Summary Plan Description

Health and Welfare Benefits

SAMPLE SPD
BlueCard PPO/Formulary/Annual Vision
NON-GRANDFATHERED

Steelworkers
Health and Welfare Fund

January, 2023

Dear Participant:

The Board of Trustees of the Steelworkers Health and Welfare Fund (the "Fund") is pleased to provide you with this Summary Plan Description which summarizes the terms and conditions of the benefits provided from the Fund for which you are or may become eligible as a represented Employee under the [collective bargaining agreement or the personnel policies of the Employer] between the United Steel, Paper and Forestry, Rubber, Manufacturing, Energy, Allied Industrial and Service Workers International Union ("USW") on behalf of Local [number] (the "Union") and [name of company] (the "Employer"). [Name of Company] began participation in the Fund on behalf of these Employees effective [put date here.]

This letter, which is referred to as the Fund Letter in the Summary Plan Description, provides additional information about the specific benefits provided to you by the Fund in accordance with the [collective bargaining agreement or the personnel policies of the Employer]. Because this Fund Letter is designed specifically for benefits provided under the [collective bargaining agreement or the personnel policies of the Employer], it may contain information that is different in some respects from the more general terms of the Summary Plan Description. For this reason, it is important that you read carefully and understand all of the information in this Fund Letter. ***To the extent that any information in this Fund Letter is inconsistent with the information in the Summary Plan Description, the information in this Fund Letter – not the Summary Plan Description – will apply.***

Types of Benefits

You are, or may become eligible for the following benefits from the Fund:

- Medical Benefits
- Prescription Drug Benefits
- Dental Benefits
- Vision Benefits
- Death Benefits
- Accidental Death and Dismemberment Benefits
- Short Term Disability Benefits

Effective Date of Coverage

As an Employee, you and your covered Dependents, including your spouse, will generally become eligible for benefits on the [insert eligibility as described in the [collective bargaining agreement or the personnel policies of the Employer], provided the required contributions to the Fund are made on your behalf. [Insert any members are not eligible for benefits here]. The Summary Plan Description may set forth additional eligibility requirements with respect to specific benefits. Please refer to the Summary Plan Description for additional requirements.

Dependents (This should only be included if the company has elected Domestic Partners)

In addition to those persons described on page 2 of this Summary Plan Description, Dependents also include:

- your Domestic Partner who is currently unmarried and not a domestic partner of another person under either statutory or common law, is at least 18 years of age and is not related to you by blood or a degree of closeness that would prohibit marriage in the law of the state in which you both reside, and with whom you have entered into a relationship in which you are mentally competent to consent to contract, have shared the same household on a continuous basis for at least six (6) months and are financially interdependent.

Termination of Coverage

Your coverage will terminate in accordance with the rules described in Section I of the Summary Plan Description. In addition, the following rules, as outlined in the [collective bargaining agreement or the personnel policies of the Employer], apply:

- Termination of Employment:
- Retirement:
- Layoff:
- Disability:

Open Enrollment (If the company does not have an open enrollment period, remove this entire paragraph.)

If you choose not to become a Participant on the earliest possible date, or if you elect to terminate your participation in a Fund benefit plan but you otherwise remain eligible, you may become a Participant during the next following open enrollment period so long as the required contributions are made to the Fund on your behalf. This also applies to your eligible Dependents. For purposes of the open enrollment, changes in your (or your Dependents) participation status can be made during the month of [name of month] for a [name of month] 1st effective date. Please contact your employer for additional information.

COBRA If the Fund handles COBRA, remove this entire paragraph.

(Company) has elected to retain responsibility for the administration of COBRA coverage for its employees. Please contact your Employer for information on how to obtain COBRA coverage.

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SECTION I: GENERAL INFORMATION

INTRODUCTION

This booklet, along with the accompanying Fund Letter identifying the particular benefits available to your group and other special rules, describes the benefits that are available to you as a Participant in the Steelworkers Health and Welfare Fund (the "Fund"), and the conditions under which the benefits are available. Please read this booklet carefully so you will understand your coverage. If you have questions about this booklet, or any other questions about the Fund (other than questions about a specific benefit or a specific claim), please contact the Steelworkers Health and Welfare Fund Administrative Office, Five Gateway Center, Fifth Floor, Pittsburgh, Pennsylvania 15222-1219 ("Fund Office"). You may also call the Fund Office toll-free at 1-888-296-7493 for assistance. Office hours are 8:00 am to 5:00 pm Eastern Time, Monday through Friday. At other times, you may leave a message and your call will be returned as soon as possible. If you have questions about a particular benefit or an outstanding claim, you should contact the benefit provider directly at the toll-free number listed on your identification card.

This booklet is intended only to provide a summary of your benefits. The terms and conditions of the benefits available from the Fund are more fully discussed in the document called the *Steelworkers Health and Welfare Plan* (the "Plan"). Please contact the Fund Office if you would like a copy of the Plan. If there are any contradictions between this booklet and the Plan, the terms of the Plan will govern.

The Fund was established in 1944. Its purpose is to provide health and other benefits to individuals employed under a collective bargaining agreement between the United Steel, Paper and Forestry, Rubber, Manufacturing, Energy, Allied Industrial and Service Workers International Union ("USW") (the "Union") or other participating union and a participating Employer. The Fund is managed by a Board of Trustees.

All contributions to the Fund are made by the Employers (or covered individuals) in accordance with the provisions of a collective bargaining agreement (or other written agreement with the Fund) that require periodic contributions to the Fund.

The Fund Office will provide you, upon written request, with information as to whether a particular Employer is contributing to this Fund on behalf of Employees working under collective bargaining agreements and, at reasonable cost, a copy of any collective bargaining agreement authorizing contributions to the Fund. A complete list of the employers contributing to the Fund may be obtained upon written request to the Fund Office.

Benefits are provided from the Fund's assets, which are held in trust (along with their earnings) for the purpose of providing benefits to covered individuals and defraying reasonable administrative expenses. Benefits may be paid either directly by the Fund from trust assets or by an entity with whom the Fund has a contract to provide benefits, such as an insurance carrier.

What benefits are available from the Fund?

The Fund provides the following benefits:

- Medical Benefits
- Prescription Drug Benefits
- Dental Benefits
- Vision Benefits
- Death Benefits
- Accidental Death and Dismemberment Benefits
- Short Term Disability Benefits

Not all Participants are eligible for all of the benefits offered. The Fund Letter accompanying this booklet lists the benefits for which you are or may become eligible.

Whom do I contact with questions about benefits?

The identification card that you receive for Medical (including Prescription Drug), Dental and/or Vision Benefits includes a toll-free phone number and an address for questions about that benefit, including whether a particular service is covered, and questions about the status of your claim. You should contact the Fund Office or the insurance company for questions about Death, Accidental Death and Dismemberment and Short-Term Disability Benefits claims. For general questions about the Fund, or if you are having problems getting a satisfactory answer to your question about a benefit, please contact the Fund Office.

KEY TERMS

The meaning of some of the terms used most frequently throughout this booklet is explained below:

Benefit
A Benefit is one of the benefits offered by the Fund. The benefits for which you are or may become eligible are listed in the Fund Letter accompanying this booklet.

Board of Trustees
The Board of Trustees is the group of individuals appointed to manage the operation and administration of the Fund.

Claims Administrator
The Claims Administrator is the entity responsible for claims processing and payment.

Dependent
Dependents include the following persons:

- your spouse;
- your children who are under age 26;
- your unmarried children who are age 26 or older and incapable of self-support as the result of physical or mental incapacity that existed before he or she reached age 26, and who is wholly dependent upon you for support.

The term "children" includes any birthchild, stepchild, legally adopted child or child placed for adoption with you, and a child for whom you have been appointed legal guardian.

Employee
An Employee is an employee or former employee of an Employer who works or worked in a job classification covered by a collective bargaining agreement requiring contributions to be made to the Fund, or who works in a position set forth in some other written agreement accepted by the Board of Trustees.

Employer
An Employer is an employer that is or was a party to a collective bargaining agreement, or other written agreement accepted by the Board of Trustees, that requires contributions to be made to the Fund on behalf of its Employees.

ERISA
ERISA is the Employee Retirement Income Security Act of 1974, as amended, a federal law that governs the operation of the Fund.

Fund
The Fund is the Steelworkers Health and Welfare Fund.

Fund Letter
The Fund Letter is the letter from the Fund that accompanies this booklet and that identifies the particular benefits available to your group and other special rules for your group that are not reflected in this more general booklet.

Fund Office
The Fund Office is the Steelworkers Health and Welfare Fund Administrative Office, Five Gateway Center, Fifth Floor, Pittsburgh, Pennsylvania 15222-1219. The Board of Trustees has delegated the day-to-day administrative duties to persons who work in the Fund Office.

Group Insurance Policy
The Group Insurance Policy is the insurance policy that the Fund has purchased from an insurance company to pay a particular benefit. If a benefit booklet describing a particular benefit refers to the Group Insurance Policy for that benefit and you would like to review that Group Insurance Policy, please contact the Fund Office.

Participant
A Participant is an Employee who has met the requirements to be eligible for benefits from the Fund, and has not lost eligibility for those benefits.

Participation Agreement
A Participation Agreement is an agreement implementing the terms and conditions of a collective bargaining agreement requiring contributions to the Fund on behalf of Employees.

Plan
The Plan is the Steelworkers Health and Welfare Plan, which is a written document describing the operation of the Fund.

Plan Administrator
The Plan Administrator is the Board of Trustees of the Steelworkers Health and Welfare Fund.

Qualifying Event
A qualifying event is an event that entitles you to elect COBRA continuation health coverage from the Fund.

Union
The Union is the United Steel, Paper and Forestry, Rubber, Manufacturing, Energy, Allied Industrial and Service Workers International Union ("USW"), or any successor thereto.

You
The terms "you" and "your" generally refer to Participants. In the section entitled Eligibility for Benefits, "you" and "your" include both Participants and Employees who are not yet Participants. In the section entitled Claims and Review Procedures the term "you" means all persons with a claim or potential claim for benefits. Also, in the section(s) describing the available benefits, the terms "you" and "your" include both Participants and Dependents.

FUND MANAGEMENT

Who manages the Fund?

The Fund is managed by the Board of Trustees, which meets periodically to review and decide Fund matters. The Board of Trustees may engage other persons or entities, such as those employed at the Fund Office, to conduct the day-to-day operations of the Fund. The Board of Trustees may also delegate certain of its duties to other persons or entities, as the Board considers advisable.

The Board (or, where applicable, the Board's delegate) has the exclusive authority, in its sole and absolute discretion, to:

- take all actions necessary to manage the Fund;
- administer and interpret the Plan and all other documents maintained in connection with the Plan; and
- decide all matters arising in connection with the operation or administration of the Plan.

The Board fully intends to continue to maintain the Plan indefinitely. However, the Board has the sole and absolute discretion to modify or terminate the Plan at any time.

What does the Fund Office do?

The Fund Office handles the day-to-day administrative functions for the Fund, including distributing this booklet and other information to you and your Dependents, responding to your requests about the Fund, and maintaining appropriate Participant and Employer information. You may contact the Fund Office with any questions that you have at the address or phone number set forth in the Introduction.

What role do Insurance Companies and other providers play?

In some cases, the Board of Trustees has contracted with an insurance company for the purchase of an insurance policy to pay benefits, or with an insurance company or other entity for the provision of administrative services for a particular benefit (such as to process claims). This booklet discusses the role that an insurance company or other entity plays, if any, with respect to a particular benefit. Because of these arrangements, if you contact the Fund Office with questions about a particular benefit, the Fund Office may in some cases refer you to an insurance carrier or other entity for an answer.

The benefits described in this Summary Plan Description (SPD) are guaranteed under a contract of insurance issued to the Fund by the following insurance companies, each of which provides claims payment and other administrative services to the Fund.

Benefit	Claims Administrator
Medical, Prescription Drug	Highmark Blue Cross Blue Shield Fifth Avenue Place 120 Fifth Avenue Pittsburgh, PA 15222
Dental	United Concordia Companies, Inc. 100 Senate Avenue Senate Plaza Camp Hill, PA 17011
Vision	Davis Vision 159 Express Street Plainville, NY 11803

Death, Accidental Death & Dismemberment	OneAmerica One American Square P.O. Box 7106 Indianapolis, IN 46207-7106
Short-Term and Long-Term Disability	OneAmerica P.O. Box 9060 Portland, ME 04104

Detailed information concerning the claims and appeals procedures of each insurance company is included in the applicable benefits section of this SPD.

ELIGIBLITY FOR BENEFITS

How do I become eligible for benefits from the Fund?

You will become a Participant in the Fund on the first day for which the required contributions to the Fund are made on your behalf for one or more benefits. That date is specified in the Fund Letter.

Once you become a Participant, you will generally be eligible to receive all of the benefits set forth in this booklet and in the Fund Letter. This booklet may also contain additional eligibility requirements for a particular benefit, such as completing an enrollment form, so you should read this booklet carefully.

If you choose not to become a Participant on the earliest possible date, or if you elect to terminate your participation in a Fund benefit plan but you otherwise remain eligible, you may become a Participant on any of the following dates, so long as the required contributions are made to the Fund on your behalf:

- a date permitted under the annual open enrollment period applicable to your Employer, if any. (the Fund Letter describes any applicable annual open enrollment period);
- the next rate renewal date as agreed to in the Participation Agreement;
- if you are or were covered under another group health plan, a date that is no later than thirty (30) days after (a) you lose coverage under that plan due to divorce, legal separation, or a termination or reduction in your hours of employment; or (b) Employer contributions to that plan stop, but only if you notify the Fund Office within thirty (30) days of losing coverage or of the termination of Employer contributions;
- if you acquire a new Dependent (including a new spouse), a date that is no later than thirty (30) days from the date on which you acquire the Dependent, so long as you notify the Fund Office within thirty (30) days of acquiring the Dependent; or
- the date you lose coverage under a Medicaid plan under title XIX of the Social Security Act or under a State child health plan under title XXI of the Social Security Act, so long as you notify the Fund Office within sixty (60) days of losing coverage.

How do my spouse and other Dependents become eligible for benefits from the Fund?

Your Dependents (including your spouse) will become eligible for benefits on the day that you become a Participant (so long as the required contributions are made to the Fund on their behalf). This booklet may contain additional eligibility requirements for a particular benefit, such as completing an enrollment form, so you should read this booklet carefully.

If you choose not to enroll your Dependents on the earliest possible date, or if you elect to terminate their participation in a Fund benefit plan but they otherwise remain eligible, any Dependent may be enrolled on any of the following dates, so long as the required contributions are made to the Fund on his or her behalf:

- a date permitted under the annual open enrollment period applicable to your Employer, if any (the Fund Letter describes any applicable open enrollment period);
- the next rate renewal date as agreed to in the Participation Agreement;
- if your Dependent is or was covered under another group health plan, a date that is no later than thirty (30) days after (a) he or she loses coverage under that plan due to divorce, legal separation, or a termination or reduction in hours of employment; or (b) Employer contributions to that plan stop, but only if you or your Dependent notifies the Fund Office within thirty (30) days of losing coverage or of the termination of Employer contributions; or
- the date your Dependent loses coverage under a Medicaid plan under title XIX of the Social Security Act or under a State child health plan under title XXI of the Social Security Act so long as you notify the Fund Office within sixty (60) days of losing coverage.

How do I lose eligibility for benefits?

You will be a Participant until the earliest of the following events occurs (unless the Fund Letter contains different rules, in which case those rules will apply):

- you cease employment with your Employer;
- your Employer is no longer required to make contributions for you, in which case you will continue to be a Participant through the last day of the month for which your Employer is required to make contributions for you;
- the Fund does not receive contributions required to be made for your coverage for any particular month, in which case you will cease to be a Participant as of the last day of the previous month; or
- the date on which the Plan terminates.

Once you stop being a Participant, you will no longer be eligible to receive any benefits, except to the extent that COBRA coverage (discussed below) applies to you. In addition, in limited circumstances, benefits may be continued to the extent provided in the applicable insurance contract.

How do my spouse and other Dependents lose their eligibility for benefits?

Each of your Dependents (including your spouse) will continue to be eligible for benefits until one of the following events occurs (unless the Fund Letter contains different rules, in which case those rules will apply):

- he or she no longer meets the definition of Dependent set forth above;
- the Fund does not receive contributions required to be made for a Dependent's coverage for any particular month, in which case he or she will cease to be eligible for benefits as of the last day of the previous month; or
- the date on which you stop being a Participant, except to the extent that COBRA coverage applies.

How do payroll deductions affect my coverage?

If your Employer requires you to contribute towards your coverage through payroll deductions and you make a change in coverage or enrollment for yourself or your Dependents, you may need to change the amount you have authorized your Employer to deduct from your pay. If you do not do so, your Employer may not make the appropriate contributions to the Fund on behalf of you and/or your Dependents, resulting in termination of your benefits. Check with your Employer for details.

What if I go on leave for family or medical reasons?

The Family and Medical Leave Act (FMLA) is a federal law that permits eligible Employees to take up to twelve (12) weeks of unpaid, job-protected leave each year from their Employer for certain specified reasons. If you qualify, you may take FMLA leave for any of the following reasons:

- the birth of your child and to care for that child;
- the placement of a child with you for adoption or foster care;
- to care for your spouse, child or parent with a serious health condition; or
- a serious health condition that makes you unable to perform your job.

During your FMLA leave, your Employer must provide you with the same health benefits that you were receiving immediately before your leave. This means that your Employer must continue to make the same contributions to the Fund on your behalf during your FMLA leave that it was making while you were at work.

Contact your Employer for further information and instructions on how to apply for FMLA leave.

What if I have military service?

If you leave employment with your Employer for certain types of military training or service, and return to your Employer within ninety (90) days, your Employer may be required under federal law to begin to contribute to the Fund on your behalf immediately upon your return, in which case you would not have to satisfy any waiting period. Contact your Employer for details.

What if I terminate employment and my new Employer's plan doesn't cover pre-existing conditions?

The Fund does not limit medical coverage for pre-existing conditions, but some plans do. Most plans are required to reduce this limit if you had prior coverage. When you lose eligibility for medical benefits, you may request a Certificate of Coverage showing the amount of time that you were continuously covered by the Fund. If you are eligible for and elect COBRA coverage as described elsewhere in this booklet, you will receive another Certificate of Coverage after your COBRA coverage expires. You may also request a Certificate of Coverage at any time while you are still covered by the Fund or during the twenty-four (24) months after you lose your eligibility for medical benefits.

EXTENDED COVERAGE

How can I continue coverage once I am no longer eligible for benefits?

Once you are no longer eligible for medical benefits, you may be able to continue coverage in two ways: by electing COBRA coverage as described below or, if your benefits are insured by a company that provides conversion rights, by purchasing an individual insurance policy. (If such a provision is offered, it will be described later in this booklet.)

What is COBRA coverage?

COBRA continuation coverage is a continuation of the group health coverage available to you and your covered Dependents from the Fund when coverage would otherwise end because of a life event known as a "qualifying event". Specific qualifying events are listed below.

Individuals who elect COBRA continuation coverage must pay for COBRA continuation coverage. The administration of COBRA coverage is the responsibility of the Fund Office.

In order to protect your and your family's rights, it is important to keep the Fund Office informed of the current addresses of all of your family members who are or could become eligible for COBRA coverage. You should also keep a copy, for your records, of any notices you send to the Fund Office.

Which of my family members are eligible for COBRA coverage?

Each of your Dependents who is covered from the Fund when a qualifying event as defined below occurs is eligible for COBRA coverage unless he or she is entitled to Medicare. In addition, if a child is born to or adopted by you while your COBRA coverage is in effect, that child is eligible for COBRA coverage. You and each of your Dependents eligible for COBRA coverage is referred to as a "qualified beneficiary".

What events are qualifying events that make me and my Dependents eligible for COBRA coverage?

You and your eligible Dependents will each become a qualified beneficiary and may independently elect COBRA coverage when a qualifying event occurs. A qualifying event may be different for you and your eligible Dependents.

Qualifying Events for You

The following events are qualifying events for you if they result in a loss of coverage, unless you are entitled to Medicare:

- reduction in your hours of employment or termination of your employment (for reasons other than gross misconduct);
- you are a retiree of an Employer contributing to the Fund on behalf of its retired employees and your former Employer commences federal bankruptcy proceedings under title 11 of the U.S. Code.

Qualifying Events for Your Dependents

The following are qualifying events for your Dependents if they result in a loss of coverage:

- your death;
- reduction in your hours of employment or termination of your employment (for reasons other than gross misconduct);
- your divorce or legal separation;
- you are a retiree of an Employer contributing to the Fund on behalf of its retired employees and your former Employer commences federal bankruptcy proceedings under title 11 of the U.S. Code;
- your becoming enrolled in Medicare (Part A, Part B, or both); or
- for a child, ceasing to qualify as a Dependent.

Employer Withdrawals from the Fund

If you or one of your Dependents has a qualifying event and your Employer withdraws from the Fund or ceases to be a participating Employer due to non-payment of contributions, you and your Dependents will be eligible for COBRA coverage until your Employer makes group health coverage available to (or starts contributing to another multiemployer plan with respect to) a class of employees formerly covered from the Fund, at which point the other plan will be required to assume the COBRA obligation with respect to you and your Dependents.

If a qualifying event occurs, how do my Dependents and I get COBRA coverage?

NOTE: If your Fund Letter provides that your Employer has elected to retain responsibility for the administration of COBRA coverage, this section does not apply and you will need to contact your Employer for details on how to obtain COBRA coverage.

The Fund will offer COBRA continuation coverage to qualified beneficiaries only after the Fund Office has been notified that a qualifying event has occurred. When the qualifying event is termination of employment or reduction in your hours of employment, your death, commencement of a proceeding in bankruptcy with respect to the Employer, or your becoming enrolled in Medicare (Part A, Part B or both), the Employer must notify the Fund of the qualifying event within thirty (30) days of the qualifying event.

For the other qualifying events (your divorce or legal separation, or your child losing eligibility for coverage as a Dependent), you or your Dependent(s) must notify the Fund Office within sixty (60) days of the qualifying event.

Once the Fund Office receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that Fund coverage would otherwise have been lost.

Is there a special rule if I am eligible for Trade Adjustment Assistance benefits?

Each qualified beneficiary is entitled to a second COBRA election period if: (a) you are certified by the Department of Labor as eligible for trade act assistance (TAA) benefits under the Trade Act of 1974 on or after November 4, 2002; (b) the qualified beneficiary lost coverage from the Fund due to your job loss that resulted in eligibility for TAA benefits; and (c) the qualified beneficiary did not elect COBRA coverage during the initial election period resulting from that job loss. Specifically, each qualified beneficiary has another opportunity to elect COBRA during the sixty (60) day period that begins on the first day of the month in which you were certified, and the election must also be made within six months after the date Fund coverage is lost. You or your Dependent(s) are responsible for notifying the Fund Office of your TAA eligibility and providing a copy of the certification. Accordingly, if you are eligible for TAA benefits, you or your Dependent(s) must contact the Fund Office immediately after you become certified or all qualified beneficiaries will lose the special COBRA rights. If a qualified beneficiary elects COBRA coverage under this provision, it will begin on the first day of the sixty (60) day election period and will last the same length of time as if an election had been made based on the original qualifying event.

How long will my COBRA coverage last?

COBRA continuation coverage is a temporary continuation of coverage. Unless there is an early cut-off as described below, COBRA continuation coverage lasts for up to eighteen (18) months if the qualifying event is the termination of or reduction in hours of your employment, or up to thirty-six (36) months if the qualifying event is your death, your divorce or legal separation, your becoming enrolled in Medicare (Part A, Part B or both), or a child losing eligibility as a Dependent. There are two ways in which this eighteen (18) month period of COBRA continuation coverage can be extended.

Disability Extension of Eighteen (18) Month Period of Continuation Coverage

If you or any covered Dependent are determined by the Social Security Administration to be disabled at some time before the 60th day of COBRA continuation coverage, you and each of your covered Dependents can receive up to an additional eleven (11) months of COBRA coverage, for a total maximum of twenty-nine (29) months. You must make sure that the Fund Office is notified of the Social Security Administration's determination within sixty (60) days of the date of the determination and before the end of the eighteen (18) month period of COBRA continuation coverage to be eligible for the additional eleven (11) months of COBRA continuation coverage.

Second Qualifying Event Extension of Eighteen (18) Month Period of Continuation Coverage

If you or a covered Dependent has another qualifying event while receiving COBRA continuation coverage, your covered Dependents can get additional months of COBRA continuation coverage, up to a maximum of thirty-six (36) months. This extension is available to your spouse and dependent children if you die, become enrolled in Medicare (Part A, Part B or both), or get divorced or legally separated. The extension is also available to a child when that child stops being eligible under the Fund as a Dependent. In all of these cases, you must make sure that the Fund Office is notified of the second qualifying event within sixty (60) days of the second qualifying event and within the initial eighteen (18) months of continuation coverage.

What will cause an early cut-off of COBRA coverage?

COBRA coverage will automatically end as of the date any of the following cut-off events occurs:

- the covered individual does not pay the premium for COBRA coverage on time;
- the covered individual becomes covered under any other group health plan that does not limit coverage for his or her pre-existing conditions;
- the covered individual becomes enrolled in Medicare (Part A, Part B or both);
- your Employer withdraws from the Fund and makes other group health coverage available to (or starts contributing to another multiemployer plan with respect to) a class of employees formerly covered from the Fund; or
- for a covered individual who is receiving COBRA coverage based on a determination of disability, the first day of the month immediately following the month in which there is a final determination by the Social Security Administration that the individual is no longer disabled.

The covered individual is required to notify the Fund Office of any of the above cut-off events and the Fund may terminate COBRA coverage retroactively to the date of the cut-off event.

How can I get additional information about COBRA?

If you have questions about your COBRA continuation rights and coverage, you should contact the Fund Office or you may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

What if a court orders the Fund to cover my children?

The Fund will comply with the terms of any judgment, decree or order that creates or recognizes the right of one or more of your children to receive medical benefits, so long as that judgment, decree or order is a Qualified Medical Child Support Order (QMCSO) under Section 609 of ERISA. Coverage under such an order will not extend the maximum period of COBRA coverage. A description of the procedures governing QMCSOs may be obtained, without charge, from the Fund Office.

CLAIM AND REVIEW PROCEDURE

How do I file a claim for benefits?

Each benefit section of this booklet sets forth a procedure for filing claims for that particular benefit with the appropriate Claims Administrator and a time limit within which your claims must be filed. The Plan document contains a general explanation of the claims procedures, including the items to be considered by the Claims Administrator and the required elements of the notification of denial of your claim or appeal. Contact the Fund Office for details.

When will I be notified of the Claims Administrator's decision on my claim?

You will be notified of the Claims Administrator's decision on your claim no later than the following date:

- Urgent Care Claims
  In the case of an Urgent Care Claim, you will be notified of the Claims Administrator's decision within seventy-two (72) hours after its receipt of the claim. An Urgent Care Claim is a claim for medical care or treatment where your life or health or ability to function properly would be seriously jeopardized by applying the longer time periods set forth below. If you do not provide enough information for the Claims Administrator to determine the benefits that are due, the Claims Administrator will notify you of the specific information necessary to complete the claim within twenty-four (24) hours after it receives the claim. You will then have a reasonable amount of time (at least forty-eight (48) hours) to provide the requested information, and the Claims Administrator will notify you of its decision within forty-eight (48) hours after it receives the information. If your claim is to extend the course of treatment beyond the period of time or number of treatments approved by the Claims Administrator and you make your claim at least twenty-four (24) hours before the period of time or number of treatments ends, you will be notified of the Claims Administrator's decision on your claim within twenty-four (24) hours of the Claims Administrator's receipt of the claim.

- Concurrent Care Decisions
  In the case of a claim involving an ongoing course of treatment, you will be notified of the Claims Administrator's decision in enough time before any reduction or termination of the treatment to permit you to file an appeal and obtain a decision on appeal before the benefit is reduced or terminated. (This rule does not apply to reductions or terminations of benefits as a result of an amendment or termination of the Plan.)

- Pre-Service Claims
  In the case of any other claim that must be approved in advance of obtaining the service or care, you will be notified of the Claims Administrator's decision within fifteen (15) days of its receipt of the claim or thirty (30) days if the Claims Administrator determines that an extension is necessary due to matters beyond its control, in which case you will be notified within the fifteen (15) day period of why the extension is required, when a decision is expected to be made, and any additional information required to decide the claim. You will then have forty-five (45) days to provide that information.

- Other Claims
  In the case of all other claims (except for claims for Death Benefits and Accidental Death and Dismemberment Benefits, which are discussed below), you will be notified of the Claims Administrator's decision within thirty (30) days of its receipt of the claim or forty-five (45) days if the Claims Administrator determines that an extension is necessary due to matters beyond its control, in which case you will be notified within the thirty (30) day period of why the extension is required, when a decision is expected to be made, and any additional information required to decide the claim. You will then have forty-five (45) days to provide that information.

- Claims for Death Benefits or Accidental Death and Dismemberment Benefits
  In the case of a claim for Death Benefits and Accidental Death and Dismemberment Benefits, you will be notified of the Claims Administrator's decision within ninety (90) days of its receipt of the claim or one hundred eighty (180) days if the Claims Administrator determines that an extension is necessary due to matters beyond its control, in which case you will be notified within the ninety (90) day period of why the extension is required and when a decision is expected to be made.

If my claim is denied, how do I appeal?

If you file a claim for benefits in accordance with the applicable benefit provisions and the Claims Administrator either denies the claim or fails to respond to you by the deadline set forth above, you may file a written appeal with the Claims Administrator within one hundred eighty (180) days of the date you were notified that the claim was denied or one hundred twenty (120) days in the case of a claim for Death Benefits or Accidental Death and Dismemberment Benefits. In support of your appeal, you may submit written comments, documents, and other information relating to your claim, and the Claims Administrator will provide you with reasonable access to, and copies of, all documents, records or other information relevant to your claim upon your request. In the case of an Urgent Care Claim (as defined above), you may request an expedited review process. If you request an expedited review process, you may submit your request for appeal orally or in writing and all information necessary to the appeal will be transmitted between the Claims Administrator and you by telephone, fax, or other similarly expeditious method.

When will the Claims Administrator notify me of its decision on my appeal?

The Claims Administrator will notify you of its decision on your appeal by the following date:

- Urgent Care Claims
  In the case of Urgent Care Claims, the Claims Administrator will notify you of its decision within seventy-two (72) hours after its receipt of the appeal.

- Pre-Service Claims; Concurrent Care Decisions
  In the case of Pre-Service Claims and Concurrent Care Decisions (as described above), the Claims Administrator will notify you of its decision within thirty (30) days of its receipt of the appeal.

- Disability and Post-Service Claims
  In the case of Disability and Post-Service claims, the Claims Administrator will notify you of its decision on the appeal within a reasonable period of time, but no later than forty-five (45) days (in the case of a Disability Claim) or sixty (60) days (in the case of a Post-Service Claim) after receipt of the appeal. If the Claims Administrator provides for two levels of appeals, a thirty (30) day period will apply instead of the forty-five (45) and sixty (60) day periods.

- Other Claims
  In the case of all other claims, the Claims Administrator will notify you of its decision on the appeal within a reasonable period of time, but no later than sixty (60) days after receipt of the appeal, which may be extended up to an additional sixty (60) days if special circumstances require an extension of time for processing the claim, in which case the Claims Administrator will notify you of the extension (along with a description of the special circumstances and the date by which it expects to render a decision).

Internal Appeal Process

The Claims Administrator maintains an internal appeal process involving one level of review. This appeal process is mandatory and must be exhausted before you are permitted to pursue legal action in accordance with §502 of the Employee Retirement Income Security Act of 1974 (ERISA).

At any time during the appeal process, you may choose to designate an authorized representative to participate in the appeal process on your behalf. You or your authorized representative shall notify the Claims Administrator in writing of the designation. For purposes of the appeal process, "you" includes designees, legal representatives and, in the case of a minor, parents entitled or authorized to act on your behalf. The Claims Administrator reserves the right to establish reasonable procedures for determining whether an individual has been authorized to act on your behalf. Such procedures as adopted by the Claims Administrator shall, in the case of an urgent care claim, permit a physician or other health care provider with knowledge of your medical condition to act as your authorized representative.

At any time during the appeal process, you may contact the Member Services Department at the toll-free telephone number listed on your ID card to inquire about the filing or status of your appeal.

If you receive notification that your coverage has been rescinded or that a claim has been denied by the Claims Administrator, in whole or in part, or is not subject to legal prohibitions against balance billing, you may appeal the decision. Your appeal must be submitted within one hundred eighty (180) days from the date of your receipt of notification of the adverse decision.

Upon request to the Claims Administrator, you may review all documents, records and other information relevant to your appeal and shall have the right to submit or present additional evidence or testimony which includes any written or oral statements, comments and/or remarks, documents, records, information, data or other material in support of your appeal. Your appeal will be reviewed by a representative from the Member Grievance and Appeals Department. The representative shall not have been involved or be the subordinate of any individual that was involved in any previous decision to deny the claim which is the subject of your appeal. In rendering a decision on your appeal, the Member Grievance and Appeals Department will consider all evidence, comments, testimony, documents, records, and other information submitted by you without regard to whether such information was previously submitted to or considered by The Claims Administrator. The Member Grievance and Appeals Department will afford no deference to any prior adverse decision on the claim which is the subject of your appeal.

Each appeal will be promptly investigated and the Claims Administrator will provide written notification of its decision within the following time frames:

- When the appeal involves a non-urgent care pre-service claim, within a reasonable period of time appropriate to the medical circumstances involved not to exceed thirty (30) days following receipt of the appeal;

- When the appeal involves an urgent care claim, as soon as possible considering the medical exigencies involved but not later than seventy-two (72) hours following receipt of the appeal; or

- When the appeal involves a post-service claim or a decision by the Claims Administrator to rescind coverage, within a reasonable period of time not to exceed thirty (30) days following receipt of the appeal.

If the Claims Administrator fails to provide notice of its decision within the above stated time frames or otherwise fails to strictly adhere to these appeal procedures, you shall be permitted to request an external review and/or pursue any applicable legal action.

In the event the Claims Administrator renders an adverse decision on your internal appeal, the notification shall include, among other items, the specific reason or reasons for the adverse decision and a statement regarding your right to request an external review and/or pursue any applicable legal action in accordance with §502 of the Employee Retirement Income Security Act of 1974 (ERISA).

External Review Process

You shall have four months from the receipt of the notice of the Claims Administrator's decision to appeal the denial resulting from the internal appeal process by requesting an external review of the decision. To be eligible for external review, the Claims Administrator's decision to be reviewed must involve:

- A claim that was denied involving medical judgment, including application of the Claim Administrator's requirements as to medical necessity, appropriateness, health care setting, level of care, effectiveness of a covered service or a determination that the treatment is experimental or investigational,
- A claim that Highmark has concluded in not subject to legal prohibitions against balance billing; or
- A determination made by the Claims Administrator to rescind your coverage

In the case of a denied claim, the request for external review may be filed by either your or your health care provider, with your written consent in the format required by or acceptable to the Claims Administrator. The request for external review should include any reasons, material justification and all reasonably necessary supporting information as part of the external review filing.

Preliminary Review and Notification

Within five business days from receipt of the request for external review, the Claims Administrator will complete a preliminary review of the external review request to determine:

- In the case of a denied claim, whether you are or were covered under this program at the time the covered service which is the subject of the denied claim was or would have been received;
- Whether you have exhausted the Claims Administrator's internal appeals process, unless otherwise not required to exhaust that process; and
- Whether you have provided all of the information and any applicable forms required by the Claims Administrator to process the external review request.

Within one business day following completion of its preliminary review of the request, the Claims Administrator shall notify you or the health care provider filing the external review request on your behalf, of its determination.

In the event that the external review request is not complete, the notification will describe the information or materials needed to complete the request in which case you, or the health care provider filing the external review request on your behalf, must correct and/or complete the external review request no later than the end of the four month period in which you were required to initiate an external review of the Claims Administrator's decision, or alternatively, 48 hours following receipt of the Claims Administrator's notice of its preliminary review, whichever is later.

In the event that the external review request is complete buy not eligible for external review, notification by the Claims Administrator will include the reasons why the request is ineligible for external review and contact information that you may use to receive additional information and assistance.

Final Review and Notification

Requests that are complete and eligible for external review will be assigned to an independent review organization (IRO) to conduct the external review. The assigned IRO will notify you, or the health care provider filing the external review on your behalf, that the request has been accepted and is eligible for external review. The notice will further state that the IRO has been assigned to conduct the external review and that any additional information which you or the health care provider may have in support of the request must be submitted, in writing, within 10 business days following receipt of the notice. Any additional information timely submitted by you or the health care provider and received by the IRO will be forwarded to the Claims Administrator. Upon receipt of the information, the Claims Administrator shall be permitted an opportunity to reconsider its prior decision regarding the claim that was denied or the matter which is the subject of the external review request.

The assigned IRO will review all of the information and documents that it timely received and decide on the external review request. The decision shall be made without regard or deference to the decision that was made in the Claims Administrator's internal appeal process. The assigned IRO shall provide written notice of its final external review decision to the Claims Administrator and you, or the health care provider filing the external review request on your behalf, within 45 days from receipt by the IRO of the external review request. Written notice of the decision shall be provided, among other information, a statement of the principal reasons for the decision including the rationale and standards relied upon by the IRO, a statement that judicial review may be available to your and current contact information for the Pennsylvania Insurance Department Office of Consumer Services or such other applicable office of health insurance consumer assistance or ombudsman.

Expedited External Review (applies to urgent care claims only)

If the Claims Administrator's initial decision or the denial resulting from the Claims Administrator's internal appeal process involves an urgent care claim, you or the health care provider on behalf of you may request an expedited external review of the Claims Administrator's decision. Requests for expedited external review are subject to review by the Claims Administrator to determine whether they are timely, complete and eligible for external review. When the request involves a denied urgent care claim, the Claims Administrator must complete its preliminary review and provide notice of its eligibility determination immediately upon receipt of the request for expedited external review. If the request is eligible for expedited external review, the Claims Administrator must then transmit all necessary documents and information that was considered in denying the urgent care claim involved to an assigned IRO in an expeditious manner. The assigned IRO will conduct the review and provide notice of its final external review decision as expeditiously as your medical condition or circumstances required, but in no event more than 72 hours following receipt by the IRO of the request for expedited external review. If notice of the decision by the IRO is not provide in writing, the IRO must provide within 48 hours following initial notice of its final external review decision, written confirmation of that decision to the Claims Administrator and you, or the health care provider filing the expedited external review on your behalf.

Member Assistance Services

You may obtain assistance with the Claims Administrator's internal appeal and external review procedures as described herein by contacting the Pennsylvania Insurance Department Office of Consumer Services or such other applicable office of health insurance consumer assistance or ombudsman.

SECTION II: MEDICAL BENEFITS

PLAN OVERVIEW

Your Employer has entered into an agreement with the Steelworkers Health and Welfare Fund to provide a managed health care plan administered by Highmark Blue Cross Blue Shield (Highmark). The plan, which is called the ***Blue Cross and Blue Shield PPO***, is a Preferred Provider Organization (PPO) that allows you to choose between two levels of health care: **In-network** or **Out-of-network.** In-network care is care you receive from providers in the Blue Cross and Blue Shield PPO network. Out-of-network care is care you receive from providers who are not in the Blue Cross and Blue Shield PPO network.

Note: All inpatient hospital care and inpatient mental health/substance abuse care must be precertified to assure it is covered. For more information, refer to the Healthcare Management section of this benefit booklet.

HOW TO FIND A NETWORK PROVIDER

The Blue Cross and Blue Shield PPO network includes physicians, specialists, hospitals and other health care providers. To locate a network provider near you, or to learn whether your current physician is in the network, refer to your separate provider directory; go online to www.highmarkbcbs.com or call 1-800-810-BLUE (2583) for more information. Additional copies of the provider directory may be obtained, without charge, by contacting Member Services at the toll-free number on your identification card. In order to maximize the benefits of your plan, you should check to see that your provider is in the network before you receive care.

KEY TERMS

To help you understand your coverage and how it works, you should be familiar with how your benefits are applied and the meaning of a few important terms you will see throughout this section. For specific amounts, refer to the Schedule of Benefits.

Benefit Period
The specified period of time during which charges for covered services must be incurred in order to be eligible for payment by the Claims Administrator. Your benefit period is a calendar year starting on January 1.

Claim
A request for preauthorization or prior approval of a covered service or for the payment or reimbursement of the charges or costs associated with a covered service. Claim includes:

- **Pre-Service Claim** – A request for preauthorization or prior approval of a covered service which, under the terms of your coverage, must be approved before you receive the covered service.
- **Urgent Care Claim** – A Pre-Service Claim which, if decided within the time periods established for making non-Urgent Care Pre-Service Claim decisions, could seriously jeopardize your life, health, ability to regain maximum function or, in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the service. Whether a request involves an urgent care claim will be determined by your attending physician or provider.
- **Post-Service Claim** – A request for payment or reimbursement of the charges or costs associated with a covered service that you have received.

Coinsurance
This is the specific percentage of the plan allowance for covered services that is your responsibility to pay after your deductible, if applicable, has been met. Refer to the Schedule of Benefits to determine the percentage your plan pays; the remaining percentage is your responsibility.

Copayment
The copayment is the specific, up-front dollar amount you must pay for certain covered services and prescription drugs. Refer to the Schedule of Benefits for the copayments applicable to your benefit program. The copayment does not vary with the cost of the service and does not apply toward the out-of-pocket limit. ***The copayment is to be paid to the provider at the time of service.***

Deductible
The deductible is a specified dollar amount that you must pay for covered services each benefit period before the plan begins to provide payment for benefits. Refer to the Schedule of Benefits for the deductible amount.

To help participants with several covered dependents, the deductible you pay for the entire family, regardless of its size, is specified under family deductible. To reach this total, you can count the expenses incurred by two or more family members. However, the deductible contributed towards the total by any one family member cannot be more that the amount of the individual deductible. If one family member meets the individual deductible and again needs to use benefits, the plan would begin to pay that person's covered services even if the deductible for the entire family had not been met.

When two or more family members are injured in the same accident, the plan begins to pay benefits when only one family member meets the deductible.

Experimental or Investigative
The use of any treatment, service, procedure, facility, equipment, drug, device or supply (intervention) which is not determined by the Claims Administrator or its designated agent to be medically effective for the condition being treated. The Claims Administrator will consider an intervention to be experimental or investigative if: the intervention does not have FDA approval to be marketed for the specific relevant indication(s); or available scientific evidence does not permit conclusions concerning the effect of the intervention on health outcomes; or the intervention is not proven to be as safe or as effective in achieving an outcome equal to or exceeding the outcome of alternative therapies; or the intervention does not improve health outcomes; or the intervention is not proven to be applicable outside the research setting. If an intervention, as defined above, is determined to be experimental or investigative at the time of the service, it will not receive retroactive coverage, even if it is found to be in accordance with the above criteria at a later date.

Medically Necessary and Appropriate (Medical Necessity and Appropriateness)
Services, supplies or covered medications that a provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are: (i) in accordance with generally accepted standards of medical practice; and (ii) clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and (iii) not primarily for the convenience of the patient, physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease. The Claims Administrator reserves the right, utilizing the criteria set forth in this definition, to render the final determination as to whether a service, supply or covered medication is medically necessary and appropriate. No benefits will be provided unless the Claims Administrator determines that the service, supply or covered medication is medically necessary and appropriate.

Out-of-Pocket Limit
The Out-of-Pocket Limit refers to the specified dollar amount of coinsurance incurred for covered services in a benefit period. When the specified dollar amount is attained, your program begins to pay 100% of all covered expenses. See your Schedule of Benefits for the out-of-pocket limit. The out-of-pocket limit does not include copayments, deductibles, prescription drug expenses, and amounts in excess of the plan allowance.

Total Maximum Out-of-Pocket
The Total Maximum Out-of-Pocket, as mandated by the federal government, refers to the specified dollar amount of deductible, coinsurance, and copayments incurred for network covered services and any qualified medical expenses in a benefit period. When the specified individual dollar amount is attained by you, or the specified family dollar amount is attained by you or your covered family members, your program begins to pay 100% of all covered expenses and no additional coinsurance, copayments and deductible will be incurred for network covered services in that benefit period. See your Schedule of Benefits for the Total Maximum Out-of-Pocket. The Total Maximum Out-of-Pocket does not include amounts in excess of the plan allowance.

Plan Allowance
The amount used to determine payment by the Claims Administrator for covered services provided to you and to determine your liability. Plan allowance is based on the type of provider who renders such services or as required by law. The plan allowance for an in-area out-of-network provider is based on an adjusted contractual allowance for like services rendered by a network provider in the same geographic region. You will be responsible for any difference between the provider's billed charges and Highmark's payment. The plan allowance for an out-of-area provider is determined based on prices received from local licensees of the Blue Cross Blue Shield Association in accordance with the Claims Administrator's participation in the BlueCard program described in the Inter-Plan Programs section of this booklet.

The plan allowance for an out-of-network state-owned psychiatric hospital is what is required by law.

Preferred Provider Organization (PPO)
A managed healthcare plan that does not require selection of a primary care physician, but is based on a provider network made up of physicians, specialists, hospitals and other health care facilities. Using the provider network helps assure that you receive maximum coverage for eligible expenses.

Summary of Benefits and Coverage (SBC)
The summary document required under the Patient Protection and Affordable Care Act of 2010, which described certain Covered Services, cost-sharing obligations, benefit limitations, exclusions and certain other coverage information.

Schedule of Benefits

The following Schedule of Benefits provides a summary of the medical benefits available to you and your eligible Dependents. Please refer to the subsequent pages for a more detailed description of covered services, limitations and exclusions.

UNDERSTANDING THE BLUE CROSS AND BLUE SHIELD PPO

In-Network and Out-of-Network Care
Each time you require medical care, you decide whether to receive care from a network provider (in-network) or from any provider of your choice (out-of-network).

- **In-Network Care** - When you receive covered services from a network provider, benefits are paid at the higher in-network level. You are responsible for any deductible, coinsurance or copayment amounts.
- **Out-of-Network Care** - When you receive covered services from a provider who is not in the Blue Cross and Blue Shield PPO network, benefits are paid at the lower out-of-network level after you satisfy an annual deductible. You are also responsible for paying any coinsurance amounts, and you may have to pay the difference between the Allowable Amount and the provider's actual charge.

  However, the following covered services when received from an out-of-network provider will be provided at the network services level of benefits and you will not be responsible for such difference:

  1. Emergency care services; and
  2. Ambulance services, when provided in conjunction with emergency care services or when provided by air.

  Additionally, in very limited circumstances, you may not be liable for charges for non-emergency covered services received from certain professional providers or ancillary providers who are not part of the network. A network facility provider who is not part of the network to render certain items and professional services (such as, but not limited to equipment, devices, anesthesiology, radiology or pathology services) to patients of the network facility provider. The selection of such professional providers or ancillary providers may be beyond your control. In that situation, you will not be liable, except for applicable network deductible, copayment, or coinsurance obligations, for the charges of the professional provider or ancillary provider.

Refer to the Schedule of Benefits for the deductible, coinsurance and copayment amounts applicable to the In-Network and Out-of-Network benefits of your plan.

Blues on Call
Blues on Call is a 24-hour health care advice and assistance service provided by specially trained registered nurses via a toll-free number – 1-888-BLUE428 or 1-888-258-3428. Your call will be kept strictly confidential. If you call about an illness or injury, the nurse listens to your symptoms, makes a comprehensive health care assessment, and helps determine the level of care needed. Depending upon the evaluation, you may be advised to seek emergency care or to call your physician. In some cases, you may be given home health care instructions and the nurse may call you back to check on your progress. You can also call the number for general health inquiries, or to listen to an audiotape on the health care topic of your choice.

Participating and Non-Participating Providers
If you receive services from a health care provider outside the Blue Cross and Blue Shield PPO network, there is another concept you need to understand: ***participating and non-participating*** health care providers.

Participating providers have entered into an agreement with Blue Cross Blue Shield pertaining to payment of benefits for covered services. These providers agree to accept the Blue Cross Blue Shield allowed charge. You will be responsible for any deductibles, coinsurance amounts, copayments, or amounts exceeding maximums. The sum of your payment plus the payment made by the plan will be accepted as payment in full. In the case of professional providers, payment must be made within sixty (60) days of notification by the Claims Administrator. If your payment is not made within sixty (60) days, the participating provider may bill you the difference between the actual charge and the Allowable Charge.

Non-participating providers have not entered into an agreement with Blue Cross Blue Shield pertaining to payment of benefits. When you receive covered services from a non-participating facility provider such as a hospital, the benefit amount will be based on an allowance as determined by the Claims Administrator. You will be responsible for payment of the remaining charges. Payment for services performed by a non-participating professional provider, such as a physician, will be made to you on the basis of the Allowable Charge. Since non-participating professional providers are not obligated to accept the Allowable Charge as payment in full, you will be responsible for payment of the remaining charges.

Eligible Providers
The following are eligible providers under this plan:

Facility Providers
- Hospitals
- Psychiatric hospitals
- Rehabilitation hospitals
- Ambulatory surgical facility
- Birthing facility
- Freestanding dialysis facility
- Freestanding nuclear magnetic resonance facility/magnetic resonance imaging facility
- Home health care agency
- Hospice
- Outpatient substance abuse treatment facility
- Outpatient physical rehabilitation facility
- Outpatient psychiatric facility
- Pediatric extended care facility
- Pharmacy provider
- Residential treatment facility
- Skilled nursing facility
- State-owned psychiatric hospital
- Substance abuse treatment facility

Professional Providers
- Audiologist
- Behavior specialist
- Certified registered nurse*
- Chiropractor
- Clinical social worker
- Dentist
- Dietician-nutritionist
- Licensed practical nurse
- Marriage and family therapist
- Nurse midwife
- Occupational therapist
- Optometrist
- Physical therapist
- Physician
- Podiatrist
- Professional counselor
- Psychologist
- Registered nurse
- Respiratory therapist
- Speech-language pathologist

- Teacher of the hearing impaired

Ancillary Providers
- Ambulance service
- Clinical laboratory
- Diabetes prevention provider
- Home infusion and suite infusion therapy provider
- Independent diagnostic testing facility (IDTF)
- Suppliers

Contracting Suppliers (for the sale or lease of):
- Durable medical equipment
- Supplies
- Orthotics
- Prosthetics

*Excluded from eligibility are registered nurses employed by a health care facility or by an anesthesiologist group.

NETWORK PHARMACIES

You must purchase drugs from a network pharmacy to be eligible for benefits under this program. *No benefits are available if drugs are purchased from a non-network pharmacy.*

- **Network Pharmacy**
  Network pharmacies have an arrangement with the Claims Administrator to provide prescription drugs to you at an agreed upon price. When you purchase covered drugs from a pharmacy in the network applicable program, present your prescription and ID card to the pharmacist. (Prescriptions that the pharmacy receives by phone from your physician or dentist may also be covered). You should request and retain a receipt for any amounts you have paid if needed for income tax or any other purpose.

  If you travel within the United States and need to refill a prescription, call Member Services for help. They can help you find a network pharmacy near the area you are visiting. You also can use the member website to find a pharmacy. Once you have the name and address of the network pharmacy, take the prescription bottle to that pharmacy. The pharmacist will contact your home pharmacy to start the refill proves. **Note: Save the new medicine container. This will make it easier to transfer the prescription back to your pharmacy at home.**

- **Mail Order Pharmacy**
  Express Scripts® is your program's mail order pharmacy. This option offers savings and convenience for prescriptions you may take on an ongoing basis. To start using mail order:
  1. Ask your doctor to write a prescription for up to a ninety-day (90-day) supply, plus refills for up to one (1) year, if appropriate.
  2. Complete the Pharmacy Mail Order Form and Health, Allergy & Medication Questionnaire. You can get these forms by calling Member Services or from the member website. After logging in at www.highmarkbcbs.com, click on the "Prescriptions" tab. Scroll down the page to "Forms to Manage Your Plan" and click on "Mail order form and health questionnaire (PDF)".
  3. Send the completed forms and your payment to the address listed on the mail order form. It usually takes about five (5) days to get your prescription after it has been processed.

Your mail order will include directions for ordering refills.

- **Exclusive Pharmacy Provider**
  The exclusive pharmacy provider has an agreement, either directly or indirectly, with the Claims Administrator pertaining to the payment and exclusive dispensing of selected prescription drugs provided to you. Please see the Prescription Drugs section for a list of the selected prescription drug categories.

HEALTHCARE MANAGEMENT

For your benefits to be paid under your program, at either the network or out-of-network level, services and supplies must be considered medically necessary and appropriate.

The Claims Administrator, or its designated agent, is responsible for determining whether care is medically necessary and provided in the appropriate setting.

A nurse will review your request for an inpatient admission to ensure it is appropriate for treatment of your condition, illness, disease, or injury, in accordance with standards of good medical practice, and the most appropriate supply or level of service that can safely be provided to you. When applied to hospitalization, this further means that you require acute care as an inpatient due to the nature of the services rendered for your condition and you cannot receive safe or adequate care as an outpatient.

Network Care
When you use a network provider for inpatient care for other than an emergency admission, the provider will contact the Claims Administrator for you to receive authorization for your care.

If the network provider is located outside the plan service area, for other than an emergency admission, you are responsible for contacting the Claims Administrator at the toll-free number listed on the back of your ID card to confirm the Claims Administrator's determination of medically necessity and appropriateness.

Out-of-area network providers are not obligated to abide by any determination of medical necessity and appropriateness rendered by the Claims Administrator. You may, therefore, receive services which are not medically necessary and appropriate for which you will be solely responsible.

Out-of-Network Care
When you are admitted to an out-of-network facility provider for other than an emergency admission, ***you are responsible*** for notifying the Claims Administrator of your admission. However, some facility providers will contact the Claims Administrator and obtain preauthorization of the inpatient admission on your behalf. Be sure to verify that your provider is contacting the Claims Administrator for preauthorization. If not, you are responsible for contacting the Claims Administrator.

You should call seven (7) to ten (10) days prior to your planned admissions. For emergency admissions, call the Claims Administrator within forty-eight (48) hours of the admission, or as soon as reasonably possible. You can contact the Claims Administrator via the toll-free Member Service telephone number located on the back of your ID card.

If you do not notify the Claims Administrator of your admission to an out-of-network facility provider, the Claims Administrator may review your care after services are received to determine if it was medically necessary and appropriate. **If your admission is determined not to be medically necessary and appropriate, you will be responsible for all costs not covered by your program.**

Remember:
Out-of-network providers are not obligated to contact the Claims Administrator or to abide by any determination of medically necessity or appropriateness rendered by the Claims Administrator. You may, therefore, receive services which are not medically necessary and appropriate for which you will be solely responsible.

Care Utilization Review Process
In order to assess whether care is provided in the appropriate setting, the Claims Administrator administers a care utilization review program comprised of prospective, concurrent and/or retrospective reviews. In addition, the Claims Administrator assists hospitals with discharge planning. These activities are conducted by a nurse working with a medical director. Here is a brief description of these review procedures:

- **Prospective Review**
  Prospective review, also known as *precertification* or *pre-service review*, begins upon receipt of treatment information.

  After receiving the request care, the Claims Administrator:
  - verifies your eligibility for coverage and availability for benefits;
  - reviews diagnosis and plan of treatment;
  - assesses whether care is medically necessary and appropriate;
  - authorizes care and assigns an appropriate length of stay of inpatient admissions.

- **Concurrent Review**
  Concurrent review may occur during the course of ongoing treatment and is used to assess the medical necessity and appropriateness of the length of stay and level of care.

- **Discharge Planning**
  Discharge planning is a process that begins prior to your scheduled hospital admission. Working with you, your family, your attending physician(s) and hospital staff, the Claims Administrator will help plan for and coordinate your discharge to assure that you receive safe and uninterrupted care when needed at the time of discharge.

- **Procedure or Covered Service Precertification**
  Precertification may be required to determine the medical necessity and appropriateness of certain procedures or covered services as determined by the Claims Administrator. Network providers in the Claims Administrator's service area and the Plan Service area are responsible for the precertification of such procedures or covered services and you will be held harmless whenever certification for such procedures or covered services is not obtained. If the procedure or covered service is deemed not to be medically necessary and appropriate, you will be held harmless, except when the Claims Administrator provides prior written notice to you that charges for the procedure or covered service will not be covered. In such case, you will be financially responsible for such procedure or covered service.

- **Retrospective Review**
  Retrospective review may occur when a service or procedure has been rendered without the required precertification.

- **Case Management Services**
  Case Management is voluntary program in which a case manager, with input from you and your health care providers, assists when you are facing and/or recovering from a hospital admission, dealing with multiple medical problems or facing catastrophic needs. Case managers can provide educational support, assist in coordinating needed health care services, put you in touch with community resources, assist in addressing obstacles to your recovery such as benefit and caregiver issues and answer your questions.

  Case managers are a free resource to all members. If you have an inpatient hospital admission, you may be contacted as part of our Outreach program. If your claims history indicates that your needs appear to be more complex, you may be contacted by a case manager. In either case, you are always free to call and request case management services if you feel you need it by contacting Member Services at the telephone number listed on the back of your ID card.

PRESCRIPTION DRUG MANAGEMENT

Your prescription drug program provides the following provisions which will determine the medical necessity and appropriateness of covered medications and supplies:

- **Early Refill Authorization**
  - **Unexpected Event**
    If your prescription is lost or stolen due to an even such as a fire or theft, you may be able to get an early refill. Call Member Services at the number on your member ID card for help. You will need a copy of the report from the fire department, police department or other agency.

    Please note: The early refill authorization does not apply to events that can be controlled, such as spilling or losing the medicine.

  - **Traveling Abroad**
    If you will be out of the country when it is time to refill your prescription, call Member Services for help. Be sure to have your member ID card and your prescription information. Please allow at least five (5) business days to complete the request.

- **Quantity Level Limits**
  Quantity level limits may be imposed on certain prescription drugs by the Claims Administrator. Such limits are based on the manufacturer's recommended daily dosage or as determined by the Claims Administrator. Quantity level limits control the quantity covered each time a new prescription order or refill is dispensed for selected prescription drugs. Each time a prescription order or refill is dispensed, the pharmacy provider may limit the amount dispensed.

- **Quantity Level Limits for Initial Prescription Orders**
  Additional quantity level limits may be imposed for your initial prescription order for certain covered medications. In such instances, the quantity dispensed will be reduced to the level necessary to establish that you can tolerate the covered medication. Consequently, the applicable cost-sharing amount will be adjusted according to the quantity level dispensed for the initial prescription order.

- **Managed Prescription Drug Coverage**
  A prescription order or refill which may exceed the manufacturer's recommended dosage over a specified period of time maybe denied by the Claims Administrator when presented to the pharmacy provider. The Claims Administrator may contact the prescription physician to determine if the prescription drug is medically necessary and appropriate. If it is determined by the Claims Administration that the prescription is medically necessary and appropriate, the prescription drug will be dispensed.

- **Preauthorization**
  The prescribing physician must obtain authorization from the Claims Administration prior to prescribing certain covered medications. The specific drugs or drug classifications which require preauthorization may be obtained by calling the toll-free Member Services telephone number appearing on your ID card.

PRECERTIFICATION, PREAUTHORIZATION, AND PRE-SERVICE CLAIMS REVIEW PROCESS

The precertification, preauthorization, and pre-service claims review processes information described below applies to both medical and prescription drug management.

Authorized Representatives
You have a right to designate an authorized representative to file or pursue a request for precertification or other Pre-Service Claim on your behalf. The Claims Administrator reserves the right to establish reasonable procedures for determining whether an individual has been authorized to act on your behalf. Procedures adopted by the Claims Administrator will, in the case of an Urgent Care Claim, permit a physician or other professional health care provider with knowledge of your medical condition to act as your authorized representative.

Decisions Involving Requests for Precertification and Other Non-Urgent Care Pre-Service Claims
You will receive written notice of any decision on a request for precertification or other pre-service claim, whether the decision is adverse or not, within a reasonable period of time appropriate to the medical circumstances involved. That period of time will not exceed fifteen (15) days from the date the Claims Administrator receives the claim.

Decisions Involving Urgent Care Claims
If your request involves an Urgent Care Claim, the Claims Administrator will decide on your request as soon as possible considering the medical exigencies involved. You will receive notice of the decision that has been made on your Urgent Care Claim no later than seventy-two (72) hours following receipt of the claim.

If the Claims Administrator determines in connection with an urgent care claim that you have not provided sufficient information to determine whether or to what extent benefits are provided under your coverage, your physician will be notified within twenty-four (24) hours following the Claims Administrator's receipt of the claim of the specific information needed to complete your claim. Your physician will then be given not less than forty-eight (48) hours to provide the specific information to the Claims Administrator. The Claims Administrator will thereafter notify you of its determination on your claim as soon as possible but not later than forty-eight (48) hours after the earlier of (i) its receipt of the additional specific information, or (ii) the date the Claims Administrator informed your physician that it must receive the additional specific information.

Similarly, when your urgent care claim seeks to extend a previously approved course of treatment and that request is made at least twenty-four (24) hours prior to the expiration of the previously approved course of treatment, the Claims Administrator will notify you of its decision as soon as possible, but no later than twenty-four (24) hours following receipt of the request.

Notices of Determination Involving Precertification Requests and Other Pre-Service Claims
Any time your request for Precertification or other Pre-Service Claim is approved, you will be notified in writing that the request has been approved. If your request for Precertification or approval of any other Pre-Service Claim has been denied, you will receive written notification of the denial which will include, among other items, the specific reason or reasons for the adverse benefit determination and a statement describing your right to file an internal appeal or request an external review.

For a description of your right to file an appeal concerning an adverse determination of a request for Precertification or any other Pre-Service Claim, refer to the Appeal Procedure section of this benefit booklet.

CARE AWAY FROM HOME

Your plan also covers care when you're away from home. If you are traveling and an urgent injury or illness occurs, you should seek treatment from the nearest hospital, emergency room or clinic. If the illness or injury is a true emergency, it will be paid at the in-network benefit level. If the treatment results in a hospital admission, you must contact the Claims Administrator at the number on your identification card to authorize your admission.

If the illness or injury is not an emergency and you receive care from an out-of-network provider, benefits for eligible services will be provided at the lower, out-of-network level.

Dependents Away at School

If your child needs medical care while away at school, it is likely that the care given at the school's medical center is included in tuition costs. If your eligible Dependent needs care that is not provided at the medical center, benefits will be paid at the higher level when care is received from a network provider. If covered services are received from a provider who is not in the network, benefits will be paid at the lower out-of-network level. In the case of an urgent illness or injury that is a true emergency, benefits for covered services will be paid at the higher in-network level.

To receive the maximum benefits of your plan, students and other Dependents temporarily away from home should schedule appointments with network physicians while at home.

Blue Cross Blue Shield Global Core Program

This program aids with medical problems you may incur while traveling outside of the United States. Services include:

- making referrals and appointments for you with nearby physicians and hospitals;
- verbal translation from a multilingual service representative;
- aiding if special help is needed;
- planning for medical evacuation services; and
- processing inpatient hospitalization claims.

For outpatient or professional services received abroad, you should pay the provider, then complete an international claim form and send it to the Blue Cross Blue Shield Global Core Service Center. Claim forms can be obtained by calling 1-800-810-BLUE or the Member Service telephone number on your ID card. Claim forms can also be downloaded from www.bcbsglobalcore.com.

INTER-PLAN PROGRAMS

Out of Area Services

The Claims Administrator has a variety of relationships with other Blue Cross and/or Blue Shield licensees referred to generally as "Inter-Plan Programs." Whenever members access health care services outside the geographic area the Claims Administrator serves, the claim for those services may be processed through one of these Inter-Plan Programs and presented to the Claims Administrator for payment in accordance with the rules of the Inter-Plan Programs policies then in effect.

Typically, members, when accessing care outside the geographic area the Claims Administrator serves, should obtain care from health care provides that have a contractual agreement (i.e., are "participating providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, members may obtain care from non-participating heath care providers. The Claims Administrator's payment practices in both instances are described below.

BlueCard® Program
Under the BlueCard® Program, when members access covered services within the geographic area served by a Host Blue, the Claims Administrator will remain responsible to the group for fulfilling the Claims Administrator's contractual obligations. However, in accordance with applicable Inter-Plan Programs policies then in effect, the Host Blue will be responsible for providing such services as contracting with and handling substantially all interactions with its participating health care providers.

Liability Calculation Method Per Claim
The calculation of the Member liability on claims for Covered Services processed through the BlueCard Program will be based on the lower of the participating health care provider's billed charges for Covered Services or the negotiated price made available to the Claims Administrator by the Host Blue.

Host Blues may use various methods to determine a negotiated price, depending on the terms of each Host Blue's health care provider contracts. The negotiated price made available to the Claims Administrator by the Host Blue may represent a payment negotiated by a Host Blue with a health care provider that is one of the following:

- an actual price. An actual price is a negotiated payment without any other increases or decreases, or

- an estimated price. An estimated price is a negotiated payment reduced or increased by a percentage to consider certain payments negotiated with the provider and other claim- and non-claim-related transactions. Such transactions may include, but are not limited to, anti-fraud and abuse recoveries, provider refunds not applied on a claim-specific basis, retrospective settlements, and performance-related bonuses or incentives; or

- an average price. An average price is a percentage of billed charges for Covered Services representing the aggregate payments negotiated by the Host Blue with all of its health care providers or a similar classification of its providers and other claim- and non-claim-related transactions. Such transactions may include the same ones as noted above for an estimated price.

Host Blues using either an estimated price or an average price may, in accordance with Inter-Plan Programs policies, prospectively increase or reduce such prices to correct for over- or underestimation of past prices (i.e., prospective adjustments may mean that a current price reflects additional amounts or credits for claims already paid to providers or anticipated to be paid to or received from providers). However, the amount paid by the Member is a final price; no future price adjustment will result in increases or decreases to the pricing of past claims. The BlueCard Program requires that the price submitted by a Host Blue to the Claims Administrator is a final price irrespective of any future adjustments based on the use of estimated or average pricing.

A small number of states require a Host Blue either (a) to use a basis for determining Member liability for Covered Services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or (b) to add a surcharge. Should the state in which health care services are accessed mandate liability calculation methods that differ from the negotiated price methodology or require a surcharge, the Claims Administrator would then calculate Member liability in accordance with applicable law.

Return of Overpayments

Under the BlueCard Program, recoveries from a Host Blue or its participating health care providers can arise in several ways, including, but not limited to, anti-fraud and abuse recoveries, health care provider/hospital audits, credit balance audits, utilization review refunds, and unsolicited refunds. In some cases, the Host Blue will engage a third party to assist in identification or collection of recovery amounts. The fees of such a third party may be netted against the recovery. Recovery amounts determined in this way will be applied in accordance with applicable Inter-Plan Programs policies, which generally require correction on a claim-by-claim or prospective basis.

Negotiated National Account Arrangements
As an alternative to the BlueCard Program, a member's claims for covered services may be processed through a negotiated national account arrangement with a Host Blue.

If the Claims Administrator has arranged for a Host Blue to make available a custom health care provider network in connection with this contract, then the terms and conditions set forth in the Claims Administrator's negotiated national account arrangements with such Host Blue shall apply.

Member liability calculation will be based on the lower of either billed covered charges or negotiated price made available to the Claims Administrator by the Host Blue that allows members access to negotiated participation agreement networks of specified participating health care providers outside of the geographic area the Claims Administrator serves.

Non-Participating Health Care Providers Outside of the Geographic Area the Claims Administrator Serves

Member Liability Calculation
When covered services are provided outside of the geographic area the Claims Administrator serves by non-participating health care providers, the amount a member pays for such services will generally be based on the Host Blue's non-participating health care provider local payment unless otherwise specified under the terms of this contract or as required by applicable state law. In these situations, the member may be responsible for the difference between the amount that the non-participating health care provider bills and the payment the Claims Administrator will make for the covered services as set forth in this paragraph.

Exceptions
In some exception cases, the Claims Administrator may pay claims from non-participating health care providers outside of the geographic area the Claims Administrator serves based on a case-specific negotiated rate in situations where, for example, a member did not have reasonable access to a participating provider, as determined by Claims Administrator in the Claims Administrator's sole and absolute discretion or by applicable state law. In any of these exception situations, the member may be responsible for the difference between the amount that the non-participating health care provider bills and the payment the Claims Administrator will make for the covered services as set forth in this paragraph.

COVERED SERVICES

This plan may not cover all of your health care expenses. Read this benefit booklet carefully to determine which health care services are covered. Please keep in mind that you could be financially responsible for total payment to the provider for any services not covered by this plan.

The plan provides benefits for the following services you receive from a provider only when such services are determined to be medically necessary and appropriate. All benefit limits, deductibles, and copayment amounts are described in the Schedule of Benefits. In-network care is covered at a higher level of benefits than out-of-network care.

Ambulance Service
The plan covers local transportation by a specially designed and equipped vehicle used only to transport the sick and injured:
- from your home, scene of accident or medical emergency to a hospital or skilled nursing facility;
- between hospitals; or
- between hospital and skilled nursing facility.
- from a hospital to your home; or
- from a skilled nursing facility to your home.

Trips must be to the closest local facility that can provide covered services appropriate for your condition. If there is no facility in the local area that can provide covered services appropriate for your condition, then ambulance service means transportation to the closest facility outside the local area that can provide the necessary service.

Transportation and related emergency services provided by an ambulance service will be considered emergency ambulance service if the injury or condition is considered emergency care. Use of an ambulance as transportation to an emergency room for an injury or condition that is not considered emergency care will not be covered as emergency ambulance services. Refer to the Covered Services section for a definition of emergency care services.

Anesthesia for Non-Covered Dental Procedures (Limited)
The plan covers general anesthesia and associated hospital and medical services normally related to the administration of general anesthesia which are rendered in connection for non-covered dental procedures or non-covered oral surgery. Benefits are provided for members age seven or under and for developmentally disabled members when determined by the Claims Administrator to be medically necessary and appropriate and when a successful result cannot be expected for treatment under local anesthesia or when a superior result can be expected from treatment under general anesthesia.

Autism Spectrum Disorders
Benefits are provided to members less than 21 years of age for the following:

- **Diagnostic Assessment of Autism Spectrum Disorders**
  Medically necessary and appropriate assessments, evaluations or tests performed by a physician, licensed physician assistant, psychologist or certified registered nurse practitioner to diagnose whether an individual has an autism spectrum disorder.
- **Treatment of Autism Spectrum Disorders**
  Services must be specified in a treatment plan developed by a physician or psychologist following a comprehensive evaluation or reevaluation performed in a manner consistent with the most recent clinical report or recommendations of the American Academy of Pediatrics. The Claims Administrator may review a treatment plan for autism spectrum disorders once every six months, or as agreed upon between the Claims Administrator and the physician or psychologist developing the treatment plan.

Treatment may include the following medically necessary and appropriate services:

- **Pharmacy Care**
  Any assessment, evaluation or test prescribed or ordered by a physician, licensed physician assistant or certified registered nurse practitioner to determine the need or effectiveness of a prescription drug approved by the food and Drug Administration (FDA) and designated by the Claims Administrator for the treatment of autism spectrum disorders.
- **Psychiatric and Psychological Care**
  Direct or consultative services provided by a psychologist or by a physician who specializes in psychiatry.
- **Rehabilitative Care**
  Professional services and treatment programs, including Applied Behavioral Analysis, provided by an autism service provider to produce socially significant improvements in human behavior or to prevent loss of attained skill or function.
- **Therapeutic Care**
  Services that are provided by a speech language pathologist, occupational therapist or physical therapist.

Dental Services Related to Accidental Injury
The plan covers dental services rendered by a physician immediately following an accidental injury to sound natural teeth. Follow-up services, if any, that are provided after the initial treatment to sound natural teeth are not covered. Injury caused by chewing or biting will not be considered accidental injury.

Diabetes Treatment
The plan covers the following services when required in connection with the treatment of diabetes and when prescribed by a physician legally authorized to prescribe such items under the law:

- equipment and supplies such as blood glucose monitors, monitor supplies, injection aids, and insulin infusion devices; and
- Diabetes Education Program when your physician certifies that you require diabetes education as an outpatient, coverage is provided for the following when rendered through an outpatient diabetes education program*:
  - visits medically necessary and appropriate upon the diagnosis of diabetes; and
  - subsequent visits under circumstances whereby your physician: a) identifies or diagnoses a significant change in your symptoms or conditions that necessitates changes in self-management, or b) identifies as medically necessary and appropriate, a new medication or therapeutic process relating to the treatment and/or management of diabetes.

*Outpatient Diabetes Education Program is a program of self-management training and education, including medical nutrition therapy, for the treatment of diabetes. Such program must be conducted under the supervision of a licensed health care professional with expertise in diabetes. Outpatient Diabetes Education services will be covered subject to the criteria of the Claims Administrator. These criteria are based on the certification programs for Outpatient Diabetes Education developed by the American Diabetes Association (ADA) and the Pennsylvania Department of Health (DOH).

Diagnostic Services

- **Advanced Imaging Services** including, but not limited to, computed tomography (CT), computed tomographic angiography (CTA), magnetic resonance imaging (MRI), magnetic resonance angiography (MRA), positron emission tomography (PET scan) and positron emission tomography/computed tomography (PET/CT scan).
- **Basic Diagnostic Services**
  - Standard Imaging Services including procedures such as skeletal x-rays, ultrasound and fluoroscopy.
  - Laboratory and Pathology Services including procedures such as non-routine Papanicolaou (PAP) smears, blood tests, urinalysis, biopsies and cultures.
  - Diagnostic Medical Services including procedures such as electrocardiograms (ECG), electroencephalograms (EEG), echocardiograms, pulmonary studies, stress tests and audiology testing.
  - Allergy Testing Services including procedures such as percutaneous, intracutaneous and patch tests.

Durable Medical Equipment
The plan covers the rental (or, at the option of the Claims Administrator, the purchase, adjustment, repairs and replacement) of durable medical equipment for therapeutic use prescribed by a Professional Provider within the scope of his/her license. Rental costs cannot exceed the total cost of purchase.

Enteral Foods

The plan covers Enteral Foods, which is a liquid source of nutrition equivalent to a prescription drug that is administered orally or enterally and which may contain some or all nutrients necessary to meet minimum daily nutritional requirements. Enteral Foods are intended for the specific dietary management of a disease or condition for which distinctive nutritional requirements are identified through medical evaluation.

- amino acid-based elemental medical enteral foods ordered by a Physician for infants and children for food protein allergies, food protein-induced enterocolitis syndrome, eosinophilic disorders and short bowel syndrome;
- nutritional supplements administered under the direction of a Physician for the therapeutic treatment of phenylketonuria, branched-chain ketonuria, galactosemia and homocystinuria; and
- enteral foods prescribed by a Physician, when administered on an Outpatient basis, considered to be the Member's sole source of nutrition and provided:
  - through a feeding tube (nasogastric, gastrostomy, jejunostomy, etc.) and utilized instead of regular shelf food or regular infant formulas; or
  - orally and identified as one (1) of the following types of defined enteral foods with:
    1. hydrolyzed (pre-digested) protein or amino acids;
    2. specialized content for special metabolic needs;
    3. modular components; or
    4. standardized nutrients.

Once it is determined that the above criteria are met, coverage for enteral foods will continue as long as it represents at least fifty percent (50%) of the Member's daily caloric requirement.

Coverage for enteral foods ***excludes*** the following:

- blenderized food, baby food, or regular shelf food;
- milk or soy based infant enteral foods with intact proteins;
- any enteral foods, when used for the convenience of you or your family members;
- nutritional supplements or any other substance utilized for the sole purpose of weight loss or gain, or for caloric supplementation, limitation or maintenance; and
- semisynthetic intact protein/protein isolates, natural intact protein/protein isolates, and intact protein/protein isolates, when provided orally.

Coverage does not include normal food products used in the dietary management of the disorders set forth in this section.

Home Health Care/Hospice Care Services

The plan covers the following services you receive from a home health care agency, hospice or a hospital program for home health care, and/or hospice care:

- skilled nursing services of a Registered Nurse (RN) or Licensed Practical Nurse (LPN), excluding private duty nursing services;
- physical medicine, occupational therapy and speech therapy services;
- medical and surgical supplies provided by the home health care agency or hospital program for home health care or hospice care;
- oxygen and its administration;
- medical social service consultations;
- health aide services when you are also receiving covered nursing or therapy and rehabilitation services; and
- family counseling related to the member's terminal condition.

Home health care benefits are not payable for:

- dietician services;
- homemaker services;
- maintenance therapy;
- dialysis treatment;
- custodial care; or
- food or home-delivered meals.

Home Infusion and Suite Infusion Therapy Services

Benefits will be provided when performed by a home infusion and/or suite infusion therapy provider at an infusion suite or in a home setting. This includes pharmaceuticals, pharmacy services, intravenous solutions, medical/surgical supplies and nursing services associated with infusion therapy. Specific adjunct non-intravenous therapies are included when administered only in conjunction with infusion therapy. Benefits for certain infusion therapy prescription drugs as identified by Highmark and which are appropriate for self-administration will be provided only when received from a participating pharmacy provider.

Home Recovery Care Services

Benefits will be provided for in-home recovery care services offered through a designated hospital program and coordinated through a home recovery care vendor. Home Recovery Care Services are available at the option of both you and your physician's approval in lieu of an inpatient admission or observation stay following an emergency room visit. You must have acute medical needs and meet other eligibility requirements of the program.

Services must be rendered in your home and benefits include coverage for:

- hospital-level, physician-led care;
- home infusion services, nursing visits, therapy services and telehealth visits;
- case management that provides stepped-up care coordination services; and
- specific equipment provided in order to coordinate home recovery care with your physicians and to help monitor your progress.

Hospital Services

The plan covers the following services received in a facility provider. Benefits will be covered only when, and so long as, they are determined to be medically necessary and appropriate for the treatment of the patient's condition.

Inpatient Hospital Services

- **Bed, Board and General Nursing Services in:**
  - A room with two or more beds.
  - A private room. Private room allowance is the average semi-private room charge.
  - A bed in a Special Care Unit which is a designated unit which has concentrated all facilities, equipment, and supportive services for the provision of an intensive level of care for critically ill patients.

- **Inpatient Ancillary Services (Hospital Services and Supplies)**
  - Operating, delivery and treatment rooms and equipment.
  - Drugs and medicines provided to you while you are an inpatient in a facility provider.
  - Whole blood, administration of blood, blood processing, and blood derivatives.
  - Anesthesia, anesthesia supplies and services rendered in a hospital or other facility provider by an employee of the hospital or other Facility Provider. Administration of anesthesia ordered by the attending professional provider and rendered by a professional provider other than the surgeon or assistant at surgery.
  - Medical and surgical dressings, supplies, casts and splints.
  - Diagnostic services.
  - Therapy and rehabilitation services.

Outpatient Hospital Services

- **Outpatient Ancillary Services (Hospital Services and Supplies)**
  - Use of operating, delivery and treatment rooms and equipment.
  - Drugs and medicines provided to you while you are an outpatient in a facility provider.
  - Whole blood, administration of blood, blood processing, and blood derivatives.
  - Anesthesia, anesthesia supplies, and services rendered in a facility provider by the attending professional provider and rendered by a professional provider other than the surgeon or assistant at surgery.
  - Medical and surgical dressings, supplies, casts, and splints.

- **Pre-Admission Testing**
  The plan covers tests and studies required in connection with your admission rendered or accepted by a hospital on an outpatient basis prior to a scheduled admission to the hospital as an inpatient.

- **Surgery**
  The plan covers hospital services and supplies for outpatient surgery including removal of sutures, anesthesia, anesthesia supplies and services furnished by an employee of the hospital or other Facility Provider other than the surgeon or assistant at surgery.

Emergency Care Services

The plan covers the treatment of bodily injuries resulting from an accident, or following the sudden onset of a medical condition, or following, the case of a chronic condition, a sudden an unexpected medical event that manifests itself by acute symptoms of sufficient severity or 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:

- Placing your health or, with respect to a pregnant woman, the health of the woman or the unborn child in serious jeopardy;
- Causing serious impairment to bodily functions; and/or
- Causing serious dysfunction of any bodily organ or part

And for which care is sought as soon as possible after the medical condition becomes evident to you.

As a PPO member, you are covered at the higher, network level of benefits for emergency care received in or outside the provider network. This flexibility helps accommodate your needs when you need care immediately.

Your outpatient emergency room visits may be subject to copayment, which is waived if you are admitted as an inpatient. (Refer to the Summary of Benefits section for your program's specific amounts.)

In emergency situations, where you must be treated immediately, go directly to your nearest hospital emergency provider or call "911" or your area's emergency number. Once the crisis has passed, call your physician to receive appropriate follow-up care.

Emergency care services are services and supplies, including drugs and medicines for outpatient emergency treatment of bodily injuries resulting from an accident of medical condition. Also included is a medical screening examination and ancillary services necessary to evaluate such injury or emergency medical condition and further medical examination and treatment as required to stabilize the patient.

In the event that you receive emergency care services from an out-of-network provider and require an inpatient admission or observation immediately resulting from your injury or emergency medical condition and upon stabilization:

- You are unable to travel using non-medical transportation or non-emergency medical transportation to an available network provider located within a reasonable travel distance; or
- You do not consent to be transferred.

Covered services directly related to such injury or emergency medical condition and received during the inpatient admission or observation will be covered at the network services level of benefits. You will not be subject to any balance billing amounts.

Treatment for any occupational injury for which benefits are provided under any worker's compensation law or any similar occupational disease law is not covered.

Maternity Services
If you think you are pregnant, you may contact your physician or go to a network obstetrician or nurse midwife. When your pregnancy is confirmed, you may continue to receive follow-up care which includes prenatal visits, medically necessary and appropriate sonograms, delivery, postpartum, and newborn care in the hospital.

The plan covers hospital, medical, and surgical services rendered by a facility provider or professional provider for:

- **Complications of Pregnancy**
  The plan covers the physical effects directly cause by pregnancy but which are not considered from a medical viewpoint to be the effect of normal pregnancy, including conditions related to ectopic pregnancy or those that require cesarean section.

- **Normal Pregnancy**
  The plan covers normal pregnancy which includes any condition usually associated with the management of a difficult pregnancy but is not considered a complication of pregnancy.

- **Nursery Care**
  The plan covers services provided to the newborn child from the moment of birth, including care which is necessary for the treatment of medically diagnosed congenital defects, birth abnormalities, prematurity, and routine nursery care. Routine nursery care includes inpatient medical visits by a professional provider. Benefits will continue for a maximum of thirty-one (31) days. To be covered as a dependent beyond the thirty-one-day (31-day) period, the newborn child must be enrolled as dependent under this program within such period. Refer to the General Information section for further eligibility information.

- **Maternity Home Health Care Visit**
  The plan covers one (1) maternity home health care visit provided at your home within forty-eight (48) hours of discharge when the discharge from a facility provider occurs prior to (a) forty-eight (48) hours of inpatients care following a normal vaginal delivery or (b) ninety-six (96) hours of inpatient care following a cesarean delivery. This visit shall be made by a network provider whose scope of practice includes postpartum care. The visit includes parent education, assistance and training in breast and bottle feeding, infant screening, clinical tests, and the performance or any necessary maternal and neonatal physical assessments. The visit may, at your sole discretion, occur at the office of your network provider. The visit is subject to all terms of the Plan.

  Under state law, the Claims Administrator is generally prohibited from restricting benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than forty-eight (48) hours following a vaginal delivery, or less than ninety-six (96) hours following a cesarean section. However, state law does not prohibit the mother's or newborn's attending provider from discharging the mother or her newborn earlier than forty-eight (48) hours (or ninety-six (96) hours as applicable) if the mother and newborn meet the medical criteria for a safe discharge contained in guidelines which recognize treatment standards used to determine the appropriate length of stay; including those of the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists. In any case, the Claims Administrator can only require that a provider obtain authorization for prescribing an inpatient hospital stay that exceeds forty-eight (48) hours (or ninety-six (96) hours).

  The Claims Administrator offers maternity education and support programs. Please reach out Member Services for more information.

Medical Services
Inpatient Medical Services
The plan covers medical care by a professional provider when you are an inpatient for a condition not related to surgery, pregnancy, or mental illness, except as specifically provided herein:

- **Concurrent Care**
  Medical care rendered concurrently with surgery during one (1) inpatient stay by a professional provider other than the operating surgeon for treatment of a medical condition separate from the condition for which surgery was performed. Medical care by two (2) or more professional providers rendered concurrently during one (1) inpatient stay when the nature or severity of your condition requires the skills of separate physicians.

- **Consultation**
  Consultation services rendered to an inpatient by another professional provider at the request of the attending professional provider. Consultation does not include staff consultations which are required by facility provider rules and regulations. Benefits are limited to one (1) consultation per consultant per admission.

- **Inpatient Medical Care Visits**
  Benefits are provided for inpatient medical care visits.

- **Intensive Medical Care**
  Medical care rendered to you when your condition requires a professional provider's constant attendance and treatment for a prolonged period of time.

- **Routine Newborn Care**
  Professional provider visits to examine the newborn infant while the mother is an inpatient.

Outpatient Medical Care Services (Office Visits)
The plan covers Medical care rendered by a professional provider when you are an outpatient for a condition not related to surgery, pregnancy, or mental illness, except as specifically provided. Benefits include medical care visits, telemedicine services and consultations for the examination, diagnosis, and treatment.

You can physically go to one of the following providers:

- Primary care physician's (PCP) or specialist's office
- Physician's office located in an outpatient hospital/hospital satellite setting
- Urgent Care Center
- Retail site, such as in a pharmacy or other retail store

Or you can interact with a professional provider as follows:

- A virtual visit between you and a PCP or retail clinic via an audio and video telecommunications system.
- A virtual visit between you and a specialist via the internet or similar electronic communications for the treatment of skin conditions or diseases.
- A specialist virtual visit between you and a specialist at a remote location via interactive audio and video telecommunications. Benefits are provided for a specialist virtual visit which is subsequent to your initial visit with your treating specialist for the same condition. The provider-based location from which you communicate with the specialist is referred to as the "originating site." Benefits will not be provided for a specialist virtual visit if the visit is related to the treatment of mental illness or substance abuse. (The specialist virtual visit is subject to availability within your service area.)

Different types of providers and their locations may require different payment amounts. The specific amounts you are responsible for paying depend on your particular benefits.

- **Allergy Extract/Injections**
  The plan covers allergy extract and allergy injections.

- **Therapeutic Injections**
  The plan covers therapeutic injections required in the diagnosis, prevention, and treatment of an injury or illness.

Mental Health Care Services
The plan provides professional, confidential mental health care that addresses your individual needs. The PPO program covers the following services you receive from a provider for the treatment of mental illness.

- **Inpatient Facility Services**
  Inpatient hospital services provided by a Facility Provider for the treatment of mental illness.

- **Inpatient Medical Services**
  Covered inpatient medical services provided by a Professional Provider:
  - individual psychotherapy;
  - group psychotherapy;
  - psychological testing;

- counseling with family members to aid your diagnosis and treatment; and
- electroshock treatment or convulsive drug therapy including anesthesia when administered concurrently with the treatment by the same professional provider.

- **Partial Hospitalization Mental Health Services**
  Benefits are only available for mental health care services provided on a partial hospitalization basis when received through a partial hospitalization program. A mental health care service provided on a partial hospitalization basis is considered an outpatient care visit and is subject to any outpatient care cost-sharing amounts.

- **Outpatient Mental Health Care Services**
  Inpatient facility service and inpatient medical benefits (except room and board) provided by a Facility Provider or Professional Provider as described above, are also available when you are an outpatient, including a virtual visit between you and a specialist or approved telemedicine provider via an audio and video telecommunications system.

- **Serious Mental Illness Care Services**
  Serious mental illnesses include schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, obsessive-compulsive disorder, anorexia nervosa, bulimia nervosa, and delusional disorder.

  Coverage is provided for inpatient care and outpatient care for the treatment of serious mental illness. A serious mental illness service provided on a partial hospitalization basis will be deemed to be an outpatient care visit subject to any outpatient care cost-sharing amounts.

Orthotic Devices
The plan covers the purchase, fitting, necessary adjustment, repairs and replacement of a rigid or semi-rigid supportive device which restricts or eliminates motion of a weak or diseased body part.

Pediatric Extended Care Services
The plan covers care received from a pediatric extended care facility that is licensed by the state and is primarily engaged in providing basic non-residential services to infants and/or young children who have complex medical needs requiring skilled nursing and therapeutic care and who may be technologically dependent.

Services rendered by a pediatric extended care facility pursuant to a treatment plan for which benefits may include one or more of the following:

- skilled nursing services of a Registered Nurse (RN) or Licensed Practical Nurse (LPN);
- physical medicine, speech therapy and occupational therapy;
- respiratory therapy;
- medical and surgical supplies provided by the pediatric extended care facility;
- acute health care support; and
- ongoing assessments of health status, growth and development.

Pediatric extended care services will be covered for children eight (8) years of age or under, pursuant to the attending physician's treatment plan only when provided in a pediatric extended care facility, and when approved by the Claims Administrator.

A prescription from the child's attending physician is necessary for admission to such facility.

No benefits are payable after the child has reached the maximum level of recovery possible for his or her particular condition and no longer requires definitive treatment other than routine supportive care.

Preventive Care Services
Preventive Benefits are offered in accordance with a predefined schedule based on age, sex, and certain risk factors. The Claims Administrator periodically reviews the schedule of covered services based on the requirements of the Patient Protection Affordable Care Act of 2010, and advice from organizations such as the American Academy of Pediatrics, the U.S. Preventive Services Task Force, the Blue Cross Blue Shield Association and, and medical consultants. Therefore, the frequency and eligibility of services is subject to change. The plan covers periodic physical examinations, well child visits, immunizations, and selected diagnostic tests. For a current schedule of covered services, log onto Highmark's member website, www.highmarkbcbs.com, or call Member Services at the number on the back of your ID card.

- **Adult and Pediatric Care**
  Routine physical examinations, regardless of medical necessity and appropriateness, including a complete medical history for adults and other items and services.

  Well-woman benefits are provided for items and services including, but not limited to, an initial physical examination to confirm pregnancy, screening for gestational diabetes, coverage for contraceptive methods, and counseling and breastfeeding support and counseling.

- **Adult Immunizations**
  The plan covers adult immunizations, including the immunizing agent, when required for the prevention of disease.

- **Diagnostic Services and Procedures**
  The plan covers routine screening tests and procedures, regardless of medical necessity and appropriateness.

- **Routine Gynecological Examination and Pap Test**
  The plan covers one (1) routine gynecological examination, including a pelvic and clinical breast examination, and one (1) routine Papnicolaou smear (pap test) per calendar year. Benefits are not subject to program deductibles or maximums.

- **Mammographic Screening**
  The plan covers:
  - An annual routine mammographic screening starting at forty (40) years of age or older.
  - Mammographic screenings for all members regardless of age when such services are prescribed by a physician.

  Benefits for mammographic screening are payable only if performed by a mammography service provider who is properly certified.

- **Pediatric Immunizations**
  The plan covers, to members under 21 years of age and dependent children, pediatric immunizations, including the immunizing agents, which conform with the standards of the Advisory Committee on Immunization Practices of the Center for Disease Control and U.S. Department of Health and Human Services. Benefits are not subject to the program deductible or dollar limits.

- **Preventive Vaccines**
  The plan covers preventive vaccines when given at participating pharmacies. These vaccines require no copay or coinsurance, and you do not have to have met your deductible to take advantage of these services.

- **Colorectal Cancer Screenings**
  The plan covers the following tests or procedures when ordered by a physician for the purpose of early detection of colorectal cancer:
  - diagnostic laboratory and pathology screening services such as a fecal-occult blood or fecal immunochemical test;
  - diagnostic x-ray screening services such as barium enema;
  - surgical screening services such as flexible sigmoidoscopy and colonoscopy and hospital services related to such surgical screening services; and
  - such other diagnostic pathology and laboratory, diagnostic x-ray, surgical screening tests and diagnostic screening services consistent with approved medical standards and practices for the detection of colon cancer.

  The plan covers members 45 years of age or older as follows, or more frequently and regardless of age when prescribed by a physician:
  - an annual fecal-occult blood test or fecal immunochemical test;
  - a sigmoidoscopy every five years;
  - a screening barium enema or test consistent with approved medical standards and practices to detect colon cancer every five (5) years; and
  - a colonoscopy every ten (10) years.

  If you are determined to be at high or increased risk, regardless of age, benefits are provided for a colonoscopy or any other combination of covered services related to colorectal cancer screening when prescribed by a physician and in accordance with the current American Cancer Society guidelines on screening for colorectal cancer as of January 1, 2008.

  Colorectal cancer screening services which are otherwise not described herein and are prescribed by a physician for a symptomatic member are not considered preventive care services. The payment for these services will be consistent with similar medically necessary and appropriate covered services.

- **Diabetes Prevention Program**
  Benefits are provided if you meet certain medical criteria of having a high risk of developing type 2 diabetes and when you are enrolled in a diabetes prevention program that is offered through a network diabetes prevention provider. Coverage is limited to one (1) enrollment in a diabetes prevention program per year, regardless of whether you complete the diabetes prevention program.

- **Tobacco Use, Counseling, and Interventions**
  The plan covers screenings for tobacco use and, for those who use tobacco products, two (2) tobacco cessation attempts per year. A tobacco cessation attempt includes four (4) tobacco cessation counseling sessions and covered medications.

Private Duty Nursing Services
The plan covers services of an actively practicing registered nurse (RN) or licensed practical nurse (LPN) when ordered by a physician provided such nurse does not ordinarily reside in your home or is not a member of your immediate family.

If you are an inpatient in a Facility Provider only when the Claims Administrator determines that the nursing services require are of a nature or degree of complexity or quantity that could not be provided by the regular nursing staff.

If you are at home only when the Claims Administrator determines that the nursing services require the skills of an RN or an LPN.

Prosthetic Appliances
The plan covers the purchase, fitting, necessary adjustments, repairs, and replacements of prosthetic devices and supplies which replace all or part of an absent body organ and it adjoining tissues, or replace all or part of the function of a permanently inoperative or malfunctioning body organ (excluding dental appliances and the replacement of cataract lenses). Initial and subsequent prosthetic devices to replace the removed breast(s) or a portion thereof are also covered.

Skilled Nursing Facility Services
The plan covers services rendered in a skilled nursing facility to the same extent benefits are available to an inpatient of a hospital.

Skilled nursing facility benefits are ***not*** payable:
- after a patient has reached the maximum level of recovery possible for his or her particular condition and no longer requires definitive treatment other than routine supportive care;
- when confinement is intended solely to assist the member with the activities of daily living or to provide an institutional environment for your convenience; or
- for treatment of substance abuse or mental illness.

Spinal Manipulations
The plan covers spinal manipulations for the detection and correction by manual or mechanical means of structural imbalance or subluxation resulting from or related to distortion, misalignment, or subluxation of or in the vertebral column.

Substance Abuse Services
Benefits are provided for individual and group counseling and psychotherapy, psychological testing and family counseling for the treatment of substance abuse and include the following:

- inpatient hospital or substance abuse treatment facility services for detoxification;
- substance abuse treatment facility services for non-hospital inpatient residential treatment and rehabilitation services; and
- outpatient hospital or substance abuse treatment facility or outpatient substance abuse treatment facility services for rehabilitation therapy.

A substance abuse service provided on a partial hospitalization basis is considered an outpatient care visit and is subject to any outpatient care cost-sharing arrangement.

Surgical Services
The plan covers the following services you receive from a Professional Provider. See the Healthcare Management section for additional information which may affect your benefits.

- **Anesthesia**
  The plan covers administration of anesthesia for covered surgery when ordered by the attending Professional Provider and rendered by a Professional Provider other than the surgeon or the assistant-at-surgery. Benefits will also be provided for the administration of anesthesia for covered oral surgical procedures in an outpatient setting when ordered and administered by the attending Professional Provider.

- **Assistant at Surgery**
  The plan covers services of a physician who actively assists the operating surgeon in the performance of a covered surgery. Benefits will be provided for an assistant at surgery only if a house staff member, intern, or resident is not available.

- **Second Surgical Opinion**
  The plan covers a consulting physician's opinion and directly related diagnostic services to confirm the need for recommended elective surgery.

  Keep in mind that:
  - the second opinion consultant must not be the physician who first recommended elective surgery;
  - elective surgery is covered surgery that may be deferred and is not an emergency;
  - use of a second surgical opinion is at your opinion;
  - if the first opinion for elective surgery and the second opinion conflict, then a third opinion and directly related diagnostic services are covered services; and
  - if the consulting opinion is against elective surgery and you decide to have the elective surgery, the surgery is a covered service. In such instance, you will be eligible for a maximum of two such consultations involving the elective surgical procedure in question, but limited to one (1) consultation per consultant.

- **Special Surgery**
  The plan covers:
  - Sterilization and its reversal regardless of medical necessity and appropriateness.
  - Oral surgery benefits are provided for limited oral surgical procedures determined to be medically necessary and appropriate including: the extraction of impacted third molars when partially or totally covered by bone; the extraction of teeth in preparation for radiation therapy; mandibular staple implant (provided the procedure is not done to prepare the mouth for dentures); lingual frenectomy, frenotomy, or frenoplasty (to correct tongue-tie); Facility Provider and anesthesia services rendered in a facility setting in conjunction with non-covered dental procedures when determined by the Claims Administrator to be medically necessary and appropriate due to your age and/or medical condition; accidental injury to the jaw or structures contiguous to the jaw except teeth; the correction of non-dental physiological condition which has resulted in a severe functional impairment; treatment for tumors and cysts requiring pathological examination of the jaw, cheeks, lips, tongue, roof, and floor of mouth; orthodontic treatment of congenital cleft palates involving the maxillary arch, performed in conjunction with bone graft surgery to correct the bony deficits associated with extremely wide clefts affecting the alveolus.
  - Mastectomy and breast cancer reconstruction benefits are provided for a mastectomy performed on an inpatient or outpatient basis for: all stages of reconstruction of the breast on which the mastectomy has been performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; prosthesis; and treatment of physical complications of mastectomy including lymphedema. Benefits are also provided for one (1) home health care visit as determined by your physician within forty-eight (48) hours after discharge if such discharge occurred within forty-eight (48) hours after an admission for a mastectomy.

- **Surgery**
  - Surgery performed by a professional provider. Separate payment will not be made for pre- and post-operative services.
  - If more than one (1) surgical procedure is performed by the same Professional Provider during the same operation, the total benefits payable will be the amount payable for the highest paying procedure and no allowance shall be made for additional procedures except where the Claims Administrator deems that an additional allowance is warranted.

Telemedicine Service
The plan covers a real time interaction between you and a designated telemedicine provider conducted by means of telephonic or audio and video telecommunications, for the purpose of providing specific outpatient covered services.

Therapy and Rehabilitation Services
The plan covers the following services when such services are ordered by a physician:

- **Physical Medicine**
  The treatment by physical means or modalities such as, but not limited to, mechanical stimulation, heat, cold, light, air, water, electricity, sound, massage, mobilization, and the use of therapeutic exercises and activities, and rehabilitative procedures, performed to relieve pain and restore level of function following disease, illness or injury.
- **Radiation Therapy**
  The treatment of disease by X-ray, gamma ray, accelerated particles, mesons, neutrons, radium, or radioactive isotopes.
- **Chemotherapy**
  The treatment of malignant disease by chemical or biological antineoplastic agents.
- **Dialysis Therapy**
  The treatment of acute renal failure or chronic irreversible renal insufficiency for removal of waste materials from the body through hemodialysis or peritoneal dialysis. Dialysis treatment includes home dialysis.
- **Respiration Therapy**
  The introduction of dry or moist gases into the lungs for treatment purposes.
- **Occupational Therapy**
  The treatment of a physically disabled person by means of constructive activities designed and adapted to promote the restoration of the person's ability to satisfactorily accomplish the ordinary tasks of daily living and those required by the persons particular occupational role.
- **Speech Therapy**
  The treatment for the correction of a speech impairment resulting from disease, surgery, injury, congenital and developmental anomalies, or previous therapeutic processes.
- **Infusion Therapy**
  The treatment by means of infusion therapy when performed by a facility provider or ancillary provider and for self-administration if the components are furnished and billed by a facility provider or ancillary provider. Benefits for certain infusion therapy prescription drugs as identified by Highmark and which are appropriate for self-administration will be provided only when received from a participating pharmacy provider.
- **Cardiac Rehabilitation**
  The physiological and psychological rehabilitation of patients with cardiac conditions through regulated exercise programs.

Transplant Services
The plan covers services furnished by a hospital which are directly and specifically related to the transplantation of organs, bones, tissue, or blood stem cells. If a human organ, bone, tissue, or blood stem cell transplant is provided from a living donor to a human transplant recipient:

- when both the recipient and the donor are members, each is entitled to the benefits their program;
- when only the recipient is a member, both the donor and the recipient are entitled to the benefits of this plan subject to the following additional limitations: 1) the donor benefits are limited to only those not provided or available to the donor from any other source including, but not limited to, other insurance coverage, other Blue Cross or Blue Shield coverage, or any government program, and 2) benefits provided to the donor will be charged against the recipient's coverage under this program to the extent that benefits remain and are available under this program after benefits for the recipient's own expenses have been paid;

- when only the donor is a member, the donor is entitled to the benefits of this program, subject to the following additional limitations: 1) the benefits are limited to only those not provided or available to the donor from any other source in accordance with the terms of this program, and 2) no benefits will be provided to the non-member transplant recipient; and
- if any organ, tissue, or blood stem cell is sold rather than donated to the membered recipient, no benefits will be payable for the purchase price of such organ, tissue, or blood stem cell; however, other costs related to evaluation and procurement are covered up to the covered member recipient's program limit.

PRESCRIPTION DRUGS

The plan pays for prescription drugs when you purchase them from a pharmacy network applicable to your program. The pharmacy network includes both major chains and independent stores. ***No benefits are available if drugs are purchased from a non-network pharmacy.***

To help contain costs, if a generic drug is available, you will be given the generic. As you probably know, generic drugs have the same chemical composition and therapeutic effects as brand names, and must meet the same requirements of the Food and Drug Administration (FDA). ***Should you choose a brand name drug when a generic is available, you must pay the price difference between the brand and generic prices in addition to the applicable copayment or coinsurance amount.***

Covered Drugs
Covered drugs include:

- drugs which, under Federal law, are required to bear the legend: "Caution: Federal law prohibits dispensing without a prescription";
- legend drugs under applicable state law and dispensed by a licensed pharmacist;
- prescription drugs listed in your program's prescription drug formulary;
- preventive drugs that are offered in accordance with a predefined schedule and are prescribed for preventive purposes. The Claims Administrator periodically reviews the Academy of Pediatrics, the U.S. Preventive Services Task Force, the Blue Cross Blue Shield Association and medical consultants. Therefore, the frequency and eligibility of services is subject to change. For a current schedule of covered preventive drugs, log onto Highmark's member website, www.highmarkbcbs.com, or call Member Services at the toll-free telephone number listed on the back of your ID card;
- immunizations that are offered in accordance with a predefined preventive schedule and that are prescribed for preventive purposes;
- prescribed injectable insulin;
- diabetic supplies, including needles and syringes; and
- certain drugs that may require prior authorization from the Claims Administrator.

Exclusive Pharmacy Provider
Covered drugs also include selected prescription drugs within, but not limited to, the following drug classifications only when such drugs are covered medications and are dispensed through an exclusive pharmacy provider. These particular prescription drugs will be limited to your plan's retail cost-sharing provisions and retail-day's supply. Please refer to the Schedule of Benefits for details.

These selected prescription drugs may be ordered by a physician or other health care provider on your behalf or you may submit the prescription order directly to the exclusive pharmacy provider. In either situation, the exclusive pharmacy provider will deliver the prescription to you.

- Oncology related therapies
- Interferons
- Agents for multiple sclerosis and neurological related therapies

- Antiarthritic therapies
- Anticoagulants
- Hematinic agents
- Immunomodulators
- Growth hormones
- Hemophilia related therapies
- Fertility drugs

For a complete listing of those prescription drugs that must be obtained through an exclusive Pharmacy Provider, contact Member Services at the toll-free telephone number on the back of your ID card.

Your prescription drug program follows a select drug list which is referred to as a "formulary." The formulary is an extensive list of Food and Drug Administration (FDA) approved prescription drugs selected for their quality, safety, and effectiveness. It includes products in every major therapeutic category. The plan covers both formulary and non-formulary drugs.

To receive a copy of the formulary, call your toll-free Member Services number. You can also look up the formulary via Highmark's website, www.highmarkbcbs.com. These listing are subject to periodic review and modification by the Claims Administrator or designated committee of physicians and pharmacists.

WHAT IS NOT COVERED

Your plan will not provide benefits for services, supplies or charges:

- For acupuncture services.

- For allergy testing, except as provided herein or as mandated by law.

- For ambulance services, except as provided herein.

- For treatment provided specifically for the purpose of assisted fertilization, including pharmacological or hormonal treatments used in conjunction with assisted fertilization, unless mandated or required by law.

- For personal hygiene and convenience items such as, but not limited to, air conditioners, humidifiers, or physical fitness equipment, stair gliders, elevators/lifts or "barrier free" home modifications, whether or not specifically recommended by a Professional Provider.

- For operations for cosmetic purposes done to improve the appearance of any portion of the body, and from which no improvement in physiological function can be expected, except as otherwise required by law. Other exceptions to this exclusion are: a) surgery to correct a condition resulting from an accident; b) surgery to correct congenital birth defects; and c) surgery to correct a functional impairment which results from a covered disease or injury.

- For otherwise covered services ordered by a court or other tribunal as part of your or your dependent's sentence.

- For custodial care, domiciliary care, protective and supportive care including educational services, rest cures, and convalescent care.

- Directly related to the care, filling, removal or replacement of teeth, the treatment of injuries to or diseases of the teeth, gums or structures directly supporting or attached to the teeth. These include, but are not limited to, apicoectomy (dental root resection), root canal treatments, soft tissue impactions, alveolectomy and treatment of periodontal disease, except for dental expenses related to accidental injury, anesthesia for non-covered dental procedures and orthodontic treatment for congenital cleft palates and provided herein.

- For a diabetes prevention program offered by other than a network diabetes prevention program.

- Rendered prior to your effective date of coverage.

- For the following services associated with the additional enteral foods benefits provided under your program: blenderized food, baby food, or regular shelf food; milk or soy-based infant formulae with intact proteins,; any formulae, when used for the convenience of you or your family members; nutritional supplements or any other substance utilized for the sole purpose of weight loss or gain, or for caloric supplementation, limitation or maintenance; semisynthetic intact protein/protein isolates, natural intact protein/protein isolates, and intact protein/protein isolates, when provided orally; normal food products used in the dietary management or the disorders provided herein.

- Which are experimental or investigative in nature.

- For eyeglasses or contact lenses and the vision examination for prescribing or fitting eyeglasses or contact lenses (except for the initial pair of contact lenses/glasses prescribed following cataract extraction in place of surgically implanted lenses, or sclera shells intended for use in the treatment of disease or injury).

- For any illness or injury suffered during your commission of a felony, as long as such illness or injury is not the result of a medical condition or an act of domestic violence.

- For palliative or cosmetic foot care including flat foot conditions, supportive devices for the foot, corrective shoes, the treatment of subluxations of the foot, care of corns, bunions, (except capsular or bone surgery), calluses, toe nails (except surgery for ingrown toe nails), fallen arches, weak feet, chronic foot strain, and symptomatic complaints of the feet, except when such devices or services are related to the treatment of diabetes.

- For any care, treatment or service which has been disallowed under the provisions of the Healthcare Management program.

- For hearing aid devices, tinnitus maskers, or examinations for the prescription or fitting of hearing aids.

- For the following services you receive from a home health care agency, hospice or a hospital program for home health care and/or hospice care: dietitian services; homemaker services; maintenance therapy; dialysis treatment; custodial care; and food or home-delivered meals.

- For immunizations required for foreign travel or employment, unless mandated or required by law.

- For inpatient admissions which are primarily for diagnostic studies.

- For inpatient admissions primarily for physical medicine services.

- For any care that is related to conditions such as learning disabilities or intellectual disabilities, which extends beyond traditional medical management or for non-medically necessary inpatient confinement. This paragraph shall not apply to care related to autism spectrum disorders. Care which extends beyond traditional medical management includes the following: a) services that are primarily educational in nature, such as academic skills training or vocational training, including tutorial services; b) neuropsychological testing, educational testing (such as I.Q., mental ability, achievement and aptitude testing), except for specific evaluation purposes directly related to medical treatment; c) services related to the treatment of learning disorders or learning disabilities; and d) services provided primarily for social or environmental change or for respite care.

- For any care that is related to autism spectrum disorders which extends beyond traditional medical management, except as otherwise provided herein. Care which extends beyond traditional medical management includes the following: a) services that are primarily educational in nature, such as academic skills training or those for remedial education or those that may be delivered in a classroom-type setting, including tutorial services; b) neuropsychological testing, educational testing (such as I.Q., mental ability, achievement and aptitude testing), except for specific evaluation purposes directly related to medical treatment; and c) services provided primarily for respite care.

- For which you would have no legal obligation to pay.

- Which are not medically necessary and appropriate as determined by the Claims Administrator.

- To the extent payment has been made under Medicare when Medicare is primary; however, this exclusion shall not apply when the group is obligated by law to offer you all the benefits of this program.

- To the extent benefits are provided to members of the armed forces while on active duty or to patients in Veteran's Administration facilities for service connected illness or injury, unless you have a legal obligation to pay.

- For telephone consultations, which do not involve telemedicine services, charges for failure to keep a scheduled visit, or charges for completion of a claim form.

- For any other medical or dental service or treatment, except as provided herein or as mandated by law.

- For any tests, screenings, examinations or any other services required by: (a) an employer or governmental body or agency in order to being or to continue working or as a condition to performing the functions of any employment in a particular setting; (b) a school, college or university in order to enter onto school property or a particular location regardless of purpose, or; (c) a government body or agency for public surveillance purposes; and that does not relate to the furnishing or administration of an individualized test, screening or evaluation determined by your attending professional provider as being medically appropriate.

- For treatment or services for injuries resulting from the maintenance or use of a motor vehicle if such treatment or service is paid or payable under a plan or policy of motor vehicle insurance, including a certified or qualified plan of self-insurance, or any fund or program for the payment of extraordinary medical benefits established by law, including medical benefits payable in any manner under the Pennsylvania Motor Vehicle Financial Responsibility Act.

- For nutritional counseling, except as provided herein, or as required by state or federal law.

- For treatment of obesity, except for medical and surgical treatment of morbid obesity or as otherwise set forth in the predefined preventive schedule. Please refer to the Preventive Services section of Covered Services for more information.

- For oral surgery procedures except for the treatment of injuries to the jaw, sound and natural teeth, mouth or face, except as provided herein.

- For routine or periodic physical examinations, the completion of forms, and preparation of specialized reports solely for insurance, licensing, employment or other non-preventive purposes, such as pre-marital examinations, physicals for school, camp, sports, or travel, which are not medically necessary and appropriate, except as provided herein or as mandated by law.

- For prescription drugs which were paid or are payable under a freestanding prescription drug program.

- For preventive care services, wellness services or programs, except as provided herein or as mandated by law.

- Which are not prescribed by or performed by or upon the direction of a Professional Provider.

- Rendered by other than ancillary providers, facility providers, or Professional Providers.

- Received from a dental or medical department maintained, in whole or in part, by or on behalf of an employer, a mutual benefit association, labor union, trust, or similar person or group.

- Which are submitted by a certified registered nurse and another Professional Provider or other Professional Provider for the same services performed on the same date for the same patient.

- Rendered by a provider who is a member of your immediate family.

- Performed by a Professional Provider enrolled in an education or training program when such services are related to the education or training program.

- For respite care.

- For treatment of sexual dysfunction not related to organic disease or injury.

- For skilled nursing facility services after you have reached the maximum level of recovery possible for your particular condition and no longer require definitive treatment other than routine supportive care; when confinement is intended solely to assist you with the activities of daily living or to provide an institutional environment for your convenience; or for treatment of substance abuse or mental illness.

- For nicotine cessation support programs and/or classes, except as otherwise set forth in the predefined preventive schedule.

- Incurred after the date of termination of your coverage except as provided herein.

- For outpatient therapy and rehabilitation services for which there is no expectation of restoring or improving a level of function or when no additional functional progress is expected to occur, unless medically necessary and appropriate.

- For treatment of temporomandibular joint (jaw hinge) syndrome with intra-oral prosthetic devices, or any other method to alter vertical dimensions and/or restore or maintain the occlusion and treatment of temporomandibular joint dysfunction not caused by documented organic joint disease or physical trauma.

- For the correction of myopia, hyperopia, or presbyopia, including but not limited to corneal microsurgery, such as keratomileusis, keratophakia, radial keratotomy, corneal ring implants, Lase-Assisted in Situ Keratomileusis (LASIK), and all related services.

- For losses sustained or expenses incurred as a result of an act of war whether declared or undeclared.

- For weight reduction programs, including all diagnostic testing related to weight reduction programs, unless medically necessary and appropriate.

- For well-baby care visits, except as provided herein.

- For any illness or bodily injury which occurs in the course of employment if benefits or compensation are available, in whole or in part, under the provisions of any federal, state, or local government's workers' compensation, occupational disease or similar type legislation. This exclusion applies whether or not you claim the benefits or compensation.

In addition, under your *Prescription Drug benefits,* the following are not covered:

- For any other prescription drug except as provided herein.

- Allergy serums.

- Compounded medications.

- Services of your attending physician, surgeon or other medical attendant.

- Prescription drugs dispensed for treatment of an illness or an injury for which the group is required by law to furnish hospital care in whole or in part, including, but not limited to, state or federal workers' compensation laws, occupational disease laws and other employer liability laws.

- Prescription drugs to which you are entitled, with or without charge, under a plan or program of any government or governmental body.

- Charges for therapeutic devices or appliances (e.g. support garments and other non-medicinal substances).

- Charges for administration of prescription drugs and/or injectable insulin, whether by a physician or other person.

- Any charges by any pharmacy provider or pharmacist except as provided herein.

- Any drug or medication except as provided herein.

- Any amounts you are required to pay directly to the pharmacy for each prescription or refill.

- Charges a prescription drug when such drug or medication is used for unlabeled or unapproved indications where such use has not been approved by the Food and Drug Administration (FDA).

- Drugs and supplies which are not medically necessary and appropriate or otherwise excluded herein.

- Any amounts above the deductible, coinsurance, copayment, or other cost-sharing amounts for each prescription order or refill that are your responsibility.

- Any prescription for more than the retail-day's supply or mail-service-day's supply as outlined in the Summary of Benefits.

- Any drug or medication which does not meet the definition of covered maintenance prescription drug, except those set forth in the predefined preventive schedule. Please refer to the Covered Drugs section for more information.

- Over-the-counter drugs, except those set forth in the predefined preventive schedule. Please refer to the Covered Drugs section for more information.

- Hair growth stimulants.

- Food supplements.

- Any drugs used to abort a pregnancy.

- Blood products.

- Antihemophiliac drugs.

- Any drugs prescribed for cosmetic purposes only.

- Any prescription drug which has been disallowed under the Prescription Drug Management section of this booklet.

- Any drugs requiring intravenous administration, except insulin and other injectables used to treat diabetes.

- Any drugs which are experimental or investigative.

- Any drugs and supplies which can be purchased without a prescription order, included but not limited to blood glucose monitors and injection aids, unless specifically described as provided herein.

- Any prescription drugs or supplies purchased at a Non-Participating Pharmacy Provider, except in connection with Emergency Care described herein.

- Any prescription drug purchased through mail order but not dispensed by a designated Mail Order Pharmacy Provider

- Any selected diagnostic agents.

- For any tests, screenings, examinations or any other services required by: (a) an employer or governmental body or agency in order to being or to continue working or as a condition to performing the functions of any employment in a particular setting; (b) a school, college or university in order to enter onto school property or a particular location regardless of purpose, or; (c) a government body or agency for public surveillance purposes; and that does not relate to the furnishing or administration of an individualized test, screening or evaluation determined by your attending professional provider as being medically appropriate.

- Otherwise covered medications ordered by a court or other tribunal unless medically necessary and appropriate or in the reimbursement of such services is required by law.

MEMBER SERVICES

Identification Card
An identification (ID) card will be issued to you. When you or a covered family member receive health care services, show your ID card to the hospital, pharmacy, or other health care provider and ask the provider to file a claim for you. Your ID card includes the following information:

- your name;
- your ID number;
- group number;
- copayment for physician office visits and emergency room visits;
- Member Services toll-free number (on back of card);
- precertification toll-free number (on back of card).

Only you or your covered family members are permitted to use this card. If your card is lost or stolen, contact Member Services immediately to request a new card.

Member Services Unit
An important component of your program is the dedicated Steelworkers Health and Welfare Fund Member Services unit. Trained representatives are available to assist you by answering any questions you may have about claims or benefits. Call the toll-free Member Services number on the back of your identification card for assistance. Written correspondence may be directed to:

Highmark Blue Cross Blue Shield
P.O. Box 1210
Pittsburgh, PA 15230

Summary of Benefits and Coverage (SBC)
You will receive the Summary of Benefits and Coverage ("SBC") in accordance with applicable state or federal requirements. SBCs will be issued to you each year prior to your open enrollment period. SBCs will also be re-issued in the event that certain benefit modifications are implemented.

Information for Non-English-Speaking Participants
If you do not speak English, call the toll-free Member Services number on the back of your identification card to be connected to an AT&T interpreter line for assistance. The Member Services representatives in the dedicated unit are trained to make this connection.

HOW TO FILE A CLAIM

If you receive services from a network provider, you will not have to file a claim. If you receive services from an out-of-network provider, you may be required to file the claim yourself. The procedure is simple. Just take the following steps:

- **Know Your Benefits.** Review this information to see if the services you received are eligible under your medical program.

- **Get an Itemized Bill** – Itemized bills must include:
  - the name and address of the service provider;

- the patient's full name;
- the date of service or supply;
- a description of the service/supply;
- the amount charged;
- the diagnosis or nature of illness;
- for durable medical equipment, the doctor's certification;
- for private duty nursing, the nurse's license number, charge per day and shift worked;
- for ambulance services, the total mileage.

Please note: If you have already made payment for the services you received, you must also submit proof of payment (receipt from doctor) with your claim form. Cancelled checks, cash register receipts, or personal itemizations are not acceptable as itemized bills.

- **Copy Itemized Bills** – You must submit originals, so you will want to make copies for your records. Once your claim is received, itemized bills cannot be returned.

- **Complete a Claim Form** – Make sure all information is completed properly, and then sign and date the form. Claim forms are available from your employee benefits department or Highmark's Member Services Department.

- **Attach Itemized Bills to the Claim Form and Mail** – After you complete the above steps, attach all itemized bills to the claim form and mail everything to the address on the form.

  Remember: Multiple services for the same family member can be filed with one claim form. However, a separate claim form must be completed for each patient.

TIME LIMIT FOR FILING CLAIMS

Your claims must be submitted no later than the end of the calendar year following the calendar year for which benefits are payable. In other words, claims must be submitted no later than December 31st of the year following the date the service was completed.

YOUR EXPLANATION OF BENEFITS

Once your claim is processed, you will receive an Explanation of Benefits (EOB) Statement. This Statement lists: the provider's charge; allowable amount, copayment, deductible and coinsurance amounts, if any, you are required to pay; total benefits payable; and total amount you owe.

ADDITIONAL INFORMATION ON HOW TO FILE CLAIMS

Member Inquiries
General inquiries regarding your eligibility for coverage and benefits do not involve the filing of a claim, and should be made by directly contacting Member Services at the toll-free number on your identification card.

Filing Benefit Claims
- Authorized Representatives
  You have a right to designate an authorized representative to file or pursue a request for reimbursement or other Post-Service Claim on your behalf. The Claims Administrator reserves the right to establish reasonable procedures for determining whether an individual has been authorized to act on your behalf.

- Requests for Precertification and Other Pre-Service Claims
  For a description of how to file a request for Precertification or other Pre-Service Claim, see the Healthcare Management section of this benefit booklet.

- Requests for Reimbursement and Other Post-Service Claims
  When a participating hospital, physician or other provider submits its own reimbursement claim, the amount paid to that participating provider will be determined in accordance with the provider's agreement with the Claims Administrator or the local Blue Cross or Blue Shield Plan serving your area. The Claims Administrator will notify you of the amount that was paid to the provider. Any remaining amounts that you are required to pay in the form of a copayment, coinsurance or program deductible will also be identified in the Explanation of Benefits (EOB) or notice. If you believe that the copayment, coinsurance or deductible amount identified in that notice is not correct or that any portion of those amounts are covered under your benefit program, you may file a claim with the Claims Administrator. For instructions on how to file such claims, you should contact Member Services at the toll-free number on your identification card.

Determinations on Benefit Claims

- Notice of Benefit Determinations Involving Requests for Precertification and Other Pre-Service Claims
  For a description of the time frames in which requests for Precertification or other Pre-Service Claim will be determined by the Claims Administrator and the notice you will receive concerning its decision, whether adverse or not, see the Healthcare Management section of this benefit booklet.

- Notice of Adverse Benefit Determinations Involving Requests for Reimbursement and Other Post-Service Claims
  The Claims Administrator will notify you in writing of its determination on your request for reimbursement or other Post-Service Claim within a reasonable period of time following receipt of your claim. That period of time will not exceed thirty (30) days from the date your claim was received. However, this thirty (30) day period of time may be extended one time by the Claims Administrator for an additional fifteen (15) days, provided that the Claims Administrator determines that the additional time is necessary due to matters outside its control, and notifies you of the extension prior to the expiration of the initial thirty (30) day Post-Service Claim determination period. If an extension of time is necessary because you failed to submit information necessary for the Claims Administrator to decide on your Post-Service Claim, the notice of extension that is sent to you will specifically describe the information that you must submit. You will have at least forty-five (45) days in which to submit the information before a decision is made on your Post-Service Claim.

  If your request for reimbursement or other Post-Service Claim is denied, you will receive written notification of that denial which will include, among other items, the specific reason or reasons for the adverse benefit determination and a statement describing your right to file an appeal. For a description of your right to file an appeal concerning an adverse benefit determination of a request for reimbursement or any other Post-Service Claim, refer to the following section.

APPEAL PROCEDURE

The Claims Administrator, Highmark, maintains an appeal process involving one level of review. At any time during the appeal process, you may choose to designate a representative to participate in the appeal process on your behalf. You or your representative shall notify the Claims Administrator in writing of the designation. For purposes of the appeal process described below, "you" includes designees, legal representatives and, in the case of a minor, parents entitled or authorized to act on your behalf. The Claims Administrator reserves the right to establish reasonable procedures for determining whether an individual has been authorized to act on your behalf. Such procedures as adopted by the Claims Administrator shall, in the case of an Urgent Care Claim, permit a physician or other health care provider with knowledge of your medical condition to act as your representative.

At any time during the appeal process, you may contact Member Services at the toll-free number on your identification card to inquire about the filing or status of your appeal.

If you receive notification that a Claim has been denied by the Claims Administrator, in whole or in part, you may appeal the decision. Your appeal must be submitted in writing (except in cases where the appeal relates to an Urgent Care Claim) and received by the Claims Administrator not later than one hundred eighty (180) days from the date you were notified of the adverse decision.

Upon request to the Claims Administrator, you may review all documents, records and other information relevant to the Claim which is the subject of your appeal and shall have the right to submit any written comments, documents, records, information, data or other material in support of your appeal. The appeal will be reviewed by a representative from the Appeal Review Department. The representative shall not have been involved in any previous decision to deny the Claim which is the subject of your appeal or the subordinate of any individual that was involved in that decision. In rendering a decision on your appeal, the Appeal Review Department will consider all comments, documents, records, and other information submitted by you without regard to whether such information was previously submitted to or considered by the Claims Administrator. The Appeal Review Department will also afford no deference to any prior adverse decision on the Claim, which is the subject of your appeal.

In rendering a decision on an appeal that is based, in whole or in part, on medical judgment, including a determination of whether a requested benefit is medically necessary and appropriate or experimental or investigative, the Appeal Review Department will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment.

Each appeal will be promptly investigated and the Claims Administrator will provide written notification of its decision within the following time frames:

- when the appeal involves a non-Urgent Care Pre-Service Claim, within a reasonable period of time appropriate to the medical circumstances not to exceed thirty (30) days following receipt of the appeal;
- when the appeal involves an Urgent Care Claim, as soon as possible considering the medical exigencies involved but not later than seventy-two (72) hours following receipt of the appeal; or
- when the appeal involves a Post-Service Claim, within a reasonable period of time not to exceed thirty (30) days following receipt of the appeal.

In the event the Claims Administrator renders an adverse decision on your appeal, the notification shall include, among other items, the specific reason or reasons for the adverse decision and a statement regarding your right to pursue legal action in accordance with §502 of the Employee Retirement Income Security Act of 1974 (ERISA).

Autism Spectrum Disorders Expedited Review and Appeal Procedures

Upon denial, in whole or in part, of a pre-service claim or post-service claim for diagnostic assessment or treatment of autism spectrum disorders, there is an appeal procedure for expedited internal review which you may choose as an alternative to those procedures set forth above. In order to obtain an expedited review, you or your authorized representative shall identify the particular claim as one related to the diagnostic assessment or treatment of an autism spectrum disorder to the Member Services Department and request an expedited review which will be provided by the Claims Administrator. If, based on the information provided at the time the request is made, the claim cannot be determined as one based on services for the diagnostic assessment or treatment of autism spectrum disorders. The Claims Administrator may request from you or the health care provider additional clinical information including the treatment plan described in the Covered Services section of the booklet.

An appeal of a denial of a claim for services for the diagnostic assessment or treatment of an autism spectrum disorder is subject to review by a Review Committee. The request to have the decision reviewed by the Review Committee may be communicated orally or be submitted in writing within 180 days from the date the denial of the claim is received, and may include any written information from you or the health care provider. The Review Committee shall be comprised of three employees of the Claims Administrator who were not involved or the subordinate of any individual that was previously involved in any decision to deny coverage or payment for the health care service. The Review Committee will hold an informal hearing to consider the appeal. When arranging the hearing, the Claims Administrator will notify you or the health care provider of the hearing procedures and rights at such hearing, including your or the health care provider's right to be present at the review and to present a case. If you or the health care provider cannot appear in person at the review, the Claims Administrator shall provide you or the health care provider the opportunity to communicate with the Review Committee by telephone or other appropriate means.

The Claims Administrator shall conduct the expedited internal review and notify you or your authorized representative of its decision as soon as possible but not later than 48 hours following the receipt of your request for an expedited review. The notification to you and the health care provider shall include, among other items, the specific reason or reasons for the adverse decision including any clinical rational, the procedure for obtaining an expedited external review and a statement regarding your right to pursue legal action in accordance with §502 of the Employee Retirement Income Security Act of 1974 (ERISA).

Following the receipt of the expedited internal review decision, you may contact the Claims Administrator to request an expedited external review pursuant to the expedited external review procedure for autism spectrum disorders established by the Pennsylvania Insurance Department.

BENEFITS AFTER TERMINATION OF COVERAGE

If you are an inpatient on the day your coverage terminates, inpatient benefits will be continued as follows:

- until the maximum amount of benefits has been paid; or
- until the inpatient stay ends; or
- until you become covered under another group plan, whichever occurs first.

Your benefits will not be continued if your coverage is terminated because you or your Employer failed to pay any required contribution.

Once you are no longer eligible for benefits, you may be able to continue coverage by either electing COBRA coverage, as described in Section I, or by converting to a direct payment health care program.

CONVERSION

If you do not wish to continue coverage by electing COBRA coverage or if you are not eligible for COBRA coverage, you have the opportunity to enroll in a Highmark Direct Payment Program. Conversion is also available to any participant that elected COBRA coverage and the duration of that coverage has expired.

If your group coverage is discontinued for any reason, except as specified below, you may convert to a direct payment program. Upon termination of your coverage, information will be sent to you directly from Blue Cross Blue Shield regarding the available conversion plans.

The conversion opportunity is not available if either of the following applies:
- you are eligible for another group health care program through your place of employment; or
- your employer's program is terminated and replaced by another health care program.

LAWS AFFECTING PLAN BENEFITS

Employees in certain states may be subject to state and federal laws which impact health insurance coverage. The benefits of this plan will be modified to reflect the provision of such laws.

NONDISCRIMINATION

Discrimination is Against the Law

Highmark complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity. Highmark does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex assigned at birth, gender identity or recorded gender. Furthermore, Highmark will not deny or limit coverage to any health service based on the fact that an individual's sex assigned at birth, gender identity, or recorded gender is different from the one to which such health service is ordinarily available. Highmark will not deny or limit coverage for a specific health service related to gender transition if such denial or limitation results in discriminating against a transgender individual.

Highmark:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - qualified sign language interpreters
  - written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provides free language services to people whose primary language is not English, such as:
  - qualified interpreters
  - information written in other languages.

If you need these services, contact the Civil Rights Coordinator.

If you believe that Highmark has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity, you can file a grievance with: Civil Rights Coordinator, P.O. Box 22492, Pittsburgh, PA 15222, Phone: 1-866-286-8295, Fax: 412-544-2475, email: CivilRightsCoordinator@highmarkhealth.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call the number on the back of your ID card (TTY: 711).

ATENCIÓN: Si usted habla español, servicios de asistencia lingüística, de forma gratuita, están disponibles para usted. Llame al número en la parte posterior de su tarjeta de identificación (TTY: 711).

请注意：如果您说中文，可向您提供免费语言协助服务。

请拨打您的身份证背面的号码（TTY：711）。

CHÚ Ý: Nếu quý vị nói tiếng Việt, chúng tôi cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Xin gọi số điện thoại ở mặt sau thẻ ID của quý vị (TTY: 711).

ВНИМАНИЕ: Если вы говорите по-русски, вы можете воспользоваться бесплатными услугами языковой поддержки. Позвоните по номеру, указанному на обороте вашей идентификационной карты (номер для текст-телефонных устройств (TTY): 711).

Geb Acht: Wann du Deitsch schwetzscht, kannscht du en Dolmetscher griege, un iss die Hilf Koschdefrei. Kannscht du die Nummer an deinre ID Kard dahinner uffrufe (TTY: 711).

알림: 한국어를 사용하시는 분들을 위해 무료 통역이 제공됩니다. ID 카드 뒷면에 있는 번호로 전화하십시오 (TTY: 711).

ATTENZIONE: se parla italiano, per lei sono disponibili servizi di assistenza linguistica a titolo gratuito. Contatti il numero riportato sul retro della sua carta d'identità (TTY: 711).

تنبيه: إذا كنت تتحدث اللغة العربية، فهناك خدمات المعاونة في اللغة المجانية متاحة لك. اتصل بالرقم الموجود خلف بطاقة هويتك (جهاز الاتصال لذوي صعوبات السمع والنطق: 711).

ATTENTION: Si vous parlez français, les services d'assistance linguistique, gratuitement, sont à votre disposition. Appelez le numéro au dos de votre carte d'identité (TTY: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, steht Ihnen unsere fremdsprachliche Unterstützung kostenlos zur Verfügung. Rufen Sie dazu die auf der Rückseite Ihres Versicherungsausweises (TTY: 711) aufgeführte Nummer an.

ધ્યાન આપશોઃ જો તમે ગુજરાતી ભાષા બોલતા હો, તો ભાષા સહાયતા સેવાઓ, મફતમાં તમને ઉપલબ્ધ છે. તમારા ઓળખપત્રના પાછળના ભાગે આવેલા નંબર પર ફોન કરો (TTY: 711).

UWAGA: Dla osób mówiących po polsku dostępna jest bezpłatna pomoc językowa. Zadzwoń pod numer podany na odwrocie karty ubezpieczenia zdrowotnego (TTY: 711).

ATTENTION: Si c'est créole que vous connaissez, il y a un certain service de langues qui est gratis et disponible pour vous-même. Composez le numéro qui est au dos de votre carte d'identité. (TTY: 711).

ប្រការចង់ចាំ ៖ បើលោកអ្នកនិយាយ ភាសាខ្មែរ ហើយត្រូវការសេវាកម្មជំនួយផ្នែកភាសាដែលអាចផ្តល់ជូនលោកអ្នក ដោយឥតគិតថ្លៃ។ សូមទូរស័ព្ទទៅលេខដែលមាននៅលើខ្នងកាតសម្គាល់របស់របស់លោកអ្នក (TTY: 711) ។

ATENÇÃO: Se a sua língua é o português, temos atendimento gratuito para você no seu idioma. Ligue para o número no verso da sua identidade (TTY: 711).

ATENSYON: Kung nagsasalita ka ng Tagalog, may makukuha kang mga libreng serbisyong tulong sa wika. Tawagan ang numero sa likod ng iyong ID card (TTY: 711).

注：日本語が母国語の方は言語アシスタンス・サービスを無料でご利用いただけます。ID カードの裏に明記されている番号に電話をおかけください (TTY: 711)。

توجه : اگر شما به زبان **فارسی** صحبت می کنید، خدمات کمک زبان، به صورت رایگان، در دسترس شماست. با شماره واقع در پشت کارت شناسایی خود (TTY: 711) تماس بگیرید.

BAA ÁKONÍNÍZIN: Diné k'ehgo yáníłti'go, language assistance services, éí t'áá níík'eh, bee níká a'doowoł, éí bee ná'ahóót'i'. ID bee nééhózingo nanitinígíí bine'dęę' (TTY: 711) jį' hodíilnih.

MEDICARE

Active Employees Over Age 65
If you are age 65 or over and actively employed, you will continue coverage under this plan and receive the same benefits available to Employees under age 65. With this option, (a) this plan will pay all eligible expenses first, and Medicare will then pay for Medicare eligible expenses, if any, not paid for by this plan; or (b) you may elect Medicare as your primary coverage. If you choose this option, you will not be eligible for any benefit under this plan. Contact your Employer or the Fund Office for specific details.

Spouses Age 65 and Over of Active Employees
If you are actively employed, your spouse has the same choices for benefit coverage as indicated above for the Employee age 65 and over.

Regardless of the choice made by you or your spouse, each of you should apply for Medicare Part A coverage three months prior to becoming age 65 to prevent any delay in enrollment. If you choose this plan as your primary coverage while actively employed, you may elect to delay enrolling in Medicare Part B coverage. You will be able to enroll for Medicare Part B later during special enrollment periods, without penalty. Contact your local Social Security Administration office for assistance.

Important Information About Your Prescription Drug Coverage and Medicare

If you (and/or your Dependents) have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage.

This notice has information about your current prescription drug coverage from the Steelworkers Health and Welfare Fund (the "Fund") and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to enroll in a Medicare drug plan. If you are considering enrolling in a Medicare drug plan, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. The Steelworkers Health and Welfare Fund has determined that the prescription drug coverage offered by the Fund is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you decide to join a Medicare drug plan at a later date.

When Can You Join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens to Your Current Coverage If You Decide to Join a Medicare Drug Plan?

If you decide to join a Medicare drug plan, your Fund prescription drug coverage will be affected. If you enroll in a Medicare prescription drug plan you can keep your Fund prescription drug coverage, but it will be secondary to Medicare prescription drug coverage. If you wish to drop your Fund prescription drug coverage you must notify your former Employer. If you drop your prescription drug coverage from the Fund you will also lose the hospital and medical coverage that supplements Medicare Part A and Medicare Part B.

If you do decide to join a Medicare drug plan and drop your current Fund coverage, be aware that you and your dependents may not be able to get this coverage back.

When Will You Pay a Higher Premium (Penalty) To Join a Medicare Drug Plan?

You should also know that if you drop or lose your current coverage from the Fund and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to enroll.

For More Information About This Notice or Your Current Prescription Drug Coverage...

Contact the Steelworkers Health and Welfare Fund at 1-888-831-3863 for further information. Note: You will get a notice of Creditable Coverage each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage from the Fund changes. You may also request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You will get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800 MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

SECTION III: DENTAL BENEFITS

PLAN OVERVIEW

Your Employer has entered into an agreement with the Steelworkers Health and Welfare Fund to provide a dental plan administered by United Concordia Companies, Inc. (UCCI).

This plan covers only services that are Dentally Necessary. You are not required to use a provider who participates with UCCI to receive the benefits of the plan; however, a Participating Provider accepts the decision of the Claims Administrator and will not bill you without your consent for services provided which are determined not Dentally Necessary. A Non-Participating Provider is not obligated to accept the determination of the Claims Administrator and may bill you for services that are not dentally necessary. You are responsible for these charges when such services are performed by a non-participating provider. You can avoid these charges by choosing a participating provider for your care.

HOW TO FIND A DENTIST

If you would like to know whether or not your provider participates with UCCI, you may simply ask him or her, or call the toll-free Member Services number on the back of your identification card for assistance.

You can also locate a participating dentist via the web at www.unitedconcordia.com. If your dentist has questions about your eligibility or benefits, instruct the office to call Member Services or visit Dental Inquiry at www.unitedconcordia.com.

KEY TERMS

Adverse Benefit Determination
A denial, reduction, or termination of or failure to make payment (in whole or in part) based on a determination of eligibility to participate in this plan or the application of any utilization review; or a determination that an item or service otherwise covered is Experimental or Investigational or not medically or Dentally Necessary or appropriate.

Authorized Representative
A person granted authority by you and the Claims Administrator to act on your behalf regarding a claim for benefit or an appeal of an Adverse Benefit Determination. An assignment of benefit is not a grant of authority to act on your behalf in pursuing and appealing a benefit determination.

Claim for Benefits
A request for a plan benefit or benefits by you in accordance with the Claims Administrator's reasonable procedure for filing benefit claims.

Coinsurance
The Coinsurance is the specific percentage of the provider’s reasonable charge you must pay for certain eligible expenses after your deductible, if applicable, has been met. Refer to the Schedule of Benefits for the percentage amounts paid by the plan. The remaining coinsurance amounts are your responsibility.

Cosmetic
Procedures which are not Dentally Necessary and which are undertaken primarily, in the opinion of the Claims Administrator, to improve or otherwise modify the patient's appearance, when the cause is not related to illness or accidental injury.

Deductible
A specified amount of expenses set forth in the Schedule of Benefits for covered services that must be paid by you before the plan will pay.

Dentally Necessary
A dental service or procedure as determined by a dentist to either establish or maintain a patient's dental health. Such determinations are based on the professional diagnostic judgment of the dentist and the standards of care that prevail in the professional community. The determination as to when a dental service is necessary shall be made by the dentist in accordance with guidelines established by the Claims Administrator. In the event of any conflict of opinion between the dentist and the Claims Administrator as to when a dental service or procedure is Dentally Necessary, the opinion of the Claims Administrator shall override that of the dentist.

Experimental or Investigative
The use of any treatment, procedure, facility, equipment, drug, or drug usage device or supply which the Claims Administrator, relying on the advice of the general dental community which includes, but is not limited to dental consultants, dental journals and/or governmental regulations, determines are not acceptable standard dental treatment of the condition being treated, or any such items requiring federal or other governmental agency approval which approval has not been granted at the time the services were rendered.

Maximum
The greatest amount the plan is obligated to pay for covered services during a specified period.

Maximum Allowable Charge
The maximum amount the plan will allow for a covered service.

Non-Participating Provider
A dentist who has not signed a contract with United Concordia Companies, Inc. (UCCI) or an affiliate of United Concordia Companies, Inc. (UCCI).

Participating Provider
A dentist who has executed a Participating Dentist Contract with United Concordia Companies, Inc. (UCCI) or an affiliate of United Concordia Companies, Inc. (UCCI) under which he/she agrees to provide covered dental care services under this plan.

Pre-Treatment Estimate/Pre-Service claim
The review by the Claims Administrator of a treatment plan to determine eligibility for benefits and the coverage for services in accordance with the Schedule of Benefits, exclusions, limitations and the plan allowance for such services.

Treatment Plan
The written report of a series of procedures recommended for the treatment of a specific dental disease, defect or injury, prepared by a dentist as a result of an examination.

Urgent Care Claim
Any claim for dental treatment when the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the patient or the ability of the patient to regain maximum function; or in the opinion of a dentist with knowledge of the patient's dental condition, would subject the patient to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. Since the Claims Administrator does not require advance approval of emergency care in order to obtain a benefit, there are no claims involving urgent care as defined under the dental plan.

SCHEDULE OF BENEFITS

The following Schedule of Benefits provides a summary of the dental benefits available to you and your eligible Dependents. Please refer to the subsequent pages for a more detailed description of covered service, limitations and exclusions.

PRE-TREATMENT ESTIMATE

A Pre-Treatment Estimate is a review in advance of treatment by the Claims Administrator to determine eligibility and coverage for planned services in accordance with the Schedule of Benefits and the dental plan allowance. A Pre-Treatment Estimate is not required to receive a benefit for any service covered under this dental plan; however, it is recommended for extensive, more costly treatment. A Pre-Treatment Estimate gives you and your dentist an estimate of your coverage and how much your share of the cost will be for the treatment being considered.

To have benefits estimated, you or your dentist should submit a claim form showing the planned procedures leaving out the dates of service. Be sure to sign the pre-treatment request. Substantiating material such as radiographs and periodontal charting may be requested by the Claims Administrator to estimate benefits. The Claims Administrator will determine benefits payable, considering exclusions and limitations and alternate treatment options based upon accepted standards of dental practice. You and your provider, if participating in United Concordia's network, will receive an explanation of the estimated benefits.

When the services are performed, simply have your dentist call the Claims Administrator at the number on the back of your identification card, or fill in the dates of service for the completed procedures on the pre-treatment notification and re-submit it to the Claims Administrator for processing. Any Pre-Treatment Estimate by the Claims Administrator is subject to your continued eligibility for benefits. The Claims Administrator may also adjust at the time of final payment to correct any mathematical errors, apply coordination of benefits, and comply with the plan in effect and remaining program maximum dollars at date of services.

ALTERNATE TREATMENT

Frequently, your dentist can choose from several alternate methods of treating a particular dental problem. For example, a tooth can be restored with either a crown or a filling; and missing teeth can be replaced with either a fixed bridge or a partial denture. In cases where alternate methods of treatment are possible and professionally acceptable, the Claims Administrator will make payment based on its allowance for the less expensive procedure provided that the less expensive procedure meets the accepted standards of dental treatment. Whenever this alternate benefit provision is applied, a Dental Advisor reviews the claim.

The Claims Administrator's decision on the allowance it will pay does not commit you to the less expensive procedure. You may decide to have the costlier treatment and to be responsible for the additional charges beyond those for the treatment paid by the Claims Administrator.

EXPERIMENTAL TREATMENT

Your plan does not cover services that the Claims Administrator determines are Experimental or Investigative in nature. Experimental and Investigative services are those that the general dental community (dental consultants, dental journals and/or governmental regulations) determine are not acceptable standard dental treatments of the condition for which care is being provided. However, situations may occur when you and your provider agree to pursue an experimental treatment. If your provider performs an experimental procedure, you are responsible for the charges. You or your provider may contact the Claims Administrator to determine whether a service is considered Experimental or Investigative.

SERVICES THAT DO NOT MEET ACCEPTED STANDARDS OF DENTAL PRACTICE

This plan will not pay for services that are considered unusual procedures or techniques or for which supplies or other services are used that do not meet the accepted standards of dental practice. A Participating Provider accepts the decision of the Claims Administrator and will not bill you for these services without your consent. A Non-Participating Provider, however, is not obligated to accept this determination and may bill you for such services. You are responsible for these charges when performed by a Non-Participating Provider.

ANNUAL AND LIFETIME MAXIMUMS

The annual and lifetime maximum benefits payable for covered services under this plan are identified in the Schedule of Benefits. All covered services, except preventive, diagnostic and orthodontics, are subject to a calendar year maximum. Orthodontics is subject to a separate lifetime maximum.

EXTENSION OF BENEFITS

Benefits for completion of a dental procedure, requiring two or more visits on separate days, will be extended for a period of ninety (90) days after termination of coverage. In the case of orthodontic treatment, if the orthodontist has agreed to or is receiving monthly payments, the extension of coverage shall be for sixty (60) days. However, if the orthodontist has agreed to accept or is receiving payments on a quarterly basis, coverage will be extended to the end of the quarter in progress or sixty (60) days, whichever is later.

PAYMENT OF BENEFITS

Payment for covered services performed by participating providers will be made to the dentist on the basis of a percentage of the Maximum Allowable Charge (MAC) or the amount charged, whichever is less. The Maximum Allowable Charge (MAC) is the maximum amount the plan will allow for a covered service as determined by the Claims Administrator from national and regionalized data. A Participating Provider must accept the Claims Administrator's allowance as payment in full for covered services. You are responsible for any coinsurance, deductibles and amounts exceeding the maximum or any service not covered by the plan. The sum of your payment and the Claims Administrator's payment will be accepted as payment in full, provided that your portion of the payment is made to the Participating Provider within 60 (sixty) days of notification by the Claims Administrator. If your payment is not made within 60 (sixty) days, the Participating Provider may bill you the difference between the charge and the MAC allowance.

Payment for covered services performed by a Non-Participating Provider will be made to you on the basis of a percentage of the MAC allowance or the amount charged, whichever is less. Non-Participating Providers are not obligated to accept the MAC allowance as payment in full. Such payment will constitute full discharge of the Claims Administrator's responsibility under the plan. You are responsible for payment of the remaining charge.

Benefits will be provided for eligible dental services when billed by the licensed dentist in charge of the case. This professional care can be performed anywhere unless otherwise indicated.

COVERED SERVICES

The plan covers the following services provided by a licensed dentist provided they are deemed Dentally Necessary by the Claims Administrator. Refer to the Schedule of Benefits for the percentage amounts payable for covered services.

Diagnostic Services

- Routine oral examinations, but not more than once in any period of six consecutive months.
- Dental X-rays
  - Full mouth X-rays, but not more than once every three years.
  - Bitewing X-rays, but not more than once in any period of six consecutive months.
  - Periapical X-rays as required.
  - Palliative emergency treatment of an acute condition requiring immediate care.

Preventative Services

- Routine prophylaxis (including cleaning, scaling and polishing of teeth), but not more than once in any period of six consecutive months.
- Topical Fluoride application for eligible dependent children under 19 years of age, but not more than once in any period of six consecutive months.
- Space Maintainers (not made of precious metal) that replace prematurely lost teeth for eligible dependent children under 19 years of age.
- Sealants for eligible dependent children through age 10 on permanent first molars and through age 15 on permanent second molars only if teeth to be sealed are free of proximal caries and there are no previous restorations on the surface to be sealed. One sealant per tooth per three- year period.

Minor Restorations

- Amalgam, silicate, acrylic, synthetic porcelain, and composite filling restorations to restore diseased or accidentally broken teeth.
- Composite restorations on posterior teeth will be limited to the allowance for amalgam restoration. The balance of the cost is your responsibility.

General Services

- Repair of broken partial or full removable dentures.
- Simple extractions.
- Endodontics, including pulpotomy and root canal treatment.
- Administration of anesthesia in connection with covered services when rendered by or under the direct supervision of a dentist other than the surgeon, assistant surgeon or attending dentist.
- Inpatient consultations if the condition requires it and the dentist in charge of the case requests the consultation. You are limited to one consultation per consultant during any one inpatient stay.

Oral Surgery

- Surgical removal of teeth.
- Surgical removal of maxillary or mandibular intrabony cysts.
- Procedures performed for the preparation of the mouth for dentures.
- Apicoectomy (surgical removal of the end of a root).
- Services of a dentist who actively assists the operating surgeon in the performance of covered surgery when the condition of the patient or the type of surgery performed requires assistance. Surgical assistance is not covered when performed by a dentist who himself performs and bills for another surgical procedure during the same operative session.

Prosthetics, Crowns, Inlay and Onlay Restorations
Coverage for prosthetics, crowns, inlays and onlays may be limited to the least expensive but adequate treatment plan, consistent with established dental standards. A more expensive treatment plan than that covered under this dental plan may be selected with the understanding that you will be responsible for paying the difference in cost between the treatment received and the Claims Administrator's allowance.

- Initial insertion of bridges (including pontics and abutment crowns, inlays and onlays).
- Initial insertion of partial or full dentures (including any adjustments during the six-month period following insertion).
- Replacement of an existing partial or full denture or bridge by a new denture or by a new bridge, but only if satisfactory evidence is presented that:
  - the existing denture or bridge was inserted at least five years prior to replacement; and
  - the existing denture or bridge is not serviceable and cannot be made serviceable. If the existing denture or bridge can be made serviceable, payment will be made toward the cost of the services that are necessary to render such appliance serviceable.
- Single unconnected crown, inlays and onlays (none of which is part of a bridge or are splinted together).
- Replacement of crowns, inlays and onlays, but only if satisfactory evidence is presented that at least five years have elapsed since the date of the insertion of the existing crown, inlay or onlay and that the appliance is not serviceable and cannot be made serviceable.
- The addition of teeth to an existing partial denture or to a bridge, but only if satisfactory evidence is presented that the addition of teeth is required to replace one or more teeth extracted after the existing denture or bridge was inserted.
- Relining or rebasing of dentures more than six months after the insertion of an initial or replacement denture, but not more than one relining or rebasing in any period of thirty-six (36) consecutive months.
- Repair of broken crowns, inlays, onlays or bridges.

Periodontal Services
- Diagnosis and treatment planning including periodontal examinations.
- Nonsurgical periodontal therapy including periodontal scaling and root planing.
- Surgical periodontal therapy.
- Maintenance – post-treatment preventive periodontal procedures (periodontal prophylaxis).

Orthodontics
- Diagnosis, including radiographs.
- Active treatment, including necessary appliances.
- Retention treatment following active treatment.

Notwithstanding any other provision in this booklet, the Claims Administrator shall make payment for orthodontics in accordance with the coinsurance percentage previously specified. The amount of the Claims Administrator's liability shall be payable over a period not to exceed the length of the approved Treatment Plan. Payments will be made no more frequently than once every three months. If the Treatment Plan is satisfactorily completed in less than the period specified in the approved Treatment Plan, the Claims Administrator shall, upon appropriate notification from the dentist, make payment in the amount of the remainder of the Claims Administrator's liability.

EXCLUSIONS AND LIMITATIONS

Your plan will not provide benefits for services, supplies or charges:

- Not specifically listed as a covered service.
- Which in the opinion of the dentist are not clinically necessary for the patient's health.
- Which are necessitated by lack of patient cooperation or failure to follow a professionally prescribed Treatment Plan.
- Started by any dentist prior to the patient's eligibility under the plan, including, but not limited to: endodontics, crowns, bridges, inlays, onlays and dentures.
- Incurred prior to the patient's effective date or after the termination date of coverage under the plan, except those services as provided for in the Extension of Benefits section.
- That do not meet accepted standards of dental treatment, which are Experimental or Investigational in nature or are considered enhancements to standard dental treatment as determined by the Claims Administrator.
- For hospitalization costs.
- Determined by the Claims Administrator to be the responsibility of Worker's Compensation or Employer's Liability, services for which benefits are covered under any Federal Government or state program, excluding Medical Assistance, or for services for treatment of any automobile related injury in which the patient is entitled to payment under an automobile insurance policy. The plan's benefits would be in excess to the third-party benefits and therefore, the Plan would have the right to recovery for any benefits paid in excess.
- For prescription drugs.
- Administration of nitrous oxide, general anesthesia and IV sedation, except as specifically included under Covered Services.
- Which are cosmetic in nature as determined by the Claims Administrator.
- Elective procedures including the prophylactic extraction of third molars within the first six months of enrollment.
- For the following that are not included as orthodontic benefits: retreatment of orthodontic cases, changes in orthodontic treatment necessitated by patient neglect.
- For any dental or medical services performed by a physician and/or services for which benefits are otherwise provided under a Medical-Surgical plan of the patient.
- For congenital mouth malformations or skeletal imbalances, including, but not limited to: treatment related to cleft palate therapy, treatment related to disharmony of facial bone, treatment related to or required as the result of orthognathic surgery including orthodontic treatment, dental implant services including placement and restoration of implants, and oral and maxillofacial and temporomandibular joint services including associated hospital, facility, anesthesia, and radiographic imaging even if the condition requiring these services involves part of the body other than the mouth or teeth, all treatment of temporomandibular disorders (TMD, TMJ, CMD, MFPD, etc.), both surgical and nonsurgical treatment, arthroscopy of the

joint and orthognathic surgery, and treatment of any malocclusion involving joints or muscles by orthodontic repositioning of the teeth. This exclusion shall not apply to newly born children of participants.

- For dental treatment of fractures and dislocations of the jaw except as a result of accidental injury.
- For treatment of malignancies or neoplasms.
- Procedures requiring appliances or restorations (except when involving full or partial dentures or correction of a dental condition as a result of accidental injury) that are necessary for adult or pediatric full mouth rehabilitation, including precision attachments or stress breakers, restoration of occlusion, to alter vertical dimension of occlusion, restorative equilibration and kinesiology.
- For the cost to replace lost, stolen or damaged prosthetic or orthodontic appliances.
- Deemed by the Claims Administrator to be of questionable efficacy.
- For broken appointments.
- Which are not Dentally Necessary as determined by the Claims Administrator.
- Arising from any intentionally self-inflicted injury or contusion, or as a consequence of your commission of or attempt to commit a felony or engagement in an illegal occupation or of being intoxicated or under the influence of illicit narcotics.
- For house calls for dental services.
- For any services for which the patient failed to follow the guidelines of the plan.

The following services will be subject to the limitations set forth below:

- Full mouth x-rays – one every three years.
- One set of bitewing x-rays per consecutive six months.
- Periodic oral evaluation – one per six months.
- Prophylaxis – one per six months.
- Fluoride treatment – one per six months through age eighteen.
- Space maintainers – only provided for eligible dependent children through age eighteen when used to maintain space as a result of prematurely lost deciduous posterior teeth and permanent first molars, or deciduous posterior teeth and permanent first molars that have not, or will not develop.
- Prefabricated stainless steel crowns – one per tooth per lifetime for age fourteen years and younger.
- Crown lengthening – one per tooth per lifetime.
- Periodontal maintenance following active periodontal therapy – four in any twelve (12) consecutive months per patient reduced by the number of routine prophylaxis received during that twelve (12) month period so that total prophylaxes for the period does not exceed four.

- Periodontal scaling and root planing – one per twenty-four (24) month period per area of the mouth.
- Placement or replacement of single crowns, single and abutment buildups and post and cores, bridges, full and partial dentures – one within five years of their placement.
- Denture relining or rebasing – integral if provided within six months of insertion by the same dentist.
- Subsequent denture relining or rebasing – limited to one every thirty-six (36) months thereafter.
- Surgical periodontal procedures – one per twenty-four (24) month period per area of the mouth.
- Sealants – one per tooth per three years through age ten on permanent first molars and through age fifteen on permanent second molars.
- Pulpal therapy – through age five on primary anterior teeth and through age eleven on primary posterior teeth.
- Root canal therapy – limited to one per tooth per lifetime.
- Inlays, onlays, crowns, dentures and bridges shall be considered completed on the date they are finally inserted.
- One consultation per consultant during any one-year period.
- If for any reason orthodontic services are terminated before completion of approved treatment, the liability of the plan will cease with payment through the month of termination.
- Functional/myofunctional therapy is covered only when provided by a dentist in conjunction with appliance therapy.

CLAIMS SUBMISSION AND PAYMENT

Upon completion of treatment, a claim needs to be filed with the Claims Administrator. If you visit a Participating Provider, the dental office will submit claims for you. The Claims Administrator will pay covered benefits directly to the Participating Provider. Both you and the dentist will receive an explanation of benefits. Claim forms may be obtained by calling Member Services at the toll-free number on your identification card.

Most dental offices submit claim forms for patients. However, if you do not receive treatment from a Participating Provider, you may have to complete and send a claim form to the Claims Administrator in the event the dental office will not do this for you. Submit the claim or pretreatment estimate to the address on the claim form. Be sure to include the patient's name, date of birth, your ID number, patient's relationship to you, your name and address, and the name and policy number of a second insurer if the patient is covered by another dental plan. Your dentist should complete the treatment and provider information, or supply an itemized receipt for you to attach to the claim form. The Claims Administrator will forward payment to you if covered services are provided by a Non-Participating Provider and you do not indicate on the claim that you wish payment to be sent to the dentist. You will receive an explanation of benefits detailing how the claim was paid, including any deductibles and copayments which were applied.

TIME LIMIT FOR FILING CLAIMS

Claims must be submitted to the Claims Administrator within ninety (90) days of the date of service or as soon as reasonably possible and, in no event, later than one year from the time the service was performed.

NOTICE OF ADVERSE BENEFIT DETERMINATION

The Claims Administrator will determine benefits and notify you of adverse benefit determinations no later than thirty (30) days after receipt of the claim.

The Claims Administrator may extend this thirty (30) day period by fifteen (15) days if additional information about the claim is required or the extension is necessary due to matters beyond the control of the Claims Administrator. The Claims Administrator will notify you of the extension before the end of the initial thirty (30) day period. The Claims Administrator will explain the circumstances requiring the extension, the additional information required and the date by which the Claims Administrator expects to make the benefit determination. You will have forty-five (45) days to provide the information requested. The time it takes you to respond to the request for additional information will not be counted toward the time the Claims Administrator is required to make the benefit determination.

If your request for reimbursement or other Post-Service Claim is denied, you will receive written notification of that denial which will include, among other items, the specific reason or reasons for the adverse benefit determination and a statement describing your right to file an appeal. For a description of your right to file an appeal concerning an adverse benefit determination of a request for reimbursement or any other Post-Service Claim, refer to the following section.

CLAIMS APPEALS

The Claims Administrator will make benefit determinations and resolve appeals in a thorough, appropriate, and timely manner to ensure that you are afforded a full and fair review of claims for benefits. Benefit determinations will be made in accordance with the plan documents and consistently among claimants. You or your authorized representative may submit written comments, documents, records and other information relating to claims or appeals. The Claims Administrator will provide a review that considers all information submitted whether or not it was considered with its first determination on the claim. Any notifications by the Claims Administrator required under these procedures will be supplied to you or your authorized representative.

If you are dissatisfied by the benefit determination, in whole or in part, you or your authorized representative may file an appeal with the Claims Administrator within one hundred eighty (180) days of receipt of the adverse benefit determination. To file an appeal, call the toll-free number listed on your notice of adverse benefit determination.

The Claims Administrator will review your appeal and notify you of its decision within sixty (60) days following your request for the appeal. Any dentist advisor involved in reviewing the appeal will be different from and not in a subordinate position to the dentist advisor involved in the initial benefit determination.

SECTION IV: VISION BENEFITS

PLAN OVERVIEW

Your employer has entered into an agreement with the Steelworkers Health and Welfare Fund to provide a vision plan that is administered by Davis Vision, Inc. This plan, which is called the Annual Plan, provides benefits for covered services from any eligible vision provider. You are not required to use a provider who participates with Davis Vision to receive benefits. You will, however, receive the greatest value and maximize your benefits if you choose a provider who participates in Davis Vision's Provider Network.

ELIGIBLE PROVIDERS OF SERVICE

The following professional providers of vision services are eligible under this plan:

- Ophthalmologists
- Optometrists
- Opticians

You may use either a network provider or an out-of-network provider for covered vision services. Providers who have entered into a contract with Davis Vision to provide eye examinations and/or materials on a scheduled fee basis are network providers. Providers of optometric services who have not entered into a contract with Davis Vision to provide vision care services are out-of-network providers.

HOW TO FIND A NETWORK PROVIDER

The Davis Vision network includes providers in both private practice and retail locations. To locate a network provider near you, contact member services at the number on your identification card or you can go online to www.davisvision.com and use the "Find a doctor" feature.

SCHEDULE OF BENEFITS

This Schedule of Benefits provides a summary of the vision benefits available to you and your Dependents. Please refer to the following pages for a more detailed description of covered services, limitations and exclusions.

SERVICE	
In-Network Reimbursement Schedule Frequency – Once Every:	**All Members**
Eye Examination	12 Months
Eyewear:	
Spectacle Lenses	12 Months
Frame	12 Months
Contact Lenses (in lieu of eyeglasses)	12 Months
Eye Examination	**Plan Pays**
Eye Examination inclusive of Dilation	100%
Contact Lens Evaluation and Fitting	100%
Spectacle Lenses	
All ranges of prescriptions and sizes	100%
Choice of glass or plastic lenses	100%
Oversize Lenses	100%
Frame	
In-Network Retail Allowance	$60
Exclusive Collection of Frames (in lieu of Frame Allowance):	
Fashion	100%
Designer	100% after $20 copayment
Premier	100% after $40 copayment
If you choose to receive services from an independent network provider you may select a Fashion frame from the exclusive "Collection" at no cost. Should you select a frame from the provider's own supply, a $60.00 retail allowance will be applied toward your frame purchase and you will be responsible for any amount over the allowance. Retail providers do not carry the collection; your frame benefit at a participating retail location will be the network retail allowance and you will be responsible for any amount over the allowance.	
Contact Lenses (in lieu of eyeglasses)	
Elective Allowance	$75[1/]
1 Pair Standard Daily Wear Contact Lenses (in lieu of Elective Allowance)	100%
Medically Necessary (with prior approval)	100%
Spectacle Lens Options	**Member Copayment**
Fashion and Gradient Tinting of Plastic Lenses	$15
Glass-Grey #3 Prescription Sunglasses	$15
Ultraviolet Coating	$15
Scratch Resistant Coating	$20
Polycarbonate Lenses	$0 or $35[2/]
Blended Segment Lenses	$20
Intermediate Vision Lenses	$30
Standard Progressive Addition Lenses (PALs)	$65
Premium PALs (Varilux™, etc.)	$105
Photochromic Lenses	$20
Ultra AR Coating	$69
Plastic Photosensitive Lenses	$70
Polarized Lenses	$75
Standard Anti-Reflective Coating (ARC)	$40
Premium ARC	$55
Hi-Index Lenses	$60
Out-of-Network Reimbursement	**Plan Pays**
Eye Examination, up to	$32
Contact Lens Evaluation and Fitting:	
Daily Wear, up to	$20
Extended Wear, up to	$30
Spectacle Lenses (per pair):	
Single, up to	$25
Bifocal, up to	$36
Trifocal, up to	$46
Lenticular, up to	$72
Frame, up to	
Contact Lenses:	
Non-Disposables, up to	$48[3/]
Disposables, up to	$75
Medically Necessary, up to	$225

[1/] *Can be applied toward disposables or specialty contact lenses (including but not limited to extended wear, hard/soft bifocal, toric and gas permeable lenses).*
[2/] *Polycarbonate lenses are covered in full for dependent children, monocular patients and patients with prescriptions ≥ +/- 6.00 diopters*
[3/] *Can be applied toward standard (hard/soft daily wear) or specialty contact lenses (including but not limited to extended wear, hard/soft bifocal, toric and gas permeable lenses).*

COVERED SERVICES

The plan covers charges by an eligible provider for the following services. The benefits payable for covered services vary depending upon whether the services are rendered by a network provider or an out-of-network provider. Refer to the Schedule of Benefits in this section for plan benefits, frequency limitations and the amounts you will owe for covered services.

Eye Examination

- Case history
- Entrance distance acuities
- External ocular evaluation including slit lamp examination
- Internal ocular examination
- Tonometry
- Distance refraction – objective and subjective
- Binocular coordination and ocular motility evaluation
- Evaluation of papillary function
- Biomicroscopy
- Gross visual fields
- Assessment and plan

Fitting of Eyeglasses, Including Follow-Up Adjustments

Materials

- Glass or plastic lenses in single vision, bifocal, trifocal or lenticular prescriptions, including oversized lenses and cataract lenses;
- Contact lenses, including evaluation and fitting;
- Medically necessary contact lenses for the correction of Keratoconus; and
- Frames from Davis Vision's Fashion Advantage Collection.

Frames and lenses from an out-of-network provider or from a network provider's own collection are payable up to the allowances shown on the Schedule of Benefits. Any amount due in excess of the allowance and/or maximum for covered lenses or frames is your responsibility.

Note: The benefit for medically necessary contact lenses for the correction of Keratoconus is available both in and out-of-network and requires prior approval. You or your provider must obtain this approval from Davis Vision before the lenses are dispensed. If the required approval is not obtained, no benefits will be paid for contact lenses for the correction of Keratoconus and the entire charge will be your responsibility. Any amount due in excess of the allowance and maximums for covered contact lenses for the correction of Keraoconus shown on the Schedule of Benefits is your responsibility.

Low Vision Program

- Comprehensive low vision evaluation in addition to an eye examination when the eye examination indicates a need for such an evaluation;
- Follow-up visits; and
- Low vision aids.

Note: The low vision program is available both in and out-of-network and requires prior approval. You or your provider must obtain this approval from Davis Vision prior to the initial low vision evaluation. If the required approval is not obtained, no benefits will be paid for any low vision services and the entire charge will be your responsibility. Any amount due in excess of the allowance and maximums for covered low vision services shown on the Schedule of Benefits is your responsibility.

Optional In-Network Items

- Fashion and Gradient Tinting of Plastic Lenses
- Glass-Grey #3 Prescription Sunglasses
- Ultraviolet Coating
- Scratch Resistant Coating
- Polycarbonate Lenses
- Blended Segment Lenses
- Intermediate Vision Lenses
- Standard Progressive Addition Lenses (PALs)
- Premium PALs (Varilux™, etc.)
- Photochromic Lenses
- Ultra AR Coating
- Plastic Photosensitive Lenses
- Polarized Lenses
- Standard Anti-Reflective Coating (ARC)
- Premium ARC
- Hi-Index Lenses
- Designer Frame
- Premier Frame

Your cost for any optional in-network item is limited to the applicable discounted fixed fee shown on the Schedule of Benefits.

SPECIAL FEATURES

- Discounts on Laser Vision Correction Services from network providers;
- A mail order replacement contact lens service, Lens 123, for the purchase of replacement contact lenses at significant savings; and
- A one-year unconditional breakage warranty for all eyeglasses completely supplied through the Davis Vision Collection.

For more information about these value-added features, visit www.davisvision.com or call 1-800-299-1910. For more information on the contact lens replacement service, visit www.Lens123.com or call 1-800-536-7123.

PAYMENT FOR COVERED SERVICES

Payment for covered services by a network provider is made on a fee schedule basis. This is the amount negotiated between the network provider and Davis Vision as full payment for eye examinations, the fitting of eyeglasses and materials you receive or purchase. Payment for covered services by an out-of-network provider is made on the basis of the Usual and Customary Charge as determined by Davis Vision. The Usual and Customary Charge is that portion of a charge that does not exceed the lesser of:

- the customary charge made by other providers rendering or furnishing such care, treatment or supplies within the same geographic area; or
- the usual charge the provider most frequently makes to patients for the same service.

Out-of-network-providers may bill you for the difference between the allowance shown on the Schedule of Benefits and the provider's actual charge for the covered service.

MAY I USE THE BENEFIT AT DIFFERENT TIMES?

You may "split" your benefits by receiving your eye examination and eyeglasses (or contact lenses) on different dates or through different provider locations, if desired. However, complete eyeglasses must be obtained at one time, from one provider. Continuity of care will best be maintained when all available services are obtained at one time from either a network or an out-of-network provider. To maximize your benefit value, we recommend that all services be obtained from a network provider.

LIMITATIONS

- Payment for an eye examination and refraction is limited to once every twelve (12) months.
- Payment for contact lens prescription and fitting is limited once every twelve (12) months.
- Payment is limited to one set of frames in any twelve (12) month period.
- Payment for lenses or contact lenses is limited to once every twelve (12) months.
- Payment will not be made for both contact lenses and eyeglasses within the same twelve (12) month period.

EXCLUSIONS

Your plan will not provide benefits for services, supplies or charges:

- For services or supplies not recommended by an eligible provider.
- For periodic vision examinations, except as provided herein.
- For eye examinations required by an employer as a condition of employment.
- For services or materials provided in connection with special procedures such as orthoptics and visual training, or in connection with medical or surgical treatment.
- For lenses which do not provide vision correction.
- For charges for the replacement of lost or stolen lenses or frames within twenty-four (24) months of service.
- For sickness or injury covered by a worker's compensation act or other similar legislations.
- Incurred as a direct or indirect result of war (declared or undeclared).
- Incurred as a result of an intentionally self-inflicted injury or injury sustained while committing a crime.
- For services or supplies furnished to you before the date your coverage is effective or after the date your coverage ends.
- For services or supplies which are not generally accepted in the United States as being necessary and appropriate.
- For any medical treatment rendered outside the United States or Canada.

- For services rendered by practitioners who are not eligible providers under this plan.

- For any expenses covered by any union welfare plan or governmental program or a plan required by law.

- For comprehensive low vision evaluations, subsequent follow-up visits following such evaluation or low vision aids for which prior approval was not obtained from Davis Vision.

- For medically necessary contact lenses prescribed for Keratoconus for which prior approval was not obtained from Davis Vision.

- For expenses covered by any other group insurance or a health maintenance organization or hospital or medical services prepayment plan available through an employer, union or association.

HOW TO FILE A CLAIM

If you use a network provider, there are no claim forms to fill out. Simply show your ID card at the time you receive the services. The provider will verify your eligibility for benefits and submit your claim directly to Davis Vision. All benefits for network services will be paid directly to the provider.

If you use a provider who is out-of-network, you must pay the provider directly and then submit a claim for reimbursement. Benefits for out-of-network services will be paid to you.

To request claim forms you can visit the Davis Vision website at www.davisvision.com or call member services at 1-800-299-1910. Send your completed claim forms to:

Vision Care Processing Unit
P.O. Box 1525
Latham, NY 12110

TIME LIMIT FOR FILING CLAIMS

Claims must be submitted within ninety (90) days of the date of service, or as soon thereafter as reasonably possible.

NOTICE OF ADVERSE BENEFIT DETERMINATION

Davis Vision, the Claims Administrator, will determine benefits and notify you of adverse benefit determination no later than thirty (30) days after receipt of a claim. This initial thirty (30) day period may be extended by fifteen (15) days if additional information about the claim is required or the extension is necessary due to matters beyond the control of the Claims Administrator. The Claims Administrator will notify you of the extension before the end of the initial thirty (30) day period, and will explain the circumstances requiring the extension, the additional information required and the date by which the Claims Administrator expects to make the benefit determination. You will have forty-five (45) days to provide the information requested. The time it takes you to respond to the request for additional information will not be counted toward the time the Claims Administrator is required to make the benefit determination.

If your request for reimbursement is denied, you will receive written notification of that denial within a reasonable period of time which will include, among other items, the specific reason or reasons for the adverse benefit determination and a statement describing your right to file an appeal.

APPEAL PROCEDURES

You have the right to appeal any determination made by the Claims Administrator with which you disagree. Your appeal must be filed within one hundred eighty (180) days of receipt of the adverse benefit determination. To file an appeal, call the toll-free number on your notice of adverse benefit determination. No special form is required to file an appeal.

Your appeal will be reviewed by the Member Appeal committee and will not involve any individual or the subordinate of any individual that participated in any prior decision concerning the claim which is the subject of your appeal. If a decision on your appeal is based in whole or in part on medical judgment, the Member Appeal committee will consult with a licensed physician in the same or similar specialty that typically manages or consults on the vision care service involved prior to deciding on your appeal. The vision care professional providing the consultation will not have participated in or be the subordinate of any individual that participated in any prior decision to deny the claim which is the subject of your appeal.

You may, upon request, review all documents, records and other information that may be relevant to your appeal. Upon request, copies of all such materials will be made available to you free of charge. In addition, the identity of any physician or medical expert whose advice was obtained in connection with the initial determination to deny your claim, whether or not that advice was relied upon, will be made available to you upon request and free of charge. You also have the right to submit any written data, comments, documents, records and other information that you wish to have the Member Appeal Committee consider prior to rendering a decision on your appeal.

Your appeal will be promptly investigated and decided. The Member Appeal committee will consider all of the comments, documents, records, reports and other information that have been made available and will not afford deference to any prior decision that has been made to deny your claim. Written notification of the decision will be provided with a reasonable period of time appropriate to the circumstances, not to exceed thirty (30) days following receipt of your appeal.

If your appeal relates to an adverse benefit determination on a reimbursement or other post-service claim, written notification of the decision will be provided within a reasonable period of time not to exceed sixty (60) days following receipt of your appeal. The notification will include, among other items, the reasons for the decision and your right to pursue a voluntary appeal and/or to pursue legal action, if necessary.

Designation of an Authorized Representative

You may authorize someone else to file and pursue a claim or file an appeal on your behalf. If you do so, you must notify Davis Vision in writing of your choice of an authorized representative. Your notice must include the representative's name, address, phone number and a statement indicating the extent to which he or she is authorized to pursue the claim and/or file an appeal on your behalf. A consent form that you may use for this purpose will be provided to you upon request.

SECTION V: COORDINATION OF BENEFITS AND SUBROGATION

COORDINATION OF BENEFITS

Most group health care plans, including this Plan, contain a coordination of benefits provision. This provision is used when you or your Dependents are eligible for payment under more than one group health plan. The object of coordination of benefits is to assure you that your covered expenses will be paid, while preventing duplicate benefit payments. Here is how the coordination of benefits provision in this Plan works:

- If you or your Dependents are eligible to receive benefits under another group health plan, benefits under this Plan will be coordinated with the benefits from any other group health plan so that not more than the provider's reasonable charge for covered services will be paid by this Plan.

- When your other group coverage does not mention coordination of benefits, then that coverage pays first. Benefits paid or payable by the other group coverage will be considered in determining if additional benefit payments can be made under this Plan.

- When the person who received care is covered as an Employee under one plan and as a Dependent under another, the plan under which the person is covered as an Employee is primary and pays first.

- When a dependent child is covered under two group plans, the plan covering the parent whose birthday falls earlier in the calendar year is primary and pays first. If both parents have the same birthday, the plan which covered the parent longer will be the primary plan.

- If you and your spouse are separated or divorced, the following applies to your children:

  - If the parent with custody of the child has not remarried, the coverage of the parent with custody pays first.

  - If the divorced parent with custody has remarried, the coverage of the parent with custody pays first, but the stepparent's coverage pays before the coverage of the parent who does not have custody.

  - Regardless of which parent has custody, whenever a court decree specifies the parent who is financially responsible for the child's health care expenses, the coverage of that parent pays first.

When none of the above circumstances applies, the coverage you have had for the longest time pays first, provided that:

(a) the benefits of a plan covering the person as an employee other than a laid-off or retired employee or as the dependent of such person shall be determined before the benefits of a plan covering the person as a laid-off or retired employee or as a dependent of such person; and

(b) if the other plan does not have a provision regarding laid-off or retired employees and, as a result, the benefits of each plan are determined after the other, then the provisions of (a) above shall not apply.

If you receive more than you should have when your benefits are coordinated, you will be expected to repay any overpayment. Coordination of benefits prevents duplication and works to the advantage of all members of the Plan.

Prescription drug benefits are not coordinated against any other health care or drug benefit coverage.

SUBROGATION

If the Fund makes payment for a benefit on account of sickness or accidental bodily injury, and you recover monies from another source on account of or in connection with that sickness or accidental bodily injury, you are responsible for reimbursing the Fund any monies paid by another source up to the amount paid by the Fund. If legal action is instituted against any such other source, the Fund is entitled to intervene and participate in that action. If you do not institute legal action, the Fund may do so in your name. If you are injured through an act or omission of another party (for example, a car accident) or where another person is otherwise responsible for your sickness or accidental bodily injury, benefits under this Fund will be provided in connection with that sickness or accidental bodily injury only if you agree in writing to:

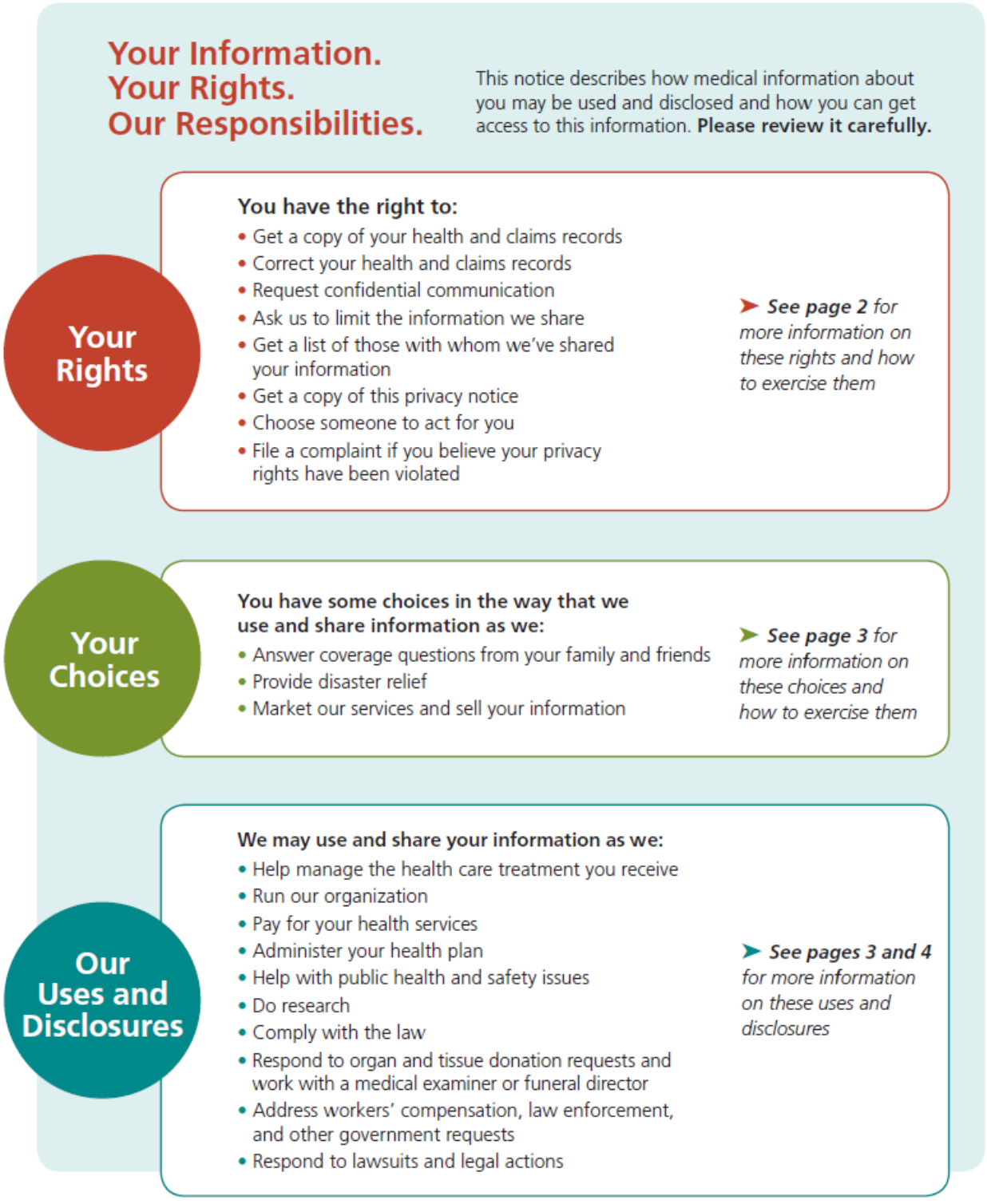
- reimburse the Fund (to the extent of benefits provided) immediately upon receipt of any payment from any other source on account of or in connection with such sickness or accidental bodily injury; and

- authorize the insurance carrier for the responsible party (or the uninsured motorist or no-fault insurance carrier) to make payment to the Fund to the extent of benefits provided; and

- provide the Fund with a lien against any monies recovered as described in paragraph 1 above; and

- authorize the Fund to intervene in any suit or other proceedings against a responsible party as described above, and/or to institute such legal action in your name in the circumstances described above.

The foregoing provisions shall also apply to your Dependents with respect to benefits provided to them.



Your Information. Your Rights. Our Responsibilities.

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

Your Rights

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

➤ ***See page 2*** *for more information on these rights and how to exercise them*

Your Choices

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

➤ ***See page 3*** *for more information on these choices and how to exercise them*

Our Uses and Disclosures

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

➤ ***See pages 3 and 4*** *for more information on these uses and disclosures*

Notice of Privacy Practices • Page 1

Your Rights

When it comes to your health information, you have certain rights.
This section explains your rights and some of our responsibilities to help you.

Get a copy of your health and claims records	• You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct health and claims records	• You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.
Ask us to limit what we use or share	• You can ask us **not** to use or share certain health information for treatment, payment, or our operations. • We are not required to agree to your request, and we may say "no" if it would affect your care.
Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting us using the information on page 1. • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.** • We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in payment for your care • Share information in a disaster relief situation *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we *never* share your information unless you give us written permission:	• Marketing purposes • Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?
We typically use or share your health information in the following ways.

Help manage the health care treatment you receive	• We can use your health information and share it with professionals who are treating you.	***Example:*** *A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.*
Run our organization	• We can use and disclose your information to run our organization and contact you when necessary. • **We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage.** This does not apply to long term care plans.	***Example:*** *We use health information about you to develop better services for you.*
Pay for your health services	• We can use and disclose your health information as we pay for your health services.	***Example:*** *We share information about you with your dental plan to coordinate payment for your dental work.*
Administer your plan	• We may disclose your health information to your health plan sponsor for plan administration.	***Example:*** *Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.*

continued on next page

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	• We can share health information about you for certain situations such as:
	  • Preventing disease
	  • Helping with product recalls
	  • Reporting adverse reactions to medications
	  • Reporting suspected abuse, neglect, or domestic violence
	  • Preventing or reducing a serious threat to anyone's health or safety

Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests and work with a medical examiner or funeral director	• We can share health information about you with organ procurement organizations. • We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you:
	  • For workers' compensation claims
	  • For law enforcement purposes or with a law enforcement official
	  • With health oversight agencies for activities authorized by law
	  • For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

This notice is effective as of September 23, 2013

This Notice of Privacy Practices applies to the following organizations.

The Steelworkers Health and Welfare Fund

HIPAA Privacy Officer, Steelworkers Health and Welfare Fund, 5 Gateway Center, 7th Floor, Pittsburgh, PA 15222. Telephone: 1-888-831-3863 Fax: (412) 562-2276

SECTION VII: STATEMENT OF ERISA RIGHTS

As a Participant, you have certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). These include the right to:

- examine, without charge, all Fund documents, including insurance contracts, collective bargaining agreements, and a copy of the latest annual report (Form 5500 series) filed by the Fund with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration. You may look at these documents at the Fund Office or other locations such as union halls and worksites where at least fifty (50) participants work;

- obtain, upon written request to the Board of Trustees, copies of documents governing the operation of the Fund, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Fund may make a reasonable charge for the copies;

- receive a summary of the Fund's annual financial report. The Board of Trustees is required by law to provide each participant with a copy of the summary annual report every year; and

- continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Fund 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 Fund on the rules governing your COBRA continuation rights.

In addition to creating rights for Fund Participants, ERISA requires the people who operate the Fund to meet certain responsibilities. These people, called "fiduciaries", must act solely in the interest of you and other Participants and beneficiaries, and must act prudently in performing their duties.

Although the Fund does not guarantee your employment, no one may fire you or discriminate against you to prevent you from obtaining a benefit or exercising your rights under ERISA (not your Employer, the Union or any other person).

If your claim for a benefit is denied, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights:

- If you ask the Board of Trustees for a copy of plan documents or the latest annual report from the plan and do not receive them within thirty (30) days, you may file suit in a Federal court. In such case, the court may require the Board of Trustees to provide the materials and pay you a fine of up to $110 a day until you receive them, unless the materials were not sent because of reasons beyond the Board of Trustees' control.

- If your claim for benefits is denied or ignored, in whole or in part, you may file suit in a state or Federal court.

- If you disagree with the Board of Trustees' (or its delegate's) decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court.

- If Plan fiduciaries ever misuse the Fund's money or 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 the court costs and legal fees – possibly the person you have sued if your case is successful. However, if you lose the case, the court may order you to pay court costs and legal fees – if the court finds your claim is frivolous, for example.

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

OTHER FACTS ABOUT THE FUND

General Information:

The Fund is a multiemployer welfare fund established by the Union. The Board of Trustees is the Plan Administrator within the meaning of, and for the purposes of, section 16(A) of ERISA, and has been designated as the agent for the service of legal process. Its address is the same as that of the Fund Office. Service of process may also be made on any individual Trustee.

Type of Administration:

Self-administration, contract administration and insurer administration.

Other Information:

The Plan Number assigned to the Fund is 501. The Board of Trustees' Employer Identification Number is 23-1317409. The Fund's fiscal records are maintained on the basis of a Plan Year that is the 12-month period beginning each January 1 and ending each December 31.

SECTION VIII: TRUSTEES

David McCall, Chairman
International Vice President - Administration
USW International Headquarters
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Pittsburgh, PA 15222

Pete Trinidad, Trustee
President
USW Local Union 6787
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Staff Representative
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Amber Miller, Trustee
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