

Summary Plan Description

Health and Welfare Benefits



ArcelorMittal USA, LLC

**For USW Represented Active Employees for Medical, Dental and
Vision Coverage, Effective January 1, 2017**



Steelworkers Health and Welfare Fund

January, 2017

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 as of January 1, 2017 for which you are or may become eligible as an active represented Employee 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") and ArcelorMittal USA, LLC (the "Employer"). ArcelorMittal USA, LLC began participation in the Fund on behalf of these Employees effective January 1, 2005 and January 1, 2017.

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. Because this Fund Letter is designed specifically for benefits provided under the collective bargaining agreement 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
- Dental Benefits (Does not apply to employees at the Minorca Mines)
- Vision Benefits

Your Benefits from the Fund do not include coverage for prescription drugs. Prescription drug benefits, life insurance and AD&D, Sickness & Accident benefits, and dental benefits for employees at the Minorca Mines are provided under separate plans sponsored by ArcelorMittal USA, LLC. Contact your Employer for information concerning these benefits.

Your benefits are not provided from Fund assets. Instead, they are provided solely from the Employer's assets and are not insured by the Fund or by any provider with which the Fund contracts.

Effective Date of Coverage

As an Employee, you and your covered Dependents, including your spouse, will generally become eligible for benefits as described in the collective bargaining agreement, provided the required contributions to the Fund are made on your behalf. 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.

Termination of Coverage

Your coverage will terminate in accordance with the rules described in Section I of this Summary Plan Description or in accordance with the eligibility requirements contained in the collective bargaining agreement.

Open Enrollment

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 annual open enrollment period for a January 1st effective date. Please contact your Employer for the dates of the annual open enrollment period.

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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.

Your benefits are not provided from Fund assets. Instead, they are provided solely from the Employer’s assets and are not insured by the Fund or by any provider with which the Fund contracts.

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 (the person to whom you are legally married);
- your children who are under age 26;
- your 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 19, 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 permanently residing in your household of which you are the head and actually being supported solely by you for whom you have been appointed legal guardian or as defined in the Collective Bargaining Agreement. Eligible children are covered to the end of the month in which the child attains age 26.

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.

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.

You should keep in mind that, even though a claim may initially be processed by an insurance company or other entity, the Board of Trustees is ultimately responsible for paying benefits. It is for this reason that, as explained in the Claims and Review Procedures section, the Board of Trustees has the final authority to grant or deny a claim.

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.

<u>Benefit</u>	<u>Claims Administrator</u>
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	The Hartford Group Life/AD&D Claims Unit P.O. Box 946790 Maitland, FL 32794-6790
Short Term Disability	The Hartford 5600 West American Boulevard Bloomington, MN 55437

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

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.

ELIGIBILITY 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 ninety (90) 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 Employer's designated eligibility administrator within ninety (90) 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 ninety (90) days from the date on which you acquire the Dependent, so long as you notify the Employer's designated eligibility administrator within ninety (90) 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 Employer's designated eligibility administrator within ninety (90) 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 ninety (90) 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 Employer's designated eligibility administrator within ninety (90) 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 Employer's designated eligibility administrator Office within ninety (90) days of losing coverage.

What if my spouse is eligible for or is enrolled in other coverage?

If your spouse is employed by an employer other than ArcelorMittal USA, LLC or its affiliates on a full-time basis (defined as thirty-two (32) or more hours per week) and is provided or offered health care coverage by his or her employer or if your spouse is retiring or retired and is not Medicare eligible and is provided or offered health care coverage by his or her employer, your spouse must enroll for that coverage even if there is a cost to participate in that coverage. A spouse who is required to pay premiums to his or her employer or employer's carrier for primary coverage will be reimbursed by the Employer upon proper application by the employee on a form provided by the Employer.

If your spouse is Medicare eligible, he or she can elect coverage either through their previous employer or as a dependent under the ArcelorMittal plan. If your Medicare eligible spouse selects coverage through his or her previous employer, he or she is ineligible for premium reimbursement from the Employer.

Your spouse is not required to pay premiums for dependent coverage under any other employer group plan or to pay premiums for his or her health care under any other employer group plan if he or she works part-time (defined as less than 32 hours per week). However, if your spouse pays premiums for dependent child(ren) coverage under his or her employer's group plan and that coverage is the primary coverage, the premiums will be eligible for reimbursement as stated above.

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. For this reason, when you lose eligibility for medical benefits, to the Claims Administrator can, upon request, provide you with 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 taken into account by the Claims Administrator (or Board of Trustees) 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.

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, 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 take into account 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.

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 Member Grievance and Appeals Department will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who is different from and not the subordinate to any individual who was consulted in a prior review.

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 taking into account 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, effectiveness of a covered service or a determination that the treatment is experimental or investigational, or
- A determination made by Highmark 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 reasonable 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 but 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 make a decision 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 provided 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 Services 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, you can go online to www.bcbs.com or contact Member Services at the toll-free number on your identification card. If you would like a copy of a provider directory, it may be obtained, without charge, by contacting Member Services. 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.

Allowed Fee

For in-network providers, the Allowed Fee shall be the lesser of the Actual Charge or the Negotiated Rate. Plan participants are not responsible for amounts charged in excess of the Allowed Fee.

For out-of-network providers, the Allowed Fee will be the negotiated rate for such facility, medical service, supply or procedure. Plan participants will be responsible for any amounts charged in excess of the Allowed Fee (except as provided herein).

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.
- **Post-Service Claim** – A request for payment or reimbursement of the charges or costs associated with a covered service that you have received.

Coinsurance

The percentage of eligible expenses paid by your plan; the remaining percentage is the percentage you pay.

Copayment

The fixed, up-front dollar amount you pay for certain covered expenses. Copayment amounts do not apply towards your deductible.

Custodial Care

Care provided primarily for maintenance of the patient or which is designed essentially to assist the patient in meeting his or her activities of daily living and which is not primarily provided for the therapeutic value in the treatment of an illness, disease, bodily injury or condition. Custodial care includes, but is not limited to, help in walking, bathing, dressing, feeding, preparation of special diets and supervision over administration of medications not requiring skilled nursing services or skilled rehabilitation services provided by trained and licensed medical personnel.

Deductible

The initial amount you must pay each year for covered services before the plan begins to pay all or part of the remaining expenses.

Emergency Care

The initial treatment of a sudden unexpected onset of a medical condition or traumatic injury. The symptoms or injury must be of sufficient severity to warrant immediate attention.

Experimental/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/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/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. Highmark 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 Highmark determines that the service, supply or covered medication is medically necessary and appropriate.

Medicare

The programs of health care for the aged and disabled established by Title XVIII of the Social Security Act of 1965, as amended.

Out-of-Pocket Maximum

The highest dollar amount for which you would be responsible each year before the plan begins to pay 100% of all covered expenses. The out-of-pocket maximum does not include out-of-network human organ and tissue coinsurance; or coinsurance or copayments paid under the prescription drug, dental, or vision plans; or amounts in excess of the Allowed Fee.

Physician

A Doctor of Medicine (M.D.); Doctor of Osteopathy (D.O.); Podiatrist or Surgical Chiropodist (D.C. or D.S.C); Dental Surgeon (D.D.S.); Chiropractor (D.C.); Doctor of Optometry (O.D.); licensed under applicable state laws and operating within the scope of that license.

Preferred Provider Organization (PPO)

A 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.

Provider

A Facility Provider, Other Facility Provider or Professional Provider licensed where required and performing within the scope of their license.

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.

Benefit	In-Network	Out-of-Network
Benefit Period	Calendar Year	
Deductible (per benefit period)		
Individual	\$200	\$500
Family	\$400	\$1,000
	(waived if participant and spouse, if applicable, completes the annual health awareness initiative)	(reduced to \$300/\$600 if participant and spouse, if applicable, completes the annual health awareness initiative)
Plan Payment Level – Based on the Allowed Fee	90% after deductible until out-of-pocket limit is met, then 100%	70% after deductible until out-of-pocket limit is met; then 100%
Out-of-Pocket Maximum (per benefit period)		
Individual	\$1,500	\$2,000
Family	\$3,000	\$4,000
Lifetime Maximum (per person)	Unlimited	Unlimited
Physician Office Visits	100% after \$20 copayment	70% after deductible
Specialist Office Visits	100% after \$20 copayment	70% after deductible
Preventive Care		
Adult		
Routine Physical exams	100% (deductible/copayment does not apply)	70% after deductible
Adult Immunizations	100% (deductible does not apply)	70% after deductible
Routine gynecological exams, including a PAP Test	100% (deductible/copayment does not apply)	70% after deductible
Mammograms, annual routine and medically necessary	100% (deductible does not apply)	70% after deductible
Well-Women Care	100% (deductible does not apply)	70% after deductible
Colorectal Cancer Screening	100% (deductible does not apply)	70% after deductible
Diagnostic services and procedures	100% (deductible does not apply)	70% after deductible
Pediatric		
Routine physical exams	100% (deductible/copayment does not apply)	70% after deductible
Pediatric immunizations	100% (deductible does not apply)	70% after deductible
Diagnostic services and procedures	100% (deductible does not apply)	70% after deductible
Emergency Room Services	100% after \$50 copayment (waived if admitted)	
Urgent Care Facility	100% after \$30 copayment	
Spinal Manipulations	100% after \$20 copayment	70% after deductible
	Limit: 18 visits/calendar year	
Physical Medicine and Occupational Therapy	100% after \$20 copayment	70% after deductible
	Combined Limit: 60 visits/calendar year	
Speech Therapy	100% after \$20 copayment	70% after deductible
Allergy Extracts	90% after deductible	70% after deductible
Allergy Injections	100% (if performed in a doctor's office)	70% after deductible
Ambulance	100% (deductible does not apply)	
Assisted Fertilization Procedures	Not Covered	
Dental Services Related to Accidental Injury	90% after deductible	70% after deductible
Diabetes Treatment	90% after deductible	70% after deductible
Diagnostic Services	90% after deductible	70% after deductible
Advanced Imaging (MRI, CAT Scan, PET scan, etc.)		
Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)	90% after deductible	70% after deductible
Durable Medical Equipment, Orthotics and Prosthetics	80% after deductible	60% after deductible
Enteral Foods	90% after deductible	70% after deductible
Hearing Aids	100% (deductible does not apply)	100% (deductible does not apply)
	Limit: \$1,700 maximum per ear in a 3 year period	
Home Infusion Therapy	90% after deductible	70% after deductible

Benefit	In-Network	Out-of-Network
Home Health Care	90% after deductible	70% after deductible Limit: 30 visits/calendar year
Hospice	100% (deductible does not apply)	
Hospital Services – Inpatient	90% after deductible Limit: 60 days physical medicine and rehabilitation	70% after deductible
Hospital Services – Outpatient	90% after deductible	70% after deductible
Infertility Counseling, Testing and Treatment ①	90% after deductible	70% after deductible
Maternity (facility & professional services)	90% after deductible	70% after deductible
Medical/Surgical Expenses (Except Office Visits)	90% after deductible	70% after deductible
Mental Health – Inpatient	90% after deductible	70% after deductible
Mental Health – Outpatient	100% after \$20 copayment	70% after deductible
Pediatric Extended Care Services	90% after deductible Limit: 100 days/calendar year	70% after deductible
Radiation Therapy	90% after deductible (if performed in a doctor’s office, 100% after \$20 copayment)	70% after deductible
Registered Dietician	90% after deductible Limit: 8 visits/calendar year	70% after deductible
Respiratory Therapy	90% after deductible	70% after deductible
Skilled Nursing Facility Care	90% after deductible	70% after deductible
Substance Abuse – Inpatient Detoxification	90% after deductible	70% after deductible
Substance Abuse – Inpatient Rehabilitation	90% after deductible	70% after deductible
Substance Abuse – Outpatient	\$20 copayment for initial visit, 100% thereafter	70% after deductible
Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, and Dialysis)	90% after deductible	70% after deductible
Transplant Services	100% (deductible does not apply)	70% hospital coverage, 80% all other coverage
Precertification Requirements	Provider is responsible	Performed by Member②

- ① Treatment includes coverage for the correction of a physical or medical problem associated with infertility.
- ② Highmark Healthcare Management (HMS) must be contacted prior to a planned inpatient admission or within 48 hours of an emergency or maternity-related inpatient admission. Some facility providers will contact HMS and obtain precertification of the inpatient admission on your behalf. Be sure to verify that your provider is contacting HMS for precertification. If not, you are responsible for contacting HMS. If this does not occur and it is later determined that all or part of the inpatient stay was not medically necessary or appropriate, you will be responsible for payment of any costs not covered.

Note - Visits or days above the annual limits are not covered and do not count towards the annual deductible or out-of-pocket maximum.

HEALTH AWARENESS INITIATIVE

The deductible for Employees will be waived for in-network services and reduced for out-of-network services to \$300 Individual/\$600 Family by participating in an annual wellness examination that may include a discussion of additional screenings and exams from the current Preventive Schedule outlined in the Patient Protection and Affordable Care Act of 2010 (“PPACA”).

Employees, and if the Employee is married, the Employee and his/her spouse, must complete a wellness examination with a physician to confirm height, weight, blood pressure, as well as a discussion of the appropriate exams, screenings, and procedures recommended by the physician and as described in the PPACA.

Employees (and their covered spouses, if applicable) must complete the appropriate wellness examination prior to September 30th preceding the plan year in order to have the deductibles waived/reduced in the following plan year (i.e. September 30, 2016 for plan year 2017 effective date). A physical from an Urgent Care Center will satisfy the requirement.

There will be no cost to comply with this program. Employees (and their spouses if applicable) will not have to pay an office visit copay for the Wellness Examination even if they already used their preventive office benefit for the Plan year in 2016. Employees (and their spouses, if applicable) will not have to pay a fee for the provider filling out any forms.

Once it is confirmed that the Wellness Examination has been performed by a physician for both the Employee and his/her spouse if applicable, the deductible for in-network services for the following year will be waived. The deductible for out-of-network services will be reduced to \$300 Individual/\$600 Family.

In addition, in January of each year that an Employee (and his/her spouse if applicable) qualifies to have the deductible waived, the Employer will contribute an amount of \$200 (\$400 for spousal coverage) to the Employee. The Employee may defer this money to their 401(k) at their discretion. The Employer is responsible for this payment, which is not part of the Steelworkers Health and Welfare Fund Plan.

No results of a wellness examination will be shared with the Company or health plan administrator.

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.

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.

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.

If the claims administrator verifies that there were no participating providers who provide the service you need within a 50-mile radius of your residence, the claim will be paid at the in-network level so the member's responsibility is no more than if the provider was a participating provider. The member will be held harmless and cannot be balanced billed.

When a participant receives services provided by a hospital based physician at an in-network facility while under the care of an in-network Primary Physician or Surgeon, they cannot be balance billed for services provided by an Out of Network provider within that facility. The Participant shall be held harmless.

Eligible Providers

The following are eligible providers under this plan:

Facility Providers

- Hospitals
- Psychiatric hospitals
- Rehabilitation hospitals

Other Facility Providers

- Alcohol abuse treatment facility
- Ambulance service
- Ambulatory surgical facility
- Birthing facility
- Day/Night psychiatric facility
- Drug abuse treatment facility
- Freestanding dialysis facility
- Freestanding nuclear magnetic resonance facility/magnetic resonance imaging facility
- Home health care agency
- Hospice facility
- Outpatient substance abuse treatment facility
- Outpatient psychiatric facility
- Pediatric Extended Care facility
- Skilled nursing facility
- State-owned psychiatric hospital
- Substance Abuse treatment facility
- Urgent care center

Professional Providers

- Audiologist
- Certified registered nurse*
- Chiropractor
- Clinical laboratory
- Dentist
- Licensed practical nurse
- Nurse midwife
- Occupational therapist
- Optometrist
- Physical therapist
- Physician
- Podiatrist
- Psychologist
- Registered dietician
- Respiratory therapist
- Speech language pathologist
- Teacher of the hearing impaired

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

HEALTHCARE MANAGEMENT SERVICE

Healthcare Management Services (HMS), a division of Highmark, is responsible for ensuring that quality care is delivered to you within the proper setting and that the services you receive are medically necessary and appropriate. Precertification or care authorization is required for all inpatient hospital admissions and all inpatient mental health/substance abuse care.

Whether you are to be admitted to an in-network or an out-of-network facility for an inpatient stay, HMS must be contacted to receive authorization for your care. When you use a network provider, the provider is responsible for obtaining the required authorization. However, if you are to be admitted to a non-network facility, **you** are responsible for obtaining the required authorization by calling HMS at the toll-free number on your identification card. You should call 7 to 14 days prior to a planned admission. Precertification is not required for emergency or maternity-related admissions, but you should notify HMS of the admission within twenty-four (24) hours, or as soon as reasonably possible.

If you do not call to authorize your admission to a facility provider, your care will be reviewed by HMS after services are received to determine if it was medically necessary and appropriate. If the admission is determined not to be medically necessary, you will be responsible for all costs not covered by the plan.

Prospective Review

Prospective review, also known as *precertification*, begins once a request for medical services is received.

After receiving the request for inpatient care, HMS:

- gathers information needed to make a decision, including patient demographics, diagnosis, and plan of treatment;
- confirms care is medically necessary and appropriate;
- reviews available information regarding the member's eligibility for coverage and/or availability of benefits;
- authorizes care or refers to a physician advisor for determination; and
- assigns an appropriate length of stay.

Concurrent Review

Concurrent review may occur during the course of inpatient hospitalization and is used to assess the medical necessity and appropriateness of the length of stay and level of care.

HMS will:

- review patient's progress and ongoing treatment plan with the facility staff; and
- decide, when necessary, to either: extend the patient's care; discuss an alternative level of care; or refer to the physician advisor for a decision.

Discharge Planning

Discharge planning is a review of the case to identify the patient's discharge needs. The process begins prior to a planned admission or, in the case of an unplanned admission, at the time of admission, and extends throughout the patient's stay in a facility. Discharge planning facilitates continuity of care and is coordinated with input from the patient's physician and facility staff.

In planning for discharge, HMS assesses the patient's:

- level of function pre- and post-admission;
- ability to perform self-care;
- primary caregiver and support system;
- living arrangements pre- and post-admission;
- special equipment, medication, and dietary needs and safety needs;
- obstacles to care;
- need for referral to case management or condition management;
- availability of benefits or need for benefit adjustments; and
- psychological needs.

Retrospective Review

Retrospective review occurs when a service or procedure has been rendered without the required authorization.

Case Management Services

Should you or a covered family member experience a serious injury or illness, the Case Management Program may be able to provide assistance.

If accepted into the program, and with the patient's permission, the program will:

- work collaboratively with the patient, family or significant others, and all providers to coordinate and implement a plan of care which meets the patient's holistic needs;
- identify community-based support and educational services to assist with the patient's ongoing health care needs; and
- assist in the coordination of benefits and alternative resources.

ADDITIONAL UTILIZATION REVIEW PROCESS INFORMATION

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. However, this fifteen (15) 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 fifteen (15) day Pre-Service Claim determination period. If an extension of time is necessary because you failed to submit information necessary for the Claims Administrator to make a decision on your Pre-Service Claim, the notice of extension will specifically describe the information that you must submit. You will have at least forty-five (45) days in which to submit the information.

Decisions Involving Urgent Care Claims

If your request involves an Urgent Care Claim, Highmark will make a decision on your request as soon as possible taking into account the medical emergency 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. This time frame may be shortened in those cases where your Urgent Care Claim request 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. In that situation, the Claims Administrator will notify you of its decision concerning your Urgent Care Claim to extend that course of treatment not later than twenty-four (24) hours following receipt of your 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 appeal.

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 Healthcare Management Services (HMS) 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.

BlueCard Worldwide Program

This program provides assistance 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;
- providing assistance if special help is needed;
- making arrangements 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 BlueCard Worldwide 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.bcbs.com.

INTER-PLAN PROGRAMS

Out of Area Services

Highmark 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 Highmark serves, the claim for those services may be processed through one of these Inter-Plan Programs and presented to Highmark 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 Highmark serves, should obtain care from health care providers 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 health care providers. Highmark’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, Highmark will remain responsible to the group for fulfilling Highmark'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 Highmark 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 Highmark 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 take into account 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 Highmark 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, Highmark 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 Highmark 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 Highmark'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 Highmark by the Host Blue that allows members access to negotiated participation agreement networks of specified participating health care providers outside of the geographic area Highmark serves.

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

Member Liability Calculation

When covered services are provided outside of the geographic area Highmark 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 Highmark will make for the covered services as set forth in this paragraph.

Exceptions

In some exception cases, Highmark may pay claims from non-participating health care providers outside of the geographic area Highmark 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 Highmark in Highmark'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 Highmark will make for the covered services as set forth in this paragraph.

HOW YOUR BENEFITS ARE APPLIED

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

Your benefit period is a 12-month period beginning each January 1st. The benefit period may also be referred to as a calendar year.

Copayment

The copayment is the up-front dollar amount you must pay for certain services such as physician office visits, and emergency room visits. Refer to the Schedule of Benefits for the copayments applicable to your benefit program. The copayment paid does not vary with the cost of the service and does not apply towards the deductible. ***The copayment is to be paid to the provider at the time of service.***

Deductible

The deductible is the amount you must pay for medically necessary and appropriate health care each year before the plan begins to pay all or part of the remaining expenses. Refer to the Schedule of Benefits for the deductible amount(s). The deductible does not include copayments or coinsurance amounts that you are required to pay or expenses for transplants at an out-of-network facility.

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 than 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.

Eligible expenses incurred during the last three months of a calendar year which are applied against the deductible for that year may be carried over and applied against the deductible for the next calendar year.

Coinsurance

This 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 to determine the percentage your plan pays; *the remaining percentage is your responsibility.*

Out-of-Pocket Maximum

This is the amount of money you pay out of your pocket for eligible health care expenses before the plan begins to pay 100% for additional eligible expenses in a calendar year. Refer to the Schedule of Benefits for the out-of-pocket maximum. The individual out-of-pocket maximum applies to each covered person per calendar year. The family out-of-pocket is the amount you have paid out of your own pocket for total covered services your family received during the calendar year. The out-of-pocket maximum includes the deductible and all copayments and all coinsurance under the medical plan but excludes expenses for transplant services at an out-of-network facility and prescription drug, dental and vision expenses. The out-of-pocket maximum does not include charges for any non-covered services or amounts in excess of the Allowed Fee.

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.

Hospital Services

- **Bed, Board and General Nursing Services in:**

- A semi-private room.
- A private room. Private room allowance is the average semi-private room charge.
- A bed in a Special Care Unit which gives intensive care to the critically ill.

- **Other Services:**

- Operating, delivery and treatment rooms and equipment.
- Drugs and medicines provided to you while you are an inpatient in a hospital or other facility.
- 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.

- **Emergency Accident Care**

The plan covers outpatient emergency hospital services and supplies to treat injuries caused by an accident.

- **Emergency Medical Care**

The plan covers the initial treatment of a sudden onset of a medical condition with acute symptoms of sufficient severity to require immediate medical attention.

- **Emergency Care Services**

The plan covers services and supplies, including drugs and medicines, for the outpatient emergency treatment of bodily injuries resulting from an accident or a 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.

- **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.

- **Pre-Admission Testing**

The plan covers outpatient tests and studies required for your scheduled admission as an inpatient.

Urgent Care

The plan covers urgent care center services and supplies to treat an unexpected episode of illness or an accidental injury requiring treatment which cannot reasonable be postponed for regularly scheduled care.

Surgical/Medical Services

- **Surgical Services**

- Performance of generally accepted operative and other invasive procedures, including the correction of fractures and dislocations.
- Usual and related pre-operative and post-operative care.
- Sterilization, regardless of medical necessity and appropriateness.
- Oral surgical services are limited to:
 - mandibular staple implant when not done to prepare the mouth for dentures;
 - accidental injury to the jaw or structures contiguous to the jaw with exception of the following which will be covered under the Dental plan:

Treatment of Fractures - Simple

D7610	Maxilla – open reduction (teeth immobilized, if present)
D7620	Maxilla – closed reduction (teeth immobilized if present)
D7630	Mandible – open reduction (teeth immobilized if present)
D7640	Mandible – closed reduction (teeth immobilized, if present)
D7650	Malar and/or zygomatic arch – open reduction
D7660	Malar and/or zygomatic arch – closed reduction
D7670	Alveolus – closed reduction, may include stabilization of teeth
D7671	Alveolus – open reduction, may include stabilization of teeth
D7680	Facial bones – complicated reduction with fixation and multiple surgical approaches

Treatment of Fractures – Compound

D7710	Maxilla – open reduction
D7720	Maxilla – closed reduction
D7730	Mandible – open reduction
D7740	Mandible – closed reduction
D7750	Malar and/or zygomatic arch – open reduction
D7760	Malar and/or zygomatic arch – closed reduction
D7770	Alveolus – closed reduction, may include stabilization of teeth
D7771	Alveolus – open reduction, may include stabilization of teeth

D7780 Facial bones – complicated reduction with fixation and multiple surgical approaches

- the correction of a 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 with the exception of the following which will be covered under the Dental plan:

Surgical Excision of Soft Tissue Lesions

D7410	Excision of benign lesion up to 1.25 cm
D7411	Excision of benign lesion greater than 1.25 cm
D7412	Excision of benign lesion, complicated
D7413	Excision of malignant lesion up to 1.25 cm
D7414	Excision of malignant lesion greater than 1.25 cm
D7415	Excision of malignant lesion, complicated
D7465	Destruction of lesion(s) by physical or chemical method, by report

Surgical Excision of Intra-Osseous Lesions

D7440	Excision of malignant tumor – lesion diameter up to 1.25 cm
D7441	Excision of malignant tumor – lesion diameter greater than 1.25 cm
D7450	Removal of benign odontogenic cyst or tumor – lesion diameter up to 1.25 cm
D7451	Removal of benign odontogenic cyst or tumor – lesion diameter greater than 1.25 cm
D7460	Removal of benign non-odontogenic cyst or tumor – lesion diameter up to 1.25 cm
D7461	Removal of benign non-odontogenic cyst or tumor – lesion diameter greater than 1.25 cm

- 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.
- When more than one 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, plus 50% of the amount that would have been payable for each of the additional procedures had those procedures been performed alone.

- **Assistant at Surgery**

The plan covers services of a physician who actively assists the operating surgeon in the performance of a covered surgery if a house staff member, intern or resident is not available.

- **Anesthesia**

The plan covers administration of anesthesia ordered by the attending Professional Provider and rendered by a Professional Provider who is not the surgeon or the assistant-at-surgery. Benefits will also be provided for the administration of anesthesia ordered by the attending Professional Provider and rendered by a Professional Provider for outpatient oral surgical procedures.

- **Second Surgical Opinion**

The plan covers a second physician's opinion and related diagnostic services to help determine the need for elective covered surgery recommended by your first physician.

Keep in mind that:

- getting a second opinion is your choice;
- your second opinion must be from someone other than the first physician who recommended the surgery;
- elective surgery means non-emergency surgery or surgery that can be deferred; and
- a third opinion is covered if the first and second opinions conflict.

You are covered for surgery even when the physicians' opinions conflict. If the consulting opinion is against the 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 consultation per consultant.

Inpatient Medical Services

The plan covers the following services you receive from a Professional Provider when you are an inpatient for a condition not related to surgery, pregnancy, or mental illness:

- **Inpatient Medical Care Visits**
- **Intensive Medical Care**
 - Constant attendance and treatment when your condition requires it for a prolonged time.
- **Concurrent Care**
 - Care rendered concurrently with surgery during one hospital stay by a Professional Provider who is not your surgeon for treatment of a medical condition separate from the condition for which surgery was performed.
 - Care by two or more Professional Providers during one hospital stay.
- **Consultation**
 - By another Professional Provider when requested by your attending Professional Provider.
 - Excludes staff consultants required by hospital rules.
- **Newborn Care**
 - Care to examine the newborn infant while the mother is an inpatient.

Physician Visits

- **Outpatient Medical Services**

The plan covers the following services you receive in the office of a professional provider;

- outpatient medical care that is not related to surgery, pregnancy or mental illness, except as specifically provided herein;
- office visits for medical care and consultations to examine, diagnose and treat an injury or illness;
- diagnostic services when required to diagnose or monitor a symptom, disease or condition;
- allergy extract and injections;
- surgery and surgical services including anesthesia and supplies; and
- therapy sessions
- consultations with a registered dietician

- **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. The plan covers up to 18 visits per benefit period.

- **Pediatric Preventive Services**

The plan covers routine pediatric care including routine physical examinations, routine diagnostic services and immunizations regardless of medical necessity and appropriateness. Check with your health care provider for specific guidelines based on the age of the patient.

- **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 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 Highmark.

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.

Diagnostic Services

The plan covers the following services when ordered by a professional provider:

- diagnostic X-ray, consisting of radiology, magnetic resonance imaging (MRI), ultrasound, and nuclear medicine;
- diagnostic pathology, consisting of laboratory and pathology tests;
- diagnostic medical procedures, consisting of electrocardiogram, electroencephalogram, and other electronic diagnostic medical procedures and physiological medical testing approved by the Claims Administrator; and
- allergy testing consisting of percutaneous, intracutaneous, and patch tests.
- 3-D Mammograms (if not provided for in the Claims Administrator's Medical Policy) will be covered when deemed medically necessary based on the results following a standard mammography (as determined by the Participant's doctor and approved by the Claims Administrator). Otherwise coverage will be provided in accordance with the Claims Administrator's Medical Policy.

When diagnostic services are rendered as physician's office or outpatient services, the copayment is based on the setting where the covered services are received. Other diagnostic services and or tests may not require a copayment.

Therapy and Rehabilitation Services

The plan covers the following services you receive from a professional provider:

- **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. The plan covers up to a maximum of 60 visits per benefit period for physical medicine and occupational therapy combined.

- **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. The plan covers up to a maximum of 60 visits per benefit period for physical medicine and occupational therapy combined.
- **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, furnished by and billed by a hospital or facility other provider in accordance with accepted medical practice
- **Cardiac Rehabilitation**
The physiological and psychological rehabilitation of patients with cardiac conditions through regulated exercise programs.

ADDITIONAL COVERED SERVICES

Colorectal Cancer Screenings

Colorectal cancer screening services which are otherwise not listed in the Preventive Schedule 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.

Mastectomy and Breast Cancer Reconstruction

The plan covers a mastectomy performed on an inpatient or outpatient basis, as well as surgery to reestablish symmetry or alleviate functional impairment in accordance with the Women's Health and Cancer Rights Act. This includes, but is not limited to, augmentation, mammoplasty, reduction mammoplasty and mastopexy. Physical complications of all stages of mastectomy are also covered, including lymphedemas. Also covered is the use of initial and subsequent prosthetic devices to replace the removed breast or portions thereof. The plan covers one home health care visit within forty-eight (48) hours after discharge, as determined by your physician, if discharge occurred within forty-eight (48) hours after your admission for a mastectomy.

Family Planning and Infertility Services

The plan covers correction of a physical or medical problem, diagnostic services, counseling, and sterilization procedures such as tubal ligation or vasectomy, including the reversal of sterilization. Treatment of infertility by means of assisted fertilization techniques such as, but not limited to: artificial insemination, in-vitro fertilization (IVF), gamete intra-fallopian transfer (GIFT), zygote intra-fallopian transfer (ZIFT), or any method used to enhance the possibility of conception through retrieval or manipulation of the sperm or ovum is *not* covered by the plan.

Maternity Services

The plan covers hospital services and surgical/medical services from a provider for:

- normal pregnancy;
- complications of pregnancy;
- miscarriage;
- therapeutic and elective abortions; and
- routine nursery care for a well newborn.

Coverage for any inpatient hospital stay in connection with childbirth for the mother or newborn child will not be less than forty-eight (48) hours following a vaginal delivery, or less than ninety-six (96) hours following a caesarean section. Coverage for a shorter length of stay may be permitted if the attending provider, after consulting with the mother, determines that further inpatient postpartum care is not necessary for the mother or the newborn child

Maternity Home Health Care Visit

If you are discharged from inpatient care prior to forty-eight (48) hours following a vaginal delivery or ninety-six (96) hours following a cesarean delivery, you are entitled to one maternity home health care visit within forty-eight (48) hours of discharge. A licensed network health care provider who offers post-partum care may provide you with parent education, assistance and training in breast and bottle feeding, infant screening and clinical tests, and any necessary maternal and neonatal physical assessments. At your discretion, the visit may occur at your provider's facility.

Ambulance Service

The plan covers local transportation by a vehicle designed, equipped and used only to transport the sick and injured:

- from your home, scene of accident or medical emergency to a hospital;
- between hospitals; or
- between hospital and skilled nursing facility.
- from a hospital to your home; or
- from a skilled nursing facility to your home; or
- to or from a local hospice facility (not required to be the closest).

Trips must be to the closest local facility that can provide covered services appropriate for your condition, except as noted above. If none, you are covered for trips to closest such facility outside your local area.

Ambulance transport is not covered if:

- the transport is solely for the convenience of the patient; or
- if it is not medically necessary.

Skilled Nursing Facility Services

The plan covers inpatient hospital services and supplies given to an inpatient of a skilled nursing facility for up to 365 calendar days per year when authorized by the Claims Administrator. 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 the convenience of a patient; and
- for treatment of alcohol abuse, drug abuse or mental illness.

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 RN or LPN, excluding private duty nursing services;
- physical therapy, occupational therapy and speech therapy;
- medical and surgical supplies;
- oxygen and its administration;
- medical social service consultations;
- health aide services when you are also receiving covered nursing or therapy services;
- respite care; and
- family counseling related to the member's terminal condition.

Home health care benefits are *not* payable for:

- dietician services;
- homemaker services;
- services provided by relatives or members of patient's household;
- care for alcoholism or drug abuse;
- maintenance therapy;
- dialysis treatment;
- custodial care (for conditions such as, but not limited to, deafness, blindness, senility, mental deficiency, dementia or intellectual disability); or
- food or home delivered meals.

Dental Services for Accidental Injury

The plan covers dental services for accidental injury to the jaw, sound natural teeth, mouth or face that occurs on or after your effective date. Injury caused by chewing or biting will not be considered accidental injury.

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. Rental costs must not be more than purchase price. Covered durable medical equipment includes penile implants and blood glucose monitors when medically necessary.

Prosthetic Appliances

The plan covers purchase, fitting, needed adjustment, repairs, and replacement of prosthetic devices and supplies that:

- replace all or part of a missing body organ and its adjoining tissues; or
- replace all or part of the function of a permanently inoperative or malfunctioning body organ.

Benefits for prosthetic appliances include:

- the first lens(es) following cataract surgery (second pair covered if the first paid does not meet the needs of the participant within the first six (6) months following cataract surgery);
- breast prostheses and two surgical brassieres each calendar year following a mastectomy;
- the first wig following cancer treatment.

Dental appliances and the replacement of cataract lenses are *not* covered

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. Non-covered items include, but are not limited to, orthopedic shoes.

Hearing Aids

The plan covers hearing aids and the examination for the prescription or fitting thereof and repair to a limit of \$1,700 per ear in a 3 year period. Replacement hearing aids are covered if at least 3 years have passed since the hearing aid being replaced was purchased and the previous hearing aid is unserviceable. Eligible services will not be subject to Plan deductibles and coinsurance.

Transplants

The plan covers the following human organ and tissue transplants. The transplant and tissue services benefits or requirements described below do not apply to cornea or kidney transplants. These services are paid as hospital, surgical/medical, or physicians' services depending on where the service is performed.

• Adult Procedures

- Bone marrow or stem cell;
 - Autologous bone marrow including high dose chemotherapy.
 - Related allogeneic bone marrow including high dose chemotherapy.
 - Unrelated allogeneic bone marrow including high dose chemotherapy.
- Heart;
- Heart/lung;
- Lung;
- Liver;
- Pancreas and kidney when performed simultaneously or pancreas transplant after a kidney transplant. (Kidney transplant alone may be covered under medical and is not part of this transplant benefit.)

• Pediatric Procedures

- Bone marrow or stem cell;
 - Autologous bone marrow including high dose chemotherapy.
 - Related allogeneic bone marrow including high dose chemotherapy.
 - Unrelated allogeneic bone marrow including high dose chemotherapy.
- Heart;
- Liver;
- Pancreas and kidney when performed simultaneously or pancreas transplant after a kidney transplant. (Kidney transplant alone may be covered under medical and is not part of this transplant benefit.)

As additional diagnoses cease to be experimental/investigative, the Claims Administrator may amend the covered transplant procedure list to include such procedures.

When a transplant is considered to be experimental/investigative, the transplant and all covered services performed in relation to the transplant are excluded under the plan. If a covered transplant is done in conjunction with an experimental/investigative transplant, the Claims Administrator will determine the portion of the charges which relate to the covered transplant and allow only those charges.

You are strongly encouraged to call Healthcare Management Services (HMS) to discuss benefit coverage when it is determined a transplant may be needed. HMS will assist you in maximizing your benefits by providing coverage information including medical policies, network requirements or exclusions. Failure to obtain this information prior to receiving transplant services could result in increased financial responsibility for you.

- **Benefit Period**

The transplant benefit period starts one day prior to the organ transplant surgery or one day prior to myeloblation therapy (high dose chemotherapy and/or irradiation). Any services performed more than one day prior to the transplant are eligible for coverage under the medical benefit with the exception of services in conjunction with BMT/Stem Cell harvesting.

The transplant benefit period ends on the earlier of the following:

- 364 days from the date of the transplant surgery or first myeloblation therapy; or
- the day before a re-transplant, if within one year. (Upon re-transplant a new transplant benefit period starts.)

- **Transplant Related Expenses**

Transplant related expenses are medically necessary services and supplies that are required as a result of a covered transplant procedure and would not be incurred if the person were not having a covered transplant procedure. Services related to the diagnosis causing the need for a covered transplant procedure which would have been performed whether or not the patient received a covered transplant procedure are not considered a transplant related expenses. Transplant related expenses during a transplant benefit period include only the following:

- Acquisition costs, also referred to as procurement (live or cadaver). Acquisition costs include medically necessary services in connection with the preparation, harvesting and storage of bone marrow, stem cell or solid organ for a covered transplant. For a living donor, acquisition costs also include the medically necessary inpatient services for the recovery of the donor following surgery, and any complications that arise as a direct result of the actual acquisition procedure for a period of six weeks from the date of the acquisition or as otherwise determined by the Claims Administrator. Cord blood is payable if the transplant is approved. Harvesting and storage of cord blood, bone marrow or stem cells for a possible future transplant are not covered under this plan. If any organ or tissue is sold rather than donated to the covered recipient, no benefits will be payable for the purchase price of such organ or tissue; however, other costs related to evaluation and procurement are covered up to the covered recipient's benefit maximum.
- Reasonable and necessary travel expenses as determined by the Claims Administrator when you obtain prior approval and are required to travel more than seventy-five (75) miles from your residence to reach a network transplant facility. Covered expenses include transportation to and from the network provider facility, lodging and meals for the patient and one companion. If the member receiving treatment is a minor, then reasonable and necessary expenses for transportation, lodging and meals may be allowed for two companions. You must submit itemized receipts for transportation, meals, and lodging expenses in a form satisfactory to the Claims Administrator. Contact Member Services for detailed information.
- Hospital charges and professional fees for the covered transplant procedure.
- Inpatient services, outpatient services, or Home Health Care Services for treatment of complications of bone marrow or stem cell transplant, or for the complications and/or rejection of the transplanted organ
- Physician fees for medical care following hospital discharge, which are identified as post-transplant.

The Claims Administrator may, at its sole discretion, cover services and supplies not specifically covered by the plan.

- **Transplant Maximum**

The lifetime maximum per member for all transplant services under this plan or any preceding or successor plan is unlimited for in-network and out-of-network services. Transplants at an out-of-network facility do not count towards the deductible or the out-of-pocket maximum.

- **Out-of-Network Transplant Facility**

If the covered transplant procedure is performed in an out-of-network facility, the plan will pay 70% of the Allowed Fee toward Hospital Services and 80% of the Allowed Fee toward all other related services. These amounts may be eligible for covered transplant procedure expenses during the thirty (30) day period beginning one day prior to the covered transplant procedure for solid organ transplants, and one day prior to myeloblastic therapy for bone marrow/stem cell transplants. After the 30th day, remaining transplant services, other than the covered transplant procedure expenses, may be eligible at 70% of the Allowed Fee for Hospital Services and 80% of the Allowed Fee for all other services for the remainder of the 365 day benefit period.

Enteral Foods

The plan covers Enteral Foods, which is a liquid source of nutrition administered under the direction of a physician which may contain some or all the nutrients necessary to meet minimum daily nutritional requirements and is administered into the gastrointestinal tract either orally or through a tube.

Coverage is provided for Enteral Foods when administered on an outpatient basis, either orally or through a tube, primarily for the therapeutic treatment of phenylketonuria, branched-chain ketonuria, galactosemia, and homocystinuria. The coverage does not include normal food products used in the dietary management of rare hereditary genetic metabolic disorders.

Additional coverage for Enteral Foods is provided when administered on an outpatient basis, when medically necessary and appropriate for your medical condition, when considered to be the sole source of nutrition, and:

- when provided through a feeding tube (nasogastric, gastrostomy, jejunostomy, etc.) and utilized, instead of regular shelf food or regular infant formulas; or;
 - when provided orally, and identified as one (1) of the following types of defined formulae:
 1. with hydrolyzed (pre-digested) protein or amino acids;
 2. with specialized content for special metabolic needs;
 3. with modular components; or
 4. with standardized nutrients.

These additional benefits are also subject to the program deductible, copayments and maximums. Once it is determined that you meet the above criteria, coverage for Enteral Foods will continue as long as the formulae represents at least 50% of your daily caloric requirements.

Additional coverage for enteral formulae *excludes* the following:

- blenderized food, baby food, or regular shelf food when used with an enteral system;
- 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;
- the following formulae when provided orally: semisynthetic intact protein/protein isolates, natural intact protein/protein isolates, and intact protein/protein isolates; and
- normal food products used in the dietary management of rare hereditary genetic metabolic disorders.

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, syringes and insulin infusion devices; and
- Outpatient Diabetes Education 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).

Disease State Management

Through the Disease State Management Program, the plan identifies members at risk for certain health problems and provides specific programs of care. You may receive assistance in self-management of health problems like diabetes, congestive heart failure or chronic obstructive pulmonary disease. Such services may include:

- an evaluation of your physical and psychosocial status;
- development of an individualized treatment plan by a nurse in conjunction with your physician;
- education and training, such as symptom monitoring, medication dosages and compliance, appropriate diet and nutrition, smoking cessation and exercise; and
- ongoing monitoring and treatment modifications.

Mental Health and Substance Abuse

The plan covers the following services for the diagnosis and treatment of a mental health disorder or for detoxification and/or rehabilitation of substance abuse:

- inpatient hospital or other facility provider services;
- inpatient medical services by a professional provider including:
 - individual psychotherapy;
 - group psychotherapy;
 - psychological testing;
 - counseling with family members to assist in your diagnosis and treatment; and
 - electroshock treatment or convulsive drug therapy including anesthesia.
- outpatient services provided by a hospital, other facility provider or professional provider;
- partial hospitalization services.

Food and Lodging for Mayo Clinic

Food and lodging charges for the patient only for every day services are provided at Mayo Clinic in Rochester, Minnesota only. These charges will be limited to a \$100 per day reimbursement maximum. If the patient is a dependent child, the food and lodging of the person accompanying the child will be eligible to be reimbursed as part of the \$100 per day maximum.

Preventive Care

Preventive Care Schedule for Office Visits, Screenings, and Related Tests and Diagnostic Procedures:

- The Preventive Schedule will include the 2016 Highmark preventive schedule for non-grandfathered plans, as well as the PSA test. Prospective changes will be made by mutual agreement of the Benefit Committee. Neither party will unreasonably withhold its agreement on proposals. Barring resolution, no change will be made.

WHAT IS NOT COVERED

Your plan will not provide benefits for services, supplies or charges (except as provided above):

- Which are not medically necessary and appropriate as determined by the Claims Administrator.
- Which are not prescribed by or performed by or upon the direction of a Professional Provider.
- Rendered by other than hospitals, other Facility Providers, Professional Providers or other Professional Providers or suppliers.
- Which are experimental/investigative in nature.
- Rendered prior to your effective date of coverage.
- Incurred after the date of termination of your coverage except as provided herein.
- For any illness or injury suffered as a result of any act of war, declared or undeclared.
- For a condition resulting from direct participation in a riot, civil disobedience, nuclear explosion or nuclear accident.
- For which you would have no legal obligation to pay.
- 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.
- 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 and you elect this coverage as primary.
- 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.
- To the extent benefits are provided to members of the armed forces and the National Health Service or to patients in Veteran's Administration facilities for services-connected illness or injury unless you have a legal obligation to pay.
- 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.

- For prescription drugs which were paid or are payable under a freestanding prescription drug program.
- For self-help training and other forms of non-medical self-care, except as provided herein.
- For nicotine cessation support programs and/or classes.
- For methadone hydrochloride treatment for which no additional functional progress is expected to occur.
- 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 or other Professional Provider enrolled in an education or training program when such services are related to the education or training program.
- For ambulance services, except as provided herein.
- For mileage costs or other travel expenses, except as authorized by the Claims Administrator.
- For operations for cosmetic purposes done to improve the appearance of any portion of the body except for cosmetic surgery to correct a condition resulting from an injury, disease, birth defect, prior covered treatment or surgery.
- For telephone consultations, charges for failure to keep a scheduled visit, or charges for completion of a claim form.
- For inpatient admissions which are primarily for diagnostic studies.
- For inpatient admissions primarily for physical medicine services.
- For custodial care, domiciliary care, residential care, protective and supportive care including educational services, rest cures and convalescent care.
- 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, and which are determined not to be medically necessary and appropriate.
- For respite 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 orthodontic treatment for congenital cleft palates as provided herein.
- For oral surgery procedures except for the treatment of injuries to the jaw, sound and natural teeth, mouth or face, unless specifically provided.
- 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 palliative or cosmetic foot care including flat foot conditions, supportive devices for the foot, 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 treatment provided specifically for the purpose of assisted fertilization, including pharmacological or hormonal treatments used in conjunction with assisted fertilization.
- 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 the replacement of hearing aids that are lost or broken prior to the three (3) year frequency limitation, hearing aid batteries and eyeglass type hearing aids to the extent the charge for such hearing aids exceeds the covered hearing aid expense for one hearing aid.
- For the correction of myopia, hyperopia or presbyopia, including but not limited to corneal microsurgery, such as keratomileusis, keratophakia, radial keratotomy, corneal ring implants and LASIX.
- For nutritional counseling, except as provided herein, or as required by state or federal law.
- For weight reduction programs, including all diagnostic testing related to weight reduction programs, except for surgical treatment of morbid obesity.
- For preventive care services, wellness services or programs, except as provided herein or as mandated by law.
- For well-baby care visits, except as provided herein.
- For allergy testing, except as provided herein or as mandated by law.
- 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 immunizations required for foreign travel or employment, unless mandated or required by law.
- For research studies or screening examination, except as provided herein.
- For marital counseling or personal growth.
- At a health spa or similar facility.
- For court ordered testing or care, unless medically necessary and authorized by the Claims Administrator.
- In excess of Allowed Fee.

- For services and supplies primarily for educational, vocational, or training purposes, except as provided herein;
- For private duty nursing services except when provided through Home Health Care benefit.
- For any care, treatment or service which has been disallowed under the provisions of the Healthcare Management Services program.
- For any other medical or dental service or treatment, except as provided herein or as mandated by law.
- Unauthorized services provided by a licensed practitioner not acting within the scope of his or her license.
- Any type of therapy, service, or supply for or relating to delays in physical or mental development, learning, reading, or language skills.
- Wearing apparel for normal use, such as orthopedic shoes, arch supports, and foot inserts.
- Certain supplies, services or personal hygiene and convenience items such as, but not limited to:
 - Alcohol swabs for diabetics, allergy-free pillows, blankets, or mattresses, automobile/van modifications (lifts, hand controls, etc.), bandages, bath chair, bathroom safety equipment, blood pressure cuffs (sphygmometer), car seats, chair/recliner, diapers, enuresis unit (wet bed alert), environmental control equipment (air cleaners, air filters, air conditioners, humidifiers, room heaters, etc.), escalator/stair lifts/home modifications such as door widening, exercise equipment, food liquidizer, health club dues, heating pad, home enema kits, hot water bottles, ice bags/packs, orthopedic mattress, scale, swimming pool/Jacuzzi/hot tub, thermometer, water purification systems, and wigs (except for the first wig following cancer treatment), wig styling, toupees, whether or not specifically recommended by a Professional Provider.
- Food, food supplements, or special diet requirements.
- Non-prescription drugs, vitamins/minerals/supplements (prescription and non-prescription), and over-the-counter medications.

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;
- Premier Pharmacy network logo;
- 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 Services 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 Highmark 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 Services 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 make a decision 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

Your benefit program maintains an appeal process involving three levels of review with the exception of urgent care claims (which are subject to 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, Highmark in writing of the designation.

For purposes of the appeal process, “you” includes designees, legal representatives and, in the case of a minor, parent(s) 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 your physician or other provider of health care with knowledge of your medical condition to act as your representative.

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.

A representative from the Appeal Review Department will review the initial appeal. The representative will be a person who was not involved in any previous adverse benefit determination regarding the claim that is the subject of your appeal and will not be the subordinate of any individual that was involved in any previous adverse benefit determination regarding the claim that is the subject of your appeal.

In rendering a decision on your appeal, the Appeal Review Department will take into account 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 previous adverse benefit determination regarding the claim that 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/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. The health care professional will be a person who was not involved in any previous adverse benefit determination regarding the claim that is the subject of your appeal and will not be the subordinate of any person involved in a previous adverse benefit determination regarding the claim that is the subject of your appeal.

Your appeal will be promptly investigated and the Claims Administrator, Highmark, will provide you with 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 taking into account 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 benefit determination on your appeal, the notification shall include, among other items, the specific reason or reasons for the adverse benefit determination, the procedure for appealing the decision and, in the case of an adverse benefit determination involving a pre-service claim, a statement regarding your right to pursue legal action in accordance with §502 of the Employee Retirement Income Security Act of 1974 (ERISA).

Your decision to proceed with a second level review of a pre-service claim (other than an urgent care claim, which involves one level of review) is voluntary. In other words, you are not required to pursue the second level review of a pre-service claim before pursuing a claim for benefits in court under §502 of ERISA. Should you elect to pursue the second level of review before filing a claim for benefits in court, your benefit program:

- Will not later assert in a court action under §502 of ERISA that you failed to exhaust administrative remedies (i.e. that you failed to proceed with a second level review) prior to the filing of the lawsuit;
- Agrees that any statute of limitations applicable to the claim for benefits under §502 of ERISA will not commence (i.e. run) during the second level review; and
- Will not impose any additional fee or cost in connection with the second level review.

If you have further questions regarding second level reviews of pre-service claims, you should contact Member Service using the telephone number on your ID card.

Second Level Review

If you are dissatisfied with the decision following the initial review of your appeal (other than an urgent care claim), you may request to have the decision reviewed by the Claims Administrator, Highmark. The request to have the decision reviewed must be submitted in writing (or communicated orally under special circumstances) within forty-five (45) days from the date of an adverse benefit determination.

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.

A representative from the Appeal Review Department will review the second level appeal. The representative will be an individual who was not involved in any previous adverse benefit determination regarding the matter under review and will not be the subordinate of any individual that was involved in any previous adverse benefit determination regarding the matter under review.

In rendering a decision on the second level appeal, the Appeal Review Department will take into account 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 previous adverse benefit determination regarding the matter under review.

In rendering a decision on a second level 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/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. The health care professional will be a person who was not involved in any previous adverse benefit determination regarding the matter under review and will not be the subordinate of any person involved in a previous adverse benefit determination regarding the matter under review.

Your second level appeal will be promptly investigated and the Claims Administrator will provide you with 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) business days 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 benefit determination on your appeal, the notification shall include, among other items, the specific reason or reasons for the adverse benefit determination, the procedure for appealing the decision and, in the case of an adverse benefit determination involving a post-service claim, a statement regarding your right to pursue legal action in accordance with §502 of the Employee Retirement Income Security Act of 1974 (ERISA).

Your decision to proceed with a third level of a claim is voluntary. In other words, you are not required to pursue the third level review of a claim before pursuing a claim for benefits in court under §502 of ERISA. Should you elect to pursue the third level review before filing a claim for benefits in court, your benefit program:

- Will not later assert in a court action under §502 of ERISA that you failed to exhaust administrative remedies (i.e. that you failed to proceed with a third level review) prior to the filing of the lawsuit;
- Agrees that any statute of limitations applicable to the claim for benefits under §502 of ERISA will not commence (i.e. run) during the third level review; and
- Will not impose any additional fee or cost in connection with the third level review.

If you have further questions regarding third level review of claims, you should contact Member Service using the telephone number on your ID card.

Third Level Review

If you are dissatisfied with the decision following the second level review of your appeal, you may request to have the decision reviewed by the Plan Administrator, who will also consult with the Employer, in accordance with procedures established for your benefit program.

BENEFITS AFTER TERMINATION OF COVERAGE

If you or one of your eligible dependents is confined in a hospital, an approved rehabilitative facility or a skilled nursing facility on the date that coverage terminates, benefits will continue to be provided subject to all of the provisions of the Plan until discharge from such hospital or facility.

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.

MEDICARE

Any benefits for services covered under both this plan and Medicare will be paid in accordance with federal law. Except when federal law requires this plan to be the primary payer, the benefits under this plan for Participants and Dependents age 65 and older, or Participants and Dependents otherwise eligible for Medicare, will not duplicate any benefits for which the member is entitled under Medicare, including Part B. Where Medicare is the primary payer, all amounts payable by Medicare for services provided to you or a Dependent shall be reimbursed by or on behalf of the member to the Plan, to the extent this plan has made payment for such services.

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 Deutsch schwetzsch, kannscht du en Dolmetscher griege, un iss die Hilf Koschdefrei. Kantscht 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 المساعدة 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 આપશો: 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).

ប្រការចងចាំ ៖ បើលោកអ្នកនិយាយ ភាសាខ្មែរ ហើយត្រូវការសេវាកម្មជំនួយផ្នែកភាសាដែលអាចផ្តល់ជូនលោកអ្នក ដោយឥតគិតថ្លៃ ។ សូមទូរស័ព្ទទៅលេខដែលមាននៅលើខ្នងកាតសម្គាល់របស់លោកអ្នក (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 yánítí'go, language assistance services, éí t'áá níik'eh, bee níká a'doowoł, éí bee ná'ahóót'i'. ID bee nééhózingo nanitínígíí bine'déé' (TTY: 711) jì' hodíłnih.

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 Advantage *Plus* 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 Advantage *Plus 2.0*, 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 and search the Advantage Plus 2.0 network. 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. Covered expenses incurred in the last three months of a calendar year that are used to satisfy the deductible for that year may be applied to meet the deductible for the next calendar year.

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.

Benefit Provisions	What the Plan Covers *				
Diagnostic Services ➤ Routine Oral Examinations (scaling and cleaning but no more than twice in a twelve (12) month period) ➤ Bitewing X-rays ➤ Emergency Treatment for Pain/Emergency Oral Evaluations	100%				
Preventive Services ➤ Routine cleanings ➤ Topical fluoride application ➤ Space maintainers (not made of precious metals) that replace prematurely lost teeth for dependent children under age 19	100%				
Basic Restorative ➤ Full mouth X-ray (excluded from deductible) ➤ Fillings ➤ Simple extractions ➤ Endodontics, including pulpotomy and root canal treatment ➤ Sealants when provided to children under age 19 ➤ Repair of removable dentures and fixed bridges ➤ Recementing of crowns, inlays, onlays and bridges ➤ Denture adjustments and relining at least 6 months after installation	85%				
Periodontal Services ➤ Diagnosis and treatment planning including periodontal examination ➤ Non-surgical periodontal therapy including periodontal scaling and root planing ➤ Surgical periodontal therapy ➤ Maintenance – post treatment preventive periodontal procedures (periodontal cleanings)	85%				
Oral Surgery ➤ Surgical removal of teeth	85%				
Prosthetics ➤ 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 bridge ➤ Dental Implants up to the extent the plan would pay for an alternative procedure under this Section.	50%				
Crown, Inlay and Onlay Restoration ➤ Single unconnected crowns, inlays and onlays ➤ Replacement of inlays and onlays, but only if satisfactory evidence is presented that at least 5 years have elapsed since the date of insertion of the existing inlay or onlay, and only if the existing inlay or onlay is unserviceable and cannot be made serviceable ➤ Replacement of crowns, but only if satisfactory evidence is presented that at least 5 years have elapsed since the date of insertion of the existing crown.	85%				
Occlusal Mouth Guards	85%				
Orthodontics (Not subject to Annual Maximum) ➤ Diagnosis, including radiographs ➤ Active treatment, including necessary appliances ➤ Retention treatment following active treatment ➤ Lifetime maximum \$2,500 ➤ Limited to dependent children under age 19	60%				
Annual Maximum	<table border="1"> <tr> <td align="center">In-Network \$2,000</td> <td align="center">Out of Network \$1,500</td> </tr> <tr> <td align="center" colspan="2">\$2,000 maximum/calendar year</td> </tr> </table>	In-Network \$2,000	Out of Network \$1,500	\$2,000 maximum/calendar year	
In-Network \$2,000	Out of Network \$1,500				
\$2,000 maximum/calendar year					
Calendar Year Deductible (excludes Diagnostic and Preventive Services, and Orthodontics)	<table border="1"> <tr> <td align="center">In Network None</td> <td align="center">Out of Network \$25/Individual \$50/Family</td> </tr> </table>	In Network None	Out of Network \$25/Individual \$50/Family		
In Network None	Out of Network \$25/Individual \$50/Family				
*Payment is based on a percentage of the Maximum Allowable Charge (MAC) or the amount charged, whichever is less. Refer to the section Payment of Benefits for more information.					

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, taking into account 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 make adjustments 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 more costly 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 oral surgery 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 negotiated with in-network participating providers. A Participating Provider must accept the MAC as payment in full for covered services. You are responsible for any coinsurance, deductibles and amounts exceeding the annual or lifetime maximum, or any service not covered by the plan.

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 provided by a licensed provider.

If the Claims Administrator verifies there were no participating providers within a 50-mile (fifty-mile) radius of your residence, the claim will be paid at the In-Network level so that the member's responsibility is no more than if the provider was a participating provider.

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 under 19 years of age.

Minor Restorations

- Amalgam, silicate, acrylic, synthetic porcelain, and composite filling restorations to restore diseased or accidentally broken teeth.
- Composite restorations on posterior teeth.

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

- Accidental injury to the jaw or structures contiguous to the jaw; the following will be covered under the Dental plan:

Treatment of Fractures - Simple

D7610	Maxilla – open reduction (teeth immobilized, if present)
D7620	Maxilla – closed reduction (teeth immobilized if present)
D7630	Mandible – open reduction (teeth immobilized if present)
D7640	Mandible – closed reduction (teeth immobilized, if present)
D7650	Malar and/or zygomatic arch – open reduction
D7660	Malar and/or zygomatic arch – closed reduction
D7670	Alveolus – closed reduction, may include stabilization of teeth
D7671	Alveolus – open reduction, may include stabilization of teeth
D7680	Facial bones – complicated reduction with fixation and multiple surgical approaches

Treatment of Fractures – Compound

D7710	Maxilla – open reduction
D7720	Maxilla – closed reduction
D7730	Mandible – open reduction
D7740	Mandible – closed reduction
D7750	Malar and/or zygomatic arch – open reduction
D7760	Malar and/or zygomatic arch – closed reduction
D7770	Alveolus – closed reduction, may include stabilization of teeth
D7771	Alveolus – open reduction, may include stabilization of teeth
D7780	Facial bones – complicated reduction with fixation and multiple surgical approaches

- Extraction of impacted third molars when partially or fully covered by bone.
- Extraction of teeth in preparation for radiation therapy.
- Maxillary or mandibular frenectomy.
- 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.
- Treatment for tumors and cysts requiring pathological examination of the jaw, cheeks, lips, tongue roof and floor of mouth; the following will be covered under the Dental plan:

Surgical Excision of Soft Tissue Lesions

D7410	Excision of benign lesion up to 1.25 cm
D7411	Excision of benign lesion greater than 1.25 cm
D7412	Excision of benign lesion, complicated
D7413	Excision of malignant lesion up to 1.25 cm
D7414	Excision of malignant lesion greater than 1.25 cm
D7415	Excision of malignant lesion, complicated
D7465	Destruction of lesion(s) by physical or chemical method, by report

Surgical Excision of Intra-Osseous Lesions

D7440	Excision of malignant tumor – lesion diameter up to 1.25 cm
D7441	Excision of malignant tumor – lesion diameter greater than 1.25 cm
D7450	Removal of benign odontogenic cyst or tumor – lesion diameter up to 1.25 cm
D7451	Removal of benign odontogenic cyst or tumor – lesion diameter greater than 1.25 cm
D7460	Removal of benign non-odontogenic cyst or tumor – lesion diameter up to 1.25 cm
D7461	Removal of benign non-odontogenic cyst or tumor – lesion diameter greater than 1.25 cm

Prosthetics, Crowns, Inlay and Onlay Restorations

Coverage for prosthetics, 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 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 inlay or onlay and that the appliance is not serviceable and cannot be made serviceable.
- Replacement of crowns, but only if satisfactory evidence is presented that at least five years have elapsed since the date of the insertion of the existing crown.
- 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.
- Dental Implants only up to the amount the Plan would have paid for an alternative procedure for the same dental problem.

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 (does not apply to crowns), 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.
- 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.
- Charges for veneers (the coating or covering of plastic or porcelain on the outside of and bonded to a crown or false tooth to cause it to blend with the color of surrounding teeth) or similar properties of crowns and pontics placed on or replacing teeth, other than the 10 upper and lower anterior teeth.
- Charges for a plaque control program (a series of instructions on the care of the teeth).

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 crown – 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, 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.
- 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.
- 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.
- 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 takes into account 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 Standard 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.

BENEFITS		
In-Network Reimbursement Schedule	Under Age 19	Age 19 & Older
Frequency – Once Every:		
Eye Examination	12 Months	12 months
Eyewear:		
<i>Spectacle Lenses</i>	12 Months	24 Months (12 months if prescription changes)
<i>Frame</i>	24 Months	24 Months
<i>Contact Lenses (in lieu of eyeglasses)</i>	12 Months	24 Months (12 months if prescription changes)
Eye Examination		
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 <i>(Polycarbonate lenses are covered in full for dependent children, monocular patients and patients with prescriptions \geq +/- 6.00 diopters)</i>		100%
Oversize Lenses		100%
Frame		
In-Network Retail Allowance		\$75
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%
Out-of-Network Reimbursement Schedule		
Eye Examination, up to		\$50
Contact Lens Evaluation and Fitting:		
<i>Daily Wear, up to</i>		\$20
<i>Extended Wear, up to</i>		\$30
Spectacle Lenses (per lens):		
<i>Single, up to</i>		\$50
<i>Bifocal, up to</i>		\$55
<i>Trifocal, up to</i>		\$60
<i>Lenticular, up to</i>		\$65
Frame, up to		\$75
Contact Lenses:		
<i>Non-Disposables, up to</i>		\$60 ^{2/}
<i>Disposables, up to</i>		\$75
<i>Medically Necessary, up to</i>		\$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/} 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).

Benefits include a low vision benefit, a discount contact lens mail order replacement program, and discounts on laser vision correction surgery from select providers.

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
- 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 Keratoconus 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
- 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.

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.
- 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 the toll-free number (on back of card). 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 scheduled fee 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.

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 twenty-four (24) months (every 12 months if prescription changes or for dependents up to age 19).
- Payment is limited to one set of frames in any twenty-four (24) month period.
- Payment for lenses or contact lenses is limited to once every twenty-four (24) months (every 12 months if prescription changes or for dependents up to age 19).
- Payment will not be made for both contact lenses and eyeglasses within the same twenty-four (24) month period (12 months if prescription changes or for dependents up to age 19).

EXCLUSIONS

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

- For services or supplies not recommended by a covered 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 covered 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.
- LASIK or similar eye surgery to improve vision.
- Drugs, services, or supplies for which the insured person is entitled to benefits under any other Section of this Plan or as provided under a Company safety glass program.
- Extra charges for photosensitive or anti-reflective lenses.
- Charges for services or supplies which are experimental in nature.
- Services or supplies for which no charge would be made in the absence of vision care benefits coverage.
- 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 the toll-free number (on back of card). 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 determinations 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 making a decision 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

The Plan is coordinated with other plans to which you or your covered dependents belong. This is designed to prevent duplication of payments when you or a dependent can collect benefits from another plan. The coordination of benefits (COB) provision operates on a primary/ secondary basis. The plan that pays first is considered the primary plan. The plan that pays second is the secondary plan. The following types of plan benefits will be coordinated with benefits from the Plan:

- governmental benefit programs provided or required by law (other than Medicaid, and other than any plan which, by law, has benefits in excess of those of any private insurance program); and
- other group health care plans to which you or your covered dependents belong.

The coordination of benefits provision does not apply to individual insurance plans. The procedure used to determine which plan is primary or secondary is as follows:

- (a) Primary coverage for the employee is under the Plan; primary coverage for a working or retired spouse is under his or her employer's plan. Should an employee have two primary plans, the plan which has covered the employee the longest is considered primary.
- (b) When dependent children are eligible for coverage under both parents' plans who are not divorced from each other, the plan of the parent whose birthday occurs first in the year will be the primary plan, except if the other plan has a rule based upon the gender of the parent and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan shall determine the order of benefits. If both parents have the same birthday, the plan which covered the parent longer will be the primary plan.

If both parents are covered under any group insurance plan toward the cost of which the Company contributes, the parents may elect to cover their dependent children under either parent's plan, but not both.

- (c) Where both plans cover the patient as a dependent child of divorced parents, benefit determination will be as follows:
 - (1) If there is a court decree which establishes financial responsibility for the medical, dental, vision or other health care expenses of such child, the plan which covers the child as a dependent of the parent with such financial responsibility will be primary and the benefits there under will be determined before the benefits of any other plan which covers the child as a dependent; or
 - (2) If there is no court decree and the parent with custody of the child has not remarried, the plan which covers the child as a dependent of the parent with custody will be primary and the benefits there under will be determined before the benefits of a plan which covers the child as a dependent of the parent without custody; or

(3) If there is no court decree and the parent with custody of the child has remarried, the plan which covers the child as a dependent of the parent with custody will be primary and the benefits there under will be determined before the benefits of a plan which covers the child as a dependent of the stepparent, but the benefits of a plan which covers the child as a dependent of the stepparent will be determined before the benefits of a plan which covers that child as a dependent of the parent without custody.

(d) Where the determination cannot be made in accordance with (a), (b), or (c) above, the plan that has covered the patient for the longer period of time is the primary plan.

Benefits are not coordinated between married Company employees or retirees.

If it is determined that benefits under the Plan should have been reduced because the benefits provided are available under another group plan, the claims administrator will have the right to recover any payment already made which is in excess of its liability. Similarly, whenever benefits which are payable under the Plan have been provided under another group plan, the claims administrator or carrier may make reimbursement direct to the insurance company or other organization providing benefits under the other plan.

For the purpose of this provision, the claims administrator or carrier may, without the consent of or notice to any person, release to or obtain from any insurance company or other organization or person any information which may be necessary regarding coverage.

Any person claiming benefits under the Plan must furnish the claims administrator or carrier such information as may be necessary or the purpose of administering this provision.

SUBROGATION

Individuals receiving benefits under the Plan are required to subrogate their rights to payment or any reimbursements received as a result of an action against a third party.

Any individual receiving benefits under the Plan agrees that his or her rights to any recovery or payment personally or for the account of such individual (including any covered dependent) arising out of any legal action or settlement (other than claims against the employee's or dependent's personal coverage for which he/she pays premiums) thereof (including any settlement prior to the institution of legal action) are subrogated to the rights of the Plan as provided hereunder. By filing a claim, he/she acknowledges and agrees (for themselves and any covered dependents) that the right to subrogation of the Plan is the right to be fully reimbursed for all payments paid by or on behalf of the Plan, from the first dollar paid after legal fees are deducted, by any source or sources of any recovery (whether deemed for personal injury or reimbursement of medical payments for any other reason) up to and including the full extent of payments made or benefits provided by or on behalf of the Plan, irrespective of whether any covered dependent has recovered for all or any part of his or her claim for personal injury or other damages and expenses arising therefrom or related thereto. He/she has the responsibility of (i) notifying the Plan promptly upon making claim against any party for any personal injuries, damages or expenses related in any way to the subrogation rights provided hereunder or receiving any settlement, court decision or payment related to such claim and (ii) cooperating with the Plan (including (a) promptly providing any information reasonably requested related to any such claim and (b) assisting the Plan in perfecting its subrogation rights).

**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

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

Thomas Conway, Chairman

International Vice President – Administration
United Steelworkers
60 Boulevard of the Allies
Pittsburgh, PA 15222

Pete Trinidad, Trustee

President
USW Local Union 6787
1100 N. Max Mochal Highway
Chesterton, IN 46304

Ann Flener-Gittlen, Trustee

Women of Steel
United Steelworkers
60 Boulevard of the Allies
Pittsburgh, PA 15222

Lewis Dopson, Trustee

Staff Representative
USW District 10
625 N. Charlotte Street
Unit 2 North
Pottstown, PA 19464

Arthur Kroll, Trustee

Assistant Director
USW District 2
20600 Eureka Road
Suite 300
Taylor, MI 48180