Laborers' COMBINED FUNDS OF WESTERN PENNSYLVANIA
Serving the Laborers' District Council of Western Pennsylvania
Pension Fund, Welfare Fund and other affiliated Funds
12 EIGHTH STREET • SUITE 500 • PITTSBURGH, PENNSYLVANIA 15222
PHONE: 412-263-0900 • WEBSITE: www.lcfowpa.com

WHRCA Enrollment Notice

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this Plan. Therefore, the following deductibles and coinsurance listed on pages 60-65 of the Welfare Fund Summary Plan Description would apply. If you would like more information on WHCRA benefits, call Highmark at 1-866-594-1732.

IMPORTANT NOTICE

This supplement explains important changes to the Laborers' District Council of Western Pennsylvania Welfare Fund (Welfare Plan) Summary Plan Description (SPD) effective October 1, 2023.

This is a Summary of Material Modifications (SMM) made to the Welfare Plan listed above, in accordance with Department of Labor regulations. Please keep this SMM with the Summary Plan Description (SPD) for the Welfare Plan. This SMM explains certain changes to the Welfare Plan. For details on the Welfare Plan, see the SPD. This Welfare Plan can be amended or terminated at any time, with or without notice. If there is a discrepancy between this SMM and the SPD, the SPD will control.

Page 34 Legal Action to Collect Benefits The explanation entitled Legal Action to Collect Benefits shall be replaced with the following provision:

Legal Actions
Except as is otherwise required by ERISA, no legal action may be instituted against Welfare Fund or the Trustees for any claim under the Plan:

1) Prior to 60 days after proof of loss has been filed in accordance with requirements of the Plan,
2) Prior to the exhaustion of all of the available Plan appeal processes and procedures, and

OVER

3) After the earlier of:

   a) One year after any final decision on appeal (or one year after the denial of a claim if no appeal is filed within one year of a denial of a claim in situations where applicable law shall not require exhaustion of available Plan appeal processes and procedures), or

   b) Three years after a right to the claim first existed under the Plan.

DAVIS VISION CHANGE

Starting September 1, 2023 as part of the acquisition by MetLife, you will begin to see the Davis Vision by MetLife logo on your vision cards and other vision communications. If you are eligible for vision coverage, you will receive a new Davis Vision by MetLife vision card. Your vision benefits and network will remain exactly the same, however you will see changes to some of the phone numbers, addresses and the website for Davis Vision.

All references to the phone number for Low Vision Services, Appeals and Member Service will be amended to: 833-EYE-LIFE (833-393-5433).

TTY Services will be amended to: Dial 711 for a relay to 833-EYE-LIFE (833-393-5433).

All references to the Davis Vision website will be amended to: www.mybenefits.metlife.com

Member Service hours will be Monday through Friday, 8 a.m. to 9 p.m., Saturday, 9:00 a.m. to 4:00 p.m. EST.

The references to the Claims Filing address will be amended to:

Davis Vision by MetLife
Attn: Claims Processing
881 Elkridge Landing Road, Suite 300
Linthicum Heights, MD 21090

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IMPORTANT NOTICE

This supplement explains important changes to the Laborers' District Council of Western Pennsylvania Welfare Fund (Welfare Plan) Summary Plan Description (SPD) effective January 1, 2023.

This is a Summary of Material Modifications (SMM) made to the Welfare Plan listed above, in accordance with Department of Labor regulations. Please keep this SMM with the Summary Plan Description (SPD) for the Welfare Plan. This SMM explains certain changes to the Welfare Plan. For details on the Welfare Plan, see the SPD. This Welfare Plan can be amended or terminated at any time, with or without notice. If there is a discrepancy between this SMM, the SPD and the official Welfare Plan document, the official Welfare Plan document will control.

SMM CORRECTION - The SMM previously sent in September 2022 stated that the acquisition of Davis Vision by MetLife would take place on January 1, 2023. Davis by MetLife experienced delays in the necessary state filings and the effective date of the migration has been delayed until July 1, 2023. If you are eligible for benefits on July 1, 2023 you will receive a new vision card.

Starting July 1, 2023 as part of the acquisition by MetLife you will begin to see the Davis Vision by MetLife logo on your vision cards and other vision communications. Your vision benefits and network will remain exactly the same, however you will see changes to some of the phone numbers, addresses and the website for Davis Vision.

All references to the phone number for Low Vision Services, Appeals and Member Service will be amended to: 833-EYE-LIFE (833-393-5433). TTY Services will be amended to: Dial 711 for a relay to 833-EYE-LIFE (833-393-5433).

All references to the Davis Vision website will be amended to: www.mybenefits.MetLife.com.

Member Service hours will be Monday through Friday, 8 a.m. to 9 p.m., Saturday, 9:00 a.m. to 4:00 p.m. EST.

The references to the Claims Filing address will be amended to: Davis Vision by MetLife
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Page 61 Under **Urgent Care Center Visits –** a line will be added with the following wording:
Copayment, if any does not apply to Urgent Care visits prescribed for the treatment of Mental Health or Substance Abuse

Page 62 Under **Therapy and Rehabilitation Services** – a line will be added with the following wording:
Copayment, if any does not apply to Therapy visits prescribed for the treatment of Mental Health or Substance Abuse

Page 63 On the **Diagnostic Services** Line – the following wording will be added:
Copayment, if any does not apply to Diagnostic Services prescribed for the treatment of Mental Health or Substance Abuse

Page 75 Under **Autism Spectrum Disorders** - the first sentence will be replaced with the following wording:
Benefits are provided to members regardless of age for the following:

Page 80 After the **Emergency Care Services** section this wording is to be added after the existing wording:
In the event that you receive emergency care services from an out-of-network provider and require an inpatient admission or observation immediately resulting from your injury or emergency medical condition, and upon stabilization:
• you are unable to travel using nonmedical transportation or nonemergency medical transportation; or
• you do not consent to be transferred.

Covered services directly related to such injury or emergency medical condition and received during the inpatient admission or observation will be covered at the network services level of benefits as set forth in the Hospital Services benefit in the Summary of Benefits section of this booklet. You will not be subject to any balance billing amounts.

Page 84 Under Outpatient Medical Care Services (Office Visits), (which begins on page 83) The **third bullet** on page 84 will be replaced with the following wording:

A specialist virtual visit between you and a specialist (including a behavioral health specialist) via audio and video telecommunications. Benefits are provided for a specialist virtual visit when you communicate with the specialist from any location, such as your home, office, or another mobile location, or if you travel to a provider-based location referred to as a provider originating site. If you communicate with the specialist from a provider originating site, you will be responsible for the specialist virtual visit provider originating site fee.

Page 94 Under **WHAT IS NOT COVERED** the **Learning Disabilities** provision wording will be replaced with the following wording:

For any care that is related to conditions such as learning disabilities, behavioral problems, or intellectual disabilities, but not including care related to autism spectrum disorders, which extends beyond traditional medical management or medically necessary and appropriate inpatient confinement. Care which extends beyond traditional medical management includes the following:

a) services that are primarily educational in nature, such as academic skills training or those for remedial education, including tutorial services;
b) neuropsychological testing, educational testing (such as I.Q., mental ability, achievement and aptitude testing), except for specific evaluation purposes directly related to medical treatment;
c) services related to the treatment of learning disorders or learning disabilities; and
d) services provided primarily for social or environmental change; or for respite care.

For any care that is related to autism spectrum disorders which extends beyond traditional medical management, except as otherwise provided herein. Care which extends beyond traditional medical management includes the following:

a) services that are primarily educational in nature, such as academic skills training or those for remedial education, including tutorial services;
b) neuropsychological testing, educational testing (such as I.Q., mental ability, achievement, and aptitude testing); except for specific evaluation purposes directly related to medical treatment; and
c) services provided primarily for respite care.

Page 95 Under **WHAT IS NOT COVERED** This wording is to be added after Motor Vehicle Accident entitled **Non- Covered Medical Service:**

Services for which coverage or reimbursement is determined to be illegal by your state of residence regardless of whether you travel to a state where the service can be legally performed.

Pages 100 and 101 Under **Non-Participating Providers Outside of the Plan Service Area** – wording will be replaced with this wording:

When you receive covered services from an out-of-network provider, in addition to your cost-sharing liability described above, you will be responsible for the difference between your plan's payment and the provider's billed charge. If you receive services which are not covered under your plan, you are responsible for all charges associated with those services. However, the following covered services when received from an out-of-network provider will be provided at the applicable network level of benefits and you will not be responsible for such difference:

1. Emergency care services provided in a hospital or freestanding emergency room; and
2. Air Ambulance services

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

Please review the Booklet's schedule of benefits for further details on cost sharing for Emergency Services.

No Prior Approval Requirement or Pre-Certification Requirement Applies When Members Receive Emergency Care services.

Page 107 Under **HEALTH CARE MANAGEMENT** the **Out-of-Network Care** provision wording will be replaced with:

When you receive covered services from an out-of-network provider, in addition to your cost-sharing liability described above, you will be responsible for the difference between your plan's payment and the provider's billed charge. If you receive services which are not covered under your plan, you are responsible for all charges associated with those services. However, the following covered services when received from an out-of-network provider will be provided at the applicable network level of benefits and you will not be responsible for such difference:

1. Emergency care services provided in a hospital or freestanding emergency room; and
2. Air Ambulance services

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

Please review the Booklet's schedule of benefits for further details on cost sharing for Emergency Services.

No Prior Approval Requirement or Pre-Certification Requirement Applies When Members Receive Emergency Care services.

Page 112 Under **GENERAL INFORMATION** this wording will be added to page 112 as a new section after the **Benefits After Termination of Coverage** section:

Benefits After Provider Termination from the Network

If at the time you are receiving medical care from a network provider, notice is received from Highmark that:

Highmark intends to terminate or has terminated all or portions of the contract of that network provider for reasons other than cause; or the contract of that network provider will not be renewed, or the participation status of that network provider is changing; you may, at your option, continue an active course of treatment with that provider until the treatment is complete or for a period of up to ninety (90) days from the date the notification of the termination or pending termination is received, whichever is shorter.

For purposes of this section, active course of treatment means:

(i) an ongoing course of treatment for a life-threatening condition, defined as a disease or condition for which likelihood of death is probable unless the course of the disease or condition is interrupted;

(ii) an ongoing course of treatment for a serious acute condition, defined as a disease or condition requiring specialized medical treatment to avoid the reasonable possibility of death or permanent harm or complex ongoing care which you are currently receiving, such as chemotherapy, radiation therapy or post-operative visits;

(iii) confirmed pregnancy, through the postpartum period;

(iv) scheduled nonelective surgery, through postoperative care;

(v) an ongoing course of treatment for a health condition that is life-threatening, degenerative, potentially disabling, or congenital and that requires specialized medical care over a prolonged period of time or for which a treating physician or health care provider attests that discontinuing care by that physician or health care provider would worsen the condition or interfere with anticipated outcomes; or

(vi) treatment for a terminal illness.

If, however, the network provider is terminated for cause and you continue to seek treatment from that provider, then your plan will not cover payment for health care services provided to you following the date of termination. Any Services authorized under this section will be covered in accordance with the same terms and conditions as applicable to a network provider. Nothing in this section shall require payment of benefits for health care services that are not otherwise provided under the terms and conditions of your plan.

Page 120 Under ***External Review*** (which begins on page 119) - the following wording will be added to the end of the first paragraph on page 120:

The Appeal Procedures and External Review Procedures shall include the Review of Claims that Highmark Determined were not Subject to Legal Prohibitions Against Balance Billing.

Pages 135 and 136 Under **TERMS YOU SHOULD KNOW** the **Plan Allowance** provision (which begins on page 135) – wording will be replaced with this wording:

The amount used to determine payment by your program for covered services provided to you and to determine your liability. Plan allowance is based on the type of provider who renders such services or as required by law.

In-Network Benefits

When covered medical services are received from a network provider, then the plan allowance is determined in accordance with the provider's contract with Highmark or on prices received from local licensees of the Blue Cross Blue Shield Association in accordance with your health care program's participation in the BlueCard program described in the How Your Health Care Program Works section of this booklet.

Out-of-Network Benefits

When covered medical services are received from an out-of-network provider as described below, the plan allowance is determined as follows:

Non-Emergency Services Received at Certain In-Network Facilities from Out-of-Network Physicians

For non-emergency covered medical services received at certain in-network facilities from out-of-network physicians when such services are either ancillary, or non-ancillary that have not satisfied the notice and consent criteria required by federal law, the plan allowance may be based on the:

(i) the reference price (as defined below) if out of area;
(ii) the recognized amount (as defined below);
(iii) the amount agreed to by the out-of-network provider and Highmark; or
(iv) the amount determined by Independent Dispute Resolution (IDR).

For the purpose of this preceding, "certain In-network facilities" are limited to a hospital, a hospital outpatient department, a critical access hospital, an ambulatory surgical center, and any other facility specified under federal law and regulation.

Emergency Services Provided by an Out-of-Network Provider

For emergency services provided by an out-of-network provider, the plan allowance is based on one of the following in the order listed below as applicable:

(i) the reference price (as defined below) if out-of-area;
(ii) recognized amount (as defined below) if out of area;
(iii) the amount agreed to by the out-of-network provider and Highmark; or
(iv) the amount determined by Independent Dispute Resolution (IDR).

Air Ambulance Transportation Provided by an Out-of-Network Provider

For Air Ambulance transportation provided by an out-of-network provider, the plan allowance is based on one of the following in the order listed below as applicable:

(i) the recognized amount (as defined below);
(ii) the amount subsequently agreed to by the out-of-network provider and Highmark; or
(iii) the amount determined by Independent Dispute Resolution (IDR).

Your cost-sharing for each of the above out-of-network providers will be based on the recognized amount.

In All Other Cases

If you receive covered medical services from an out-of-network provider, the plan allowance for an out-of-network provider located in the Highmark service area is based on an adjusted contractual allowance for like services rendered by a network provider in the same geographic region. You will be responsible for any difference between the provider's billed charges and your program's payment. The plan allowance for an out-of-area network state-owned psychiatric hospital is what is required by law.

When covered medical services are received from an out-of-network provider outside of the Highmark service area, the plan allowance may be determined on the basis of the reference price (as defined below) or on prices received from local licensees of the Blue Cross Blue Shield Association in accordance with your health care program's participation in the BlueCard program described in the How Your Health Care Program Works section of this booklet.

Summary of Benefits

This Summary of Benefits is a brief description of covered services.

Benefit	Performance Blue PPO		PPO Blue	
	In-Network	Out-of-Network	In-Network	Out-of-Network
General Provisions				
PLAN YEAR (1)	**CALENDAR YEAR**			
Deductible (per plan year) Individual Family	$800 $1,600 If you and your spouse voluntarily complete the wellness requirements, the in-network deductible is **waived**.	$1,600 $3,200	$2,000 $4,000 If you and your spouse voluntarily complete the wellness requirements the in-network individual deductible will be reduced to $1,200 and the family deductible will be reduced to $2,400.	$2,400 $4,800
Plan Pays – payment based on the plan allowance	100% after deductible	80% after deductible	100% after deductible	80% after deductible
Out-of-Pocket Limit (Once met, plan pays 100% coinsurance for the rest of the plan year) Individual Family	None None	$4,800 $9,600	None None	$4,800 $9,600
Total Maximum Out-of-Pocket (Includes deductible, coinsurance, copays, prescription drug cost sharing and other qualified medical expenses, Network only) (2) Once met, the plan pays 100% of covered services for the rest of the benefit period. Individual Family	$8,150 $16,300	Not Applicable Not Applicable	$8,150 $16,300	Not Applicable Not Applicable
Office/Clinic/Urgent Care Visits				
Retail Clinic Visits & Virtual Visits	100% after $15 copayment	80% after deductible	100% after $15 copayment	80% after deductible
Primary Care Provider Office Visits & Virtual Visits	100% after $15 copayment	80% after deductible	100% after $15 copayment	80% after deductible
Specialist Office & Virtual Visits	100% after $30 copayment	80% after deductible	100% after $30 copayment	80% after deductible
Virtual Visit Originating Site Fee	100% after deductible	80% after deductible	100% after deductible	80% after deductible
Urgent Care Center Visits	100% after $15 copayment	80% after deductible	100% after $15 copayment	80% after deductible
	Copayment, if any does not apply to Urgent Care visits prescribed for the treatment of Mental Health or Substance Abuse			
Telemedicine (3)	100% (deductible does not apply)	Not Covered	100% (deductible does not apply)	Not Covered
Preventive Care (4)				
Routine Adult Physical exams	100% (deductible does not apply)	80% after deductible	100% (deductible does not apply)	80% after deductible
Adult immunizations	100% (deductible does not apply)	80% after deductible	100% (deductible does not apply)	80% after deductible
Colorectal cancer screening	100% (deductible does not apply)	80% after deductible	100% (deductible does not apply)	80% after deductible
Routine gynecological exams, including a Pap Test	100% (deductible does not apply)	80% (deductible does not apply)	100% (deductible does not apply)	80% (deductible does not apply)
Mammograms, annual routine and medically necessary	Routine and Medically Necessary: 100% (deductible does not apply)	80% after deductible	Routine and Medically Necessary: 100% (deductible does not apply)	80% after deductible
Diagnostic services and procedures	100% (deductible does not apply)	80% after deductible	100% (deductible does not apply)	80% after deductible
Routine Pediatric Physical exams	100% (deductible does not apply)	80% after deductible	100% (deductible does not apply)	80% after deductible
Pediatric immunizations	100% (deductible does not apply)	80% (deductible does not apply)	100% (deductible does not apply)	80% (deductible does not apply)
Diagnostic services and procedures	100% (deductible does not apply)	80% after deductible	100% (deductible does not apply)	80% after deductible
Emergency Services				
Emergency Room Services	100% after $100 copayment (waived if admitted)		100% after $100 copayment (waived if admitted)	
Ambulance – Emergency (5)	100% after deductible		100% after deductible	
Ambulance – Non-Emergency (5)	100% after deductible	80% after deductible	100% after deductible	80% after deductible
Hospital and Medical/Surgical Expenses (including maternity)				
Hospital Inpatient	100% after deductible	80% after deductible	100% after deductible	80% after deductible
Hospital Outpatient	100% after deductible	80% after deductible	100% after deductible	80% after deductible
Maternity (non-preventive facility & professional services) including dependent daughter	Facility: 100% after deductible Professional: 100% after $15 copayment	80% after deductible	Facility: 100% after deductible Professional: 100% after $15 copayment	80% after deductible
Medical Care (including inpatient visits and consultations)/**Surgical Expenses**	100% after deductible	80% after deductible	100% after deductible	80% after deductible
Therapy and Rehabilitation Services				
	Copayment, if any does not apply to Therapy visits prescribed for the treatment of Mental Health or Substance Abuse			
Physical Medicine	100% after $20 copayment per provider per date of service	80% after deductible	100% after $20 copayment per provider per date of service	80% after deductible
Respiratory Therapy	100% after deductible		100% after deductible	

Benefit	Performance Blue PPO		PPO Blue	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Speech & Occupational Therapy	100% after $20 copayment per provider per date of service	80% after deductible	100% after $20 copayment per provider per date of service	80% after deductible
Spinal Manipulations & Acupuncture	100% after $20 copayment perprovider per date of service	80% after deductible	100% after $20 copayment per provider per date of service	80% after deductible
Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy &Dialysis)	100% after deductible	80% after deductible	100% after deductible	80% after deductible
Mental Health / Substance Abuse				
Inpatient	100% after deductible	80% after deductible	100% after deductible	80% after deductible
Inpatient Detoxification/Rehabilitation	100% after deductible	80% after deductible	100% after deductible	80% after deductible
Outpatient Mental Health- Includes Virtual Behavioral Health Visits	100% after $15 copayment	80% after deductible	100% after $15 copayment	80% after deductible
Outpatient Substance Abuse Services	100% after $15 copayment	80% after deductible	100% after $15 copayment	80% after deductible
Other Services				
Allergy Extracts and Injections	100% after deductible	80% after deductible	100% after deductible	80% after deductible
Autism Spectrum Disorder including Applied Behavior Analysis (6)	100% after deductible $40,000 maximum per member per plan year (includes prescription drug)	80% after deductible	100% after deductible $40,000 maximum per member per plan year (includes prescription drug)	80% after deductible
Assisted Fertilization Procedures	Not Covered		Not Covered	
Dental Services Related to Accidental Injury	100% after deductible	80% after deductible	100% after deductible	80% after deductible
Diagnostic Services	Copayment, if any does not apply to Diagnostic services prescribed for the treatment of Mental Health or Substance Abuse			
Advanced Imaging (MRI, CAT, PET scan, etc.)	(7) **Member Savings Site:** 100% after deductible **All Other Network Providers:** $50 copayment then 100% after deductible	80% after deductible	(6) **Member Savings Site:** 100% after deductible **All Other Network Providers:** $50 copayment then 100% after deductible	80% after deductible
Basic Diagnostic Services (standard imaging and lab/pathology)	(7) **Member Savings Site:** 100% after deductible **All Other Network Providers:** $50 copayment then 100% after deductible	80% after deductible	(6) **Member Savings Site:** 100% after deductible **All Other Network Providers:** $50 copayment then 100% after deductible	80% after deductible
Basic Diagnostic Services (diagnostic medical and allergy testing)	(7) **Freestanding Facility :** 100% after deductible **All Other Network Providers :** $50 copayment then 100% after deductible	80% after deductible	(6) **Freestanding Facility:** 100% after deductible **All Other Network Providers:** $50 copayment then 100% after deductible	80% after deductible
Durable Medical Equipment, Orthotics & Prosthetics	100% after deductible	80% after deductible	100% after deductible	80% after deductible
Routine Eye Exam / Foot Care Services	100% after deductible	80% after deductible	100% after deductible	80% after deductible
Hearing Aids	100% after deductible Limit: Up to $300 per ear 48 months after previous purchase	80% after deductible	100% after deductible Limit: Up to $300 per ear 48 months after previous purchase	80% after deductible
Home Health Care (8)	100% after deductible Limit: 120 visits/plan year	80% after deductible	100% after deductible Limit: 120 visits/plan year	80% after deductible
Hospice	100% after deductible	80% after deductible	100% after deductible	80% after deductible
Infertility Counseling, Testing & Treatment (9)	100% after deductible	80% after deductible	100% after deductible	80% after deductible
Private Duty Nursing	100% after network deductible		100% after network deductible	
Skilled Nursing Facility Care	100% after deductible	80% after deductible	100% after deductible	80% after deductible
Transplant Services	100% after deductible	80% after deductible	100% after deductible	80% after deductible
Precertification Requirements (10)	YES		YES	
Prescription Drug Program Hard Mandatory Generic (11) Defined by the National Pharmacy Network - Not Physician Network. Prescriptions filled at a non-network pharmacy are not covered. (12) Your plan uses the Comprehensive Formulary with an Incentive Benefit Design (13,14)	**Retail Drugs (30 day Supply)** $10/ generic copay $25 formulary brand copay $50 non-formulary brand copay **Maintenance Prescription Drug Third fill at Retail Pharmacy** **Maintenance Drugs through Mail Order or CVS (90-day Supply)** $20 generic copay $50 formulary brand copay $100 non-formulary brand copay			

This is not a contract. This benefits summary presents plan highlights only. Please refer to the policy / plan documents, as limitations and exclusions apply. The policy / plan documents control in the event of a conflict with this benefit summary.

1) Your group's plan year is based on a Calendar Year, January 1 through December 31.
2) The Network Total Maximum Out-of-Pocket (TMOOP) is mandated by the federal government, TMOOP must include deductible, coinsurance, copays, prescription drug cost share and any qualified medical expense.
3) Services are provided for acute care for minor illnesses. Services must be performed by a Highmark approved telemedicine provider. Virtual Behavioral Health visits provided by a Highmark approved telemedicine provider are eligible under the Outpatient Mental Health / Substance Abuse benefit.
4) Services are limited to those listed on the Highmark Preventive Schedule (Women's Health Preventive Schedule may apply). Gender, age and frequency limits may apply.
5) Medically necessary Air Ambulance services rendered by out-of-network providers will be covered at the highest network tier level of benefits.
6) Coverage for eligible members to age 21. Services will be paid according to the benefit category (e.g. speech therapy). Treatment for autism spectrum disorders does not reduce visit/day limits.
7) Member Savings Sites are independent laboratories and x-ray / imaging centers that perform diagnostic services at a reduced rate as well as Ambulatory Surgical Centers that are multispecialty and those delivering surgeries. Many providers may send their services out to a hospital for processing causing a facility charge in addition to the professional component, resulting in higher cost share for the member. When members use a Member Savings Site they can be confident that they will pay a lower cost share (i.e. not encountering multiple copays).
8) The maternity home health care visit for network care is not subject to the program copayment, coinsurance or deductible amounts, if applicable. See Maternity Home Health Care Visit in the Covered Services section.
9) Treatment includes coverage for the correction of a physical or medical problem associated with infertility. Contact Highmark Customer Service for the exact benefit.
10) Highmark Medical Management & Policy (MM&P) must be contacted prior to a planned inpatient admission or within 48 hours of an emergency or maternity-related inpatient admission. Be sure to verify that your provider is contacting MM&P for precertification. If this does not occur and it is later determined that all or part of the inpatient stay was not medically necessary or appropriate, you will be responsible for payment of any costs not covered.
11) Under the hard mandatory generic provision, when you purchase a brand drug that has a generic equivalent, you will be responsible for the brand drug copayment plus the difference in cost between the brand and generic drugs. Regardless if the patient or provider requested the brand name.
12) Certain retail participating pharmacy providers may have agreed to make covered medications available at the same cost-sharing and quantity limits as the mail order coverage. You may contact Highmark at 1-866-594-1732 or the website at Highmarkbcbs.com for a listing of those pharmacies who have agreed to do so.
13) The quantity level limit for your initial prescription order may be reduced, depending on the particular medication, to a quantity level necessary to establish that you can tolerate the medication. The cost-sharing provision indicated above will be adjusted accordingly for the initial prescription order based upon the initial quantity dispensed. If you are able to tolerate the medication, the remainder of the available days supply for the initial prescription order will be filled and you will be responsible for the balance of the applicable cost-sharing amount indicated above.
14) The Highmark formulary is an extensive list of Food & Drug Administration (FDA) approved prescription drugs selected for their quality, safety and effectiveness. It includes products in every major therapeutic category. The formulary was developed by the Highmark Pharmacy and Therapeutics Committee made up of clinical pharmacists and physicians and may, from time to time, be revised by the committee. Your program includes coverage for both formulary and non-formulary drugs at the specific copayment or coinsurance amounts listed above. With the Smart90 CVS Network, after two fills at a retail pharmacy that is not CVS you must choose between a 90-day supply through CVS retail pharmacy stores or through Express Scripts Mail Order Pharmacy.

DISCLAIMER

The Laborers' District Council of Western Pennsylvania Welfare Fund and the Laborers' Combined Funds have prepared this summary for overview purposes only and all benefits effective are subject to the descriptions, definitions, and other details in the Welfare Fund Summary Plan Description and are tentative and subject to final review.

1/1/2024

Laborers' COMBINED FUNDS OF WESTERN PENNSYLVANIA
Serving the Laborers' District Council of Western Pennsylvania Pension Fund, Welfare Fund and other affiliated Funds
12 EIGHTH STREET • SUITE 500 • PITTSBURGH, PENNSYLVANIA 15222
PHONE: 412-263-0900 • WEBSITE: www.lcfowpa.com

IMPORTANT NOTICE

This supplement explains Trustee changes to the Laborers' District Council of Western Pennsylvania Welfare Fund (Welfare Plan) and Pension Fund (Pension Plan). Please keep this information with your Welfare and Pension Summary Plan Descriptions.

Effective January 25, 2023 the Trustees have been updated as follows:

LABORERS' DISTRICT COUNCIL OF WESTERN PENNSYLVANIA WELFARE AND PENSION FUND BOARD OF TRUSTEES

EMPLOYEE TRUSTEES

Philip Ameris, Chairman
President-Business Manager
Laborers' District Council of W. Pa.
12 Eighth Street, 6th Floor
Pittsburgh, PA 15222

James E. Boyd, Business Manager
Laborers' Local Union #1451
816 Ligonier Street, Suite 202
Latrobe, PA 15650

Robert L. Furka, Business Manager
Laborers' Local Union #323
6 Chesapeake Street, Suite 200A
Lyndora, PA 16045

Joseph J. Laquatra, Jr., Business Manager
Laborers' Local Union #1058
12 Eighth Street
Pittsburgh, PA 15222

Jason Markovich, Business Manager
Laborers' Local Union #373
611 Thompson Run Road
Monroeville, PA 15146

Mark G. Toy, Business Manager
Laborers' Local Union #952
186 Blaney Road
Kittanning, PA 16201

EMPLOYER TRUSTEES

Paul V. Scabilloni, Secretary/Treasurer
President
Marsa, Inc.
1000 Castleview Road
Pittsburgh, PA 15234

Michael A. Facchiano, Jr., President
Michael Facchiano Contracting, Inc.
801 McNeilly Road
Pittsburgh, PA 15226

John C. Mascaro, Jr., President/CEO
Mascaro Construction Company, L.P.
1720 Metropolitan Street
Pittsburgh, PA 15233

George E. Mezey, President
Trumbull Corporation
P.O. Box 6774
Pittsburgh, PA 15212

Jake Ploeger, Director/President
Trumbull Corporation
P.O. Box 6774
Pittsburgh, PA 15212

Joseph A. Wattick, V.P. of Operations
Mosites Construction Company
400 Mosites Way
Pittsburgh, PA 15205

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IMPORTANT NOTICE

This supplement explains important changes to the Laborers' District Council of Western Pennsylvania Welfare Fund (Welfare Plan) Summary Plan Description (SPD) that become effective January 1, 2023.

This is a Summary of Material Modifications (SMM) made to the Welfare Plan listed above, in accordance with the Department of Labor regulations. Please keep this SMM with the Summary Plan Description (SPD) for the Welfare Plan. This SMM explains certain changes to the Welfare Plan. For detail on the Welfare Plan, see the SPD. This Welfare Plan can be amended or terminate at any time, with or without notice. If there is a discrepancy between this SMM, the SPD and the official Welfare Plan document, the official Welfare Plan document will control.

REPLACEMENT OF EMPLOYEE TRUSTEE

Effective 8-1-2022 Employee Trustee William Brooks was replaced by Jason Markovich. Mr. Markovich's address is:
Local Union #373
611 Thompson Run Road
Monroeville, PA 15146

PLAN CHANGE

The Community Blue PPO Plan will be replaced by the Performance Blue PPO Plan Effective January 1, 2023. The benefits are the same under the Performance Blue PPO Plan as they are with the Community Blue PPO Plan. All references to Community Blue PPO will be replaced with Performance Blue PPO throughout the entire SPD.

PRESCRIPTION CHANGE

Starting January 1, 2023, your pharmacy benefits will be modified. Specifically, the new coverage mandates the use of a generic drug, when available. For any new prescription if you and/or your provider choose to use a brand prescription when a generic is available, you will pay the cost difference between the brand prescription and the generic prescription, plus any brand co-payment.

The Prescription Drug Program on Page 64 shall be amended from Soft Mandatory Generic (11) to state: Hard Mandatory Generic (11)

Page 65 footnote 11 will be amended to state: Under the hard mandatory generic provision, when you purchase a brand drug that has a generic equivalent, you will be responsible for the brand drug copayment plus the difference in cost between the brand and generic drugs. Regardless if the patient or provider requested the brand name.

DAVIS VISION CHANGE

Starting January 1, 2023 as part of the acquisition by MetLife you will begin to see the Davis Vision by MetLife logo on your vision cards and other vision communications. Your vision benefits and network will remain exactly the same, however you will see changes to some of the phone numbers, addresses and the website for Davis Vision.

All references to the phone number for Low Vision Services, Appeals and Member Service will be amended to: 833-EYE-LIFE (833-393-5433).

TTY Services will be amended to: Dial 711 for a relay to 833-EYE-LIFE (833-393-5433).

All references to the Davis Vision website will be amended to: www.metlife.com/mybenefits.

Member Service hours will be Monday through Friday, 8 a.m. to 9 p.m., Saturday, 9:00 a.m. to 4:00 p.m. EST.

The references to the Claims Filing address will be amended to:

Davis Vision by MetLife
Attn: Claims Processing
PO Box 967
Rancho Cordova, CA 95741

Page 1 **VISION CARE PROGRAM – DAVIS VISION** heading will be amended to state:
VISION CARE PROGRAM – DAVIS VISION BY METLIFE

Pages 49 and 50 The grid will be amended to state:

SECTION TWO: VISION CARE PROGRAM

SUMMARY OF VISION BENEFITS

This Summary of Benefits is a brief description of covered Vision Care Program services.
www.metlife.com/mybenefits

Benefit	Frequency Once every	In-Network Copay	In-Network Coverage		Out-of-Network Reimbursement Schedule[1]
Eye examinations	12 months	$0	Includes dilation when professionally indicated		Up to $40
Spectacle Lenses	12 months	$0	Clear glass or plastic lenses in any single vision, bifocal, trifocal or lenticular prescription. Covered in full. (See below for additional lens options and coatings)		***Single Vision Lenses:*** Up to $50 ***Bifocal Lenses:*** Up to $80 ***Trifocal Lenses:*** Up to $105 ***Lenticular:*** Up to $110
Frames	12 months	$0	**Davis Vision Collection Frames[2]:**	**Member price:** Fashion: $0 Designer: $15 Premier: $40	N/A
			OR, Non Collection Frame Allowance	$90 toward any frame from provider. No copay required	Up to $50
Contact Lens Evaluation, Fitting and Follow-up Care	12 months	N/A	**Non Collection Standard, Soft Contacts[3]:**	15% discount off Provider's Usual and Customary Charge	N/A
			Non Collection Specialty Contacts[4]:	15% discount off Provider's Usual and Customary Charge	N/A
Contact Lenses	12 months	$0	**Contact Lens Allowance:**	$105 allowance towards any Provider's supply	Elective Contacts: Up to $105
			OR, Visually Required Contacts:	Covered with Prior Approval	Visually Required Contacts: Up to $225

Optional Frames, Lens Types and Coatings	Member Price
Davis Vision Collection Frames	**Fashion:** $0 Designer: $15 Premier: $40
Tinting of Plastic Lenses or Glass Grey #3 Lenses	$0
Scratch-Resistant Coating	Standard: $0 Premium: $30
Ultraviolet Coating	$0
Anti-Reflective Coating:	Standard: $40 Premium: $55 Ultra: $69 Ultimate: $85
Polycarbonate Lenses[5]	$0 - $25
High-Index Lenses 1.59 or less	$30
High-Index Lenses between 1.60 and 1.67	$54
High-Index Lenses 1.74	$120
Progressive Lenses	Standard: $5**0** Premium: $54 Ultra: $104 Ultimate: $175
Polarized Lenses	$75
Photochromic Lenses (i.e. Transitions®[6], etc.	Plastic: $50 Glass: $20
Digital Single Vision Lenses	$30
Blended Lenses	$40
Scratch Protection Plan	Single Vision Lenses: $20 Multifocal: $40
Trivex Lenses	$50
Blue Light Filtering	$15

[1] You may use an out-of-network provider, however you will receive the greatest value by staying in-network. If you go out-of-network, pay the provider at the time of service, then submit a claim to Davis Vision for reimbursement. You will be reimbursed up to the amounts indicated above. Submit claims for reimbursement to:
Davis Vision by MetLife
Attn: Claims Processing
PO Box 967
Rancho Cordova, CA 95741

[2] The Davis Vision Collection is available at most participating independent provider locations.

[3] Including, but not limited to, toric, multifocal and gas permeable contact lenses.

[4] Members are entitled to one pair of eyeglasses and one contact lens benefit within the same benefit period, on both an in and out-of-network basis.

[5] Polycarbonate lenses are covered in full for dependent children, monocular patients and patients with prescriptions +/- 6.00 diopters or greater.

[6] Transitions is a registered trademark of Transitions Optical Inc.

Page 53 **Laser Correction Surgery** will be amended to state: Any member or dependent that wishes to receive Lasik Vision Correction can receive discounts at any Davis Vision Lasik provider. For further information visit www.metlife.com/mybenefits.

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IMPORTANT NOTICE

This supplement explains important changes to the Laborers' District Council of Western Pennsylvania Welfare Fund (Welfare Plan) Summary Plan Description (SPD). Please keep this with the SPD for the Welfare Plan.

PRESCRIPTION CHANGES THAT BECOME EFFECTIVE 1-1-21

Market Watch

o High Cost Low Value- If a prescribed drug is made up of two components, you will be given two separate prescriptions for the components that make up that drug, if it is more cost effective, with the same clinical result.

o Prescription drugs with an over-the-counter equivalent will no longer be covered.

o New to market drugs- If another drug already exists to treat the same condition, and works in a similar fashion, the new medication will be excluded from coverage until a detailed review has been conducted evaluating its clinical efficacy, safety and value.

CVS Smart 90 Mandatory Mail Order

o Maintenance medications must be filled at either a CVS retail pharmacy or through Express Scripts home delivery. If a member does not refill their maintenance medication prescription in one of the aforementioned ways, the member will be responsible for the full cost of the medication.

These changes have been adopted by the Fund's Board of Trustees because of significant increases in prescription drug costs and other expenses, and are based on strong recommendations of the Fund's actuaries and other experts. These changes will also help the Fund avoid changes in hours rules or reductions or elimination of other benefits arising from ever-rising drug and medical benefits charges by providers.

(9-20)

Welfare Fund
Summary Plan Description

Laborers' District Council of Western Pennsylvania Welfare Fund

Planning For A Healthier Tomorrow

Effective January 1, 2022

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MOBILE DEVICE FRIENDLY

https://www.lcfowpa.com

Verify paid benefit hours reported by your employers
Check annual wellness requirement status
Update your address or phone number
Send unreported paystubs
View complete copies of benefits booklets
Download/upload benefit forms
Important news and deadlines
Answers to your FAQ's
AND MORE!

Questions about your medical or pension benefits?

Email us!

Medical benefits: benefits@lcfowpa.com

Pension benefits: pension@lcfowpa.com

LABORERS' DISTRICT COUNCIL OF WESTERN PENNSYLVANIA WELFARE FUND

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EMPLOYEE TRUSTEES

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ADMINISTRATIVE OFFICE

Laborers' Combined Funds of Western PA
Kevin Hribar, Administrator
12 Eighth Street, Suite 500
Pittsburgh, PA 15222
Telephones: 412-263-0900 Toll Free 1-800-242-2538
Fax: 412-263-2813

ACTUARY

Services Provided by Cowden Associates, Inc.

CERTIFIED PUBLIC ACCOUNTANT

Kenneth M. Wasserman CPA

SECURITIES CUSTODIAN

BNY Mellon

LEGAL COUNSEL AND AGENT FOR THE SERVICE OF LEGAL PROCESS

Howard Grossinger, Attorney

TO ALL PARTICIPANTS

This Booklet describes the features of the Benefit Plan of the Laborers' District Council of Western Pennsylvania Welfare Fund for Employees in the Construction Industry (referred to at times as the CIP Program) and for Employees in the Supply, and other Industries, Government, Union Personnel, and Office and Supervisory Employees (referred to at times as the Conjunct Program). Protection and comprehensive benefit coverages for you and your Dependents are essential features of our programs.

Total benefit security for all participating Laborers and their Eligible Dependents is the continuing objective of the Trustees of the Laborers' District Council of Western Pennsylvania Welfare Fund. The Benefit Plan described in this Booklet contains many innovations in comprehensive coverage for all participants. Review this Booklet with members of your family so they will be fully informed of their coverages. A summary of benefits follows this introduction.

While our complete benefit programs are described in detail in this Booklet, we may issue information from time to time to keep you and your family completely informed of all facets of the Benefit Plan. We hope that the Benefit Plan will be a great help in maintaining your and your Dependents' good health and that the Benefit Plan will also help in periods of hardship caused by accident or illness involving you or your Dependents.

The assets of the Welfare Fund are the sole source of funding for the benefits provided. There is no obligation or liability on the Board of Trustees or any other individual or entity to provide benefits and/or payments in excess of the assets in the Trust Fund, collected and available for such purposes. As a participant, you will be responsible for certain payments - such as co-payments and deductibles – which are described in detail in this summary.

Concern for the total benefit security of our participants and their families continues to be the basis for all our benefit programs. The protections offered by these benefits are important to you and your family. Learn as much about them as you can. They may provide extensive financial protection in the event of injury, illness or death. You and your family deserve no less.

If you have any questions, call the Laborers' Combined Funds' Office. We will be glad to help you.

For your convenience and easy reference, the Booklet is divided into an Introduction-Summary of Benefits, and three parts:

Part I: Eligibility and Administrative Rules
Part II: Non-Medical Benefits
Part III: Medical Benefits

TABLE OF CONTENTS

INTRODUCTION – SUMMARY OF BENEFITS

The Trustees of the Welfare Fund shall have the final discretion to construe and interpret the provisions of this Benefit Plan and may delegate to benefit providers claim review and appeal functions with regard to claims for benefits from the Fund, subject to the general oversight of the Trustees.

BASIC/PREMIER BLUE CROSS BLUE SHIELD PLANS

The Laborers' Welfare Plan provides for comprehensive medical benefits for participants through Highmark Blue Cross Blue Shield. These plans are explained in detail in PART III of this Booklet.

VISION CARE PROGRAM – DAVIS VISION

Through Davis Vision, the Trustees have contracted with a geographically convenient panel of doctors to provide vision care to you and your dependents. While a non-panel doctor may also be chosen, the highest level of quality of benefits will be available to you if you receive care through a panel doctor. For additional information regarding the Vision Care Program, please refer to PART II, Section Two of this Booklet for benefits details.

SHORT TERM DISABILITY BENEFITS FOR EMPLOYEES ONLY

Principal Life Insurance Company provides Short Term Disability Benefits for Covered Employees. If an actively employed Covered Employee is fully and continuously disabled by a non-occupational accidental injury or illness that prevents him/her from working and which requires continuous medical care as certified by a medical professional, he/she will receive a payment of $300 per week, except as otherwise provided below, for up to 26 weeks, payable for disability from first day of injury or eighth day of sickness. For additional information regarding the Short Term Disability Benefits for Employees Only, please refer to PART II, Section Three of this Booklet for benefits details.

DEATH

Principal Life Insurance Company provides Death Benefits.

Active Employee	$ 10,000
Eligible Spouse	$ 5,000
Eligible Covered Children from live birth and older*	$ 2,500

** Includes eligible, covered children through age 25 or those who have extended coverage and a child who qualifies for continued coverage as a handicapped child.*

For additional information regarding the Death Benefits, please refer to PART II, Section Three of this Booklet for benefits details.

ACCIDENTAL DEATH OR ACCIDENTAL DISMEMBERMENT FOR EMPLOYEES ONLY

Principal Life Insurance Company provides Accidental Death and Accidental Dismemberment Benefits for Covered Employees.

Accidental Death..... $ 10,000
(100% of Scheduled Benefit)

Accidental Loss of Both Hands or Feet or Sight of Both Eyes
or combination of any two (hand, foot, sight in one eye)..... $ 16,000
(160% of Scheduled Benefit)

Accidental Loss of One Hand or Foot or Sight of One Eye ..... $ 4,000
(40% of Scheduled Benefit)

Accidental Loss of the Thumb and Index finger on Same Hand..... $ 2,500
(25% of Scheduled Benefit)

Accidental Death and Dismemberment Benefits are available for Active Employees only. For additional information regarding the Accidental Death and Dismemberment, please refer to PART II, Section Three of this Booklet for additional details.

RETIREE DEATH BENEFITS

On and after January 1, 2011, upon the death of an individual who: (1) had become a Retired Employee prior to January 1, 2011; and (2) had a total of five years of Credited Service, his Beneficiary shall be paid the sum of $5,000. The terms “Retired Employee” and “Credited Service” are defined in the Benefit Plan of the Laborers’ District Council of Western Pennsylvania Pension Fund. For additional information regarding the Retiree Death Benefits, please refer to PART II, Section Four of this Booklet.

FUTURE CHANGES IN THE BENEFIT PLAN

The Welfare Fund’s Board of Trustees regularly reviews claims experience, coverage availabilities, costs and the actuarial soundness of the Fund, and the Trustees reserve the right to modify or cancel any of the benefits, rules or other features of the Fund’s Benefit Plan.

PART I – ELIGIBILITY AND ADMINISTRATIVE RULES

SECTION ONE: TERMS USED IN THIS PART I

Adverse Benefit Determination

A denial, reduction or termination of a benefit, or failure to provide or pay for (in whole or in part) a benefit. This can also include a denial of participation in the Plan. For health coverage, it also means a claim which is denied because the treatment is experimental or investigational or not medically necessary.

Benefit Period

For the CONSTRUCTION INDUSTRY PROGRAM shall mean each period of six (6) successive calendar months beginning on March 1, and on September 1, each year.

For the CONJUNCT PROGRAM shall mean the calendar month following the work month for which a contribution is made.

Changes in Family Status

For the Welfare Fund to administer consistent coverage for you and your Covered Dependents, you must notify the Fund Office of any address changes or changes in family status (births, adoptions, deaths, marriages, divorces, etc.) that affect your coverage. Changes must be reported immediately when the event takes place.

If you fail to report a change in family status (like a divorce) which may disclose the loss of eligibility of any dependent for Plan benefits, you can be held personally liable to reimburse all payments and expenses associated with benefits payments made after the date that the person became ineligible for Plan benefits. Likewise, if you fail to report a change in family status (like a birth or marriage) which would make a new dependent eligible, the actual eligibility of such a new dependent will not begin until the change in family status occurs and is reported, and in no case will coverage of such a newly Eligible Dependent be made retroactive for more than 60 days prior to the date of such a report, and the submission of documents (like a marriage license or birth certificate) deemed appropriate by the Welfare Fund to confirm the eligibility of the proposed new Eligible Dependent.

Welfare fund plans are required to recognize a Qualified Medical Child Support Order (QMCSO). A QMCSO must be issued by a court or an agency of a court. A child who is the subject of a QMCSO is defined to be an “alternate recipient” and is treated as a beneficiary under the plan.

To qualify as a QMSCO, a Medical Support Order must:

A. Create or recognize the existence of an alternate recipient’s right to receive benefits for which the participant or beneficiary is eligible under a group health plan or to assign those rights;

B. Clearly specify the name and last known mailing address of the participant and the name and mailing address of each alternate recipient covered by the order;

C. Specify a reasonable description of the type of coverage to be provided by the plan to each alternate recipient or the manner in which the type of coverage is to be determined;

D. Specify each plan that the order applies to and the period to which such order applies; and

E. Not require a plan to provide any type or form of benefit not otherwise provided under the plan.

The Omnibus Budget Reconciliation Act of 1993 (OBRA), provides that group health plans such as the Welfare Fund cannot consider Medicaid eligibility in enrolling an alternate recipient in the Plan. The Plan must also comply with an alternate recipient's assignment of rights under Medicaid.

COBRA also requires all group health plans, including the Welfare Fund, to provide that from the time a child is placed in a participant's home for adoption, the child is to be treated in the same manner as the natural children of the participant even though the adoption has not become final. Of course, it will be necessary for participants to notify their Employers and the Welfare Fund that a child has been placed in the participant's home for adoption so that the Welfare Fund can enter the child on the Fund's records as an Eligible Dependent.

An individual who is eligible for benefits under this Benefit Plan as an Eligible Employee may not also have eligibility, at the same time, as a Covered Dependent of any other Eligible Employee. An individual who enjoys eligibility as a Covered Dependent of one Eligible Employee may not enjoy multiple coverages or benefits as a Covered Dependent of any other Eligible Employee, at the same time. In any other circumstance, no individual shall be entitled to enjoy multiple coverages or benefits at the same time under this Benefit Plan.

Contributions

Shall mean the regular payments which the Employer has agreed to contribute to the Fund on behalf of the Employees.

Covered Dependent (also referred to as Eligible Dependent)

Shall include the spouse of an Eligible Employee and any "child" (defined below) through age 25. There shall be no coverage for such child beyond age 25, except in situations where extended coverage may be available where the child is incapable of self-sustaining employment because of mental or physical handicap, or due to other extended coverage rights.

The term "spouse," as used herein, shall mean a legal marriage partner of the Eligible Employee. Upon divorce, the former spouse of the Eligible Employee is no longer a "spouse" or Covered Dependent.

The term "child," as used herein, shall include natural children of the Employee. The term "child" shall also include any legally adopted child, any child placed for adoption such that the Employee has assumed and retains a legal obligation for total or partial support of such child in anticipation of adoption of such child, or any stepchild.

Also, if an unmarried dependent child over age 25 is incapable of self-sustaining employment because of mental or physical handicap, and

A. became incapable while he was a Covered Dependent as defined herein, and

B. is chiefly dependent upon the Eligible Employee for support and maintenance, and

C. if the Eligible Employee furnishes due proof of such incapacity, then such dependent child's eligibility for benefits shall be continued for as long as Employee remains eligible and such dependent child remains in such condition.

Coverage because of mental or physical handicap will cease on the first to occur of:

A. Cessation of the handicap.

B. Failure to give proof that the handicap continues.

C. Failure to have an exam requested by the Fund to determine eligibility.

D. Termination of Dependent coverage as to your child for any reason other than reaching the maximum age.

A child shall in no event be a Covered Dependent of more than one Active Employee nor shall a dependent be eligible as a Covered Dependent if he or she is also an Active Employee.

Live birth shall be required for death benefit coverage for a child of an Eligible Employee.

The only children who may be considered eligible, despite a failure to meet the above-stated eligibility requirements, are those children whose coverage by this Benefit Plan may be required pursuant to a Qualified Medical Child Support Order, as provided under applicable Federal law, if such an Order has been issued by a court of appropriate jurisdiction.

Coverage of any Covered Dependent will terminate at the end of the month in which the Covered Dependent last meets the above requirements.

Coverage for any Covered Dependent of a retired former employee not eligible based upon hours of work or current employment for contributing Employers, or a disabled former Employee entitled to coverage under former provisions of the Benefit Plan will terminate when the Covered Dependent:

A. No longer meets the definition of a Covered Dependent;

B. Becomes eligible for Medicare Coverage, except where the Covered Dependent is entitled to Medicare solely on the basis of end stage renal disease during the first 30 months (or other period specified by Federal law) of Medicare eligibility; or

C. Last meets qualification for eligibility or coverage under provisions of the Benefit Plan.

Any change in marital status, eligibility for Medicare, dependent status, or place of residence will also affect your coverage. Each time a change occurs, please notify the Fund Office promptly so that the changes can be processed to assure coverage.

A Covered Dependent's newborn child will be considered eligible for medical coverages for a period of 31 days commencing on the infant's birth date.

Covered Person
Shall mean either an Eligible Employee or a Covered Dependent.

Eligible Employee (also referred to as Covered Employee)
Shall mean an individual who is at the time eligible for benefits as provided in the rules of eligibility.

Employee (also referred to as "You")
For the CONSTRUCTION INDUSTRY PROGRAM, "Employee" shall mean an individual who is employed by an Employer and is represented for collective bargaining purposes by the Union. For the CONSTRUCTION INDUSTRY PROGRAM, shall also mean an individual who is certified by the Union as being involved in working on a project for organizing purposes, to encourage other persons working on such project to designate the Union as their collective bargaining representative, but such an individual shall only be considered an Employee, in such circumstances, for a continuous period not to exceed twelve (12) months in each instance, during which time such individual may arrange to pay for those coverages identical to those available under this Benefit Plan to those enjoying coverage under COBRA, and at the same payment amounts and arrangements applicable to those enjoying coverages under COBRA.

For the CONJUNCT PROGRAM, "Employee" shall mean an individual represented for collective bargaining purposes by the Union in the Supply Industries (Lumber, Ready-Mix and Building), Scrap, Local Union Personnel and Miscellaneous Employees. It shall also include an individual employed by the United States of America, the Commonwealth of Pennsylvania, a municipality, school district or county of the Commonwealth of Pennsylvania and any public authority or agency established pursuant to the authority of the laws, ordinances or resolutions of any of the foregoing (referred to in this Summary as "Government Employees").

The term "Employee" shall also mean a business representative or assistant business representative of the Union, provided the Employer agrees in a written application approved by the Trustees to contribute or remit, or does contribute or remit to the Trust Fund for all its business representatives or assistant business representative in accordance with the Welfare Fund Trust Agreement and Benefit Plan.

The term "Employee" shall also mean an employee of the Union, or of an entity affiliated with the Union, who is not a business representative or assistant business representative; provided the Employer agrees in a written application approved by the Trustees to contribute or remit, and does contribute or remit to the Trust Fund in accordance with the Welfare Fund Trust Agreement and Benefit Plan for all its employees who are not business representatives or assistant business representatives.

The term "Employee" shall also mean an employee of this Fund's Administrative Office.

The term "Employee shall also mean an employee who is otherwise eligible pursuant to rules of eligibility adopted by the Trustees.

The term "Employee" shall also include an office or supervisory employee of an Employer, as above defined, provided the Employer agrees in a written application approved by the Trustees to contribute or remit to the Trust Fund and does contribute or remit to the Trust Fund in accordance with the Plan for all its office and/or supervisory employees, except that such an office or supervisory employee may exercise a right to decline coverage if the said office and supervisory employee: (1) presents evidence satisfactory to both the Employer and the Fund to establish that the employee has other medical coverages in effect for the employee and dependents; (2) signs documents suitable to the Fund waiving his/her and his/her dependents' entitlement to any and all benefits available to Fund participants; (3) acknowledges that future rights to enroll for Fund benefits may be delayed or unavailable; and (4) waives all his/her and his/her dependents' claims against the Employer, the Union, the Fund, and the Fund's Trustees arising from the exercise of the right to decline coverage. In addition, if the Employer employs Conjunct Employees who are represented by the Union, the Employer's office and supervisory employees may only exercise a right to decline coverage under the same terms and conditions as may be provided for the Employer's Conjunct Employees under the collective bargaining agreement with the Union.

Employer
Shall mean any Employer who is a member of the Constructor's Association of Western Pennsylvania or any other Association or group of Employers or any individual Employer who has duly executed a Collective Bargaining Agreement with the Union requiring periodic payments to the Fund in the form of remittances or contributions on behalf of its Employees, or any Employer not a party to such a Collective Bargaining Agreement who satisfies the requirements for participation as established by the Trustees and agrees to be bound by the Trust Agreement.

Member
With respect to some benefits explanations, such as the Vision Care Program, member refers to eligible participants in that plan or program.

Pension Fund
Shall mean the Laborers' District Council of Western Pennsylvania Pension Fund.

Trust and Fund
Shall mean the trust estate, as it is from time to time constituted, including investments, the income from any such investments, contributions, and any other properties received or held by the Trustees or on behalf of the Trustees for the purposes of the Trust Agreement.

Trustees
Shall mean the Trustees then designated and appointed in accordance with the Trust Agreement.

Union
Shall mean the Laborers' District Council of Western Pennsylvania or one of its Local Unions.

Work Period
For the CONSTRUCTION INDUSTRY PROGRAM shall mean each period of six (6) successive calendar months beginning on February 1 and on August 1 each year, preceding the "Benefit Period" which begins seven (7) months later.

For the CONJUNCT PROGRAM shall mean the calendar work month preceding a "Benefits Month" for which a contribution is made.

SECTION TWO: ELIGIBILITY

Eligibility Rules for Benefits-Construction Industry Program

Work Periods and Benefit Periods

Initial eligibility for coverage during a six month Benefit Period must be established by hourly contributions through work for one or more contributing Employers for at least 425 paid hours during the prior Work Period. Future eligibility during subsequent six month Benefit Periods can be established in one of two ways: (a) work for one or more contributing Employers for at least 425 paid hours during the one Work Period immediately prior to the Benefit Period for which eligibility is sought; or (b) work for one or more contributing Employers totaling at least 1,100 paid hours during the two Work Periods immediately prior to the Benefit Period for which eligibility is sought. Examples are detailed below:

IF your paid hours total at least 425 for contributing Employers during this Work Period (February 1 through July 31) or your combined paid hours for the Work Period (February 1 through July 31) and the previous Work Period of (August 1 through January 31) together total 1,100 paid hours or more	**Work Period** February March April May June July
THEN you and your dependents become eligible for this Benefit Period (September 1 through February 28)	**Benefit Period** September October November December January February
IF your paid hours total at least 425 for contributing Employers during this Work Period (August 1 through January 31) or your combined paid hours for the Work Period (August 1 through January 31) and the previous Work Period (February 1 through July 31) together total 1,100 paid hours or more	**Work Period** August September October November December January
THEN you and your dependents become eligible for this Benefit Period (March 1 through August 31)	**Benefit Period** March April May June July August

PLEASE NOTE – Eligibility may not be obtained retroactively by combining paid hours from any two consecutive Work Periods. An Employee who believes that there is an error on any eligibility statement he receives must submit any proposed correction to the Fund Office within twelve (12) months of the date the alleged erroneous statement was issued to him/her.

Apprentice Program

Participants in the Western Pennsylvania Laborers' Apprentice Program shall be provided with free coverage under this Benefit Plan, except for Short Term Disability Benefits, for one (1) Benefit Period, commencing at the beginning of the Benefit Period next following the date of the individual's first participation in that Apprentice Program. Coverage shall continue for the full term of the said Benefit Period, or until the termination date of the individual's participation in the Apprentice Program, whichever shall first occur.

Conjunct Program

Contribution Periods and Benefit Periods

A Conjunct Contribution Employee for whom a contribution to the Trust Fund has been made will be provided a Benefit Month of coverage in the month following the Work Month. The following table sets out examples of the relation between Contribution/Work Month and Benefit Month for Conjunct Employees:

Examples:

If contribution is made for the work month of	***Employee is eligible for benefits in the month of***
September	October
October	November
November	December

Contribution rates for Conjunct Employees will be established on the basis of projected costs so that the anticipated contributions during the period of the contract will support the benefits provided.

Conjunct rates are specified and made a part of each collective bargaining agreement and/or established by the Trustees from time to time for agreements covering Conjunct Program participants.

Unused Benefit Eligibility

Unused benefit eligibility earned prior to termination of employment may be applied toward continued coverage opportunities. Unused benefit eligibility earned prior to the death of an Employee will be applied towards continued coverage of Eligible Dependents.

SECTION THREE: COBRA CONTINUATION COVERAGE

COBRA Benefits

Your participation in the group health benefits coverage may be affected by a federal law if you or your Covered Dependents' coverage ends. Your current medical, prescription drug, vision, death, and accidental death and dismemberment coverages may be continued at your own expense under certain circumstances. The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended, requires most employers that sponsor group health plans to allow employees and their dependents to continue their health coverage at group rates under certain circumstances when coverage under the plans would otherwise end due to these events.

This coverage is called COBRA continuation coverage. COBRA coverage continues for up to 18, 31 or 36 months, depending on how you and/or your dependents lost coverage. Qualified beneficiaries are eligible for COBRA continuation coverage if your group health benefits coverage would otherwise be lost due to certain qualifying events, which are described in the following paragraphs.

Qualified beneficiaries include you and your Eligible Dependents who were covered under a group health plan at the time of an initial qualifying event that would otherwise result in termination of coverage. Your qualified beneficiaries can also include your children born to or placed with you for adoption during the time you're covered by COBRA. They have the same rights as your other qualified dependents.

Death, accidental death and accidental dismemberment benefit coverage will be provided to COBRA enrollees in the amounts and at the levels indicated in this Booklet.

COBRA Self-Payments

The cost of the COBRA premiums is described in the section "Cost of COBRA Continuation Coverage". In order to off-set some of the Employee's costs, to the extent they are available, contribution credits, including banking credits earned prior to July 31, 1975, will be applied toward COBRA amounts due. These credits, if any, will only be available after a valid COBRA election form is executed, and only for Employee or Employees plus dependent(s).

First, any contribution credits earned and not exhausted will be applied to offset the cost of any continuation coverage, including COBRA. Then, the Employee shall again have the right to apply any Employer contributions earned during each work period until his or her COBRA continuation coverage terminates.

The Employee can re-establish eligibility for a subsequent benefit period by achieving the required hours during a work period. Once eligibility is re-established, COBRA coverage will cease.

COBRA – Qualifying Events at a Glance

COBRA coverage continues for you and your Covered Dependents for 18 months if you became eligible for COBRA because of:

Reduction in hours (below the minimum to be eligible for health care coverage);

Termination of employment for any reason except gross misconduct.

COBRA coverage for your Covered Dependents who are qualified beneficiaries can also be extended for up to 36 months from the original qualifying event date if, during the 18-month period, they experience one of the events listed below for 36-month events. You must notify the Fund Office within 60 days after a second qualifying event occurs if you want to extend your COBRA coverage.

Your enrolled spouse and children who are Covered Dependents can continue coverage for up to 36 months from the date they would otherwise lose coverage due to one of the following qualifying events:

A. Your death;

B. Your divorce or legal separation from your spouse;

C. Your child's loss of status as a Covered Dependent child; or

D. Your entitlement to Medicare.

COBRA coverage continues for you and your Covered Dependents for up to a total of 31 months if the Social Security Administration determines that:

A. You or your Covered Dependent is disabled at the time of an 18-month qualifying event (termination of employment or reduction of hours) or within the first 60 days of the beginning of COBRA coverage. Notice of the determination must be provided to the Fund Office before the end of the initial 18-month period. This 13-month extension is also available for all qualified Covered Dependents in your family, not just the disabled individual. This extension also applies if you are determined to be disabled under the Social Security Act, applicable workers' compensation law or by another governmental determination.

If you lose group health coverage due to termination of employment or reduction of hours within 18 months of becoming entitled to Medicare, your qualified Covered Dependent's COBRA continuation coverage will not end before 36 months from the date you become entitled to Medicare.

Your initial COBRA continuation coverage generally must be identical to the coverage you had immediately before the qualifying event. However, any modification that affects active employees will also affect you. If you want to add to your COBRA coverage either a spouse who you married after the qualifying event or a child born or adopted after the qualifying event, you must notify the Fund Office within 60 days of the marriage or birth or adoption. In addition, qualified beneficiaries have the same enrollment and election change rights as active employees.

For additional information or questions regarding COBRA continuation coverage, rights and obligations, please contact the Fund Office.

COBRA and the Family Medical Leave Act (FMLA)

An FMLA leave does not make you eligible for COBRA coverage. However, regardless of whether you lose coverage because of nonpayment of premium during an FMLA leave, you may be eligible for COBRA on the last day of the FMLA leave, if you decide not to return to active employment, depending on whichever situation occurs the earliest:

A. When you definitively inform the Fund Office that you are not returning at the end of the leave; or

B. The end of the leave, assuming you do not return to work.

For purposes of an FMLA leave, you will be eligible for COBRA, as described above, only if:

A. You or your Covered Dependent is covered by the Plan on the day before the leave begins (or you or your Covered Dependent becomes covered during the FMLA leave);

B. You or your Covered Dependent loses coverage under the Plan before the end of what would be the maximum COBRA period; and

C. You do not return to employment at the end of the FMLA leave.

Military Service

If an eligible Employee or a non-eligible Employee with an active connection with a participating Employer enters the military service (other than a temporary tour of duty not exceeding 30 days) and subsequently returns to work or makes himself available for work as a Laborer within the jurisdiction of the Fund for a participating Employer within the period during which he had re-employment rights under federal law, he will be eligible for Fund benefits for the balance of the Benefits Period in which he returned to work or makes himself available for work for a participating Employer and for the next following Benefits Period, provided that within 30 days after his return to such work or availability for work he files a written notice of such return with the Fund Office. In the case of an eligible Employee, his eligibility will terminate on the last day of the month following entry into military service (other than a temporary tour of duty not exceeding 30 days).

If you take military leave, whether for active duty or for training, you are entitled to extend your medical coverage for up to 24 months as long as you give the Fund Office advance notice of the leave (with certain exceptions). Your total leave, when added to any prior periods of military leave from the Fund cannot exceed five years (with certain exceptions). If the entire length of the leave is 30 days or less, you will not be required to pay more for coverage than the amount you paid before the leave. If the entire length of the leave is 31 days or longer, you may be required to pay 102% of the full amount necessary to cover an Employee who is not on military service.

The Fund will comply with all applicable legal requirements regarding participants involved in military service.

Right of Certain Retirees to Continue Coverage After Exhaustion of COBRA Rights

Certain disability retirees and early retirees, who are age 55 or over, shall be eligible to continue to pay monthly to obtain medical, vision and prescription coverages only, for themselves and Eligible Dependents, after such retirees have exhausted any extension of coverage opportunities under the COBRA provisions of the Welfare Fund Benefit Plan. The over-age 55 disability and early retirees eligible to pay for such continuation of coverage are those with 15 or more years of credited service, without a Break in Service, under the hours rules of the Laborers' District Council of Western Pennsylvania Pension Plan, or under rules of any pension plan of the Laborers' International Union of North America. After the death of such an eligible retiree his Eligible Dependents shall have the option to continue to pay for available coverages and benefits.

If the retiree was not a participant in the Laborers' District Council of Western Pennsylvania Pension Plan, or a pension plan of the Laborers' International Union, the record of participation of the retiree under the Welfare Fund will be used to determine eligibility for the right to continue to pay for such medical, vision and prescription coverages. In using the records of the Welfare Plan for such purposes, each 1,000 hours per year or the equivalent shall be considered a year of Credited Service. There will not be more than one year of Credited Service in a calendar year, nor any service credited for time before a Break-in-Service.

The right to continue coverage applies only to medical, vision, prescription benefits, and does not apply to death, accidental death, dismemberment and/or Short Term Disability benefits. Eligibility for benefit coverage under the Welfare Fund does not automatically qualify a participant to benefits under the Laborers' District Council of Western Pennsylvania Pension Plan or any pension plan of the Laborers' International Union of North America. An early retiree must conform to the eligibility requirements of each fund in order to be eligible for coverage under such fund.

If an early retiree and disabled retiree who is otherwise eligible had the right to extend coverage under COBRA, he or she must have taken advantage of that opportunity and must fully exhaust all COBRA coverage rights before the early retiree becomes eligible to take advantage of the opportunity to extend coverage further under these self-payment rules.

The following rules and/or requirements shall be applicable:

A. Coverage by the Welfare Fund through either COBRA or other self-payments by the early retiree must commence as of the first month of eligibility termination after retirement, and be continued thereafter, without interruption, until the month when the early retiree or his Eligible Dependents shall reach age 65, or become eligible for Medicare, or no longer meet the definition of a covered dependent.

B. Payments for coverage by the early retiree must be continuously timely and be paid in accordance with all applicable requirements and conditions as may be established from time to time by the Trustees of the Welfare Fund. If any payment for coverage is not received by the Welfare Fund by the date it is due, coverage shall terminate.

C. The right of any and all early retirees to continue such medical, vision and prescription benefit coverages under this program will be reviewed on an ongoing basis by the Trustees of the Welfare Fund, and may be changed or terminated at any time. Further, the amount

required to be paid by an early retiree to continue coverage will be determined on at least an annual basis by the Board of Trustees of the Welfare Fund, and may be changed from time to time by the Trustees.

Any continuation of coverage provided for any early retiree, and any Eligible Dependents, will cease upon the occurrence of the following:

A. The Welfare Fund no longer provides group health benefits to any participants or Eligible Dependents;

B. The premium for continued coverage is not paid by the early retiree;

C. The early retiree or eligible dependent becomes covered under another group health plan;

D. The early retiree or eligible dependent becomes eligible for Medicare coverage; and

E. The maximum term of coverage for the early retiree or eligible dependent ends.

After an early retiree reaches age 65, or becomes eligible for Medicare, arrangements will permit an eligible dependent to pay monthly for continued medical, vision and prescription coverages from the Welfare Fund provided:

A. That coverage is implemented during an election period for same established by the Trustees of the Welfare Fund;

B. That timely payments are made for such continued coverage each consecutive month beginning with the first month after such eligible dependent has exhausted all other eligibility rights for continuation of coverage under the Welfare Fund Benefit Plan, including all COBRA coverage rights;

C. That the Welfare Fund continues to provide group medical, vision and prescription benefit coverages to participants and dependents;

D. That such eligible dependent is not covered under any other group medical benefit plan;

E. That such eligible dependent has not reached age 65, or become eligible for coverage under Medicare; and

F. That such eligible dependent remains eligible for benefit coverage under the terms of the Welfare Fund Benefit Plan.

If the Welfare Fund's group health plan or its costs change, premiums for coverage of early retirees and/or their eligible dependents may also change. All participating early retirees and/or their Eligible Dependents will be notified of any such change. Accordingly, the Fund Office should be notified immediately if there is any change of address of any early retiree and/or Eligible Dependents.

Notification of Eligibility for COBRA

If you are eligible for COBRA, the Fund Office will send you an enrollment form and cost information on continuing your benefits. You will have 60 days from the later of the date you would lose coverage because of the qualifying event or the receipt of notice from the Fund Office, to complete and return the form to the Fund Office advising that you want continuation of coverage. At the end of the continuation coverage period, you will be allowed to enroll in an individual conversion health plan if you had that right while covered by the Fund. If you do not elect continuation coverage, after application of any banking credits earned prior to July 31, 1975 and not exhausted, your group health coverage will end in accordance with the eligibility rules of the Welfare Fund.

If you are receiving extended COBRA continuation coverage due to a disability and if Social Security determines that you or your Covered Dependent is no longer disabled, you must notify the Fund Office within 30 days of notification by Social Security.

In order to be eligible for COBRA rights in the event of a divorce or a child losing eligibility, you or your Covered Dependent must notify the Fund Office within 60 days of one of these events. Notice of COBRA continuation rights will be sent within 14 days of the Fund receiving your notice of such an event. In order to receive initial or extended COBRA coverage, your spouse or other Covered Dependent will need to complete a COBRA election form and provide required documentation to the Fund Office.

Under the Trade Act of 2002, there is a second 60-day COBRA election period for individuals who become eligible for trade adjustment assistance (TAA). An individual who did not originally elect COBRA coverage during the election period may elect continuation coverage during the 60-day period that begins on the first day of the month in which he or she is determined to be TAA eligible (as long as the election is not later than six months after the date of the TAA-related loss of coverage).

Electing COBRA Coverage

To elect continuation coverage, you must complete an election form and furnish it to the Fund Office in accordance with the directions on the form.

The Employee's spouse may elect continuation coverage even if the Employee does not. Continuation coverage may be elected for only one, several, or for all Covered Dependent children who are qualified beneficiaries. A parent may elect to continue coverage on behalf of any Covered Dependent children. The Employee or the Employee's spouse can elect continuation coverage on behalf of all of the qualified beneficiaries.

In considering whether to elect continuation coverage, you should take into account that a failure to continue your group health coverage will affect your future rights under federal law.

First, you or your Covered Dependents who are older than age 19 could lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage, and election of continuation coverage may help you not have such a gap. Second, you will lose the guaranteed right to purchase individual health

insurance policies that do not impose such pre-existing condition exclusions if you do not get continuation coverage for the maximum time available to you. Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the qualifying event listed previously. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

Payment for COBRA Coverage

If you elect the continuation coverage, you will be required to make payment so that your COBRA coverage commences on the day immediately following the termination of your prior regular Fund coverage. You must pay the continuation premium to maintain the coverage. There will be a forty-five (45) day grace period for the payment of the initial premium from the date you elect to continue the coverage. Coverage will not be in effect until premiums are paid.

After your initial premium payment, premiums will be payable on the first of each month. A 30-day grace period will be allowed for all premium payments after the initial premium. If any premium payment is not received within the grace period, coverage will automatically terminate.

Cost of COBRA Continuation Coverage

Any period of continuation coverage which is provided under self-payment, retirement after age 62 until age 65, or other provisions of this Benefit Plan, except for a period of contribution provided for under former total and permanent disability provisions, shall be incorporated into and coordinated with the period of continuation coverage to which you are entitled under COBRA. Therefore, the period of COBRA continuation coverage, except in total and permanent disability continuation situations provided under former Plan provisions, shall be computed from the date of the qualifying event, as described previously, whether or not other Plan continuation coverage precedes the actual initiation of coverage provided under the COBRA law. Any periods of continuation provided under former permanent disability provisions shall not be incorporated into and coordinated with the expanded continuation rights provided under COBRA. Any continuation of coverage under COBRA shall begin, instead, at the end of the continuation period provided for under any former permanent disability provisions.

If you elect COBRA coverage, you pay the full cost of coverage for you and your Covered Dependents plus a 2% administration fee – or 102% of the total premium.

If the Welfare Fund's group health plan or its costs change, your premiums will also change. You will be notified of any such change. Therefore, in the case of any address change, please notify the Fund Office immediately.

When COBRA Ends

The COBRA "clock" starts on the later of the date your regular coverage would otherwise end or the date of the qualifying event. COBRA coverage will terminate before the end of the 18, 31 or 36 month period for any of the following reasons:

A. You or your Covered Dependents, after electing COBRA continuation coverage, first become covered under another group health plan that does not contain any exclusions or limitations for pre-existing conditions that apply to you or your dependents;

B. You or your Covered Dependents, after electing COBRA continuation coverage, first become entitled to Medicare (COBRA coverage ends only for a person who is entitled to Medicare);

C. You do not pay your premiums within 30 days of the due date (or 45 days in the case of the first payment);

D. Coverage is no longer provided for any Employee;

E. You or your Covered Dependent is on a 13-month disability extension and Social Security determines that you or your Covered Dependent is no longer disabled. In this instance, you are responsible for notifying the Fund Office within 30 days after the date Social Security determines you or your Covered Dependent is no longer disabled; or

F. Your maximum coverage period ends.

SECTION FOUR: ADDITIONAL ELIGIBILITY RULES

Employees Retiring After Age 62

You and your Eligible Dependents may continue to receive benefits, pursuant to the rules of the Plan, except for Short Term Disability Benefits, when you retire under the Laborers' District Council of Western Pennsylvania Pension Plan or the rules of any pension plan of the Laborers' International Union of North America and the following conditions are met:

A. You must be at least age 62 (normal retirement age) while eligible for benefits under this Plan, or after having been eligible for benefits under this Plan in the twelve (12) month period immediately preceding your 62nd birthday.

B. You must have a total of at least five (5) years of Credited Service without a Break in Service under the Laborers' District Council of Western Pennsylvania Pension Plan's hours rules, or under the rules of any pension plan of the Laborers' International Union of North America.

Your coverage will continue until either you become eligible for Medicare or attain age 65.

A self-payment to continue coverage in these circumstances may be required.

Continuation of Medical Coverage for Covered Spouses and Covered Dependents of Retirees

After the exhaustion of all other eligibility rights for continuation of coverage, including all available COBRA coverage rights, special arrangements for continuation of medical benefits coverage may be available to a spouse and/or Eligible Dependents of an Employee who:

A. Has retired at age 62 or later under the terms of the Normal Retirement provisions of the Laborers' District Council of Western Pennsylvania Pension Fund Benefit Plan or a plan of the Laborers' International Union of North America; and

B. Has extended medical benefit coverage from this Fund as a result of that status and other applicable provisions of this Benefit Plan.

The special arrangements will permit such a spouse and/or eligible dependent to voluntarily purchase continued medical benefit coverage from this Fund provided:

A. That coverage is elected during the 60-day election period which begins on the date of receipt of the election notice;

B. That such coverage is purchased each consecutive month beginning with the first month after such spouse and/or eligible dependent has exhausted all other eligibility rights for continuation of coverage;

C. That the Fund continues to provide group medical benefit coverage to participants and dependents;

D. That such spouse/ eligible dependent is not covered under any other group medical benefits plan;

E. That such spouse/ eligible dependent has not reached age 65;

F. That such spouse/eligible dependent is not entitled to enroll in Medicare coverage; and

G. That such dependent is eligible for benefits by meeting the Covered Dependent definition.

The amount charged for the continued coverage shall be established, from time to time, by the Trustees of the Welfare Fund.

Conformity with Pension Plan Eligibility Requirements

Eligibility for benefits under the Welfare Fund does not automatically qualify a participant for benefits under the Laborers' District Council of Western Pennsylvania Pension Plan and vice versa. The participant must conform to the eligibility requirements of each Fund in order to be eligible for coverage under both Funds.

If the Employee is not a participant in the Laborers' District Council of Western Pennsylvania Pension Plan or a pension plan of the Laborers' International Union the records of the Welfare Plan will be used to establish eligibility for benefits for Welfare Plan participants retiring after age 62. In using records of the Welfare Plan for the welfare benefits enumerated, because the Employee is not a Laborers' District Council of Western Pennsylvania Pension Plan participant, each 1,000 hours per year or the equivalent per year shall be a year of Credited Service. There will not be more than one (1) year of Credited Service in a calendar year nor any service credited for time before a break in service.

Early Retiree Coverage Eligibility

Under arrangements suitable to the Board of Trustees, an Employer may submit appropriate contributions to continue coverage eligibility for an Employee who is an Early Retiree under the rules of the Laborers' District Council of Western Pennsylvania Pension Plan and his Covered Dependents, subject to requirements that: (a) the Employer shall have a benefit arrangement in place which provides that all of the similarly situated Early Retirees of the Employer shall be eligible for such Employer contributions and coverage; (b) such coverage must commence upon the first month of such Early Retirement and be continued thereafter for such Early Retiree until the month when he or she reaches age 65; (c) payments for coverage by the Employer shall commence during the first month the said Early Retiree loses coverage eligibility enjoyed through prior Employer contributions, COBRA, or other arrangements which provided such eligibility; and (d) such other conditions as the Trustees may adopt from time to time shall apply concerning eligibility.

Medicare

Active Employees Age 65 or Over

If you continue to be actively employed after you reach age 65, you must choose one of the following:

A. Continue to be covered under the Fund sponsored plan for the same benefits available to Employees under age 65. In this case, the Fund sponsored plan will pay all eligible expenses first. Medicare will then pay for Medicare eligible expenses, if any, not paid for by the Fund sponsored plan.

B. Elect Medicare as your primary coverage. In this case, you will not be eligible for the medical portions of the Fund sponsored plan, but will continue to be eligible for vision and prescription drug coverage.

Spouses of Active Employees Who are Age 65 or Older

If you continue to be actively employed, your spouse who is age 65 or older has the same choices indicated previously for the Employee who is age 65 or older.

Regardless of the choice made by you or your spouse, each one of you should apply for Medicare Part A coverage about three months prior to becoming age 65. If you choose the Fund sponsored plan as primary, you may delay enrolling for Medicare Part B at such time. However, you may be permitted to enroll for Part B later, without a penalty, only during special enrollment periods. The Fund suggests that you review the rules regarding Medicare to understand the benefits that are available and how to avoid penalties for late enrollments.

Special Enrollment Period

An Eligible Employee and/or Eligible Dependent may also be able to enroll during a special enrollment period. A special enrollment period is not available to an Eligible Employee and his or her Eligible Dependents if coverage under the prior plan was terminated for cause, or because premiums were not paid on a timely basis.

An Eligible Employee and/or Eligible Dependent does not need to elect COBRA continuation coverage to preserve special enrollment rights. Special enrollment is available to an Eligible Employee and/or Eligible Dependent even if COBRA is elected.

A special enrollment period applies to an Eligible Employee and any Eligible Dependents when one of the following events occurs:

A. Birth

B. Legal adoption

C. Placement for adoptions

D. Marriage

A special enrollment period applies for an Eligible Employee and/or Eligible Dependent who did not enroll during the Initial Enrollment Period if the following are true:

A. The Eligible Employee and/or Eligible Dependent had existing health coverage under another plan at the time they had an opportunity to enroll during the Initial Enrollment Period; and

B. Coverage under the prior plan ended because of any of the following:

   - Loss of eligibility (including, without limitation, legal separation, divorce or death).
   - The employer stopped paying the contributions. This is true even if the Eligible Employee and/or Eligible Dependent continues to receive coverage under the prior plan and to pay the amounts previously paid by the employer.
   - In the case of COBRA continuation coverage, the coverage ended.

The Eligible Employee and/or Eligible Dependent no longer lives or works in an HMO service area if no other benefit option is available.

The plan no longer offers benefits to a class of individuals that include the Eligible Employee and/or Eligible Dependent.

- An Eligible Employee and/or Eligible Dependent incurs a claim that would exceed a lifetime limit on all benefits.

Special Enrollment and Premium Assistance Under the Children's Health Insurance Program ("CHIP")

In accordance with Federal law, effective April 1, 2009, in addition to other enrollment opportunities provided under the Welfare Fund Benefit Plan, there are two special enrollment opportunities under the Children's Health Insurance Program ("CHIP"). Under CHIP, there is a sixty (60) day period for Employees and Eligible Dependents to enroll in the Benefit Plan if they: (1) lose their Medicaid or CHIP coverage because they are no longer eligible for such coverage; or (2) become eligible for a state premium assistance program. The CHIP premium assistance program permits a state CHIP program to provide coverage to a CHIP participant by paying an eligible participant's share of the Benefit Plan's premium for providing such coverage. In the alternative, the parent of a child receiving CHIP premium assistance may disenroll an eligible child from coverage under the Benefit Plan during any month and instead enroll the child in the State's child health plan. Please contact the Fund Office for enrollment or other information, by calling 412-263-0900 or toll free at 1-800-242-2538.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov.**

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2019. Contact your State for more information on eligibility –

ALABAMA—Medicaid
Website: http://myalhipp.com/
Phone: 1-855-692-5447

ALASKA – Medicaid
The AK Health Insurance Premium Payment Program
Website: http://myakhipp.com/
Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx

ARKANSA – Medicaid
Website: http://myarhipp.com/
Phone: 1-855-MyARHIPP (855-692-7447)

COLORADO – Health First Colorado
(Colorado's Medicaid Program) &
Child Health Plan Plus (CHP+)
Health First Colorado Website: https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711
CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus
CHP+ Customer Service: 1-800-359-1991/ State Relay 711

FLORIDA – Medicaid
Website: http://www.flmedicaidtplrecovery.com/hipp/
Phone: 1-877-357-3268

GEORGIA – Medicaid
Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
Phone: 678-564-1162 ext. 2131

INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19-64
Website: http://www.in.gov/fssa/hip/
Phone: 1-877-438-4479
All other Medicaid
Website: http://www.indianamedicaid.com
Phone 1-800-403-0864

IOWA – Medicaid
Website: http://dhs.iowa.gov/Hawki
Phone: 1-800-257-8563

KANSAS – Medicaid
Website: https://www.kdheks.gov/hcf/
Phone: 1-785-296-3512

KENTUCKY – Medicaid
Website: http://chfs.ky.gov
Phone: 1-800-635-2570

LOUISIANA – Medicaid
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331
Phone: 1-888-695-2447

MAINE – Medicaid
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html
Phone: 1-800-442-6003
TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/
Phone: 1-800-862-4840

MINNESOTA – Medicaid
Website: https://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.jsp
Phone: 1-800-657-3739

MISSOURI – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

MONTANA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084

NEBRASKA – Medicaid
Website: http://www.ACCESSNebraska.ne.gov
Phone: (855) 632-7633
Lincoln: (402) 473-7000
Omaha: (402) 595-1178

NEVADA – Medicaid
Medicaid Website: http://dwss.nv.gov/
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid
Website: https://www.dhhs.nh.gov/oii/hipp.htm
Phone: 603-271-5218
Toll free number for the HIPP program: 1-800-852-3345, ext. 5218

NEW JERSEY – Medicaid and CHIP
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Medicaid Phone: 609-631-2392
CHIP Website http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710

NEW YORK – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid
Website: https://medicaid.ncdhhs.gov/
Phone: 919-855-4100

NORTH DAKOTA – Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON – Medicaid
Website: http://healthcare.oregon.gov/Pages/index.aspx
http://www.oregonhealthcare.gov/index-es.html
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid
Website: http://www.dhs.pa.gov/provider/medicalassistance/
healthinsurancepremiumpaymenthippprogram/index.htm
Phone: 1-800-692-7462

RHODE ISLAND – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/
Phone: 855-697-4347, or 401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA – Medicaid
Website: http://www.scdhhs.gov
Phone: 1-888-549-0820

SOUTH DAKOTA – Medicaid
Website: http://www.dss.sd.gov
Phone: 1-888-828-0059

TEXAS – Medicaid
Website: https://www.gethipptexas.com/
Phone: 1-800-440-0493

UTAH – Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/
CHIP Website: http://health.utah.gov/chip
Phone: 1-877-543-7669

VERMONT – Medicaid
Website: http://www.greenmountaincare.org/
Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm
Medicaid Phone: 1-800-432-5924
CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm
CHIP Phone: 1-855-242-8282

WASHINGTON – Medicaid
Website: http://www.hca.wa.gov/
Phone: 1-800-562-3022 ext. 15473

WEST VIRGINIA – Medicaid
Website: http://mywvhipp.com/
Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP
Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf
Phone: 1-800-362-3002

WYOMING – Medicaid
Website: https://wyequalitycare.acs-inc.com/
Phone: 307-777-7531

To see if any other states have added a premium assistance program since July 31, 2019, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

What Is Considered a Qualifying Life Event (QLE)?

Qualifying life events are those situations that cause a change in your life that has an effect on your health insurance options or requirements. The Internal Revenue Service states that a qualifying event must have an impact on your insurance needs or change what health insurance plans that you qualify for. In either case, the qualifying life event would trigger a special enrollment period that would make you eligible to select a new plan option through the Fund.

Examples of Qualifying Life Events

Loss of health-care coverage

- Losing health insurance for any reason except not paying premiums
- Losing eligibility (Medicaid, Medicare or a Children's Health Insurance Program)
- Turning 26 and losing coverage through a parent's plan
- Loss of job-based coverage (quit or fired)

Changes in household

- Marriage, divorce or legal separation
- Pregnancy, adoption of a child or any adding of dependents
- Losing coverage due to a death in the family

Changes in residence

- Moving to a different coverage area (state or county)
- Student moving schools
- Workers moving to and from the place they live and work

Other qualifying events

- Changes in income that affect the coverage you qualify for
- Becoming a US citizen
- Released from incarceration
- Your spouse retires, which forces you to lose coverage
- Your spouse changes jobs

What Is a Special Enrollment Period (SEP)?

Under the Affordable Care Act (ACA), a special enrollment period is a set period in which you would be allowed to enroll or change your health insurance coverage. The special enrollment period lasts 60 days from the date of a qualifying life event. During these 60 days, you would be allowed to enroll in a new health insurance plan. Once the 60 days have expired, the SEP would be over. At that point, you would have had to submit an election form for the new plan option. If you did not choose a new plan option you would remain in your current plan until the next enrollment period when you could then elect a new plan.

How to Prove a Qualifying Event

You may need to provide documentation of your qualifying life event so the Fund administrator can confirm that you meet SEP requirements.

You will have 60 days to send documents to the Fund that detail your qualifying life event. It is important to note that your policy start date for your newly elected plan will begin the first of the month following the date in which the qualifying event incurred. If you are not approved for an SEP, then you would remain in your current plan until the next enrollment period when you could then elect a new plan.

For example, if you were recently married and wanted to add your spouse to your coverage and change your plan option, you would be required to provide a fully completed Employee Identification Card, an election form and a copy of your marriage license. You would have 60 days from the date of your marriage to add your spouse to coverage and elect a new plan option.

Continuous Creditable Coverage

Continuous Creditable Coverage is defined as health care coverage under any of the types of plans listed below, during which there was no break in coverage of 63 consecutive days or more:

A. A group health plan.

B. Health insurance coverage.

C. Medicare.

D. Medicaid.

E. Medical and dental care for members and certain former members of the uniformed services, and for their Eligible Dependents.

F. A medical care program of the Indian Health Services Program or a tribal organization.

G. A state health benefits risk pool.

H. The Federal Employees Health Benefits Program.

I. The State Children's Health Insurance Program (S-CHIP).

J. Health plans established and maintained by foreign governments or political subdivisions and by the U.S. government.

K. Any public health benefit program provided by a state, county, or other political subdivision of a state.

L. A health benefit plan under the Peace Corps Act.

M. A waiting period for health care coverage will be included in the period of time counted as Continuous Creditable Coverage.

SECTION FIVE: QUESTIONS AND ANSWERS

This section contains answers to questions most frequently asked about the Benefit Plan of the Laborers' District Council of Western Pennsylvania Welfare Fund. Read them over carefully so you may be familiar with all phases of your benefit programs.

If there is some question on which you would like to have additional information, please call the Fund Office, and they will be glad to help you. However, should any conflict or question arise concerning any of the information in this questions and answers section, please refer to the provisions of the Plan and Trust Agreement, which will prevail and apply.

How is the Fund financed?

Contributions are made by each Employer that has a signed agreement in effect requiring Welfare Fund contributions or remittances to be reported and paid. The reports of the contributing Employers are sent to the Fund Office, where they are reviewed, and audits are conducted, to see that each Employer is discharging its obligation and making contributions in accordance with its agreement.

How are Remittance Reports processed?

Reports and payments are mailed directly to a Post Office lock box or through the online portal where they are picked up "around the clock" by bank personnel. All monies received are deposited in a Welfare Fund bank account. Hours/Gross Wages listed in the reports and the amounts paid are credited to each Employee's permanent personal account by the Fund Office and provide the basis for determining benefits. Social Security numbers are very important as the data from the reports and the amounts paid for each Employee is recorded in your account in the Fund's records, using your Social Security number as your identification number. When reporting to a new Employer, provide your Social Security card rather than quote the number from memory.

How are Fund Office records kept?

We record all transactions – your welfare and pension accounts, your Employers' contributions and remittances, and related records.

Who audits Fund Office records?

The books and accounts of the Fund are audited yearly by independent certified public accountants. In addition, all the records are available for examination by any of the Trustees, by the Internal Revenue Service, and by any authorized agencies of the state or federal governments.

Does the Fund publish financial reports?

At the close of each year the Administrator prepares for the Trustees a Summary Annual Report as required by ERISA. These reports are then printed and mailed to all Employees. All Employers are also sent a copy of each annual report.

However, as described in the Summary Annual Report, you have the right to receive a copy of the full annual report, or any part thereof, on request, which includes various documents.

To obtain a copy of the full annual report, or any part thereof, write or call the Fund Office. There may be a charge to cover copying costs.

You also have the right to receive from the Plan Administrator, on request and at no charge, a statement of the assets and liabilities of the Plan and accompanying notes, or a statement of income and expenses of the Plan and accompanying notes, or both. If you request a copy of the full annual report from the Plan Administrator, these two statements and accompanying notes will be included as part of that report. The charge to cover copying costs given above does not include a charge for the copying of these portions of the report because these portions are furnished without charge.

Who is responsible for receiving and handling the monies paid?

The Trustees, who serve without pay, are responsible for the management of all business affairs of the Fund, including the receipt and disbursement of all money. Half of these Trustees are appointed by the Union and half are appointed by the Employers. These Trustees, in turn, delegate the day-to-day work to the Fund's Administrator and staff, who accomplish the work.

How are funds protected?

All monies received are deposited in bank accounts in the name of the Welfare Fund. No withdrawals or disbursements can be made except by authorization of the Board of Trustees upon the signature of at least two (2) designated Trustees. The Trustees, the Administrator and all the office employees are covered by fidelity bond insurance.

What are Administrative Office expenses?

The customary expenses of operating an administrative office, including the salaries of the office employees and the Administrator are paid by the Welfare Fund. No salary is paid to any Trustee, Employer representative, or to any Union official or agent.

How do I become eligible for benefits?

After you complete the eligibility requirements set forth in PART I, Section 2, you must complete an Employee Identification Card on which you must list accurate data about yourself and your dependents to become enrolled in the Plan. You can get this card from the Fund Office or on line at www.lcfowpa.com under the "Forms" tab. You will be credited with hours during any Work Period for which contributions or remittances were received. This will be credited towards your eligibility in the subsequent Benefit Period for coverage for you and eligible Covered Dependents under the terms of the applicable Plan of Benefits.

How long will my eligibility continue?

As long as you are credited for the sufficient hours of work during each Work Period for which contributions are received, your benefits will continue in effect.

If you do not continue to be eligible in the CONSTRUCTION INDUSTRY PROGRAM because you have not been credited with a sufficient number of hours, you and your Covered Dependents may continue to be eligible for medical and certain other Fund benefit coverages, if you qualify and make COBRA payments. See the COBRA provisions of this Booklet for more information.

How can I be sure I have sufficient hours?

For Construction Industry Program employees, you should retain your pay stubs for proof of the hours you worked during each Work Period or for the pay period relating to the Work Period. By keeping track of the hours for which you received pay, you can easily tell if you have enough hours before the Construction Industry Program Work Period closes. This information is available on the Fund Office website after you sign in at www.lcfowpa.com under the "My Benefits" section.

If the hours credited on your eligibility statement from the Fund Office do not agree with your payroll records, contact the Fund Office. You must contact the Fund Office to report any errors no later than twelve (12) months after you receive any eligibility statement with which you have any disagreement.

For the Conjunct Program, the hours worked by a Conjunct Program participant do not determine eligibility for a Benefit Month. Rather, for Conjunct Program participants, contribution rates are specified and made part of each collective bargaining agreement and/or established by the Trustees from time to time in agreements covering Conjunct Program participants. If a contribution is made on your behalf for a Work Month, you will have a Benefit Month of coverage in the month following the Work Month.

Who determines benefits?

When the Fund started in 1953, the Trustees set up a schedule of benefits based upon estimated income and estimated benefit payments. Since that time, the Trustees have periodically reviewed the actual income and the actual benefit payment experience, and as a result of their studies, the schedule of benefits has been revised from time to time. One of the principal responsibilities of the Board of Trustees is to provide the best benefits possible while maintaining the financial security of the Fund.

What benefits are provided?

For the Eligible Employee and Covered Dependents the Welfare Plan provides hospitalization, comprehensive medical, prescription drug and vision care benefits. In addition, the Employee is covered by Short Term Disability benefits which are payable if the Employee is unable to work because of a non-occupational illness or injury. Death Benefits are paid for the Covered Employee, spouse and eligible children. Accidental Death or Dismemberment Benefits are paid only for the Covered Employee.

Will my other insurance policies affect benefits?

You may have as many individual (non-group) policies as you may choose. Such policies, whether for hospitalization, accidents, life, etc., in no way affect your benefits under the Welfare Fund Benefit Plan. Other group coverage, however, will be subject to the coordination of benefits provisions explained in PART III of this Booklet.

What if another party is responsible for the payment of medical or other charges which have been paid by the Welfare Fund's Benefit Plan?

The Welfare Fund has an equitable interest in all benefits and payments made and maintains an equitable lien and/or constructive trust with respect to such benefits and payments. By accepting benefits under the Welfare Fund's Benefit Plan, you and your Covered Dependents recognize the Fund's equitable interests and constructive trust and agree to cooperate in any effort by the Fund to recover such benefits from the responsible party, and assign your rights to the Fund in such circumstances to pursue such a recovery. If you have an attorney or other representative, he or she will be expected to pursue and protect the Fund's rights to recover in any settlement, litigation, or other claim proceeding against the responsible party. If the Fund's attorney or other representative is required to pursue such a recovery, by litigation or other means, you or your Covered Dependents will be expected to fully cooperate in such efforts, and will be considered to have assigned all of your equitable and legal rights in connection with the Fund's efforts to recover any amounts it may be due, or to enforce its equitable interests, lien, and/or constructive trust.

Will I be earning eligibility for Welfare Fund benefit coverage if I work outside the Fund area?

Reciprocity Agreements have been adopted by the Trustees of this Fund. In areas where these agreements are in effect, they provide for the transfer of contributions or remittances to the Welfare Fund where the Employee normally resides and/or has coverage. If you are performing work outside the jurisdictional area, advise the Fund Office so it may request transfer of contributions or remittances. This request can also be done on the Funds' Website: www.lcfowpa.com.

Do I need the consent of my beneficiary to change beneficiaries?

You do not need the consent of your beneficiary to make any change in your beneficiary or beneficiaries, except where such a change may be limited or prohibited by applicable law or by a valid court order.

Can I qualify for extended medical or other coverages after becoming totally and permanently disabled?

Medical and certain other coverages will be available through self-payments based on COBRA requirements. See the COBRA provisions of this Booklet for more information.

Is there any benefit coverage available to me after I retire and become eligible for Medicare?

The Fund makes Medicare Advantage Group Plans available to Medicare eligible participants and retirees. Please contact the Fund Office for more information about the available plans and qualification requirements.

Can I continue to maintain my Welfare Fund medical or other coverage after my eligibility terminates?

Medical and certain other Fund benefit coverages will be available through self-payment based on COBRA requirements. See the COBRA provisions of this Booklet for more information.

Is there any continuation of medical coverage available to me if I retire between age 62 and 65?

If you qualify for age 62-65 extended medical coverage, and take normal retirement, you may be required to make some self-payments to maintain such medical and certain other Fund benefit coverages. The amount of this payment will be reviewed periodically.

Am I eligible for any extended medical or other coverages if I am unable to work because of a work-related injury or illness?

Medical and certain other coverages will be available through self-payments based on COBRA requirements. See the COBRA provisions of this Booklet for more information.

How many hours will I need to work in order to become eligible for Welfare Fund benefits?

You may obtain eligibility for Welfare benefits under the Construction Industry Program by working either: (a) 425 paid hours for which Employer contributions are due during any particular Work Period; or (b) a combined total of 1,100 paid hours during the current Work Period and the immediately prior Work Period. One may not combine the hours worked in any two consecutive Work Periods to gain retroactive eligibility for coverage during any prior Benefit Period when there was a lack of eligibility. Eligibility in the Conjunct Program requires Employer contributions for each month of eligibility.

SECTION SIX: CLAIMS AND ADMINISTRATION

Medicare Coordination of Benefits

Under the Federal Medicare Secondary Payer Law, unless you elect otherwise, the Welfare Fund is primary payer, and Medicare is secondary payer, for the following covered persons:

A. Employees, eligible based upon paid hours for contributing Employers, age 65 or over and their spouses age 65 or over;

B. Employees, eligible based upon paid hours or current employment for contributing Employers, and their disabled Covered Dependents; and

C. Covered Employees or Eligible Dependents entitled to Medicare solely on the basis of end stage renal disease during the first 30 months (or other period specified by federal law) in which they are eligible for Medicare benefits.

Right of Recovery

When payments have been made by the Welfare Fund, Principal Life Insurance Company, Davis Vision, and/or Highmark Blue Cross Blue Shield with respect to allowable benefits in a total amount, at any time, in excess of the maximum amount of payments due under this Benefit Plan, irrespective of to whom paid, the Welfare Fund shall have an equitable interest, an equitable lien and/or a constructive trust with respect to all such benefits and payments, and shall have the right to recover such payments from: (1) any person to, for, or with respect to whom payment was made; (2) any person or party who could be held responsible for such payment or reimbursement of it; and/or (3) any insurance company which may be responsible for such payments. The Welfare Fund, at its option, may also offset, recoup, and/or recover the amount of any overpayment from payments due or thereafter becoming due to you or a Covered Dependent, in such installments, and to such extent, as the Fund shall determine to be appropriate.

You, on your own behalf, or on behalf of your Covered Dependents, shall upon request execute and deliver such instruments and papers as may be requested or required, and do whatever else is necessary to secure such rights to and for the Welfare Fund, Principal Life Insurance Company, Davis Vision, and/or Highmark Blue Cross Blue Shield.

Payments to Beneficiary

In the event that it shall be found that any Covered Employee to whom a benefit is payable is unable to care for his or her affairs because of illness or accident, any payment due (unless prior claim therefore shall have been made by a duly qualified guardian or other legal representative) may be paid to the spouse, children, parents, brothers and sisters, nephews and nieces or other person deemed by the Trustees to have incurred expense for such Covered Employee otherwise entitled to such payment. Any such payment shall be a payment for the account of the Covered Employee and shall be a complete discharge of any liability of the Plan and Fund with regard to any such payment.

Examination by the Welfare Fund

The Welfare Fund, through a designated physician, shall have the right and opportunity to examine the person whose injury or sickness is the base of any claim, when and so often as it may reasonably require during the pendency of any claim hereunder.

Legal Action to Collect Benefits

No action at law or in equity shall be brought to recover under the Plan prior to the expiration of 60 days after proof of loss has been filed in accordance with the requirements of the Plan, and prior to the exhaustion of all of the available Plan appeal processes and procedures, except in situations wherein applicable law shall not require such exhaustion of available Plan appeal processes and procedures. Further, no such action may be brought at all unless brought within the time limits provided under applicable law. If any time limitation of the Plan with respect to giving notice, filing proof of loss or commencing an action at law or in equity is less than that permitted by the law of the state in which the covered person resides at the time the Plan is in effect, such limitation is hereby extended to agree with the minimum period permitted by such law.

Claims for Non-Health Benefits

Claims for Short Term Disability benefits will be initially determined by the Claims Administrator within 45 days of receipt of your filing of a complete claim; however, a 30-day extension is provided if the Claims Administrator provides a notice with an explanation of the reason for the delay. A second 30-day extension is permitted if circumstances so warrant. If the Claims Administrator requires additional information, you will be afforded 45 days to provide the specified information. You will receive a written notification of the Claim Administrator's determination. If you disagree, an appeal of the Adverse Benefit Determination must be submitted in writing within 180 days of receipt. The Plan, or its designated representative, will make a benefit Determination on Review within 45 days of receipt of your appeal, subject to an available 45-day extension.

Claims for life insurance benefits will be initially determined by the Claims Administrator within 90 days of receipt of your filing of a complete claim; however, a 90-day extension is provided if the Claims Administrator provides a notice with an explanation of the reason for the delay. You will receive a written notification of the Claim Administrator's determination. If you disagree, an appeal of the Adverse Benefit Determination must be submitted in writing within 60 days of receipt. The Plan, or its designed representative, will make a benefit Determination on Review within 60 days of receipt of your appeal, subject to an available 60-day extension.

Plan Abuse

Abuse of the Benefit Plan of the Welfare Fund is a serious concern. In the event that it is determined that any Eligible Employee or Covered Dependent has made misrepresentations, committed fraud, or otherwise acted improperly with respect to any claim for benefits under the Plan, the Trustees may elect to impose limitations or restrictions upon persons involved in such improper conduct, up to and including the suspension of eligibility of such person or persons for benefits otherwise available under the Plan. Furthermore, in appropriate cases, the Trustees may pursue civil or criminal proceedings, as they may deem appropriate, to address such improper conduct.

Authorization for Release of Information

By the submission of any claim for benefits or the acceptance of any benefits under any aspect of this Benefit Plan, the Eligible Employee or Covered Dependent claiming or accepting such benefits authorizes the release of any and all medical records, documents, reports, files and information as may be requested or desired by the Welfare Fund relative to such claim or acceptance.

Authority of the Trustees

The Trustees shall have the authority to construe and/or interpret the terms and conditions of the Welfare Fund Trust Agreement, and of the Plan of Benefits, as well as to determine eligibility on any claim for benefits, and any factual and/or legal constructions, interpretations, conclusions or determinations adopted by the Trustees in good faith shall be binding upon Employees, Covered Dependents, and any other person or persons who may be or claim to be interested herein, provided that any construction, interpretation, conclusion or determination made as aforesaid, which shall be in contravention of or inconsistent with any then effective collective bargaining agreement applicable thereto, shall not be binding upon the affected Employer or Association of Employers, or upon Employees or the Union. It is intended that any and all factual and/or legal constructions, interpretations, conclusions or determinations adopted by the Trustees in good faith are to be accorded deference upon judicial or other review.

The Trustees shall also have the authority to modify or cancel any of the benefits, rules or other features of the Fund's Benefit Plan.

SECTION SEVEN: PLAN INFORMATION

Complaint and Grievance Procedures

The Trustees of the Welfare Fund contract with private providers such as Highmark Blue Cross Blue Shield, Principal Life Insurance Company and Davis Vision in order to afford Employers, Participants and the Union the quality and price options desired for medical, hospitalization, life, Short Term Disability and vision benefits. Pursuant to these contracts, claims processing and appeal functions are administered by these providers on behalf of the Plan.

In response to Federal regulations, the Trustees have taken steps to ensure that all contractual providers of benefits are processing claims in a manner which is consistent with the laws and regulations governing the claims and appeal processes. Since different providers administer claims for specific benefits covered under their respective contracts, the Plan's overall claims and appeal procedure uses generic terms to refer to any representative administering benefit claims as the "Claims Administrator." Each of these providers will use their own claim forms and notices in performing their roles under the claims and appeal processes. Although the language in provider documents may differ from that used in the Plan's claims and appeal procedures, their handling of claims and appeals is governed by the procedures of the Plan and by federal regulations. If you have questions regarding how to file a claim or appeal an Adverse Benefit Determination, you should refer to the specific review and dispute instructions provided by the entity responsible for administration of the specific benefit.

Claims should be in writing, stating the basis of the claim. Specific forms setting forth the precise information needed for the various types of benefits are available from the Fund Office, or from your health care provider. The Plan has a specific amount of time to evaluate and respond to claims for benefits, beginning on the date when a complete and proper claim is received. Different timetables apply to the prompt processing of four categories of medical claims, with more prompt handling required for those of a more urgent nature. Please refer to the Medical Claims Appeal Procedures on page 118.

Information required by the Employee Retirement Income Security Act of 1974 (ERISA)

Name of Plan

Laborers' District Council of Western Pennsylvania Welfare Fund

Name and Address of Joint Board of Trustees

Board of Trustees
Laborers' District Council of Western Pennsylvania Welfare Fund
12 Eighth Street, Suite 500
Pittsburgh, PA 15222

A complete list of the Employers and Employee organizations sponsoring the Plan may be obtained by participants and beneficiaries upon written request to the Plan Administrator, and is available for examination.

Employer Identification Number

The Employer Identification Number (EIN) issued to the Board of Trustees is 25-6035806. The Plan number is 501.

Type of Administration of the Plan

The Plan is administered by the Board of Trustees of the Laborers' District Council of Western Pennsylvania Welfare Fund. Benefits are provided from the Fund's assets, which are accumulated under the provisions of the collective bargaining agreements and the Fund's Trust Agreement and held in a trust fund for the purpose of providing benefits to cover Participants and defraying reasonable administrative expenses. Assets of the Fund are managed under authority of the Board of Trustees.

Name, Address and Business Phone Number of Plan Administrator

Board of Trustees
Laborers' District Council of Western Pennsylvania Welfare Fund
Attention: Laborers' Combined Funds
Kevin Hribar, Administrator
12 Eighth Street, Suite 500
Pittsburgh, PA 15222
Telephone: 412-263-0900 or 1-800-242-2538

Name and Address of Person Designated as Agent for Service and Legal Process

Howard Grossinger, Esquire
247 Fort Pitt Blvd., 4th Floor
Pittsburgh, PA 15222

Service of legal process may be made on a Plan Trustee or the Plan Administrator.

Employee Trustees

PHILIP AMERIS, Chairman
President and Business Manager
Laborers' District Council of W. PA
12 Eighth Street, 6th Floor
Pittsburgh, PA 15222

JAMES E. BOYD
Business Manager
Laborers' Local Union #1451
816 Ligonier Street, Suite 202
Latrobe, PA 15650

WILLIAM J. BROOKS
Business Manager
Laborers' Local Union #373
611 Thompson Run Road
Monroeville, PA 15146

ROBERT L. FURKA
Business Manager
Laborers' Local Union #323
306 E. Brady Street
Butler, PA 16001

JEFFREY R. HORNER
Business Manager
Laborers' Local Union #824
316 W. Linn Street
Bellefonte, PA 16823

JOSEPH J. LAQUATRA, J R.
Business Manager
Laborers' Local Union #1058
12 Eighth Street
Pittsburgh, PA 15222

MARK G. TOY
Business Manager
Laborers' Local Union #952
186 Blaney Road
Kittanning, PA 16201

Employer Trustees

PAUL V. SCABILLONI
Secretary/Treasurer
President
Marsa, Inc.
1000 Castleview Road
Pittsburgh, PA 15234

MICHAEL A. FACCHIANO, President
Michael Facchiano Contracting, Inc.
801 McNeilly Road
Pittsburgh, PA 15226

JOHN C. MASCARO, JR., President/CEO
Mascaro Construction Company, L.P.
1720 Metropolitan Street
Pittsburgh, PA 15233

GEORGE E. MEZEY, President
Trumbull Corporation
P.O. Box 6774
Pittsburgh, PA 15212

JAKE PLOEGER, Director/President
Trumbull Corporation
P.O. Box 6774
Pittsburgh, PA 15212

JOSEPH A. WATTICK, V.P. of Operations
Mosites Construction Company
400 Mosites Way
Pittsburgh, PA 15205

Collective Bargaining Agreements

Copies of Collective Bargaining Agreements are available to participants and beneficiaries who are covered by such Agreements, at the respective Local Union Offices listed below:

LABORERS' DISTRICT COUNCIL OF WESTERN PENNSYLVANIA
12 Eighth Street, 6th Floor
Pittsburgh, PA 15222

LABORERS' LOCAL UNION 323
6 Chesapeake Street, S-200A
Lyndora, PA 16045

LABORERS' LOCAL UNION 373
611 Thompson Run Road
Monroeville, PA 15146

LABORERS' LOCAL UNION 419
453 West Patriot Street
Somerset, PA 15501

LABORERS' LOCAL UNION 603
703 French Street, 2nd Floor
Erie, PA 16501

LABORERS' LOCAL UNION 824
316 West Linn Street
Bellefonte, PA 16823

LABORERS' LOCAL UNION 833
Box 17
1017 Third Avenue
New Brighton, PA 15066

LABORERS' LOCAL UNION 910
303 Wallace Building
406 Main Street
Johnstown, PA 15901

LABORERS' LOCAL UNION 952
186 Blaney Road
Kittanning, PA 16201

LABORERS' LOCAL UNION 964
20 South Mercer Street
Suite 2A
New Castle, PA 16101

LABORERS' LOCAL UNION 1058
12 Eighth Street
Pittsburgh, PA 15222

LABORERS' LOCAL UNION 1451
816 Ligonier Street
Suite 202
Latrobe, PA 15650

Eligibility for Benefits

The Plan's requirements with respect to eligibility for benefits appear in SECTIONS TWO AND FOUR of PART I of this Booklet.

Statement Relative to Pension Benefit Guaranty Corporation

The benefits under this Plan are not insured by the Pension Benefit Guaranty Corporation. It does not provide insurance coverage for Welfare Fund benefits.

Sources of Contributions to the Plan

All contributions to the Plan are made by Employers in accordance with collective bargaining agreements and/or participation agreements in force with the Laborers' District Council of Western Pennsylvania and/or one of its affiliated Local Unions.

Designated as Actuary for the Fund

Cowden Associates, Inc.
Four Gateway Center, Suite 605
444 Liberty Avenue
Pittsburgh, PA 15222-1222

Certified Public Accountant

Kenneth M. Wasserman CPA
3616 Liberty Avenue
Pittsburgh, PA 15201

Medical Claims Administrator

Highmark Blue Cross Blue Shield
PO Box 1210
Pittsburgh, PA 15230
1-866-594-1732

Life Insurance Accidental Death and Dismemberment and Short Term Disability Claims Administrator

Principal Life Insurance Company
711 High Street
Des Moines, IA 50392
1-877-257-6978

Securities Custodian

BNY Mellon
Trust and Investment Department
One Mellon Bank Center
Pittsburgh, PA 15258-0001

Vision Claims Administrator

Davis Vision, Inc.
P.O. Box 791
Latham, NY 12110
Attention: Quality Assurance

Date of End of the Plan Year

The date of the end of the fiscal year is December 31.

Procedures to be followed in presenting Claims for Benefits under the Plan

Claims filing procedures are described on pages 33, 53, 48 and 111.

Remedies are available under the Plan for the redress of claims which are denied in whole or in part, including provisions required by Section 503 of the Employee Retirement Income Security Act (ERISA).

If a participant wishes to appeal a denial of a claim in whole or in part, he should file a request for a review within 60 days after receiving the denial; he will be informed of the time and place of the hearing of his appeal. For a complete description, see pages 36, 54 and 118.

Rights and Protections Under ERISA

As a participant in the Plan you are entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974 (ERISA). Under ERISA, you are entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Administrator's office and at other specified locations such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the 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 Administrator is required by law to furnish each participant with a copy of the summary annual report.

Continue Group Health Benefits 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 Eligible Dependents may have to pay for such coverage. Review this Booklet and the documents governing the Plan for the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating certain rights for you, ERISA imposes duties upon the people who are responsible for operating the 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 or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator.

If you have a claim for benefits which 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 a 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 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.

The Welfare Fund's Privacy and Disclosure Practices under HIPAA with Regard to Participants' Protected Health Information ("PHI")

The following provisions highlight privacy and disclosure practices with regard to participants' Protected Health Information (PHI). Generally, the Welfare Fund maintains records as to participants' eligibility and enrollment, and Highmark, as Administrator of the Plan, maintains medical records relating to participants.

1. Your Rights and Responsibilities

A. Get an electronic or paper copy of your PHI

You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

B. Ask us to correct your PHI

You can ask us to correct health information about you that you think is incorrect or incomplete. We guarantee that we will respond within 60 days of your request with the corrected changes or reasons why your request was not approved.

C. Request confidential communications

You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.

D. Get a list of those with whom we've shared information

You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment, and health care operations and certain other disclosures.

E. Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically.

F. Choose someone to act for you

If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

G. File a complaint if you feel your rights are violated

You can complain if you feel we have violated your rights by contacting us using the information on page 150. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**

2. Your Choices

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

A. You have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

B. In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

3. Our Uses and Disclosures

We typically use or share your health information in the following ways:

A. **Treatment:** we can use your health information and share it with other professionals who are treating you.

B. **Operations:** we can use and share your health information to run the Fund, improve your care, and contact you when necessary.

C. **Billing:** we can use and share your health information to bill and get payment from health plans or other entities.

D. **Public Health and Safety Issues:** we can share health information about you for certain situations such as preventing disease, helping product recalls, reporting adverse reactions to medications, reporting suspected abuse, neglect, or domestic violence, and preventing or reducing a serious threat to anyone's health or safety.

E. **Research:** we can use or share your information for health research.

F. **Comply with the law**: we will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

G. **Organ and Tissue Donation Requests:** we can share health information about you with organ procurement organizations.

H. **Work with a medical examiner or funeral director:** we can share health information with a coroner, medical examiner, or funeral director when an individual dies.

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

J. **Respond to lawsuits and legal action:** we can share health information about you in response to a court or administrative order, or in response to a subpoena.

How else can we use or share your health information?

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

4. Our Responsibilities

A. We are required by law to maintain the privacy and security of your protected health information.

B. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.

C. We must follow the duties and privacy practices described in this notice and give you a copy of it.

D. We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

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

Changes to the Terms of this Notice

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

Laborers' District Council of Western Pennsylvania Welfare Fund
12 Eighth Street, Suite 500
Pittsburgh, PA 15222
lcfowpa.com
Privacy Officer – Plan Administrator
412-263-2178
Effective date 1-1-2022

PART II – NON-MEDICAL BENEFITS

SECTION ONE: BENEFITS COVERAGE AVAILABILITY

Termination of Benefit Coverage

If you lose your eligibility, your coverage will cease on the last day of the last Benefit Period (Construction Industry Program) or month (Conjunct Program) during which you were eligible for benefits.

Death Benefits

If you or one of your Covered Dependents die within 31 days after coverage terminates, then the Death Benefit will be payable, as it would have been on the last day of coverage.

Change in Family Status

Your dependent's eligibility for Fund benefits may change if you experience one of the events listed below. You must notify the Fund Office of the change within 31 days of the event, in writing, on the appropriate Fund form and provide documentation as required by the Fund.

A. **Your Marital Status Changes** – Marriage, divorce, death of spouse, legal separation or annulment.

B. **Your Number of Dependents Changes** – The birth, death, adoption or placement for adoption of a child.

C. **Termination/Commencement of Employment** – The beginning or the end of employment of the Employee or spouse.

D. **Your Dependent Begins or Ceases to Meet Eligibility Requirements** – Your dependent satisfies (or ceases to satisfy) Covered Dependent eligibility requirements.

E. **You Have a Qualified Medical Child Support Order (QMCSO)** – A QMCSO requires you to enroll or disenroll a child.

F. **Qualifying Life Event** – Those situations that cause a change in your life that has an effect on your health insurance options or requirements.

G. **Change in Residence** – Change in residence of Employee, spouse or dependent, resulting in eligibility or loss of eligibility.

H. **Change in Legal Custody** – An election to enroll or disenroll a child pursuant to a change in legal custody.

I. **Medicare/Medicaid Entitlement** – You, your spouse or dependent becomes entitled – or loses entitlement – to Medicare or Medicaid.

J. **COBRA Eligibility** – You, your spouse or dependent become eligible for COBRA.

K. **Active Military Service** – You, your spouse or dependent enters active military service.

Your dependents' eligibility for Fund benefits may change if you or your Eligible Dependents lose Medicaid or CHIP coverages because they are no longer eligible for such coverages or if they become eligible for a state premium assistance program. You must notify the Fund Office of the change within **60** days of the event, in writing, on the appropriate Fund form and provide documentation as required by the Fund.

If you are enrolled for Employee only coverage and thereafter acquire a dependent, coverage will become effective on the date you acquire the dependent, if you provide timely notice of same to the Fund Office, and the dependent meets the requirements to be a Covered Dependent.

Ineligible Children

When each of your children ceases to be eligible for benefits from the Fund, they will be given opportunities to enroll under COBRA Continuation coverage or an individual conversion policy will be offered by Highmark Blue Cross Blue Shield.

Subrogation

Subrogation means that if you incur health care expenses for injuries due to an accident or intentional act caused by another person or organization, the person or organization causing the injuries is responsible for paying these expenses, and the Welfare Fund, Highmark Blue Cross Blue Shield or another insurer for the Fund has the right to seek repayment from the other person or organization or his/her/its insurance company for benefits already paid. This right arises as a result of the equitable interest, equitable lien and/or constructive trust the Fund, Highmark Blue Cross Blue Shield, or the Fund's other insurance carriers may have with respect to the benefits provided and payments made by them. The Fund, Highmark Blue Cross Blue Shield or another insurer for the Fund will provide eligible benefits when needed, but you may be asked to provide documents or take other necessary actions to support the subrogation efforts.

Subrogation does not apply to benefits you receive from an individual insurance policy you may have purchased for yourself or your dependents or where subrogation is specifically prohibited by law.

SECTION TWO: VISION CARE PROGRAM

SUMMARY OF VISION BENEFITS

This Summary of Benefits is a brief description of covered Vision Care Program services.
www.davisvision.com

Benefit	Frequency Once every	In-Network Copay	In-Network Coverage		Out-of-Network Reimbursement Schedule[1]
Eye examinations	12 months	$0	Includes dilation when professionally indicated		Up to $40
Spectacle Lenses	12 months	$0	Clear glass or plastic lenses in any single vision, bifocal, trifocal or lenticular prescription. Covered in full. (See below for additional lens options and coatings)		***Single Vision Lenses:*** Up to $50 ***Bifocal Lenses:*** Up to $80 ***Trifocal Lenses:*** Up to $105 ***Lenticular:*** Up to $110
Frames	12 months	$0	**Davis Vision Collection Frames[2]:**	**Member price:** Fashion: $0 Designer: $15 Premier: $40	N/A
			OR, Non Collection Frame Allowance	$90 toward any frame from provider. No copay required	Up to $50
Contact Lens Evaluation	12 months	N/A	**Standard, Contact Lens Types[3]:**	15% discount off Provider's Usual and Customary Charge	N/A
			Specialty Contact Lens Types[4]:	15% discount off Provider's Usual and Customary Charge	N/A
Contact Lenses	12 months	$0	**Contact Lens Allowance:**	$105 allowance towards any Provider's supply	Elective Contacts: Up to $105
			OR, Medically Necessary Contacts:	Covered in full after Prior Approval	Medically Necessary Contacts: Up to $225

CONTINUED ON NEXT PAGE

Optional Frames, Lens Types and Coatings	Member Price
Tinting of Plastic Lenses or Glass Grey #3 Lenses	$0
Oversize Lenses	$0
Scratch-Resistant Coating	$0
Ultraviolet Coating	$0
Anti-Reflective Coating:	Standard: $40 Premium: $55 Ultra: $69
Polycarbonate Lenses[5]	$0 or $25
High-Index Lenses 1.59 or less	$30
High-Index Lenses between 1.60 and 1.67	$54
Progressive Addition Lenses	Standard: $5**0** Premium: $54 Ultra: $104
Polarized Lenses	$75
Photochromic Lenses	Plastic: $50 Glass: $20
Intermediate Lenses	$30
Blended Segment Lenses	$40
Scratch Protection Plan	Single Vision Lenses: $20 Multifocal: $40

[1] You may use an out-of-network provider, however you will receive the greatest value by staying in-network. If you go out-of-network, pay the provider at the time of service, then submit a claim to Davis Vision for reimbursement. You will be reimbursed up to the amounts indicated above. Submit claims for reimbursement to:

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

[2] The Davis Vision Collection is available at most participating independent provider locations.

[3] Including, but not limited to, toric, multifocal and gas permeable contact lenses.

[4] Members are entitled to one pair of eyeglasses and one contact lens benefit within the same benefit period, on both an in and out-of-network basis.

[5] Polycarbonate lenses are covered in full for dependent children, monocular patients and patients with prescriptions +/- 6.00 diopters or greater.

Davis Vision, has contracted with a geographically convenient panel of in-network doctors to provide vision care to you and your dependents. While an out-of-network doctor may also be chosen, you will receive the greatest value by staying in-network. Please retain this Benefit Summary and Vision Care Program description that includes detailed benefit information and instructions on how to use that program. Member Service is available toll free at 1-800-999-5431 (automated help is available 24/7; live help is available 7 days a week, Monday through Friday, 8 a.m. to 11 p.m., Saturday, 9:00 a.m. to 4:00 p.m. and Sunday, 12 p.m. to 4 p.m. EST (TYY Services: 1-800-523-2847)).

How to Obtain Vision Care Services

To locate a provider, you can call a Member Service Representative or use the Interactive Voice Response System at: 1-800-999-5431 or go to www.davisvision.com and click "Find an Eye Care Professional."

Once you have located a provider, you can then contact the provider to make an appointment. When you call to make an appointment, tell your provider that you are a Davis Vision member with coverage under The Laborers' District Council of Western Pennsylvania Welfare Fund Benefit Plan. Provide your member ID number, name and date of birth, and do the same for your Covered Dependents seeking vision services.

Schedule of Benefits

Lenses and frames to be supplied in the program from participating, in-network doctors will be only first quality materials fabricated in Davis Visions' proprietary laboratories, and in all cases should conform to, or exceed their quality standards.

Vision Benefits if You Choose a Panel Doctor

Eye Examination and Refractive Services (Once Every 12 Months)

In the Davis Vision program, participants will be entitled to a comprehensive eye examination with a preferred optometrist or ophthalmologist, which includes the following components:

A. Case history – chief complaint, eye and vision history, medical history
B. Entrance distance acuities
C. External ocular evaluation including slit lamp examination
D. Internal ocular examination (dilated retinal examination, when professionally indicated)
E. Tonometry
F. Distance refraction – objective and subjective
G. Binocular coordination and ocular motility evaluation
H. Evaluation of pupillary function
I. Biomicroscopy
J. Gross visual fields
K. Assessment and plan
L. Patient education
M. Form completion – school, motor vehicle, etc.

A Dilated Retinal Examination (DRE) is universally recognized as a critical diagnostic procedure in the detection and management of diabetes, glaucoma, hypertension and many other ocular and/or systemic diseases (up to 30 altogether). These examinations can lead to higher quality patient care, improved lifestyle through early detection and intervention, and lower overall health care costs.

Dispensing Service

If vision analysis indicates the necessity for lenses and/or frames, the following will be included at no cost to you:

A. Consultation/instructions regarding vision problems
B. Prescribing and ordering lenses
C. Assistance in frame selection
D. Proper fitting and adjustment of eyeglasses
E. Verification of accuracy of finished eyeglasses
F. Follow-up maintenance, as necessary
G. Subsequent visits requiring frame adjustments for comfort and efficiency for a period not to exceed 90 days

Lenses (Once Every 12 Months)

Lens coverage includes, at no cost: (1) clear single vision glass or plastic lenses; or (2) standard type bifocal or trifocal lenses (round, flattop, or executive), in glass or plastic. All powers and sizes of lenses are also included at no cost to you or your Covered Dependents. Aphakic lenses will be supplied if deemed medically necessary. Also covered at no charge are solid and gradient tints, UV coating and scratch resistant coatings on glass or plastic lenses.

Should photogray, blended segment or progressive additional lenses, or any other special type lenses be selected, you or your Covered Dependents must pay an additional amount based on a surcharge schedule.

Safety glasses are only payable if the lenses are processed at a Davis Lab.

Frames (Once Every 12 Months)

A selection of first quality frames will be available from a panel doctor at no cost to you or your Covered Dependents. Should a special type frame (i.e., a non-plan frame) be desired, you or your Covered Dependent shall receive an allowance of $90.

Eyeglass Warranty

Davis Vision provides a breakage warranty to repair or replace a Collection frame and/or lens(es) for a period of one year from the date of delivery.

How Reimbursement is Made to a Vision Panel Doctor

If you use a panel doctor, there is no charge to you for the covered vision care services and materials provided under the Fund's Benefit Plan. The Fund pays the panel doctors in full for examinations and dispensing services and up to the Fund's allowance for materials supplied.

Contact Lenses (Once Every 12 Months)

A $105.00 allowance will be applied toward any contacts once every 12 months.

When deemed medically necessary, and with prior approval, medically necessary contact lenses will be covered in-full, when obtained in-network.

Mail Order Replacement Contact Lens Program

After you use your contact lens supply. You may obtain contacts through the Davis Vision mail order contact lens program for additional discounts. By accessing www.davisvisioncontacts.com you can easily order replacement contact lenses at a discount and have them shipped directly to your doorstep.

Laser Correction Surgery

Any member or dependent that wishes to receive Lasik Vision Correction can receive discounts at any Davis Vision Lasik provider. For further information contact Qualsight at 1-855-502-2020.

Low Vision Services

Upon approval, Low Vision services including an evaluation, follow up services and low vision aids up to the lifetime maximum are available through the Davis Vision Program. Please call 1-800-999-5431 for details.

Vision Benefits if You Choose a Non-Panel Doctor

If you use an out-of-network provider, you may be required pay the provider at the time of the service and then submit a claim to Davis Vision for reimbursement up to the following amounts: eye examination -$40, single vision spectacle lenses - $50, bifocal spectacle lenses $80, trifocal spectacle lenses - $105, lenticular spectacle lenses -$110, frame $50, elective contact lenses - $105, medically necessary contact lenses- $225.

Vision Care Program Exclusions

Your vision plan does not cover: medical treatment of eye disease or injury; vision therapy; special lens designs, coatings or safety glasses, other than those described herein; replacement of lost eyewear; non-prescription (plano) lenses; contact lenses and eyeglasses in the same benefit cycle; services not performed by a licensed professional; or two pair of eyeglasses in lieu of bifocals.

General Claims Filing

In general, network providers handle the claims process for you. If you receive services and/or materials out-of-network, however, you will have to pay the provider and seek reimbursement through the claims process. Claims must be filed no later than 12 months from the date of service. Claims will generally be paid within 30 days of receipt. For reimbursement for out-of-network services, you must submit receipts to:

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

Receipts for services received together must be submitted together. Receipts for services and materials purchased on different dates must be submitted together.

The telephone number for inquiries to Davis Vision concerning claims is 1-800-999-5431.

Denials

If a claim is partially paid, you will receive a written notice explaining how the claim was processed and a notice of your appeal rights as to the unpaid portion. If a claim is denied in whole, a written Notice of Benefit Determination will be sent to you. This notice will include:

A. The address and timeframe for submitting an appeal.

B. A statement that an appeal must be submitted in writing, and any other information that should be included with the appeal request.

C. A statement that you have a right to submit written comments, documents, records and other information relating to the claim.

D. A statement that you will be provided, at no charge and upon request, reasonable access to and copies of all documents, records and other information relevant to the claim.

E. A statement that you and the Plan may have other voluntary dispute resolution options, such as mediation, and information about how to obtain information about such options.

F. A statement that you may have a right to bring a civil action under Section 502(a) of ERISA following denial of an appeal.

G. A statement that you will be provided, at no charge and upon request, a copy of any specific internal rules, guidelines or protocols that were relied upon in denying the claim.

H. A statement that you will be provided, upon request and at no additional charge, an explanation of any scientific or clinical basis for denying the claim.

You, or your duly authorized representative, may appeal the denial.

Appeals

Appeals should be submitted to: Davis Vision, Inc., P.O. Box 791 Latham, NY 12110, Attention: Quality Assurance.

Appeals must be in writing and received by Davis Vision within 180 days after your receipt of the Notice of Benefit Determination

Appeals will be decided within 30 days after receipt by Davis Vision. If an appeal is denied, a written Notice of Benefit Appeal Determination will be sent to you. This notice will include similar information to that in the Notice described in the previous Denials section.

Telephone inquiries concerning appeals should be made to Davis Vision Customer Services Department at 1-800-999-5431.

Subrogation – Vision Care Program

See page 48 for a discussion of subrogation as it applies to hospital as well as non-hospital benefits. It is also applicable to Vision Care Program benefits.

Coordination of Benefits – Vision Care Program

See page 112 for a complete discussion of coordination of benefits as it applies to hospital as well as non-hospital benefits. It is also applicable to Vision Care Program benefits.

SECTION THREE: SHORT TERM DISABILITY, DEATH AND ACCIDENTAL DEATH OR DISMEMBERMENT BENEFITS

Short Term Disability Benefits for Active Covered Employees

If an actively employed Covered Employee is fully and continuously disabled by a non-occupational accidental injury or illness that prevents him/her from working and which requires continuous medical care as certified by a medical professional, he/she will receive a payment of $300 per week, except as otherwise provided below.

Written certification of disability acceptable to Principal Life Insurance Company shall be required. Benefits for actively employed Covered Employees begin with the first day of disability due to non-occupational accidental injury, pregnancy complications or maternity, or the eighth day of disability due to a non-occupational illness, and will continue up to a maximum of 26 weeks for any one period of disability. Successive periods of disability due to the same, related or unrelated causes not separated by return to active employment status for 14 consecutive calendar days shall be considered one period of disability.

Claims for Short Term Disability benefits should be submitted with reasonable promptness following the onset of a period of disability. To file a claim, please call 1-877-257-6978. You will be asked a series of questions related to your employment and disability. Principal Life will utilize this information to set up and begin the review of your claim. It will be necessary for you to sign an authorization for your physician to release information to Principal Life for the claim review process.

Short Term Disability benefits will not be payable for any disability that

A. Results from willful self-injury or self-destruction, while sane or insane; or

B. Results from war or an act of war, riot, military service or insurrection; or

C. Results from the commission or attempted commission of a criminal act not the result of a medical condition (such as depression or addiction) or involving domestic violence; or

D. Is a new disability that begins after a prior Short Term Disability benefit payment period has ended or a claim for benefit has ended or a claim for benefits has been denied and you have not returned to active employment; or

E. Is a continuation of a disability for which a Short Term Disability benefit payment period has ended or a claim for benefits has been denied and you have not returned to active employment (except as provided for a recurring disability); or

F. Results from an injury or sickness for which workers' compensation (including a settlement) is paid; or

G. Is for any week in which unemployment compensation is paid; or

H. Is to a retiree, except where both: (a) the retiree is not receiving a pension benefit or is receiving a mandated "age 70 ½" retirement benefit and (b) is otherwise eligible for Welfare Fund benefits as a result of then- current employment for which contributions are being remitted by an Employer.

Social Security (FICA) and other applicable taxes must be withheld from Short Term Disability benefits paid to Active Covered Employees.

Death

The Fund has contracted with Principal Life Insurance Company to administer and provide the Death Benefits. Upon receipt of required proof, the following Death Benefits will be paid for deaths of eligible participants:

Actively Employed Employee	$ 10,000
Eligible Spouse	$ 5,000
Eligible Children from live birth and older*	$ 2,500

** Includes eligible, covered children through age 25 or those who have extended coverage and a child who qualifies for continued coverage as a handicapped child.*

Accidental Death or Accidental Dismemberment for Active Covered Employees Only

The Fund has contracted with Principal Life Insurance Company to administer and provide the Accidental Death and Dismemberment Benefits. In order to be eligible for Accidental Death and Dismemberment Benefits, the Employee must be eligible to receive Welfare Benefits and be an actively employed Employee who suffers injury due to accidental means. Your injury must be the direct and sole cause of loss and not be due to the limitations set as follows:

Accidental Death..... $ 10,000
(100% of Scheduled Benefit)

Accidental Loss of either:
A. both hands
B. both feet
C. sight of both eyes
D. combination of any two (hand, foot, sight in one eye) ..... $ 16,000
(160% of Scheduled Benefit)

Accidental Loss of either:
A. one hand
B. one foot
C. sight of one eye ..... $ 4,000
(40% of Scheduled Benefit)

Accidental Loss of the Thumb and Index finger on Same Hand..... $ 2,500
(25% of Scheduled Benefit)

Accidental Loss used in this section with reference to a hand or a foot is:

- A hand is severed at or above the wrist
- A foot is severed at or above the ankle

With reference to eye means the vision is not correctable to better than 20/200. No payments will be made for any Accidental Death and Dismemberment losses caused or contributed to by:

A. willful self-injury or self-destruction, while sane or insane; or

B. disease, medical or surgical treatment of disease, or complications following the surgical treatment of disease; or

C. voluntary participation in a riot, assault, felony, criminal activity, or insurrection; or

D. participating in flying, except as a passenger on a commercial aircraft or as a passenger in a Policyholder-owned or leased aircraft on company business; or

E. active duty as a member of a military organization in a country, excluding National Guard or reservists who are participating in training, drills, or weekend duties; or

F. war or act of war

Total payments for all Accidental Death and Dismemberment losses under the Benefits Payable that result from the same accident will not exceed $16,000. Total payment for loss of life will not exceed $10,000. Payment for loss of life will be paid to the beneficiary you named for Life Insurance. Payment for any other loss will be to you. The Accidental Death and Dismemberment benefits are payable for on and off the job losses.

Beneficiaries

Covered Employees are reminded of the need to designate primary and contingent beneficiaries for Death and Accidental Benefits. If the primary designated beneficiary for any Death and Accidental Benefits dies at the same time or within 15 days after the Covered Employee dies, but before the Principal received written proof of the Covered Employee's death, payments will be made to the contingent designated beneficiary, as if the primary beneficiary had died before the Covered Employee. If no designated beneficiary survives the Covered Employee, any Death and Accidental Benefits shall be paid in equal shares to the first of the following classes of survivors of the Covered Employee: (1) spouse; (2) children, legally born or adopted by Covered Employee; (3) parents; or (4) the estate of the Covered Employee. If a Covered Dependent dies, any resulting Death Benefits shall be paid to the Covered Employee, if living, or otherwise Covered Employee's contingent beneficiary. If no designated contingent beneficiary applies, benefits will be paid in equal shares to the first of the following classes of survivors of the Covered Dependent: (1) spouse; (2) children, legally born or adopted by Covered Employee; (3) parents; or (4) the estate of the Covered Dependent. A Covered Employee's rights to designate any beneficiary may be limited by the application of any Order issued by a court of competent jurisdiction.

The Covered Employee may change the beneficiary from time to time by submitting such change in writing in a document deemed appropriate by the Fund Office. Such change of beneficiary shall relate back and take effect as of the date the Covered Employee signed the changed designation of beneficiary document.

SECTION FOUR: RETIREE DEATH BENEFITS

Retiree Death Benefits

On and after January 1, 2011, upon the death of an individual who: (1) became a Retired Employee before January 1, 2011 entitled to monthly retirement annuity benefits from the Laborers' District Council of Western Pennsylvania Pension Fund, and (2) had a total of five years of Credited Service, as defined in the Benefit Plan of the Laborer's District Council of Western Pennsylvania Pension Fund, his beneficiary shall be paid the sum of $5,000.

Principal Life Insurance Company

Principal Life Insurance Company provides these retiree death benefits for such eligible Retired Employees under a group life insurance policy. To apply for the retiree death benefit, the beneficiary should contact the Fund Office and a claim form will be provided. After the claim form is completed by the beneficiary, it should be forwarded to the Fund Office, with an original certified death certificate for the deceased retiree. If you have any questions regarding the claim process, please call the Fund Office.

Designate Your Beneficiary

It is very important to identify a beneficiary for these death benefits on the proper form, which can be supplied by the Fund Office. If you wish to change your beneficiary, you must do so in writing, on a form that you can also obtain from the Fund Office.

If there is no beneficiary designated at the time of your death, benefits will be paid instead to your survivor(s) in the following order:

A. your spouse;

B. if there is no spouse, to your children;

C. if there is no spouse or child, to your parents; or

D. if there is no spouse, child or parent, to your estate.

SECTION FIVE: WELLNESS

What is "Wellness"?

Wellness programs are organized and coordinated programs that have the goal of enhancing the physical, mental, and emotional status of individuals. Over the next few years, the Fund will be working to develop ways to help promote your and your family's wellness and health through various programs. Additionally, the Fund will work to promote wellness by incorporating wellness into some of the benefits in which you already participate.

For example, the Fund has already begun this wellness initiative by allowing you and your spouse to voluntarily complete a Sharecare RealAge Test and have a routine physical with the appropriate diagnostic health screening every year in order to have the **in-network** deductible waived or reduced.

The Fund will develop several initiatives, programs and incentives to increase your health and health risk awareness and to promote healthier lifestyles and activities. Some of the aspects of wellness will be voluntary and some may be required as part of the Fund's ongoing efforts to support your healthier lifestyle.

As we continue to develop these programs, this Benefit Plan booklet will be updated and you will be provided with information about the programs so that you have the opportunity to take full advantage of them as they become available.

PART III – MEDICAL BENEFITS

SUMMARY OF BENEFITS

This Summary of Benefits is a brief description of covered services.

Benefit	Community Blue PPO		PPO Blue	
	In-Network	Out-of-Network	In-Network	Out-of-Network
	General Provisions			
PLAN YEAR (1)	**CALENDAR YEAR**			
Deductible (per year period) Individual Family	$800 $1,600 If you and your spouse voluntarily complete the wellness requirements, the in-network deductible is waived.	$1,600 $3,200	$2,000 $4,000 If you and your spouse voluntarily complete the wellness requirements the in-network individual deductible will be reduced to $1,200 and the family deductible will be reduced to $2,400.	$2,400 $4,800
Plan Pays – payment based on the plan allowance	100% after deductible	80% after deductible	100% after deductible	80% after deductible
Out-of-Pocket Limit (Once met, plan pays 100% coinsurance for the rest of the plan year) Individual Family	None None	$4,800 $9,600	None None	$4,800 $9,600
Total Maximum Out-of-Pocket (Includes deductible, coinsurance, copays, prescription drug cost sharing and other qualified medical expenses, Network only)(2) Once met, the plan pays 100% of covered services for the rest of the benefit period. Individual Family	$ 8,150 $16,300	Not Applicable Not Applicable	$ 8,150 $16,300	Not Applicable Not Applicable
	Office/Clinic/Urgent Care Visits			
Retail Clinic Visits & Virtual Visits	100% after $15 copayment	80% after deductible	100% after $15 copayment	80% after deductible
Primary Care Provider Office Visits & Virtual Visits	100% after $15 copayment	80% after deductible	100% after $15 copayment	80% after deductible
Specialist Office & Virtual Visits	100% after $30 copayment	80% after deductible	100% after $30 copayment	80% after deductible
Virtual Visit Originating Site Fee	100% after deductible	80% after deductible	100% after deductible	80% after deductible

Benefit	Community Blue PPO		PPO Blue	
	In-Network	Out-of-Network	In-Network	Out-of-Network
	Office/Clinic/Urgent Care Visits (CONTINUED)			
Urgent Care Center Visits	100% after $15 copayment	80% after deductible	100% after $15 copayment	80% after deductible
Telemedicine(3)	100% (deductible does not apply)	Not Covered	100% (deductible does not apply)	Not Covered
	Preventive Care (4)			
Routine Adult Physical exams	100% (deductible does not apply)	80% after deductible	100% (deductible does not apply)	80% after deductible
Adult immunizations	100% (deductible does not apply)	80% after deductible	100% (deductible does not apply)	80% after deductible
Colorectal cancer screening	100% (deductible does not apply)	80% after deductible	100% (deductible does not apply)	80% after deductible
Routine gynecological exams, including a Pap Test	100% (deductible does not apply)	80% (deductible does not apply)	100% (deductible does not apply)	80% (deductible does not apply)
Mammograms, annual routine and medically necessary	Routine and Medically Necessary: 100% (deductible does not apply)	80% after deductible	Routine and Medically Necessary: 100% (deductible does not apply)	80% after deductible
Diagnostic services and procedures	100% (deductible does not apply)	80% after deductible	100% (deductible does not apply)	80% after deductible
Routine Pediatric Physical exams	100% (deductible does not apply)	80% after deductible	100% (deductible does not apply)	80% after deductible
Pediatric immunizations	100% (deductible does not apply)	80% (deductible does not apply)	100% (deductible does not apply)	80% (deductible does not apply)
Diagnostic services and procedures	100% (deductible does not apply)	80% after deductible	100% (deductible does not apply)	80% after deductible
	Emergency Services			
Emergency Room Services	100% after $100 copayment (waived if admitted)		100% after $100 copayment (waived if admitted)	
Ambulance – Emergency (5)	100% after deductible		100% after deductible	
Ambulance – Non-Emergency (5)	100% after deductible	80% after deductible	100% after deductible	80% after deductible

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Benefit	Community Blue PPO		PPO Blue	
	In-Network	Out-of-Network	In-Network	Out-of-Network
	Hospital and Medical/Surgical Expenses (including maternity)			
Hospital Inpatient	100% after deductible	80% after deductible	100% after deductible	80% after deductible
Hospital Outpatient	100% after deductible	80% after deductible	100% after deductible	80% after deductible
Maternity (non-preventive facility & professional services) including dependent daughter	Facility: 100% after deductible Professional: 100% after $15 copayment	80% after deductible	Facility: 100% after deductible Professional: 100% after $15 copayment	80% after deductible
Medical Care (including inpatient visits and consultations)/ **Surgical Expenses**	100% after deductible	80% after deductible	100% after deductible	80% after deductible
	Therapy and Rehabilitation Services			
Physical Medicine	100% after $20 copayment per provider per date of service	80% after deductible	100% after $20 copayment per provider per date of service	80% after deductible
Respiratory Therapy	100% after deductible		100% after deductible	
Speech & Occupational Therapy	100% after $20 copayment per provider per date of service	80% after deductible	100% after $20 copayment per provider per date of service	80% after deductible
Spinal Manipulations & Acupuncture	100% after $20 copayment per provider per date of service	80% after deductible	100% after $20 copayment per provider per date of service	80% after deductible
Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy & Dialysis)	100% after deductible	80% after deductible	100% after deductible	80% after deductible
	Mental Health / Substance Abuse			
Inpatient	100% after deductible	80% after deductible	100% after deductible	80% after deductible
Inpatient Detoxification/ Rehabilitation	100% after deductible	80% after deductible	100% after deductible	80% after deductible
Outpatient Mental Health- Includes Virtual Behavioral Health Visits	100% after $15 copayment	80% after deductible	100% after $15 copayment	80% after deductible
Outpatient Substance Abuse Services	100% after $15 copayment	80% after deductible	100% after $15 copayment	80% after deductible

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Benefit	Community Blue PPO		PPO Blue	
	In-Network	Out-of-Network	In-Network	Out-of-Network
	Other Services			
Allergy Extracts and Injections	100% after deductible	80% after deductible	100% after deductible	80% after deductible
Autism Spectrum Disorder including Applied Behavior Analysis (6)	100% after deductible $40,000 maximum per member per plan year (includes prescription drug)	80% after deductible	100% after deductible $40,000 maximum per member per plan year (includes prescription drug)	80% after deductible
Assisted Fertilization Procedures	Not Covered		Not Covered	
Dental Services Related to Accidental Injury	100% after deductible	80% after deductible	100% after deductible	80% after deductible
Diagnostic Services *Advanced Imaging* (MRI, CAT, PET scan, etc.)	(7) **Member Savings Site:** 100% after deductible **All Other Network Providers:** 100% after deductible and $50 copayment applies	80% after deductible	(6) **Member Savings Site:** 100% after deductible **All Other Network Providers:** 100% after deductible and $50 copayment applies	80% after deductible
Basic Diagnostic Services (standard imaging and lab/pathology)	(7) **Member Savings Site:** 100% after deductible **All Other Network Providers:** 100% after deductible and $50 copayment applies	80% after deductible	(6) **Member Savings Site:** 100% after deductible **All Other Network Providers:** 100% after deductible and $50 copayment applies	80% after deductible
Basic Diagnostic Services (diagnostic medical and allergy testing)	(7) **Member Savings Site:** 100% after deductible **All Other Network Providers:** 100% after deductible and $50 copayment applies	80% after deductible	(6) **Member Savings Site:** 100% after deductible **All Other Network Providers:** 100% after deductible and $50 copayment applies	80% after deductible

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Benefit	Community Blue PPO		PPO Blue	
	In-Network	Out-of-Network	In-Network	Out-of-Network
	Other Services (CONTINUED)			
Durable Medical Equipment, Orthotics & Prosthetics	100% after deductible	80% after deductible	100% after deductible	80% after deductible
Routine Eye Exam / Foot Care Services	100% after deductible	80% after deductible	100% after deductible	80% after deductible
Hearing Aids	100% after deductible Limit: Up to $300 per ear 48 months after previous purchase	80% after deductible	100% after deductible Limit: Up to $300 per ear 48 months after previous purchase	80% after deductible
Home Health Care (8)	100% after deductible Limit: 120 visits/plan year	80% after deductible	100% after deductible Limit: 120 visits/plan year	80% after deductible
Hospice	100% after deductible	80% after deductible	100% after deductible	80% after deductible
Infertility Counseling, Testing and Treatment (9)	100% after deductible	80% after deductible	100% after deductible	80% after deductible
Private Duty Nursing	100% after network deductible		100% after network deductible	
Skilled Nursing Facility Care	100% after deductible	80% after deductible	100% after deductible	80% after deductible
Transplant Services	100% after deductible	80% after deductible	100% after deductible	80% after deductible
Precertification Requirements (10)	YES		YES	
Prescription Drug Program Soft Mandatory Generic (11) Defined by the National Pharmacy Network - Not Physician Network. Prescriptions filled at a non-network pharmacy are not covered. (12) Your plan uses the Comprehensive Formulary with an Incentive Benefit Design (13,14)	**Retail Drugs (30-day Supply)** $10 generic copay $25 formulary brand copay $50 non-formulary brand copay **Maintenance Prescription Drug Third fill at Retail Pharmacy** **Maintenance Drugs through Mail Order or CVS (90-day Supply)** $20 generic copay $50 formulary brand copay $100 non-formulary brand copay			

This is not a contract. This benefits summary presents plan highlights only. Please refer to the policy / plan documents, as limitations and exclusions apply. The policy / plan documents control in the event of a conflict with this benefit summary.

Footnotes*

1. Your group's plan year is based on a Calendar Year, January 1st through December 31st.
2. The Network Total Maximum Out-of-Pocket (TMOOP) is mandated by the federal government, TMOOP must include deductible, coinsurance, copays, prescription drug cost share and any qualified medical expense.
3. Services are provided for acute care for minor illnesses. Services must be performed by a Highmark approved telemedicine provider. Virtual Behavioral Health visits provided by a Highmark approved telemedicine provider are eligible under the Outpatient Mental Health/Substance Abuse benefit.
4. Services are limited to those listed on the Highmark Preventive Schedule (Women's Health Preventive Schedule may apply). Gender, age and frequency limits may apply.
5. Medically necessary Air Ambulance services rendered by out-of-network providers will be covered by the highest network tier level of benefits.
6. Coverage for eligible members to age 21. Services will be paid according to the benefit category (e.g. speech therapy). Treatment for autism spectrum disorders does not reduce visit/day limits.
7. Member Savings Sites are independent laboratories and x-ray/imaging centers that perform diagnostic services at a reduced rate as well as Ambulatory Surgical Centers that are multi-specialty and those delivering surgeries. Many providers may send their services out to a hospital for processing causing a facility charge in addition to the professional component, resulting in higher cost share for the member. When members use a Member Savings Site they can be confident that they will pay a lower cost share (i.e. not encountering multiple copays).
8. The maternity home health care visit for network care is not subject to the program copayment, coinsurance or deductible amounts, if applicable. See Maternity Home Health Care Visit in the Covered Services section.
9. Treatment includes coverage for the correction of a physical or medical problem associated with infertility. Contact Highmark Customer Service for the exact benefit.
10. Highmark Medical Management & Policy (MM&P) must be contacted prior to a planned inpatient admission or within 48 hours of an emergency or maternity-related inpatient admission. Be sure to verify that your provider is contacting MM&P for precertification. If this does not occur and it is later determined that all or part of the inpatient stay was not medically necessary or appropriate, you will be responsible for payment of any costs not covered.
11. You are responsible for the payments differential when a generic drug is authorized by the physician and the patient purchases a brand name drug. Your payment is the price difference between the brand drug and generic drug in addition to the brand drug copayment or coinsurance amounts which may apply
12. Certain retail participating pharmacy providers may have agreed to make covered medications available at the same cost-sharing and quantity limits as the mail order coverage. You may contact Highmark at 1-866-594-1732 or the website at Highmarkbcbs.com for a listing of those pharmacies who have agreed to do so.
13. The quantity level limit for your initial prescription order may be reduced, depending on the particular medication, to a quantity level necessary to establish that you can tolerate the medication. The cost-sharing provision indicated above will be adjusted accordingly for the initial prescription order based upon the initial quantity dispensed. If you are able to tolerate the medication, the remainder of the available days supply for the initial prescription order will be filled and you will be responsible for the balance of the applicable cost-sharing amount indicated above.
14. The Highmark formulary is an extensive list of Food & Drug Administration (FDA) approved prescription drugs selected for their quality, safety and effectiveness. It includes products in every major therapeutic category. The formulary was developed by the Highmark Pharmacy and Therapeutics Committee made up of clinical pharmacists and physicians and may, from time to time, be revised by the committee. Your program includes coverage for both formulary and non-formulary drugs at the specific copayment or coinsurance amounts listed above.

DISCLAIMER

The Laborers' District Council of Western Pennsylvania Welfare Fund and the Laborers' Combined Funds have prepared this summary for overview purposes only and all benefits effective 1/1/2022 are subject to the descriptions, definitions, and other details in the Welfare Fund Summary Plan Description and are tentative and subject to final review.

LEVELS OF BENEFITS

The Laborers' District Council of Western Pennsylvania Welfare Fund provides two Highmark plans for you to choose from, Community Blue and PPO Blue. While the benefits in both plans are identical there is a difference in the in-network providers and deductibles for which you would be financially responsible.

COMMUNITY BLUE

In the Community Blue PPO plan only Community Blue providers are considered **in-network providers**. Please note that when you use an in-network provider in this plan you will have an in-network individual deductible of $800 and a $1,600 family deductible. These in-network deductibles are waived if you and your spouse voluntarily complete the wellness requirements. Under this plan UPMC providers are considered **out-of-network providers**. When you use an out-of-network provider you will be responsible for a $1,600 individual deductible and a $3,200 family deductible as well as 20% coinsurance for those services. See the Summary of Benefits.

PPO BLUE

The PPO Blue plan includes all providers in the Highmark network including UPMC as **in-network providers**. This means that you will receive in-network benefits for all providers in the Highmark network including UPMC. Please note that when you use an in-network provider under this plan you will be responsible for a $2,000 individual deductible and a $4,000 family deductible. The in-network individual deductible will be reduced to $1,200 and the family deductible will be reduced to $2,400 if you and your spouse voluntarily complete the wellness requirements. If you use an out-of-network provider under this plan you will be responsible for an individual deductible of $2,400 and a family deductible of $4,800 as well as 20% coinsurance for those services. See the Summary of Benefits.

If you become eligible for benefits after the annual election period you and your dependents will automatically be enrolled in the Community Blue plan. You will then have the opportunity to elect PPO Blue in the next election period, unless you have a Qualifying Life Event.

If you made a plan election in a prior election period and regain eligibility you and your dependents will be enrolled in the previously selected plan and remain in that plan until a change is requested during a future election period or you have a Qualifying Life Event.

There will be an annual election period between October and November of each year when you will have the option to change your plan for you and your dependents for the following year. This election will be locked in for the entire following year unless you have a Qualifying Life Event.

If no election is made during the annual election period you and your dependent(s) will remain in your current Highmark plan until a change is elected during a future election period or you have a Qualifying Life Event.

HOW CAN MY IN-NETWORK DEDUCTIBLE BE WAIVED OR REDUCED?

The Community Blue plan of the Laborers' District Council of Western Pennsylvania Welfare Fund has a yearly **in-network** individual deductible of $800 and a family deductible of $1,600. You have the opportunity to have the **in-network** deductible waived if you and your spouse (if applicable) voluntarily elect to meet the wellness requirements by completing the Sharecare RealAge® Test and having a routine physical exam with the appropriate diagnostic health screenings. If the wellness requirements are met by September 30th every year the **in-network** deductible will be waived for the following calendar year.

The PPO Blue plan of the Laborers' District Council of Western Pennsylvania Welfare Fund has a yearly in-network individual deductible of $2,000 and a family deductible of $4,000. You have the opportunity to have the **in-network** deductible reduced to $1,200 individual or $2,400 family, if you and your spouse (if applicable) voluntarily elect to meet the wellness requirements by completing the Sharecare RealAge® Test and having a routine physical exam with the appropriate diagnostic health screenings. If the wellness requirements are met by September 30th every year the **in-network** deductible will be reduced for the following calendar year.

What is the RealAge® Test and how do I complete one?

A. The RealAge® Test (RAT) is a survey about your wellness and health.

B. The RAT is a confidential survey that provides you with information about your health.

C. The information you provide on the RAT will not be shared with the Fund, your Union, personnel at the Fund Office, your employer, or even your spouse. The information will not be used to assess or determine your eligibility for health care coverage. Only total group statistical information, regarding the large groups covered by the plans, will be shared with the Fund. This will ensure that your personal health information is kept completely confidential. The only thing that the Fund will know about the RAT is that you and your spouse completed it. The RAT is designed to help you understand your health and health risks and to help you make better choices about your health.

D. The personalized RAT will make it easier for you to set and reach health goals. In some cases, Highmark Blue Cross Blue Shield and its health program affiliates may be able to offer additional personalized services to you.

E. The information on your RAT and any feedback from Highmark Blue Cross Blue Shield should be shared with your physician.

F. You should complete the RAT online on the Sharecare website at mycare.sharecare.com **NOT** on **Sharecare.com**. You and your spouse MUST register with separate email addresses and passwords. If you and your spouse are taking the RAT on the same device one after the other, please leave the site and re-enter mycare.sharecare.com for the second RAT. You must register through a mobile browser or desktop NOT using the Sharecare app. If you have any difficulties accessing the RAT you can call Sharecare at 1-800-858-9063. If you do not have internet access, you may complete and mail a paper RAT. If you request a paper version of the RAT, be sure you are registered by Sharecare at the time of your request to earn credit. Call Sharecare at 1-800-858-9063 for the paper RAT and to be registered. Please be sure to call and request a paper RAT **NO LATER** than August 15th as it takes about 15 business days to receive the paper RAT once it is requested. **Note: If you are submitting a paper**

RAT the completion date will be determined by the date the profile is received not the date it is postmarked. It is strongly recommended that if at all possible, the RAT should be completed online.

G. The RAT must be voluntarily completed **every year by September 30th** by you and your spouse along with the routine physical and diagnostic health screening requirements to have the **in-network** deductible waived or reduced.

By completing the RAT, you and your spouse are voluntarily authorizing to release genetic information asked within the RAT.

What is the annual routine physical exam with appropriate diagnostic health screenings and what are the requirements?

A. If you and your spouse voluntarily elect to have an annual routine physical exam with health diagnostic screenings along with the completion of the Sharecare RealAge® Test (RAT) the **in-network** deductible will be waived or reduced.

B. Your routine exam and screening results are confidential between you and your medical professional provider. The Fund will be notified when you and your spouse complete the RAT, have physical exam(s) and have the health screenings. This part of the wellness requirement is strictly to help you understand your health and health risks and to help you make better choices about your health.

C. You and your doctor may decide if there are additional services or care that you may need as a result of the physical exam.

D. You and your spouse can obtain routine physical exams from your primary care physicians or other professional providers. You may also find a doctor by going to www.highmarkbcbs.com. If you have trouble accessing the website or do not have computer access, you can call Highmark Customer Service at 1-866-594-1732 to find providers in your area.

E. A minimum of one of the following diagnostic health screenings is required in conjunction with your physical exam to meet the wellness requirements:
   - Lipid Panel
   - Fasting Blood Glucose
   - Routine Cholesterol Screening

Ask if there are any special instructions for your exam or health screenings when making your appointment**. (Remember to use a Member Savings Site for your lab work to avoid the $50 copayment).**

The routine physical and diagnostic health screening requirements must be voluntarily completed **every year** by you and your spouse along with the RAT to have the **in-network** deductible waived or reduced.

If your spouse's preventive exam and diagnostic health screening are covered by another insurance company, please submit a copy of the explanation of benefits for the preventive exam and appropriate diagnostic health screenings to the Fund Office so it may be considered to satisfy their wellness requirement.

If you are eligible, or become eligible, for Welfare Fund benefits in the period from January 1st through June 30th, you and your spouse must voluntarily complete the RAT and have annual routine physical exam(s) with the diagnostic health screening **by September 30th of that year** in order to have the **in-network** deductible waived or reduced for the following year. Those who do not complete the requirements will be responsible for the in-network deductible effective on January 1st of the following year.

If you become eligible for Welfare Fund benefits between July 1st and December 31st of any year the **in-network** deductible will initially be waived or reduced and you and your spouse must voluntarily complete the RAT and have annual routine physical exam(s) with the diagnostic health screening by **September 30th of the following year** in order to meet the wellness requirements. Those who do not complete the requirements will be responsible for the in-network deductible effective on January 1st of the following year.

Having Your In-Network Deductible Waived or Reduced After the Voluntary Completion Period Has Passed

Once you are responsible for the **in-network** deductible you can have it waived or reduced by completing the wellness requirements. Once the wellness requirements have been met, the **in-network** deductible will be waived or reduced for you and your eligible dependents the first day of the following month.

If you fail to meet the September 30th deadline, the earliest the in-network deductible could be waived or reduced would be February 1st of the following year.

While on COBRA, your tier will remain the same as it was prior to when your COBRA began. (subject to any plan modifications made to the Welfare Plan for all participants). It is very important that you and your spouse continue to voluntarily meet the wellness requirements while you are on COBRA in order to have your in-network deductible waived or reduced once you achieve eligibility through paid hours. If you and your spouse elect not to complete the voluntary wellness requirements while on COBRA, the in-network deductible will not be waived or reduced once your COBRA coverage ends, and you achieve eligibility through paid hours.

TO AVOID A $50 COPAYMENT REMEMBER TO USE A MEMBER SAVINGS SITE FOR ALL YOUR LAB WORK AND IMAGING SERVICES

There could be a $50 copayment when you receive lab work or imaging services. You can avoid this copay by using a Member Savings Site. If the services you receive are billed as an outpatient hospital service you will be charged a $50 copay.

Even if you have testing done in your doctors' office, a clinic, etc., lab work and imaging services that are processed **and billed as an outpatient hospital service will result in a $50 copay that you will be responsible to pay.**

To get information on Highmark PPO participating Member Savings Sites near you do one of the following:

- Visit Highmark's website at www.highmarkbcbs.com
- Contact Highmark Customer Service at 1-866-594-1732
- Contact Highmark's MyCare Navigator at 1-888-258-3428 (1-888-BLUE-428)

IT IS YOUR RESPONSIBILITY TO USE A MEMBER SAVINGS SITE

MEDICAL PLANS

INTRODUCTION TO YOUR HEALTH CARE PROGRAMS

Disclosure
Your health benefits are provided under a benefit plan of the Laborers' District Council of Western Pennsylvania Welfare Fund.

Non-Assignment
Highmark is authorized by the member to make payments directly to providers furnishing Covered Services provided under the programs described in this benefit booklet; however, Highmark reserves the right to make these payments directly to the member. The right of a member to receive payment for a Covered Service described in this benefits booklet is not assignable, except to the extent required by law, nor may benefits described in this benefit booklet be transferred either before or after Covered Services are rendered. Any (direct or indirect) attempt to accomplish such an assignment shall be null and void. Nothing contained in this benefit booklet shall be construed to make Highmark Blue Cross Blue Shield, the group health plan or the group health plan sponsor liable to any assignee to whom a member may be liable for medical care, treatment, or services.

This booklet provides you with the information you need to understand your health care programs. We encourage you to take the time to review this information, so you understand how your health care programs work.

Refer to your Summary of Benefits on pages 1 and 60-65 of this booklet. The Summary of Benefits will tell you what you need to know about your benefits, exclusions and how your plan works.

For a number of reasons, we think you'll be pleased with your health care programs:

- ***Your health care programs give you freedom of choice.*** You are not required to select a primary care physician to receive covered care. You have access to a large provider network of physicians, hospitals, and other providers in the Highmark service area, as well as providers across the country who are part of the local Blue Cross and Blue Shield PPO network. For a higher level of coverage, you need to receive care from one of these network providers. However, you can go outside the local network and still receive care at the lower level of coverage. To locate a network provider near you, or to learn whether your current physician is in the network, contact Dedicated Customer Service at 1-866-594-1732, MyCare Navigator at 1-888-BLUE-428 or online at **www.highmarkbcbs.com.**
- ***Your health care programs give you "stay healthy" care.*** You are covered for a range of preventive care, including physical examinations and selected diagnostic tests. Preventive care is a proactive approach to health management that can help you stay on top of your health status and prevent more serious, costly care down the road.

You can review your Preventive Care Guidelines online at your Highmark member website. And, as a member of your health care program, you get important extras. Along with 24-hour assistance with any health care question via Blues On Call, your member website connects you to a range of self-service tools that can help you manage your coverage. You can also access programs and services designed to help you make and maintain healthy improvements. And you can access a wide range of care cost and care provider quality tools to assure you spend your health care dollars wisely.

We understand that prescription drug coverage is of particular concern to our members. You'll find in-depth information on these benefits in this booklet.

If you have any questions on your Highmark programs, please call the Dedicated Customer Service at 1-866-594-1732. For TTY/TDD hearing impaired service, please dial 711 and the number on the back of your ID card. (1-866-594-1732)

Information for Non-English-Speaking Members

Non-English-speaking members have access to clear benefits information. They can call Dedicated Customer Service at 1-866-594-1732to be connected to a language services interpreter line. Highmark Member Service representatives are trained to make the connection.

As always, we value you as a member, look forward to providing your coverage, and wish you good health.

How Your Benefits Are Applied

To help you understand your coverage and how it works, here's an explanation of some benefit terms found on your Summary of Benefits, which is included at the end of this booklet. For specific amounts, refer to your Summary of Benefits.

Plan Year

The specified period of time during which charges for covered services must be incurred in order to be eligible for payment by your program. A charge shall be considered incurred on the date you receive the service or supply for which the charge is made. Your plan year is a calendar year starting January 1.

Medical Cost-Sharing Provisions

Cost sharing is a requirement that you pay part of your expenses for covered services. The terms "copayment," "deductible" and "coinsurance" describe methods of such payment.

Coinsurance

The coinsurance is the specific percentage of the plan allowance for covered services that is your responsibility. You may be required to pay any applicable coinsurance at the time you receive care from a provider. Refer to the Plan Payment Level in the Summary of Benefits for the percentage amounts paid by the program.

Copayment

The copayment for certain covered services is the specific, upfront dollar amount which will be deducted from the plan allowance and is your responsibility. See the Summary of Benefits for the copayment amounts.

Deductible

The deductible is a specified dollar amount you must pay for covered services each plan year before the program begins to provide payment for benefits. See the Summary of Benefits for the deductible amount. You may be required to pay any applicable deductible at the time you receive care from a provider.

Family Deductible

The family deductible is a specified dollar amount of covered services that must be incurred by covered family members before the program begins to provide payment for benefits. See the Summary of Benefits for the family deductible amount.

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

When two or more covered family members are injured in the same accident, only one deductible will be applied to the aggregate of such charges.

Out-of-Pocket Limit
The out-of-pocket limit refers to the specified dollar amount of expense incurred for covered services in a plan year. When the specified dollar amount is attained, the level of benefit increases as specified in the Summary of Benefits. See the Summary of Benefits for the out-of-pocket limit.

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

Maximum
The greatest amount of benefits that the program will provide for covered services within a prescribed period of time. This could be expressed in dollars, number of days or number of services.

Out-of-Pocket Credit
If your group changes group health care expense coverage during your plan year, the amount you paid toward your out-of-pocket limit during the last partial plan year for services covered under your prior coverage will be applied to the network and out-of-network (combined) out-of-pocket limit of the initial plan year under this program. This credit is similarly applied toward your total maximum out-of-pocket for network covered services.

Prescription Drug Cost-Sharing Provisions
Cost-sharing is a requirement that you pay part of your covered expense. The following provision(s) describe the methods of such payment.

Prescription drug benefits are not subject to the overall program deductible or coinsurance.

Copayment
The copayment is the specific, upfront dollar amount you pay for covered medications which will be deducted from the provider's allowable price by Highmark. Your copayment obligation is the amount specified in the Summary of Benefits, or the cost of the covered medication, whichever is lower.

Covered Services - Medical Programs

Both Community Blue PPO and PPO Blue provide benefits for the following services you receive from a provider when such services are determined to be medically necessary and appropriate. All benefit limits, deductibles and copayment amounts are described in the Summary of Benefits.

Network care is covered at a higher level of benefits than out-of-network care. *For the lowest out-of-pocket costs, use a network provider. It is the members' responsibility to make sure that a provider is in the network, call Member Service at 1-866-594-1732. Or visit www.highmarkbcbs.com.*

Acupuncture Services

Acupuncture services for pain therapy when both of the following are true:

A. Another method of pain management has failed.

B. The service is performed by a provider in the provider's office.

Ambulance Service

Ambulance service providing local transportation by means of a specially designed and equipped vehicle used only for transporting the sick and injured:

A. from your home, the scene of an accident or medical emergency to a hospital or skilled nursing facility;

B. between hospitals; or

C. between a hospital and a skilled nursing facility;

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

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

Local transportation by means of a specially designed and equipped vehicle used only for transporting the sick and injured:

A. From a hospital to your home; or

B. From a skilled nursing facility to your home.

Anesthesia for Non-Covered Dental Procedures (Limited)

Benefits will be provided for general anesthesia and associated hospital and medical services normally related to the administration of general anesthesia which are rendered in connection with non-covered dental procedures or non-covered oral surgery. Benefits are provided for members age seven or under and for developmentally disabled members when determined by

Highmark to be medically necessary and appropriate and when a successful result cannot be expected for treatment under local anesthesia, or when a superior result can be expected from treatment under general anesthesia.

Autism Spectrum Disorders

Benefits are provided to members under 21 years of age for the following:

Diagnostic Assessment of Autism Spectrum Disorders

Medically necessary and appropriate assessments, evaluations or tests performed by a physician, licensed physician assistant, psychologist or certified registered nurse practitioner to diagnose whether an individual has an autism spectrum disorder.

Treatment of Autism Spectrum Disorders

Services must be specified in a treatment plan developed by a physician or psychologist following a comprehensive evaluation or reevaluation performed in a manner consistent with the most recent clinical report or recommendations of the American Academy of Pediatrics. Highmark may review a treatment plan for autism spectrum disorders once every six months, or as agreed upon between Highmark and the physician or psychologist developing the treatment plan.

Treatment may include the following medically necessary and appropriate services:

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

Dental Services Related to Accidental Injury

Dental services rendered by a physician immediately following an accidental injury to sound natural teeth. Follow-up services, if any, that are provided after the initial treatment to sound natural teeth are not covered. Injury as a result of chewing or biting shall not be considered an accidental injury.

This section does not apply to Benefits for Oral Surgery. Benefits for Oral Surgery are described under Special Surgery.

Diabetes Treatment

Coverage is provided for the following when required in connection with the treatment of diabetes and when prescribed by a physician legally authorized to prescribe such items under the law:

A. Equipment and supplies: Blood glucose monitors, monitor supplies, and insulin infusion devices

B. Diabetes Education Program*: When your physician certifies that you require diabetes education as an outpatient, coverage is provided for the following when rendered through a diabetes education program:
   a. Visits medically necessary and appropriate upon the diagnosis of diabetes
   b. Subsequent visits under circumstances whereby your physician: a) identifies or diagnoses a significant change in your symptoms or conditions that necessitates changes in your self-management, or b) identifies, as medically necessary and appropriate, a new medication or therapeutic process relating to your treatment and/or management of diabetes

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

Diagnostic Services

Benefits will be provided for the following covered services when ordered by a professional provider:

A. **Advanced Imaging Services** include, but are not limited to, computed tomography (CT), computed tomographic angiography (CTA), magnetic resonance imaging (MRI), magnetic resonance angiography (MRA), positron emission tomography (PET scan), positron emission tomography/computed tomography (PET/CT scan).

B. **Basic Diagnostic Services**

C. **Standard Imaging Services** – procedures such as skeletal x-rays, ultrasound and fluoroscopy

D. **Laboratory and Pathology Services** – procedures such as non-routine Papanicolaou (PAP) smears, blood tests, urinalysis, biopsies and cultures

E. **Diagnostic Medical Services** – procedures such as electrocardiograms (ECG), electroencephalograms (EEG), echocardiograms, pulmonary studies, stress tests, audiology testing

F. **Allergy Testing Services** – allergy testing procedures such as percutaneous, intracutaneous, and patch tests

Durable Medical Equipment

The rental or, at the option of Highmark, the purchase, adjustment, repairs and replacement of durable medical equipment for therapeutic use when prescribed by a professional provider within the scope of their license. Rental costs cannot exceed the total cost of purchase.

Enteral Foods

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

Coverage is provided for enteral foods when administered on an outpatient basis for:

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

Once it is determined that you meet the above criteria, coverage for enteral formulae will continue as long as it represents at least 50% of your daily caloric requirement.

Coverage for enteral formulae <u>excludes</u> the following:

A. Blenderized food, baby food, or regular shelf food
B. Milk or soy-based infant formulae with intact proteins
C. Any formulae, when used for the convenience of you or your family members
D. Nutritional supplements or any other substance utilized for the sole purpose of weight loss or gain, or for caloric supplementation, limitation or maintenance
E. Semisynthetic intact protein/protein isolates, natural intact protein/protein isolates, and intact protein/protein isolates, when provided orally
F. Normal food products used in the dietary management of rare hereditary genetic metabolic disorders

This coverage does not include normal food products used in the dietary management of the disorders included above.

Hearing Care Services

Benefits include coverage for diagnostic testing, and purchase and/or replacement of hearing aid devices, when prescribed by a professional provider when the hearing loss is due to an illness or accident which is not work related.

Benefits for replacement hearing aids are provided up to a limit of $300 per ear, if replaced after 48 months of the initial or previous purchase.

Home Health Care/Hospice Care Services

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

A. Skilled nursing services of a Registered Nurse (RN) or Licensed Practical Nurse (LPN), excluding private duty nursing services
B. Physical medicine, speech therapy and occupational therapy
C. Medical and surgical supplies provided by the home health care agency or hospital program for home health care or hospice care
D. Oxygen and its administration
E. Medical social service consultations
F. Health aide services when you are also receiving covered nursing services or therapy and rehabilitation services
G. Family counseling related to the member's terminal condition

No home health care/hospice benefits will be provided for:

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

Home Infusion and Suite Infusion Therapy Services

Benefits will be provided when performed by a home infusion and/or suite infusion therapy provider at an infusion suite or in a home setting. This includes pharmaceuticals, pharmacy services, intravenous solutions, medical/surgical supplies and nursing services associated with infusion therapy. Specific adjunct non-intravenous therapies are included when administered only in conjunction with infusion therapy.

Hospital Services

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

Inpatient Services

Bed and Board

Bed, board and general nursing services are covered when you occupy:

A. a semi-private room with two or more beds;

B. a private room. Private room allowance is the average semi-private room charge; or

C. a bed in a special care unit which is a designated unit which has concentrated all facilities, equipment and supportive services for the provision of an intensive level of care for critically ill patients.

Ancillary Services

Hospital services and supplies including, but not restricted to:

A. use of operating, delivery and treatment rooms and equipment;

B. drugs and medicines provided to you while you are an inpatient in a facility provider;

C. whole blood, administration of blood, blood processing, and blood derivatives;

D. anesthesia, anesthesia supplies and services rendered in a facility provider by an employee of the facility provider. Administration of anesthesia ordered by the attending professional provider and rendered by a professional provider other than the surgeon or assistant at surgery;

E. medical and surgical dressings, supplies, casts and splints;

F. diagnostic services; or

G. therapy and rehabilitation services.

Outpatient Services

Ancillary Services

Hospital services and supplies including, but not restricted to:

A. use of operating, delivery and treatment rooms and equipment;

B. drugs and medicines provided to you while you are an outpatient in a facility provider;

C. whole blood, administration of blood, blood processing, and blood derivatives;

D. anesthesia, anesthesia supplies and services rendered in a facility provider by an employee of the facility provider. Administration of anesthesia ordered by the attending professional provider and rendered by a professional provider other than the surgeon or assistant at surgery;

E. medical and surgical dressings, supplies, casts and splints.

Pre-Admission Testing

Tests and studies, as indicated in the Basic Diagnostic Services subsection above, required in connection with your admission rendered or accepted by a hospital on an outpatient basis prior to a scheduled admission to the hospital as an inpatient.

Surgery

Hospital services and supplies for outpatient surgery including removal of sutures, anesthesia, anesthesia supplies and services rendered by an employee of the facility provider, other than the surgeon or assistant at surgery.

Emergency Care Services
In emergency situations, where you must be treated immediately, go directly to your nearest hospital emergency provider; or call "911" or your area's emergency number.

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

Your outpatient emergency room visits are subject to a copayment, which is waived if you are admitted as an inpatient.

Once the crisis has passed, call your physician to receive appropriate follow-up care.

Refer to the Terms You Should Know section for a definition of emergency care services. Treatment for any occupational injury for which benefits are provided under any worker's compensation law or any similar occupational disease law is not covered.

Observation Care and Emergency Room
Emergency Room doctors may continue emergency treatment for a patient that is considered observation (per CMS guidelines). Observation care is an outpatient option that is used when a patient's condition needs to be evaluated promptly, but the appropriateness of an inpatient admission has not been confirmed. Unfortunately, observation care can and does mirror inpatient care since observation patients may stay for many days and nights in a hospital bed, receive medical and nursing care, diagnostic tests, treatments, supplies, medications and food. The classification of the patient is considered "outpatient" and not inpatient.

Emergency Room and Observation claims are administered as follows: if the ER stay spans multiple dates of service on the same claim, the ER copayment will be applied on a three (3) floating benefit period. Typically what that means to a member is if the observation spans over 72 hours they will be charged an additional ER copayment.

Example:

- ***Member goes to ER – member is not admitted as an inpatient however is kept in observation for 68 hours then released. The member will be charged one (1) copayment.***
- ***Member goes to ER – member is not admitted as an inpatient however is kept in observation for 75 hours then released. The member will be charged two (2) copayments.***

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

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

Consultation
Consultation services rendered to an inpatient by another professional provider at the request of the attending professional provider. Consultation does not include staff consultations which are required by facility provider rules and regulations.

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

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

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

Maternity Services

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

Hospital, medical and surgical services rendered by a facility provider or professional provider for:

Complications of Pregnancy
Physical effects directly caused by pregnancy but which are not considered from a medical viewpoint to be the effect of normal pregnancy, including conditions related to ectopic pregnancy or those that require cesarean section.

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

Under Federal law, your self-insured group health program generally 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 cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or newborn earlier than 48 hours (or 96 as applicable). In any case, under Federal law, your self-insured program can only require that a provider obtain authorization for prescribing an inpatient hospital stay that exceeds 48 hours (or 96 hours).

Normal Pregnancy
Normal pregnancy includes any condition usually associated with the management of a difficult pregnancy but is not considered a complication of pregnancy.

Nursery Care
Covered services provided to the newborn child from the moment of birth, including care which is necessary for the treatment of medically diagnosed congenital defects, birth abnormalities, prematurity and routine nursery care. Routine nursery care includes inpatient medical visits by a professional provider. Benefits will continue for a maximum of 31 days. To be covered as a dependent beyond the 31-day period, the newborn child must be enrolled as a dependent under this program within such period.

If you are pregnant, now is the time to enroll in the Baby Blueprints® Maternity Education and Support Program offered by Highmark. Please refer to the Member Services section of this booklet for more information.

Mental Health Care Services

Your mental health is just as important as your physical health. That's why your Highmark plans provide professional, confidential mental health care that addresses your individual needs. You have access to a wide range of mental health and substance abuse professional providers, so you can get the appropriate level of responsive, confidential care.

You are covered for a full range of counseling and treatment services. Your program covers the following services you receive from a provider to treat mental illness:

Inpatient Facility Services
Inpatient hospital services provided by a facility provider or residential treatment facility provider that satisfies the criteria established by the plan for the treatment of mental illness.

Inpatient Medical Services

- Covered inpatient medical services provided by a professional provider:
- Individual psychotherapy
- Group psychotherapy
- Psychological testing
- Counseling with family members to assist in your diagnosis and treatment
- Electroshock treatment or convulsive drug therapy including anesthesia when administered concurrently with the treatment by the same professional provider

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

Outpatient Mental Health Care Services
Inpatient facility service and inpatient medical benefits (except room and board) provided by a facility provider or professional provider as previously described, are also available when you

are an outpatient, including a virtual visit between you and a specialist via an audio and video telecommunications system.

Substance Abuse Procedure

- If a member tests positive for substance abuse, the member is encouraged to seek treatment for Substance Abuse.
- To initiate the process, member calls the Highmark Behavioral Unit (Unit) at 1-800-258-9808.
- The Unit will assist the member in locating the best treatment facility based on the member's preference and location for an evaluation. Most treatment facilities offer treatment evaluations at no cost to the member. Treatment evaluations may be scheduled in advance or provided on a walk-in basis.
- During the call to the Unit the members needs **to "ask for a referral to a Highmark Behavioral Coach"** (Coach). The referral to the Coach will result in a follow up call from the Coach to the member.
- When the member's evaluation by a treatment facility is completed, the facility will recommend a treatment plan for the member.
- Upon admission to the treatment program the member will complete an Authorization to Disclose Health Information (ADHI) form.
- Upon completion of the treatment plan, the treating provider will inform the Coach of the member's status, i.e., treatment was completed successfully or not completed successfully.
- The Coach will inform the Laborers' about the member's treatment completion status.
- The Coach will remain available to the member for any additional case management or other services that may be of benefit to the member.

Orthotic Devices

Purchase, fitting, necessary adjustment, repairs and replacement of a rigid or semi-rigid supportive device which restricts or eliminates motion of a weak or diseased body part.

Outpatient Medical Care Services (Office Visits)

Medical care rendered by a professional provider when you are an outpatient for a condition not related to surgery, pregnancy or mental illness, except as specifically provided. Benefits include medical care visits and consultations for the examination, diagnosis and treatment of an injury or illness.

Please note that as a Highmark member, you enjoy many convenient options for where you can receive outpatient care. You can physically go to one of the following providers:

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

Or you can interact with a professional provider as follows:

- A virtual visit between you and a PCP or retail clinic via an audio and video telecommunications system
- A virtual visit between you and a specialist via the internet or similar electronic communications for the treatment of skin conditions or diseases
- A specialist virtual visit between you and a specialist via audio and video telecommunications. Benefits are provided for a specialist virtual visit when you communicate with the specialist from any location, such as your home, office or another mobile location, or if you travel to a provider-based location referred to as a 'provider originating site. If you communicate with the specialist from a provider originating site, you will be responsible for the specialist virtual visit provider originating site fee. Benefits will not be provided for a specialist virtual visit if the visit is related to the treatment of mental illness or substance abuse.

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

Allergy Extract/Injections
Benefits are provided for allergy extract and allergy injections.

Therapeutic Injections
Therapeutic injections required in the diagnosis, prevention and treatment of an injury or illness.

Preventive Care Services

Preventive benefits are offered in accordance with a predefined schedule based on age, sex and certain risk factors. The schedule of covered services is periodically reviewed based on the requirements of the Patient Protection Affordable Care Act of 2010, and advice from organizations such as the American Academy of Pediatrics, the U.S. Preventive Services Task Force, the Blue Cross Blue Shield Association and medical consultants. Therefore, the frequency and eligibility of services is subject to change. Benefits include periodic physical examinations, well child visits, immunizations and selected diagnostic tests. For a current schedule of covered services, log onto your Highmark member website, www.highmarkbcbs.com, or call Dedicated Customer Service at 1-866-594-1732. Benefits will be provided for covered services. Refer to the Summary of Benefits.

Adult and Pediatric Care
Routine physical examinations, regardless of medical necessity and appropriateness, including a complete medical history for adults, and other items and services. Well-woman benefits are provided for female members for items and services including, but not limited to, an initial physical examination to confirm pregnancy, screening for gestational diabetes, coverage for contraceptive methods and counseling and breastfeeding support and counseling.
Periodic testing for hazardous materials and asbestos testing for the contract holders only.

Adult Immunizations
Benefits are provided for adult immunizations, including the immunizing agent, when required for the prevention of disease.

Colorectal Cancer Screenings
Benefits are provided for the following tests or procedures when ordered by a physician for the purpose of early detection of colorectal cancer:

- Basic diagnostic laboratory and pathology screening services such as a fecal-occult blood or fecal immunochemical test
- Basic diagnostic standard imaging screening services such as barium enema
- Surgical screening services such as flexible sigmoidoscopy and colonoscopy and hospital services related to such surgical screening services
- Such other basic diagnostic laboratory and pathology, basic diagnostic standard imaging, surgical screening tests, basic diagnostic medical and advanced imaging screening services consistent with approved medical standards and practices for the detection of colon cancer

Benefits are provided for members 50 years of age or older as follows, or more frequently and regardless of age when prescribed by a physician:

- An annual fecal-occult blood test or fecal immunochemical test
- A sigmoidoscopy every five years
- A screening barium enema or test consistent with approved medical standards and practices to detect colon cancer every five years
- A colonoscopy every 10 years

If you are determined to be at high or increased risk, regardless of age, benefits are provided for a colonoscopy or any other combination of covered services related to colorectal cancer screening when prescribed by a physician and in accordance with the American Cancer Society guidelines on screening for colorectal cancer as of January 1, 2008.
Colorectal cancer screening services which are otherwise not described herein and are prescribed by a physician for a symptomatic member are not considered preventive care services. The payment for these services will be consistent with similar medically necessary and appropriate covered services.

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

Foot Care
Foot care including palliative or cosmetic foot care such as flat foot conditions, supportive devices for the foot, the treatment of subluxations of the foot, care of corns, bunions, calluses, toe nails, fallen arches, weak feet, chronic foot strain, symptomatic complaints of the feet, shoe orthotics, nail trimming, cutting and debriding.

Mammographic Screening
Benefits are provided for the following:

- An annual routine mammographic screening starting at 40 years of age or older pursuant to the 2002 recommendations by the United States Preventive Services Task Force.
- Mammographic screenings for all members regardless of age when such services are prescribed by a physician.

Benefits for mammographic screening are payable only if performed by a mammography service provider who is properly certified by the Pennsylvania Department of Health in accordance with the Mammography Quality Assurance Act of 1992.

Pediatric Immunizations
Benefits are provided for those pediatric immunizations, including the immunizing agents, which conform with the standards of the Advisory Committee on Immunization Practices of the Center for Disease Control and U.S. Department of Health and Human Services.

Routine Eye Examination
Benefits will be provided for one comprehensive, routine eye examination, including but not limited to eye refraction and glaucoma testing, limited to one every other calendar year.

Routine Gynecological Examination and Pap Test
Benefits are provided for one routine gynecological examination, including a pelvic and clinical breast examination, and one routine Papanicolaou smear (pap test) per calendar year.

Routine Screening Tests and Procedures
Benefits are provided for routine screening tests and procedures, regardless of medical necessity and appropriateness.

Tobacco Use, Counseling and Interventions
Benefits are provided for screenings for tobacco use and, for those who use tobacco products, two tobacco cessation attempts per year. A tobacco cessation attempt includes four tobacco cessation counseling sessions and covered medications.

Private Duty Nursing Services

Services of an actively practicing Registered Nurse (RN) or Licensed Practical Nurse (LPN) when ordered by a physician, providing such nurse does not ordinarily reside in your home or is not a member of your immediate family.

- If you are an inpatient in a facility provider only when Highmark determines that the nursing services required are of a nature or degree of complexity or quantity that could not be provided by the regular nursing staff.
- If you are at home only when Highmark determines that the nursing services require the skills of an RN or an LPN.

Prosthetic Appliances

Purchase, fitting, necessary adjustments, repairs, and replacements of prosthetic devices and supplies which replace all or part of an absent body organ and its adjoining tissues, or replace all

or part of the function of a permanently inoperative or malfunctioning body organ (excluding dental appliances and the replacement of cataract lenses). Initial and subsequent prosthetic devices to replace the removed breast(s) or a portion thereof are also covered.

Wigs that are provided in relation to a medical condition. Benefits are limited to $500 per purchase.

Skilled Nursing Facility Services

Services rendered in a skilled nursing facility to the same extent benefits are available to an inpatient of a hospital.

No benefits are payable:

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

Spinal Manipulations

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

Substance Abuse Services

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

- Inpatient hospital or substance abuse treatment facility services for detoxification
- Substance abuse treatment facility services for non-hospital inpatient residential treatment and rehabilitation services
- Outpatient hospital or substance abuse treatment facility or outpatient substance abuse treatment facility services for rehabilitation therapy

For purposes of this benefit, a substance abuse service provided on a partial hospitalization basis shall be deemed an outpatient care visit and is subject to any outpatient care cost-sharing amounts.

Surgical Services

This program covers the following services you receive from a professional provider. See the Health Care Management section for additional information which may affect your benefits.

Anesthesia

Administration of anesthesia for covered surgery when ordered by the attending professional provider and rendered by a professional provider other than the surgeon or the assistant at surgery. Benefits will also be provided for the administration of anesthesia for covered oral

surgical procedures in an outpatient setting when ordered and administered by the attending professional provider.

Assistant at Surgery
Services of a physician who actively assists the operating surgeon in the performance of covered surgery.

Mastectomy and Breast Cancer Reconstruction
Benefits are provided for a mastectomy performed on an inpatient or outpatient basis and for the following:

- All stages of reconstruction of the breast on which the mastectomy has been performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses; and
- Treatment of physical complications of mastectomy, including lymphedema

Benefits are also provided for one home health care visit, as determined by your physician, within 48 hours after discharge, if such discharge occurred within 48 hours after an admission for a mastectomy.

Special Surgery

Oral Surgery
Benefits are provided for the following limited oral surgical procedures determined to be medically necessary and appropriate:

- Extraction of impacted third molars when partially or totally covered by bone
- Extraction of teeth in preparation for radiation therapy
- Mandibular staple implant, provided the procedure is not done to prepare the mouth for dentures
- Lingual frenectomy, frenotomy or frenoplasty (to correct tongue-tie)
- Facility provider and anesthesia services rendered in a facility setting in conjunction with non-covered dental procedures when determined by Highmark to be medically necessary and appropriate due to your age and/or medical condition
- Accidental injury to the jaw or structures contiguous to the jaw except teeth
- The correction of a non-dental physiological condition which has resulted in a severe functional impairment
- Treatment for tumors and cysts requiring pathological examination of the jaw, cheeks, lips, tongue, roof and floor of the mouth
- Orthodontic treatment of congenital cleft palates involving the maxillary arch, performed in conjunction with bone graft surgery to correct the bony deficits associated with extremely wide clefts affecting the alveolus
- Extraction of full and partial bony symptomatic wisdom teeth.
- Five or more teeth removed at one time at one sitting in a dentist office or hospital.

Sterilization

- Sterilization regardless of medical necessity and appropriateness.

Second Surgical Opinion

A consulting physician's opinion and directly related diagnostic services to confirm the need for recommended elective surgery.

Keep in mind that:

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

Surgery

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

Temporomandibular Joint Disorder Treatment (TMJ)

Benefits provided for the treatment of temporomandibular joint (TMJ) disorders, whether the services are considered to be medical or dental in nature.

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

Benefits provided include diagnosis evaluation, panorex, physical therapy ultrasound and mandibular repositioning therapy of the joint. Benefits will also be provided for any splint, occlusal guard or appliance.

Therapy and Rehabilitation Services

This program covers the following services when such services are ordered by a physician:

- Cardiac rehabilitation
- Chemotherapy
- Dialysis treatment
- Infusion therapy when performed by a facility provider or ancillary provider and for self-administration if the components are furnished and billed by a facility provider or ancillary provider
- Occupational therapy
- Physical medicine
- Radiation therapy
- Respiratory therapy
- Speech therapy

Transplant Services

Benefits will be provided for covered services furnished by a hospital which are directly and specifically related to the transplantation of organs, bones, tissue or blood stem cells.

If a human organ, bone, tissue or blood stem cell transplant is provided from a living donor to a human transplant recipient:

- when both the recipient and the donor are members, each is entitled to the benefits of their program;
- when only the recipient is a member, both the donor and the recipient are entitled to the benefits of this program subject to the following additional limitations: 1) the donor benefits are limited to only those not provided or available to the donor from any other source, including, but not limited to, other insurance coverage, other Blue Cross or Blue Shield coverage or any government program; and 2) benefits provided to the donor will be charged against the recipient's coverage under this program to the extent that benefits remain and are available under this program after benefits for the recipient's own expenses have been paid;
- when only the donor is a member, the donor is entitled to the benefits of this program, subject to the following additional limitations: 1) the benefits are limited to only those not provided or available to the donor from any other source in accordance with the terms of this program; and 2) no benefits will be provided to the non-member transplant recipient; and
- if any organ, tissue or blood stem cell is sold rather than donated to the member recipient, no benefits will be payable for the purchase price of such organ, tissue or blood stem cell; however, other costs related to evaluation and procurement are covered up to the member recipient's program limit.

COVERED SERVICES – PRESCRIPTION DRUG PROGRAM

Prescription drugs are covered when you purchase them through the pharmacy network applicable to your program. For convenience and choice, these pharmacies include both major chains and independent stores. To locate a network pharmacy, go to www.highmarkbcbs.com, log in and choose **Prescriptions**. Or call Member Service at 1-866-594-1732. *No benefits area available if drugs are purchased from a non-network pharmacy.*

To help contain costs, if a generic drug is available, you will be given the generic. As you probably know, generic drugs have the same chemical composition and therapeutic effects as brand names and must meet the same FDA requirements.

Should you purchase a brand name drug when a generic is available and authorized by your doctor, you must pay the price difference between the brand and generic prices in addition to the applicable copayment or coinsurance amount.

Covered Drugs

Covered drugs include:

- those which, under Federal law, are required to bear the legend: "Caution: Federal law prohibits dispensing without a prescription;"
- legend drugs under applicable state law and dispensed by a licensed pharmacist;
- prescription drugs listed in your prescription drug formulary;
- preventive drugs that are offered in accordance with a predefined schedule and are prescribed for preventive purposes. Highmark periodically reviews the schedule based on legislative requirements and the advice of the American Academy of Pediatrics, the U.S. Preventive Services Task Force, the Blue Cross Blue Shield Association and medical consultants. Therefore, the frequency and eligibility of services is subject to change. For a current schedule of covered preventive drugs, log onto the member website at www.highmarkbcbs.com, or call Dedicated Customer Service at 1-866-594-1732;
- prescribed injectable insulin;
- diabetic supplies, including needles and syringes; and
- certain drugs that may require prior authorization

Specialty Tier Drugs

Specialty drugs are unique, high cost products that are intended to be used in a limited number of individuals, require special handling, and/or require special or limited distribution systems. Specialty drugs include, but are not limited to biotechnology and other injectable products, chemotherapeutic agents, and novel oral agents. See your Summary of Benefits for the specific cost sharing amounts which apply to specialty drugs.

Exclusive Pharmacy Provider
Covered drugs also include selected prescription drugs within, but not limited to, the following drug classifications only when such drugs are covered medications and are dispensed through an exclusive pharmacy provider. These particular prescription drugs will be limited to your benefit program's retail cost-sharing provisions and retail days supply.

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

- Oncology-related therapies
- Interferons
- Agents for multiple sclerosis and neurological related therapies
- Antiarthritic therapies
- Anticoagulants
- Hematinic agents
- Immunomodulators
- Growth hormones
- Hemophilia related therapies
- Fertility drugs

For a complete listing of those prescription drugs that must be obtained through an exclusive pharmacy provider, contact Dedicated Customer Service at 1-866-594-1732.

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

To receive a copy of the formulary, call Dedicated Customer Service at 1-866-594-1732.

You can also look up the formulary via Highmark's Web site, www.highmarkbcbs.com.

These listings are subject to periodic review and modification by Highmark or a designated committee of physicians and pharmacists.

WHAT IS NOT COVERED

Except as specifically provided in this program or as Highmark is mandated or required to provide based on state or federal law, no benefits will be provided for services, supplies, prescription drugs or charges:

Key Word	Exclusion
Allergy Testing	For allergy testing, except as provided herein.
Ambulance	For ambulance services, except as provided herein.
Assisted Fertilization	Related to treatment provided specifically for the purpose of assisted fertilization, including pharmacological or hormonal treatments used in conjunction with assisted fertilization.
Comfort / Convenience Items	For personal hygiene and convenience items such as, but not limited to, air conditioners, humidifiers, or physical fitness equipment, stair glides, elevators/lifts or "barrier free" home modifications, whether or not specifically recommended by a professional provider.
Cosmetic Surgery	For operations for cosmetic purposes done to improve the appearance of any portion of the body, and from which no improvement in physiological function can be expected, except as otherwise provided herein. Other exceptions to this exclusion are: a) surgery to correct a condition resulting from an accident; b) surgery to correct a congenital birth defect; and c) surgery to correct a functional impairment which results from a covered disease or injury.
Court Ordered Services	For otherwise covered services ordered by a court or other tribunal as part of your or your dependent's sentence.
Custodial Care	For custodial care, domiciliary care, protective and supportive care including educational services, rest cures and convalescent care.
Dental Care	Directly related to the care, filling, removal or replacement of teeth, except as previously defined, the treatment of injuries to or diseases of the teeth, gums or structures directly supporting or attached to the teeth. These include, but are not limited to, apicoectomy (dental root resection), root canal treatments, soft tissue impactions, alveolectomy and treatment of periodontal disease, except for dental expenses related to accidental injury, anesthesia for non-covered dental procedures and orthodontic treatment for congenital cleft palates as provided herein.
Diabetes Prevention Program	For a diabetes prevention program offered by other than a network diabetes prevention provider or a YMCA diabetes prevention eligible provider.
Effective Date	Rendered prior to your effective date of coverage.
Enteral Foods	For the following services associated with the additional enteral foods benefits provided under your program: blenderized food, baby food, or regular shelf food; milk or soy-based infant formulae with intact proteins; any formulae, when used for the convenience of you or your family members; nutritional supplements or any other substance utilized for the sole purpose of weight loss or gain, or for caloric supplementation, limitation or maintenance; semisynthetic intact protein/protein isolates, natural intact protein/protein isolates, and intact protein/protein isolates, when provided orally; normal food products used in the dietary management of the disorders provided herein.

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Key Word	Exclusion
Experimental / Investigative	Which are experimental/investigative in nature.
Eyeglasses/ Contact Lenses	For eyeglasses or contact lenses and the vision examination for prescribing or fitting eyeglasses or contact lenses (except for the initial pair of contact lenses/glasses prescribed following cataract extraction in place of surgically implanted lenses, or sclera shells intended for use in the treatment of disease or injury).
Felonies	For any illness or injury you suffer during your commission of a felony, as long as such illness or injuries are not the result of a medical condition or an act of domestic violence.
Health Care Management program	For any care, treatment, prescription drug or service which has been disallowed under the provisions of Health Care Management program.
Home Health Care	For the following services you receive from a home health care agency, hospice or a hospital program for home health care and/or hospice care: dietitian services; homemaker services; maintenance therapy; dialysis treatment; custodial care; food or home-delivered meals.
Immunizations	For immunizations required for foreign travel or employment, except as provided herein..
Inpatient Admissions	For inpatient admissions which are primarily for diagnostic studies.
	For inpatient admissions which are primarily for physical medicine services.
Learning Disabilities	For any care that is related to conditions such as hyperkinetic syndromes, learning disabilities, behavioral problems or mental retardation, but not including care related to autism spectrum disorders, which extends beyond traditional medical management or for inpatient confinement for environmental change. Care which extends beyond traditional medical management or for inpatient confinement for environmental change includes the following: a) services that are primarily educational in nature, such as academic skills training or those for remedial education or those that may be delivered in a classroom-type setting, including tutorial services; b) neuropsychological testing, educational testing (such as I.Q., mental ability, achievement and aptitude testing), except for specific evaluation purposes directly related to medical treatment; c) services provided for purposes of behavioral modification and/or training; d) services related to the treatment of learning disorders or learning disabilities; e) services provided primarily for social or environmental change or for respite care; f) developmental or cognitive therapies that are not restorative in nature but used to facilitate or promote the development of skills which the member has not yet attained; and g) services provided for which, based on medical standards, there is no established expectation of achieving measurable, sustainable improvement in a reasonable and predictable period of time.
	For any care that is related to autism spectrum disorders which extends beyond traditional medical management, except as otherwise provided herein. Care which extends beyond traditional medical management includes the following: a) services that are primarily educational in nature, such as academic skills training or those for remedial education or those that may be delivered in a classroom-type setting, including tutorial services; b) neuropsychological testing, educational testing (such as I.Q., mental ability, achievement and aptitude testing); except for specific evaluation purposes directly related to medical treatment; and c) services provided primarily for respite care.

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Key Word	Exclusion
Legal Obligation	For which you would have no legal obligation to pay.
Medically Necessary and Appropriate	Which are not medically necessary and appropriate as determined by Highmark.
Medicare	To the extent payment has been made under Medicare when Medicare is primary; however, this exclusion shall not apply when the Fund is obligated by law to offer you all the benefits of this program.
	For any amounts you are required to pay under the deductible and/or coinsurance provisions of Medicare or any Medicare supplemental coverage.
Methadone Hydrochloride	For methadone hydrochloride treatment for which no additional functional progress is expected to occur.
Military Service	To the extent benefits are provided to members of the armed forces while on active duty or to patients in Veteran's Administration facilities for service connected illness or injury, unless you have a legal obligation to pay.
Miscellaneous	For telephone consultations which do not involve telemedicine services, charges for failure to keep a scheduled visit, or charges for completion of a claim form.
	For any other medical or dental service or treatment or prescription drug except as provided herein.
Motor Vehicle Accident	For treatment or services for injuries resulting from the maintenance or use of a motor vehicle if such treatment or service is paid or payable under a plan or policy of motor vehicle insurance, including a certified or qualified plan of self-insurance, or any fund or program for the payment of extraordinary medical benefits established by law, including medical benefits payable in any manner under the Pennsylvania Motor Vehicle Financial Responsibility Act.
Nutritional Counseling	For nutritional counseling, except as provided herein.
Obesity	For treatment of obesity, except for medical and surgical treatment of morbid obesity or as otherwise set forth in the predefined preventive schedule. Please refer to the Preventive Services section of Covered Services for more information.
Oral Surgery	For oral surgery procedures, except for the treatment of accidental injury to the jaw, sound and natural teeth, mouth or face, except as provided herein.
Physical Examinations	For routine or periodic physical examinations, the completion of forms, and the preparation of specialized reports solely for insurance, licensing, employment or other non-preventive purposes, such as pre-marital examinations, physicals for school, camp, sports or travel, which are not medically necessary and appropriate, except as provided herein.
Prescription Drugs (Medical Program)	For prescription drugs which were paid or are payable under a freestanding prescription drug program.
Preventive Care Services	For preventive care services, wellness services or programs, except as provided herein.

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Key Word	Exclusion
Provider of Service	Which are not prescribed by or performed by or upon the direction of a professional provider.
	Rendered by other than ancillary providers, facility providers or professional providers.
	Received from a dental or medical department maintained, in whole or in part, by or on behalf of an employer, a mutual benefit association, labor union, trust, or similar person or group.
	Which are submitted by a certified registered nurse and another professional provider for the same services performed on the same date for the same member.
	Rendered by a provider who is a member of your immediate family.
	Services performed by a provider with your same legal residence.
	Performed by a professional provider enrolled in an education or training program when such services are related to the education or training program.
Respite Care	For respite care.
Sexual Dysfunction	For treatment of sexual dysfunction that is not related to organic disease or injury.
Skilled Nursing	For skilled nursing facility services after you have reached the maximum level of recovery possible for your particular condition and no longer require definitive treatment other than routine supportive care; when confinement is intended solely to assist you with the activities of daily living or to provide an institutional environment for your convenience; or for treatment of substance abuse or mental illness.
Smoking (nicotine) Cessation	For nicotine cessation support programs and/or classes, except as otherwise set forth in the predefined preventive schedule. Please refer to the Preventive Services section of Covered Services for more information.
Sterilization	For reversal of sterilization.
Termination Date	Incurred after the date of termination of your coverage except as provided herein.
Therapy	For outpatient therapy and rehabilitation services for which there is no expectation of restoring or improving a level of function or when no additional functional progress is expected to occur, unless medically necessary and appropriate.
Vision Correction Surgery	For the correction of myopia, hyperopia or presbyopia, including but not limited to corneal microsurgery, such as keratomileusis, keratophakia, radial keratotomy, corneal ring implants, Laser-Assisted in Situ Keratomileusis (LASIK) and all related services.
War	For losses sustained or expenses incurred as a result of an act of war whether declared or undeclared.
Weight Reduction	For weight reduction programs, including all diagnostic testing related to weight reduction programs, unless medically necessary and appropriate.
Well-Baby Care	For well-baby care visits, except as provided herein.
Workers' Compensation	For any illness or bodily injury which occurs in the course of employment if benefits or compensation are available, in whole or in part, under the provisions of any federal, state, or local government's workers' compensation, occupational disease or similar type legislation. This exclusion applies whether or not you claim the benefits or compensation.

In addition, under your Prescription Drug benefits, except as specifically provided in this program or as Highmark is mandated or required to provide based on state or federal law, no benefits will be provided for:

Prescription Drugs (Drug Program)	Services of your attending physician, surgeon or other medical attendant;
	Prescription drugs dispensed for treatment of an illness or an injury for which the group is required by law to furnish hospital care in whole or in part-including, but not limited to-state or federal workers' compensation laws, occupational disease laws and other employer liability laws.
	Prescription drugs to which you are entitled, with or without charge, under a plan or program of any government or governmental body.
	Charges for therapeutic devices or appliances (e.g., support garments and other non-medicinal substances).
	Charges for administration of prescription drugs and/or injectable insulin, whether by a physician or other person.
	Any charges by any pharmacy provider or pharmacist except as provided herein.
	Any drug or medication except as provided herein.
	Any amounts you are required to pay directly to the pharmacy for each prescription or refill.
	Charges for a prescription drug when such drug or medication is used for unlabeled or unapproved indications and where such use has not been approved by the Food and Drug Administration (FDA).
	Drugs and supplies that are not medically necessary and appropriate or otherwise excluded herein.
	Any amounts above the deductible, coinsurance, copayment or other cost-sharing amounts for each prescription order or refill that are your responsibility.
	Any prescription for more than the retail days supply or mail-service days supply as outlined in the Summary of Benefits.
	Any drug or medication which does not meet the definition of covered maintenance prescription drug, except those set forth in the predefined preventive schedule. Please refer to the Covered Drugs section for more information.
	Over-the-counter drugs, except those set forth in the predefined preventive schedule. Please refer to the Covered Drugs section for more information.
	Hair growth stimulants.
	Food supplements.
	Immunizations/biologicals.
	Any drugs used to abort a pregnancy.
	Blood products.
	Antihemophilia drugs.
	Any drugs prescribed for cosmetic purposes only.
	Any prescription drug which has been disallowed under the Prescription Drug Management section of this booklet.
	Any drugs requiring intravenous administration, except insulin and other injectables used to treat diabetes.
	Compounded medications.
	Any drugs which are experimental/investigative.
	Any drugs and supplies which can be purchased without a prescription order, including but not limited to blood glucose monitors and injection aids, unless specifically described as provided herein.
	Any prescription drugs or supplies purchased at a non-participating pharmacy provider, except in connection with emergency care described herein.
	Any brand drugs, except those set forth in the predefined preventive schedule. Please refer to the Covered Drugs section for more information.
	Any prescription drug purchased through mail order but not dispensed by a designated mail order pharmacy provider.
	Any selected diagnostic agents.
	Allergy serums.

HOW YOUR HIGHMARK PLANS WORK

Your programs provide responsive, flexible coverage that lets you get the medically necessary and appropriate care you want from the health care provider you select.

Here is how your health care programs work when you or a covered family member needs certain medical services, including:

- Primary care provider office visits
- Specialist office visits
- Physical, speech and occupational therapy
- Diagnostic services
- Inpatient and outpatient hospital services
- Home health or hospice care

Network Care

Network care is care you receive from providers in the program's network.
When you receive health care within the network, you enjoy maximum coverage and maximum convenience. You present your ID card to the provider who submits your claim.

Out-of-Network Care

Out-of-network care is care you receive from providers who are not in the network.
Out-of-network providers are not in the plan's network. When using out-of-network providers, you may still have coverage for most eligible services, except you will share more financial and paperwork responsibilities. In addition, you may be responsible for paying any differences between the plans payments and the provider's actual charges. Finally, you may need to file your own claims and obtain precertification for inpatient care. You should always check with the provider before getting care to understand at what level your care will be covered.

Remember: If you want to enjoy maximum benefits coverage, you need to be sure you receive care from a network provider. See the Summary of Benefits for your coverage details.

Even though a hospital may be in the network, not every doctor providing services in that hospital is in the network. For example: If you are having surgery, make sure that all of your providers, including surgeons, anesthesiologists and radiologists, are in the network.

Out-of-Area Care

Your program also provides coverage for you and your eligible dependents when you receive care from providers located outside the plan service area. For specific details, see the Inter-Plan Arrangements below.

If you are traveling and an urgent injury or illness occurs, you should seek treatment from the nearest hospital, emergency room or clinic: If the treatment results in an admission the provider must obtain precertification from Highmark. However, it is important that you confirm Highmark's determination of medical necessity and appropriateness. If precertification is not obtained and the admission is not considered to be medically necessary and appropriate, you will be responsible for all costs associated with the stay. For specific details, see the Health Care Management section of this booklet.

Inter-Plan Arrangements

Out-of-Area Services

Highmark has a variety of relationships with other Blue Cross and/or Blue Shield licensees referred to generally as "inter-plan arrangements." These inter-plan arrangements operate under rules and procedures issued by the Blue Cross Blue Shield Association. Whenever members access health care services outside the geographic area Highmark serves, the claim for those services may be processed through one of these inter-plan arrangements, as described generally below.

Typically, when accessing care outside the geographic area Highmark serves, members obtain care from health care providers that have a contractual agreement ("participating providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, members may obtain care from health care providers in the Host Blue geographic area that do not have a contractual agreement ("non-participating providers") with the Host Blue. Highmark remains responsible for fulfilling our contractual obligations to you. Highmark's payment practices in both instances are described below.

BlueCard® Program

The BlueCard® Program is an inter-plan arrangement. Under this arrangement, when members access covered services outside the geographic area Highmark serves, the Host Blue will be responsible for contracting and handling all interactions with its participating health care providers. The financial terms of the BlueCard Program are described generally below.

Liability Calculation Method per Claim

Unless subject to a fixed dollar copayment, the calculation of the member liability on claims for covered services will be based on the lower of the participating provider's billed charges for covered services or the negotiated price made available to Highmark by the Host Blue.

Host Blues determine a negotiated price, which is reflected in the terms of each Host Blue's health care provider contracts. The negotiated price made available to Highmark by the Host Blue may be represented by one of the following:

- an actual price – An actual price is a negotiated rate of payment in effect at the time a claim is processed without any other increases or decreases, or
- an estimated price – An estimated price is a negotiated rate of payment in effect at the time a claim is processed, reduced or increased by a percentage to take into account certain payments negotiated with the provider and other claim- and non-claim-related transactions. Such transactions may include, but are not limited to, anti-fraud and abuse recoveries, provider refunds not applied on a claim-specific basis, retrospective settlements and performance-related bonuses or incentives, or
- an average price – An average price is a percentage of billed charges for covered services in effect at the time a claim is processed representing the aggregate payments negotiated by the Host Blue with all of its health care providers or a similar classification of its providers and other claim- and non-claim-related transactions. Such transactions may include the same ones as noted above for an estimated price.

Host Blues determine whether or not they will use an actual, estimated or average price. Host Blues using either an estimated price or an average price may prospectively increase or reduce such prices to correct for over- or underestimation of past prices, (ie, prospective adjustment may mean that a current price reflects additional amounts or credits for claims already paid or anticipated to be paid to providers or refunds received or anticipated to be received from providers). However, the BlueCard Program requires that the amount paid by the member is a final price; no future price adjustment will result in increases or decreases to the pricing of past claims determining. The method of claims payment by Host Blues is taken into account by Highmark in your premiums.

Special Cases: Value-Based Programs
If members receive covered services under a Value-Based Program inside a Host Blue's service area, you will not be responsible for paying any of the provider incentives, risk-sharing, and/or care coordinator fees that are a part of such an arrangement, except when a Host Blue passes these fees to Highmark through average pricing or fee schedule adjustments.

Return of Overpayments
Recoveries of overpayments from a Host Blue or its participating and non-participating providers can arise in several ways, including, but not limited to, anti-fraud and abuse recoveries, audits/health care provider/hospital bill audits, credit balance audits, utilization review refunds and unsolicited refunds. Recoveries will be applied so that corrections will be made, in general, on either a claim-by-claim or prospective basis. If recovery amounts are passed on a claim-by-claim basis from a Host Blue to Highmark, they will be credited to your account. In some cases, the Host Blue will engage a third party to assist in identification or collection of overpayments. The fees of such a third party may be charged to you as a percentage of the recovery.

Non-Participating Providers Outside of the Plan Service Area

Member Liability Calculation
When covered services are provided outside of the plan service area by non-participating providers, the amount(s) a member pays for such services will generally be based on either the Host Blue's non-participating provider local payment or the pricing arrangements required by applicable law. In these situations, the member may be responsible for the difference between the amount that the non-participating provider bills and the payment Highmark will make for the covered services as set forth in this paragraph. Payments for out-of-network emergency services are governed by applicable federal and state law.

Exceptions
In some exception cases, Highmark may pay claims from non-participating health care providers outside of the plan service area based on the provider's billed charge. This may occur in situations where a member did not have reasonable access to the participating provider, as determined by Highmark in Highmark's sole and absolute discretion or by applicable law. In other exception cases, Highmark may pay such claims based on the payment Highmark would make if Highmark were paying a non-participating provider inside the plan service area. This may occur where the Host Blue's corresponding payment would be more than the plan in-service area non-participating provider payment. Highmark may choose to negotiate a payment with such provider on an exception basis.

Unless otherwise stated, in any of these exception situations, the member may be responsible for the difference between the amount that the non-participating health care provider bills and payment Highmark will make for the covered services as set forth in this paragraph.

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

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

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

No Prior Approval Requirement or Pre-Certification Requirement applies when members receive Emergency Care services.

Blue Cross Blue Shield Global Core Program

If members are outside the United States (hereinafter "BlueCard service area"), they may be able to take advantage of the Blue Cross Blue Shield Global Core Program when accessing covered services. The Blue Cross Blue Shield Global Core Program is unlike the BlueCard Program available in the BlueCard service area in certain ways. For instance, although the Blue Cross Blue Shield Global Core Program assists members with accessing a network of inpatient, outpatient and professional providers, the network is not served by a Host Blue. As such, when members receive care from providers outside the BlueCard service area, they will typically have to pay the providers and submit the claims themselves to obtain reimbursement for these services.

Inpatient Services

In most cases, if members contact the service center for assistance, hospitals will not require members to pay for inpatient covered services, except for their cost-sharing amounts. In such cases, the hospital will submit member claims to the service center to initiate claims processing. However, if the member paid in full at the time of service, the member must submit a claim to obtain reimbursement for covered services. **Members must contact Highmark to obtain precertification for non-emergency inpatient services**.

Outpatient Services

Physicians, urgent care centers and other outpatient providers located outside the BlueCard service area will typically require members to pay in full at the time of service. Members must submit a claim to obtain reimbursement for covered services.

Submitting a Blue Cross Blue Shield Global Core Claim
When members pay for covered services outside the BlueCard service area, they must submit a claim to obtain reimbursement. For institutional and professional claims, members should complete a Blue Cross Blue Shield Global Core International claim form and send the claim form with the provider's itemized bill(s) to the service center address on the form to initiate claims processing. The claim form is available from Highmark, the service center or online at www.bcbsglobalcore.com. If members need assistance with their claim submissions, they should call the service center at 800-810-BLUE (2583) or call collect at 804-673-1177, 24 hours a day, seven days a week.

Your Provider Network

The network includes: primary care physicians; a wide range of specialists; mental health and substance abuse providers; community and specialty hospitals; and laboratories.

To determine if your physician is in the network, call Dedicated Customer Service at 1-866-594-1732, or log into www.highmarkbcbs.com.

Getting your care "through the network" also assures you get quality care. All physicians are carefully evaluated before they are accepted into the network. We consider educational background, office procedures and performance history to determine eligibility. Then we monitor care on an ongoing basis through office record reviews and patient satisfaction surveys.

Please note that while you or a family member can use the services, including behavioral health and well-woman care, of any network physician or specialist without a referral and receive the maximum coverage under your benefit programs, you are encouraged to select a personal or primary care physician. This helps establish an ongoing relationship based on knowledge and trust and helps make your care consistent. Your personal physician can help you select an appropriate specialist and work closely with that specialist when the need arises. In addition, primary care providers or their covering physicians are on call 24/7.

Remember:
It is *your* responsibility to ensure that you receive network care. You may want to double-check any provider recommendations to make sure the doctor or facility is in the network.

How to Obtain Information Regarding Your Physician

To view information regarding your PCP or network specialist, visit Highmark's website at www.highmarkbcbs.com and click on "Find a Doctor" to start your search. Search for the physician, then click on the provider's name to view the following information:

- Name, address, telephone numbers
- Professional qualifications
- Specialty
- Medical school attended
- Residency completion
- Board certification status
- Hospital affiliations

In addition to this information, to obtain more information on network providers, you may call Dedicated Customer Service at 1-866-594-1732.

Eligible Providers

Eligible network providers include facilities, general practitioners, internists, obstetricians/ gynecologists and a wide range of specialists.

Facility Providers

A. Hospital
B. Psychiatric hospital
C. Rehabilitation hospital
D. Ambulatory surgical facility
E. Birthing facility
F. Day/night psychiatric facility
G. Freestanding dialysis facility
H. Freestanding nuclear magnetic resonance facility/magnetic resonance imaging facility
I. Home health care agency
J. Hospice
K. Outpatient substance abuse treatment facility
L. Outpatient physical rehabilitation facility
M. Outpatient psychiatric facility
N. Pediatric extended care facility
O. Pharmacy provider
P. Residential treatment facility
Q. Skilled nursing facility
R. State-owned psychiatric hospital
S. Substance abuse treatment facility

Professional Providers

A. Audiologist
B. Behavior specialist
C. Certified registered nurse*
D. Chiropractor
E. Clinical social worker
F. Dentist
G. Dietician-nutritionist
H. Licensed practical nurse
I. Marriage and family therapist
J. Nurse-midwife
K. Occupational therapist
L. Optometrist
M. Physical therapist
N. Physician
O. Podiatrist
P. Professional counselor
Q. Psychologist
R. Registered nurse
S. Respiratory therapist
T. Speech-language pathologist
U. Teacher of hearing impaired

Ancillary Providers

A. Ambulance service
B. Clinical laboratory
C. Diabetes prevention provider
D. Home infusion therapy provider
E. Independent diagnostic testing facility (IDTF)
F. Suite infusion therapy provider
G. Suppliers

Contracting Suppliers (for the sale or lease of):

A. Durable medical equipment
B. Supplies
C. Orthotics
D. Prosthetics

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

Prescription Drug Providers

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

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

  If you travel within the United States and need to refill a prescription, call Dedicated Customer Service for help at 1-866-594-1732. They can help you find a network pharmacy near the area you are visiting. You also can use the member website to find a pharmacy. Once you have the name and address of the network pharmacy, take the prescription bottle to that pharmacy. The pharmacist will contact your home pharmacy to start the refill process. **Note: Save the new medicine container. This will make it easier to transfer the prescription back to your pharmacy at home.**

- **Mail Order Pharmacy:** Express Scripts® is your program's mail order pharmacy. This option offers savings and convenience for prescriptions you may take on an ongoing basis.

  To start using mail order:

  1. Ask your doctor to write a prescription for up to a 90-day supply, plus refills for up to one year, if appropriate.
  2. Complete the Pharmacy Mail Order Form and Health, Allergy & Medication Questionnaire. You can get these forms by calling Dedicated Customer Service at 1-866-594-1732 or from your member website. After logging in, click on the "Prescriptions" tab. Scroll down the page to "Forms to Manage Your Plan" and click on "Mail order form and health questionnaire (PDF)".
  3. Send the completed forms and your payment to the address listed on the mail order form. It usually takes about five days to get your prescription after it has been processed.

  Your mail order will include directions for ordering refills.

- **Exclusive Pharmacy Provider:** The exclusive pharmacy provider has an agreement, either directly or indirectly, with Highmark pertaining to the payment and exclusive dispensing of selected prescription drugs provided to you. Please refer to the Covered Services - Prescription Drug Program section for a list of the selected prescription drug categories.

HEALTHCARE MANAGEMENT

Medical Management

For your benefits to be paid under your program, services and supplies must be considered medically necessary and appropriate. However, not all medically necessary and appropriate services are covered under your program.

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

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

Network Care

When you use a network provider for inpatient care, the provider will contact Highmark for you to receive authorization for your care.

If the network provider is located outside the Highmark service area, you are responsible for contacting Highmark at 1-866-594-1732 to confirm Highmark's determination of medical necessity and appropriateness.

Out-of-Network Care

When you are admitted to an out-of-area network facility provider, you are responsible for notifying Highmark of your admission. However, some facility providers will contact Highmark and obtain preauthorization of the inpatient admission on your behalf. Be sure to verify that your provider is contacting Highmark for preauthorization. If not, you are responsible for contacting Highmark.

You should call 7 to 10 days prior to your planned admission. For emergency admissions, call Highmark within 48 hours of the admission, or as soon as reasonably possible. You can contact Highmark via the Dedicated Customer Service at 1-866-594-1732.

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

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

Care Utilization Review Process

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

Prospective Review

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

After receiving the request for care, Highmark:

- verifies your eligibility for coverage and availability of benefits;
- reviews diagnosis and plan of treatment;
- assesses whether care is medically necessary and appropriate;
- authorizes care and assigns an appropriate length of stay for inpatient admissions

Concurrent Review

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

Discharge Planning

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

Procedure or Covered Service Precertification

Precertification may be required to determine the medical necessity and appropriateness of certain outpatient procedures or covered services as determined by Highmark.

In-Area Care

Network providers are responsible for the precertification of such procedures or covered services and you will be held harmless whenever certification for such procedures or covered services is not obtained. If the procedure or covered service is deemed not to be medically necessary and appropriate, you will be held harmless, except when Highmark provides prior written notice to you that charges for the procedure or covered service will not be covered. In such case, you will be financially responsible for such procedure or covered service.

Out-of-Area Care

Whenever you utilize an out-of-area provider, it is your responsibility to first contact Highmark to confirm the medical necessity and appropriateness of such procedures or covered services. If you do not contact Highmark for certification, those procedures or covered services may be reviewed after they are received to determine medical necessity and appropriateness. If the procedure or covered service is determined to be medically necessary and appropriate, benefits

will be paid in accordance with the plan. If the procedure or covered service is determined not to be medically necessary and appropriate, no benefits will be provided. In such case you will be financially responsible for the full amount of the out-of-area provider's charge.

Out-of-Network Care
Whenever you utilize an out-of-network provider, it is your responsibility to first contact Highmark to confirm the medical necessity and appropriateness of such procedures or covered services. If you do not contact Highmark for certification, those procedures or covered services may be reviewed after they are received to determine medical necessity and appropriateness. If the procedure or covered service is determined to be medically necessary and appropriate, benefits will be paid in accordance with the plan. If such procedure or covered service is determined not to be medically necessary and appropriate, no benefits will be provided. In such case, you will be financially responsible for the full amount of the out-of-network provider's charge.

If you have any questions regarding Highmark's determination of medical necessity and appropriateness of certain outpatient procedures or covered services, you can contact Highmark via the Dedicated Customer Service at 1-866-594-1732.

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

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

Individual Case Management
Highmark, in its sole discretion, reserves the right to limit access to a benefit, regardless of the disease or condition, when Highmark identifies utilization patterns that could potentially result in harm to you or the public.

Highmark case managers are a free resource to all Highmark members. If you have an inpatient hospital admission, you may be contacted as part of our Outreach Program. If your claims history indicates that your needs appear to be more complex, you may be contacted by a case manager from our Complex Program. In either case, you are always free to call and request case management services if you feel you need it by contacting Dedicated Customer Service at 1-866-594-1732.

Selection of Providers

You have the option of choosing where and whom to go to for covered services. You may utilize a network provider or an out-of-network provider. However, covered services received from a network provider are usually provided at a higher level of benefits than those received from an out-of-network provider and certain non-emergency services may only be covered when rendered by a network provider. Please note that benefits for covered telemedicine services are only provided when such services are rendered by a designated telemedicine provider.

In the event you require non-emergency covered services that are not available within the network, Highmark may refer you to an out-of-network provider. You must notify Highmark prior to receiving a covered service from an out-of-network provider in order for Highmark to facilitate this arrangement. In such cases, services will be covered at the network level so that you will not be responsible for any greater out-of-pocket amount than if services had been rendered by a network provider. You will not be responsible for any difference between Highmark's payment and the out-of-network provider's billed charge.

Prescription Drug Management

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

Early Refill Authorization

Unexpected Event

If your prescription is lost or stolen due to an event such as a fire or theft, you may be able to get an early refill. Call Dedicated Customer Service at 1-866-594-1732 for help. You will need a copy of the report from the fire department, police department or other agency.

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

Traveling Abroad

If you will be out of the country when it is time to refill your prescription, call Dedicated Customer Service at 1-866-594-1732 for help. Be sure to have your member ID card and your prescription information. Please allow at least five business days to complete the request.

Individual Case Management

Highmark, in its sole discretion, reserves the right to limit access to a benefit, regardless of the disease or condition, when Highmark identifies utilization patterns that could potentially result in harm to you or the public.

Quantity Level Limits

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

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

Managed Prescription Drug Coverage
A prescription order or refill which may exceed the manufacturer's recommended dosage over a specified period of time may be denied by Highmark when presented to the pharmacy provider. Highmark may contact the prescribing physician to determine if the covered medication is medically necessary and appropriate. The covered medication will be dispensed if it is determined by Highmark to be medically necessary and appropriate.

To obtain prescription medication that requires a prior authorization, your physician must complete the "Prescription Drug Medication Request Form" and return it using either the fax number or the address as shown on the form for clinical review. Once a clinical decision has been made, a decision letter will be mailed to you and your provider.

If we say no to your request for an exception, you can ask for a review of our decision by making an appeal.

Preauthorization
Certain prescription drugs may require preauthorization to ensure the medical necessity and appropriateness of the prescription order. The prescribing physician must obtain authorization from Highmark prior to prescribing certain covered medications. The specific drugs or drug classifications which require preauthorization may be obtained by calling Dedicated Customer Service at 1-866-594-1732.

Precertification, Preauthorization and Pre-Service Claims Review Processes

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

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

Decisions Involving Requests for Precertification and Other Non-Urgent Care Pre-Service Claims

You will receive written notice of any decision on a request for precertification or other pre-service claim, whether the decision is adverse or not, within a reasonable period of time appropriate to the medical circumstances involved. That period of time will not exceed 15 days from the date Highmark receives the claim.

Decisions Involving Urgent Care Claims

If your request involves an urgent care claim, Highmark will make a decision on your request as soon as possible taking into account the medical exigencies involved. You will receive notice of the decision that has been made on your urgent care claim no later than 72 hours following receipt of the claim.

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

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

Notices of Determination Involving Precertification Requests and Other Pre-Service Claims

Any time your request for precertification or other pre-service claim is approved, you will be notified in writing that the request has been approved. If your request for precertification or approval of any other pre-service claim has been denied, you will receive written notification of that denial which will include, among other items, the specific reason or reasons for the adverse benefit determination and a statement describing your right to file an internal appeal or request an external review.

For a description of your right to file an appeal concerning an adverse benefit determination involving a request for precertification or any other pre-service claim, see the Appeal Procedure subsection in the How to File a Claim section of this benefit booklet.

GENERAL INFORMATION

Conversion

If your Benefit Plan does not offer continuation of coverage, or if you do not wish to continue coverage through your Benefit Plan's program, you may be able to enroll in an individual conversion program available from Highmark. Also, conversion is available to anyone who has elected continued coverage through your employer's program and the term of that coverage has expired.

If your coverage through your Benefit Plan is discontinued for any reason, except as specified below, you may be able to convert to a direct payment program.

The conversion opportunity is not available if either of the following applies:

- You are eligible for another group health care benefits program through your place of employment.
- When your Benefit Plan program is terminated and replaced by another health care benefits program.

Termination of Your Coverage Under the Welfare Fund's Contract

Your coverage will be terminated in the following instances:

A. When you cease to be a member, your coverage will terminate at the end of the last month for which payment was made.

B. When you fail to pay the required contribution, your coverage will terminate at the end of the last month for which payment was made.

Termination of the contract automatically terminates the coverage for all the members. It is the responsibility of the Welfare Fund to notify you of the termination in coverage. However, coverage will be terminated regardless of whether the notice is given to you by the Welfare Fund.

If it is proven that you obtained or attempted to obtain benefits or payment for benefits through fraud or intentional misrepresentation of a material fact, Highmark Blue Cross Blue Shield may, upon notice to you, terminate your coverage under the program.

Benefits After Termination of Coverage

If you are an inpatient on the day your coverage terminates, facility provider benefits for inpatient covered services will be continued as follows:

A. Until the maximum amount of benefits has been paid; or

B. Until the inpatient stay ends; or

C. Until you become covered, without limitation as to the condition for which you are receiving inpatient care, under another group program; whichever occurs first.

D. If you are pregnant on the date coverage terminates, no additional coverage will be provided.

If you are totally disabled at the time your coverage terminates due to termination of active employment, benefits, will be continued for covered services directly related to the condition

causing such total disability. This benefit extension does not apply to covered services relating to other conditions, illnesses, diseases or injuries and is not available if your termination was due to fraud or intentional misrepresentation of a material fact. This total disability extension of benefits will be provided as long as you remain so disabled as follows:

A. Up to a maximum period of 12 consecutive months; or

B. Until the maximum amount of benefits has been paid; or

C. Until the total disability ends; or

D. Until you become covered without limitation as to the disabling condition under other group coverage, whichever occurs first. If you are required to pay any premium, your benefits will not be continued if your coverage is terminated because you failed to pay the required premium.

Coordination of Benefits

Most health care programs, including your health care programs, contain a coordination of benefits provision. This provision is used when you, your spouse or your covered dependents are eligible for payment under more than one health care program. The object of coordination of benefits is to ensure that your covered expenses will be paid, while preventing duplicate benefit payments.

Here is how the coordination of benefits provision works:

A. When your other coverage does not mention "coordination of benefits," then that coverage pays first. Benefits paid or payable by the other coverage will be taken into account in determining if additional benefit payments can be made under your program.

B. When the person who received care is covered as an employee under one contract, and as a dependent under another, then the employee coverage pays first.

C. When a dependent child is covered under two contracts, the contract covering the parent whose birthday falls earlier in the calendar year pays first. But, if both parents have the same birthday, the program which covered the parent longer will be the primary program. If the dependent child's parents are separated or divorced, the following applies:

   - The parent with custody of the child pays first
   - The coverage of the parent with custody pays first but the stepparent's coverage pays before the coverage of the parent who does not have custody.
   - Regardless of which parent has custody, whenever a court decree specifies the parent who is financially responsible for the child's health care expenses, the coverage of that parent pays first.

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

- The benefits of a program covering the person as an employee other than a laid-off or retired employee or as the dependent of such person shall be determined before the benefits of a

program covering the person as a laid-off or retired employee or as a dependent of such person and if

- The other program does not have this provision regarding laid-off or retired employees, and, as a result, plans do not agree on the order of benefits, then this rule is disregarded.

If you receive more than you should have when your benefits are coordinated, you will be expected to repay any overpayment.

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

Subrogation

As used in this booklet, "subrogation" refers to the Plan's right to seek payment and/or reimbursement from a person or organization responsible, or potentially responsible, for the Plan's payment of health care expenses you incurred in connection with an injury.

The Plan also has the right to seek payment and/or reimbursement from you if you receive a payment, settlement, judgment or award from a person, organization or insurance company in connection with an injury caused or alleged to be caused by the person or organization. The Plan has this right regardless of whether:

- liability is admitted by any potentially responsible person or organization;
- the payment, settlement, judgment or award you received identifies medical benefits provided by the Plan; or
- the payment, settlement, judgment or award is otherwise designated as "pain and suffering" or "non-economic damages" only.

The Plan shall have a first priority lien on the proceeds of any payment, settlement or award you receive in connection with an injury caused by a person or organization. The lien shall be in the amount of benefits paid on your behalf regardless of whether you are made-whole for your loss or because you have incurred attorney fees or costs.

The Plan will provide eligible benefits when needed, but you may be asked to show, execute and/or deliver documents, or take other necessary actions to support the Plan in any subrogation efforts. Neither you nor any of your dependents shall do anything to prejudice the right given to the Plan by this Subrogation section without the Plan's consent.

Subrogation does not apply to an individual insurance policy you may have purchased for yourself or your dependents, or when enforcing this provision is prohibited by an applicable state or federal law.

If you or an Eligible Dependent are pursuing a claim to recover money from any person or entity for injuries for which the Plan covered related medical expenses, you are required to promptly advise the Welfare Fund, and to provide information and other cooperation in connection with the Plan's subrogation rights and interests. You must also require any legal or other representative assisting in such claim to provide such information and cooperation.

A RECOGNIZED IDENTIFICATION CARD

Carry your ID card with you at all times, destroy any previously issued cards, and show this card to the hospital, doctor, pharmacy, or other health care professional whenever you need medical care.

If your card is lost or stolen, please contact Highmark Dedicated Customer Service at 1-866-594-1732 immediately. You can also request additional or replacement cards online by logging onto www.highmarkbcbs.com.

Below is a sample of the type of information that will be displayed on your ID card:

A. Your name and your dependent's name, if applicable

B. Identification number

C. Group number

D. Copayment for physician office visits and emergency room visits

E. Pharmacy network logo (when applicable)

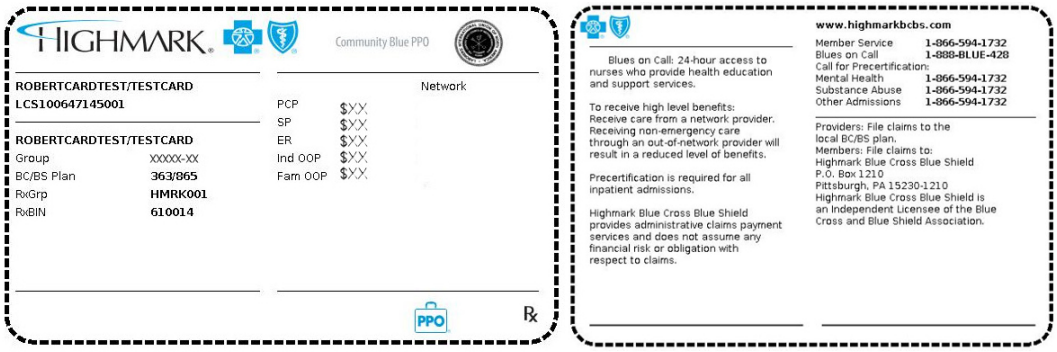
F. Dedicated Customer Service toll-free number 1-866-594-1732

G. Toll-free telephone number for out-of-network facility admissions 1-866-594-1732

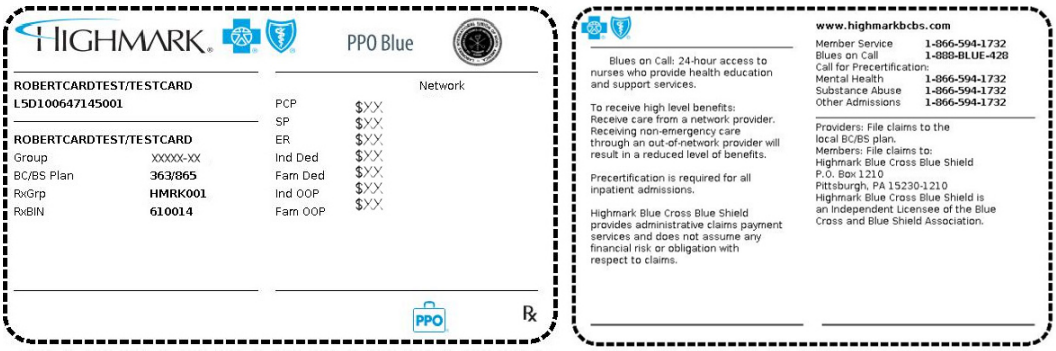
H. Suitcase symbol

There is a logo of a suitcase on your ID card. This suitcase logo lets hospitals and doctors know that you are a member of a Blue Cross and Blue Shield plan, and that you have access to Blue providers nationwide.

Community Blue PPO:



PPO Blue:



HOW TO FILE A CLAIM

In most instances, hospitals and physicians will submit a claim on your behalf. If your claim is not submitted directly by the provider, you may be required to file the claim yourself.

If you receive medications from a network pharmacy and present your ID card, you will not have to file a claim. If you forget your ID card when you go to a network pharmacy, the pharmacy may ask you to pay in full for the prescription.

If you have to file a claim, the procedure is simple. Just take the following steps:

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

B. ***Get an Itemized Bill.*** Itemized bills must include:
   - The name and address of the service or pharmacy provider
   - The patient's full name
   - The date of service or supply or purchase
   - A description of the service or medication/supply
   - The amount charged
   - For a medical service, the diagnosis or nature of illness
   - For durable medical equipment, the doctor's certification
   - For private duty nursing, the nurse's license number, charge per day and shift worked, and signature of provider prescribing the service;
   - For ambulance services, the total mileage
   - Drug and medicine bills must show the prescription name and number and the prescribing provider's name.

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

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

D. ***Complete a Claim Form.*** Make sure all information is completed properly, and then sign and date the form. *Claim forms can be downloaded from blog.highmarkhealth.org by entering "forms" in the search box. Claim forms are also available from your employee benefits department, or call Dedicated Customer Service at 1-866-594-1732.*

E. ***Attach Itemized Bills to the Claim Form and Mail.*** After you complete the above steps, attach all itemized bills to the claim form and mail everything to the address on the back of your ID card.

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

Your claims must be submitted no later than the end of the plan year following the plan year for which benefits are payable.

Your Explanation of Benefits Statement

When you submit a claim, you will receive an Explanation of Benefits (EOB) statement that lists:

A. The provider's actual charge

B. The allowable amount as determined by Highmark

C. The copayment; deductible and coinsurance amounts, if any, that you are required to pay

D. Total benefits payable

E. The total amount you owe

In those instances when you are not required to submit a claim because, for example, the network provider will submit the bill as a claim for payment under its contract with Highmark, you will receive an EOB only when you are required to pay amounts other than your required copayment.

You can get your EOBs online. Simply register on Highmark's website at www.highmarkbcbs.com. Your EOB can also be mailed to you. If you do not owe a payment to the provider, you may not receive an EOB.

Using the Mail Service Pharmacy Benefit

To order your prescription through our mail service pharmacy, visit our website or call Dedicated Customer Service at 1-866-594-1732 to obtain a Mail Service Pharmacy Order Form and envelope. Mail your prescription and any applicable copayment or coinsurance, along with the Mail Service Pharmacy Order Form to the address listed on the form. Your order will be processed promptly and your medication will be sent to you via U.S. mail or UPS. Included with your order will be instructions for ordering refills. Refills can be ordered by phone, mail or online at www.express-scripts.com.

How to Voice a Complaint

In the event that you are dissatisfied with any aspect of your health care benefits or you have an objection regarding participating health care providers, coverage, operations or management policies, please contact Highmark's Dedicated Customer Service at 1-866-594-1732 or by mail at the address listed below. Please include your identification and group numbers as displayed on your ID card.

Highmark Blue Cross Blue Shield
P.O. Box 226
Pittsburgh, PA 15222

A representative will review, research and respond to your inquiry as quickly as possible.

If the informal dissatisfaction process is not successful and does not meet your needs, you have the right to have your objection reviewed by our Member Grievance and Appeals Department. For details about how this process works, please refer to the Appeal Procedure section of this booklet or call Highmark's Dedicated Customer Service at 1-866-594-1732.

Fraud or Provider Abuse
If you think that a provider is committing fraud, please let us know. Examples of fraud include: Submitting claims for services that you did not get; Adding extra charges for services that you did not get; giving you treatment for services you did not need. Please call the local state toll-free Fraud Hotline.

Additional Information on How to File a Claim

Member Inquiries

General inquiries regarding your eligibility for coverage and benefits do not involve the filing of a claim, and should be made by directly contacting the Dedicated Customer Service at 1-866-594-1732.

Filing Benefit Claims

Authorized Representatives
You have the right to designate an authorized representative to file or pursue a request for reimbursement or other post-service claim on your behalf. Highmark reserves the right to establish reasonable procedures for determining whether an individual has been authorized to act on your behalf.

Requests for Precertification and Other Pre-Service Claims
For a description of how to file a request for precertification or other pre-service claim, see the Precertification, Preauthorization and Pre-Service Claims Review Processes subsection in the Health Care Management section of this benefit booklet.

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

Determinations on Benefit Claims

Notice of Benefit Determinations Involving Requests for Precertification and Other Pre-Service Claims
For a description of the time frames in which requests for precertification or other pre-service claims will be determined by Highmark and the notice you will receive concerning its decision, whether adverse or not, see the Precertification, Preauthorization and Pre-Service Claims Review Processes subsection in the Health Care Management section of this benefit booklet.

Notice of Adverse Benefit Determinations Involving Requests for Reimbursement and Other Post-Service Claims

Highmark will notify you in writing of its determination on your request for reimbursement or other post-service claim within a reasonable period of time following receipt of your claim. That period of time will not exceed 30 days from the date your claim was received. However, this 30-day period of time may be extended one time by Highmark for an additional 15 days, provided that Highmark determines that the additional time is necessary due to matters outside its control, and notifies you of the extension prior to the expiration of the initial 30-day post-service claim determination period. If an extension of time is necessary because you failed to submit information necessary for Highmark to make a decision on your post-service claim, the notice of extension that is sent to you will specifically describe the information that you must submit. In this event, you will have at least 45 days in which to submit the information before a decision is made on your post-service claim.

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

For a description of your right to file an appeal concerning an adverse benefit determination of a request for reimbursement or any other post-service claim.

Appeal Procedure

Your benefit program maintains an appeal process involving one level of review. At any time during the appeal process, you may choose to designate a representative to participate in the appeal process on your behalf. You or your representative shall notify Highmark in writing of the designation.

For purposes of the appeal process, “you” includes designees, legal representatives and, in the case of a minor, parent(s) entitled or authorized to act on your behalf.

Highmark reserves the right to establish reasonable procedures for determining whether an individual has been authorized to act on your behalf. Such procedures as adopted by Highmark shall, in the case of an urgent care claim, permit your physician or other provider of health care with knowledge of your medical condition to act as your representative.

At any time during the appeal process, you may contact Dedicated Customer Service at 1-866-594-1732 to inquire about the filing or status of your appeal.

If you receive notification that a claim has been denied by Highmark, in whole or in part, you may appeal the decision. Your appeal must be submitted not later than 180 days from the date you received notice from Highmark of the adverse benefit determination.

Upon request to Highmark, you may review all documents, records and other information relevant to the claim which is the subject of your appeal and shall have the right to submit or present additional evidence or testimony, which includes any written or oral statements, comments and/or remarks, documents, records, information, data or other material in support of your appeal.

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

In rendering a decision on your appeal, the Appeal Review Department will take into account all evidence, comments, testimony, documents, records, and other information submitted by you without regard to whether such information was previously submitted to or considered by Highmark. The Appeal Review Department will also afford no deference to any previous adverse benefit determination regarding the claim that is the subject of your appeal.

In rendering a decision on appeal that is based, in whole or in part, on medical judgment, including determinations of whether a requested benefit is medically necessary and appropriate or experimental/investigative, the Appeal Review Department will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The health care professional will be a person who was not involved in any previous adverse benefit determination regarding the claim that is the subject of your appeal and will not be the subordinate of any person involved in a previous adverse benefit determination regarding the claim that is the subject of your appeal.

Your appeal will be promptly investigated and Highmark will provide you with written notification of its decision within the following time frames:

- When the appeal involves a non-urgent care pre-service claim, within a reasonable period of time appropriate to the medical circumstances not to exceed 30 days following receipt of the appeal;
- When the appeal involves an urgent care claim, as soon as possible taking into account the medical exigencies involved but not later than 72 hours following receipt of the appeal; or
- When the appeal involves a post-service claim, within a reasonable period of time not to exceed 60 days following receipt of the appeal.

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

External Review

You have four months from the date you receive notice of a final Highmark adverse benefit determination to file a request for an external review with Highmark. To be eligible for external review, the decision of Highmark must have involved (i) a claim that was denied involving medical judgment, including, application of Highmark's requirements as to medical necessity, appropriateness, health care setting, level of care, effectiveness of a covered service or a determination that the treatment is experimental or investigational; or (ii) a determination made by your Plan Administrator to rescind your coverage.

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

Preliminary Review

Highmark will conduct a preliminary review of your external review request within five business days following the date on which Highmark receives the request. Highmark's preliminary review will determine whether:

- You were covered by your Plan at all relevant times;
- The adverse benefit determination relates to your failure to meet your Plan's eligibility requirements;
- You exhausted the above-described appeal process; and
- You submitted all required information or forms necessary for processing the external review.

Highmark will notify you of the results of its preliminary review within one business day following its completion of the review. This will include our reasons regarding the ineligibility of your request, if applicable, and will further provide you with contact information for the Employee Benefits Security Administration. If your request is not complete, Highmark's notification will describe the information or materials needed to make the request complete. You will then have the balance of the four month filing period or, if later, 48 hours from receipt of the notice, to perfect your request for external review; whichever is later.

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

Referral to an Independent Review Organization (IRO)

Highmark will, randomly or by rotation, select an IRO to perform an external review of your claim if your request is found acceptable after preliminary review. The IRO will be accredited by a nationally-recognized accrediting organization. Within five business days thereafter, Highmark will provide the IRO with documents and information we considered when making our final adverse benefit determination. The IRO may reverse Highmark's final adverse benefit determination if the documents and information are not provided to the IRO within the five-day time frame.

The IRO will timely notify you in writing of your eligibility for the external review and will provide you with at least 10 business days following receipt of the notice to provide additional information.

The IRO will review all information and documents that are timely received. In reaching its decision, the IRO will review your claim de novo. In other words, the IRO will not be bound by any decisions or conclusions reached during the above-described appeal process.

The assigned IRO must provide written notice of its final external review decision within 45 days after the IRO received the request for the external review. The IRO will deliver its notice of final external review decision to you and Highmark. The IRO's notice will inform you of:

- The date it received the assignment to conduct the review and the date of its decision;
- References to the evidence or documentation, including specific coverage provisions and evidence-based standards, considered in reaching its decision;
- A discussion of the principal reason(s) for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;
- A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either you or your Plan;
- A statement that judicial review may be available to you; and
- Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under Section 2793 of the Public Health Service Act.

Coverage or payment for the requested benefits will be paid immediately upon Highmark's receipt of the IRO's notice of a final external review decision from the IRO that reverses Highmark's prior final internal adverse benefit determination.

Expedited External Review (Applies to Urgent Care Claims Only)
You are entitled to the same procedural rights to an external review as described above on an expedited basis:

- If the final adverse benefit determination involves a medical condition for which the time frame for completion of an expedited internal appeal would seriously jeopardize your life or your health or would jeopardize your ability to regain maximum function and you filed a request for an expedited internal appeal; or
- Following a final internal adverse benefit determination, if you have a medical condition where the time frame for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or the final internal adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but you have not been discharged from the facility rendering the emergency services.

In the above circumstances, Highmark will immediately conduct a preliminary review and will immediately notify you of our reasons regarding the ineligibility of your request, if applicable, and will further provide you with contact information for the Employee Benefits Security Administration. If your request is not complete, Highmark's notification will describe the information or materials needed to make the request complete. You will then have 48 hours from receipt of the notice, to perfect your request for external review.

Referral to an Independent Review Organization (IRO)
Highmark will, randomly or by rotation, select an IRO to perform an external review of your claim if your request is found acceptable after preliminary review. The IRO will be accredited by

a nationally-recognized accrediting organization. Thereafter, Highmark will immediately provide the IRO with documents and information we considered when making our final adverse benefit determination via the most expeditious method (e.g., electronic, facsimile, etc.).

The IRO will review all information and documents that are timely received. In reaching its decision, the IRO will review your claim de novo. In other words, the IRO will not be bound by any decisions or conclusions reached during the above-described appeal process.

The assigned IRO must provide notice of its final external review decision as expeditiously as possible, but in no event more than 72 hours from the time the IRO received the request for the external review. The IRO must provide written notice of its final external review decision to you and to Highmark, if not originally in writing, within 48 hours of its original decision. The IRO's written notice will inform you of:

- The date it received the assignment to conduct the review and the date of its decision;
- References to the evidence or documentation, including specific coverage provisions and evidence-based standards, considered in reaching its decision;
- A discussion of the principal reason(s) for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;
- A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either you or your Plan;
- A statement that judicial review may be available to you; and
- Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under Section 2793 of the Public Health Service Act.

Coverage or payment for the requested benefits will be paid immediately upon Highmark's receipt of the IRO's notice of a final external review decision from the IRO that reverses Highmark's prior final internal adverse benefit determination.

MEMBER SERVICE

When you have questions about a claim, benefits or coverage, your Dedicated Customer Service Representatives are here to help you. Just call 1-866-594-1732 or log in to the Highmark member website at www.highmarkbcbs.com. For TTY/TDD hearing impaired service, please dial 711 and the number on the back of your ID card. (1-866-594-1732).

As a Highmark member, you have access to a wide range of readily available health education tools and support services, all geared to help you "Have a Greater Hand in Your Health."

Blues on Call℠ - 24/7 Health Decision Support

Just call **1-888-BLUE-428 (1-888-258-3428)** to be connected to a specially-trained wellness professional. You can talk to a Health Coach whenever you like, any time of the day, any day of the week.

Health Coaches are specially-trained registered nurses, dietitians and respiratory therapists who can help you make more informed health care and self-care (when appropriate) decisions. They can assist with a health symptom assessment, provide health-related information, and discuss your treatment options. Please be assured that your discussions with your Health Coach are kept strictly confidential.

Help with common illnesses, injuries and questions

Health Coaches can address any health topic that concerns you:

- Everyday conditions, such as a rash, an earache or a sprain
- A recent diagnosis you've received
- A scheduled medical test
- Planned surgery or other medical procedure
- Questions to ask your doctor at your next appointment
- How to care for a child or elder

You don't have to be ill to talk to a Health Coach. Call to learn about programs and other resources available to help you manage:

- Stress
- Personal nutrition
- Weight management
- Physical activities
- Insomnia
- Depression

Help with chronic conditions

If you have diabetes, asthma, congestive heart failure, chronic obstructive pulmonary disease or coronary artery disease, you need to manage your condition every day in order to stay healthy and avoid hospital stays. That means keeping track of medications, tests, doctor appointments

and your diet. Your Blues On Call Health Coach can help you work more closely with your doctor and get more involved in taking good care of yourself.

You can even establish a relationship with a specific Health Coach and schedule time to talk about your concerns and conditions.

myCare Navigator℠ - 24/7 Health Advocate Support

Getting the right care and finding the right doctor and wellness services for you and your family is now as quick and easy as calling myCare Navigator at 1-888-BLUE-428.

Your dedicated health advocate can help you and your family members:

- locate a primary care physician or get an appointment with a hard-to-reach specialist;
- get your medical records transferred;
- get a second opinion;
- understand your health care options;
- locate wellness resources, such as services for your special needs child or quality elder care for a parent; or
- handle billing questions and make the most of your care dollars.

Get the help you need to navigate the health care system easily and effectively. The same number that connects you to Blues On Call now connects you to your health advocate, myCare Navigator. So call **1-888-BLUE-428** for *total* care support!

Highmark Website

As a Highmark member, you have a wealth of health information at your fingertips. It's easy to access offerings online as well as an app for Sharecare. Whether you are looking for a health care provider or managing your claims…want to make informed health care decisions on treatment options, or lead a healthier lifestyle, Highmark can help with tools and resources both online and through an app.

Go to www.highmarkbcbs.com for your claims information or connect to Sharecare via app or web for features such as the RealAge health risk assessment, daily tracking functionality, AskMD symptom checker, Health Profile and a comprehensive library of medical information.

Through the power of technology and a partnership with Sharecare, you will have the ability to meaningfully engage and manage all your health in one place—at your fingertips, through your smartphones. Sharecare serves as the digital companion to Highmark's Well360 health management strategy and capitalizes on intrinsic motivation to draw members to the platform, leading to high levels of engagement. Featured digital platform capabilities include the RealAge health risk assessment, daily tracking functionality, AskMD symptom checker, Health Profile and a comprehensive library of medical information, all presented to you through ultra-personalized content, navigation and messaging which is driven by artificial intelligence of member navigation patterns and claims information. Intervention programs tailored to an individual have been shown to increase engagement, reduce attrition, lead to better outcomes

than untailored programs, and are proven by the 60%+ daily engagement that the Sharecare platform has demonstrated. More engaged members means lower risk and increased cost management potential.

Wellness Coaching

Starting to improve one's health can be difficult, and it can be even harder to choose the best wellness programs and activities to help along the way. A personal wellness coach can provide the guidance needed in the areas of weight management, nutrition, physical activity, stress management, and overall wellness. Call 1-888-BLUE-428 (1-888-258- 3428) to talk with a coach today. Wellness coaching hours are 8:30 am - 8:30 pm EST:

- **Personal Wellness Coaching** is individual telephonic lifestyle coaching done by credentialed wellness coaches who empower participants to make healthy, sustainable lifestyle changes. Topics of nutrition, weight management, physical activity, stress management, tobacco cessation and more can be discussed.

- **Drop 10 in 10** is a 10-week integrated, comprehensive, and multi-modal weight loss program that helps members understand weight management basics, the importance of physical activity and stress management, how to meal plan, and best practices for handling challenges. Coaches utilize Motivational Interviewing techniques, including the Stages of Change, to engage members at all motivation levels to produce the best outcomes.

- **How to Be Tobacco Free** is a tobacco cessation program where members engage with an experienced coach around triggers, coping skills, overcoming barriers, staying quit, and Nicotine Replacement Therapy (NRT) options. The program is modeled after the evidence-based National Cancer Institute's 'Clearing the Air' program.

- **Daily Steps to Less Stress** is a stress awareness program designed to help members build skills and learn techniques needed to balance life's day-to-day ups and downs. Members can engage with an experienced coach to assess their level of stress, recognize areas for improvement, learn proven strategies to cope with stress, and become more stress-resilient.

- **AIM for Change** is designed to help members learn about healthy eating basics, the value of physical activity, and how both nutrition and physical activity are key components for long-term weight management and improved health. This foundational program also addresses a member's barriers to change and helps set them up for success.

- **Time to Sleep Well** is an integrated, multi-modal sleep awareness program where members can learn techniques and gain tools needed to help improve their sleep. Members can engage with an experienced coach to assess their sleep patterns, recognize areas for improvement, and learn proven strategies to improve their sleep.

Virtual Medicine

When you and your family need quick care for minor illnesses, virtual medicine is a convenient option that allows you to resolve many of your medical issues through the convenience of online video consultations. You can use this service 24/7 to visit U.S. board-certified, state licensed doctors who can diagnose, recommend treatment and prescribe medication, when appropriate.

When can I use it?

- When you need care now
- When considering the ER or urgent care center for non-emergency issues (In emergency situations, such as heart attack or stroke symptoms, always go to the emergency room or call 911)
- On or on a business trip

How Virtual Medicine Works

From check-in to diagnosis, virtual doctor visits are designed to be comfortable and familiar, while being as simple as possible. Get started today and you will be ready when you need it. It's easy to start taking advantage of virtual medicine. Just register online. Create an account by following the simple directions by downloading their app or using the website noted for the type of service you need:

Create an account:

1. Enter your name, address, etc.
2. Complete a brief health history.
3. Include any allergies.

Select your doctor:

1. Look through doctor profiles.
2. Choose a doctor and click "start visit".

Enter your health info and start the visit

1. Tell us who the visit is for, you or your child.
2. Share any historical conditions and allergies with the doctor.
3. Enter your health insurance information.
4. Begin your live video visit.

Wrap up

1. View the doctor's notes and diagnosis.
2. If you are prescribed medication, it will automatically be sent to your pharmacy.

Minor Medical problems - Doctor on Demand (doctorondemand.com) address issues like:

- Cold and flu
- Rashes
- Pinkeye
- Headaches

Behavioral Health - Amwell (amwell.com) address issues like:

- Depression
- Anxiety
- Relationship challenges

(For reliable and convenient scheduled therapy visits with certified therapists)

Dermatology problems - Dermatologist on Call (dermatologistoncall.com) address issues like:

- Rashes
- Moles
- Skin, hair or nail issues

(Pictures can be taken of your symptoms to send to a consulting dermatologist through a secure website.)

If your primary care physician has virtual medicine capabilities and chooses to use this service, you may be able to visit your primary care doctor virtually. Additionally, after you see a specialist in person, you can take advantage of virtual visits for any follow-up visits needed. These visits take place in real time at a primary care provider's office, outpatient clinic or other location close to you that has the equipment needed for virtual visits.

If you have any questions about these services call Highmark's Customer Service at 1-866-594-1732.

Baby Blueprints®

If You Are Pregnant, Now Is the Time to Enroll in Baby Blueprints

If you are expecting a baby, this is an exciting time for you. It's also a time when you have many questions and concerns about your health and your developing baby's health.

To help you understand and manage every stage of pregnancy and childbirth, Highmark offers the Baby Blueprints Maternity Education and Support Program.

By enrolling in this free program, you will have access to online information on all aspects of pregnancy and childbirth. Baby Blueprints will also provide you with personal support from a nurse health coach available to you throughout your pregnancy.

Easy Enrollment

Just call toll-free at 1-866-918-5267. You can enroll at any time during your pregnancy.

iDental Discount

iDental is a dental discount plan presented by United Concordia. This is not dental insurance rather a dental plan we've designed to provide savings for you and your family when you visit a participating dentist.

Plan Features and Highlights

- Oral health and wellness for you and your eligible dependents
- Orthodontia (orthotdontics) included
- More participating dentists in more locations
- Present your card and pay the discounted fee at the time of your treatment
- No annual limits
- Direct access to *ALL* participating dentists – including specialists

Activate Your Member's Area Login Account

1. Visit your Member's Area by going to:
   a. Laborers'.Dentalplans.com/Activate
2. Enter activation code and your new DentalPlans Member ID number listed on the ID card:
   a. Your activation code is: **23092**
   b. Your member ID number
3. You will then be prompted to update your email address and choose a password to continue to the Member's Area:
   a. If you do not have an email address the system will create one for you using the following format: 23092FirstNameLastName@dentalplans.com

How to Use Your Plan – Member's Area Features

1. Print additional ID cards. Click "Print My Card"
2. Find a dentist. Click "Find a Dentist" in your Member's Area homepage. Enter you ZIP code and click "SELECT YOUR DENTIST" to locate participating providers who accept the iDental Discount Plan by United Concordia. You may also conduct a more specific search by entering a dentist's last name.
3. Customize your Members' Area and save your dentist's contact information to your My Dentist page.
4. Review the fee schedule for iDental Discount Plan by United Concordia.
5. When making your appointment, it is important that you reference that you are a member of iDental Discount Plan by United Concordia through Dentalplans.com

Any questions regarding iDental, contact Member C.A.R.E. at 1-855-326-0566

MEMBER RIGHTS AND RESPONSIBILITIES

Your participation in PPO Blue or Community Blue is vital to maintaining quality in your program and services. Your importance to this process is reflected in the following statement of principles.

You have the right to:

1. Receive information about your group health plan, its practitioners and providers, and your rights and responsibilities.
2. Be treated with respect and recognition of your dignity and right to privacy.
3. Participate with practitioners in decision-making regarding your health care. This includes the right to be informed of your diagnosis and treatment plan in terms that you understand and participate in decisions about your care.
4. Have a candid discussion of appropriate and/or medically necessary treatment options for your condition(s), regardless of cost or benefit coverage. Your group health plan does not restrict the information shared between practitioners and patients and has policies in place, directing practitioners to openly communicate information with their patients regarding all treatment options regardless of benefit coverage.
5. Voice a complaint or file an appeal about your group health plan or the care provided and receive a reply within a reasonable period of time.
6. Make recommendations regarding the Members' Rights and Responsibilities policies.

You have a responsibility to:

1. Supply to the extent possible, information that the organization needs in order to make care available to you, and that its practitioners and providers need in order to care for you.
2. Follow the plans and instructions for care that you have agreed on with your practitioners.
3. Communicate openly with the physician you choose. Ask questions and make sure you understand the explanations and instructions you are given, and participate in developing mutually agreed upon treatment goals. Develop a relationship with your doctor based on trust and cooperation.

Women's Health Cancer Rights

Do you know that your Plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema? Call Highmark at 1-866-594-1732 for more information.

How We Protect Your Right to Confidentiality

We have established policies and procedures to protect the privacy of our members' protected health information ("PHI") in all forms, including PHI given verbally, from unauthorized or improper use. Some of the ways we protect your privacy include not discussing PHI outside of our offices, e.g., in hallways, elevators, as well as verifying your identity before we discuss PHI with you over the phone. As permitted by law, we may use or disclose protected health information for treatment, payment and health care operations, such as: claims management, routine audits, coordination of care, quality assessment and measurement, case management, utilization review, performance measurement, customer service, credentialing, medical review and underwriting. With the use of measurement data, we are able to manage members' health care needs, even targeting certain individuals for quality improvement programs, such as health, wellness and disease management programs.

If we ever use your protected health information for non-routine uses, we will ask you to give us your permission by signing a special authorization form, except with regard to court orders and subpoenas.

You have the right to access the information your doctor has been keeping in your medical records, and any such request should be directed first to your network physician.

You benefit from the many safeguards we have in place to protect the use of data we maintain. This includes requiring our employees to sign statements in which they agree to protect your confidentiality, using computer passwords to limit access to your protected health information, and including confidentiality language in our contracts with physicians, hospitals, vendors and other health care providers.

Our Privacy Department reviews and approves policies regarding the handling of confidential information

Recognizing that you have a right to privacy in all settings, we even inspect the privacy of examination rooms when we conduct on-site visits to physicians' offices. It's all part of safeguarding the confidentiality of your protected health information.

TERMS YOU SHOULD KNOW

Applied Behavioral Analysis – The design, implementation and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior or to prevent loss of attained skill or function, including the use of direct observation, measurement and functional analysis of the relations between environment and behavior.

Assisted Fertilization – Any method used to enhance the possibility of conception through retrieval or manipulation of the sperm or ovum. This includes, but is not limited to, Artificial Insemination, In Vitro Fertilization (IVF), Gamete Intra-Fallopian Transfer (GIFT), Zygote Intra-Fallopian Transfer (ZIFT), Tubal Embryo Transfer (TET), Peritoneal Ovum Sperm Transfer, Zona Drilling, and sperm microinjection.

Artificial Insemination – A procedure, also known as intrauterine insemination (IUI) or intracervical/intravaginal insemination (ICI), by which sperm is directly deposited into the vagina, cervix or uterus to achieve fertilization and pregnancy.

Autism Spectrum Disorders – Any of the pervasive developmental disorders defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, or its successor, including autistic disorder, Asperger's disorder and pervasive developmental disorder not otherwise specified.

Blues On Call – A 24-hour health decision support program that gives you ready access to a specially-trained health coach.

Board-Certified – A designation given to those physicians who, after meeting strict standards of knowledge and practices, are certified by the professional board representing their specialty.

Brand Drug – A recognized trade name prescription drug product, usually either the innovator product for new drugs still under patent protection or a more expensive product marketed under a brand name for multi-source drugs and noted as such in the pharmacy database used by Highmark.

Claim – A request for precertification, preauthorization or prior approval of a covered service or for the payment or reimbursement of the charges or costs associated with a covered service. Claims include:

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

Community Blue PPO and PPO Blue Network Service Area – The geographic area consisting of the following counties in western Pennsylvania:

Allegheny	Centre (part)	Forest	Mercer
Armstrong	Clarion	Greene	Potter
Beaver	Clearfield	Huntingdon	Somerset
Bedford	Crawford	Indiana	Venango
Blair	Elk	Jefferson	Warren
Butler	Erie	Lawrence	Washington
Cambria	Fayette	McKean	Westmoreland
Cameron			

Covered Services – A service or supply specified by your program which is eligible for payment when rendered by a provider.

Custodial Care – Care provided primarily for maintenance of the patient or which is designed essentially to assist the patient in meeting the activities of daily living and which is not primarily provided for its therapeutic value in the treatment of an illness, disease, bodily injury, or condition.

Designated Agent – An entity that has contracted, either directly or indirectly, with your health care program to perform a function and/or service in the administration of this program. Such function and/or service may include, but is not limited to, medical management and provider referral.

Diabetes Prevention Program – A 12-month program using curriculum approved by the Centers for Disease Control to deliver a prevention lifestyle intervention for those at high risk of developing type 2 diabetes. The program includes behavioral and motivational content focusing on moderate changes in both diet and physical activity.

Diabetes Prevention Provider – An entity that offers a diabetes prevention program based on an in-person/onsite or digital model and that has an agreement with Highmark. If the program is based on an in-person/onsite model, the program must offer services through a participating member association which has a contract with the YMCA.

Emergency Care Services – The treatment of bodily injuries resulting from an accident, or following the sudden onset of a medical condition, or following, in the case of a chronic condition, a sudden and unexpected medical event that manifests itself by acute symptoms of sufficient severity or severe pain, such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:

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

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

Exclusions – Services, supplies or charges that are not covered by your program.

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

Medical researchers constantly experiment with new medical equipment, drugs and other technologies. In turn, health care plans must evaluate these technologies.

Decisions for evaluating new technologies, as well as new applications of existing technologies, for medical and behavioral health procedures, pharmaceuticals and devices should be made by medical professionals. That is why a panel of more than 400 medical professionals works with a nationally recognized Medical Affairs Committee to review new technologies and new applications for existing technologies for medical and behavioral health procedures and devices. To stay current and patient-responsive, these reviews are ongoing and all-encompassing, considering factors such as product efficiency, safety and effectiveness. If the technology passes the test, the Medical Affairs Committee recommends it be considered as acceptable medical practice and a covered benefit. Technology that does not merit this status is usually considered "experimental/investigative" and is not generally covered. However, it may be re-evaluated in the future.

A similar process is followed for evaluating new pharmaceuticals. The Pharmacy and Therapeutics (P & T) Committee assesses new pharmaceuticals based on national and international data, research that is currently underway and expert opinion from leading clinicians. The P & T Committee consists of at least one Highmark-employed pharmacist and/or medical director, five board-certified, actively practicing network physicians and two Doctors of Pharmacy currently providing clinical pharmacy services within the Highmark service area. At the committee's discretion, advice, support and consultation may also be sought from physician subcommittees in the following specialties: cardiology, dermatology, endocrinology, hematology/oncology, obstetrics/gynecology, ophthalmology, psychiatry, infectious disease, neurology, gastroenterology and urology. Issues that are addressed during the review process include clinical efficacy, unique value, safety, patient compliance, local physician and specialist input and pharmacoeconomic impact. After the review is complete, the P & T Committee makes recommendations.

Situations may occur when you elect to pursue experimental/investigative treatment. If you have a concern that a service you will receive may be experimental/investigational, you or the hospital and/or professional provider may contact Highmark's Member Service to determine coverage.

Explanation of Benefits (EOB) – This is the statement you'll receive from Highmark after your claim is processed. It lists: the provider's charge, allowable amount, copayment, deductible and coinsurance amounts, if any, you're required to pay; total benefits payable; and total amount you owe.

Generic Drug – A drug that is available from more than one manufacturing source and accepted by the FDA as a substitute for those products having the same active ingredients as a brand drug and listed in the FDA "Approved Drug Products with Therapeutic Equivalence Evaluations," otherwise known as the Orangebook, and noted as such in the pharmacy database used by Highmark.

Immediate Family – Your spouse, child, stepchild, parent, brother, sister, mother-in-law, father-in-law, brother-in-law, sister-in-law, daughter-in-law, son-in-law, grandchild, grandparent, stepparent, stepbrother or stepsister.

Infertility – The medically documented inability to conceive with unprotected sexual intercourse between partners of the opposite biological sex for a period of at least 12 months. The inability to conceive may be due to either partner.

Inpatient – A member who is a registered bed patient in a hospital or skilled nursing facility and for whom a room and board charge is made.

Maintenance Prescription Drug – A prescription drug prescribed for the control of a chronic disease or illness, or to alleviate the pain and discomfort associated with a chronic disease or illness.

Maximum – The greatest amount payable by the program for covered services. This could be expressed in dollars, number of days, or number of services for a specified period of time. There are two types of maximums:

- **Program Maximum** – The greatest amount payable by the program for all covered services.
- **Benefit Maximum** – The greatest amount payable by the program for a specific covered service.

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

Medicare Eligible Expenses – Expenses of the kinds covered by Medicare, to the extent recognized as reasonable and medically necessary and appropriate by Medicare. If this program provides for benefits not covered by Medicare, Highmark reserves the right to determine whether such benefits are medically necessary and appropriate.

Methadone Maintenance – The treatment of heroin or other morphine-like drug dependence where you are taking methadone hydrochloride daily in prescribed doses to replace the previous heroin or other morphine-like drug abuse.

Multi-Source Brand Drug – A recognized trade name drug product that does not have patent protection and for which a generic equivalent exists.

Network – Depending on where you receive services, the network is designated as one of the following:

- **Community Blue Network** – all Community Blue providers that have entered into a network agreement, either directly or indirectly with Highmark.
- **PPO Blue** – all PPO Blue providers that have entered into a network agreement, either directly or indirectly with Highmark.
- **Highmark Blue Shield Participating Facility Provider Network** – all Highmark Blue Shield participating facility providers that have entered into an agreement, either directly or indirectly, with Highmark.
- **PremierBlue Shield Preferred Professional Provider Network** – all PremierBlue Shield Preferred Professional providers who have an agreement, either directly or indirectly, with Highmark.

Network Provider – An ancillary provider, professional provider or facility provider who has entered into an agreement, either directly or indirectly, with Highmark Blue Cross Blue Shield or with any licensee of the Blue Cross Blue Shield Association located out-of-area, pertaining to payment as a participant in your network for covered services rendered to a member.

Network Service – A service, treatment or care that is provided by a network provider.

Partial Hospitalization – The provision of medical, nursing, counseling or therapeutic mental health care services or substance abuse services on a planned and regularly scheduled basis in a facility provider designed for a patient or client who would benefit from more intensive services than are generally offered through outpatient treatment but who does not require inpatient care.

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

program's participation in the BlueCard program described in the How Your Health Care Program Works section of this booklet.

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

In some cases, an allowance may be negotiated with an out-of-area non-participating provider. The negotiated reimbursement amount will be based on prevailing market reimbursement amounts. In the event the negotiations with a non-participating out-of-area provider are unsuccessful, the plan allowance will be based on pricing determined by a national database. For facility claims, the pricing will be determined on the basis of detailed data reflecting actual reported billings and payments over the preceding 24 months and includes an inflation factor. For professional claims, pricing will be determined on median-based cost of care that is adjusted for geography.

Emergency Services Provided by an Out-of-Network Provider

For emergency services provided by an out-of-network provider, the plan allowance is based on one of the following, in the order listed below, as applicable;

(i) The reference price (as defined below) if out-of-area;
(ii) Recognized amount price (as defined below) if out-of-area;
(iii) The amount agreed to by the out-of-network provider and Highmark; or
(iv) The amount determined by Independent Dispute Resolution (IDR)

Air Ambulance Transportation Provided by an Out-of-Network Provider

For Air Ambulance transportation provided by an out-of-network provider, the plan allowance is based on one of the following, in the order listed below, as applicable;

(i) The recognized amount (as defined below) if out-of-area;
(ii) The amount subsequently agreed to by the out-of-network provider and Highmark; or
(iii) The amount determined by Independent Dispute Resolution (IDR)

Plan Year – The specified period of time during which charges for covered services must be incurred in order to be eligible for payment by your program. A charge shall be considered incurred on the date you receive the service or supply for which the charge is made.

Precertification (Preauthorization) – The process through which medical necessity and appropriateness of inpatient admissions, services or place of services is determined by Highmark prior to or after an admission or the performance of a procedure or service.

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

Primary Care Physician (PCP) – A physician whose practice is limited to family practice, general practice, internal medicine or pediatrics and who may supervise, coordinate and provide specific basic medical services and maintain continuity of patient care.

Provider's Allowable Price – The amount at which a participating pharmacy provider has agreed, either directly or indirectly, with the health plan to provide covered medications to you under this program.

Recognized Amount– Except as otherwise provided, the plan allowance and the amount which coinsurance and applicable deductible is based on for covered medical services when provided by:

(i) Out-of-network emergency service providers; and

(ii) Non-emergency service received at certain in-network facilities by non-network providers, when such services are either ancillary or non-ancillary provider services that have not satisfied the notice and consent criteria under federal law and regulation. For the purpose of this definition, "certain facilities" are limited to a hospital (a hospital outpatient department, a critical access hospital, an ambulatory surgical center); as defined in federal law and regulation. The Recognized Amount is based on:

(i) an all-payer model agreement, if adopted;

(ii) State law; or

(iii) The lesser of the qualifying payment amount as determined by Highmark (or the local licensee of the Blue Cross Blue Shield Association when the claim is incurred outside the Highmark service area) under applicable law and regulation, or the amount billed by the provider or facility.

The recognized amount for air ambulance services provided by an out-of-network provider will be calculated based on the lesser of the qualifying payment amount as determined under applicable law and regulation or the amount billed by the air ambulance service provider.

Reference Price – Means a percentage of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for Medicare for the same or similar service within the geographic market. When a rate is not published by CMS for the service, Highmark uses the price determined by a nationally recognized database or if no such price is available, then 50% off billed charges.

Single Source Brand Drug – A recognized brand drug under patent protection which prohibits the manufacturing of generic equivalent products.

Specialist – A physician, other than a primary care provider, whose practice is limited to a particular branch of medicine or surgery.

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

You or Your – Refers to individuals who are covered under the program.

Highmark is a registered mark of Highmark Inc.

Community Blue, PPO Blue, Blues On Call and myCare Navigator are service marks of the Blue Cross Blue Shield Association, an association of independent Blue Cross and Blue Shield companies.

Baby Blueprints, BlueCard, Blue Cross, Blue Shield and the Cross and Shield symbols are registered service marks of the Blue Cross Blue Shield Association.

The Blue Cross Blue Shield Association is an independent company that does not provide Highmark Blue Cross Blue Shield products and services.

Express Scripts is a registered trademark of Express Scripts Holding Company.

You are hereby notified that Highmark Blue Cross Blue Shield provides administrative services only on behalf of your self-funded group health plan. Highmark Blue Cross Blue Shield is an independent corporation operating under licenses from the Blue Cross and Blue Shield Association ("the Association"), which is a national association of independent Blue Cross and Blue Shield companies throughout the United States. Although all of these independent Blue Cross and Blue Shield companies operate from a license with the Association, each of them is a separate and distinct operation. The Association allows Highmark Blue Cross Blue Shield to use the familiar Blue Cross and Blue Shield words and symbols. Highmark Blue Cross Blue Shield is neither the insurer nor the guarantor of benefits under your group health plan. Your Group remains fully responsible for the payment of group health plan benefits.

NOTICE OF PRIVACY PRACTICES

PART I – NOTICE OF PRIVACY PRACTICES (HIPAA)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

THIS NOTICE ALSO DESCRIBES HOW WE COLLECT, USE AND DISCLOSE NON-PUBLIC PERSONAL FINANCIAL INFORMATION.

Our Legal Duties

At Highmark Inc. ("Highmark"), we are committed to protecting the privacy of your "Protected Health Information" (PHI). PHI is your individually identifiable health information, including demographic information, collected from you or created or received by a health care provider, a health plan, your employer, or a health care clearinghouse that relates to: (i) your past, present, or future physical or mental health or condition; (ii) the provision of health care to you; or (iii) the past, present, or future payment for the provision of health care to you.

This Notice describes our privacy practices, which include how we may use, disclose, collect, handle, and protect our members' protected health information. We are required by applicable federal and state laws to maintain the privacy of your protected health information. We also are required by the HIPAA Privacy Rule (45 C.F.R. parts 160 and 164, as amended) to give you this Notice about our privacy practices, our legal duties, and your rights concerning your protected health information. We are also required to notify affected individuals following a breach of unsecured health information.

We will inform you of these practices the first time you become a Highmark customer. We must follow the privacy practices that are described in this Notice as long as it is in effect. This Notice became effective September 23, 2013, and will remain in effect unless we replace it.

On an ongoing basis, we will review and monitor our privacy practices to ensure the privacy of our members' protected health information. Due to changing circumstances, it may become necessary to revise our privacy practices and the terms of this Notice. We reserve the right to make the changes in our privacy practices and the new terms of our Notice will become effective for all protected health information that we maintain, including protected health information we created or received before we made the changes. Before we make a material change in our privacy practices, we will change this Notice and notify all affected members in writing in advance of the change. Any change to this notice will be posted on our website and we will further notify you of any changes in our annual mailing.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

I. Uses and Disclosures of Protected Health Information

In order to administer our health benefit programs effectively, we will collect, use and disclose protected health information for certain of our activities, including payment and health care operations.

A. Uses and Disclosures of Protected Health Information for Payment and Health Care Operations

The following is a description of how we may use and/or disclose protected health information about you for payment and health care operations:

Payment

We may use and disclose your protected health information for all activities that are included within the definition of "payment" as set out in 45 C.F.R. § 164.501. We have not listed in this Notice all of the activities included within the definition of "payment," so please refer to 45 C.F.R. § 164.501 for a complete list.

For example:
We may use and disclose your protected health information to pay claims from doctors, hospitals, pharmacies and others for services delivered to you that are covered by your health plan, to determine your eligibility for benefits, to coordinate benefits, to examine medical necessity, to obtain premiums, and/or to issue explanations of benefits to the person who subscribes to the health plan in which you participate.

Health Care Operations

We may use and disclose your protected health information for all activities that are included within the definition of "health care operations" as set out in 45 C.F.R. § 164.501. We have not listed in this Notice all of the activities included within the definition of "health care operations," so please refer to 45 C.F.R. § 164.501 for a complete list.

For example:
We may use and disclose your protected health information to rate our risk and determine the premium for your health plan, to conduct quality assessment and improvement activities, to credential health care providers, to engage in care coordination or case management, and/or to manage our business.

B. Uses and Disclosures of Protected Health Information to Other Entities

We also may use and disclose protected health information to other covered entities, business associates, or other individuals (as permitted by the HIPAA Privacy Rule) who assist us in administering our programs and delivering health services to our members.

(i) Business Associates.

In connection with our payment and health care operations activities, we contract with individuals and entities (called "business associates") to perform various functions on our behalf or to provide certain types of services (such as member service support, utilization management, subrogation, or pharmacy benefit management). To perform these functions

or to provide the services, business associates will receive, create, maintain, use, or disclose protected health information, but only after we require the business associates to agree in writing to contract terms designed to appropriately safeguard your information.

(ii) Other Covered Entities.

In addition, we may use or disclose your protected health information to assist health care providers in connection with *their* treatment or payment activities, or to assist other covered entities in connection with certain of *their* health care operations. For example, we may disclose your protected health information to a health care provider when needed by the provider to render treatment to you, and we may disclose protected health information to another covered entity to conduct health care operations in the areas of quality assurance and improvement activities, or accreditation, certification, licensing or credentialing.

II. Other Possible Uses and Disclosures of Protected Health Information

In addition to uses and disclosures for payment, and health care operations, we may use and/or disclose your protected health information for the following purposes:

A. To Plan Sponsors

We may disclose your protected health information to the plan sponsor of your group health plan to permit the plan sponsor to perform plan administration functions. For example, a plan sponsor may contact us regarding a member's question, concern, issue regarding claim, benefits, service, coverage, etc. We may also disclose summary health information (this type of information is defined in the HIPAA Privacy Rule) about the enrollees in your group health plan to the plan sponsor to obtain premium bids for the health insurance coverage offered through your group health plan or to decide whether to modify, amend or terminate your group health plan.

B. Required by Law

We may use or disclose your protected health information to the extent that federal or state law requires the use or disclosure. For example, we must disclose your protected health information to the U.S. Department of Health and Human Services upon request for purposes of determining whether we are in compliance with federal privacy laws.

C. Public Health Activities

We may use or disclose your protected health information for public health activities that are permitted or required by law. For example, we may use or disclose information for the purpose of preventing or controlling disease, injury, or disability.

D. Health Oversight Activities

We may disclose your protected health information to a health oversight agency for activities authorized by law, such as: audits; investigations; inspections; licensure or disciplinary actions; or civil, administrative, or criminal proceedings or actions. Oversight agencies seeking this information include government agencies that oversee: (i) the health care system; (ii) government benefit programs; (iii) other government regulatory programs; and (iv) compliance with civil rights laws.

E. Abuse or Neglect

We may disclose your protected health information to a government authority that is authorized by law to receive reports of abuse, neglect, or domestic violence.

F. Legal Proceedings

We may disclose your protected health information: (1) in the course of any judicial or administrative proceeding; (2) in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized); and (3) in response to a subpoena, a discovery request, or other lawful process, once we have met all administrative requirements of the HIPAA Privacy Rule. For example, we may disclose your protected health information in response to a subpoena for such information.

G. Law Enforcement

Under certain conditions, we also may disclose your protected health information to law enforcement officials. For example, some of the reasons for such a disclosure may include, but not be limited to: (1) it is required by law or some other legal process; or (2) it is necessary to locate or identify a suspect, fugitive, material witness, or missing person.

H. Coroners, Medical Examiners, Funeral Directors, and Organ Donation

We may disclose protected health information to a coroner or medical examiner for purposes of identifying a deceased person, determining a cause of death, or for the coroner or medical examiner to perform other duties authorized by law. We also may disclose, as authorized by law, information to funeral directors so that they may carry out their duties. Further, we may disclose protected health information to organizations that handle organ, eye, or tissue donation and transplantation.

I. Research

We may disclose your protected health information to researchers when an institutional review board or privacy board has: (1) reviewed the research proposal and established protocols to ensure the privacy of the information; and (2) approved the research.

J. To Prevent a Serious Threat to Health or Safety

Consistent with applicable federal and state laws, we may disclose your protected health information if we believe that the disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.

K. Military Activity and National Security, Protective Services

Under certain conditions, we may disclose your protected health information if you are, or were, Armed Forces personnel for activities deemed necessary by appropriate military command authorities. If you are a member of foreign military service, we may disclose, in certain circumstances, your information to the foreign military authority. We also may disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, and for the protection of the President, other authorized persons, or heads of state.

L. Inmates

If you are an inmate of a correctional institution, we may disclose your protected health information to the correctional institution or to a law enforcement official for: (1) the institution to provide health care to you; (2) your health and safety and the health and safety of others; or (3) the safety and security of the correctional institution.

M. Workers' Compensation

We may disclose your protected health information to comply with workers' compensation laws and other similar programs that provide benefits for work-related injuries or illnesses.

N. Others Involved in Your Health Care

Unless you object, we may disclose your protected health information to a friend or family member that you have identified as being involved in your health care. We also may disclose your information to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status, and location. If you are not present or able to agree to these disclosures of your protected health information, then we may, using our professional judgment, determine whether the disclosure is in your best interest.

O. Underwriting

We may disclose your protected health information for underwriting purposes; however, we are prohibited from using or disclosing your genetic information for these purposes.

P. Health Information Exchange

We all participate in a Health Information Exchange (HIE). An HIE is primarily a secure electronic data sharing network. In accordance with federal and state privacy regulations, regional health care providers participate in the HIE to exchange patient information in order to facilitate health care, avoid duplication of services, such as tests, and to reduce the likelihood that medical errors will occur.

The HIE allows your health information to be shared among authorized participating healthcare providers, such as health systems, hospitals and physicians, for the purposes of Treatment, Payment or Healthcare Operations purposes. Examples of this health information may include:

- General laboratory, pathology, transcribed radiology reports and EKG Images
- Results of outpatient diagnostic testing (GI testing, cardiac testing, neurological testing, etc.)
- Health Maintenance documentation/Medication
- Allergy documentation/Immunization profiles
- Progress notes, Urgent Care visit progress notes
- Consultation notes
- Inpatient operative reports
- Discharge summary/Emergency room visit discharge summary notes

All participating providers who provide services to you will have the ability to access your information. Providers that do not provide services to you will not have access to your information. Information may be provided to others as necessary for referral,

consultation, treatment or the provision of other healthcare services, such as pharmacy or laboratory services. All participating providers have agreed to a set of standards relating to their use and disclosure of the information available through the HIE. Your health information shall be available to all participating providers through the HIE.

You cannot choose to have only certain providers access your information. Patients who do not want their health information to be accessible through the HIE may choose not to participate or may "opt-out."

In order to opt-out, you must complete an opt-out Form, which is available at highmark.com or by calling the customer service number located on the back of your membership card. You should be aware, if you choose to opt-out, your health care providers will not be able to access your health information through the HIE. Even if you chose to opt-out, your information will be sent to the HIE, but provider will not be able to access this information. Additionally, your opt-out does not affect the ability of participating providers to access health information entered into the HIE prior to your opt-out submission.

III. Required Disclosures of Your Protected Health Information

The following is a description of disclosures that we are required by law to make:

A. Disclosures to the Secretary of the U.S. Department of Health and Human Services

We are required to disclose your protected health information to the Secretary of the U.S. Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA Privacy Rule.

B. Disclosures to You

We are required to disclose to you most of your protected health information that is in a "designated record set" (defined below) when you request access to this information. We also are required to provide, upon your request, an accounting of many disclosures of your protected health information that are for reasons other than payment and health care operations.

IV. Other Uses and Disclosures of Your Protected Health Information

Sometimes we are required to obtain your written authorization for use or disclosure of your health information. The uses and disclosures that require an authorization under 45 C.F.R. § 164.508(a) are:

1. For marketing purposes
2. If we intend to see your PHI
3. For use of Psychotherapy notes, which are notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of a conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical record. An Authorization for use of psychotherapy notes is required unless:
   a) Used by the person who created the psychotherapy note for treatment purposes, or
   b) Used or disclosed for the following purposes:

i. the provider's own training programs in which students, trainees, or practitioners in mental health learn under supervision to practice or improve their skills in group, joint family or individual counseling;
ii. for the provider to defend itself in a legal action or other proceeding brought by an individual that is the subject of the notes;
iii. if required for enforcement purposes;
iv. if mandated by law;
v. if permitted for oversight of the provider that created the note;
vi. to a coroner or medical examiner for investigation of the death of any individual in certain circumstances; or
vii. if needed to avert a serious and imminent threat to health or safety.

Other uses and disclosures of your protected health information that are not described above will be made only with your written authorization. If you provide us with such an authorization, you may revoke the authorization in writing, and this revocation will be effective for future uses and disclosures of protected health information. However, the revocation will not be effective for information that we already have used or disclosed, relying on the authorization.

V. Your Individual Rights

The following is a description of your rights with respect to your protected health information:

A. Right to Access

You have the right to look at or get copies of your protected health information in a designated record set. Generally, a "designated record set" contains medical and billing records, as well as other records that are used to make decisions about your health care benefits. However, you may not inspect or copy psychotherapy notes or certain other information that may be contained in a designated record set.

You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so, if you request the information in an electronic format that is not readily producible, we will provide the information in a readable electronic format as mutually agreed upon. You must make a request in writing to obtain access to your protected health information.

To inspect and/or copy your protected health information, you may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. The first request within a 12-month period will be free. If you request access to your designated record set more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. If you request an alternative format, we will charge a cost-based fee for providing your protected health information in that format. If you prefer, we will prepare a summary or an explanation of your protected health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.

We may deny your request to inspect and copy your protected health information in certain limited circumstances. If you are denied access to your information, you may request that the denial be reviewed. A licensed health care professional chosen by us will

review your request and the denial. The person performing this review will not be the same one who denied your initial request. Under certain conditions, our denial will not be reviewable. If this event occurs, we will inform you in our denial that the decision is not reviewable.

B. Right to an Accounting

You have a right to an accounting of certain disclosures of your protected health information that are for reasons other than treatment, payment or health care operations. You should know that most disclosures of protected health information will be for purposes of payment or health care operations.

An accounting will include the date(s) of the disclosure, to whom we made the disclosure, a brief description of the information disclosed, and the purpose for the disclosure.

You may request an accounting by calling Member Services at 1-866-594-1732, or submitting your request in writing to the Highmark Privacy Department, 120 Fifth Avenue Place 1814, Pittsburgh, PA 15222. Your request may be for disclosures made up to 6 years before the date of your request, but in no event, for disclosures made before April 14, 2003.

The first list you request within a 12-month period will be free. If you request this list more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.

C. Right to Request a Restriction

You have the right to request a restriction on the protected health information we use or disclose about you for treatment, payment or health care operations. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement unless the information is needed to provide emergency treatment to you. Any agreement we may make to a request for additional restrictions must be in writing signed by a person authorized to make such an agreement on our behalf. We will not be bound unless our agreement is so memorialized in writing. We have a right to terminate this restriction, however if we do so, we must inform you of this restriction.

You may request a restriction by Member Services at 1-866-594-1732, or writing to the Highmark Privacy Department, 120 Fifth Avenue Place 1814, Pittsburgh, PA 15222. In your request tell us: (1) the information whose disclosure you want to limit; and (2) how you want to limit our use and/or disclosure of the information.

D. Right to Request Confidential Communications

If you believe that a disclosure of all or part of your protected health information may endanger you, you have the right to request that we communicate with you in confidence about your protected health information by alternative means or to an alternative location. For example, you may ask that we contact you only at your work address or via your work e-mail.

You must make your request in writing, and you must state that the information could endanger you if it is not communicated in confidence by the alternative means or to the

alternative location you want. We must accommodate your request if it is reasonable, specifies the alternative means or location, and continues to permit us to collect premiums and pay claims under your health plan, including issuance of explanations of benefits to the subscriber of the health plan in which you participate.

In the event that a Confidential Communication is placed against you, then you will no longer have the ability to access any of your health and/or policy information online.

E. Right to Request Amendment

If you believe that your protected health information is incorrect or incomplete, you have the right to request that we amend your protected health information. Your request must be in writing, and it must explain why the information should be amended.

We may deny your request if we did not create the information you want amended or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement to be appended to the information you wanted amended. If we accept your request to amend the information, we will make reasonable efforts to inform others, including people you name, of the amendment and to include the changes in any future disclosures of that information.

F. Right to a Paper Copy of this Notice

If you receive this Notice on our website or by electronic mail (e-mail), you are entitled to receive this Notice in written form. Please contact us using the information listed at the end of this Notice to obtain this Notice in written form.

VI. Questions and Complaints

If you want more information about our privacy policies or practices or have questions or concerns, please contact us using the information listed below.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your protected health information or in response to a request you made to amend or restrict the use or disclosure of your protected health information or to have us communicate with you in confidence by alternative means or at an alternative location, you may complain to us using the contact information listed below.

You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to protect the privacy of your protected health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Office: Highmark Privacy Department
Telephone: 1-866-228-9424 (toll free)
Fax: 1-412-544-4320
Address: 120 Fifth Avenue Place 1814
Pittsburgh, PA 15222

PART II – NOTICE OF PRIVACY PRACTICES (GRAMM-LEACH-BLILEY)

Highmark is committed to protecting its members' privacy. This notice describes our policies and practices for collecting, handling and protecting personal information about our members. We will inform each group of these policies the first time the group becomes a Highmark member and will annually reaffirm our privacy policy for as long as the group remains a Highmark customer. We will continually review our privacy policy and monitor our business practices to help ensure the security of our members' personal information. Due to changing circumstances, it may become necessary to revise our privacy policy in the future. Should such a change be required, we will notify all affected customers in writing in advance of the change.

In order to administer our health benefit programs effectively, we must collect, use and disclose non-public personal financial information. Non-public personal financial information is information that identifies an individual member of a Highmark health plan. It may include the member's name, address, telephone number and Social Security number or it may relate to the member‘s participation in the plan, the provision of health care services or the payment for health care services. Non-public personal financial information does not include publicly available information or statistical information that does not identify individual persons.

Information we collect and maintain: We collect non-public personal financial information about our members from the following sources:

- We receive information from the members themselves, either directly or through their employers or group administrators. This information includes personal data provided on applications, surveys or other forms, such as name, address, Social Security number, date of birth, marital status, dependent information and employment information. It may also include information submitted to us in writing, in person, by telephone or electronically in connection with inquiries or complaints.
- We collect and create information about our members' transactions with Highmark, our affiliates, our agents and health care providers. Examples are: information provided on health care claims (including the name of the health care provider, a diagnosis code and the services provided), explanations of benefits/payments (including the reasons for claim decision, the amount charged by the provider and the amount we paid), payment history, utilization review, appeals and grievances.

Information we may disclose and the purpose: We do not sell any personal information about our members or former members for marketing purposes. We use and disclose the personal information we collect (as described above) only as necessary to deliver health care products and services to our members or to comply with legal requirements. Some examples are:

- We use personal information internally to manage enrollment, process claims, monitor the quality of the health services provided to our members, prevent fraud, audit our own performance or to respond to members' requests for information, products or services.
- We share personal information with our affiliated companies, health care providers, agents, other insurers, peer review organizations, auditors, attorneys or consultants who assist us in administering our programs and delivering health services to our members. Our contracts

with all such service providers require them to protect the confidentiality of our members' personal information.

- We may share personal information with other insurers that cooperate with us to jointly market or administer health insurance products or services. All contracts with other insurers for this purpose require them to protect the confidentiality of our members' personal information.
- We may disclose information under order of a court of law in connection with a legal proceeding.
- We may disclose information to government agencies or accrediting organizations that monitor our compliance with applicable laws and standards.

We may disclose information under a subpoena or summons to government agencies that investigate fraud or other violations of law.

How we protect information: We restrict access to our members' non-public personal information to those employees, agents, consultants and health care providers who need to know that information to provide health products or services. We maintain physical, electronic, and procedural safeguards that comply with state and federal regulations to guard non-public personal financial information from unauthorized access, use and disclosure.

For questions about this Privacy Notice, please contact:

Contact Office: Highmark Privacy Department
Telephone: 1-866-228-9424 (toll free)
Fax: 1-412-544-4320
Address: 120 Fifth Avenue Place 1814
Pittsburgh, PA 15222

HIPAA PORTABILITY

Maximum Policy Benefit

The terms of this Summary Plan Description may define and establish terms relating to a Maximum Policy Benefit. This maximum policy benefit may impose a preexisting condition limitation under the updated HIPAA Portability regulations.

Complaints

If you believe your privacy rights have been violated, you may complain to the Fund and to the Secretary of Health and Human Services. The Plan will not retaliate against you for filing a complaint.

To file a complaint with the Plan, send a written statement to HIPAA Compliance Officer, Laborers' District Council of Western Pennsylvania Welfare Fund, 12 Eighth Street, Suite 500, Pittsburgh, PA 15222. For further information, call the HIPAA Compliance Officer at 1-800-762-1288 or 412-263-0900. The HIPAA Compliance Officer or the Fund will send to you by mail a written response within 60 days of receipt of your written complaint. In addition, you may file a written complaint with the Secretary of the U.S. Department of Health and Human Services, Herbert H. Humphrey Building, 200 Independence Avenue, S.W., Washington, DC 20001. Current law provides that a complaint to the Secretary must be filed within 180 days of when the complainant knew or should have known the act or omission complained of occurred, unless the time limit is waived by the Secretary for good cause shown.

Contact

For more information on the Laborers' District Council of Western Pennsylvania Welfare Fund Benefit Plan privacy policies or your rights under HIPAA, contact the HIPAA Compliance Officer at 1-800-762-1288 or 412-263-0900.

Additional Contacts

The following is a list of key contacts you may need to communicate with to exercise your rights under the HIPAA privacy rule for health care benefit plans offered by the Fund:

Highmark Blue Cross Blue Shield
120 Fifth Avenue Place S-2024
Pittsburgh, PA 15222
Attention: Member Service

Davis Vision
Vision Care Processing Unit
P.O. Box 1525
Latham, NY 12110
1-800-999-5431

Short Term Disability Benefits
(For Employees Only)
and Retiree Death Benefit
Principal Life Insurance Company
711 High Street
Des Moines, IA 50392
1-877-257-6978

Life Insurance
Principal Life Insurance Company
711 High Street
Des Moines, IA 50392
1-800-245-1522

Rights and Protection Under ERISA

Statement of Employee Retirement Income Security Act of 1974 (ERISA) Rights

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan Participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.

Receive a Summary of the Plan's Annual Financial Report

The Plan Administrator is required by law to furnish each participant with a copy of the 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 welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which 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 domestic relations order or 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 Your Questions

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

ERISA Statement

Name of Plan: Laborers' District Council of Western Pennsylvania Welfare Fund

Name, Address and Telephone Number of Plan Sponsor, Named Fiduciary and Plan Administrator:

Laborers' District Council of Western Pennsylvania Welfare Fund
12 Eighth Street, Suite 500
Pittsburgh, PA 15222
412 263-0900

The Plan Sponsor retains all fiduciary responsibilities with respect to the Plan except to the extent the Plan Sponsor has delegated or allocated to other persons or entities one or more fiduciary responsibility with respect to the Plan.

Employer Identification Number (EIN): 25-6035806

IRS Plan Number: 501

Effective Date of Plan: January 1, 2008

Claims Fiduciary: Laborers' District Council of Western Pennsylvania Welfare Fund

Type of Plan: Employee benefits plan including health, vision, disability, life and accidental death and dismemberment benefits

Type of Administration of the Plan:

Administrators of Benefits

Medical/Prescription Benefits
Highmark Blue Cross Blue Shield
120 Fifth Avenue Place S-2024
Pittsburgh, PA 15230
Attention: Member Service
1-866-594-1732

Short Term Disability/ Retiree Death Benefits
Principal Life Insurance Company
711 High Street
Des Moines, IA 50392
1-877-257-6978

Vision Benefit
Davis Vision, Inc.
Vision Care Processing Unit
P.O. Box 1525
Latham, NY 12110
1-800-999-5431

Life/Accidental Death and Dismemberment Benefits
Principal Life Insurance Company
711 High Street
Des Moines, IA 50392
1-800-245-1522

The Plan is administered on behalf of the Plan Administrator by Highmark Blue Cross Blue Shield pursuant to the terms of the group Policy. Highmark Blue Cross Blue Shield provides administrative services for the Plan including claims processing, claims payment, and handling appeals.

Person designated as agent for service of legal process: Plan Administrator

Source of contributions and funding under the Plan: There are Employer and Employee contributions to the Plan. The Plan pays premiums to some insurers for coverage.

Method of calculating the amount of contribution: Employee-required contributions to the Plan Sponsor are the employee's share of costs as determined by Plan Sponsor. From time to time, the Plan Sponsor will determine the required employee contributions for reimbursement to the Plan Sponsor and distribute a schedule of such required contributions to employees.

Date of the end of the year for purposes of maintaining Plan's fiscal records: The Plan year shall be a twelve month period ending January 1.

Determinations of Qualified Medical Child Support Orders: The Plan's procedures for handling qualified medical child support orders are available without charge upon request to the Plan Administrator.

For Additional Information Contact

Laborers' District Council of Western Pennsylvania Welfare Fund
12 Eighth Street, Suite 500 Pittsburgh, PA 15222
Telephone: (412) 263-0900

If you live outside of Metropolitan Pittsburgh,
USE TOLL FREE SERVICE NUMBER 1-800-242-2538
Website: www.lcfowpa.com

LABORERS' COMBINED FUNDS

Kevin Hribar
Administrator

January 1, 2022