Coverage for the mastectomy-related services or benefits required under the WHCRA will be subject to the same deductibles and co-insurance or co-payment provisions that apply with respect to other medical or surgical benefits provided under the Plan.

If you have any questions about the WHCRA, please contact the Fund Office.

## STATEMENT OF ERISA RIGHTS

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

### RECEIVE INFORMATION ABOUT YOUR PLAN AND BENEFITS

Examine, without charge, at the Plan Administrator’s office and at other specified locations, such as work sites and Fund Office, 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 Benefit Security Administration.

Obtain, upon written request to the Plan Administrator, 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 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

Continue health care coverage for yourself or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

### 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 exercising any right to which you are entitled or may become entitled under the terms of the Plan or ERISA.

### ENFORCE YOUR RIGHTS

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of the Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file a 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 are 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 a suit in a state or Federal court. In addition, if you disagree with the Plan’s decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file a 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.

## **ASSISTANCE WITH YOUR QUESTIONS**

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefit Security Administration, U.S. Department of Labor, listed in your telephone directory of the Division of Technical Assistance and Inquiries, Employee Benefit Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefit Security Administration.