



National Automatic Sprinkler Industry  
Welfare Fund

2017

Plan Document  
and  
Summary Plan Description

**For Additional Information and Assistance Contact the Fund Office**

National Automatic Sprinkler Industry Welfare Fund  
8000 Corporate Drive  
Landover, MD 20785

Telephone Assistance: 301-577-1700

Toll Free Numbers for:

*Benefits Verification or Assistance:* 800-638-2603

*To Certify Hospital Admissions:* 866-343-3709

*Medical PPO Provider Finder:* 800-810-BLUE

*Delta Dental Provider Finder:* 800-932-0783

Mail Order Prescription Inquiries or Assistance: 866-544-6775

Vision Service Plan Service: 800-877-7195

Website [www.nasifund.org](http://www.nasifund.org)

This booklet is both the Summary Plan Description and the Plan Document for the NASI Welfare Fund plan of benefits. Interpretations regarding eligibility for benefits, claims, status of employees and employers, or any other matter relating to the Welfare Fund should only be obtained through the full Board of Trustees or the Fund Administrator. The Trustees are not obligated by, responsible for, or bound by opinions, information or representations from other sources.

**The Board of Trustees has full discretionary authority to interpret the Plan and decide all issues pertaining to the Plan. Additionally, the Board of Trustees may, in its sole discretion, amend or terminate the Plan and any of its provisions, including classes of coverage, eligibility and requirements for coverage, availability, nature and extent of benefits and conditions and methods of payment.**

Dear Member:

We are pleased to provide you with this updated booklet that provides details about your plan of benefits. You've received this booklet based on your work in employment covered by the Plan. However, you must satisfy the eligibility requirements shown on the following pages in order to qualify for benefits. Since the purpose of the Welfare Fund is to benefit you and your family, we urge you to read this booklet carefully so that you will understand the complete plan of benefits, as well as the eligibility rules and the procedures for filing claims. You can also find the text of this booklet on the internet at [www.nasifund.org](http://www.nasifund.org).

The Trustees strive to provide the most appropriate benefits that will contribute to the security, health and well-being of the Union membership. Changing economic conditions require a constant assessment of the benefit plan to maintain its financial stability.

Please remember that you have the right to submit to the Trustees for their consideration any questions or concerns in connection with the operation or administration of the Plan.

Sincerely,

BOARD OF TRUSTEES

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# I. Eligibility

## Plan Eligibility

The NASI Welfare Plan offers optional Benefit Levels for all active eligible employees. The Fund establishes the contribution rate required for each of the Benefit Levels. If you are an active eligible employee, the Benefit Level that applies to you depends on the contribution rate negotiated under the Collective Bargaining Agreement (see Definitions, page 92) of your Home Local Union and your classification, for example, as a journeyman, apprentice, residential fitter, trainee, or office staff. For an additional hourly contribution rate, employers electing Level 2 or Level 3 medical benefits may negotiate to add (individually or in any combination) Life and Accidental Death and Dismemberment, Weekly Disability Benefits, Dental Benefits, or Vision Benefits. The Local Union will submit a form to the Fund Office to indicate the additional benefits that have been negotiated in conjunction with Level 2 or 3.

If the contribution rate for your Home Local Union or classification is less than the rate for a particular Benefit Level, the Benefit Level for your Home Local Union or classification will be changed to the Benefit Level with a lower contribution requirement that is less than or equal to the contribution rate for your Home Local Union or classification. The Plan will then provide the following benefits (in order) until any excess of your contribution rate over the rate established for the Benefit Level is used: Dental Benefits, Weekly Disability Benefits, Vision Benefits, Life and Accidental Death and Dismemberment Benefits. If there is no Benefit Level with a contribution requirement less than or equal to the contribution rate for your Home Local Union or classification, you will not be eligible for benefits under this Plan.

It is your Local Union's responsibility to notify the Fund Office if you move out of a classification to which a different Benefit Level applies. If the Benefit Level that applies to you changes because you change classifications or Home Local Union, your benefits will be paid under the Level that applies to your new classification or Home Local Union as of the first day of the month after you have worked 80 or more hours in a month for which contributions at the rate applicable to the new Benefit Level are received by the Fund.

If you travel outside of your Home Local Union, your Benefit Level will be the Level that applies to you under the contribution rate of your Home Local Union and/or your classification. Retirees are covered at the Benefit Level for the journeyman classification for their local union unless a lower level is negotiated specifically for retirees. The retiree self-pay amount will be set by the Board of Trustees.

## Who is Eligible

### Eligibility for Employees

Eligibility is based upon hours worked under the Collective Bargaining Agreements, which

obligate employers to report and pay contributions to this Fund on your behalf and for which contributions have been received.

Eligibility can also be based upon contributions received for hours worked under participation agreements which obligate employers to report and pay contributions to this Fund on your behalf.

Individual contributions to gain or maintain eligibility are not allowed. In certain circumstances, however, you may make monthly payments for coverage provided under the Self-Pay Plan. Under the circumstances described in "Continuation Coverage," individuals may pay COBRA premiums to purchase continued health coverage.

Hours are not credited, and therefore eligibility is not granted unless the contributions are actually received. In addition, hours will be credited if you are on a leave of absence under the provisions of the Family and Medical Leave Act of 1993.

The Family and Medical Leave Act ("FMLA") of 1993 entitles employees eligible under the Act to take up to 12 weeks of unpaid job-protected leave each year for the employee's own illness, or to care for a seriously ill child, Spouse or parent; the birth or placement of a child with the employee in the case of adoption or foster care or a "qualifying exigency" as defined in applicable regulations arising out of the fact that a covered family member is on active duty or called to active duty status in the National Guard or Reserves in support of a federal contingency operation. In addition, the FMLA provides that an eligible Employee who is a qualifying family member or next of kin of a covered military service member is able to take up to 26 work weeks of leave in a single 12-month period to care for the covered service member with a serious illness or injury incurred in the line of duty.

Employees eligible for leave under the FMLA are those who have been employed at least 12 months by the employer and who have provided at least 1,250 hours of service to the employer. An employee at a work site at which there are fewer than 50 employees is not eligible for FMLA leave unless the total number of employees of that employer within a 75-mile radius of that employee equals or is greater than 50. Contact the Fund Office if you are planning to take FMLA leave so that the Fund is aware of your employer's responsibility to report the period of your absence. In addition, if you have any questions about the FMLA, you should contact your employer or the nearest office of the Wage and Hour Division, listed in most telephone directories under U. S. Government, Department of Labor, Employment Standards Administration.

This Fund also has reciprocal agreements with certain other U.A. welfare funds. When contributions are received by this Fund from a reciprocal fund, the actual hours worked will be credited for eligibility purposes under this Fund. In the event a reciprocal fund makes contributions at a rate that is greater than the corresponding NASI Welfare Fund contribution rate, additional prorated hours will be credited. Contributions made to this Fund which are forwarded to a reciprocal fund will not be counted for eligibility purposes in any way.

Eligibility is based on payroll reports, with monthly cutoff dates determined by each employer. Contribution reports with hours worked are not due and processed until late in

the following month. The Fund Office, therefore, cannot certify in advance when benefits will start or end. Notices are sent as soon as eligibility can be determined.

All employees should keep track of the hours they work each month. The Fund Office can advise you of your eligibility status if you have a record of your hours worked. However, the final determination of eligibility will be based upon contributions actually received by the Fund Office.

### Initial Eligibility for Employees Covered by a Collective Bargaining Agreement

You become eligible for benefits on the first of the month after you are credited with a total of 600 hours of work under a Collective Bargaining Agreement or a participation agreement, within a period of no more than six (6) consecutive months.

However, if you become Totally Disabled (see Definitions, page 95) before you establish your initial eligibility for benefits, a period of up to one year during which you are Totally Disabled will not be counted in determining the six-consecutive-month period for gaining initial eligibility. In other words, the months before and after your period of Total Disability will be treated as if they are consecutive.

In addition, for purposes of satisfying the Initial Eligibility hours requirement only, you will be credited with your hours worked for up to three (3) months under a Collective Bargaining Agreement or participation agreement for which your employer is required to contribute but has not done so. You must provide documentation acceptable to the Trustees of your actual hours worked. In order to become eligible under this special rule, you must be working for a non-delinquent employer on the date of your eligibility.

If you or one of your eligible dependents is confined in a Hospital (see Definitions, page 93) or Disabled on the day you become eligible, benefits are payable from the date you become covered for all services rendered from that date.

If you work in employment covered by this Plan and, before you become eligible for benefits, become employed in work covered by the National Automatic Sprinkler Metal Trades Welfare Plan, the contributions for hours you worked in employment covered by this Plan may be transferred to the National Automatic Sprinkler Metal Trades Welfare Fund and the hours credited toward your initial eligibility in that Plan. Similarly, if you work in employment covered by the National Automatic Sprinkler Metal Trades Welfare Plan and, before you become eligible for benefits, become employed in work covered by this Plan, the contributions for hours you worked in employment covered by the National Automatic Sprinkler Metal Trades Welfare Plan may be transferred to this Fund and the hours credited toward your initial eligibility in this Plan. The contributions and hours will not be transferred automatically; you must request the transfer in writing. The transfer may be requested by letter or e-mail.

If you are eligible for benefits under the National Automatic Sprinkler Metal Trades Welfare Plan, and your employer becomes obligated to contribute to (or you otherwise transfer to work requiring contributions to) the National Automatic Sprinkler Industry (“NASI”)



Welfare Plan, your eligibility under the NASI Welfare Plan is established the first day of the first month after two consecutive months in which you are credited with a total of 80 or more hours of work. If you were, but are no longer, eligible for benefits under the National Automatic Sprinkler Metal Trades Welfare Plan, and you lost eligibility within the last 12 months, you can establish eligibility under the NASI Welfare Fund on the first of the month after two consecutive months in which you are credited with a total of 80 or more hours of work, provided that you have remained available for work covered by the Plan as verified by your Local Union.

## Reinstatement

During the first 12 months after losing eligibility, you will be eligible again on the first of the month after two consecutive months in which you are credited with a total of 80 or more hours of work, provided that you have remained available for work covered by the Plan as verified by your Local Union. After 12 months of ineligibility, you must again qualify under the Initial Eligibility rule.

For purposes of reinstatement only, in calculating the 12-month period, the Fund will consider hours you worked for which contributions were required but not paid to the Fund. Your reinstatement must still be based on hours you have worked for which contributions have been received.

## Termination of Eligibility

### Termination of Eligibility for Active Employees

Eligibility for benefits will terminate on:

the last day of the fourth month following the last two consecutive months in which you are credited with 80 or more hours of work with at least one hour in the second of those two months ("Continuing Eligibility period"), or if earlier,

the date that you cease to be available for work covered by the Plan as verified by your Local Union.

This termination date is extended if you are Disabled. These extensions are described below in the sections entitled "Disability Extension" and "Total Disability Extension".

### Eligibility During and After Periods of Uniformed Service

**When You Leave:** If you enter the Uniformed Services as defined in the Uniformed Services Employment and Reemployment Rights Act (USERRA) for active military duty or training, inactive duty or training, full-time National Guard or Public Health Service duty, or fitness-for-duty examination, and you otherwise meet the requirements of USERRA (see below), coverage for you and your eligible dependents will terminate under the termination of eligibility rule for active employees, as stated above as if you remained available for

employment. For example, if you are eligible for benefits and leave Covered Employment for active military duty, your family eligibility will terminate on the last day of the fourth month following the last two consecutive months in which you are credited with 80 or more hours of work with at least one hour in the second of those two months. You may then self-pay for continuation coverage for the lesser of 24 months or the remaining period of qualified uniformed service under the procedures set forth below for COBRA Continuation Coverage. You must make that election within 60 days of the date your coverage would otherwise terminate.

**When You Return:** If you are discharged other than dishonorably from Uniformed Service, and you otherwise meet the requirements of USERRA (see below), Plan coverage for you and your eligible dependents will be reinstated on the day you return to work in Covered Employment. You and your eligible dependents will be eligible for a period immediately following your return to Covered Employment that is the same as your period of eligibility after the date that you left Covered Employment to enter the Uniformed Services described above. At the end of that period of eligibility, if you have not yet worked sufficient hours in Covered Employment to again meet the requirements for Continuing Eligibility, you may then self-pay for continuation coverage under the procedures set forth below for COBRA Continuation Coverage. You must make that election within 60 days of the date your coverage would otherwise terminate. You may continue to self-pay at the COBRA rate until you again meet the requirements for Continuing Eligibility or until the maximum period of COBRA Continuation Coverage is reached, whichever first occurs.

Requirements of USERRA: The requirements of USERRA that you must meet to be covered by this section include:

- You (or an appropriate military officer) must give advance written or oral notice to the employer that you are entering uniformed service (unless such advance notice is impossible, unreasonable or precluded by military necessity);
- You must not be dishonorably discharged upon the conclusion of the uniformed service;
- The cumulative length of all of your absences with the employer due to uniformed service must generally be no longer than five years.
- Upon leaving the uniformed service, you must report back to your pre-service employer for reemployment and/or report to your local union for a referral to Covered Employment within the following specified periods of time:
  - Uniformed service of less than 31 days, or for any length for a fitness for duty examination – you must generally report for work on the first regularly-scheduled workday at least 8 hours after you arrive home from service.
  - Uniformed service of more than 30 days, but less than 181 days – you must generally report for work within 14 days after completion of service.

- Uniformed service of more than 180 days – you must report for work within 90 days after completion of the service.

## If You Are Disabled

When an employee eligible for benefits becomes Disabled, benefits are extended while the Disability (see Definitions, page 93) continues as outlined below. Please note those situations where eligibility is automatic and those where notice must be filed with the Fund.

### Disability Extension

An employee who becomes Disabled while eligible for benefits may extend eligibility for up to four additional months while the Disability continues. Regular benefits will continue for you and your eligible dependents. In no event can your eligibility be longer than eight months from the last two consecutive months in which you worked 80 or more hours with at least one hour in the second of these two months.

The extension is not available to employees who cease to be available for work covered by the Plan as verified by their Local Union.

If you qualify for and are receiving Weekly Disability Income Benefits, the extension is automatic while you are receiving benefits. Otherwise, you must provide satisfactory evidence of your Disability to the Fund Office.

Disability is defined as the inability to perform work in the Sprinkler Industry. In addition, you must not receive any substantial compensation related to any employment, and you must be under the regular care of a Physician who certifies the Disability. Evidence of on-the-job workers' compensation as well as off-the-job Disabilities or illness may be used to qualify for Disability coverage. It is not the responsibility of your Physician, employer, workers' compensation insurance company, Business Manager or Business Agent to submit evidence of your Disability to the Fund Office, although they may assist you. During this period, the Fund has the right to request evidence of continuing Disability and may require you to have a physical examination by a Physician chosen and paid for by the Fund. Benefits are terminated when you become eligible for Medicare (where permitted by the Medicare Secondary Payer rules) or when you recover from the Disability.

### Total Disability Extension

If you qualify for a Social Security Disability Award **and file the award with the Fund Office before the effective date of your eligibility for Medicare**, benefits may be restored or continued depending on the date of Disability shown on your Award. The Fund may request evidence of your continuing eligibility for a Social Security Disability Award.

If the effective date of Disability shown on the Award is during the period you were eligible for benefits (including the Disability extension), benefits are restored retroactively to that date. If the date is during or after the period you were on the 12-month additional coverage for Disabled employees, the Total Disability Extension of benefits will not apply.

Benefits include dependent coverage and all active employee benefits (except dependent life insurance, Accidental Death and Dismemberment, or Weekly Disability Income Benefits). Retiree Death Benefits paid by the NASI Pension Fund are deducted from the \$15,000 life insurance coverage to which you are entitled under this Plan. Life insurance coverage terminates whenever you recover or when you reach age 61.

If benefits are terminated and then restored retroactively, and if during the period of termination you obtained individual insurance protection for yourself or dependents eligible for retroactive benefits, this Plan will reimburse you for amounts actually paid for individual insurance premiums and any difference in deductibles between this Plan and your other insurance. This Plan will not reimburse you for premiums paid for other group insurance coverage. Non-bargaining unit employees and office employees are not eligible for the Disability extension unless initially eligible for health benefits under a Collective Bargaining Agreement.

### Coverage for Disabled Employees or Dependents

You can retain Comprehensive Medical and Substance Abuse coverage for up to 12 additional months if you (or your dependent) are Disabled when termination of eligibility would normally occur. Other family members will also retain Comprehensive Medical and Substance Abuse coverage for up to 12 additional months if you (the Disabled employee) are Disabled when termination of eligibility would normally occur.

During this period, the Fund has the right to request evidence of continuing Disability and may require you to have a physical examination by a Physician chosen and paid for by the Fund. Benefits are terminated at the end of the 12 months or, if earlier, upon recovery from the Disability.

If the employee entitled to coverage under this provision of the Plan recovers from the Disability and returns to employment covered by the Fund, the employee and his or her dependents will be eligible for benefits as of the date of the employee's return to work and for the following calendar month. In order for eligibility to continue beyond this period, the employee must satisfy the requirements for Reinstatement on page 4. The employee must promptly notify the Fund in writing of his or her return to work.

Coverage under this section will be extended for up to 13 additional months, rather than 12 additional months, if you (the employee) are Disabled due to a work-related illness or injury when termination of eligibility would normally occur. All other provisions of this section remain the same.

### Termination of Disability Coverage

Benefits will continue until the date you recover or qualify for Medicare coverage, but not longer than 29 months from the last two consecutive months in which you worked 80 or more hours with at least one hour in the second of those two months. Life insurance continues as explained above.

## Dependent Eligibility

Your eligible dependents include:

1. Your Spouse;
2. Your biological or legally-adopted child, a child legally placed with you for adoption, your stepchild or legally-placed foster child from Enrollment until the end of the month in which the child attains age 26;
3. Your unmarried “other” child. An unmarried “other” child includes a grandchild or any other child who lives with you in a parent-child relationship, who depends on you for more than one-half of his or her financial support, and for whom you have a legal obligation to provide health care. Your “other” child is covered from Enrollment until the end of the calendar month in which the child reaches 19 years of age.

In the event both your grandchild and your child who is a parent of your grandchild live with you, both must depend on you for at least 50% of their financial support for the grandchild to be considered an eligible dependent. As noted above, your child (the parent of your grandchild) may be an eligible dependent without regard to whether you provide financial support to your child.

Your unmarried “other” child who is over age 18, can be considered an eligible dependent if at least one of the following applies:

- your unmarried “other” child is a full-time student in an accredited school or college, in which case dependent status will continue until the end of the calendar month in which the child reaches 23 years of age provided that he or she either (a) lives with you for more than one-half of the year and does not provide more than one-half of his or her own support or (b) depends on you for more than one-half of his or her financial support;
- Your unmarried “other” child who otherwise satisfies the eligibility criteria of a full-time student as stated above immediately before taking a “medically necessary leave of absence” from a postsecondary educational institution. Eligible dependent status under this section will continue until the earlier of (a) one year after the first day of the medically necessary leave of absence or (b) the date coverage would otherwise terminate under the terms of the Plan. Coverage will only apply under this section if the Plan has received written certification by a treating physician of the “other” child stating that the “other” child is suffering from a serious illness or injury and that the leave of absence or change in enrollment status is medically necessary. A “medically necessary leave of absence” means a leave of absence or any other change in enrollment of

the child at such institution, such as a change to part-time student status, that begins while the child is suffering from a serious illness or injury that is medically necessary as certified by the treating physician, and that causes such child to lose student status for purposes of continued eligibility under the Plan; or

- Your unmarried “other” child who is a part-time student in an accredited school or college until the end of the calendar month in which the child reaches 23 years of age, provided that the child is unable to attend school or college on a full-time basis because of a disabling condition that began while the child was covered by this Plan and provided that the child depends on you for more than one-half of his or her financial support. Satisfactory documentation of disability must be supplied to the Fund office.

For purposes of determining dependent eligibility, the terms “full-time and part-time student” are defined by the standard established by the student’s school or college.

4. Your biological or legally-adopted child, a child legally placed with you for adoption, your stepchild or legally-placed foster child, or your “other” child, who is unmarried, dependent upon you for financial support, and incapable of self-support because of a physical or mental Disability that occurred while an eligible dependent prior to age 26 (prior to age 19 in the case of an “other” child). The eligibility for the child will continue as long as the child continues to be incapable of earning a living due to the physical or mental disability, and the child either (a) is permanently and totally disabled, lives with you for more than one-half of the year and does not provide more than one-half of his/her own support or (b) depends on you for more than one-half of his/her financial support. Proof of incapacity must be submitted to the Fund Office prior to age 26 (prior to age 19 in the case of an “other” child) and may be required periodically thereafter.
5. Your child covered by Qualified Medical Child Support Orders (QMCSO), see page 25. However, if your child who is the subject of the QMCSO is not your “dependent” as defined in Internal Revenue Code Sections 105(b) or 152, you may be subject to income tax on the fair market value of the coverage provided to that child by the Plan under the terms of the QMCSO.

You must enroll your eligible dependents for coverage to become effective. See Enrollment, page 20.

If your dependent’s eligibility under the Plan as a dependent child terminated before 2011 because of age, and your dependent incurred a claim or claims before enrolling under the terms of the Plan effective on or after January 1, 2011, as amended to comply with the “Adult Child” coverage requirements of the Patient Protection and Affordable Care Act, the

enrollment of your dependent child may be retroactively effective up to 60 days prior to the completion of the enrollment process.

## In the Event You Die While Eligible for Benefits

In the event you die while eligible for benefits under the rules stated above, benefits for your dependents will be continued for 12 months from the last two consecutive months in which you worked 80 or more hours with at least one hour in the second of those two months.

Your Spouse and dependents may be eligible for further benefits as explained under the Retiree Eligibility (see page 13) and Continuation Coverage rules (see page 21).

## Termination of Dependent Coverage

Benefits for dependents end on the earliest of the following:

1. the date employee coverage terminates;
2. for your Spouse and any stepchildren, the date you and your Spouse are divorced;
3. the date that your “other” child marries. An “other” child who marries cannot regain dependent coverage;
4. the date your “other” child becomes eligible for employee benefits under this Plan;
5. the date that is 12 months after the expiration of a deceased employee's Continuing Eligibility Period (see "In the Event You Die While Eligible for Benefits" above);
6. on the last day of the month in which the dependent is no longer an eligible dependent for any other reason; or
7. on the last day of the month in which your Spouse submits a written request to terminate your Spouse's coverage. A Spouse who terminates coverage in this way may reenroll in accordance with the Enrollment provisions of this booklet (see page 20) and can obtain coverage under the plan for claims incurred after the date of the reenrollment.
8. on the last day of the month in which you submit a written request to terminate your dependent child's coverage. A dependent child who terminates coverage in this way may reenroll in accordance with the Enrollment provisions of this booklet (see page 20) and can obtain coverage under the plan for claims incurred after the date of the reenrollment.

## Notification Requirement upon Divorce

In addition to the notice requirements under COBRA, you have an obligation to promptly notify the Fund Office in writing following a divorce. Unless COBRA is elected, the divorced Spouse and children of the divorced Spouse (stepchildren of the participant) become ineligible for benefits upon the divorce. **If notice of the divorce is not provided to the Fund Office, and as a result, benefits are paid to an ineligible dependent, the Trustees may decide to recover those benefits by treating such benefits as an advance to you, and deducting such amounts from benefits which become due to you until the entire amount of benefits erroneously paid is recovered.** Also, if notice of divorce is not provided to the Fund office within 60 days, your Spouse and children of your divorced Spouse will lose their right to elect COBRA Continuation Coverage.

## Retiree Eligibility

### Eligibility at Retirement

To be eligible or to maintain eligibility for retiree benefits, you must apply for benefits and meet all of the following requirements:

1. You must receive a monthly pension from the NASI Pension Fund and agree to authorize a deduction from your monthly pension check. The amount of the deduction is subject to periodic adjustment by the Trustees. You are not, however, required to make the retiree self-payment during a Disability extension of coverage as described earlier.
2. You must have been eligible for benefits from this Welfare Fund for at least ten years and also eligible during at least seven out of the last ten years prior to the start of your pension.
3. During the three years made up of the year you retire and the two calendar years before you retire, you must have a total of 500 hours of work reported to the Fund (not 500 hours each year, but a total of 500 hours). If you retire on January 1st, you must have at least 500 hours during the three-calendar-year period before the effective date of your pension.

Solely for the purpose of satisfying Item 2 above, the Fund will count as periods of eligibility for benefits those periods of work for an Employer who has failed to pay contributions due to the Fund provided that (a) you document to the satisfaction of the Fund that you worked for the delinquent Employer for the period for which you want your employment credited for this purpose, (b) a judgment was obtained against the Employer requiring the Employer to pay contributions for the period for which you want your employment credited for this purpose and (c) periods of employment will not be credited after the date on which your Union requests you to cease working for the Employer.

Solely for the purpose of satisfying the requirement in Item 2 for eligibility in seven out of



the last ten years prior to the start of your pension and in Item 3 above for 500 hours in the three-calendar year period prior to the effective date of your pension, the Fund will ignore periods of time that you are receiving workers' compensation benefits from an Employer if you return to employment covered by this Fund before you retire. Periods of work before and after the time period you were receiving workers' compensation will be counted for the purpose of satisfying these requirements.

If you retire on or after January 1, 1998, with at least 20 pension credits in the NASI Pension Plan, and you become Disabled from sprinkler work before you retire, you can qualify for pensioner medical coverage by having a total of 500 hours of work reported to the Fund during the 72 months before you retire. In order to qualify under this rule, you must supply evidence of total Disability from sprinkler work to the satisfaction of the Trustees.

If you are a Disability retiree, in lieu of Item 3 above, you must have 500 hours reported during the 36-month period prior to the commencement of your disabling condition.

If you refuse retiree coverage when first eligible or if you terminate existing retiree benefits, you are not allowed to re-enroll at a later date.

The continuation of retiree benefits depends upon the continued participation of your Sprinkler Local Union in this Fund and upon the financial condition of the Fund.

As shown on the Summary of Benefits, retiree coverage consists of Comprehensive Medical and Substance Abuse coverage. Depending on your Plan of benefits, retiree coverage may include Dental, Vision and Hearing Aid benefits. Retiree benefits do not include Life or Accidental Death and Dismemberment Benefits, Weekly Disability Income Benefits or Asbestosis Screening. Benefits provided under employee coverage continue until your eligibility as an active employee terminates. If you are eligible for retiree coverage but are not currently covered by the Plan, benefits will commence as of the effective date of your pension. Once you qualify for retiree benefits, you are subject to retiree coverage rather than benefits as an active employee. However, if you qualify for a Disability pension, life insurance coverage will continue until you reach age 61. Any retiree death benefits paid by the NASI Pension Fund are deducted from the \$15,000 Life Insurance Benefit that may be payable under this Plan.

Retiring members should note that welfare benefits for your Spouse will continue after your death only if your Spouse receives a survivor's pension. This factor may affect your decision to select an optional form of pension payment.

### Disability Retirees Who Return to Employment

If you retire on Disability and later recover from that Disability and return to employment covered by the Plan, your retiree benefits will continue until the last day of the fifth month following the month in which you return to employment. You must make timely monthly self-payments to the Fund by the end of each month for which coverage is purchased. If any payment is not received by the end of each month, your coverage will cease as of the end of the preceding month.

## Retiree Coverage for Dependents

When you retire, your Spouse is covered as a dependent if you have been married for at least six months on the effective date of your pension. Other dependents are also covered under the regular rules of the Plan. No new dependents, other than your newborn and legally adopted children, may be added after your retirement. A Spouse to whom you are married after the first effective date of your pension is not covered, even if you return to Covered Employment.

## Retiree Coverage for Spouses and/or Dependents of Deceased Employees

After you die, your Spouse and any eligible dependents may be eligible for retiree benefits.

1. In general, your Spouse and eligible dependents (if any) may be eligible for retiree benefits if all of the following requirements are met:
  - you were eligible for Welfare Fund benefits for ten or more years, and for at least seven of the last ten years prior to your date of death;
  - you had a total of at least 500 hours of work credited by the Fund during the three-calendar-year period ending with the year of your death; and
  - your surviving Spouse qualifies for survivor benefits from the NASI Pension Fund and agrees to the necessary pension deduction for retiree benefits.
  
2. In the event your surviving Spouse and dependents do not qualify under item 1 above but your surviving Spouse supports your eligible dependent(s) after your death, your surviving Spouse and your eligible dependents may be eligible for retiree benefits if:
  - you were eligible for Welfare Fund benefits or otherwise entitled to coverage for Welfare Fund benefits from the NASI Welfare Fund on the date of your death; and
  - your surviving Spouse qualifies for survivor benefits from the NASI Pension Fund and agrees to the necessary pension deduction for retiree medical benefits.

If your surviving Spouse is only eligible for retiree benefits because he or she meets the requirements of this provision, his or her eligibility will terminate on the earliest of any of the events described in the dependent and Spouse provisions of the "Termination of Retiree Coverage" section of this Plan or the last day of the month in which your dependents no longer satisfy dependent eligibility requirements.

3. In the event you do not have a surviving Spouse who qualifies for survivor benefits from the NASI Pension Fund, your dependent children will not qualify for benefits under either 1 or 2 above. However, your dependent children only will qualify for benefits if:
  - you had vested pension rights with the NASI Pension Fund;
  - your dependent children are in the custody of your surviving Spouse, former Spouse or their grandparent; and
  - your dependents were eligible for Welfare Fund benefits on the date of your death.

Your dependent children will continue to be covered by the Plan under this provision until the earlier of the date your surviving Spouse or former Spouse remarries (if custody of a child is with the Spouse or former Spouse) or the date your dependent child no longer qualifies as an eligible dependent as defined in the Plan.

No new dependents may be enrolled after your retirement except a newborn child of a deceased employee or a child recently placed for adoption with the family of a deceased employee.

### Retiree Coverage for Spouses of Deceased Retirees

A retiree's surviving Spouse and any eligible dependents may continue retiree benefits as long as the Spouse qualifies for survivor benefits from the NASI Pension Fund and agrees to the necessary pension deduction for retiree benefits. No new dependents may be enrolled except a newborn child of the deceased retiree or a child recently placed for adoption with the family of a deceased employee.

### Termination of Retiree Coverage

Your retiree coverage terminates upon your death or, if earlier, when you withdraw authorization for the required pension deduction for retiree benefits. If you withdraw authorization for the required pension deduction for retiree benefits, you will not be eligible again for coverage until you meet the Initial Eligibility rules for employees.

Retiree coverage for your dependents or surviving Spouse terminates on the earliest of:

1. the date pension benefits stop;
2. the last day of the month following withdrawal of the required authorization for pension deductions for retiree benefits;
3. the date the surviving Spouse remarries; or

4. in the case of a dependent, the last day of the month in which the dependent no longer satisfies dependent eligibility requirements.

## Suspension of Retiree Coverage

Your retiree coverage will be suspended if you perform any amount of employment in the sprinkler, plumbing, or pipefitting Industry, either as an employee or self-employed, in union or non-union employment. However, effective August 1, 2006, if you are a retiree eligible for coverage who returns to Covered Employment for which contributions are received, you can reinstate your active employee coverage one time effective the first of the month after two consecutive months in which you are credited with 80 or more hours of work. In order to qualify for this one-time per individual exception, you must provide the Fund written notice of your return to work. Retiree coverage will be extended at the applicable rate for the month you return to work and, if necessary, the subsequent month. In the event you fail to work the minimal number of hours to have coverage reinstated under this one-time rule by the end of the second month after the suspension of your retiree coverage, you will have to requalify for active eligibility under the initial eligibility rule above.

If you are a Disability pensioner and later recover from Disability and return to Covered Employment, you may continue retiree coverage for up to six months by making the appropriate retiree self-payment to the Fund.

When you retire a second time, you will be eligible for retiree benefits if you were eligible for and elected retiree coverage upon the first date of retirement. If you elected retiree health coverage during your first retirement, you may elect retiree coverage at your second retirement, and you will not have to meet the 500-hour requirement in the three-calendar-year period before your second retirement. In addition, when you retire a second time, you cannot elect retiree health coverage if you were not eligible for, or if you refused, retiree health coverage on your first retirement.

## Retired Employee Subsidy Account (RESA)

The Plan permits each Sprinkler Fitter Local Union (the “Sprinkler Local”) to negotiate with Employers in its jurisdiction for a separate contribution to partially subsidize the cost its eligible Retirees must pay for coverage under the Plan. The Plan also permits each Sprinkler Local to contribute Sprinkler Local assets to the Fund to partially subsidize the cost its eligible Retirees must pay for coverage under the Plan. The separate contributions made for this purpose will be assets of the Fund and generally available to Fund creditors. However, the Fund will separately account for such contributions on a Sprinkler Local by Sprinkler Local basis with the intention that such separately accounted for amounts will be used to subsidize the cost of coverage for eligible Retirees who are connected to the Sprinkler Local, as described below. This feature is referred to as a retired employee subsidy account, or “RESA”. If provided, this subsidy is in addition to the subsidy that the Fund generally provides Retirees.

To be eligible to receive a subsidy, you must be represented by or work in the jurisdiction of a Sprinkler Local that has contributed Sprinkler Local assets to establish a RESA and/or has

negotiated with Employers in its jurisdiction for a separate contribution to its RESA. In addition, you must satisfy the eligibility rules and connection tests set forth below.

## Plan Eligibility Requirements

To be eligible to receive a subsidy described in this section, you must satisfy the following requirements:

- You must be eligible for Retiree benefits or benefits as a surviving Spouse from the Fund;
- You must be receiving a pension from the NASI Pension Fund;
- You must satisfy the connection tests (described below) to a Sprinkler Local which has established a RESA; and
- If you are a surviving Spouse, your Spouse must have satisfied the connection tests (described below) to a Sprinkler Local that established the RESA at the time of your Spouse's death.

## Connection Tests

You must have a connection with a particular Sprinkler Local to receive a subsidy from that Local's RESA. There are two steps for making this determination. First, each Retiree will be deemed connected to a particular Sprinkler Local RESA based upon the connection tests set forth below, applied in order (see Step 1). If a Retiree is deemed connected to a Sprinkler Local RESA as a result of the application of a connection test (applied in order), the subsequent connection tests do not apply for so long as the Retiree receives a benefit from that Sprinkler Local RESA. Second, after a Retiree has been connected to a Sprinkler Local RESA, whether that RESA will pay a subsidy for that Retiree depends on whether the Retiree satisfies any eligibility conditions adopted by that Sprinkler Local RESA and approved by the Trustees of the Fund (see Step 2). A Retiree connected to a particular Sprinkler Local RESA may fail to qualify for a subsidy because the Retiree has not satisfied the eligibility conditions of that Sprinkler Local RESA. In that case, the Retiree may be considered connected to another Sprinkler Local RESA.

### **Step 1: Connection to a Sprinkler Local RESA**

(a) Under this rule, a Retiree will first be connected to the Sprinkler Local RESA to which Employer RESA contributions have been made on the Retiree's behalf for 60% of his or her total hours worked in Covered Employment in the 60 months just prior to retirement. All Employer RESA contributions will be considered transferred and credited to the Retiree's Home Sprinkler Local RESA (i.e., the Sprinkler Local of which the Retiree is a member or which represents the Retiree) if the Retiree's Home Sprinkler Local has established a RESA. This rule will be applied as if all of the Employer RESA contributions so "transferred" were made to the Retiree's Home Sprinkler Local RESA.

(b) If a Retiree is not connected to a Sprinkler Local RESA after applying the connection test described in paragraph (a), a Retiree shall be connected to his or her Home Sprinkler Local RESA to the extent and for such period that the RESA is funded with Sprinkler Local assets paid to the Welfare Fund.

(c) A Sprinkler Local may elect, with the Trustees' consent, to have the Fund adopt a rule that applies to that Sprinkler Local's RESA which provides that, if a Retiree is not connected to a Sprinkler Local RESA after applying the connection tests described in paragraphs (a) and (b), the Retiree shall be connected to his or her Home Sprinkler Local RESA that is funded with Employer RESA contributions. If this rule is adopted, the Sprinkler Local may elect, with the Trustees' consent, to have the Fund adopt a requirement that applies to that Sprinkler Local's RESA which provides a Retiree will not be eligible to receive RESA benefits unless RESA contributions have been made to the Home Sprinkler Local RESA on the Retiree's behalf for 60% of his or her total hours worked in Covered Employment in a number of months (elected by the Sprinkler Local with the Trustees' approval) since contributions to the Local Union RESA started, and just prior to retirement.

## **Step 2: Satisfaction of Special Eligibility Conditions**

If a Sprinkler Local so elects with the Trustees' consent, the Fund will impose as a condition for receiving a subsidy an eligibility rule for that Sprinkler Local's RESA that requires: (i) the Retiree to have fully paid all applicable union dues or agency fees lawfully and uniformly levied by the Sprinkler Local; (ii) the Retiree to have paid such union dues or agency fees to the Sprinkler Local for the period of time since the Local established its RESA but not to exceed a specified number of years (up to 10) immediately prior to the Retiree's retirement; and/or (iii) in the 10 years prior to his/her retirement, the Retiree to have worked in that Sprinkler Local's jurisdiction at least a specified percentage (i.e., 30%, 50% or 70%) of the Retiree's total hours in Covered Employment. A Local RESA may grandfather existing retirees and/or widows as of the date the RESA is effective.

You will be notified upon request of any rules or requirements that are adopted by a particular Local Sprinkler RESA, and the rules or requirements adopted for a particular Sprinkler Local RESA will be applied on a uniform basis.

## **Amount of RESA Subsidy**

The Plan permits a Sprinkler Local RESA to subsidize either all, or a percentage (in 5% increments) of the difference between (i) the cost of Retiree coverage paid by the Retiree as of 2003 or any other base year after 2003 (i.e., \$335.00 per month for non-Medicare Retirees, \$195.00 for Retirees who first become eligible for Medicare on or after January 1, 2002 or \$145.00 per month for Retirees who were eligible for Medicare before January 1, 2002), and (ii) such higher amount Retirees are otherwise required to pay for subsequent years.

The amount of subsidy that a Sprinkler Local RESA will provide to its eligible Retirees, if any, will be determined by the Sprinkler Local (provided that the Trustees approve the amount of such subsidy) or by the Sprinkler Local and Employers in negotiations.

Once established, the amount of the subsidy must remain in effect for at least one year (subject to the satisfaction of the funding requirements set forth below). The amount of the subsidy may only be changed prospectively to be effective no sooner than 90 days after approval of the Trustees.

## Funding of the RESA

A RESA may be funded by Sprinkler Local assets contributed by a Sprinkler Local and/or Employer contributions negotiated by a Sprinkler Local and Employers.

Before the subsidy may be paid from a Sprinkler Local RESA, there must be six (6) months of subsidy in the RESA for the Retirees who are eligible for the subsidy from that Sprinkler Local RESA at that time.

If the amount in a Sprinkler Local RESA falls below three (3) months of subsidy for the Retirees who are eligible for the subsidy from that Sprinkler Local RESA at that time, Retirees will be advised that the subsidy will be discontinued and the amount deducted from their pension benefits will be the entire Retiree portion required by the Fund until further notice.

If contributions to a particular Sprinkler Local RESA cease, the RESA will continue paying the Retiree subsidy without regard to the previous paragraph until the RESA is exhausted.

The assets of the RESA are Fund assets. However, they will be separately accounted for with the intention that they will be used for the benefit of the Retirees of the Sprinkler Local who meet the connection and eligibility rules of the Plan. Even if RESA assets came from Sprinkler Local assets, they may not be withdrawn or paid to a Sprinkler Local.

The investment earnings and administrative expenses of each RESA, as determined by the Trustees, will be allocated to each RESA. Additionally, any liability arising from the operation or administration of a particular Sprinkler Local's RESA will be charged to that RESA.

## Reservation of Rights

The right to receive a RESA subsidy is not vested and, along with the RESA provisions set forth above, can be amended or terminated at any time.

## Eligibility for Non-Bargaining Unit Employees

### Officers, Shareholders, and Relatives

If you are an officer, shareholder, or relative of an officer or shareholder of a contributing employer you will receive (or should request) a copy of "Guidelines for Participation in the Sprinkler Industry Trust Funds." This booklet specifies contribution requirements for officers, shareholders and employees of corporations and contribution requirements when

family ownership interests are involved.

Officers, shareholders and relatives of officers and shareholders of a contributing employer who work in Covered Employment will be eligible to participate in the NASI Welfare Fund on the first day of the fifth month following four consecutive months of monthly Plan coverage payments made to the Fund on their behalf. To continue your eligibility, your employer must sign a participation agreement and agree to maintain certain employment records and comply with other requirements as noted in the Guidelines for Participation. The employer must also submit the monthly Plan coverage payment which applies to you regardless of the number of hours that you work. The Trustees may change the amount of the monthly Plan coverage payment from time to time.

### Termination of Eligibility for Officers, Shareholders and Relatives

Eligibility for benefits terminates on the last day of the month in which the eligibility requirements are no longer satisfied. Coverage will terminate on the first day of the month following the last month for which the monthly Plan coverage payment was received, or earlier, in the event of a delinquency in making contributions for employees covered by the Collective Bargaining Agreement.

### Eligibility for Office Employees

Fund Office and local union employees are eligible for benefits under participation agreements. Office employees who initially became eligible under a participation agreement are eligible for benefits on the first day of the month following the 15th day after the employee starts full-time employment with the Fund Office or local union. All office employees' benefits include surviving dependent eligibility and retiree eligibility. Office employees who first became eligible under Collective Bargaining Agreements between a Sprinkler Fitter Local Union and an employer are subject to the general eligibility rules for employees set forth in Part I of this Booklet. You will not be required to reestablish initial eligibility as an office employee but will be permitted to continue your current eligibility for benefits if you:

- initially became eligible for Plan benefits under the terms of a Collective Bargaining Agreement between a Sprinkler Fitter Local Union and an employer, and
- are eligible for Plan benefits either as an employee or as a retiree as of the date you start full-time employment with the Fund Office or a Local Union.

Fund Office and local union employees (and their Spouses) may also be eligible for benefits as retirees. Qualification is the same as stated above; however, when the pension plan provided by the employer is other than the NASI Pension Plan, that employer-sponsored pension plan is substituted for the NASI Pension Plan in determining whether the Fund Office or local union employee qualifies for retiree medical benefits.



## Termination of Eligibility for Office Employees

Benefits for office employees who initially became eligible under a participation agreement continue until the earlier of the following: (1) the last day of the month in which employment ends, (2) when contributions are no longer made on their behalf or (3) when the employee no longer satisfies eligibility requirements.

Office employees who initially become eligible under a Collective Bargaining Agreement between a Sprinkler Fitter Local Union and an employer terminate coverage under the same rules set forth in Part I of this Booklet for employees covered by Collective Bargaining Agreements.

## Enrollment

### How to Enroll

In order for any benefits to be paid, it is necessary for all employees and dependents to be enrolled. You must enroll yourself and your dependents within 60 days of the date you gain eligibility under this plan. You should add new dependents within 60 days of certain life events such as the date of your marriage, the birth of your child, the placement of a child with you for adoption or as a foster child or within 60 days of the date an “other” child becomes your dependent. With your Enrollment Form, you are required to provide documents establishing your dependent’s status such as a proof of marriage or birth certificate. **If you fail to enroll yourself or any dependent child or spouse other than a newborn child within this 60-day period, you will be able to enroll at any later date, but such later enrollment will provide benefits only for covered expenses that are incurred on or after the date of that later enrollment. In the case of a newborn child enrollment may be made retroactive to the date of the child’s birth provided you were continuously eligible from the date of the child’s birth to the completion of the child’s enrollment process.**

Enrollment is done by completing an Enrollment Form and mailing it to the Fund Office along with the supporting documents. Enrollment Forms are provided to newly eligible employees whose address has been provided to the Fund office. Enrollment Forms are also available on the Fund’s website or by calling the Fund Office. Enrollment Forms may also be available from your employer or local union.

### Important

You must report all changes in family status and maintain your current address with the Fund Office. You will be required to reimburse the Welfare Fund for any claim paid in error by the Fund Office because you have failed to update the enrollment status of your dependents. Important events that must be reported include your divorce or marriage and your dependent losing eligibility.

## Continuation of Coverage

If you or your dependents are eligible and make the proper applications and timely premium payments, coverage may be continued under the Plan's COBRA coverage. This section of your plan explains COBRA Coverage, when it may become available to you and your family, and what you need to do to protect your right to get it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA Coverage.

The right to COBRA coverage was created by a federal law. COBRA coverage can become available to you and other members of your family when coverage under this Plan would otherwise end.

You may have other options available to you if you lose coverage under this Plan. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees. You may also qualify for Self-Pay Coverage under this Plan.

## COBRA Continuation Coverage

In certain circumstances in which coverage for benefits from this Plan would otherwise end because of life events called "Qualifying Events", you can pay to continue health coverage for a limited period of time. This extended coverage is called COBRA Continuation Coverage. COBRA Continuation Coverage is available to you and your eligible dependents who are covered by this Plan on the day before the Qualifying Event. One example of such a Qualifying Event would be the termination of employment that caused loss of Plan coverage. Individuals who were covered by the Plan on the day before a "Qualifying Event" and who have the right to elect COBRA Continuation Coverage are called "Qualified Beneficiaries". A child who is born to you or a child under age 18 who is placed for adoption with you while you are receiving COBRA Continuation Coverage will automatically be a "Qualified Beneficiary" for purposes of COBRA.

A "Qualified Beneficiary" who elects COBRA Continuation Coverage is responsible for paying the full cost of this coverage once all coverage under this Plan ends. Once you have elected COBRA Continuation Coverage, you must make your first payment not later than 45 days after the date of your election (this is the date the election notice is post-marked, if mailed). If you do not make your first payment for COBRA Continuation Coverage in full not later than 45 days after the date of your election, you will lose all COBRA Continuation Coverage rights under the Plan. You are responsible for making sure that the amount of your first payment is correct. After you make your first payment for COBRA Continuation Coverage, you will be required to make monthly payments for each subsequent coverage period. Payment is due on the first day of the month for which you are purchasing coverage. You will be given a grace period of 30 days to make each periodic payment, and late payments will not be accepted after the last day of the grace period. You will not be billed.

The COBRA rates are established by the Trustees and can change from time to time. COBRA Coverage does not include the Death Benefit, the Accidental Death and Dismemberment Benefit or the Weekly Disability Income Benefit.

If you elect and pay for COBRA Continuation Coverage when your eligibility terminates because your Employer has not paid the required contributions on your behalf, the Plan will reimburse all or a portion of your COBRA payments if the delinquent Employer contributions are collected, and your eligibility is restored based on the contributions.

## COBRA Rules for Employees

As an employee, you have the right to elect COBRA Continuation Coverage for yourself and/or for your Spouse and/or for your eligible dependent children. Coverage can be continued for up to 18 months from the date you would lose coverage under the Plan because you leave Covered Employment (for reasons other than gross misconduct) or because you do not have sufficient hours of Covered Employment for which contributions are received by the Fund to continue eligibility.

Under certain circumstances, a disabled person and his or her family may extend COBRA Continuation Coverage for up to a total of 29 months following termination of employment or a reduction in hours of employment. To qualify for the additional 11 months of coverage, the disabled person must have a determination of disability from the Social Security Administration. The disability would have to have started at some time before the 60th day of COBRA Continuation Coverage and must last at least until the end of the 18-month period of coverage for this extension to apply. The determination from the Social Security Administration must be filed with the Plan within the later of the following: (1) 60 days from the date of the Social Security Disability determination; (2) the date of the Qualifying event or the date the disabled person would lose coverage under the Plan; or (3) the date the individual is informed of this notice requirement and procedure. The extended COBRA Continuation Coverage applies to the disabled individual and all covered non-disabled family members. (See “Where to Send Notices and Information in Connection with COBRA Continuation Coverage” on page 25.)

If an individual receives extended COBRA Continuation Coverage because of a disability, the disabled person must also notify the Plan within 30 days of a final determination by the Social Security Administration that the person is no longer disabled or, if later, within 30 days of the date the individual is informed of this notice requirement and procedure. COBRA Continuation Coverage ends if Medicare coverage begins before the 29-month period expires or if the disabled person recovers from the disability and has already received 18 months of COBRA Continuation Coverage.

## COBRA Rules for Retired Employees

As described on pages 21-26, when your active employment under the Plan ends, you have the right to purchase COBRA Continuation Coverage for yourself and your Spouse for up to 18 months (or 29 months if you qualify for the disability extension described above). If your active employment ends because you are retiring, you must choose between COBRA

coverage for the limited period of time described or Retiree Coverage described on pages 11-15. You must reject the other type of coverage when you make this choice. If you choose Retiree Coverage, you will not qualify for COBRA Continuation Coverage even if your Retiree Coverage later terminates.

If your family experiences another Qualifying Event while receiving Retiree Coverage, the Spouse and dependent children in your family can get up to 36 additional months of Retiree Coverage as a COBRA benefit. This extension is available to your Spouse and dependent children if you die, become entitled to Medicare (Part A, Part B, or both), or you and your Spouse get divorced, or if your dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the Spouse or dependent child to lose Retiree Coverage. In many cases, your Spouse and/or dependent children will continue to qualify for Retiree Coverage under other rules of the Plan.

### COBRA Rules for Eligible Dependents

If you choose not to purchase COBRA Continuation Coverage, your Spouse and/or eligible dependent children can separately purchase COBRA Continuation Coverage for themselves by making the election and the required monthly premium payments. The COBRA Continuation Coverage for dependents can be continued for up to 18 months (29 months if there is a disabled person electing coverage) if coverage would otherwise end because of the termination of the employee's Covered Employment or a reduction in the employee's hours of Covered Employment. However, coverage can be continued for up to 36 months for your Spouse and eligible dependent children if their coverage would otherwise end because of:

- your death;
- your divorce from your Spouse;
- your dependent child's loss of status as an eligible dependent under this Plan (see page 10).

If your family experiences another Qualifying Event while receiving COBRA Continuation Coverage, the Spouse and dependent children in your family can get additional months of COBRA Continuation Coverage, up to a maximum of 36 months. This extension is available to your Spouse and dependent children if you die, become entitled to Medicare (Part A, Part B, or both), you and your Spouse get divorced, or if your dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the Spouse or dependent child to lose coverage under the Plan had the first Qualifying Event not occurred.

If you became enrolled in Medicare (Part A, Part B, or both) within 18 months prior to your initial COBRA Qualifying Event, then the Spouse and dependent children in your family might be entitled to additional months of COBRA Continuation Coverage, up to a maximum of 36 months from the date you became enrolled in Medicare. Your eligible dependents are not entitled to any extension, however, if you become enrolled in Medicare after the date of your Qualifying Event.

## Notification Requirements for COBRA Continuation Coverage

You or your Spouse or your eligible dependent child must notify the Fund Office in writing within 60 days of a divorce or a child's loss of dependent status under the Plan. Your dependents should notify the Plan in writing within 60 days of your death. Failure to provide timely notification of your divorce or other loss of dependent status will result in your ineligibility to purchase COBRA Continuation Coverage.

An employer must notify the Plan within 60 days of your death or eligibility for Medicare Benefits. To assure timely notification, dependents should also notify the Plan within 60 days of your death and you, the participant, should notify the Plan of your eligibility for Medicare Benefits. Failure to provide timely notification in either of these circumstances may result in your ineligibility to purchase COBRA Continuation Coverage.

The Plan will determine when your eligibility for benefits would end due to your termination of Covered Employment or the reduction in your hours of employment for which contributions are received by the Fund (See "Where to Send Notices and Information in Connection with COBRA Continuation Coverage" on page 25.).

Following receipt of a notice from your dependent or employer or after your loss of eligibility due to termination of Covered Employment or reduction in your hours of employment for which contributions are received by the Fund is determined, the Plan will notify you and your eligible dependents of your and/or your dependents' rights to purchase COBRA Continuation Coverage and the cost of the coverage.

## Election of COBRA Continuation Coverage

You and each of your dependents have an independent right to elect COBRA Continuation Coverage. To elect COBRA Continuation Coverage, you and/or your Spouse and/or your eligible dependent child must complete an election form provided by the Fund Office and submit it to the Fund Office within 60 days after the later of the date coverage would otherwise end or the date you, your Spouse or eligible dependent child receives the notice of the right to elect COBRA Continuation Coverage (See "Where to Send Notices and Information in Connection with COBRA Continuation Coverage" on page 25.).

If you are otherwise eligible for the Self-Pay Plan, you may reject COBRA Continuation Coverage and instead elect coverage under the Self-Pay Plan.

## Termination of COBRA Continuation Coverage

COBRA Continuation Coverage may terminate earlier than the maximum period (18, 29 or 36 months) if:

- all health benefits provided by the Plan terminate;
- you, your Spouse or your eligible dependent child who has elected COBRA Continuation Coverage does not make the required payments to the Fund on time;
- you become covered under Medicare after the date of your COBRA election (COBRA coverage for your Spouse and eligible children will continue); or

- you, your Spouse or your eligible dependent child first become covered by another group health plan after the loss of coverage from this Plan unless that replacement plan limits coverage due to pre-existing conditions, and the pre-existing condition limitation actually applies to you after your coverage under this Plan is taken into account.

## Where to Send Notices and Information in Connection with COBRA Continuation Coverage

Notices and information concerning COBRA Continuation Coverage should be sent to:

Eligibility Department  
NASI Welfare Fund  
8000 Corporate Drive  
Landover, MD 20785

(301) 577-1700

Questions concerning your COBRA Continuation Coverage rights should also be addressed to the Eligibility staff of the Fund Office as indicated above.

## Keep Your Plan Informed of Address Changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of your family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

## Qualified Medical Child Support Orders

The Plan is required to recognize Qualified Medical Child Support Orders ("QMCSOs"). QMCSOs require health plans to recognize State court orders that the Plan finds to be Qualified Medical Child Support Orders, as defined by federal law. A QMCSO requires the Plan to provide health benefit coverage for an eligible employee's children, even if the eligible employee does not have custody of the children.

A QMCSO is a judgment, decree, or order issued by a court of competent jurisdiction or by a state administrative body that has the force of a court judgment, decree, or order. To be a QMCSO, a judgment, decree or order must require a child to be enrolled in the Plan as a form of child support or health benefit coverage pursuant to state domestic relations law or enforce a state law relating to medical child support. The order must include:

- the name and last known mailing address (if any) of the eligible employee and the name and mailing address of each child covered by the order,
- a reasonable description of the type of coverage to be provided by the Plan,

- the period of coverage to which the order pertains, and
- the name of the Plan.

Such an order is not "qualified" if it requires the Plan to provide any type or form of benefit not otherwise provided under the Plan except to the extent necessary to comply with a state law relating to medical child support orders. Upon receipt of an order, the Plan will notify, in writing, the eligible employee and each child covered by the order of the Plan's procedures for determining whether the order is qualified. The Plan will also notify the eligible employee and each affected child in writing of its determination as to whether an order is a "Qualified Medical Child Support Order". A copy of the QMCSO Procedures adopted by the Trustees may be obtained without charge from the Fund Office.

If you have questions about QMCSOs, you should contact the Fund Office.

### Self-Pay Coverage

The Self-Pay Plan offers an affordable, subsidized, self-payment plan to provide coverage for unemployed and disabled members and their families. Under the Self-Pay Plan, you are responsible to pay a portion of the cost to maintain coverage.

*If you are unemployed:* Unemployed individuals electing coverage under the Self-Pay Plan must be available for work as verified by your Local Union and must continue to be available for work for the duration of the coverage.

*If you are disabled:* Disabled individuals must provide satisfactory documentation of total disability from sprinkler work and must either remain disabled or be available for work as verified by your Local Union for the duration of the coverage.

If you are unemployed or disabled, coverage may be maintained for a period of up to two years from the date that you last worked a total of 80 hours in a two-consecutive-month period with at least one hour in the second of those two months for which contributions have been received.

*If you return to work following unemployment or disability:* If you return to work after being unemployed or disabled, you may use the Self Pay Plan to provide coverage for you and your family during the period between your return to work and the date that you reestablish eligibility under the Plan's Eligibility rules. In the event you become unemployed or disabled prior to reestablishing eligibility, coverage may be maintained for a period of up to two years from the date that you last worked a total of 80 hours in a two-consecutive-month period with at least one hour in the second of those months for which contributions have been received.

*If you are injured on the job and receive Workers' Compensation Benefits:* If you are injured on the job and receive Workers' Compensation Benefits, coverage may be maintained so long as you are receiving Workers' Compensation benefits but no longer than five years from the date

that you last worked a total of 80 hours in a two-consecutive-month period with at least one hour in the second of those two months for which contributions have been received. If your Workers' Compensation Benefits end because of a time limitation imposed by applicable state law and not because of a change in your physical condition, coverage may be maintained based on medical evidence that you would continue to qualify for Workers' Compensation Benefits if the time limitation under state law did not apply but no longer than five years from the date that you last worked a total of 80 hours in a two-consecutive-month period with at least one hour in the second of those two months for which contributions have been received.

*If you return to work after having received Workers' Compensation Benefits:* If you return to work after recovering from an injury that occurred while working on the job and for which you received Workers' Compensation benefits, you may use the Self-Pay Plan to provide coverage for you and your family during the period between your return to work and the date that you reestablish eligibility under either the Plan's Eligibility rules. If, prior to reestablishing eligibility, you incur an injury on the job for which you receive Workers' Compensation benefits, coverage under the Plan may be maintained so long as you are receiving Workers' Compensation benefits but no longer than five years from the date you last worked a total of 80 hours in a two-consecutive-month period with at least one hour in the second of those two month for which contributions have been received.

The Trustees determine the amount of the self-payment premium that may be changed from time to time. The Self-Pay Plan of benefits is outlined in Part II, Summaries of Benefits and Deductibles.

If you elect and pay for the Self-Pay Plan when your eligibility terminates because your Employer has not paid the required contributions on your behalf, the Plan will reimburse all or a portion of your Self-Pay Plan payments if the delinquent Employer contributions are collected, and your eligibility is restored based on the contributions.

If your family experiences another Qualifying Event while receiving Self-Pay Coverage, the Spouse and dependent children in your family can get up to 36 additional months of Self-Pay Coverage. This extension is available to your Spouse and dependent children if you die, become entitled to Medicare (Part A, Part B, or both), or you and your Spouse get divorced, or if your dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the Spouse or dependent child to lose Self-Pay Coverage.

## Confidentiality and Protection of Your Health Information

The Fund will comply with the Standards for Privacy of Individually Identifiable Health Information promulgated by the Department of Health and Human Services pursuant to the Health Insurance Portability and Accountability Act of 1996 ("Privacy Rules"). Under these standards, the Fund will protect the privacy of individually identifiable health information and will block or limit the disclosure of this information to the Trustees, Employers, the Union, your family members, service providers and other third parties. Protected health information will be disclosed only (1) to the extent authorized by the patient; (2) as necessary for the administration of the plan, including the review and payment of claims and the



determination of appeals; or (3) as otherwise authorized or required by law. The Fund has adopted certain written rules and policies to ensure that it complies with applicable law with regards to its use, disclosure and maintenance of protected health information.

You may authorize the disclosure of your protected health information to third parties by signing a written authorization and submitting it to the Fund Office. You may also cancel any previous written authorization you have provided the Fund by submitting a written cancellation of authorization with the Fund Office. You may request these forms from the Fund Office.

The Fund has provided participants with a Notice of Privacy Practices for Protected Health Information. If you need a copy of the Notice or would like additional information about the Fund's use and disclosure of protected health information or your rights with regards to this information, you may request a copy of the Notice from the Fund Office.

## II. Summaries of Benefits and Deductibles

### Level 1

For Eligible Employees and Retirees and Their Eligible Dependents

#### *Preventive Services*

As required by federal law, In-Network Preventive Services (see Definitions on page 95) are covered by this Plan without the application of the Deductible and at 100% coverage. Covered Preventive Services are described beginning on page 56.

#### *Walk-in Clinic/Urgent Care Center Benefit*

The cost of services provided at an In-Network Walk-in Clinic or In-Network Urgent Care Center will be covered at 90% and will not be subject to the Deductible.

#### *Comprehensive Medical Benefit:*

If expenses are incurred "In-Network" through the PPO or if you live out of a PPO area, coverage is subject to the Deductible, then 75% of the first \$10,000.00 (not including Deductible) of allowed charges incurred up to the Usual and Customary charge (UC) (see Definitions, page 96), then 100% of Usual and Customary charges thereafter, up to the Maximum Lifetime Medical Benefit.

\* The annual Deductible and Out-of-Pocket Maximum may be increased or decreased if you are invited to participate in the Personal Health Management Program. Review the section describing the Personal Health Management Program on page 62 for detailed information concerning how the Deductible and Out-of-Pocket Maximum may be affected.

- Deductible per calendar year, per person \$400\*
- Deductible per calendar year, per family \$1,200  
(three times the individual Deductible)
- Maximum Lifetime Medical Benefit, per person unlimited
- Out-of-Pocket maximum, per year, per person (including Deductible) \$2,900\*

In no event will the In-Network Out-of-Pocket maximum for a family exceed \$12,700.

If expenses are incurred "Out-of-Network" from someone other than a PPO service provider, coverage is subject to the Deductible, then 55% of the first \$11,111.11 (not including Deductible) of allowed charges incurred up to the Usual and Customary charge, then 100% of Usual and Customary charges thereafter, up to the Maximum Lifetime Medical

Benefit.

- Deductible per calendar year, per person \$900
- Deductible per calendar year, per family (three times the individual Deductible) \$2,700
- Maximum Lifetime Medical Benefit, per person unlimited
- Out-of-Pocket maximum, per year, per person (not including Deductible) \$5,000

***Comprehensive Medical Benefit includes:***

- Chiropractic Care, limit 20 sessions per year
- Diagnostic Laboratory or Pathology Test and X-Ray
- Hospital Expenses, including inpatient care, room and board, and outpatient care such as emergency room services
- Hospice Care
- Medical Care, including, but not limited to, Physicians' visits, ambulance service, rental of Durable Medical Equipment, visiting nurses
- Mental or Nervous Disorder Treatments
- Organ or Tissue Transplant
- Inpatient and Outpatient Substance Abuse Treatments
- Surgical Expenses
- Well Child Care
- Second Surgical Opinion 100% of Usual and Customary charges
- Orthotic Devices once every two consecutive years
- Hearing Aid Benefit within a five-consecutive-year period (no dependent coverage) \$400
- Out-of-Pocket expense reimbursement for care at a Blue Distinction Center + (see Definitions, page 92) for Bariatric Surgery, Cardiac Care, Knee and Hip Replacement, Spine Surgery, Maternity Care, and Transplants provided that the facility is designated by the Blue Cross Blue Shield Association as a Blue Distinction Center+ for that procedure. (Retired participants and beneficiaries who are Medicare-eligible are ineligible for the \$500 reimbursement.) \$500

***Prescription Drug Benefit:***

75% coverage for preferred drugs and 65% coverage for non-preferred drugs is provided through mail order and retail pharmacies. Maintenance drugs purchased at retail are subject to reimbursement limitation. Brand coverage is limited to generic cost when generic is available. Coverage for maintenance drugs related to your chronic condition may be increased if you are invited to participate in the Personal Health Management Program. Review the section describing the Personal Health Management Program on page 62 for detailed information concerning how coverage for certain maintenance drugs may be affected.

***Dental Benefit:***

- Dental Deductible per calendar year, per person \$75
  
- Deductible per calendar year, per family \$225  
(three times the individual Deductible)
  
- Preventive and diagnostic services (exam, cleaning, some x-rays), 90% of Usual and Customary charges up to maximum annual amount
  
- Class I restorative services, 80% of Usual and Customary charges up to maximum annual amount
  
- Class II restorative services, 70% of Usual and Customary charges up to maximum annual amount
  
- Maximum annual amount (includes all charges) \$3,000
  
- Oral Surgery (additional to maximum annual amount) \$500
  
- Orthodontia, 70% of Usual and Customary charges  
Lifetime Maximum \$3,000
  
- TMJ, 50% of Usual and Customary charges  
Lifetime Maximum \$1,000

(There are no maximum limitations for pediatric dental.)

***Vision Care Benefit:***

**Coverage provided only through Vision Service Plan (no out of network benefits):**  
Subject to Deductible, then paid in full if provided by Vision Service Plan (extra cost for some items or uncovered items)

- Vision Deductible per person per year \$10
- One exam in a 12-month period unless more than one exam is Medically Necessary.
- One pair eyeglasses/contact lenses in a 12-month period unless the prescription has changed due to a medical condition or surgery related to a medical condition (where surgery would otherwise be covered by the Plan).
- Exam and eyeglasses subject to Deductible, then paid in full (extra cost for some items or uncovered items).
- Contact lenses
  - per person annual allowance \$100  
(no maximum limitation for pediatric vision)

**For Active Eligible Employees Only (no Life or Accidental Death or Dismemberment benefits are payable with respect to Retirees)**

- Life Insurance \$15,000
- Accidental Death Benefit \$15,000
- Accidental Dismemberment and Injury Benefit (no more than \$15,000 total per accident):
  - Accidental Loss of both hands, feet, or sight of both eyes \$15,000
  - Accidental Loss of both speech and hearing in both ears \$15,000
  - Accidental Paralysis of arms and legs (quadriplegia) \$15,000
  - Accidental Loss of one hand or foot or sight of one eye \$7,500
  - Accidental Paralysis of both legs (paraplegia) or of both limbs on one side of body (hemiplegia) \$7,500
  - Accidental Loss of speech or hearing in both ears \$7,500
  - Accidental Paralysis of one arm or one leg (uniplegia) \$3,750
  - Accidental Loss of thumb and index finger on same hand \$3,750

The Plan will pay up to the full benefit (\$15,000) for all losses that result from one accident, except as may be provided under Additional Benefits under the Accidental Death and Personal Loss provisions.

- Weekly Disability Benefit for up to 26 weeks for the same Disability,
  - per week \$250

**For Dependents of Actively Eligible Employees (no Death Benefits are payable with respect to Dependents of Retirees)**

- Death Benefit payable upon the death of Spouse or Dependent Child
  - Spouse \$3,000
  - Dependent Child (15 days to 19 years old) \$2,000

## Level 2

### For Eligible Employees and Retirees and Their Eligible Dependents

#### ***Preventive Services***

As required by federal law, In-Network Preventive Services (see Definitions on page 95) are covered by this Plan without the application of the Deductible and at 100% coverage. Covered Preventive Services are described beginning on page 56.

#### ***Walk-in Clinic/Urgent Care Center Benefit***

The cost of services provided at an In-Network Walk-in Clinic or In-Network Urgent Care Center will be covered at 90% and will not be subject to the Deductible.

#### ***Comprehensive Medical Benefit:***

If expenses are incurred "In-Network" through the PPO or if you live out of a PPO area, coverage is subject to the Deductible, then 70% of the first \$12,500.00 (not including Deductible) of allowed charges incurred up to the Usual and Customary charge, then 100% of Usual and Customary charges thereafter, up to the Maximum Lifetime Medical Benefit.

\* The annual Deductible and Out-of-Pocket Maximum may be increased or decreased if you are invited to participate in the Personal Health Management Program. Review the section describing the Personal Health Management Program on page 62 for detailed information concerning how the Deductible and Out-of-Pocket Maximum may be affected.

- Deductible per calendar year, per person \$700\*
- Deductible per calendar year, per family  
(three times the individual Deductible) \$2,100
- Maximum Lifetime Medical Benefit, per person unlimited
- Out-of-Pocket maximum, per year, per person (not including Deductible) \$4,450\*

In no event will the In-Network Out-of-Pocket maximum for a family exceed \$12,700.

If expenses are incurred "Out-of-Network" from someone other than a PPO service provider, coverage is subject to the Deductible, then 55% of the first \$14,444.45 (not including Deductible) of allowed charges incurred up to the Usual and Customary charge, then 100% of Usual and Customary charges thereafter, up to the Maximum Lifetime Medical Benefit.

- Deductible per calendar year, per person \$1,500

- Deductible per calendar year, per family (three times the individual Deductible) \$4,500
- Maximum Lifetime Medical Benefit, per person unlimited
- Out-of-Pocket maximum, per year, per person (not including Deductible) \$6,500

***Comprehensive Medical Benefit includes:***

- Chiropractic Care, limit 20 sessions per year
- Diagnostic Laboratory or Pathology Test and X-Ray
- Hospital Expenses, including inpatient care, room and board, and outpatient care such as emergency room services
- Hospice Care
- Medical Care, including, but not limited to, Physicians' visits, ambulance service, rental of Durable Medical Equipment, visiting nurses
- Mental or Nervous Disorder Treatment
- Organ or Tissue Transplant
- Inpatient and Outpatient Substance Abuse Treatments
- Surgical Expenses
- Orthotic Devices once every two consecutive years
- Well Child Care
- Second Surgical Opinion 100% of UC
- Hearing Aid Benefit within a five–consecutive-year period (no dependent coverage) \$400
- Out-of-Pocket expense reimbursement for care at a Blue Distinction Center + (see Definitions, page 92) for Bariatric Surgery, Cardiac Care, Knee and Hip Replacement, Spine Surgery, Maternity Care, and Transplants provided that the facility is designated by the Blue Cross Blue Shield Association as a Blue Distinction Center+ for that procedure. (Retired participants and beneficiaries who are Medicare-eligible are ineligible for the \$500 reimbursement.) \$500

***Prescription Drug Benefit:***

75% coverage for preferred drugs and 65% coverage for non-preferred drugs is provided through mail order and retail pharmacies. Maintenance drugs purchased at retail are subject to reimbursement limitation. Brand coverage is limited to generic cost when generic is available. Coverage for maintenance drugs related to your chronic condition may be increased if you are invited to participate in the Personal Health Management Program. Review the section describing the Personal Health Management Program on page 62 for detailed information concerning how coverage for certain maintenance drugs may be affected.

*PLEASE NOTE: Employers may negotiate Life, Accidental Death and Dismemberment, Disability, Vision and Dental benefits as components of this Level 2 Plan for an additional cost per hour.*

***Dental Benefit.*** (available only to those groups that have negotiated the additional contribution for Level 2 dental benefits)

- Dental Deductible per calendar year, per person \$75
  
- Deductible per calendar year, per family \$225  
(three times the individual Deductible)
  
- Preventive and diagnostic services (exam, cleaning, some x-rays), 90% of Usual and Customary charges up to maximum annual amount
  
- Class I restorative services, 80% of Usual and Customary charges up to maximum annual amount
  
- Class II restorative services, 50% of Usual and Customary charges up to maximum annual amount
  
- Maximum annual amount (includes all charges) \$2,000
  
- Oral Surgery (additional to maximum annual amount) \$500
  
- Orthodontia, 70% of Usual and Customary charges \$3,000  
Lifetime Maximum
  
- TMJ, 50% of Usual and Customary charges \$1,000  
Lifetime Maximum

(There are no maximum annual limitations for pediatric dental.)

**Coverage provided only through Vision Service Plan (no out of network benefits):**  
Subject to Deductible, then paid in full if provided by Vision Service Plan (extra cost for



some items or uncovered items)

- Vision Deductible per person per year \$10
  
- One exam in a 12-month period unless more than one exam is Medically Necessary.
  
- One pair eyeglasses/contact lenses in a 12-month period unless the prescription has changed due to a medical condition or surgery related to a medical condition (where surgery would otherwise be covered by the Plan).
  
- Exam and eyeglasses subject to Deductible, then paid in full (extra cost for some items or uncovered items).
  
- Contact lenses
  - per person allowance \$100

(There is no maximum limitation for pediatric vision.)

## Level 3

### For Eligible Employees and Retirees and Their Eligible Dependents

#### ***Preventive Services***

As required by federal law, In-Network Preventive Services (see Definitions on page 95) are covered by this Plan without the application of the Deductible and at 100% coverage. Covered Preventive Services are described beginning on page 56.

#### ***Walk-in Clinic/Urgent Care Center Benefit***

The cost of services provided at an In-Network Walk-in Clinic or In-Network Urgent Care Center will be covered at 90% and will not be subject to the Deductible.

#### ***Comprehensive Medical Benefit:***

If expenses are incurred "In-Network" through the PPO or if you live out of a PPO area, coverage is subject to the Deductible, then 70% of the first \$16,666.67 (not including Deductible) of allowed charges incurred up to the Usual and Customary charge, then 100% of Usual and Customary charges thereafter, up to the Maximum Lifetime Medical Benefit.

\* The annual Deductible and Out-of-Pocket Maximum may be increased or decreased if you are invited to participate in the Personal Health Management Program. Review the section describing the Personal Health Management Program on page 62 for detailed information concerning how the Deductible and Out-of-Pocket Maximum may be affected.

- Deductible per calendar year, per person \$800\*
- Deductible per calendar year, per family (three times the individual Deductible) \$2,400
- Maximum Lifetime Medical Benefit, per person unlimited
- Out-of-Pocket maximum, per year, per person (not including Deductible) \$5,800\*

In no event will the In-Network Out-of-Pocket maximum for a family exceed \$12,700.

If expenses are incurred "Out-of-Network" from someone other than a PPO service provider, coverage is subject to the Deductible, then 55% of the first \$20,000.00 (not including Deductible) of allowed charges incurred up to the Usual and Customary charge, then 100% of Usual and Customary charges thereafter, up to the Maximum Lifetime Medical Benefit.

- Deductible per calendar year, per person \$1,700
- Deductible per calendar year, per family \$5,100

- (three times the individual Deductible)
- Maximum Lifetime Medical Benefit, per person unlimited
- Out-of-Pocket maximum, per year, per person (not including Deductible) \$9,000

***Comprehensive Medical Benefit includes:***

- Chiropractic Care, limit 20 sessions per year
- Diagnostic Laboratory or Pathology Test and X-Ray
- Hospital Expenses, including inpatient care, room and board, and outpatient care such as emergency room services
- Hospice Care
- Medical Care, including, but not limited to, Physicians' visits, ambulance service, rental of Durable Medical Equipment, visiting nurses
- Mental or Nervous Disorder Treatment
- Organ or Tissue Transplant
- Inpatient and Outpatient Substance Abuse Treatments
- Surgical Expenses
- Orthotic Devices once every two consecutive years
- Well Child Care
- Second Surgical Opinion 100% of UC
- Hearing Aid Benefit within a five-consecutive-year period \$400  
(no dependent coverage)
- Out-of-Pocket expense reimbursement for care at a \$500  
Blue Distinction Center + (see Definitions, page 92) for Bariatric Surgery, Cardiac Care, Knee and Hip Replacement, Spine Surgery, Maternity Care, and Transplants provided that the facility is designated by the Blue Cross Blue Shield Association as a Blue Distinction Center+ for that procedure. (Retired participants and beneficiaries who are Medicare-eligible are ineligible for the \$500 reimbursement.)

***Prescription Drug Benefit:***

75% coverage for preferred drugs and 65% coverage for non-preferred drugs is provided

through mail order and retail pharmacies. Maintenance drugs purchased at retail are subject to reimbursement limitation. Brand coverage is limited to generic cost when generic is available. Coverage for maintenance drugs related to your chronic condition may be increased if you are invited to participate in the Personal Health Management Program. Review the section describing the Personal Health Management Program on page 62 for detailed information concerning how coverage for certain maintenance drugs may be affected.

*PLEASE NOTE: Employers may negotiate Life, Accidental Death and Dismemberment, Disability, Vision and Dental benefits as components of this Level 3 Plan for an additional cost per hour.*

**Dental Benefit.** (available only to those groups that have negotiated the additional contribution for Level 3 dental benefits)

- Dental Deductible per calendar year, per person \$75
- Deductible per calendar year, per family \$225  
(three times the individual Deductible)
- Preventive and diagnostic services (exam, cleaning, some x-rays), 90% of Usual and Customary charges up to maximum annual amount
- Class I restorative services, 80% of Usual and Customary charges up to maximum annual amount
- Class II restorative services, 50% of Usual and Customary charges up to maximum annual amount
- Maximum annual amount (includes all charges) \$2,000
- Oral Surgery (additional to maximum annual amount) \$500
- Orthodontia, 70% of Usual and Customary charges \$3,000  
Lifetime Maximum
- TMJ, 50% of Usual and Customary charges \$1,000  
Lifetime Maximum

(There are no maximum annual limitations for pediatric dental.)

**Coverage provided only through Vision Service Plan (no out of network benefits):**

Subject to Deductible, then paid in full if provided by Vision Service Plan (extra cost for some items or uncovered items)

- Vision Deductible per person per year \$10

- One exam in a 12-month period unless more than one exam is Medically Necessary.
  - One pair eyeglasses/contact lenses in a 12-month period unless the prescription has changed due to a medical condition or surgery related to a medical condition (where surgery would otherwise be covered by the Plan).
  - Exam and eyeglasses subject to Deductible, then paid in full (extra cost for some items or uncovered items).
  - Contact lenses
    - per person allowance \$100
- (There is no maximum limitation for pediatric vision.)

## Self-Pay Plan for Unemployed or Disabled Individuals and their Families

### *Preventive Services*

As required by federal law, In-Network Preventive Services (see Definitions on page 95) are covered by this Plan without the application of the Deductible and at 100% coverage. Covered Preventive Services are described beginning on page 56.

### *Walk-in Clinic/Urgent Care Center Benefit*

The cost of services provided at an In-Network Walk-in Clinic or In-Network Urgent Care Center will be covered at 90% and will not be subject to the Deductible.

### *Comprehensive Medical Benefit:*

If expenses are incurred "In-Network" through a PPO or if you live out of the PPO area, coverage is subject to the Deductible, then 70% of the first \$9,166.67 (not including Deductible) of allowed charges incurred up to Usual and Customary, then 100% of Usual and Customary charges thereafter, up to the Maximum Lifetime Medical Benefit.

\* The annual Deductible and Out-of-Pocket Maximum may be increased or decreased if you are invited to participate in the Personal Health Management Program. Review the section describing the Personal Health Management Program on page 62 for detailed information concerning how the Deductible and Out-of-Pocket Maximum may be affected.

- Deductible per calendar year, per person \$450\*
- Deductible per calendar year, per family (three times the individual Deductible) \$1,350
- Maximum Lifetime Medical Benefit, per person unlimited
- Out-of-Pocket maximum, per year, per person (not including Deductible) \$3,200\*

In no event will the In-Network Out-of-Pocket maximum for a family exceed \$12,700.

If expenses are incurred "Out-of-Network" (not through a PPO), coverage is subject to the Deductible, then 50% of the first \$11,000.00 (not including Deductible) of allowed charges incurred up to Usual and Customary, then 100% of Usual and Customary charges thereafter, up to the Maximum Lifetime Medical Benefit.

- Deductible per calendar year, per person \$900
- Deductible per calendar year, per family \$2,700

(three times the individual Deductible)

- Maximum Lifetime Medical Benefit, per person unlimited
- Out-of-Pocket maximum, per year, per person (not including Deductible) \$5,500

***Comprehensive Medical Benefit includes:***

- Chiropractic Care, limit 20 sessions per year
- Diagnostic Laboratory or Pathology Test and X-Ray
- Hospital Expenses, including inpatient care, room and board, and outpatient care such as emergency room services
- Hospice Care
- Medical Care, including, but not limited to, Physicians' visits, ambulance service, rental of Durable Medical Equipment, visiting nurses
- Mental or Nervous Disorder Treatment
- Organ or Tissue Transplant
- Inpatient and Outpatient Substance Abuse Treatments
- Orthotic Devices once every two consecutive years
- Surgical Expenses
- Well Child Care
- Second Surgical Opinion 100% of UC
- Out-of-Pocket expense reimbursement for care at a Blue Distinction Center + (see Definitions, page 92) for Bariatric Surgery, Cardiac Care, Knee and Hip Replacement, Spine Surgery, Maternity Care, and Transplants provided that the facility is designated by the Blue Cross Blue Shield Association as a Blue Distinction Center+ for that procedure. (Retired participants and beneficiaries who are Medicare-eligible are ineligible for the \$500 reimbursement.) \$500

***Prescription Drug Benefit:***

75% coverage for preferred drugs and 65% coverage for non-preferred drugs is provided through mail order and retail pharmacies. Maintenance drugs purchased at retail are subject

to reimbursement limitation. Brand coverage is limited to generic cost when generic is available. Coverage for maintenance drugs related to your chronic condition may be increased if you are invited to participate in the Personal Health Management Program. Review the section describing the Personal Health Management Program on page 62 for detailed information concerning how coverage for certain maintenance drugs may be affected.

***Other Benefits:***

- Death Benefit Payable for Death of Employee \$5,000
- Accidental Death and Dismemberment for Employee \$5,000
- Weekly Disability Benefit for up to 13 weeks for the same Disability, per week
  - Employee only \$200
- Dental Benefits 60% of Usual and Customary charges up to maximum benefit
  - Deductible \$200
  - Annual Dental Maximum \$3,000
  - Orthodontia - Lifetime Maximum \$3,000
- TMJ, 50% of Usual and Customary charges
  - Lifetime Maximum \$1,000

(there are no maximum limitations for pediatric dental)

*Vision Care and Hearing Aid benefits are not available under the Self-Pay Plan.*



## Schedule for COBRA Beneficiaries of Level 1

### ***Preventive Services***

As required by federal law, In-Network Preventive Services (see Definitions on page 95) are covered by this Plan without the application of the Deductible and at 100% coverage. Covered Preventive Services are described beginning on page 56.

### ***Walk-in Clinic/Urgent Care Center Benefit***

The cost of services provided at an In-Network Walk-in Clinic or In-Network Urgent Care Center will be covered at 90% and will not be subject to the Deductible.

### ***Comprehensive Medical Benefit:***

If expenses are incurred "In-Network" through the PPO or if you live out of a PPO area, coverage is subject to the Deductible, then 75% of the first \$10,000.00 (not including Deductible) of allowed charges incurred up to the Usual and Customary (see Definitions, page 96) charge, then 100% of Usual and Customary charges thereafter, up to the Maximum Lifetime Medical Benefit.

\* The annual Deductible and Out-of-Pocket Maximum may be increased or decreased if you are invited to participate in the Personal Health Management Program. Review the section describing the Personal Health Management Program on page 62 for detailed information concerning how the Deductible and Out-of-Pocket Maximum may be affected.

- Deductible per calendar year, per person \$400\*
- Deductible per calendar year, per family \$1,200  
(three times the individual Deductible)
- Maximum Lifetime Medical Benefit, per person unlimited
- Out-of-Pocket maximum, per year, per person (not including Deductible) \$2,900\*

In no event will the In-Network Out-of-Pocket maximum for a family exceed \$12,700.

If expenses are incurred "Out-of-Network" from someone other than a PPO service provider, coverage is subject to the Deductible, then 55% of the first \$11,111.11 (not including Deductible) of allowed charges incurred up to the Usual and Customary charge, then 100% of Usual and Customary charges thereafter, up to the Maximum Lifetime Medical Benefit.

- Deductible per calendar year, per person \$900
- Deductible per calendar year, per family \$2,700

- (three times the individual Deductible)
- Maximum Lifetime Medical Benefit, per person unlimited
- Out-of-Pocket maximum, per year, per person (not including Deductible) \$5,000

***Comprehensive Medical Benefit includes:***

- Chiropractic Care, limit 20 sessions per year
- Diagnostic Laboratory or Pathology Test and X-Ray
- Hospital Expenses, including inpatient care, room and board, and outpatient care such as emergency room services
- Hospice Care
- Medical Care, including, but not limited to, Physicians' visits, ambulance service, rental of Durable Medical Equipment, visiting nurses
- Mental or Nervous Disorder Treatment
- Organ or Tissue Transplant
- Inpatient and Outpatient Substance Abuse Treatments
- Surgical Expenses
- Orthotic Devices once every two consecutive years
- Well Child Care
- Second Surgical Opinion 100% of UC
- Hearing Aid Benefit within a five-consecutive-year period \$400  
(no dependent coverage)
- Out-of-Pocket expense reimbursement for care at a \$500  
Blue Distinction Center + (see Definitions, page 92) for Bariatric Surgery, Cardiac Care, Knee and Hip Replacement, Spine Surgery, Maternity Care, and Transplants provided that the facility is designated by the Blue Cross Blue Shield Association as a Blue Distinction Center+ for that procedure. (Retired participants and beneficiaries who are Medicare-eligible are ineligible for the \$500 reimbursement.)

***Prescription Drug Benefit:***

75% coverage for preferred drugs and 65% coverage for non-preferred drugs is provided through mail order and retail pharmacies. Maintenance drugs purchased at retail are subject to reimbursement limitation. Brand coverage is limited to generic cost when generic is available. Coverage for maintenance drugs related to your chronic condition may be increased if you are invited to participate in the Personal Health Management Program. Review the section describing the Personal Health Management Program on page 62 for detailed information concerning how coverage for certain maintenance drugs may be affected.

***Dental Benefit:***

- Dental Deductible per calendar year, per person \$75
  
- Deductible per calendar year, per family \$225  
(three times the individual Deductible)
  
- Preventive and diagnostic services (exam, cleaning, some x-rays), 90% of Usual and Customary charges up to maximum annual amount
  
- Class I restorative services, 80% of Usual and Customary charges up to maximum annual amount
  
- Class II restorative services, 70% of Usual and Customary charges up to maximum annual amount
  
- Maximum annual amount (includes all charges) \$3,000
  
- Oral Surgery (additional to maximum annual amount) \$500
  
- Orthodontia, 70% of Usual and Customary charges \$3,000  
Lifetime Maximum
  
- TMJ, 50% of Usual and Customary charges \$1,000  
Lifetime Maximum

(There are no maximum annual limitations for pediatric dental.)

***Vision Care Benefit:***

**Coverage provided only through Vision Service Plan (no out of network benefits):**  
Subject to Deductible, then paid in full if provided by Vision Service Plan (extra cost for some items or uncovered items)

- Vision Deductible per person per year \$10
  - One exam in a 12-month period unless more than one exam is Medically Necessary.
  - One pair eyeglasses/contact lenses in a 12-month period unless the prescription has changed due to a medical condition or surgery related to a medical condition (where surgery would otherwise be covered by the Plan).
  - Exam and eyeglasses subject to Deductible, then paid in full (extra cost for some items or uncovered items).
  - Contact lenses
    - per person allowance \$100
- (There is no maximum limitation for pediatric vision.)

## Schedule for COBRA Beneficiaries of Level 2

### ***Preventive Services***

As required by federal law, In-Network Preventive Services (see Definitions on page 95) are covered by this Plan without the application of the Deductible and at 100% coverage. Covered Preventive Services are described beginning on page 56.

### ***Walk-in Clinic/Urgent Care Center Benefit***

The cost of services provided at an In-Network Walk-in Clinic or In-Network Urgent Care Center will be covered at 90% and will not be subject to the Deductible.

### ***Comprehensive Medical Benefit:***

If expenses are incurred "In-Network" through the PPO or if you live out of a PPO area, coverage is subject to the Deductible, then 70% of the first \$12,500.00 (not including Deductible) of allowed charges incurred up to the Usual and Customary charge, then 100% of Usual and Customary charges thereafter, up to the Maximum Lifetime Medical Benefit.

- \* The annual Deductible and Out-of-Pocket Maximum may be increased or decreased if you are invited to participate in the Personal Health Management Program. Review the section describing the Personal Health Management Program on page 62 for detailed information concerning how the Deductible and Out-of-Pocket Maximum may be affected.

- Deductible per calendar year, per person \$700\*
- Deductible per calendar year, per family (three times the individual Deductible) \$2,100
- Maximum Lifetime Medical Benefit, per person unlimited
- Out-of-Pocket maximum, per year, per person (not including Deductible) \$4,450\*

In no event will the In-Network Out-of-Pocket maximum for a family exceed \$12,700.

If expenses are incurred "Out-of-Network" from someone other than a PPO service provider, coverage is subject to the Deductible, then 55% of the first \$14,333.33 (not including Deductible) of allowed charges incurred up to the Usual and Customary charge, then 100% of Usual and Customary charges thereafter, up to the Maximum Lifetime Medical Benefit.

- Deductible per calendar year, per person \$1,500
- Deductible per calendar year, per family \$4,500

(three times the individual Deductible)

- Maximum Lifetime Medical Benefit, per person unlimited
- Out-of-Pocket maximum, per year, per person (not including Deductible) \$6,500

***Comprehensive Medical Benefit includes:***

- Chiropractic Care, limit 20 sessions per year
- Diagnostic Laboratory or Pathology Test and X-Ray
- Hospital Expenses, including inpatient care, room and board, and outpatient care such as emergency room services
- Hospice Care
- Medical Care, including, but not limited to, Physicians' visits, ambulance service, rental of Durable Medical Equipment, visiting nurses
- Mental or Nervous Disorder Treatment
- Organ or Tissue Transplant
- Inpatient and Outpatient Substance Abuse Treatments
- Surgical Expenses
- Well Child Care
- Orthotic Devices once every two consecutive years
- Second Surgical Opinion 100% of UC
- Hearing Aid Benefit within a five-consecutive-year period (no dependent coverage) \$400
- Out-of-Pocket expense reimbursement for care at a Blue Distinction Center + (see Definitions, page 92) for Bariatric Surgery, Cardiac Care, Knee and Hip Replacement, Spine Surgery, Maternity Care, and Transplants provided that the facility is designated by the Blue Cross Blue Shield Association as a Blue Distinction Center+ for that procedure. (Retired participants and beneficiaries who are Medicare-eligible are ineligible for the \$500 reimbursement.) \$500

***Prescription Drug Benefit:***

75% coverage for preferred drugs and 65% coverage for non-preferred drugs is provided through mail order and retail pharmacies. Maintenance drugs purchased at retail are subject to reimbursement limitation. Brand coverage is limited to generic cost when generic is available. Coverage for maintenance drugs related to your chronic condition may be increased if you are invited to participate in the Personal Health Management Program. Review the section describing the Personal Health Management Program on page 62 for detailed information concerning how coverage for certain maintenance drugs may be affected.

***Dental Benefit:***

- Dental Deductible per calendar year, per person \$75
  
- Deductible per calendar year, per family \$225  
(three times the individual Deductible)
  
- Preventive and diagnostic services (exam, cleaning, some x-rays), 90% of Usual and Customary charges up to maximum annual amount
  
- Class I restorative services, 80% of Usual and Customary charges up to maximum annual amount
  
- Class II restorative services, 50% of Usual and Customary charges up to maximum annual amount
  
- Maximum annual amount (includes all charges) \$2,000
  
- Oral Surgery (additional to maximum annual amount) \$500
  
- Orthodontia, 70% of Usual and Customary charges \$3,000  
Lifetime Maximum
  
- TMJ, 50% of Usual and Customary charges \$1,000  
Lifetime Maximum

(There are no maximum annual limitations for pediatric dental.)

***Vision Care Benefit:***

**Coverage provided only through Vision Service Plan (no out of network benefits):**  
Subject to Deductible, then paid in full if provided by Vision Service Plan (extra cost for some items or uncovered items)

- Vision Deductible per person per year \$10
  - One exam in a 12-month period unless more than one exam is Medically Necessary.
  - One pair eyeglasses/contact lenses in a 12-month period unless the prescription has changed due to a medical condition or surgery related to a medical condition (where surgery would otherwise be covered by the Plan).
  - Exam and eyeglasses subject to Deductible, then paid in full (extra cost for some items or uncovered items).
  - Contact lenses
    - per person allowance \$100
- (There is no maximum limitation for pediatric vision.)



## Schedule for COBRA Beneficiaries of Level 3

### ***Preventive Services***

As required by federal law, In-Network Preventive Services (see Definitions on page 95) are covered by this Plan without the application of the Deductible and at 100% coverage. Covered Preventive Services are described beginning on page 56.

### ***Walk-in Clinic/Urgent Care Center Benefit***

The cost of services provided at an In-Network Walk-in Clinic or In-Network Urgent Care Center will be covered at 90% and will not be subject to the Deductible.

### ***Comprehensive Medical Benefit:***

If expenses are incurred "In-Network" through the PPO or if you live out of a PPO area, coverage is subject to the Deductible, then 70% of the first \$16,666.67 (not including Deductible) of allowed charges incurred up to the Usual and Customary charge, then 100% of Usual and Customary charges thereafter, up to the Maximum Lifetime Medical Benefit.

\* The annual Deductible and Out-of-Pocket Maximum may be increased or decreased if you are invited to participate in the Personal Health Management Program. Review the section describing the Personal Health Management Program on page 62 for detailed information concerning how the Deductible and Out-of-Pocket Maximum may be affected.

- Deductible per calendar year, per person \$800\*
- Deductible per calendar year, per family (three times the individual Deductible) \$2,400
- Maximum Lifetime Medical Benefit, per person unlimited
- Out-of-Pocket maximum, per year, per person (not including Deductible) \$5,800\*

In no event will the In-Network Out-of-Pocket maximum for a family exceed \$12,700

If expenses are incurred "Out-of-Network" from someone other than a PPO service provider, coverage is subject to the Deductible, then 55% of the first \$20,000.00 (not including Deductible) of allowed charges incurred up to the Usual and Customary charge, then 100% of Usual and Customary charges thereafter, up to the Maximum Lifetime Medical Benefit.

- Deductible per calendar year, per person \$1,700
- Deductible per calendar year, per family (three times the individual Deductible) \$5,100

- Maximum Lifetime Medical Benefit, per person unlimited
- Out-of-Pocket maximum, per year, per person (not including Deductible) \$9,000

***Comprehensive Medical Benefit includes:***

- Chiropractic Care, limit 20 sessions per year
- Diagnostic Laboratory or Pathology Test and X-Ray
- Hospital Expenses, including inpatient care, room and board, and outpatient care such as emergency room services
- Hospice Care
- Medical Care, including, but not limited to, Physicians' visits, ambulance service, rental of Durable Medical Equipment, visiting nurses
- Mental or Nervous Disorder Treatment
- Organ or Tissue Transplant
- Inpatient and Outpatient Substance Treatments
- Surgical Expenses
- Well Child Care
- Orthotic Devices once every two consecutive years
- Second Surgical Opinion 100% of UC
- Hearing Aid Benefit within a five-consecutive-year period (no dependent coverage) \$400
- Out-of-Pocket expense reimbursement for care at a Blue Distinction Center + (see Definitions, page 92) for Bariatric Surgery, Cardiac Care, Knee and Hip Replacement, Spine Surgery, Maternity Care, and Transplants provided that the facility is designated by the Blue Cross Blue Shield Association as a Blue Distinction Center+ for that procedure. (Retired participants and beneficiaries who are Medicare-eligible are ineligible for the \$500 reimbursement.) \$500

***Prescription Drug Benefit:***

75% coverage for preferred drugs and 65% coverage for non-preferred drugs is provided

through mail order and retail pharmacies. Maintenance drugs purchased at retail are subject to reimbursement limitation. Brand coverage is limited to generic cost when generic is available. Coverage for maintenance drugs related to your chronic condition may be increased if you are invited to participate in the Personal Health Management Program. Review the section describing the Personal Health Management Program on page 62 for detailed information concerning how coverage for certain maintenance drugs may be affected.

## III. Comprehensive Medical Coverage - How It Works

Your medical coverage is divided into Comprehensive Medical (including Preventive Services), Dental and Other Benefits. Part IV contains a description of your Comprehensive Medical Benefits and what each section covers.

Comprehensive Medical coverage includes a wide range of covered medical expenses for you and your eligible dependents. The following rules apply to Comprehensive Medical expenses.

### Plan Requirements

#### Preferred Provider Organizations (PPO)

The Plan has contracted with various Preferred Provider Organizations, known as "PPOs", in areas where participants reside. In general, you must use PPO providers in order for the Plan to pay benefits at the "In-Network" level shown on the Summary of Benefits and Deductibles. Information regarding Physicians and Hospitals participating in your PPO is available by contacting the PPO in your area.

In addition, the following care will be treated as "In-Network":

1. Emergency care – care delivered at the emergency department of a hospital for a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent person (including the parent of a minor child or the guardian of a disabled individual) who possesses an average knowledge of health and medicine assess that such condition requires immediate treatment, or which the participant could reasonably expect that in the absence of immediate medical attention could place the health of the individual (or in the case of a pregnant woman, the health of the unborn child) in serious jeopardy; could result in serious impairment to bodily functions or serious dysfunction of any bodily organ or part, or where the participant has no control over where he or she is taken for treatment. Emergency care includes a medical screening and such further medical examination and treatment as are required to stabilize the patient;
2. Services provided by a non-PPO provider such as a lab, anesthesiologist or radiologist in a PPO Hospital when a PPO Physician is treating the individual;
3. Chiropractic treatment if chiropractors are not included in the applicable PPO Network; and
4. Care provided by a psychologist or a psychiatric social worker if these providers are not included in the applicable PPO network.

5. Services of a provider which leaves the PPO network during a continuous course of treatment of a participant for an illness or condition if, as the result of the provider leaving the network, the participant would be required to change Physicians during the course of a specific treatment. For these purposes, a continuous course of treatment means a limited and specific plan or program of treatment to address a specific illness or condition such as pregnancy or a course of chemotherapy.
6. If you live in an area covered by a PPO but there is not an appropriate PPO provider within 30 miles of where you live, your benefits will be paid at the In-Network level of benefits.
7. If a provider is treated as In-Network because of one of the above exceptions, an on-going continuous course of treatment by that provider will also be considered In-Network.

### **You May Pay More if You Use an Out-of-Network Provider / Risk of Balance Billing.**

If you use an Out-of-Network provider, the Fund will pay for the covered services in accordance with the Plan, but you may incur significantly higher out-of-pocket expenses, including a higher coinsurance percentage. In certain instances, the Out-of-Network provider also may charge you for the remainder (or “balance”) of the provider’s bill after applying payment from the Fund—this practice is often referred to as balance billing. This is true whether you use an Out-of-Network provider by choice, for level of expertise, for convenience, for location, because of the nature of the services, or based on the recommendation of a provider. However, you should be aware that certain states prohibit balance billing, in which case you should not be responsible for amounts balance billed.

### **Preventive Services**

As required by federal law, Preventive Services (see Definitions, page 95) are covered by this Plan without the application of the Deductible and at 100% coverage. This level of coverage is available only to services provided by or obtained In-Network. Services provided by an Out-of-Network provider are subject to the Out-of-Network deductible and co-insurance without regard to whether the service would otherwise be considered a Preventive Service.

Regarding the coverage for the Office Visits associated with Preventive Services:

- (1) if a Preventive Service is billed separately (or is tracked as individual encounter data separately) from an office visit, then this Plan will impose cost-sharing requirements with respect to the office visit,
- (2) if a Preventive Service is not billed separately (or is not tracked as individual encounter data separately) from an office visit, and the primary purpose of the office visit is the delivery of the preventive item or service, then this Plan will not impose cost-sharing requirements with respect to the office visit and,

- (3) if a Preventive Service is not billed separately (or is not tracked as individual encounter data separately) from an office visit, and the primary purpose of the office visit is not the delivery of the preventive item or service, then this plan will impose cost-sharing requirements with respect to the office visit.

Example:

Facts: An individual covered by this Plan visits an in-network health care provider to discuss recurring abdominal pain. During the visit, the individual has a blood pressure screening, which has in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force with respect to the individual. The provider bills the Plan for an office visit.

Conclusion: In this Example, the blood pressure screening is provided as part of an office visit for which the primary purpose was not to deliver preventive items or services. Therefore, the Plan will impose a cost-sharing requirement for the office visit charge.

The list below shows the Preventive Services subject to this no Deductible/100% In-Network coverage.

#### **Covered Preventive Services for Adults**

- Abdominal Aortic Aneurysm one-time screening for men of specified ages who have ever smoked
- Alcohol Misuse screening and counseling
- Aspirin use for men and women of certain ages
- Blood Pressure screening for all adults
- Cholesterol screening for adults of certain ages or at higher risk
- Colorectal Cancer screening for adults over 50
- Depression screening for adults
- Type 2 Diabetes screening for adults with high blood pressure
- Diet counseling for adults at higher risk for chronic disease
- HIV screening for all adults at higher risk
- Immunization vaccines for adults – doses, recommended ages, and recommended populations vary:
  - Hepatitis A
  - Hepatitis B
  - Herpes Zoster
  - Human Papillomavirus
  - Influenza
  - Measles, Mumps, Rubella
  - Meningococcal
  - Pneumococcal
  - Tetanus, Diphtheria, Pertussis
  - Varicella
- Obesity screening and counseling for all adults

- Sexually Transmitted Infection (STI) prevention counseling for adults at higher risk
- Tobacco Use screening for all adults and cessation interventions for tobacco users
- Syphilis screening for all adults at higher risk
- Annual lung cancer screening with low-dose computed tomography in adults ages 55-80 who have a 30 pack-year smoking history and currently smoke or have quit within the past 15 years.
- Hepatitis C screening for persons at high risk and persons born between 1945 and 1965.
- Hepatitis B screening for persons at high risk for infection.

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

- Anemia screening on a routine basis for pregnant women
- Bacteriuria urinary tract or other infection screening for pregnant women
- BRCA counseling about genetic testing for women at higher risk
- Breast Cancer Mammography screenings every 1 to 2 years for women over 40
- Breast Cancer Chemoprevention counseling for women at higher risk
- Breast Feeding interventions to support and promote breast feeding
- Cervical Cancer screening for sexually active women
- Chlamydia Infection screening for younger women and other women at higher risk
- Contraception: Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, not including abortifacient drugs
- Domestic and interpersonal violence screening and counseling for all women
- Folic Acid supplements for women who may become pregnant
- Gestational diabetes screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes
- Gonorrhea screening for all women at higher risk
- Hepatitis B screening for pregnant women at their first prenatal visit
- Human Immunodeficiency Virus (HIV) screening and counseling for sexually active women
- Human Papillomavirus (HPV) DNA Test: high risk HPV DNA testing every three years for women with normal cytology results who are 30 or older
- Osteoporosis screening for women over age 60 depending on risk factors
- Rh Incompatibility screening for all pregnant women and follow-up testing for women at higher risk
- Tobacco Use screening and interventions for all women, and expanded counseling for pregnant tobacco users
- Sexually Transmitted Infections (STI) counseling for sexually active women
- Syphilis screening for all pregnant women or other women at increased risk
- Well-woman visits to obtain recommended preventive services
- Low-dose aspirin for pregnant women who are at higher risk of an abrupt and dangerous increase in blood pressure known as preeclampsia.

### **Covered Preventive Services for Children**

- Alcohol and Drug Use assessments for adolescents
- Autism screening for children at 18 and 24 months
- Behavioral assessments for children of all ages
- Cervical Dysplasia screening for sexually active females
- Congenital Hypothyroidism screening for newborns
- Developmental screening for children under age 3, and surveillance throughout childhood
- Dyslipidemia screening for children at higher risk of lipid disorders
- Fluoride Chemoprevention supplements for children without fluoride in their water source
- Gonorrhea preventive medication for the eyes of all newborns
- Hearing screening for all newborns
- Height, Weight and Body Mass Index measurements for children
- Hematocrit or Hemoglobin screening for children
- Hemoglobinopathies or sickle cell screening for newborns
- HIV screening for adolescents at higher risk
- Immunization vaccines for children from birth to age 18 —doses, recommended ages, and recommended populations vary:
  - Diphtheria, Tetanus, Pertussis
  - Haemophilus influenzae type b
  - Hepatitis A
  - Hepatitis B
  - Human Papillomavirus
  - Inactivated Poliovirus
  - Influenza
  - Measles, Mumps, Rubella
  - Meningococcal
  - Pneumococcal
  - Rotavirus
  - Varicella
- Iron supplements for children ages 6 to 12 months at risk for anemia
- Lead screening for children at risk of exposure
- Medical History for all children throughout development
- Obesity screening and counseling
- Oral Health risk assessment for young children
- Phenylketonuria (PKU) screening for this genetic disorder in newborns
- Sexually Transmitted Infection (STI) prevention counseling for adolescents at higher risk
- Tuberculin testing for children at higher risk of tuberculosis
- Vision screening for all children
- Tobacco use interventions to prevent initiation of tobacco use in school-aged children and adolescents.
- Hepatitis B screening for persons at high risk for infection.



## Benefit for Treatment in In-Network Walk-in Clinic or In-Network Urgent Care Center

The cost of services provided at an In-Network Walk-in Clinic or In-Network Urgent Care Center will be covered at 90% and will not be subject to the Deductible. In addition, in the event specimens are collected (e.g. blood, urine) during an In-Network Walk-in Clinic or In-Network Urgent Care Center visit with the analysis performed and billed by a separate lab service, charges associated with the associated lab work will also be covered at 90% and will not be subject to the Deductible.

**NOTE:** The bills submitted by Walk-in Clinics and Urgent Care Centers may not identify them as a Walk-in Clinic or Urgent Care Center and, in such a case, the Plan may not be able to process the claim as described in this section. If you visit one of these facilities, please retain your paperwork including the name of the Walk-in Clinic or Urgent Care Center and review your Explanation of Benefits to make certain that the benefit was processed as provided by an In-Network Walk-in Clinic or In Network Urgent Care Center. If the facility was not identified for purposes of this benefit, simply contact the Fund Office and provide the documentation of your visit including the name of the Walk-in Clinic or Urgent Care Center.

## The Deductible

In each calendar year that you or an eligible dependent has covered Comprehensive Medical expenses, you must pay the amount shown in the Schedule of Benefits as the "Deductible" before the Plan will cover any of your Comprehensive Medical expenses. The Deductible applies separately to each eligible person in each calendar year with these exceptions:

Deductibles for a family cannot exceed three times the individual Deductible in a calendar year. The limit is satisfied after family members collectively meet the family Deductible in a calendar year.

Any expenses applied against the Deductible for the last three months of a calendar year will also count towards the Deductible for the next calendar year. This carry-over will not count toward meeting the family Deductible in a following year.

If you are an eligible employee in the National Automatic Sprinkler Metal Trades (NASMT) Welfare Fund and subsequently become covered by this Plan, any expenses in a calendar year which are applied against the Deductible for an eligible employee or eligible dependent in the NASMT Welfare Fund will also be applied towards the individual and family Deductibles under the rules of this Plan.

The Plan will cover 100% of the costs of Preventive Services described in the preceding section without regard to whether that individual has met the

Deductible.

## Co-insurance of Covered Expenses

After the Deductible has been met each calendar year, the Plan will pay a percentage of covered Usual and Customary charges (see Definitions, page 96), and the patient is responsible for the remainder. This is your co-insurance amount. Your co-insurance amount may vary, depending on whether you use a PPO provider ("In-Network"), and based on your plan of benefits. Co-insurances are shown on the Summaries of Benefits in Part II of this booklet.

## 100% Payment of Covered Expenses After Out-of-Pocket Maximum

After an individual's portion of covered Comprehensive Medical expenses exceed the Out-of-Pocket maximum expense (plus the Deductible in the case of expenses incurred "Out-of-Network") in a calendar year (this stated amount is referred to as the Out-of-Pocket maximum expense), most covered benefits will be paid at 100% for that person for the rest of that calendar year and, in many situations, the next calendar year, after the individual Deductible for the next year is met. If an individual pays the Out-of-Pocket maximum in a calendar year, the amount that the individual pays in that year will be carried forward and applied towards the individual's Out-of-Pocket maximum in the next year. In the event some or all of your Out-of-Pocket expenses for a calendar year are reimbursed under a provision of the Plan, those reimbursed expenses no longer count toward that year's Out-of-Pocket maximum expense.

The Out-of-Pocket maximum expense applies to each person covered under the Plan and there is no family maximum limit. If you meet the "In-Network" Out-of-Pocket maximum expense, you will still be responsible for paying for medical care that is provided "Out-of-Network". From time-to-time, the Out-of-Pocket maximum expense level under the Plan may be changed. If you reach your Out-of-Pocket maximum expense in one year and the Out-of-Pocket maximum is increased for the following year, you will have to pay the amount of the increase in the Out-of-Pocket maximum expense in the second year (in addition to your Deductible) before covered benefits will be paid at 100% for that next year. For example, if you meet the Out-of-Pocket maximum expense this year, but next year the Out-of-Pocket maximum expense is increased by \$500, you will be subject to the standard co-insurance after you meet your Deductible for the next year until your Out-of-Pocket expenses for that second year reach \$500. Only then will your expenses be covered at 100% for that second year. The maximums are shown on the Summaries of Benefits in Part II of this booklet (see Definitions, Out-of-Pocket Expenses, page 94).

## Unlimited Lifetime Maximum Benefit

There is no lifetime maximum comprehensive medical benefit limitation.

## Exceptions

Maximums and co-insurance amounts differ depending on whether you are using an "In-Network" service provider through a PPO, and on your level of benefits. Please see the

Summaries of Benefits in Part II of this booklet for details.

## **Personal Health Management Program**

This benefit Program provides telephone counseling and support to individuals with chronic conditions. A representative will contact you about enrolling if you are identified as someone with a chronic condition who may not be following the recommended treatment guidelines for your condition. If you enroll in the Program, you will work with a registered nurse from Carewise Health through a series of regular phone calls designed to help you better manage your chronic condition.

### **What is a “chronic condition?”**

Chronic (long-term, persistent) conditions usually require continuous management to improve health or reduce symptoms. With the right support, people with chronic conditions can learn how to manage their symptoms and even slow the progression of their illnesses.

### **Which conditions are covered under the Personal Health Management Program?**

The chronic conditions that are included in the Program are:

- Asthma
- Atrial Fibrillation
- Chronic Obstructive Pulmonary Disease (COPD)
- Congestive Heart Failure
- Diabetes
- High Cholesterol
- High Blood Pressure
- Heart Disease
- Acute, Recurring Low Back Pain
- Stroke

### **How does this Program help people with chronic illness?**

The Personal Health Management Program was designed to help participants learn how to work in partnership with their doctors to achieve an effective treatment plan. It helps participants create strategies for developing self-care skills and establishing new health habits that will have a lasting impact. Participants who actively engage in the Program will work to improve the quality of their lives, boost work productivity, prevent escalating health problems and reduce their healthcare costs.

### **What’s involved if I agree to participate when a representative calls me?**

Once enrolled in the Program, your own Personal Nurse Advocate will call to schedule regular phone call appointment times that are convenient for your schedule to discuss your condition and treatment.

Calls generally last about 10 – 20 minutes and occur about once per month. During these calls, you'll talk about your condition, treatment, progress, etc. The length of time you will participate in the Program depends on your individual circumstances and what's needed to help you improve. On average, a commitment lasts about 4 to 5 months.

### **What can a Carewise Health Nurse do for me that my doctor can't?**

Your Carewise Health Personal Nurse Advocate is not a substitute for your doctor. You should consider the Nurse an additional resource. For example, a Personal Nurse Advocate can help you prepare for your next doctor's appointment and gather questions to take with you.

Your Nurse can also reach out to your doctor's office on your behalf—for example if he or she has a question about multiple medications you're taking and potential drug interactions. The information from the Nurse is meant to supplement your physician's care—it is not meant to replace it or interfere with it.

### **Who is eligible for this Program?**

You and your covered spouse and dependent children age 18 and older are eligible to participate in the Program and may be contacted by Carewise Health.

### **Is there a reward for participating in this Program?**

If you are contacted, enroll and remain actively engaged in the Program, you will be rewarded in the next calendar year in the following ways:

- You'll pay less out of pocket for maintenance medications related to your condition: You'll pay 10% coinsurance instead of 25% (or 35%) coinsurance.
- Your individual annual deductible will be \$200 instead of the standard In-Network Deductible for your Level of benefits. For example, the \$400 Deductible for Level 1 Benefits will become \$200 as will the \$450 Deductible for the Self-Pay Plan.
- You'll be responsible for less out of your own pocket. The annual In-Network Out-of-Pocket maximum will be \$1,000 instead of the annual In-Network Out-of-Pocket maximum otherwise applicable to your Level of benefits. For example, the \$2,500 In-Network Out-of-Pocket maximum for Level 1 Benefits will become \$1,000 as will the \$2750 In-Network Out-of-Pocket maximum for the Self-Pay Plan.

### **Are there penalties for not participating?**

If you are contacted and you decline participation, or you enroll but do not actively engage in the Program, you will be assessed the following penalty in the next calendar year:

- Increased individual annual deductible: The annual individual Deductible will be \$800 instead of the individual Deductible otherwise applicable to your Level of benefits. For example, the \$400 individual Deductible for Level 1 Benefits will become \$800 as will the \$450 individual Deductible for the Self-Pay Plan.

- Increased individual out-of-pocket maximum: The annual In-Network Out-of-Pocket maximum will be \$5,000 instead of the annual In-Network Out-of-Pocket maximum otherwise applicable to your Level of benefits. For example, the \$2,500 In-Network Out-of-Pocket maximum for Level 1 Benefits will become \$5,000 as will the \$2750 In-Network Out-of-Pocket maximum for the Self-Pay Plan.

### **What if I'm identified but feel that I'm not able to participate?**

The NASI Welfare Fund is committed to helping you achieve your best health. If you can demonstrate that you are unable to participate in telephone counseling to qualify for the Program reward (and to avoid the penalty), you may contact Carewise Health at 866-691-8433 to discuss (and, if you wish, you may include your doctor) whether there may be a reasonable alternative for you to qualify for the reward (and avoid the penalty) in light of your health status.

### **Assignment of Benefits**

It is common practice for participants to authorize the Fund to pay benefits directly to a Hospital or Physician. While the Fund routinely honors such directions, it is under no obligation to do so in every case. For example, if there has been a benefit overpayment, or you otherwise owe money to the Fund, the Fund may choose to offset the overpayment against future benefits even if you have requested that benefits be paid directly to your Hospital or Physician. This is true even if the Fund has pre-certified coverage.

### **Pre-Certification of Hospital Admission**

Call 1-866-343-3709 as soon as you or your dependent are planning an admission, preferably at least 7 days prior to the anticipated admission date or within 48 hours after an emergency admission. This applies to medical, surgical, and psychiatric hospitalization.

This call may come from you, a family member, friend, admitting Physician, or Hospital and is used to identify the member, the patient, and the Physician. You speak with a Medical Review Specialist, a specially trained Registered Nurse, who asks for the patient's name, age and the Physician's name and phone number. The Specialist then contacts your Physician and continues to monitor your case until discharge. The Medical Review Specialist discusses with your Physician the admitting diagnosis, the procedure(s) to be performed during the hospitalization, the treatment plan and the approximate number of days of confinement required.

Notification of your certified admission is provided to your Physician, the Hospital and the Fund Office 24 hours after certification.

### **Continued Stay Review**

During your hospitalization, the medical review staff monitors your Hospital stay to make sure that you were admitted as planned and, provided no complications arise, that you are discharged on the scheduled day.

## Medical Case Management

Some seriously ill patients have complex medical situations that cannot be effectively reviewed in a phone conversation. Such situations might include premature infants, cancer patients, head injuries, spinal cord injuries, AIDS cases, or adolescent psychiatric cases. Such cases are automatically identified for special attention through the Hospital Pre-Certification process.

After a case is identified and discussions are held with the attending Physician, a Case Manager (a specially trained Registered Nurse) within the patient's geographic area contacts the Fund Office and the patient/family within twenty-four hours to arrange an initial meeting. During this meeting, the Case Manager discusses any questions that the patient/family might have and helps you and your Physician explore all possible alternatives to your current level of care. The Case Manager is familiar with local/community resources and custom, and is tied into a sophisticated national network of leading medical providers. In this way, a collective body of specialized medical expertise can be focused on your case to enhance your recovery/rehabilitation. Once you and your Physician select the treatment plan, the Case Manager can help coordinate and implement your decision.

If you have been discharged from an inpatient psychiatric program, experienced mental health personnel review your case. Contacts are made with your Physician to discuss the appropriateness of treatment, certify specific additional visits and determine a reasonable time at which measurable progress should be made.

## Covered Services

Comprehensive Medical coverage includes expenses incurred for Hospital, surgical, medical care, home care, diagnostic/pathology/x-ray tests, organ and tissue transplants, mental and nervous disorder treatment, hospice care, rehabilitation care in a Convalescent Facility (see Definitions, page 92), well-child care, chiropractic care, prescription drugs, and second surgical opinions. The Plan also provides hearing aids, substance abuse treatment, dental and vision care.

Covered services are discussed in more detail in Part IV of this booklet, entitled "Benefits." It is important, however, that you become familiar with the limitations and general exclusions described in the following paragraphs because they affect the scope of your coverage under this Plan.

## Benefits Under the Newborns' and Mothers' Health Protection Act

Under Federal law, group health plans may not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider (e.g., Physician, nurse-midwife, or Physician assistant), after consulting with the

mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable).

Also, under Federal law, plans may not set the level of benefits or Out-of-Pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan may not, under Federal law, require that a Physician or other health care provider obtain authorization from the plan for prescribing a length of stay of up to 48 hours (or 96 hours).

## Benefits Under the Women's Health and Cancer Rights Act

In the case of any participant or beneficiary receiving benefits under the Plan in connection with a mastectomy and who elects breast reconstruction, coverage will be provided under the Plan for:

- reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedema.

As with other benefits under the Plan, applicable Deductibles and/or coinsurance limitations apply to the above coverage.

## Limitations and Exclusions

Covered Services are subject to the following limitations and general exclusions. Please read this section carefully. Becoming familiar with the limits imposed will help you understand what services are covered and the level of your coverage.

### Comprehensive Medical Benefit Limitations

In general, the NASI Welfare Fund covers expenses for non-work-related illness or injury.

Comprehensive Medical Coverage does not include:

1. routine physical examinations, except once per year;
2. eye refraction except following accidental injury; eyeglasses, contact lenses, lens implants or fittings except as necessary in connection with cataract surgery or except as covered under Vision Care;

3. charges for furniture installation, set-up, or maintenance or modifications to home or car;
4. educational training for natural childbirth;
5. in vitro fertilization, artificial insemination;
6. services to reverse voluntary, surgically induced infertility;
7. services and supplies not prescribed;
8. therapeutic devices, including but not limited to hypodermic needles, syringes, support garments, or other non-medical substances purchased for self-use, except paraphernalia necessary for the administration of insulin;
9. replacement or repair of a prosthetic appliance unless outgrown;
10. orthopedic shoes (except when joined to braces);
11. routine care of feet, including callus or corn paring, trimming of toenail, or treatment of chronic conditions of the foot;
12. radial keratotomy, LASIK and other refractive surgery;
13. acupuncture;
14. organ transplants except as specifically provided by the Plan;
15. therapy for marriage-related problems;
16. physical, occupational, myofunctional therapy, or pulmonary rehabilitation except following illness or injury;
17. non-medical services associated with learning disabilities, mental retardation, developmental delay, autistic disease of childhood, behavioral problem, special education;
18. hypnotism, stress management, or goal-oriented behavior modification therapy;
19. cosmetic, plastic, or reconstructive surgery except to repair or alleviate damage resulting from or caused by injury, congenital defect or disfigurement related to disease;
20. construction services, purchase or rental of supplies, appliances, or equipment for personal hygiene, beautification, comfort or convenience;



21. travel or lodging;
22. transportation of a family member or of medical personnel, equipment or supplies;
24. services not related to specific diseases;
25. dental services except as required for treatment of an injury to sound natural teeth or for dental surgery directly related to cancer surgery of the mouth or for services directly related to dentogenesis imperfecta, incontinentia pigmenti or anodontia (including partial anodontia).
26. claims for benefits to Medicare-eligible participants and dependents by providers who have opted out of Medicare except to the extent payment would be made if the providers continued to participate in Medicare.

In addition to Comprehensive Medical Benefit Limitations, the following limitations also apply:

### Second Surgical Opinion Limitations

The Second Surgical Opinion Benefit does not include a consultation:

1. with a Physician who is not certified as a specialist in the medical field of the proposed surgery;
2. with a Physician or associate of the Physician who performs the surgery or has a financial interest in the outcome of the recommendation;
3. in connection with proposed surgery for which a surgical benefit would not be payable under the Plan;
4. unless the patient is examined in person by the Physician rendering the second or third medical opinion;
5. obtained after surgery is performed; or
6. in excess of two consultations in connection with the proposed surgery.

### Hospital Expenses Limitations

Hospital Expenses do not include:

1. Hospitalization for dental care unless certified by your Physician as necessary to protect your life or health;
2. Hospitalization primarily for diagnostic study directed toward a definite

illness or injury where treatment consists of physical therapy, hydrotherapy or occupational therapy unless the services can be provided only on an inpatient basis and the patient's physical condition requires hospitalization.

### Durable Medical Equipment Limitations

Covered Expenses include Durable Medical Equipment when it is prescribed by a physician who documents the necessity of the item, is necessary for the treatment of a disease or injury to improve body function lost as the result of a disease, injury or congenital abnormality or is Medically Necessary to enable the patient to perform essential activities of daily living.

Examples of these activities include eating, toileting, bathing, walking, transferring from bed to chair and bed to wheelchair or walker. However, it does not include equipment to enable someone to drive a vehicle or equipment solely for the convenience of the patient's caretaker.

Expenses for Durable Medical Equipment are not covered unless the equipment:

1. is of strong construction for repeated use;
2. is appropriate for home use and is safe and effective without medical supervision;
3. is primarily and customarily used to serve a medical purpose and is not normally of use to persons who do not have a disease or injury;
4. is not aesthetic in nature;
5. is less expensive than alternative equipment;
6. is not used to enhance the home or environment, to change temperature or humidity or air quality;
7. is not for exercise or training;
8. is not for the treatment of temporomandibular joint (TMJ) syndrome.

### Diagnostic Laboratory, Pathology, and X-Ray Expenses Limitations

Diagnostic Laboratory and Pathology Test and X-Ray Examination expenses do not include:

1. dental X-rays unless required due to injury to natural teeth (Dental X-rays may be covered under Dental Care); and
2. camp, school and employment physical; pre-marital blood tests and similar tests.

### Covered Organ or Tissue Transplant Limitations

Covered Organ or Tissue Transplant coverage does not cover:

1. transplants other than those listed as a Covered Transplant Procedure;
2. animal organ or tissue;
3. charges for procedures not generally accepted by the medical profession as safe, effective, and appropriate treatment of the patient's medical condition; and
4. charges for lodging or for the preservation, storage or transplantation of a tissue or organ of a donor.

### Hospice Care Limitations

Hospice Care does not include the following:

1. care in a Hospice that is not Medicare-certified;
2. care unless life expectancy is six months or less;
3. bereavement counseling exceeding a maximum of 12 sessions within six months after the patient's death;
4. services provided by a volunteer, pastoral counselor or someone who does not normally charge for his services, a person who ordinarily resides in your home, or a member of your family;
5. services that could have been provided by a properly trained person of the eligible person's household without endangering his life or seriously impairing his condition;
6. custodial, domestic, or housekeeping services;
7. services of a masseur, physical culturist, companion or sitter, or physical education instructor;
8. benefits for Hospice Care services for a period greater than six months.

### Rehabilitation Care Limitations

Rehabilitation Care does not include Custodial Care (see Definitions, page 93).

### Chiropractic Care Limitations

Chiropractic Care does not include:

1. a follow-up visit unless a chiropractic manipulation is performed during the visit;
2. charges for more than 20 visits per calendar year;
3. charges for more than two additional modalities per day in addition to the chiropractic manipulation; and
4. expenses for laboratory tests.

### Prescription Drugs Limitations

If your physician prescribes a drug for which a generic equivalent exists, the NASI Welfare Fund will provide reimbursement only up to the cost of the generic equivalent, even if your doctor says the prescription must be dispensed as written.

No Prescription Drug benefits are payable for:

1. a non-legend, patent or proprietary drug, medicine or medication not requiring a prescription, except insulin, unless the drug, medicine, or medication is a compounding of two or more drugs, medicines, or medications, which compounding, by law, must be prescribed;
2. separate charges for medication, legend or non-legend, that is consumed or administered, in whole or in part, at the place where it is dispensed;
3. drugs or devices for birth control for dependent children;
4. nonprescription drugs and vitamins, minerals, laetrile, enzymes, diet foods, or dietary supplements whether prescribed or not, except such vitamins and minerals that meet the definition of Preventive Services (see Definitions, page 95) and for specific vitamins that require a prescription for situations where no reasonable over-the-counter equivalent (or non-prescription alternative) is available. The specific vitamins covered by the Plan that require a prescription and have no reasonable over-the-counter equivalent available are:

Calafol Rx  
 Cardiotek Rx  
 ComBgen  
 Folgard Rx/ Folgard Rx 2.2  
 Folpace Rx  
 Foltx  
 Mephyton  
 Metanx  
 Rocaltrol

5. because there are effective over-the-counter alternatives for proton-pump inhibitors (“PPIs”) and for non-sedating antihistamines, prescription drug coverage does not include coverage for PPIs or for non-sedating antihistamines whether prescribed or not except for individuals with one (or more) of the following medical conditions in which case PPI coverage is available:
  - Hypersecretory conditions such as Zollinger-Ellison Syndrome, mastocytosis, and multiple endocrine adenomas
  - Barrett’s Esophagus
  - Esophageal peptic stricture
  - Erosive esophagitis
  - Esophageal cancer

Additionally, coverage of PPIs will be provided for individuals for whom it is medically established that the individual needs a PPI that is not available over-the-counter.

6. drugs or classes of drugs that require prior authorization from the Fund’s pharmacy benefit manager unless such prior authorization has been received. A list of drugs requiring prior authorization is available from the Fund Office upon request.

### Mail-Order Maintenance Drug Benefit Limitation

If you purchase maintenance drugs from a source other than Express Scripts, you will be reimbursed at the level of coverage available through the Express Scripts mail-order pharmacy. This may reduce the amount of the Plan's reimbursement.

### Hearing Aid Benefit Limitations

Expenses under the Hearing Aid Benefit do not include:

1. special education or training;
2. medical or surgical treatment;
3. purchase, replacement or repair of hearing appliances more than once in a five-consecutive-year period;
4. hearing aid expenses of dependents; and
5. charges that are covered as a benefit under another provision of the Plan.

### Dental Limitations

TMJ treatment does not include the following expenses:

1. services or supplies other than those used primarily or exclusively to alter occlusion and/or reposition the lower jaw;
2. services or supplies that can be self-administered by the patient following instruction; and
3. orthodontic bonding.

Orthodontic limitations include the following:

1. No benefits are payable for the replacement or repair of an orthodontic appliance.
2. If orthodontic treatment is terminated, benefits are payable only for services incurred prior to the date of termination. If treatment is resumed, remaining benefits shall be resumed.
3. Benefits are payable only for months that coverage is in force.

No Dental Benefit shall be payable for:

1. charges for a plaque control program;
2. more than one set of diagnostic X-rays during any 36 month period per eligible person except X-rays required to diagnose a specific condition or its treatment;
3. more than two charges for bitewings during any calendar year.
4. a consultation if another service is rendered to the eligible person on the date of the consultation or during the three-month period immediately following the date of the consultation;
5. replacement of a lost or stolen prosthetic device;
6. dental services and supplies rendered solely for cosmetic purposes unless required as a result of injury;
7. charges for sealants unless specifically covered;
8. oral hygiene;
9. dietary instruction;
10. charges for duplicate appliances;

11. more than two dental cleanings in any calendar year;
12. more than two routine oral examinations in any calendar year;
13. replacement of an existing crown, partial or full removable denture or fixed bridgework unless:
  - a. the replacement is required to replace one or more additional teeth;  
or
  - b. the existing dentures or bridgework cannot be made serviceable due to a change in the structure of the mouth caused by injury or illness;  
or
  - c. the existing crown, dentures or bridgework were installed at least five years prior to its replacement and the existing denture or bridgework cannot be made serviceable. (However, in the case of a child who needs dentures as a result of a medical necessity, this five-year rule may be waived to accommodate the child's growth, if deemed necessary and appropriate by the Trustees.); or
  - d. the existing denture is an immediate temporary denture and replacement by a permanent denture is required and takes place within 12 months from the date of installation of the temporary denture.
14. crowns and/or inlays installed as multiple abutments and splints for periodontal treatment unless a period of at least three years has elapsed from the initial installation of the replaced crown or inlay;
15. a prosthetic device, including bridges, crowns and the fitting thereof ordered before coverage under the Plan commenced, or which were ordered while covered by the Plan but are installed or delivered more than 30 days after termination of benefits;
16. a drug, medicine or supply intended for personal hygiene, such as toothpaste and cleaning devices; and
17. adult fluoride treatment.

### Vision Benefit Limitations

No Vision Benefit is payable for:

1. contact lenses, sunglasses, or other eyeglass lenses not prescribed by an optometrist or ophthalmologist;

2. replacement or repair of lost, scratched, or broken lenses (including contact lenses), or eyeglass frames;
3. medical or surgical treatment of the eyes;
4. orthoptics or vision training;
5. two pair of glasses in lieu of bifocals; and
6. subnormal vision aids.
7. services or items not obtained through a Vision Service Plan Provider.

## General Exclusions

The Plan does not pay "medical" benefit expenses unless the charge is for services or supplies covered by the Plan. In addition, the Plan does not pay for charges in connection with the following:

1. medical services or supplies, including prescription drugs, considered educational, investigational, or experimental. A drug, device or medical treatment or procedure is considered experimental or investigational if:
  - a. it is a drug or device that cannot be lawfully marketed without approval of the U. S. Food and Drug Administration and for which approval for marketing has not been given at the time the drug or device is furnished;
  - b. if reliable evidence shows that the drug, device or medical treatment or procedure is the subject of ongoing phase I, II, or III clinical trials or is under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis; or
  - c. if reliable evidence shows that the consensus of opinion among experts regarding the drug, device or medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis. For this purpose, reliable evidence means only published reports and articles in the authoritative medical and scientific literature: the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device or medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device or medical treatment or procedure.



- d. This general exclusion for educational, investigational, or experimental services or products does not include the routine patient costs for items or services furnished in connection with participation in a clinical trial if those costs would otherwise be covered under the plan. "Routine patient costs" has the same meaning as that term is defined in the Public Health Services Act Section 2709 and includes items or services that are otherwise covered under the plan and are used for the direct clinical management of the patient, but does not include items or services used solely to satisfy the data collection and analysis needs of the clinical trial.
2. medical services or supplies available without cost or for which you are not legally required to pay in the absence of the Plan;
3. medical services or supplies furnished in or by a federal, state, or local government agency or program or in or by a Hospital or institution other than co-insurance amounts paid by the employee or dependent unless required by law;
4. medical services or supplies, including prescription drugs, furnished in or by a nursing home, sanatorium, rest home, convalescent home, extended care facility or similar establishment unless it is a Convalescent Facility;
5. private duty nursing care, unless ordered by the Physician as Medically Necessary (see Definitions, page 94);
6. Custodial Care or domiciliary care regardless of the facility where provided;
7. medical services or supplies furnished by an individual who ordinarily resides in the patient's home or is related to the patient by blood or marriage;
8. services not rendered, or in an amount more than the amount billed;
9. charges for services or supplies in excess of UC;
10. expenses that are not Medically Necessary (see page 94);
11. services rendered by an individual who does not meet the definition of Physician (see page 95);
12. services rendered primarily for training or educational purposes; and
13. food or food supplements.

The plan does not pay medical or non-medical charges in connection with the following:

1. services or supplies for an injury or illness that arises out of or in the course of employment, whether or not compensable under workers' compensation,

occupational disease, or similar laws. Under specific circumstances, the Fund may pay such benefits subject to the right of reimbursement (see pages 100-103);

2. an injury or illness caused by an act of war, or determined by the Secretary of Veterans' affairs to have been incurred in, or aggravated during, performance of services sustained while in the armed forces;
3. claims not submitted within two years of the time the service was rendered unless it is established to the satisfaction of the Trustees that a delay in submitting a claim within the two-year period was solely the result of a billing practice outside the control of the employee or dependent and the claim is submitted within eight years from the time the service was rendered;
4. charges for failure to keep a scheduled appointment or for the completion of any form; or
5. services or supplies to the extent covered by state or federal no-fault insurance or expenses which are covered under third-party liability insurance coverage, such as homeowners' or automobile insurance, or expenses for which a third party is liable.

## IV. Benefits

### Comprehensive Medical Benefits

Comprehensive Medical coverage includes the following categories of health benefits. Remember, Comprehensive Medical coverage is subject to Deductibles, co-insurance rules, and the limitations and exclusions described in Part III of this booklet.

#### Hospital Expenses

The Plan pays Hospital Expenses, including:

1. room and board for semi-private room;
2. operating, delivery, recovery and treatment room and equipment fees;
3. diagnostic laboratory and pathology tests, including electrocardiograms and electroencephalograms;
4. X-ray examinations;
5. radiotherapy including use of X-ray, radon, radium, cobalt, and other radioactive substances;
6. services or supplies furnished by a Hospital for treatment in the outpatient department, emergency room or ambulatory surgical facility;
7. pre-surgical tests;
8. bandages, surgical dressings, casts, splints, trusses, braces, and crutches;
9. prescription drugs taken or administered during hospitalization;
10. anesthesia and its administration;
11. oxygen and its administration;
12. whole blood, blood plasma, plasma extenders, and blood transfusions;
13. routine nursery care of a newborn child of an eligible employee;
14. inpatient treatment of a mental or nervous disorder;
15. confinement for medical complications of alcoholism or drug abuse, including cirrhosis, delirium tremens, hepatitis; and

16. general nursing care services of a licensed practitioner.

## Surgical Expenses

The Plan pays surgical expenses, including:

1. an incision, excision, or electrocauterization of any organ or part of the body;
2. treatment of a fracture;
3. cosmetic, plastic or reconstructive surgery to repair injury, or disfigurement related to disease, or for repair of congenital defects;
4. reduction of a dislocation;
5. endoscopic procedures;
6. suturing of wounds;
7. X-ray or radium therapy or laser therapy if used in lieu of a cutting operation;
8. injection treatment of hernias, hemorrhoids, or varicose veins;
9. anesthesia services;
10. services of a dentist or Physician for repair of injury to sound natural teeth;  
and
11. assistant surgeon fees not to exceed 20% of the covered surgical expense;
12. bilateral surgery, when procedures are performed on both sides of the body during the same surgical session or on the same day, the additional procedures will be subject to bilateral surgery payment reductions based on the Medicare Physician Fee Schedule Relative Value Unit file;
13. multiple surgical procedures, when more than one surgical procedure is performed on the same service date during the same surgical session, additional procedures will be subject to multiple procedure payment reductions based on the Centers for Medicare and Medicaid Services (CMS) Relative Value Unit file for multiple surgical reductions and the American Medical Association Current Procedural Technology book.

## Medical Care Expenses

The following services and supplies are payable if furnished on an inpatient basis or as an outpatient in an emergency room of a Hospital, in a Physician's office or in an Outpatient Facility (see Definitions, page 94):

1. Physician visits (no benefit is payable for a visit in the Hospital in connection with a surgical procedure or post-operative care unless the visit is by a Physician other than the surgeon performing the operation);
2. services of a nurse-midwife (for eligible employees or the Spouse of an eligible employee) up to an amount that does not exceed the amount that would be payable if the services were performed by a Physician;
3. rental of a wheelchair, hospital-type bed, mechanical device for treatment of respiratory paralysis or other durable medical equipment;
4. orthopedic appliance implants;
5. services by a licensed practitioner for physical therapy, hydrotherapy, or occupational therapy;
6. speech therapy through the use of appropriate programs for treatment of developmental speech dysfunction resulting from injury or illness;
7. kidney dialysis when performed in a Medicare-approved facility;
8. ambulance service for emergency transportation to or from the nearest Hospital equipped to provide the required medical care;
9. orthopedic braces and appliances;
10. prosthetic devices or implants;
11. immunizations if within standard medical practice;
12. oxygen;
13. visiting nurses (in home only, not in an acute care setting); and
14. services of a dentist or Physician required as a result of injury to sound natural teeth or for surgery directly related to cancer surgery of the mouth or for services directly related to dentogenesis imperfecta, incontinentia pigmenti or anodontia (including partial anodontia).

## Medical Care in the Home

The Plan covers the following medical services or supplies in the home:

1. hemodialysis (if less expensive than dialysis in a Medicare-approved facility), including the reasonable cost of an artificial kidney machine, Medically Necessary supplies, services and training, home testing for dialysis, and rental

of durable medical equipment. All charges are reduced by any expenses covered by Medicare;

2. charges for IV therapy and training of the patient or others to administer the medication; and
3. Physician's visits.

### Diagnostic Laboratory and Pathology Test and X-Ray Examination Expenses

The Plan covers expenses incurred for laboratory and pathology tests and for X-ray examinations performed for diagnostic testing when generally accepted as a standard or reasonable test for the condition.

### Organ or Tissue Transplants

Under certain circumstances, the Plan pays for Covered Expenses for Covered Organ or Tissue Transplant Services for you or your eligible dependent. Covered Expenses are subject to the Comprehensive Medical Deductible and co-insurance rules applicable to all Comprehensive Medical Care.

Covered Organ or Tissue Transplant Services consist of the following:

1. organ and tissue procurement consisting of the removal from a cadaver, preservation, storage, and transporting of the organ or tissue, if you or your dependent is the recipient;
2. reasonable expenses of an uninsured live donor as a recipient's Covered Expense, if you or your eligible dependent is the recipient;
3. reasonable charges for transportation to the nearest transplant facility;
4. if you or your eligible dependent is a donor for a Covered Transplant Procedure, reasonable expenses for donor testing and charges for removing the organ or tissue, and other reasonable expenses in the same manner as for treatment of illness; and
5. other services that would be covered under the Comprehensive Medical Benefit in the same manner as any other treatment or injury.

The Plan pays for the following Covered Transplant Procedures of human-to-human organ or tissue:

1. bone marrow (conventional or autologous);
2. heart;

3. liver;
4. kidney; and
5. cornea.

### Mental or Nervous Disorder Treatment

The plan covers medical expenses for the treatment of mental or nervous disorders.

### Substance Abuse Treatment

The Plan covers medical expenses for individual or group therapy, and inpatient or outpatient treatment by a psychiatrist, licensed clinical psychologist or similar professional who is in private practice and licensed to practice substance abuse treatment.

### Hospice Care

Hospice Care consists of expenses for the following medical care if you or your dependent is terminally ill:

1. home visits by nurses and other health care professionals;
2. management of pain;
3. medical treatments as prescribed;
4. instruction and supervision for family members in the care of the patient;
5. help in obtaining medical equipment, supplies or medication;
6. psychological counseling and emotional support to the patient and family;  
and
7. inpatient confinement in a Hospice facility.

### Rehabilitation Care in a Convalescent Facility

Rehabilitation Care means services and supplies that are provided within generally accepted medical standards to establish a program of medical treatment which can reasonably be expected to contribute substantially to the improvement of the individual's medical condition and is not merely for maintenance or stabilization of such individual's medical condition.

Rehabilitation Care includes expenses for room and board, meals, occupational, speech and physical therapy, and general services and supplies essential to daily medical care, if these services or supplies would be payable as Hospital Expenses and if the confinement is

Medically Necessary and constitutes appropriate alternative care as determined by the Plan's medical review process.

## Well Care

The Plan covers expenses related to a routine physical examination (including routine OB/GYN exams) by a Physician. This benefit is limited to one examination per year for each participant and each covered dependent unless such care meets the definition of Preventive Services (See Definitions on page 95). In addition, routine immunizations, including diphtheria/tetanus/pertussis (DTP), measles/mumps/rubella (MMR), poliomyelitis, and influenza are covered.

## Chiropractic Care

Chiropractic Care includes expenses for the initial office visit (including patient history, examination, and diagnostic X-rays) and follow-up visits for manipulation for treatment of spinal maladjustments or subluxation.

## Prescription Drug Coverage

Prescription Drugs include legend drugs, injectable insulin, or other state-controlled drugs that, by law, must be prescribed by a Physician and dispensed by a licensed pharmacist.

To ensure the appropriate use of prescription drug coverage, the Trustees may inquire into the facts and circumstances of the purchase of any prescription drug, including prescription and refill details.

There are two parts to the Pharmaceutical services the Plan provides through Express Scripts:

1. The Retail Pharmacy - The prescription card will allow you and your eligible dependents to purchase any non-maintenance prescriptions covered by the Plan at discounted prices. You will pay only your portion of the cost depending on the Level of Benefits that applies to you. You will also be allowed to purchase any first-time maintenance prescription drugs, up to a 30-day supply two times at the Retail Pharmacy. Reimbursement for additional refills of maintenance medications at the Retail Pharmacy is available, but you must purchase paying the full price for the prescription and then submit the receipt to the Plan for reimbursement. In such circumstances, the amount of the reimbursement will be limited to the amount the prescription would have cost the Plan had you used the Mail-Order pharmacy.
2. The Mail Order Service - The Plan provides an opportunity for you to purchase long-term "maintenance" prescription drugs, at significantly reduced costs, through the mail from Express Scripts. Mail order is a convenient way to save money on the purchase of your prescription maintenance medications. (A few examples of conditions treated with maintenance drugs are high blood



pressure, ulcers, arthritis, heart or thyroid conditions, emphysema, and diabetes.)

You will receive your order within 10-14 days after Express Scripts receives your order. Your medication will be delivered to your home via UPS or first class U.S. mail. Your participation in this program is completely voluntary. When you use this method of purchasing your maintenance drug prescriptions, you may obtain up to a 90-day supply. You are responsible for the usual 25% co-insurance for preferred drugs and 35% for non-preferred drugs on the discounted prescription drug cost. You can learn whether a particular drug is on the Express Scripts “formulary” and therefore is a “preferred” drug by calling Express Scripts or by signing on to the Express Scripts website. A link to the Express Scripts website can be found on the [www.nasifund.org](http://www.nasifund.org) website.

Your prescription will be filled with the generic equivalent when available and permissible by law. Generic drugs are subject to the same FDA (Food and Drug Administration) regulations and require the same high standards for purity, strength, safety and effectiveness as brand-name medications. If you or your physician directs that Express Scripts dispense a brand name drug when a generic equivalent is available, you will be charged for the entire difference in the cost between the brand-name drug and the generic substitute.

The Plan does not cover charges that exceed the Express Scripts price for drugs.

## Second Surgical Opinion

The Plan covers charges for consultation with a Physician and tests in connection with determining whether proposed non-emergency, elective surgery is Medically Necessary. Expenses are payable in an amount equal to the actual charge, to the extent Usual and Customary. Charges for a third surgical opinion are also covered if the second surgical opinion does not confirm the need for the proposed surgery.

## Hearing Aid Benefit

Expenses include the installation and the cost of the hearing appliance(s) up to the maximum listed in the Summary of Benefits. No hearing aid benefit is payable for dependents.

## Substance Abuse Treatment Benefit

Substance Abuse Treatment includes expenses incurred for medical care if you (or your dependent) are confined in a Treatment Facility for treatment and rehabilitation related to alcoholism or chemical dependency.

The Plan pays charges related to Treatment Facility confinement that are charged by the Facility or are generally charged by a Facility. Examples include:

1. room and board;

2. psychological testing;
3. prescription drugs;
4. detoxification;
5. family counseling;
6. Laboratory tests;
7. drug screening; and
8. individual or group therapy.

If you (or your dependent) are confined as an inpatient in a Hospital solely for the treatment of a medical complication of alcoholism or drug abuse (such as cirrhosis of the liver, delirium tremens, or hepatitis), the Plan covers such confinement to the same extent as for any other disease.

### Treatment Facilities

To qualify as a Treatment Facility, an institution or unit of a Hospital must meet all applicable licensing standards of the jurisdiction in which it is located, and must generally meet the following criteria:

1. primarily engage on a full-time basis in providing (for compensation from its patients) a program for diagnosis, evaluation, and effective treatment of alcoholism or drug abuse, whichever condition is being treated;
2. provide all medical detoxification services necessary as an adjunct to its effective treatment programs continuously on a 24-hour basis;
3. provide all normal infirmary-level medical services required for the treatment of any disease or injury manifested during the treatment period, whether or not related to the alcoholism or drug abuse, continuously on a 24-hour basis; and provide, or have an agreement with a Hospital in the area to provide, any other medical services that may be required during the treatment period;
4. function under the supervision of a staff of Physicians on a continuous 24-hour basis and provide skilled nursing services by licensed nursing personnel under the direction of a full-time registered graduate nurse; and
5. prepare and maintain a written individual plan of treatment for each patient based on a diagnostic assessment of the patient's medical, psychological and social needs with documentation that the plan is under the supervision of a Physician.

## Dental and Vision Benefits

Reimbursement rates for Dental and Vision Care benefits are not subject to the rules for Comprehensive Medical Coverage and are as shown in the Summary of Benefits.

Upon written request to the Fund Office, a Participant and/or Dependent may opt out of (and, if applicable, opt back in to) Dental and/or Vision Benefits from this Plan. Because contribution rates are included in Collective Bargaining Agreements, the contribution on behalf of an individual Participant or Dependent who has opted out will not be reduced.

Any such opt-out (or, if applicable, opt-in) will be effective the first day of the second calendar month after your written request is received by the Fund Office. If you have opted out and wish to opt back into Dental and/or Vision Benefits, you will be permitted to do so only if the Benefit Level by which you are covered otherwise includes the benefit that you have opted out of and now seek to elect.

### Dental Benefit

Subject to the Dental Deductible, co-insurance, and maximum amounts shown in the Schedule of Benefits, Dental benefits include a wide variety of covered dental services or supplies for you or your eligible dependent.

### Pretreatment Review

There will be occasions when work prescribed by your dentist for care and treatment of specific dental problems will be more expensive than usual. When these situations occur, you might want to have the Plan review the dentist's recommended treatment plan before the work begins. The Plan will notify your dentist that it either concurs with the recommended course of treatment or will ask any questions and make any alternate recommendations necessary. At the same time, the Plan will indicate the amount payable for each approved service.

Whenever charges for a proposed dental service or series of services are expected to exceed \$400, the Plan recommends that you contact the Fund office before commencing the procedure. Have your dentist submit a claim form showing the recommended treatment plan and fees, together with appropriate diagnostic X-rays, to the Fund Office. When the treatment plan is finished, your dentist will resubmit the claim form for payment.

Failure to comply with the pretreatment review process will not invalidate a claim. However, the possibility of any misunderstanding will be greatly reduced if both you and your dentist understand beforehand exactly what services will be approved and the benefits that will be paid.

**Dental Benefits** include Preventive and Diagnostic Services, Class I Restorative Services, and Class II Restorative Services, as outlined below:

## Preventive and Diagnostic Services

1. Prophylaxis

Professional cleaning and scaling of teeth. Benefits paid for two cleanings in any calendar year.

2. Oral Examinations

Benefits paid for two routine examinations in any calendar year. Other examinations are limited by medical necessity.

3. Topical Fluoride Application (for individuals under 19 years of age)

A treatment series, usually consisting of four treatments during which a solution of sodium fluoride is applied to the teeth to help prevent tooth decay. Benefits paid for one series of treatments during any period of 12 consecutive months.

4. Space Maintainers

An appliance used in a child after early loss of a first tooth. It prevents other teeth from drifting while maintaining sufficient space for the permanent tooth to emerge.

5. X-Rays (Radiographs)

Intra-oral Radiographs

a. One complete series (with or without bitewings) during any 36-month period.

b. Single Radiographs:

Periapical, Bitewing, Occlusal. Two charges for Bitewings during a calendar year.

Extra-oral Radiographs

a. Posteroanterior and lateral skull and facial bone - survey film

b. Temporomandibular Joint - single film

c. Panoramic-maxillary and mandibular - single film

6. Topical Application of sealants on a back tooth (for individuals under age 19).

Benefits for one treatment per tooth during any period of 36 consecutive months. A topical sealant is a strong plastic which is applied to a back tooth in liquid form and cured to hardness. This protects the tooth against bacteria and helps prevent tooth decay.

## Class I Restorative Services

### 1. Fillings

Dental restorations inserted in the teeth. Most common fillings are:

- a. Amalgam - used primarily in back teeth;
- b. Acrylic and Plastic - tooth shade restorations used normally for front teeth;
- c. Silicate - also a tooth shade restoration, often referred to as synthetic porcelain, normally used in front teeth; and
- d. Composite Resin - tooth shade restoration used in back teeth as an alternative to amalgam. It is also used in front teeth. (Gold fillings, if used, are covered as a Class II restorative service.)

### 2. Periodontics

Treatment of diseases of the gums and supporting structures of the teeth. An additional \$500 calendar year maximum applies for oral surgery, including surgery for periodontal disease; provided that this maximum does not apply to pediatric oral surgery.

### 3. Endodontics

Treatment of the dental pulp including root canal therapy.

### 4. Extractions

Simple extractions and surgical extractions of the natural teeth.

### 5. Anesthetics

When Medically Necessary and administered in connection with oral or dental surgery.

### 6. Oral Surgery

Excision of impacted teeth, excision of tooth root without extraction of

entire tooth, and other procedures on the gums and tissues not performed in connection with the extraction of teeth. An additional \$500 calendar-year maximum applies for oral surgery, including surgery for periodontal disease; provided that this maximum does not apply to pediatric oral surgery.

7. Prosthodontics

Installation of full and partial removable dentures including any precision attachments.

8. Repair of Prosthodontics

Repair or recementing of crowns, inlays, bridgework, or dentures, or relining of dentures.

9. Drugs

Prescription drugs, including injection of antibiotic drugs by the attending dentist.

Should hospitalization be Medically Necessary because of dental injuries or disease, benefits are paid for Hospital charges under the Comprehensive Medical Coverage and for the dentist and anesthesiologist under the Dental Benefits.

## Class II Restorative Services

1. Inlays

Dental restorations inserted in or on the teeth.

- a. Gold Inlay - used primarily in the back teeth. More expensive and not as common as the amalgam filling but better and advisable in some cases.
- b. Porcelain Inlay - Baked porcelain filling primarily used in the front teeth.

2. Crowns

A tooth shade restoration which usually covers the whole exposed (coronal) portion of a tooth. Crowns are made by a laboratory from impressions taken by a dentist. Crowns are frequently used in bridgework or to restore badly damaged teeth. Like fillings, crowns are available in many types - plastic, acrylic, gold, and porcelain, in addition to stainless steel.

3. Prosthodontics

Installation of full and partial fixed bridgework including any precision attachments.

4. Orthodontics

Preventive and corrective treatment of dental irregularities (crooked teeth) resulting from growth, and which requires repositioning to establish occlusion or appearance. See the maximum lifetime benefit shown in the Summary of Benefits.

### Temporomandibular Joint (TMJ) Dysfunction

Charges by a dentist for diagnostic services and Medically Necessary treatment that is recognized as effective and appropriate treatment for TMJ and its symptoms. Children eligible for the orthodontic benefit are not eligible for TMJ coverage.

### Vision Benefits

This is a special plan to obtain vision benefits. Participating Physicians have agreed to provide a complete examination and high quality lenses and frames.

When you want to obtain vision care services, call a Vision Service Plan (“VSP”) participating Physician to make an appointment. For details on how to locate a VSP participating Physician, use the Vision Service Plan link on the Plan’s website ([www.nasifund.org](http://www.nasifund.org)), contact the Fund Office or call VSP at 1-800-877-7195. The VSP participating Physician will contact VSP to verify your eligibility and plan coverage. The Physician will also obtain authorization so you can receive services and materials. If you are not currently eligible for services, the VSP participating Physician is responsible for communicating this to you. After your eye exam, the Physician will determine if eyewear is necessary. If so, the participating Physician will coordinate your prescription with one of the VSP contract wholesale laboratories, and dispense your eyewear. VSP will pay the participating Physician directly for covered services and materials.

### Reimbursement for Services Purchased on Your Own

Effective January 1, 2011, the NASI Welfare Fund will not reimburse for vision examinations and/or glasses you obtain from a non-VSP provider. No Out-of-Network vision benefit is available from the plan.

### Coverage Outline

The following expenses are covered by VSP after payment of the Deductible, and are also available for reimbursement if purchased on your own:

1. one examination or vision analysis in a 12-month period performed by a

- licensed optometrist or ophthalmologist, unless it is established that more than one examination or analysis is Medically Necessary during a 12-month period due to a medical condition or surgery related to a medical condition (where such surgery would otherwise be covered by the Plan);
2. one pair of prescription contact lenses or one pair of prescription eyeglass lenses with frames, including bifocals or trifocals, if prescribed, in a 12-month period, unless it is established that the prescription has changed due to a medical condition or surgery related to a medical condition (where such surgery would otherwise be covered by the Plan). Oversize and plastic lenses are available at no extra charge;
  3. contact lenses together with necessary professional services shall be provided:
    - a. following cataract surgery;
    - b. if visual acuity cannot be corrected to 20/70 in the better eye without contact lenses; or
    - c. for prescription lenses for visual correction, but no more than once in a 12-month period, up to the allowance shown in the Summary of Benefits.

The following are available at extra cost:

1. frames costing more than the Plan provides;
2. tinted, photochromatic, sun lenses, other than pink tint 1 or 2;
3. coated lenses; and
4. blended, no-line bifocals.



## V. Definitions

The following terms have special meanings when used in this Summary Plan Description.

### Blue Distinction Center +

means a subset of the facilities/hospitals designated by the Blue Cross Blue Shield Association as Blue Distinction Centers which are additionally designated as Blue Distinction Centers + with respect to medical care within specified categories and procedures.

### Collective Bargaining Agreement

means the labor agreement in force and effect between a sprinkler fitter Local Union and the National Fire Sprinkler Association or an employer together with any modifications, supplements or amendments.

### Co-insurance

means the percentage of covered Usual and Customary charges which you are responsible to pay after the Deductible has been met each calendar year. For example, if the Plan will pay 75% of the Usual and Customary charges for Covered Expenses under the Comprehensive Medical Coverage, you are responsible for 25% of the Usual and Customary charges for such Covered Expenses. You are also responsible for payment of any balance that exceeds the Usual and Customary charge.

### Convalescent Facility

means an institution that is licensed to keep patients regularly overnight. The facility must provide supervision by a legally qualified Physician or a registered professional nurse, 24-hour skilled nursing care by licensed nursing personnel under the direction of a full-time registered professional nurse, and training in self-care for the essential activities of daily living. The institution must also maintain a complete medical record on each patient and have a utilization review plan for all of its patients. Institutions such as clinics, or places for rest, educational care, care of the aged, Custodial Care do not qualify as Convalescent Facilities. To qualify for coverage, confinement in a Convalescent Facility must occur within 14 days after a minimum three-day Hospital confinement for the same illness.

### Covered Employment

means employment of an Employee by an Employer in a category covered by a Collective Bargaining Agreement for which the Employer is obligated by its Agreement to contribute to the Fund. "Covered Employment" also means employment of an Employee by an Employer in a category of work for which the Employer is obligated to make contributions to the Fund pursuant to an agreement with the Trustees or as required by applicable law.

## Covered Expense

means a charge to the extent it is within the Usual and Customary amount that is allowable under the Plan for a service or supply that is Medically Necessary for diagnosis, treatment, mitigation or cure of an illness or injury to a structure or function of the mind or body. No amount in excess of the actual charge for a service or supply will be considered a Covered Expense.

## Custodial Care

means services and supplies, including room and board and other institutional services, which are provided whether or not you are Disabled, primarily to assist you in the activities of daily living. Such services and supplies are Custodial Care without regard to the practitioner or provider by whom or by which they are prescribed, recommended or performed. Room and board and skilled nursing services, when provided in a Hospital or other institution for which coverage is specifically provided, are not Custodial Care when such services must be combined with other necessary therapeutic services and supplies in accordance with generally accepted medical standards to establish a program of medical treatment which can reasonably be expected to contribute substantially to the improvement of the individual's medical condition and is not merely for the maintenance or stabilization of such individual's medical condition.

## Deductible

means the initial Covered Expenses that you must pay each year before a benefit is payable from the Plan. The Deductible is taken from the first expenses you incur during a calendar year. Any expenses incurred during the last three months of a calendar year and applied against the Deductible will also be applied against the Deductible for the next calendar year.

## Disability and Disabled

means the inability to perform the duties of your occupation because of a medically determinable physical or mental impairment, as certified by your Physician, and the inability to receive substantial compensation for any employment. For a dependent, Disability means the inability to perform, due to a medically determinable physical or mental impairment, the functions and activities of a person of like age and sex who is in good health.

## Hospital

means an institution that is accredited as a Hospital by the Joint Commission on Accreditation of Health Care Organizations or any similar Hospital in a foreign country. A licensed facility that is set up, equipped, and operated under the direction of a Physician solely as a birthing center for prenatal care, delivery, and immediate postpartum care is a "Hospital." Hospital does not include rest or nursing homes, convalescent homes or institutions, sanatoriums or similar institutions which primarily operate training schools for patients or primarily provide Custodial or institutional care. To be considered a Hospital for purposes of this Plan, a Hospital must: regularly keep patients overnight; have full

diagnostic, surgical and therapeutic facilities under the supervision of a staff of legally qualified Physicians; and regularly provide 24-hour nursing service by registered graduate nurses.

### Medically Necessary

means services or supplies that are: furnished or prescribed by a Physician or other licensed provider to identify or treat a diagnosed or reasonably suspected illness or injury; consistent with the diagnosis and treatment of the patient's condition; in accordance with standards of good medical practice; is generally accepted by the medical profession as safe, effective and appropriate treatment of the patient's medical condition; is required for reasons other than the convenience of the patient, Physician, or other licensed provider; and the most appropriate level of service or supply that can be provided safely for the patient. When the term "Medically Necessary" is used to describe inpatient care in a Hospital, it means that your medical symptoms and condition are such that the service or supply cannot be provided safely on an outpatient basis. The fact that services or supplies are furnished or prescribed by a Physician or other licensed provider does not necessarily mean that the services and supplies are "Medically Necessary."

### Out-of-Pocket Expenses

means an individual's co-insurance portion of the medical expenses not paid by the Plan in that calendar year plus, if applicable, the Deductible, as described in this definition. For expenses incurred "In-Network," the Out-of-Pocket Expenses include the Deductible. For example, an individual submits claims for medical services in the amount of \$1,400. That member is eligible under a plan that has a \$400 "In-Network" individual Deductible and 75% "In-Network" coverage, so the plan pays 75% of \$1,000 (\$1,400 less the \$400 Deductible) or \$750. The individual's Out-of-Pocket Expense is \$650 (\$400 Deductible plus \$250 co-insurance not paid by the Plan).

For expenses incurred "Out-of-Network," the Out-of-Pocket expenses do not include the Deductible. For example, an individual submits a claim for medical services incurred "Out-of-Network" in the amount of \$1,900. That member is eligible under a plan that has a \$900 "Out-of-Network" individual Deductible and 55% "Out-of-Network" coverage, so the Plan pays 55% of \$1,000 (\$1,900 less the \$900 Deductible) or \$550. The individual's Out-of-Pocket Expense is \$450 (the co-insurance not paid by the Plan) even though the individual is also responsible for the \$900 Deductible that is not included in "Out-of-Pocket Expenses".

Out-of-Pocket Expenses apply to each person covered under the Plan in accordance with the limits described in "Summaries of Benefits and Deductibles" in Part II of this booklet.

### Outpatient Facility

means a clinic or other establishment that provides surgery, diagnosis, and treatment on an outpatient basis. The facility must have an attending medical staff consisting of at least one Physician and anesthesiologist (or a nurse anesthetist under the supervision of a Physician). Outpatient Facilities include alternative care facilities such as stand-alone surgical centers or 24-hour clinics. The following are not Outpatient Facilities: Convalescent homes, nursing

homes, homes for the needy, homes for nursing and domiciliary care, infirmaries or orphanages, sanatoriums, maternity homes for prenatal or postnatal care, or other homes or institutions primarily providing Custodial Care. Other facilities, not otherwise covered by the Plan, may be approved in advance by the Fund if they fall within standard medical practice and treatment is recommended by a Physician.

## Physician

means a person who is licensed to practice medicine or to perform surgery in the state in which they practice, who is practicing within the scope of his or her license and who is providing a service covered by the Plan. Physician includes a doctor of medicine, osteopathy, dental surgery, or podiatry. Physician charges also include the services of a qualified professional chiropractor, physical therapist, psychologist, occupational therapist, optometrist, nurse-midwife, nurse anesthetist and physician's assistant and any health care provider who is acting within the scope of that provider's license or certification under applicable State law.

## Preventive Services

means evidence-based items or services that have, in effect, a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force with respect to the individual involved; immunizations for routine use in children, adolescents, and adults that have a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved; with respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration; and with respect to women, to the extent not described above, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration, when services are obtained through a preferred provider (or pharmacy benefit manager, as appropriate). Any change to a recommendation or guideline that occurs after September 23, 2009 will be covered as a preventive service as of the first day of the first plan year beginning on or after the date that is one year after the new recommendation or guideline went into effect.

## Spouse

means, for purposes of this Plan, a person to whom a covered employee or retiree is considered married under applicable law. An individual of the same sex as a Participant will be considered the Participant's Spouse for purposes of this Plan if the marriage was legally performed in a jurisdiction that recognizes same-sex marriage.

## Total Disability and Totally Disabled

mean your complete inability to engage in substantial, gainful activity because of a medically determinable physical or mental impairment that is expected to last permanently or indefinitely. Proof of your eligibility for a Social Security Disability Award is proof of Total Disability. For a dependent, Total Disability means the complete inability to perform the

functions and activities of a person of like sex and age who is in good health, due to a medically determinable physical or mental impairment that is expected to last permanently or indefinitely.

### Usual and Customary (UC)

means a level of charges that does not exceed the prevailing level generally charged by providers in the "locality" for like or comparable services or supplies. The term "locality" means a geographical area that includes a cross-section of persons or entities regularly furnishing the type of treatment, services, or supplies for which the charge is made. In determining whether charges are Usual and Customary, consideration is given to the condition being treated and to any medical complications or unusual circumstances that may require additional time, skill, or experience. Benefits are payable according to the plan's UC scale as determined and changed from time to time by the Board of Trustees. Where appropriate, the UC charge is based upon at least the 75<sup>th</sup> percentile of the scale used. For example, the scale promulgated by the Health Insurance Association of America is known as Ingenix; however, other industry sources are used if the Ingenix scale is not available. In any event, Covered Expenses under this plan must not exceed the actual amount charged for a service or supply, up to the Usual and Customary level, except where medical service is rendered on an emergency basis.

## VI. Coordination of Benefits

### What "Coordination" Means

Your Medical, Dental, and Vision are "coordinated" with any benefits payable to you or to your covered dependents for the same expenses from other insurance plans.

Coordination means that benefits from the Plan described in this booklet and from other benefit plans can total, but not exceed, 100% of allowable expenses for each covered person in each calendar year. It is intended to permit full payment of actual allowable expenses without unnecessary duplication of benefits.

"Allowable expenses" are any necessary, Usual and Customary charges for Medical, Dental, and Vision Benefits and services covered in full or in part under this Plan and any other plan to which the person making the claim belongs. For Weekly Disability Income Benefits, "allowable expenses" are two-thirds of your average weekly earnings during the 12-month period prior to your Disability.

Expenses not covered by any plan to which a person belongs are not allowable - for example, charges for personal comfort items such as television rental in the Hospital.

"Other insurance plans" include group plans (insured or self-insured) such as benefits available from your Spouse's employer and Medicare. For employees (and their dependents) who are on a Disability or maternity extension, or who are retired, "other insurance plans" also includes any individual or private insurance policies.

### How Coordination Works If Covered Under a Group Health Plan

This Plan always pays allowable expenses after a plan that does not have a coordination of benefits provision. In addition, the following rules apply:

- A plan covering you as an employee pays benefits before a plan covering you as a dependent.
- For someone who is covered as a dependent under the plans of both parents, the plan of the parent whose birthday falls earlier in the year will pay before the plan of the other parent. This "Birthday Rule" applies only if both plans contain the same rule. If the other plan pays benefits under the gender rule, then the plan covering the male participant pays first.
- If a participant and spouse are both eligible employees under this Plan, they are treated as though they are covered under two separate plans and benefits are coordinated according to these rules.
- If priority still is not established, the coverage that has been in effect for the longer period of time pays benefits first.

- The following special rules apply for dependent coverage in case of legal separation or divorce:
  - If the parent with physical custody has not remarried, the benefit plan covering the parent with custody pays first. The plan covering the parent without custody pays second.
  - If the parent with physical custody has remarried, the benefit plan covering the parent with custody pays first. The stepparent's plan pays second. The plan of the parent without custody pays third.

## Your Coordination of Benefits "Savings Bank"

When the Fund is able to save dollars that would have been payable on your behalf in the absence of other insurance, the Plan creates a Coordination of Benefits "Savings Bank" for you. The Savings Bank is credited with the difference between the benefit payable without other coverage and the amount actually paid by NASI Welfare Fund for an allowable expense. Savings for any one year are held and subsequent bills incurred in that year may be paid from that year's savings.

The following is an example of how the NASI Welfare Fund uses this Savings Bank concept to pay a greater amount on a benefit than would otherwise be allowable.

Mrs. Smith is the dependent Spouse of an eligible sprinkler fitter. She has insurance through her employer in addition to her coverage under the NASI Welfare Fund. She goes to the emergency room for an acute illness. The hospital charges \$2,000 for their services. After a \$400 Deductible, her employer's insurance will pay 75% of \$1,600, or \$1,200.

In the absence of other coverage, the NASI Welfare Fund would also apply a \$400 Deductible and would cover 75% of the \$1,600 balance. Although the Fund has a benefit payable of \$1,200.00, only \$800 remains to be paid of the hospital's \$2,000 charge. The Fund adjusts its benefit payment by \$400.00 and pays the hospital \$800.

On this claim, the NASI Welfare Fund has saved \$400.00. The hospital is paid in full and a Savings Bank is created in the amount of \$400.00 for use on any other medical claim incurred by Mrs. Smith in that calendar year.

Suppose Mrs. Smith leaves employment in that year and loses her employer-provided coverage. She goes to the Physician for her annual physical for which the Physician charges \$200. The NASI Welfare Fund's normal benefit payment of 75% for this service would pay \$150. However, in this example, the Plan will pay the full \$200 expense after deducting \$50 from Mrs. Smith's Savings Bank.

If the allowable expenses on any other claim for Mrs. Smith for that year are not fully reimbursed by the combination of other coverage and the NASI Welfare Fund coverage, the NASI Welfare Fund will draw from the Savings Bank the amount necessary to reimburse

any unpaid allowable expense.

Please bear in mind that savings are not transferable from one year to another; savings from one individual cannot be used to increase the benefit of another individual.

A Savings Bank is not created when Medicare is your primary coverage.

## Coverage for Retirees with Medicare

If you are a retired or inactive disabled employee or the dependent of a retired employee (including an employee on a disability pension) and you become eligible for Medicare, Medicare will be your primary coverage as soon as permitted under applicable law. After Medicare has covered the expense, the Fund will apply the Plan provisions (deductible and co-insurance) to the balance of the bill remaining after the Medicare payment. As an example, assume a \$5,000 total claim where Medicare paid \$4,000. The remaining \$1,000 will be considered for payment under the Plan's provisions. If the coverage is for Level 1, and this is the first claim of the year, the deductible of \$400 will apply, leaving \$600. Coinsurance of 75% will result in plan payment of \$450. You will be financially responsible for the remainder of \$150 (\$400 deductible plus \$150 co-insurance). If the deductible has already been satisfied, and out-of-pocket limits have not been reached, the coinsurance of 75% will result in plan payment of \$750, and you will be responsible for the remaining \$250.

If you are not eligible for Medicare when you retire, the Fund will be your primary coverage until you become eligible for Medicare. However, if your dependent is eligible for Medicare when you retire, even if you are not eligible for Medicare at that time, Medicare will provide your dependent's primary coverage, and the Fund will provide benefits as described above for your dependent.

Medicare has two parts – Hospital Insurance (Part A) and Medical Insurance (Part B). Part A covers inpatient Hospital care and generally is available to all individuals over age 65 at no cost. Part B covers Physician services, outpatient Hospital services and other medical supplies and is optional. You must pay a monthly premium for Part B. To have adequate coverage, you and your Spouse must sign up for both Medicare Part A and Part B when eligible.

***The Fund will pay benefits as if you have both Medicare Part A and Part B Benefits – whether you are signed up for them or not.***

All medical claims after your enrollment in Medicare must be submitted to Medicare first. After Medicare pays the claim, submit a copy of the bill along with the Medicare Explanation of Benefits to the Fund Office.

***The Fund will pay claims for benefits by providers who have opted out of Medicare as if those providers continue to participate in Medicare. Therefore, even if Medicare denies payment because your provider has opted out of Medicare, the Fund will pay the claim as if Medicare paid its share.***



## Coverage for Retirees with Medicare when they travel or live outside of the United States

Medicare does not pay for hospital or medical services outside of the United States. In order to have adequate coverage when traveling or living outside the United States, you need to purchase travel insurance or other medical insurance because the NASI Welfare Fund will not provide primary medical coverage for Medicare-eligible individuals; instead, the Plan will limit its coverage to the amount the Plan would have paid on your behalf had you received those services in the United States. For example, if you are hospitalized in the United States, Medicare Part A pays all of the cost of the hospitalization but for the deductible (\$1,132 in 2011). If you are, instead, hospitalized outside of the United States, the Plan will process your claim assuming your medical expense was \$1,132 (i.e., the amount that would not have been covered by Medicare if the expense was incurred in the United States), and you will be responsible for the remainder of the charges unless you have travel insurance or other coverage.

## Enrolling in Medicare

It is important that you or your eligible dependent visit an office of the Social Security Administration during the three-month period prior to the individual's 65th birthday, or earlier if you are disabled, to learn all about Medicare. For questions on coverage by this Plan or help in comparing benefits offered by this Plan and Medicare, please contact the Fund Office. ***Remember, the Fund will pay benefits as if you have both Medicare Part A and Part B benefits – whether you are signed up for them or not.***

Effective January 1, 2006, the out of pocket health care costs that you might incur because either you or your eligible dependent did not enroll in Medicare Part B when eligible will not exceed \$5,000 per family. This cap on out-of-pocket costs will apply only once per family and will only apply to claims incurred up to the next Medicare Part B enrollment date. Notwithstanding the foregoing, if the Fund discovers that you or your dependent have failed to enroll in Medicare Part B when eligible and advises you of this, the cap on out of pocket costs will only apply until the next Medicare Part B enrollment date after the Fund advises you to enroll.

## Subrogation

### Cases Involving a Third Party

This Plan is not required to pay you or your dependent for an injury (including an illness) for which another party may be liable. The Plan may, however, advance benefits to the injured party (you or your dependent) while a third party's liability is being determined. You must notify the plan in writing as soon as the injured party institutes a claim against another person or entity, and the Fund Office will require the injured party to sign a Reimbursement/Subrogation acknowledgement form before any benefits are paid. If you, your dependent (if applicable), or your attorney refuse to sign the Reimbursement/Subrogation acknowledgement form, the plan may withhold payment of any benefits as a result of the injury caused by a third-party and may recoup by offset or

lawsuit any amount already paid.

## **Reimbursement**

If you or your dependent should recover damages from an insurance company or from the other party (for example, in a lawsuit), then you must reimburse the Plan for the payments it has made or will make in connection with the injury. If you are injured by another party, you are required as a condition of receiving benefits from the Fund to sign a form acknowledging the Fund's right to recover under the terms of the Plan. The Fund's subrogation right is established by the Plan and not by the acknowledgement form. In the event you receive benefits in such a case, the Fund's subrogation interest in your recovery is governed by the terms of the Plan whether or not you have signed the acknowledgement form.

Under the terms of the Plan, the acceptance of benefits by a participant or dependent (or someone acting on his or her behalf) who has been injured by another party constitutes an agreement by the injured person to reimburse the Fund for benefits paid up to the full amount of the recovery due to the injury. The Fund has a right to first reimbursement out of any recovery whether or not the amounts recovered are designated to cover medical expenses. By accepting benefits from the Fund, the injured person agrees that any amounts recovered by the injured person by judgment, settlement or compromise will be applied first to reimburse the Fund, without reduction for attorney's fees or costs, even if the injured person is not made whole. Amounts recovered by the injured person in excess of benefits paid by the Fund are the separate property of the injured person. In addition, amounts received from an individual health insurance policy for which the injured person or a member of the injured person's family has paid premiums are also the separate property of the injured person. However, amounts received from a personal homeowner insurance policy, an automobile policy or a group insurance arrangement of any kind, regardless of whether the injured person or a member of the injured person's family has paid premiums on such policy or arrangement, are subject to the Fund's right to be reimbursed under this section.

By accepting benefits in excess of \$300 from the Fund for an injury for which another person may be liable, the injured person agrees to file a claim for benefits under any and all applicable policies of insurance, including but not limited to homeowner insurance, automobile insurance or any liability policy held for a public or commercial entity. The injured person agrees to notify the Fund promptly of efforts made to recover from a third party including filing a suit to recover amounts in connection with the injury. Furthermore, in the event the injured person or someone acting on his or her behalf receives payments from any source for claims related to the injury, the injured person agrees to notify the Fund promptly. By accepting benefits from the Fund the injured person agrees that neither the injured person nor anyone acting on behalf of the injured person will settle any claim relating to the accident without the written consent of the Fund.

In the event an injured person accepts benefits from the Fund and amounts are recovered from claims arising from the injury, the amounts recovered are assets of the Fund by virtue of the Fund's subrogation interest. Such Fund assets may not be distributed without a release from the Fund of its subrogation interest.

In the event monies are recovered and the Fund is not reimbursed to the extent of its subrogation interest in accordance with Plan provisions, the Fund may bring suit against the injured person, insurers and any recipients of the Fund assets improperly distributed without the consent of the Fund. The Fund may recover benefits paid on behalf of the injured person by treating such benefits as an advance and deducting such amounts from benefits which become due to the injured person and his or her immediate family until the Fund's subrogation interest is recovered. Such benefits may be deducted from amounts due to third parties who have provided medical services despite any certification of coverage that the Plan may have provided to such providers.

### **Subrogation**

The Plan is not required to participate in an injured person's claims to demand reimbursement from an injured person or to invoke its subrogation rights. The Plan may request that the injured person assign or subrogate his or her claim or any other right of recovery to the Plan so that the Plan can enforce its right to recovery. The injured person must cooperate fully with the Plan in connection with any claim brought by the Plan to recover its assigned or subrogated interest. By accepting benefits from the Fund, the injured person authorizes the Fund to elect to pursue any claims arising from the injury in the name of the injured person and/or the Fund's name and to sue, compromise or settle such claims without the approval of the injured person to the extent of benefits paid and/or to be paid. If the injured person does not cooperate or if the injured person or anyone acting on the injured person's behalf takes any action which harms the Plan's subrogated interest, the Plan is entitled to cease payment of any benefits connected to the third-party-caused injury and recover from the injured person the amount of plan benefits paid. The Plan may bring a lawsuit against the injured person to collect payments already made or may collect these amounts by offset against any future benefit payments otherwise due to the injured person and their immediate family. If legal proceedings are instituted, the Plan may recover the costs and attorney's fees incurred.

### **Cases Involving Work-Related Claims**

In general, the NASI Welfare Fund does not cover expenses for an illness or injury that arises out of the course of employment. However, an exception exists if you have a work-related injury or illness for which a claim has been filed with a workers' compensation insurance carrier or with a federal or state court or agency. In the event that claim has been initially denied, then the Fund, upon request, may pay benefits arising from the work-related injury or illness.

By accepting these benefits from the Fund, you agree to actively pursue your work-related claim and also agree that the Fund has the power to institute, compromise or settle such a claim in your name to the extent of benefits paid. By accepting these benefits, you also agree that any amounts recovered by award, judgment, settlement or otherwise, and regardless of how the proceeds are characterized, are assets of the Fund and will be applied first to reimburse the Fund, in full and without any reduction for attorneys' fees or costs, for benefits paid due to the work-related claim. Once benefits are paid under this provision, you

may not settle your work-related claim without the written consent of the NASI Welfare Fund.

As a condition of receiving benefits from the Fund, you are required to sign a form acknowledging the Fund's right to reimbursement under the Plan. The Fund's right to reimbursement is established by the Plan and not by the form. The Fund's interest in your recovery is governed by the terms of the Plan whether or not you have signed the form. Therefore, the Plan has the rights described in this section even if you have not notified the Plan.

If monies are recovered and the Fund is not reimbursed to the extent of its interest in accordance with Plan provisions, the Fund may bring suit against you, any insurer and any recipients of the Fund assets improperly distributed without the consent of the Fund. The Fund may recover benefits paid on your behalf by treating such benefits as an advance and deducting such amounts from benefits which become due to you and your immediate family until the Fund's interest is recovered. Such benefits may be deducted from amounts due to third parties who have provided medical services despite any certification of coverage which the Plan may have provided to such providers.

### Payment to Third Parties

Generally, benefits payable under the Plan cannot be alienated, transferred, assigned, or otherwise promised to a person or party other than the employee. However, there are some exceptions to this rule. You may direct that benefits payable to you be paid to an institution or provider of medical care that provided medical care for which benefits are payable under this Plan. However, the Fund is not obligated to accept such direction from you, and no payment by the Fund pursuant to your direction shall be considered as recognition by the Fund of a duty or obligation to pay a provider of medical care except to the extent to which the Fund actually chooses to do so. If there has been a benefit overpayment, or you otherwise owe money to the Fund, the Fund may choose to offset the overpayment against future benefits even if you have assigned those benefits to your Hospital or Physician. This is true even if the Fund has pre-certified coverage.

Additionally, should another group insurance or employee benefit plan pay benefits that are subsequently payable under this Plan, this Plan may reimburse the other benefit plan for the benefit that plan paid. Likewise, if you or a third party makes COBRA or other self-payments to this Plan that later become unnecessary because you gained eligibility under this Plan for that month, the NASI Welfare Fund may reimburse the party making the premium payment.

All benefits under the Plan shall be exempt, to the extent permitted by law, from the claims of creditors and from all orders, decrees, garnishments, executions or other legal process or proceedings.

## VII. Other Benefits

### Your Life Insurance Plan of Benefits (Active Employees Only)

The Plan provides life insurance benefits for you and your eligible dependents as shown in the Summary of Benefits. If any portion of this section is inconsistent with the provisions of the insurance policy that provides these benefits, the insurance policy terms govern.

### Death Benefits

Payments for the death of your eligible Spouse or child are paid to you in a lump sum. If you are not living at the time of payment, the benefit is paid to your designated beneficiary.

If you die while you are an employee, a death benefit will be paid in a lump sum to your designated beneficiary based on the most recent form the Fund Office received prior to your death. You may name anyone you wish as your beneficiary and change your beneficiary at any time by filling out a new form. A divorce does not change your beneficiary or invalidate your beneficiary designation. If you are divorced and wish to change your beneficiary, you must submit a new form to the Fund Office.

Unless your beneficiary form provides otherwise:

- If more than one beneficiary is designated, they will share equally;
- If one beneficiary dies before you do, any remaining beneficiaries will share equally;
- If you do not name a beneficiary or if the persons named do not survive you, payment will be made to the surviving person or persons in the first of the following classes:
  - your Spouse;
  - your child(ren) (or guardian if a minor(s));
  - your parents; or
  - your estate.

If you and your Spouse are both eligible employees under this Plan, you are separately entitled to death benefits as described above.

### Disclaimer of Death Benefits

If a Beneficiary signs and delivers to the Fund Office a written disclaimer of Plan benefits which satisfies the requirements of Section 2518 of the Code and the Regulations thereunder, and the benefits, but for the disclaimer, would otherwise pass to such individual as a result of the death of a Participant or a Beneficiary, the

individual executing such disclaimer of benefits shall be deemed to have failed to survive the deceased Participant or Beneficiary from whom he otherwise would have taken. For such a disclaimer to be effective for purposes of the Plan, the following conditions must be satisfied:

- The disclaimer must be an irrevocable and unqualified written refusal by the individual who would otherwise receive Plan benefits as a Beneficiary not to accept such benefits;
- The written disclaimer must be received in the Fund Office no later than the date that is nine (9) months after the date of death of the Participant or Beneficiary by reason of which the disclaiming individual would be entitled to Plan benefits;
- The disclaiming individual has not accepted any portion of the Plan benefits being disclaimed;
- As a result of the disclaimer, the Plan benefits are paid in accordance with the Plan document and without any direction on the part of the individual making the disclaimer to a person other than the individual making the disclaimer, and
- The disclaimer must satisfy the requirements of applicable state law which must be evidenced by an opinion of counsel for the disclaiming individual submitted with the disclaimer.

## Accidental Death and Dismemberment

Accidental Death and Dismemberment (AD&D) Benefits are payable as shown in the Summary of Benefits. Benefits are payable if you sustain an accidental injury which results in the loss of life, a limb, or sight. Accidental Death and Dismemberment Benefits are not available to your dependents.

The following rules apply to Accidental Death and Dismemberment Benefits:

- For benefits to be paid, the loss must occur within 365 days of the date of the accident and be a direct result of bodily injury sustained from that accident independent of other causes.
- Brain Damage benefit will be paid if permanent and irreversible physical damage to the brain causing the complete inability to perform all the substantial and material functions of normal and everyday life manifests itself within 30 days of the accidental injury, the Employee requires hospitalization for at least 5 days and the brain damage persists for 12 consecutive months after the injury.

- Loss of a hand or foot means severance at or above the wrist or ankle joint; for an eye, it means the total and irrecoverable loss of sight. The Plan does not pay for the loss of use of the hand and/or foot (but does pay for quadriplegia, paraplegia or hemiplegia).

Certain other benefits may be available under the terms of the insurance contract. Contact the Fund Office if you have questions about the current insurance contract coverage.

- Losses from the following circumstances are not covered:
  - bodily or mental infirmity;
  - disease, ptomaines or bacterial infection except a pyogenic infection that occurs through an accidental cut or wound;
  - medical or surgical treatment (unless made necessary by an injury covered under the plan);
  - suicide or intentionally self-inflicted injury;
  - any act of war or injury while in military service for any country for any country or international authority except the United States National Guard;
  - committing or attempting to commit a felony;
  - the voluntary intake or use by any means of 1) any drug, medication or sedative unless it is taken or used as prescribed by a physician or unless it is an “over the counter” drug taken as directed; 2) alcohol in combination with any drug, medication or sedative; or 3) poison, gas or fumes;
  - driving a vehicle or other device while intoxicated as defined by the laws of the jurisdiction in which the vehicle or device was being operated; or
  - riding in or descending from an aircraft as a pilot or crew member or in any capacity other than passenger; travel in an aircraft for the purpose of parachuting.

## Loss of Benefits or Disability

Employee life insurance (but not AD&D) may be converted to individual coverage upon loss of eligibility as explained earlier. Life insurance (but not AD&D) is also continued until your 61st birthday if you are Totally Disabled as explained earlier in the “Disability Extension” section (see page 6). If life insurance is continued because of Total Disability, any retiree Death Benefits paid by the NASI Pension Fund are deducted from the \$15,000 Life Insurance Benefit provided under this Plan.

## Your Weekly Disability Income Benefits

Benefits are payable to eligible employees for periods of Disability caused by illness or injury up to the amount shown in the Summary of Benefits.

Benefits are payable from the first day for an accident or confinement in a Hospital or from the eighth day of illness, whichever comes first. When outpatient surgery causes a Disability that lasts more than one week, Weekly Disability Income Benefits will be paid retroactively to the first day of Disability. Injuries sustained on the job are not covered because these are covered by workers' compensation protection carried by each employer.

Successive Disability periods separated by less than two weeks of continuous active employment are considered as one continuous period of Disability unless they arise from different and unrelated causes.

You do not have to be confined to your home to collect benefits, but you must be under the care of a Physician. No Disability will be considered as beginning prior to your first visit to a Physician. You cannot receive benefits for any day on which you perform work of any kind, anywhere, for direct or indirect compensation or profit.

Weekly Disability Income Benefits are generally subject to taxes in the same manner as your wages; accordingly, Social Security taxes must be deducted from these benefits.

Weekly Disability Income Benefits are payable only during a period of Disability. Once you recover from a Disability, you must notify the Fund Office of your recovery. If you receive Disability payments after your recovery, those payments must be returned to the Fund. If an overpayment is made for Disability payments during a period when you were not Disabled and you do not return these payments to the Fund, that amount (plus any reasonable interest charge that the Fund may impose) will be deducted from your next claim for benefits of any kind from this Fund.

The Fund, in determining whether you have been Disabled or if a Disability is continuing, reserves the right to request an updated medical report, or to require you to submit to a periodic physical examination at the Fund's expense by a Physician selected by the Fund. Your benefits may be terminated if you refuse to undergo a physical examination requested by the Fund.

## Disability at Retirement

You cannot collect Weekly Disability Income Benefits and pension benefits at the same time. Weekly Disability Income Benefits may be used before the effective date of your retirement. Once you have retired, you cannot receive Weekly Disability Income Benefits unless you return to work and meet the eligibility requirements as a new employee.



## VIII. How to File a Claim

For non-Medicare-eligible individuals, your Physician or Hospital should submit claims directly to their local Blue Cross Blue Shield plan with the following information:

ID number - SFI followed by your Unique Identification Number (on your ID card or available from the Fund Office)

Group No. - P14558

Claims of Medicare-eligible individuals are to be submitted directly to the Fund office at the following address:

NASI Welfare Fund  
8000 Corporate Drive  
Landover, MD 20785

Prescription claims are typically completed by the local or mail-order pharmacy. Bring your prescription script from your doctor to your local pharmacy or, for prescriptions you will be taking for more than 60 days, mail your prescription script to the mail-order pharmacy (Express Scripts) using the form available on the Fund's website or by calling Express Scripts at 1-866-544-6775. Your local pharmacy will need information from your identification card to complete the claims process. If you exceed the two-fill (60 day) limit for prescription drugs at your local pharmacy, you can purchase the drug and submit the prescription receipt to the Fund office (or directly to Express Scripts) using the retail purchase reimbursement form available on the Fund's website.

Prescription claims requiring pre-authorization (see page 72): Certain drugs or classes of drugs require prior authorization from the Fund's Pharmacy Benefits Manager (Express Scripts) before the prescription may be filled. A list of drugs or classes of drugs that require prior authorization is available from the Fund Office upon request. When you first bring your prescription from your doctor to your local pharmacy, the pharmacy will advise you whether prior authorization is required. Express Scripts will work with you, your pharmacy and your doctor to gather the information necessary to determine whether the prior authorization can be granted. If the prior authorization cannot be granted, you will be notified as described in Section IX Claims and Appeals Procedures.

Dental claims are filed directly with Delta Dental by participating dentists. Non-participating dentists and you may file industry standard claim forms for dental services in cases where the claim is not automatically filed by sending the claim to the following address:

Delta Dental  
P. O. Box 2105  
Mechanicsburg, PA 17055-2105

Vision claims must be filed by a participating Vision Service Plan ("VSP") provider. To find a VSP provider, call VSP at 1-800-877-7195. If you obtain glasses and/or a visual acuity examination by a provider that is not a part of the Vision Service Plan, no coverage is

available from the NASI Welfare Fund.

## Claim Forms - in General

The Fund office accepts industry standard claim forms. No special form is required for most claims. Here is a list of some of the Fund's forms and their associated use:

- Health Insurance Claim Form – used for Weekly Disability Income Benefits and submission of prescription receipts purchased at the retail pharmacy.
- Attending Dentist's Statement – used both for obtaining a pre-treatment estimate of charges and for filing any Dental claim.
- Prescription mail order drug form – used to submit prescription scripts to Express Scripts.
- Prescription retail purchase reimbursement form – used to make claim for prescriptions purchased at the local pharmacy where you paid the full price for the prescription rather than just your co-insurance portion of the cost.
- Enrollment Form – used to enroll dependents and to update beneficiary information can be printed off the Fund's website or obtained by calling the Fund office
- Beneficiary Form – used to provide and to update beneficiary information.

Forms can be printed off the Fund's website or obtained by calling the Fund office.

## Choosing a PPO Provider

Please contact the Fund Office, or refer to the Fund's website ([www.nasifund.org](http://www.nasifund.org)) to learn the name of your network Preferred Provider (PPO). Take advantage of the savings available through the PPO.

## Instructions for Completing Forms

Fully complete the patient member information section of the claim form. Claim forms with missing information will delay processing and payment. Your phone number and area code are important. If written confirmation is not required, the Fund can resolve any details with you promptly on the telephone.

Follow the general information guidelines below when a claim occurs.

If a hospitalization becomes necessary, follow the procedures and present your Identification Card upon admission. The Hospital can verify eligibility and coverage by calling the numbers printed on the back of the Identification Card. The patient (or parent if a minor) must sign, authorizing the release of information to the NASI Welfare Fund. In lieu of filling

out a Health Insurance claim form, your Physician can file an industry standard claim with the local Blue Cross Blue Shield plan.

Prescription drug receipts must show the following information:

- the name of the patient
- the prescribing Physician(s)
- the pharmacy prescription number
- the date filled
- the amount billed
- the quantity of the drug
- the NDC #

### Life and Accidental Death Claims

A certified copy of the death certificate needs to be submitted. In the case of accidental death, a police report or newspaper account of the accident will assist resolution of the claim. Life and accidental death claims must be filed within ten years of the date of death.

### Claims Filing Deadline

Claims must be filed within two years from the date covered services are provided, or they will not be covered.

## IX. Claims and Appeals Procedures and Requests for Pre-Service Evaluations

### General Rules—IMPORTANT

In order to receive benefits from the Fund, a claim must be made as described in these procedures. Claims may be made by a claimant directly or through a provider subject to the limitations on assignments. There are special procedures for some claims as explained below. Claim forms are available from the Fund Office.

A claim is considered filed as described in Section VIII beginning on page 108 of the booklet. Unless specifically provided for in this booklet, telephone calls and e-mails are not acceptable means of filing claims. Filing an incomplete claim or filing a claim at the wrong address may delay payment. Properly completed claims must be accompanied by a bill from the provider and such other proof as may be required by the Fund (or provider if the provider processes claims).

Some types of requests to the Fund are not considered claims. For example, requests for a determination whether a person is eligible for benefits or whether a particular benefit will be paid are not claims. Casual inquiries about benefits or the circumstances under which benefits might be paid are also not claims. The Fund will respond to inquiries that are not claims, but these rules and the appeal procedures discussed below do not apply.

Claims must be filed as soon as reasonably possible after the expense is incurred. We recommend that you send a claim for benefits to the Fund within 90 days of the date of service. Any claims submitted more than two years from the date of service will not be covered.

Both in determining initial claims and in deciding appeals, the Fund will make all determinations in accordance with the applicable Plan documents, policies and rules and will apply the provisions consistently, to the extent reasonable, with respect to similarly situated claimants.

### Types of Claims—Definitions

As described below, the procedures that apply to claims differ depending on whether your claim is a “Pre-Service Claim” or a “Post-Service Claim”. These and other important terms are defined in this subsection.

#### Pre-Service Claim

A “Pre-Service Claim” is any claim for which the terms of the Plan condition receipt of the benefit, in whole or part, on approval of the benefit in advance of obtaining medical care.

ONLY claims related to Specified Drugs Requiring Preauthorization are Pre-Service Claims. See page 72 for drugs requiring pre-authorization.

### Urgent Care Claim

An “Urgent Care Claim” is a Pre-Service Claim that involves “urgent care”. In general, an urgent situation is one which, in the opinion of the attending provider, the patient’s health may be in serious jeopardy or the patient may experience pain that cannot be adequately controlled while the patient waits for a decision on the pre-authorization. If the patient or provider believes the patient’s situation is urgent, the expedited review must be requested by phone at 1-800-753-2851.

ONLY Pre-Service Claims may be considered Urgent Care Claims under this Plan and the applicable regulations.

### Post-Service Claim

A “Post-Service Claim” is any claim for a benefit that does not require pre-approval by the Fund. In the case of this type of claim, you request coverage or reimbursement after medical care has already been provided. Except claims related to Specified Drugs Requiring Pre-Authorization on Page 72, all claims for benefits provided by the Fund are Post-Service Claims.

### Concurrent Care Claim

A “Concurrent Care Claim” is any claim to extend a course of treatment beyond the period of time or number of treatments that the Fund has already approved as an ongoing course of treatment to be provided over a period of time or number of treatments.

### Disability Claims

“Disability Claims”, which include Loss of Time Benefit Claims and Accidental Dismemberment Claims, are handled as Post-Service Medical Claims. However, there are some special time periods that apply to processing Disability Claims.

### Claims Procedure for Health Care Claims

The following procedures apply to health care claims (i.e., health, dental and vision claims) except that this procedure does not apply to optional pre-service evaluations of a Hospital admission (see page 64) and optional pre-service evaluations of medical services (see page 124). As explained above, except for one limited type of claim, the Plan does not require pre-approval before you receive medical care.

Please note that the Plan intends to follow all applicable legal requirements when adjudicating benefit claims, and decisions regarding hiring, compensation, termination,

promotion, or other similar matters with respect to an individual such as a claims adjudicator or medical expert will not be based upon the likelihood that the individual will support the denial of benefits.

**Post-Service Claims** (All claims except coverage requests for specified drugs requiring pre-authorization, see page 72.)

After you file a claim for benefits, the Fund Office will generally notify you of its benefit determination within 30 days after receiving your claim. The Fund Office will seek extensions beyond the 30-day period only for circumstances that are beyond the control of the Fund Office. If the Fund Office determines an extension is appropriate, the initial 30-day period may be extended by an additional 15 days, provided that the Fund Office notifies you of the extension prior to the expiration of the initial 30-day period. The extension notice will indicate the special circumstances requiring an extension of time and the date by which the Fund Office expects to decide your claim. If the initial 30-day period of time is extended due to your failure to submit information necessary to decide a claim, the written notification described above will set forth the specific information required from you, and you will have at least 45 days to provide the requested information. In that case, the Plan's time for making a benefit determination is tolled from the date the Fund Office sends you an extension notification until the date you respond to the request for additional information or your time to respond expires. If you provide additional information in response to such a request, a decision will be rendered within 15 days of when the information was received by the Plan.

**Pre-Service Claims** (ONLY coverage requests for specified drugs requiring pre-authorization, see page 72)

The prescriber of a drug that requires pre-authorization should submit the prior authorization request electronically. Alternatively, the prescriber or the dispensing Pharmacist may call the Express Scripts Coverage Review Department at 1-800-753-2851 or the prescriber may submit a completed coverage review form to Fax 1-877-329-3760. Coverage review forms may be obtained online at [www.express-scripts.com/services/physicians](http://www.express-scripts.com/services/physicians).

After you file a coverage review request, you will generally be notified of the determination within 15 days after receiving your coverage request. If the necessary information needed to make a determination is not received from the prescriber within 15 days, a letter will be sent to the patient and the prescriber informing them that certain information must be received within 45 days, or the claim will be denied. If the additional information is provided in response to this request, a determination will be made within 15 days of when the information is received.

**Urgent Care Claims** (Pre-Service Claims-- ONLY coverage requests for specified drugs requiring pre-authorization, see page 72)

If your situation meets the definition of an urgent care claim under the law, an urgent review may be requested. In this case, the review will be conducted as soon as possible but not later

than 72 hours after receipt of your request at the proper address unless your request is incomplete, that is, you have failed to submit information necessary to decide the request. If the patient or provider believes the patient's situation is urgent, the expedited review must be requested by phone at 1-800-753-2851.

You will be notified as soon as possible if your request is incomplete but not later than 24 hours after receiving your request. You will then have 48 hours to provide the specified information. Upon receiving this additional information, you will be notified of the coverage determination as soon as possible, within the earlier of 48 hours after receiving the information or the end of the period within which you must provide the information.

### Concurrent Care Claims

If the Fund has approved an ongoing course of treatment to be provided over a period of time, it will notify you in advance of any reduction in or termination of this course of treatment. If you submit a claim to extend a course of treatment, and that claim involves urgent care, the Fund will notify you of its determination within 24 hours after receiving your claim, provided the Fund receives your claim at least 24 hours prior to the expiration of the course of treatment. If the claim does not involve urgent care, the request will be decided within the time frame stated above.

### Notification of Denial of Claim (All claims including coverage review requests for specified drugs requiring preauthorization, see page 72)

If your application for benefits is denied in whole or in part or if there is a rescission of your coverage, the Fund Office, or Express Scripts in the case of a pre-service drug coverage review for specified drugs requiring preauthorization, will provide you with a written or electronic notice, which sets forth:

1. sufficient information to identify the claim involved including (where applicable) the date of service of the benefits denied, the health care provider, the claim amount, and the right to receive upon request the diagnosis code, treatment code and the meanings of these codes;
2. the reason(s) for the denial of the claim (including the denial code and its corresponding meaning) or rescission;
3. a description of any standard used to deny your claim;
4. references to the specific plan provisions on which the benefit determination or rescission was based;
5. if an internal rule or guideline was relied upon in denying your claim or rescinding your coverage, either a copy of the rule or guideline or a statement that you have the right to receive a free copy of the internal rule or guideline upon request;

6. if the denial is based on medical necessity or experimental treatment or a similar exclusion or limit, either an explanation of the scientific or clinical judgment for the decision, applying the terms of the Plan to your medical circumstances, or a statement that this will be provided free of charge upon request;
7. a description of any additional material or information which might help your claim (including an explanation of why that information may be helpful);
8. a description of any internal or external appeals available, how to initiate them and applicable filing deadlines, including the right to bring a civil legal action under ERISA if the claim continues to be denied on review;
9. a statement that you or your representative, may submit information in support of your claim in writing upon filing a request for review of denial of benefits or a rescission;
10. a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits; and
11. disclosure of the availability of, and the contact information for, an applicable office of health insurance consumer assistance or ombudsman established under the Public Health Service Act Section 2793.

The Fund, or Express Scripts in the case of a pre-service drug coverage review for specified drugs requiring preauthorization, will provide the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning, as soon as practicable after receiving a request. The Fund, or Express Scripts, will not consider a request for such diagnosis and treatment information, in itself, to be an appeal.

A “rescission” of coverage is a retroactive cancellation or termination of your coverage. The Plan may rescind coverage if the person whose coverage is rescinded (or the person through whom coverage of a dependent is obtained) performs an act, practice or omission that constitutes fraud or if the individual makes an intentional misrepresentation of material fact. Termination of coverage for failure to pay a premium, including a COBRA or self-pay premium, or to have contributions made on an individual’s behalf is not a rescission. Likewise, termination of coverage retroactive to the date of divorce (or other event making a dependent ineligible for coverage) is not a “rescission” where the Fund Office is not notified of a divorce or other disqualifying event and COBRA is not elected and/or the full COBRA premium is not paid by the employee or ex-spouse for coverage. Prospective termination is not a rescission. The Fund must provide 30-days notice to each participant who would be affected by the rescission before a rescission can occur.

## Appeals Procedure for Denied Health Care Claims



Post-Service Claims Appeals (All claims except coverage reviews for specified drugs requiring pre-authorization, see page 72.)

If you receive a notice that your health care claim for benefits has been denied in whole or in part, or if there has been a rescission of your coverage, you may submit a written appeal to the Trustees, requesting that the Board of Trustees review your benefit denial, rescission of coverage or the Fund policy, determination or action with which you disagree. Your written appeal must be submitted within 180 days of receiving the notice of denial of benefits or rescission of coverage. An appeal should be sent to:

Board of Trustees  
National Automatic Sprinkler Industry Welfare Fund  
8000 Corporate Drive  
Landover, MD 20785

Your written appeal should state the reason for your appeal. This does not mean that you are required to cite all applicable Plan provisions or to make "legal" arguments; however, you should state clearly why you believe you are entitled to the benefit you claim or why you are entitled to restoration of your coverage following a rescission. You are permitted to submit written comments, documents, records and other information relating to your claim even if such information was not submitted in connection with your initial claim for benefits. The Trustees can best consider your position if they clearly understand your claims, reasons and/or objections. Upon request, you will also have access to, and the right to obtain free copies of, all documents, records and information relevant to your claim.

The Trustees, or a designated Committee of the Trustees, will conduct a full review of all the information that you submit in connection with your appeal. Neither the Trustees nor any member of a Committee designated by the Trustees, nor a subordinate thereof, will have been involved in the initial benefit determination. You are entitled to review the Plan's claim file and to present evidence and testimony in support of your claim. The decision on appeal will not give deference to the initial denial. The Fund Office will provide you (free of charge) with new or additional evidence considered, relied upon, or generated by (or at the direction of) the Plan in connection with the claim, as well as any new or additional rationale for a denial at the internal appeals stage, and a reasonable opportunity for you to respond to such new evidence or rationale. In such cases, if the Plan receives new or additional information so late that it would be impossible to give it to you in time for you to have a reasonable opportunity to respond, the period for deciding your appeal will be tolled until you have a reasonable opportunity to respond.

If the initial denial was based, in whole or in part, on a medical judgment, the Trustees shall consult with a medical professional who has appropriate training and experience in the relevant field of medicine relating to the appeal. The medical professional will be an individual who was not consulted, and is not the subordinate of any professional consulted, in connection with the initial denial. You have the right to learn the identity of any health care professional contacted in connection with your claim.

The Trustees, or a designated Committee of the Trustees, will review your appeal at their quarterly meeting immediately following receipt of your appeal, unless the Fund Office receives your appeal within 30 days before the date of the meeting. In that case, your appeal will be reviewed at the second quarterly meeting following receipt of the appeal. You may wish to contact the Fund Office concerning the date of the next meeting, so that you may submit your appeal in time to be heard at that meeting. If special circumstances require an extension of time for reviewing your claim, you will be notified in writing of the need for the extension. The notice will be provided prior to the commencement of the extension, will describe the special circumstances requiring the extension and will set forth the date the Trustees will decide your appeal. Such date will not be later than the third meeting of the Trustees or Committee following the Fund Office's receipt of your appeal. However, in cases where the Fund Office must provide you with any new or additional evidence (or rationale for denial) considered, relied upon, or generated by the Plan in connection with your claim, and the Plan receives such new or additional information so late that it would be impossible to give it to you in time for you to have a reasonable opportunity to respond, the period for deciding your appeal will be tolled until you have a reasonable opportunity to respond.

**Notification of Determination of Appeal:** Once your claim has been reviewed and a benefit determination has been made, you will receive a written or electronic notice of the decision within 5 days. If your claim is denied, you will receive a written notification that contains the following information:

1. sufficient information to identify the claim involved, including where applicable, the date of service of the benefits denied, the health care provider, the claim amount, and the right to receive upon request the diagnosis code, treatment code and the meanings of these codes;
2. the reason(s) for the denial of the claim (including the denial code and its corresponding meaning) and a discussion of the decision or rescission;
3. a description of any standard used to deny your claim;
4. references to the specific plan provisions on which the benefit determination or rescission was based;
5. if an internal rule or guideline was relied upon in denying your claim or rescinding your coverage, either a copy of the rule or guideline or a statement that you have the right to receive a free copy of the internal rule or guideline upon request;
6. if the denial is based on medical necessity or experimental treatment or a similar exclusion or limit, either an explanation of the scientific or clinical judgment for the decision, applying the terms of the Plan to your medical circumstances, or a statement that this will be provided free of charge upon request;
7. the identification of any medical or vocational experts whose advice was obtained in connection with the benefit determination, regardless of whether the advice was relied upon in making the benefit determination;

8. a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits;
9. a description of the external review process, including information on how to initiate an external review and applicable time limits, and the right to bring a civil legal action under ERISA;
10. A statement describing any voluntary alternative dispute resolution options that may be available by contacting the U.S. Department of Labor, and the right to bring a civil legal action under ERISA; and
11. disclosure of the availability of, and the contact information for, an applicable office of health insurance consumer assistance or ombudsman established under the Public Health Service Act Section 2793.

The Plan will provide the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning, as soon as practicable after receiving your request. The Plan will not consider a request for such diagnosis and treatment information, in itself, to be a request for an external review.

#### External Review of an Adverse Health Care Benefit Determination after Appeal for Post-Service Claims (All claims except coverage requests for specified drugs requiring pre-authorization, see page 72.)

Standard External Review: If you receive an adverse benefit determination on your appeal concerning your health care claim or a rescission of your coverage, you have the right to request an external review. The request should be sent to the address identified above for submitting an appeal to the Trustees. Your request for an external review must be made no later than four (4) months after the date you receive the adverse decision on your appeal. If there is no corresponding date four (4) months after the date of receipt of such notice, the request must be filed by the first day of the fifth (5th) month following the receipt of the notice. For example, if the date of receipt of the notice is October 30, because there is not February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday or Federal holiday.

Within five (5) business days following receipt, the Fund Office will make a preliminary review to determine whether:

1. You are or were covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, were covered under the Plan at the time the health care item or service was provided;

2. The adverse benefit determination or the final adverse benefit determination does not relate to your failure to meet the requirements for eligibility to participate under the terms of the Plan (eligibility claims are not subject to external review);
3. You have exhausted the Plan's internal appeal process unless you are not required to exhaust the final internal appeals process; and
4. You have provided all the information and forms required to process an external review.

Within one (1) business day after completion of the preliminary review, the Fund Office will issue a written notification to you. If the request is complete but not eligible for external review, the notification will include the reasons for its ineligibility and the toll-free (if available) contact information for the Employee Benefits Security Administration. If the request is not complete, the notification will describe the information or materials needed to make the request complete. The Plan will allow you to perfect the request for external review within the later of: (a) the four-month filing period, or (b) the 48 hour period after the receipt of notification.

If your case is eligible for external review, it will be forwarded to an Independent Review Organization (IRO) accredited by a nationally-recognized accrediting organization, and the IRO will contact you. The Fund Office will contract with at least three (3) IROs for assignments under the Plan and rotate claim assignments among them or incorporate other independent, unbiased methods for selection of IROs, such as random selection.

With respect to claims for which an adverse benefit determination has not been initiated by September 20, 2011, the Federal external review process applies only to:

1. An adverse benefit determination (including a final adverse benefit determination) by the Plan that involves medical judgment (including, but not limited to, those based on the Plan's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or the Plan's determination that a treatment is experimental or investigational), as determined by the external reviewer. Additional examples of situations where a claim is considered to involve medical judgment include adverse benefit determinations based on:
  - a. The appropriate health care setting for providing medical care to an individual (such as outpatient versus inpatient care or home care versus rehabilitation facility);
  - b. Whether treatment by a specialist is medically necessary or appropriate (pursuant to the Plan's standard for medical necessity or appropriateness);
  - c. Whether treatment involved "emergency care", affecting coverage or the level of coinsurance;
  - d. A determination that a medical condition is a preexisting condition;

- e. The Plan's general exclusion of an item or service, if the Plan covers the item or service in certain circumstances based on a medical condition;
  - f. Whether a participant or beneficiary is entitled to a reasonable alternative standard for a reward under the Plan's wellness program, if any;
  - g. The frequency, method, treatment, or setting for a recommended preventive service, to the extent not specified, in the recommendation or guideline of the U.S. Preventive Services Task Force, the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, or the Health Resources and Services Administration (as described in PHS Act section 2713 and its implementing regulations); and
  - h. Whether the Plan is complying with the nonquantitative treatment limitation provisions of the Mental Health Parity and Addiction Equity Act and its implementing regulations, which generally require, among other things, parity in the application of medical management techniques;
2. A rescission of coverage (whether or not the rescission has any effect on any particular benefit at that time).

Once you are contacted by the IRO, you will have ten business days to submit additional information directly to the IRO if you choose to do so. The IRO is not required to, but may accept and consider additional information submitted after ten (10) business days. The IRO will use legal experts where appropriate to make coverage determinations under the Plan. Within five (5) business days after the assignment of the IRO, the Fund Office will provide to the IRO the documents and information considered in making the adverse benefit determination or final internal appeal including information that you previously submitted to the Fund Office. Failure by the Fund Office to timely provide the documents and information will not delay the conduct of the external review. If the Fund Office does not timely provide the documents and information, the IRO may terminate the external review and make a decision to reverse the adverse benefit determination or final internal adverse benefit determination. Within one (1) business day after making such a decision, the IRO must notify you and the Plan.

Upon receipt of any information that you submit, the IRO must forward the information to the Plan within one (1) business day. The Fund Office may, but is not required to, reconsider its adverse benefit determination or final internal adverse benefit determination. Reconsideration by the Plan will not delay the external review. If the Fund Office decides to reverse its adverse benefit determination or final internal adverse benefit determination and provide coverage or payment, the Fund Office will provide written notice of its decision to you and the IRO within one (1) business day after making its decision. The IRO will terminate the external review upon receiving this notice from the Fund Office.

The IRO will review all of the information and documents timely received. In reaching a decision, the IRO will review the claim de novo and will not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. In addition to the

documents and information provided, the IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:

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

Within 45 days after the IRO receives your request for external review from the Fund Office, the IRO will issue to you a written notice of its final external review decision. The written decision of the IRO will contain:

1. A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount (if applicable), and the reason for the previous denial);
2. The date the IRO received the assignment to conduct the external review and the date of the IRO decision;
3. References to the evidence or documentation, including the specific coverage provisions and evidence based standards, considered in reaching its decision;
4. A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;
5. A statement that the determination is binding except to the extent that other remedies may be available under the State or federal law to either the group health plan or to you;

6. A statement that judicial review may be available to you;
7. current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under the Public Health Service Act Section 2793.

Upon receipt of a notice of final external review decision reversing the adverse benefit determination or final internal adverse benefit determination, the Plan will immediately provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim. The IRO's decision is binding on you and the Plan, except to the extent other remedies are available under State or Federal law, and except that the requirement that the decision be binding shall not preclude the Plan from making payment on the claim or otherwise providing benefits at any time, including after a final external review decision that denied the claim or otherwise fails to require such payment or benefits. For this purpose, the Plan must provide any benefits, including making payment on the claim, pursuant to the final external review decision without delay, regardless of whether the Plan intends to seek judicial review of the external review decision and unless or until there is a judicial decision otherwise.

**Expedited External Review:** When external review is otherwise available, the Plan will allow you to make a request for an expedited external review at the time you receive:

1. An adverse benefit determination on appeal involving a medical condition for which the timeframe to complete a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, and you have filed a request for an expedited internal appeal, or
2. A final internal adverse benefit determination if you have a medical condition where the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function or if the final internal adverse benefit determination appeal concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency care services but have not been discharged from a facility.

Immediately upon receipt of the request for expedited external review, the Fund Office will review the request to determine whether the request meets the reviewability requirements using the same criteria above that apply to a standard external review. The Plan will immediately send a notice of its eligibility determination that meets the requirements above for a standard external review eligibility determination notice.

Upon determination that request is eligible for expedited external review following the preliminary review, the Fund Office will assign an IRO in accordance with the requirements for assigning an IRO for a standard external review above. The Plan will provide or transmit all necessary documents and information considered in making the adverse benefit determination or final internal adverse benefits determination to the assigned IRO electronically or by telephone or fax or any other available expeditious method.

The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the information or documents described above under the procedures for standard external review. In reaching a decision, the IRO will review the claim de novo and is not bound by any decisions or conclusions reached during the Plan's internal claims and appeals process.

The IRO will provide written notice to you and the Plan of the final external review decision, in accordance with the requirements above for standard external review, except that the notice will be provided as expeditiously as possible but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, then within 48 hours after the date of providing that notice, the IRO must provide written confirmation of that decision to you and the Plan.

If the IRO reverses the Plan's adverse benefit determination or final internal adverse benefit determination, the Plan will immediately provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim. The IRO's decision is binding on you and the Plan, except to the extent other remedies are available under State or Federal law and except that the requirement that the decision be binding shall not preclude the Plan from making payment on the claim or otherwise providing benefits at any time, including after a final external review decision that denied the claim or otherwise fails to require such payment or benefits. For this purpose, the Plan must provide any benefits, including by making payment on the claim, pursuant to the final external review decision without delay, regardless of whether the Plan intends to seek judicial review of the external review decision and unless or until there is a judicial decision otherwise.

IROs must maintain records of all claims and notices associated with the external review process for six (6) years. An IRO must make such records available for examination by you, the Plan, or State or Federal oversight agency upon request, except where such disclosure would violate State or Federal privacy laws.

### Procedures for Optional Pre-Service Evaluation of Hospital Admissions

The Fund urges you to obtain evaluation of Hospital admissions (see page 64) and provides these special optional procedures for such requests. A purpose for this evaluation is to inform you regarding the likelihood as to whether the contemplated admission meets the Plan's medical necessity standard and other Plan requirements for coverage. Although an advance determination is not required for you to obtain medical care, it may be advisable to obtain information whether coverage for a contemplated procedure may be denied because it is experimental or might otherwise not be covered by the Plan.

For all requests for evaluation of Hospital admissions, the initial request is made by calling a Medical Review Specialist with American Health (our Utilization Review/Case Management firm) at 1-866-343-3709. For such inquiries, American Health will notify you of its evaluation within 30 days after receiving your inquiry. If the initial 30-day period of time needs to be extended due to a failure to provide American Health with the information it needs to make an evaluation, you will be notified of the specific information American



Health needs, and you or your medical care provider will have at least 45 days to provide the requested information.

It is important to remember that an evaluation by American Health is not a denial of benefits. It is an optional service provided by the Plan to enable you to obtain an evaluation of whether a particular hospital admission is likely to be covered by the Plan. If the evaluation is negative, you are still free to obtain the services and submit a claim which will be evaluated based on the actual information submitted in support of the claim and not the information submitted for the advance evaluation.

## Procedures for Optional Pre-Service Evaluation of Medical Services

The Fund provides the opportunity for optional pre-service evaluation of Medical Services and provides these special procedures for such requests. A purpose for this evaluation is to inform you regarding the likelihood as to whether the contemplated medical procedure or service meets the Plan's medical necessity standard and other Plan requirements for coverage. Although an advance determination is not required for you to obtain medical care, it may be advisable to obtain information whether coverage for a contemplated procedure may be denied because it is experimental or might otherwise not be covered by the Plan.

For all requests for evaluation of Medical Services, the initial request may be made by calling the Fund Office and speaking to a Claims Service Representative at 1-800-638-2603 or by email request to [mail@nasifund.org](mailto:mail@nasifund.org) or by writing to:

Claims Department  
National Automatic Sprinkler Industry Welfare Fund  
8000 Corporate Drive  
Landover, MD 20785

For such requests for evaluation the Fund Office will notify you of its evaluation within 30 days after receiving your inquiry. If the initial 30-day period of time needs to be extended due to a failure to provide the Fund Office with the information it needs to make an evaluation, you will be notified of the specific information needed, and you or your medical care provider will have at least 45 days to provide the requested information.

It is important to remember that an evaluation by the Fund Office is not a denial of benefits. It is an optional service provided by the Plan to enable you to obtain an evaluation whether particular medical services are likely to be covered by the Plan. If the evaluation is negative, you are still free to obtain the services and submit a claim which will be evaluated based on the actual information submitted in support of the claim and not the information submitted for the advance evaluation.

**Pre-Service and Urgent Appeals (ONLY coverage requests for specified drugs requiring pre-authorization, see page 72.)**

**Level 1 Appeal:** When your initial coverage review request for a drug requiring pre-authorization has been denied, you or your authorized representative may submit a request

for appeal within 180 days from your receipt of notice that the request for coverage has been denied. To request an appeal, the request must be submitted in writing by mail or fax to:

Express Scripts  
 Attention: Clinical Appeals Department  
 PO Box 66588  
 St Louis, MO 63166-6588  
 FAX: 1-877-852-4070

The following information must be included with the request:

- Name of patient
- Member ID
- Phone number
- The drug name for which coverage has been denied
- A brief description of why the claimant disagrees with the denial of coverage
- Any additional information that may be relevant to the appeal including statements from the prescriber, bills or other documents.

An urgent appeal may be submitted if, in the opinion of the attending provider, the time period for making a non-urgent care determination could seriously jeopardize the life or health of the patient or the patient’s ability to regain maximum function or would subject the patient to severe pain that cannot be adequately managed without the drug that is the subject of the appeal.

Urgent appeals must be submitted by phone 1-800-753-2851 or fax 1-877-852-4070. Appeals submitted by mail will not be considered for urgent processing unless a subsequent phone call or fax identifies the appeal as urgent.

**How a Level 1 Appeal/Urgent Appeal is Processed by Express Scripts:** Appeal decisions and notifications are made as follows (from Express Scripts Reviews and Appeals Overview, page 3):

Type of Appeal	Decision Timeframe  Decisions are completed as soon as possible from receipt of request but no later than:	Notification of Decision	
		Approval	Denial
Standard Pre-Service	15 days	<u>Patient:</u> automated call (letter if call not successful)	<u>Patient:</u> letter
Urgent	72 hours	<u>Patient:</u> automated call and letter <u>Prescriber:</u> Fax (letter if fax not successful)	<u>Patient:</u> live call and letter <u>Prescriber:</u> Fax (letter if fax not successful)

If new information is received and considered or relied upon in the review of the appeal, such information will be provided to the patient and prescriber together with an opportunity to respond prior to issuance of any final adverse determination.

The content of the letters is the same as described in the section entitled “Notification of Determination of Appeal” on page 117.

The decision made on an urgent appeal is final. In the urgent care situation, there is only one required level of appeal prior to an external review. A voluntary appeal to the Trustees of the Fund is available but not required. See page 129.

**Level 2 Appeal after a Level 1 appeal has been denied:** When a Level 1 appeal has been denied, a request for a Level 2 appeal may be submitted by you or your authorized representative within 90 days from receipt of notice of denial of the Level 1 appeal. To request a Level 2 appeal, the request must be submitted in writing by mail or by fax to:

Express Scripts  
Attention: Clinical Appeals Department  
PO Box 66588  
St Louis, MO 63166-6588  
FAX: 1-877-852-4070

The following information must be included with the request:

- Name of patient
- Member ID
- Phone number
- The drug name for which coverage has been denied
- A brief description of why the claimant disagrees with the denial of coverage
- Any additional information that may be relevant to the appeal including statements from the prescriber, bills or other documents.

If an appeal that was not considered urgent as a Level 1 appeal becomes urgent because of the passage of time or otherwise, the appeal may be considered urgent as a Level 2 appeal. A Level 2 appeal may be urgent if, in the opinion of the attending provider, the time period for making a non-urgent care determination could seriously jeopardize the life or health of the patient or the patient’s ability to regain maximum function or would subject the patient to severe pain that cannot be adequately managed without the drug that is the subject of the appeal.

Urgent appeals must be submitted by phone 1-800-753-2851 or fax 1-877-852-4070. Appeals submitted by mail will not be considered for urgent processing unless a subsequent phone call or fax identifies the appeal as urgent.

**How a Level 2 Appeal is Processed by Express Scripts:** Appeal decisions and notifications are made as follows (from Express Scripts Reviews and Appeals Overview, page 5):

Type of Appeal	Decision Timeframe  Decisions are completed as soon as possible from receipt of request but no later than:	Notification of Decision	
		Approval	Denial
Standard Pre-Service	15 days	<u>Patient:</u> automated call (letter if call not successful)	<u>Patient:</u> letter
Urgent	72 hours	<u>Patient:</u> automated call and letter  <u>Prescriber:</u> Fax (letter if fax not successful)	<u>Patient:</u> live call and letter  <u>Prescriber:</u> Fax (letter if fax not successful)

If new information is received and considered or relied upon in the review of the appeal, such information will be provided to the patient and prescriber together with an opportunity to respond prior to issuance of any final adverse determination.

The content of the letters is the same as described in the section entitled “Notification of Determination of Appeal” on page 117.

**External Review of a Denial of Appeal of a Coverage Review Request for a Drug Requiring Pre-Authorization**

The right to request an independent external review may be available for an adverse benefit determination involving medical judgment, rescission, or a decision based on medical information, including determinations involving treatment that is considered experimental or investigational.

Generally, all internal appeal rights must be exhausted prior to requesting an external review. The external review will be conducted by an independent review organization with medical experts that were not involved in the prior determination of the claim.

To submit an external review, the request must be mailed or faxed to:

MCMC, LLC  
 Attn: Express Scripts Appeal Program,  
 300 Crown Colony Drive, Suite 203,  
 Quincy, MA 02169-0929.  
 Phone: 1 617- 375- 7700 ext. 28253  
 Fax: 1 617- 375- 7683

The request for external review must be received within 4 months of the date of the final internal adverse benefit determination (denial) of a coverage review request for a drug requiring pre-authorization. (If the date that is 4 months from that date is a Saturday, Sunday or holiday, the deadline will be the next business day).

As explained above, urgent care appeals of a denial of a coverage review request for a drug requiring pre-authorization have only one required level of internal appeal before external appeal may be requested.

A voluntary appeal to the Trustees of the Fund is also available but not required. See page 129.

**How an External Review is processed for a Denial of Appeal of a Coverage Review Request for a Drug Requiring Pre-Authorization** (from Express Scripts Reviews and Appeals Overview, page 6):

**Standard External Review:** MCMC will review the external review request within 5 business days to determine if it is eligible to be forwarded to an Independent Review Organization (IRO) and the patient will be notified within 1 business day of the decision.

If the request is eligible to be forwarded to an IRO, the request will randomly be assigned to an IRO and the appeal information will be compiled and sent to the IRO within 5 business days of assigning the IRO. The IRO will notify the claimant in writing that it has received the request for an external review, and, if the IRO has determined that the claim involves medical judgment, the letter will describe the claimant's right to submit additional information within 10 business days for consideration to the IRO. Any additional information the claimant submits to the IRO will also be sent back to the claims administrator for reconsideration. The IRO will review the claim within 45 calendar days from receipt of the request and will send the claimant, the plan and Express Scripts written notice of its decision. If the IRO has determined that the claim does not involve medical judgment, the IRO will notify the claimant in writing that the claim is ineligible for a full external review.

**Urgent External Review:** Once an urgent external review request is submitted, the claim will immediately be reviewed to determine if it is eligible for an urgent external review. An urgent situation is one where (in the opinion of the attending provider) the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health or the ability for the patient to regain maximum function or would subject the patient to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

If the claim is eligible for urgent processing, the claim will immediately be reviewed to determine if the request is eligible to be forwarded to an IRO, and the claimant will be notified of the decision. If the request is eligible to be forwarded to an IRO, the request will randomly be assigned to an IRO, and the appeal information will be compiled and sent to the IRO. The IRO will review the claim within 72 hours from receipt of the request and will send the claimant written notice of its decision.

**Voluntary Trustee Review of Pre-Service and Urgent Care Claims** (ONLY coverage requests for specified drugs requiring pre-authorization, see page 72):

The Trustees have designated Express Scripts, acting in a fiduciary capacity, to review and decide pre-service claims related to specified drugs requiring pre-authorization to conform to the timing requirements for such claims. The Trustees have also made available a voluntary appeal to the Trustees of such Pre-Service and Urgent Care Claims. The voluntary appeal will take place ONLY at the Trustees' regularly scheduled meetings. In addition the following apply to the voluntary appeal:

- The Fund will not assert that a claimant has failed to exhaust administrative remedies where a claimant elects to pursue a claim in court rather than through the voluntary level of appeal. The voluntary appeal to the Trustees of Pre-Service and Urgent Care Claims decided by Express Scripts is purely voluntary.
- The Fund agrees that the statute of limitations applicable to pursuing the claimant's claim in court will be tolled during the period of the voluntary appeal process to the Trustees.
- The voluntary appeal to the Trustees of Pre-Service and Urgent Care Claims decided by Express Scripts is available only after the claimant has pursued the required levels of appeal described above.
- The claimant will be provided with sufficient information to make an informed judgment about whether to submit a claim through the voluntary appeal process.
- No fees or costs are imposed on the claimant as part of the voluntary appeal process.

## Claims Procedures for Disability Claims

After you file a claim for benefits, the Fund Office will generally notify you of its decision within a reasonable period of time, but not later than 45 days after it receives the claim. However, if the Fund Office determines that special circumstances require an extension of time for processing the claim, the Fund Office will notify you, in writing and before the end of the initial period, that it will need additional time to decide the claim. The Fund Office will seek extensions beyond the 45-day period only for circumstances that are beyond the control of the Fund Office. If the Fund Office determines an extension is appropriate, the initial 45-day period may be extended by an additional 30 days, provided that the Fund Office notifies you of the extension prior to the expiration of the initial 45-day period. The extension notice will:

1. indicate the special circumstances requiring an extension of time;
2. set forth the date by which the Fund Office expects to decide your claim;
3. explain the standards on which entitlement to a benefit is based;
4. describe the unresolved issues that prevent the claim from being decided;
5. specify the additional information that may be needed to decide your claim; and
6. provide you with at least 45 days within which to provide the specified information.

If a period of time is extended due to your failure to submit information necessary to decide the claim, the period for making the benefit determination by the Fund Office will be tolled from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information or your time to respond expires. If you provide additional information in response to such a request, a decision will be rendered within 15 days of when the information was received by the Plan.

If the Fund Office decides that it is unable to decide your claim during the first 30-day extension due to matters beyond its control, a second 30-day extension is possible. In the event that a second 30-day extension is required, the Fund Office will notify you of the extension prior to the expiration of the initial 30-day extension period and the notification will contain the same information required to be included in the first notice.

If your application for benefits is denied in whole or in part, the Fund Office will provide you with a written or electronic notice that sets forth:

1. the reason(s) for the denial;
2. references to any pertinent Plan provisions, internal rules, guidelines, protocols or other criteria relied on in making the adverse determination;
3. a description of any additional materials or information which might help your claim (including an explanation of why that information may be helpful);
4. a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all Plan documents, records, and other information relevant to the claim for benefits;
5. a description of the appeals procedures and applicable filing deadlines, including the right to bring a civil legal action under ERISA if the claim continues to be denied on review; and
6. if the determination is based on an internal rule, guideline, protocol, or other similar criterion, a statement that such a rule, guideline, protocol, or criterion was relied upon in making the denial, along with either a copy of the specific rule, guideline, protocol, or criterion, or a statement that a copy will be provided to you free of charge upon request.

### Appeals Procedures for Disability Claims

If your disability claim is denied, you may submit a written appeal to the Trustees, requesting that the Board of Trustees review your benefit denial. Your written appeal must be submitted within 180 days of receiving the notice of denial of benefits. Your appeal should be sent to:

Board of Trustees

National Automatic Sprinkler Industry Welfare Fund  
8000 Corporate Drive  
Landover, MD 20785

Your written appeal should state the reason for your appeal. This does not mean that you are required to cite all applicable Plan provisions or to make "legal" arguments; however, you should state clearly why you believe you are entitled to the benefit you claim. You are permitted to submit written comments, documents, records and other information relating to your claim even if such information was not submitted in connection with your initial claim for benefits. The Trustees can best consider your position if they clearly understand your claims, reasons and/or objections.

The Trustees, or a designated Committee of the Trustees, will review your appeal at their quarterly meeting immediately following receipt of your appeal, unless the Fund Office received your appeal within 30 days of the date of the meeting. In that case, your appeal would be reviewed at the second quarterly meeting following receipt of the appeal. You may wish to contact the Fund Office concerning the date of the next meeting, so that you may submit your appeal in time to be heard at that meeting. If special circumstances require an extension of time for reviewing your claim, you will be notified in writing of the need for the extension. The notice will be provided prior to the commencement of the extension, describe the special circumstances requiring the extension and set forth the date the Trustees will decide your appeal. Such date will not be later than the third meeting of the Trustees or Committee following the Fund Office's receipt of your appeal.

Neither the Trustees nor any member of a Committee designated by the Trustees, nor a subordinate thereof, will have been involved in the initial benefit determination. The Trustees, or the designated Committee of the Trustees, will give no deference to the initial claim denial. Additionally, if the initial denial was based, in whole or in part, on a medical judgment, the Trustees shall consult with a medical professional who has appropriate training and experience in the relevant field of medicine relating to the appeal. The medical professional will be an individual who was not consulted, nor is the subordinate of any professional consulted, in connection with the initial denial. You have the right to learn the identity of any health care professional contacted in connection with your claim.

Once your claim has been reviewed and a benefit determination has been made, you will receive written or electronic notice of the decision within 5 days. If your appeal is denied, the notice will be written in a manner calculated to be understood by you and will include:

1. the specific reason(s) for the adverse determination;
2. references to the specific Plan provisions on which the determination was based;
3. a statement that you are entitled to receive upon request and free of charge reasonable access to, and make copies of, all records, documents and other information relevant to your benefit claim upon request;
4. if the determination was based on an internal rule, guideline, protocol, or other similar criterion, a statement that such a rule, guideline, protocol, or criterion was relied upon in making the denial, along with either a copy of the specific rule,



guideline, protocol, or criterion, or a statement that a copy will be provided to you free of charge upon request;

5. a statement describing your right to bring a civil legal action under ERISA.

## Claims Procedure for Life, Accidental Death and Dismemberment Claims, and Claims Relating to Fund Policy Changes, Determinations or Actions

The following procedure applies to claims not covered by the claims procedures for health care or disability claims set forth above. For example, the procedure applies to claims for life insurance or accidental death and dismemberment insurance benefits, and claims related to a Fund policy change, determination, or action (including an eligibility determination) with which you disagree that is not a benefits denial or rescission of coverage. With respect to claims for eligibility to participate in health care or disability benefits, this procedure applies if you are inquiring solely about eligibility to participate in those programs. Claims involving both an eligibility determination and a current claim for benefits for health care or disability benefits are subject to the benefits claims procedures for those programs, described above.

After you file a claim, the Fund Office will generally notify you of its decision within a reasonable period of time, but not later than 90 days after it receives the claim. However, if the Fund Office determines that special circumstances require an extension of time for processing the claim, the Fund Office will notify you, in writing and before the end of the initial period, that it will need additional time to decide the claim. The extension notice will indicate the special circumstances requiring an extension of time and the date by which the Fund Office expects to decide your claim. For claims, such date will not exceed 90 days from the end of the initial 90-day period.

If your claim is denied in whole or in part, the Fund Office will provide you with a written notice that:

1. explains the reason or reasons for the decision;
2. includes specific references to Plan provisions upon which the decision is based;
3. provides a description of any additional material or information that might be helpful to decide the claim (including an explanation of why that information might be necessary);
4. include a statement that you are entitled to receive upon request and free of charge reasonable access to , and copies of, all Plan documents, records, and other information relevant to the claim for benefits; and
5. describes the appeals procedures and applicable filing deadlines, including the right to bring a civil legal action under ERISA if the claim continues to be denied on review.

## Appeals Procedure for Life, Accidental Death and Dismemberment Claims, and Claims relating to Fund Policy Changes, Determination or Actions

If you disagree with the decision reached by the Fund Office, you may submit a written appeal requesting a review of the decision. The written appeal must be submitted within 60 days of receiving the initial adverse decision. The appeal should clearly state the reason or reasons why you disagree with the Fund Office's decision. You may submit written comments, documents, records and other information relating to the claim even if such information was not submitted in connection with the initial claim for benefits. Additionally, upon request and free of charge, you may have reasonable access and copies of all Plan documents, records and other information relevant to the claim.

The Fund Office will generally notify you of its decision on appeal within 60 days after the appeal is received, unless special circumstances require an extension of time for processing. In which event, a decision should be rendered as soon as possible but in no event later than 120 days after such receipt. The decision will be in writing and will include:

1. specific reasons for the decision with specific references to the pertinent Plan provisions on which the decision is based;
2. a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim;
3. a statement describing your right to bring a civil legal action under ERISA.

## Statute of Limitations and Exhaustion of Administrative Remedies

You may not commence a judicial proceeding against any person, including the Plan, a Plan fiduciary, the Plan Administrator, the Plan Trustees, the Fund Office, or any other person, with respect to a claim for health care, disability, life insurance, accidental death and dismemberment insurance, fund policy changes, determination or actions, or other claims for benefits without first exhausting the appropriate claims procedures set forth above. If you have exhausted these procedures and are dissatisfied with the decision on appeal of a denied claim, you may bring an action under Section 502 of ERISA in an appropriate court to review the Plan's decision on appeal, but only if the action is commenced no later than the earlier of (1) the applicable statute of limitations, or (2) the second anniversary of the date of the decision on appeal.

In the case of health plans subject to the expanded claims procedure requirements under PPACA, notwithstanding the previous paragraph, if the Plan fails to adhere to all of the requirements of the procedures set forth above for health Plan claims or rescissions of health Plan coverage, then to the extent mandated by PPACA, you may initiate an external review or bring an action in an appropriate court under state law or section 502(a) of ERISA, but only if the action is commenced no later than the earlier of (1) the applicable statute of limitations or (2) the second anniversary of the date of the decision in the external appeal. However, you cannot initiate an external review or bring an action in an appropriate court

under state law or section 502(a) of ERISA without first exhausting the claims procedures set forth above if the violation by the Plan was:

1. De minimis;
2. Not likely to cause you prejudice or harm;
3. Attributable to good cause or matters beyond the Plan's control;
4. In the context of an ongoing good-faith exchange of information; and
5. Not reflective of a pattern or practice of non-compliance by the Plan.

Within 10 days of the Plan's receipt of your written request, you are entitled to an explanation of the Plan's basis for asserting that it meets the above exception that includes a specific description of its bases, if any, for asserting the violation should not cause the internal claims and appeals process to be deemed exhausted. If an external reviewer or a court rejects your request for immediate review on the basis that the Plan met the requirements for the exception, then the Plan will provide you with notice of the opportunity to resubmit and pursue the internal appeal of the claim within a reasonable time after the external reviewer or court rejected the claim for immediate review (but not to exceed ten days). Time periods for re-filing the claim shall begin to run upon your receipt of such notice.

You may only renew your appeal if you have any material additional information or new arguments to present. A renewed appeal will only consider the impact of the new information or new arguments, must be submitted in writing, and the rules and limits stated above apply. In connection with an appeal or a renewed appeal, you may review pertinent documents in the Fund Office after making appropriate arrangements, or you may request that documents be provided to you. Such information will be provided free of charge.

## X. General Information/ERISA Rights

The following information is provided as specified in Section 102(b) of the Employee Retirement Income Security Act of 1974 (ERISA).

### Official Name of Plan:

National Automatic Sprinkler Industry Welfare Fund

### Type of Administration:

Collectively bargained, joint-trusted labor management trust; self-administered.

### Type of Plan:

The Plan is a welfare benefit plan providing hospital, medical, dental, vision, disability, and accidental death and dismemberment benefits. The Plan is self-funded.

Name and address of the Administrator, the Plan office, and the person designated as agent for the service of legal process:

Michael W. Jacobson, Fund Administrator  
National Automatic Sprinkler Industry Welfare Fund  
8000 Corporate Drive  
Landover, MD 20785

(In addition, service of legal process may be made on any Plan Trustee.)

### Names, Titles and Addresses of the Plan Trustees:

#### Union Trustees

Brian Dunn  
Road Sprinkler Fitters Local Union 669  
7050 Oakland Mills Road, Suite 200  
Columbia, MD 21046

Peter Gibbons  
Sprinkler Fitters Local Union 550  
46 Rockland St  
Boston, MA 02132

Michael R. Mahler  
Sprinkler Fitters Local Union 268  
1544 S. 3rd Street  
St. Louis, MO 63104

#### Employer Trustees

Fred Barall  
National Fire Sprinkler Association, Inc.  
514 Progress Drive Suite A  
Linthicum Heights, MD 21090

Rory Schnurr  
National Fire Sprinkler Association, Inc.  
514 Progress Drive Suite A  
Linthicum Heights, MD 21090

Cornelius J. Cahill  
National Fire Sprinkler Association, Inc.  
514 Progress Drive Suite A  
Linthicum Heights, MD 21090

Robert J. Cooper, Jr.  
Road Sprinkler Fitters Local Union 669  
7050 Oakland Mills Road, Suite 200  
Columbia, MD 21046

Gregg Huennekens  
National Fire Sprinkler Association, Inc.  
514 Progress Drive Suite A  
Linthicum Heights, MD 21090

Brian E. Fisher  
Road Sprinkler Fitters Local Union 669  
7050 Oakland Mills Road, Suite 200  
Columbia, MD 21046

Rob Vincent  
National Fire Sprinkler Association, Inc.  
514 Progress Drive Suite A  
Linthicum Heights, MD 21090

### Source of Financing of the Plan and Identity of Any Organization Through Which Benefits are Provided:

Payments are made to the trust by individual employers under the provisions of Collective Bargaining Agreements, by retirees and employees through self-payments. Income is earned from investment of contributions. All monies are used exclusively for providing benefits to eligible employees and their dependents and for expenses incurred with respect to the operation and administration of the Plan.

The Fund Office will provide you, upon written request, information as to whether an employer is contributing to this Fund on behalf of employees working under a Collective Bargaining Agreement.

The Plan has arrangements with various organizations such as preferred provider networks that affect the payment of benefits. The following is a list of those organizations and the services they provide to the Plan.

#### Utilization Review/Case Management

American Health Holding, Inc.  
100 West Old Wilson Bridge Road  
Worthington, OH 43085  
866-343-3709

#### Preferred Provider Organization

Blue Cross Blue Shield  
300 East Randolph Street  
Chicago, IL 60601  
312-653-8365

#### Prescription Drug Program

Express Scripts  
1 Express Way  
St. Louis, MO 63121  
(314) 996-0900

## Accidental Death and Dismemberment Insurance; Life Insurance

Aetna Life Insurance Company  
151 Farmington Avenue  
Hartford, CT 06156  
800-872-3862

## Dental Benefits

Delta Dental  
One Delta Drive  
Mechanicsburg, PA 17055  
800-932-0783

## Vision Benefits

Vision Service Plan, Inc.  
3333 Quality Drive  
Rancho Cordova, CA 95670  
800-877-7195

All other benefits are administered under the direction of the Trustees. Except as indicated above, no other payments provided for in this Plan are insured by any contract of insurance other than through a stop-loss contract, and there is no liability on the Board of Trustees or any other individual or entity to provide payment over and beyond the amount in the Fund. The Trustees, in their sole discretion, have full authority to interpret the Plan and decide all issue relating to the Plan. In addition, the Trustees, in their sole discretion, may terminate, suspend, withdraw, amend or modify the Plan and any of its provisions, in whole or in part, at any time, including the existence and duration of coverage for all employees, retirees, and eligibility and requirements for coverage, the availability, nature and extent of benefits and conditions for and method of payment of benefits.

Date of the End of the Plan Year: December 31

Internal Revenue Service Plan Identification Number:

53-0215881

The Plan Number is:

501

Plan Termination; Amendment or Elimination of Benefits; Interpretation of Plan:

The Fund may be terminated by a document in writing adopted by the Trustees. The Fund may be terminated if, in the opinion of the Trustees, the Trust Fund is not adequate to carry

out the intent and purpose of the Fund as stated in its Trust Agreement or is not adequate to meet the payments due or which may become due under the Plan of Benefits. The Fund may also be terminated if there are no individuals living who can qualify as Employees or Beneficiaries under the Plan. Finally, the Fund may be terminated if there are no longer any Collective Bargaining Agreements requiring contributions to the Fund. The Trustees have complete discretion to determine when and if the Fund should be terminated.

If the Fund is terminated, the Trustees will: (a) pay the expenses of the Fund incurred up to the date of termination as well as the expenses in connection with the termination; (b) arrange for a final audit of the Fund; (c) give any notice and prepare and file any reports which may be required by law; and (d) apply the assets of the Fund in accordance with the Plan of Benefits including amendments adopted as part of the termination until the assets of the Fund are distributed.

No part of the assets or income of the Fund will be used for purposes other than for the exclusive benefit of the employees and the beneficiaries or the administrative expenses of the Fund. Under no circumstances will any portion of the Fund revert or inure to the benefit of any contributing employer, the Association or the Union either directly or indirectly.

Upon termination of the Fund, the Trustees will promptly notify the Union, the Association, employers, and all other interested parties. The Trustees will continue as Trustees for the purpose of concluding the affairs of the Fund.

In addition, the Trustees have complete discretion to interpret the Plan and to amend or modify the Plan and any of its provisions, in whole or in part, at any time. This means that the Trustees can reduce or eliminate benefits or modify the availability, nature and extent of benefits and conditions for and method of payment of benefits. The Trustees may also modify length of coverage for all employees, dependents and retirees, and eligibility requirements for coverage.

## ERISA RIGHTS STATEMENT

As a participant in the National Automatic Sprinkler Industry Welfare Fund, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

### Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefits Administration.

Obtain, upon written request to the Plan administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements,

and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan administrator is required by law to furnish each participant with a copy of this summary annual report.

## Continue Group Health Plan Coverage

Continue health care coverage for yourself, Spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA Continuation Coverage rights.

## Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

## Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the plan and do not receive them within 30 days, you may file suit in Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

## Assistance with Questions

If you have any questions about your Plan, you should contact the Plan administrator. If



you have any questions about this statement or about your rights under ERISA, 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.

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