2021

Iron Workers
Welfare Plan *of* Western Pennsylvania

January 1, 2021

IRON WORKERS WELFARE PLAN *of* WESTERN PENNSYLVANIA

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DEAR ACTIVE PARTICIPANTS:

The Board of Trustees is pleased to present this revised Summary Plan Description (SPD) that replaces all prior SPD booklets. This SPD, which also serves as the official Plan Document, describes the eligibility requirements of the Welfare Plan and includes the procedures you must follow when filing a claim. The SPD also includes information concerning the administration of the Welfare Plan as required by the Employee Retirement Income Security Act of 1974 (ERISA).

We urge you to read this SPD carefully and to keep it in a convenient place for future reference. The Welfare Plan is designed to help you and your family in meeting the rising costs of medical care as well as providing a measure of protection in the event of your death or disability. If the benefits provided under this Welfare Plan are used wisely, and only when needed, the Welfare Plan will continue to provide security and the sense of wellbeing for which it is intended.

If you have any questions about the Welfare Plan or how to apply for benefits, do not hesitate to contact the Plan Office.

The Board of Trustees

IMPORTANT

It is important that you notify the Plan Office whenever you have a change in any one of the following:

- **Home Address and Phone Number.** Advise the Plan Office promptly so that their records will be up to date if they should need to communicate with you about any matter concerning your coverage.
- **Beneficiary Designation.** Contact the Plan Office to obtain the necessary form if you want to change the beneficiary for your Life Insurance and Accidental Dismemberment Insurance.
- **Family composition.** Give prompt written notice to the Plan Office about any change in your family status such as marriage or divorce, birth of a child, the marriage of any of your enrolled children, or death of any dependent.

The Trustees reserve the right and have the full authority and right to amend, alter, modify, terminate and interpret all provisions concerning the nature, amount and duration of benefits to be provided. All benefits provided must always be within the financial limits of the Welfare Plan and must be consistent with a prudent funding policy established by the Trustees. The Trustees have the full authority and right to determine eligibility requirements for participation in this program.

The Welfare Plan may be terminated by the Trustees or in certain circumstances, for example, if future collective bargaining agreements do not require employer contributions to the Welfare Plan. In the event of Welfare Plan termination, benefits for covered expenses incurred prior to the termination date fixed by the Trustees will be paid to eligible individuals as long as the Welfare Plan's assets exceed its liabilities. Full benefits may not be paid if the Welfare Plan's liabilities exceed its assets. Excess assets, if any, then remaining after the payment of all Welfare Plan liabilities will be utilized for purposes similar to the Welfare Plan's present purposes. You will be notified in writing if the Welfare Plan is amended or terminated.

Notify the Plan Office whenever you have a change in Home Address, Phone Number, Beneficiary Designation or Family Composition.

TABLE *of* CONTENTS

SCHEDULE OF BENEFITS vii

VALUE BANK 2

ELIGIBILITY RULES 4

- Initial Eligibility 4
- Lag Month 4
- Delinquent Employer Contributions 5
- Continued Eligibility 5
- Reinstatement of Eligibility 6
- Eligibility Status for Members Employed by Certain Entities 6
- Reinstatement of Eligibility for Members Employed by Certain Entities 6
- Reciprocal Contributions 6
- Participation Agreements 7
- Limitation on Participation for Owners and Management Employees 7
- Continued Eligibility During Disability Periods 8
- Family and Medical Leave Act (FMLA) 9
- Members in Military Service 9
- Definition of Eligible Dependents 10
- Benefits for Dependents of Deceased Members 10
- Continued Eligibility During Apprenticeship Training 11
- Special Continuation of Coverage in June 2020 11

CHOOSING YOUR BENEFITS 12

- Initial Eligibility 12
- Open Enrollment 12
- Change in Status Event 13

LIFE INSURANCE BENEFIT (MetLife) 15

- Benefit Amount 15
- Beneficiary 15
- Total and Permanent Disability 16
- Conversion Privilege Feature 16

ACCIDENTAL DISMEMBERMENT AND LOSS OF SIGHT INSURANCE BENEFIT (MetLife) 17

- Benefit Amount 17
- General Exclusions and Limitations 18

IRONWORKER MANAGEMENT PROGRESSIVE ACTION TRUST (IMPACT) OFF-THE-JOB ACCIDENT PLAN 19

TABLE *of* CONTENTS

WEEKLY ACCIDENT AND SICKNESS BENEFIT (LOSS OF WAGES) 19
- Non-Occupational Injury or Sickness 20
- Occupational Injury 21
- Exclusions 21

MEMBERSHIP ASSISTANCE PROGRAM 22

MEDICAL BENEFITS UNDER COMMUNITY BLUE 22
- How Your Benefits are Applied 23
- Prescription Drug Cost-Sharing Provisions 24
- Covered Services - Medical Program 27
- Covered Services - Prescription Drug Program 48
- What is Not Covered 50
- How Community Blue Works 60
- Healthcare Management 71
- Benefits After Termination of Coverage 78
- Coordination of Benefits 78
- Subrogation 80
- A Recognized Identification Card 80
- Member Service 81
- Member Rights and Responsibilities 85
- Terms You Should Know 87

SUPPLEMENTAL HOME HEALTH CARE BENEFITS 96

OTHER COVERED SERVICES 97

SUPPLEMENTAL MEDICAL BENEFIT 98

VOLUNTARY DENTAL PROGRAM 99

VOLUNTARY VISION PROGRAM 100

BENEFITS FOR CERTAIN RETIRED MEMBERS 100
- Retiree Death Benefits 100
  - Benefit Amount 101
  - Beneficiary 101
- Retiree Health Insurance Reimbursement Benefit 102
  - For Early Retirees 102
  - For Retirees Eligible for the 48-Month Extended Disability Benefit 104
  - Death Prior to Retirement 104

TABLE *of* CONTENTS

BENEFITS FOR CERTAIN DISABLED MEMBERS 105
- Continuation of Health Coverage for Certain Disabled Members and Their Dependents 105
- 48-Month Extended Disability Benefit 105

COBRA CONTINUATION COVERAGE 109
- Qualifying Events 109
- Notice Requirements 110
- COBRA Continuation Coverage 111
- Premium Cost 111
- Length of COBRA Continuation Coverage 112
- Adding New Dependents to Your COBRA Continuation Coverage 113
- Loss of Other Group Health Plan Coverage or Other Health Insurance Coverage 113
- Termination of COBRA Continuation Coverage 114
- Conversion Privilege 114

CLAIMS AND APPEALS PROCEDURES 115
- Member Inquiries 115
- Filing Benefit Claims 116
  - For Health Care Benefits Covered Under Community Blue 116
  - For Health Care Benefits Not Covered Under Community Blue 125
  - For Weekly Accident and Sickness Benefits and 48 Month Extended Disability Benefits 127
  - For Life Insurance or Accidental Dismemberment or Loss of Sight Insurance 130
- Discretionary Authority to Determine Claims 131
- Exhaustion of Remedies 131
- Overpayments or Mistaken Payments 132

INFORMATION REQUIRED BY THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 133

STATEMENT OF ERISA RIGHTS 135

STATEMENT OF GRANDFATHERED STATUS 137

HIGHMARK NOTICE OF PRIVACY PRACTICES 138

SCHEDULE *of* BENEFITS

LIFE INSURANCE BENEFIT

Covered continuously by the Welfare Plan for 12 months or longer. $50,000
During the first 12 months of coverage under the Welfare Plan $25,000

ACCIDENTAL DISMEMBERMENT AND LOSS OF SIGHT BENEFIT

Maximum Benefit $20,000

WEEKLY ACCIDENT AND SICKNESS BENEFIT

Maximum Weekly Benefit $490

RETIREE DEATH BENEFIT

(See Page 100 for Eligibility Requirements)

Eligible Members. $7,500

RETIREE HEALTH INSURANCE REIMBURSEMENT BENEFIT

(See Page 102 for Eligibility Requirements and Explanation)

Individual Coverage . . . . . up to $400 per month ($500 effective July 1, 2020)
Family Coverage . . . . . up to $800 per month ($1,000 effective July 1, 2020)

Summary of HM COMMUNITY BLUE Value Benefits PLAN

HIGHMARK. Community Blue PPO

On the chart below, you'll see what your plan pays for specific services. You may be responsible for a facility fee, clinic charge or similar fee or charge (in addition to any professional fees) if your office visit or service is provided at a location that qualifies as a hospital department or a satellite building of a hospital.

Iron Workers Welfare Plan of WPA — Group #'s 017926-00, 02, 03, 04, 10, 12, 13, 14, 70, 72, 80, 82

BENEFIT	NETWORK	VALUE-BASED (1)	OUT-OF-NETWORK
General Provisions			
Deductible *(per benefit period) (2)*			
Individual	$4,000	$4,000	$10,000
Family	$8,000	$8,000	$20,000
Plan Payment Level – *Based on the plan allowance*	80% after deductible	80% after deductible	60% after deductible
Out-of-Pocket Maximums includes deductible *(Once met, plan payment level becomes 100%)*			
Individual	$5,000	$5,000	$10,000
Family	$10,000	$10,000	$20,000
Total Maximum Out-of-Pocket *(Includes deductible, coinsurance, copays, prescription drug cost sharing and other qualified medical expenses, Network only) (3) Once met, plan pays 100% of covered services for rest of benefit period.*			
Individual	$7,900		Not Applicable
Family	$15,800		Not Applicable
Office/Clinic/Urgent Care Visits			
Retail Clinic Visits	80% after $30 copayment*	80%	60% after deductible
Primary Care Physician Office Visits	80% after $30 copayment*	80%	60% after deductible
Specialist Office Visits	80% after $30 copayment*	80%	60% after deductible
Urgent Care Center Visits	80% after $30 copayment*	80%	60% after deductible
Telemedicine Visits	100%	100%	Not Covered
Preventive Care (4)			
Adult			
Routine physical exams	100%	100%	Not Covered
Adult Immunizations	100%	100%	60% after deductible
Colorectal Cancer Screening	100%	100%	60% after deductible
Routine gynecological exams, including a Pap Test	100%	100%	60% (deductible does not apply)
Mammograms, annual routine and medically necessary	100%	100%	60% after deductible
Diagnostic services & procedures	100%	100%	60% after deductible

BENEFIT	NETWORK	VALUE-BASED (1)	OUT-OF-NETWORK
Pediatric			
Routine physical exams	100%	100%	Not Covered
Pediatric immunizations	100%	100%	60% (deductible does not apply)
Diagnostic services & procedures	100%	100%	60% after deductible
Hospital and Medical/Surgical Expenses (including maternity)			
Hospital Services – Inpatient	80% after deductible	80% after deductible	60% after deductible
Hospital Services – Outpatient	80% after deductible	80% after deductible	60% after deductible
Maternity *(facility & professional)*	80% after deductible	80% after deductible	60% after deductible
Medical/Surgical Expenses *(except office visits)*	80% after deductible	80% after deductible	60% after deductible
Emergency Services			
Emergency Room Services	80% after $100 copayment* (waived if admitted)		
Ambulance	80% after network deductible		
Therapy and Rehabilitation Services			
Physical Medicine	80% after deductible	80% after deductible	60% after deductible
Respiratory Therapy	80% after network deductible		
Speech & Occupational Therapy	80% after deductible	80% after deductible	60% after deductible
Spinal Manipulations	80% after $30 copayment*	80% after $30 copayment*	60% after deductible
Therapy Services *(Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)*	80% after deductible	80% after deductible	60% after deductible
Mental Health/Substance Abuse			
Inpatient	80% after deductible	80% after deductible	60% after deductible
Inpatient Detoxification/Rehabilitation	80% after deductible	80% after deductible	60% after deductible
Outpatient	80%	80%	60% after deductible
Other Services			
Allergy Extracts and Injections	80% after deductible	80% after deductible	60% after deductible
Autism Spectrum Disorders including Applied Behavior Analysis *(5)*	80% after deductible	80% after deductible	60% after deductible
Assisted Fertilization Procedures	Not Covered		
Dental Services Related to Accidental Injury	80% after deductible	80% after deductible	60% after deductible
Diagnostic Services			
Advanced Imaging *(MRI, CAT, PET scan, etc.)*	80% after deductible	80% after deductible	60% after deductible
Basic Diagnostic Services *(standard imaging, diagnostic medical, lab/pathology, allergy testing)*	80% after deductible	80% after deductible	60% after deductible

MEDICAL *and* PRESCRIPTION DRUG BENEFITS

BENEFIT	NETWORK	VALUE-BASED (1)	OUT-OF-NETWORK
Durable Medical Equipment, Orthotics and Prosthetics	80% after deductible	80% after deductible	60% after deductible
Home Health Care	80% after deductible	80% after deductible	60% after deductible
Hospice	80% after deductible	80% after deductible	60% after deductible
Infertility Counseling, Testing and Treatment *(6)*	80% after deductible	80% after deductible	60% after deductible
Private Duty Nursing	80% after network deductible		
Skilled Nursing Facility Care	80% after deductible	80% after deductible	60% after deductible Limit: 100 days/benefit period
Transplant Services	80% after deductible	80% after deductible	60% after deductible
Precertification Requirements *(7)*	Yes		
Prescription Drugs			
Premier Prescription Drug Program *Mandatory Generic (8)* *Defined by National Pharmacy Network - Not Physician Network. Prescriptions filled at a non-network pharmacy are not covered.*	**Retail Drugs (31-day Supply)** $15 generic copayment $30 brand formulary copayment $45 brand non-formulary copayment **Maintenance Drugs through Mail Order (90-day Supply)** $30 generic copayment $60 brand formulary copayment $90 brand non-formulary copayment	**Retail Drugs (31-day Supply)** $0 generic copayment $0 brand formulary copayment $0 brand non-formulary copayment **Maintenance Drugs through Mail Order (90-day Supply)** $0 generic copayment $0 brand formulary copayment $0 brand non-formulary copayment	Not Covered

* Services marked with an asterisk (*) do not apply towards the in or out of network deductibles or out of pockets amounts.

(1) Value Based Benefits apply to medical claims filed with eight chronic conditions diagnoses – asthma, CAD, CHF, COPD, depression, diabetes, high blood pressure, and high cholesterol. Prescriptions filled for the management of these eight chronic conditions have no copayments.

(2) Your group's benefit period is based on a Calendar Year which runs from January 1 to December 31.

(3) 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.

(4) Services are limited to those listed on the Highmark Preventive Schedule. Gender, age and frequency limits may apply.

(5) 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. If ASD benefit period dollar maximum applies only non-essential health benefits will accumulate.

(6) Treatment includes coverage for the correction of a physical or medical problem associated with infertility. Infertility drug therapy may or may not be covered depending on your group's prescription drug program.

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

(8) Prescriptions are covered as long as they are listed on the prescription drug formulary applicable to your plan. Your plan has coverage for both formulary and non-formulary medications at the applicable copayments. The member is responsible for the payment differential when a generic drug is authorized by the physician and the patient elects to purchase a brand drug. The member 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.

Summary of HM COMMUNITY BLUE Core Benefits PLAN

On the chart below, you'll see what your plan pays for specific services. You may be responsible for a facility fee, clinic charge or similar fee or charge (in addition to any professional fees) if your office visit or service is provided at a location that qualifies as a hospital department or a satellite building of a hospital.

Iron Workers Welfare Plan of WPA

Group #'s 017258-00, 02, 03, 04, 10, 12, 13, 14, 70, 72, 80, 82

BENEFIT	NETWORK	VALUE-BASED (1)	OUT-OF-NETWORK
General Provisions			
Deductible *(per benefit period) (2)*			
Individual	$2,500	$2,500	$5,000
Family	$5,000	$5,000	$10,000
Plan Payment Level – *Based on the plan allowance*	90% after deductible	90% after deductible	70% after deductible
Out-of-Pocket Maximums includes deductible *(Once met, plan payment level becomes 100%)*			
Individual	$5,000	$5,000	$10,000
Family	$10,000	$10,000	$20,000
Office/Clinic/Urgent Care Visits			
Retail Clinic Visits	90% after $25 copayment*	90%	70% after deductible
Primary Care Physician Office Visits	90% after $25 copayment*	90%	70% after deductible
Specialist Office Visits	90% after $25 copayment*	90%	70% after deductible
Urgent Care Center Visits	90% after $25 copayment*	90%	70% after deductible
Telemedicine Visits	100%	100%	Not Covered
Preventive Care (4)			
Adult			
Routine physical exams	90% after $25 copayment*	90% after $25 copayment*	Not Covered
Adult Immunizations	90% after deductible	90% after deductible	70% after deductible
Colorectal Cancer Screening	90% after deductible	90% after deductible	70% after deductible
Routine gynecological exams, including a Pap Test	90% after $25 copayment*	90% after $25 copayment*	70% (deductible does not apply)
Mammograms, annual routine and medically necessary	90% (deductible does not apply)	90% (deductible does not apply)	70% after deductible
Diagnostic services & procedures	90% after deductible	90% after deductible	70% after deductible
Pediatric			
Routine physical exams	90% after $25 copayment*	90% after $25 copayment*	Not Covered
Pediatric immunizations	90% (deductible does not apply)	90% (deductible does not apply)	70% (deductible does not apply)
Diagnostic services & procedures	90% after deductible	90% after deductible	70% after deductible

BENEFIT	NETWORK	VALUE-BASED (1)	OUT-OF-NETWORK
Hospital and Medical/Surgical Expenses (including maternity)			
Hospital Services – Inpatient	90% after deductible	90% after deductible	70% after deductible
Hospital Services – Outpatient	90% after deductible	90% after deductible	70% after deductible
Maternity *(facility & professional services)*	90% after deductible	90% after deductible	70% after deductible
Medical/Surgical Expenses *(except office visits)*	90% after deductible	90% after deductible	70% after deductible
Emergency Services			
Emergency Room Services	90% after $100 copayment* (waived if admitted)		
Ambulance	90% after network deductible		
Therapy and Rehabilitation Services			
Physical Medicine	90% after deductible	90% after deductible	70% after deductible
Respiratory Therapy	90% after network deductible		
Speech & Occupational Therapy	90% after deductible	90% after deductible	70% after deductible
Spinal Manipulations	90% after $25 copayment*	90% after $25 copayment*	70% after deductible
Therapy Services *(Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)*	90% after deductible	90% after deductible	70% after deductible
Mental Health/Substance Abuse			
Inpatient	90% after deductible	90% after deductible	70% after deductible
Inpatient Detoxification/Rehabilitation	90% after deductible	90% after deductible	70% after deductible
Outpatient	90%	90%	70% after deductible
Other Services			
Allergy Extracts and Injections	90% after deductible	90% after deductible	70% after deductible
Autism Spectrum Disorders including Applied Behavior Analysis *(4)*	90% after deductible	90% after deductible	70% after deductible
Assisted Fertilization Procedures	Not Covered		
Dental Services Related to Accidental Injury	90% after deductible	90% after deductible	70% after deductible
Diagnostic Services			
Advanced Imaging *(MRI, CAT, PET scan, etc.)*	90% after deductible	90% after deductible	70% after deductible
Basic Diagnostic Services *(standard imaging, diagnostic medical, lab/pathology, allergy testing)*	90% after deductible	90% after deductible	70% after deductible
Durable Medical Equipment, Orthotics and Prosthetics	90% after deductible	90% after deductible	70% after deductible
Home Health Care	90% after deductible	90% after deductible	70% after deductible
Hospice	90% after deductible	90% after deductible	70% after deductible

BENEFIT	NETWORK	VALUE-BASED (1)	OUT-OF-NETWORK
Infertility Counseling, Testing and Treatment *(5)*	90% after deductible	90% after deductible	70% after deductible
Private Duty Nursing	90% after network deductible		
Skilled Nursing Facility Care	90% after deductible	90% after deductible	70% after deductible Limit: 100 days/benefit period
Transplant Services	90% after deductible	90% after deductible	70% after deductible
Precertification Requirements *(6)*	Yes		
	Prescription Drugs		
Premier Prescription Drug Program *Mandatory Generic (7)* *Defined by National Pharmacy Network - Not Physician Network. Prescriptions filled at a non-network pharmacy are not covered.*	**Retail Drugs (31-day Supply)** $15 generic copayment $25 brand formulary copayment $40 brand non-formulary copayment **Maintenance Drugs through Mail Order (90-day Supply)** $30 generic copayment $50 brand formulary copayment $80 brand non-formulary copayment	**Retail Drugs (31-day Supply)** $0 generic copayment $0 brand formulary copayment $0 brand non-formulary copayment **Maintenance Drugs through Mail Order (90-day Supply)** $0 generic copayment $0 brand formulary copayment $0 brand non-formulary copayment	Not Covered

* Services marked with an asterisk (*) do not apply towards the in or out of network deductibles or out of pockets amounts.

(1) Value Based Benefits apply to medical claims filed with eight chronic conditions diagnoses – asthma, CAD, CHF, COPD, depression, diabetes, high blood pressure, and high cholesterol. Prescriptions filled for the management of these eight chronic conditions have no copayments.

(2) Your group's benefit period is based on a Calendar Year which runs from January 1 to December 31.

(3) Services are limited to those listed on the Highmark Preventive Schedule. Gender, age and frequency limits may apply.

(4) 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. If ASD benefit period dollar maximum applies only non-essential health benefits will accumulate.

(5) Treatment includes coverage for the correction of a physical or medical problem associated with infertility. Infertility drug therapy may or may not be covered depending on your group's prescription drug program.

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

(7) Prescriptions are covered as long as they are listed on the prescription drug formulary applicable to your plan. Your plan has coverage for both formulary and non-formulary medications at the applicable copayments. The member is responsible for the payment differential when a generic drug is authorized by the physician and the patient elects to purchase a brand drug. The member 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.

Summary of HM COMMUNITY BLUE Standard Benefits PLAN

On the chart below, you'll see what your plan pays for specific services. You may be responsible for a facility fee, clinic charge or similar fee or charge (in addition to any professional fees) if your office visit or service is provided at a location that qualifies as a hospital department or a satellite building of a hospital.

Iron Workers Welfare Plan of WPA — Group # 017920-00, 02, 03, 04, 10, 12, 13, 14, 70, 72, 80, 82

BENEFIT	NETWORK	VALUE-BASED (1)	OUT-OF-NETWORK
General Provisions			
Deductible *(per benefit period) (2)*			
Individual	$1,000	$1,000	$2,000
Family	$2,000	$2,000	$4,000
Plan Payment Level – *Based on the plan allowance*	90% after deductible	90% after deductible	70% after deductible
Out-of-Pocket Maximums includes deductible *(Once met, plan payment level becomes 100%)*			
Individual	$2,500	$2,500	$3,000
Family	$5,000	$5,000	$6,000
Total Maximum Out-of-Pocket *(Includes deductible, coinsurance, copays, prescription drug cost sharing and other qualified medical expenses, Network only) (3) Once met, plan pays 100% of covered services for rest of benefit period.*			
Individual	$7,900		Not Applicable
Family	$15,300		Not Applicable
Office/Clinic/Urgent Care Visits			
Retail Clinic Visits	90% after $20 copayment	90% after $20 copayment	70% after deductible
Primary Care Physician Office Visits	90% after $20 copayment	90% after $20 copayment	70% after deductible
Specialist Office Visits	90% after $20 copayment	90% after $20 copayment	70% after deductible
Urgent Care Center Visits	90% after $20 copayment	90% after $20 copayment	70% after deductible
Telemedicine Visits	100%	100%	Not Covered
Preventive Care (4)			
Adult			
Routine physical exams	100%	100%	Not Covered
Adult Immunizations	100%	100%	70% after deductible
Colorectal Cancer Screening	100%	100%	70% after deductible
Routine gynecological exams, including a Pap Test	100%	100%	70% (deductible does not apply)
Mammograms, annual routine and medically necessary	100%	100%	70% after deductible
Diagnostic services & procedures	100%	100%	70% after deductible

BENEFIT	NETWORK	VALUE-BASED (1)	OUT-OF-NETWORK
Pediatric			
Routine physical exams	100%	100%	Not Covered
Pediatric immunizations	100%	100%	70% (deductible does not apply)
Diagnostic services & procedures	100%	100%	70% after deductible
Hospital and Medical/Surgical Expenses (including maternity)			
Hospital Services – Inpatient	90% after deductible	90% after deductible	70% after deductible
Hospital Services – Outpatient	90% after deductible	90% after deductible	70% after deductible
Maternity *(facility & professional)*	90% after deductible	90% after deductible	70% after deductible
Medical/Surgical Expenses *(except office visits)*	90% after deductible	90% after deductible	70% after deductible
Emergency Services			
Emergency Room Services	90% after $100 copayment* (waived if admitted)		
Ambulance	90% after network deductible		
Therapy and Rehabilitation Services			
Physical Medicine	90% after deductible	90% after deductible	70% after deductible
Respiratory Therapy	90% after network deductible		
Speech & Occupational Therapy	90% after deductible	90% after deductible	70% after deductible
Spinal Manipulations	90% after $20 copayment*	90% after $20 copayment*	70% after deductible
Therapy Services *(Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)*	90% after deductible	90% after deductible	70% after deductible
Mental Health/Substance Abuse			
Inpatient	90% after deductible	90% after deductible	70% after deductible
Inpatient Detoxification/Rehabilitation	90% after deductible	90% after deductible	70% after deductible
Outpatient	90%	90%	70% after deductible
Other Services			
Allergy Extracts and Injections	90% after deductible	90% after deductible	70% after deductible
Autism Spectrum Disorders including Applied Behavior Analysis *(5)*	90% after deductible	90% after deductible	70% after deductible
Assisted Fertilization Procedures	Not Covered		
Dental Services Related to Accidental Injury	90% after deductible	90% after deductible	70% after deductible
Diagnostic Services			
Advanced Imaging *(MRI, CAT, PET scan, etc.)*	90% after deductible	90% after deductible	70% after deductible
Basic Diagnostic Services *(standard imaging, diagnostic medical, lab/pathology, allergy testing)*	90% after deductible	90% after deductible	70% after deductible

BENEFIT	NETWORK	VALUE-BASED (1)	OUT-OF-NETWORK
Durable Medical Equipment, Orthotics and Prosthetics	90% after deductible	90% after deductible	70% after deductible
Home Health Care	90% after deductible	90% after deductible	70% after deductible
Hospice	90% after deductible	90% after deductible	70% after deductible
Infertility Counseling, Testing and Treatment *(6)*	90% after deductible	90% after deductible	70% after deductible
Private Duty Nursing	90% after network deductible		
Skilled Nursing Facility Care	90% after deductible	90% after deductible	70% after deductible Limit: 100 days/benefit period
Transplant Services	90% after deductible	90% after deductible	70% after deductible
Precertification Requirements *(7)*	Yes		
Prescription Drugs			
Premier Prescription Drug Program *Mandatory Generic (8)* *Defined by National Pharmacy Network - Not Physician Network. Prescriptions filled at a non-network pharmacy are not covered.*	**Retail Drugs (31-day Supply)** $15 generic copayment $25 brand formulary copayment $40 brand non-formulary copayment **Maintenance Drugs through Mail Order (90-day Supply)** $30 generic copayment $50 brand formulary copayment $80 brand non-formulary copayment	**Retail Drugs (31-day Supply)** $0 generic copayment $0 brand formulary copayment $0 brand non-formulary copayment **Maintenance Drugs through Mail Order (90-day Supply)** $0 generic copayment $0 brand formulary copayment $0 brand non-formulary copayment	Not Covered

* Services marked with an asterisk (*) do not apply towards the in or out of network deductibles or out of pockets amounts.

(1) Value Based Benefits apply to medical claims filed with eight chronic conditions diagnoses – asthma, CAD, CHF, COPD, depression, diabetes, high blood pressure, and high cholesterol. Prescriptions filled for the management of these eight chronic conditions have no copayments.

(2) Your group's benefit period is based on a Calendar Year which runs from January 1 to December 31.

(3 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.

(4) Services are limited to those listed on the Highmark Preventive Schedule. Gender, age and frequency limits may apply.

(5) 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. If ASD benefit period dollar maximum applies only non-essential health benefits will accumulate.

(6) Treatment includes coverage for the correction of a physical or medical problem associated with infertility. Infertility drug therapy may or may not be covered depending on your group's prescription drug program.

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

(8) Prescriptions are covered as long as they are listed on the prescription drug formulary applicable to your plan. Your plan has coverage for both formulary and non-formulary medications at the applicable copayments. The member is responsible for the payment differential when a generic drug is authorized by the physician and the patient elects to purchase a brand drug. The member 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.

Summary of HM COMMUNITY BLUE Premier Benefits PLAN

On the chart below, you'll see what your plan pays for specific services. You may be responsible for a facility fee, clinic charge or similar fee or charge (in addition to any professional fees) if your office visit or service is provided at a location that qualifies as a hospital department or a satellite building of a hospital.

Iron Workers Welfare Plan of WPA

Group #'s 017257-00, 02, 03, 04, 10, 12, 13, 14, 70, 72, 80, 82

BENEFIT	NETWORK	VALUE-BASED (1)	OUT-OF-NETWORK
General Provisions			
Deductible *(per benefit period) (2)*			
Individual	$200	$200	$400
Family	$400	$400	$800
Plan Payment Level – *Based on the plan allowance*	90% after deductible	90% after deductible	70% after deductible
Out-of-Pocket Maximums includes deductible *(Once met, plan payment level becomes 100%)*			
Individual	$1,500	$1,500	$3,000
Family	$3,000	$3,000	$6,000
Office/Clinic/Urgent Care Visits			
Retail Clinic Visits	90% after $20 copayment*	90%	70% after deductible
Primary Care Physician Office Visits	90% after $20 copayment*	90%	70% after deductible
Specialist Office Visits	90% after $20 copayment*	90%	70% after deductible
Urgent Care Center Visits	90% after $20 copayment*	90%	70% after deductible
Telemedicine Visits	100%	100%	Not Covered
Preventive Care (3)			
Adult			
Routine physical exams	90% after $20 copayment*	90% after $20 copayment*	Not Covered
Adult Immunizations	90% after deductible	90% after deductible	70% after deductible
Colorectal Cancer Screening	90% after deductible	90% after deductible	70% after deductible
Routine gynecological exams, including a Pap Test	90% after $20 copayment*	90% after $20 copayment*	70% (deductible does not apply)
Mammograms, annual routine and medically necessary	90% (deductible does not apply)	90% (deductible does not apply)	70% after deductible
Diagnostic services & procedures	90% after deductible	90% after deductible	70% after deductible
Pediatric			
Routine physical exams	90% after $20 copayment*	90% after $20 copayment*	Not Covered
Pediatric immunizations	90% (deductible does not apply)	90% (deductible does not apply)	70% (deductible does not apply)
Diagnostic services & procedures	90% after deductible	90% after deductible	70% after deductible

BENEFIT	NETWORK	VALUE-BASED (1)	OUT-OF-NETWORK
Hospital and Medical/Surgical Expenses (including maternity)			
Hospital Services – Inpatient	90% after deductible	90% after deductible	70% after deductible
Hospital Services – Outpatient	90% after deductible	90% after deductible	70% after deductible
Maternity *(facility & professional services)*	90% after deductible	90% after deductible	70% after deductible
Medical/Surgical Expenses *(except office visits)*	90% after deductible	90% after deductible	70% after deductible
Emergency Services			
Emergency Room Services	90% after $100 copayment* (waived if admitted)		
Ambulance	90% after network deductible		
Therapy and Rehabilitation Services			
Physical Medicine	90% after deductible	90% after deductible	70% after deductible
Respiratory Therapy	90% after network deductible		
Speech & Occupational Therapy	90% after deductible	90% after deductible	70% after deductible
Spinal Manipulations	90% after $20 copayment*	90% after $20 copayment*	70% after deductible
Therapy Services *(Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)*	90% after deductible	90% after deductible	70% after deductible
Mental Health/Substance Abuse			
Inpatient	90% after deductible	90% after deductible	70% after deductible
Inpatient Detoxification/Rehabilitation	90% after deductible	90% after deductible	70% after deductible
Outpatient	90%	90%	70% after deductible
Other Services			
Allergy Extracts and Injections	90% after deductible	90% after deductible	70% after deductible
Autism Spectrum Disorders including Applied Behavior Analysis *(4)*	90% after deductible	90% after deductible	70% after deductible
Assisted Fertilization Procedures	Not Covered		
Dental Services Related to Accidental Injury	90% after deductible	90% after deductible	70% after deductible
Diagnostic Services			
Advanced Imaging *(MRI, CAT, PET scan, etc.)*	90% after deductible	90% after deductible	70% after deductible
Basic Diagnostic Services *(standard imaging, diagnostic medical, lab/pathology, allergy testing)*	90% after deductible	90% after deductible	70% after deductible
Durable Medical Equipment, Orthotics and Prosthetics	90% after deductible	90% after deductible	70% after deductible
Home Health Care	90% after deductible	90% after deductible	70% after deductible
Hospice	90% after deductible	90% after deductible	70% after deductible

BENEFIT	NETWORK	VALUE-BASED (1)	OUT-OF-NETWORK
Infertility Counseling, Testing and Treatment *(5)*	90% after deductible	90% after deductible	70% after deductible
Private Duty Nursing	90% after network deductible		
Skilled Nursing Facility Care	90% after deductible	90% after deductible	70% after deductible Limit: 100 days/benefit period
Transplant Services	90% after deductible	90% after deductible	70% after deductible
Precertification Requirements *(6)*	Yes		
Prescription Drugs			
Premier Prescription Drug Program *Mandatory Generic (7)* *Defined by National Pharmacy Network - Not Physician Network. Prescriptions filled at a non-network pharmacy are not covered.*	**Retail Drugs (31-day Supply)** $10 generic copayment $20 brand formulary copayment $35 brand non-formulary copayment **Maintenance Drugs through Mail Order (90-day Supply)** $20 generic copayment $40 brand formulary copayment $70 brand non-formulary copayment	**Retail Drugs (31-day Supply)** $0 generic copayment $0 brand formulary copayment $0 brand non-formulary copayment **Maintenance Drugs through Mail Order (90-day Supply)** $0 generic copayment $0 brand formulary copayment $0 brand non-formulary copayment	Not Covered

* Services marked with an asterisk (*) do not apply towards the in or out of network deductibles or out of pockets amounts.

(1) Value Based Benefits apply to medical claims filed with eight chronic conditions diagnoses – asthma, CAD, CHF, COPD, depression, diabetes, high blood pressure, and high cholesterol. Prescriptions filled for the management of these eight chronic conditions have no copayments.

(2) Your group's benefit period is based on a Calendar Year which runs from January 1 to December 31.

(3) Services are limited to those listed on the Highmark Preventive Schedule. Gender, age and frequency limits may apply.

(4) 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. If ASD benefit period dollar maximum applies only non-essential health benefits will accumulate.

(5) Treatment includes coverage for the correction of a physical or medical problem associated with infertility. Infertility drug therapy may or may not be covered depending on your group's prescription drug program.

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

(7) Prescriptions are covered as long as they are listed on the prescription drug formulary applicable to your plan. Your plan has coverage for both formulary and non-formulary medications at the applicable copayments. The member is responsible for the payment differential when a generic drug is authorized by the physician and the patient elects to purchase a brand drug. The member 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.

Summary of HM COMMUNITY BLUE Deluxe Benefit PLAN

On the chart below, you'll see what your plan pays for specific services. You may be responsible for a facility fee, clinic charge or similar fee or charge (in addition to any professional fees) if your office visit or service is provided at a location that qualifies as a hospital department or a satellite building of a hospital.

Iron Workers Welfare Plan of WPA

Group #'s 017256-00, 02, 03, 04, 10, 12, 13, 14, 70, 72, 80, 82

BENEFIT	NETWORK	VALUE-BASED (1)	OUT-OF-NETWORK
General Provisions			
Benefit Period *(2)*	Calendar Year		
Deductible *(per benefit period) (2)*			
Individual	None	None	$250
Family	None	None	$500
Plan Payment Level – *Based on the plan allowance*	100%	100%	70% after deductible
Out-of-Pocket Maximums includes deductible *(Once met, plan payment level becomes 100%)*			
Individual	Not Applicable	Not Applicable	$2,000
Family	Not Applicable	Not Applicable	$4,000
Office/Clinic/Urgent Care Visits			
Retail Clinic Visits	100% after $20 copayment	100%	70% after deductible
Primary Care Physician Office Visits	100% after $20 copayment	100%	70% after deductible
Specialist Office Visits	100% after $20 copayment	100%	70% after deductible
Urgent Care Center Visits	100% after $20 copayment	100%	70% after deductible
Telemedicine Visits	100%	100%	Not Covered
Preventive Care (3)			
Adult			
Routine physical exams	100% after $20 copayment	100% after $20 copayment	Not Covered
Adult Immunizations	100%	100%	70% after deductible
Colorectal Cancer Screening	100%	100%	70% after deductible
Routine gynecological exams, including a Pap Test	100% after $20 copayment	100% after $20 copayment	70% (deductible does not apply)
Mammograms, annual routine and medically necessary	100%	100%	70% after deductible
Diagnostic services & procedures	100%	100%	70% after deductible
Pediatric			
Routine physical exams	100% after $20 copayment	100% after $20 copayment	Not Covered
Pediatric immunizations	100%	100%	70% (deductible does not apply)
Diagnostic services & procedures	100%	100%	70% after deductible

BENEFIT	NETWORK	VALUE-BASED (1)	OUT-OF-NETWORK
Hospital and Medical/Surgical Expenses (including maternity)			
Hospital – Inpatient	100%	100%	70% after deductible
Hospital – Outpatient	100%	100%	70% after deductible
Maternity *(facility & professional services)*	100%	100%	70% after deductible
Medical/Surgical Expenses *(except office visits)*	100%	100%	70% after deductible
Emergency Services			
Emergency Room Services	100% after $50 copayment (waived if admitted)		
Ambulance	100%		
Therapy and Rehabilitation Services			
Physical Medicine	100%	100%	70% after deductible
Respiratory Therapy	100%		
Speech & Occupational Therapy	100%	100%	70% after deductible
Spinal Manipulations	100% after $20 copayment	100% after $20 copayment	70% after deductible
Other Therapy Services *(Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)*	100%	100%	70% after deductible
Mental Health/Substance Abuse			
Inpatient	100%	100%	70% after deductible
Inpatient Detoxification/Rehabilitation	100%	100%	70% after deductible
Outpatient	100%	100%	70% after deductible
Other Services			
Allergy Extracts and Injections	100%	100%	70% after deductible
Autism Spectrum Disorders including Applied Behavior Analysis *(4)*	100%	100%	70% after deductible
Assisted Fertilization Procedures	Not Covered		
Dental Services Related to Accidental Injury	100%	100%	70% after deductible
Diagnostic Services			
Advanced Imaging *(MRI, CAT, PET scan, etc.)*	100%	100%	70% after deductible
Basic Diagnostic Services *(standard imaging, diagnostic medical, lab/pathology, allergy testing)*	*100%*	*100%*	*70% after deductible*
Durable Medical Equipment, Orthotics and Prosthetics	100%	100%	70% after deductible
Home Health Care	100%	100%	70% after deductible
Hospice	100%	100%	70% after deductible

BENEFIT	NETWORK	VALUE-BASED (1)	OUT-OF-NETWORK
Infertility Counseling, Testing and Treatment *(5)*	100%	100%	70% after deductible
Private Duty Nursing		100%	
Skilled Nursing Facility Care	100%	100%	70% after deductible Limit: 100 days/benefit period
Transplant Services	100%	100%	70% after deductible
Precertification Requirements *(6)*		Yes	
Prescription Drugs			
Premier Prescription Drug Program *Mandatory Generic (7)* Defined by National Pharmacy Network - Not Physician Network. Prescriptions filled at a non-network pharmacy are not covered.	**Retail Drugs (31-day Supply)** $10 generic copayment $20 brand formulary copayment $35 brand non-formulary copayment **Maintenance Drugs through Mail Order (90-day Supply)** $10 generic copayment $20 brand formulary copayment $35 brand non-formulary copayment	**Retail Drugs (31-day Supply)** $0 generic copayment $0 brand formulary copayment $0 brand non-formulary copayment **Maintenance Drugs through Mail Order (90-day Supply)** $0 generic copayment $0 brand formulary copayment $0 brand non-formulary copayment	Not Covered

(1) Value Based Benefits apply to medical claims filed with eight chronic conditions diagnoses – asthma, CAD, CHF, COPD, depression, diabetes, high blood pressure, and high cholesterol. Prescriptions filled for the management of these eight chronic conditions have no copayments.

(2) Your group's benefit period is based on a Calendar Year which runs from January 1 to December 31.

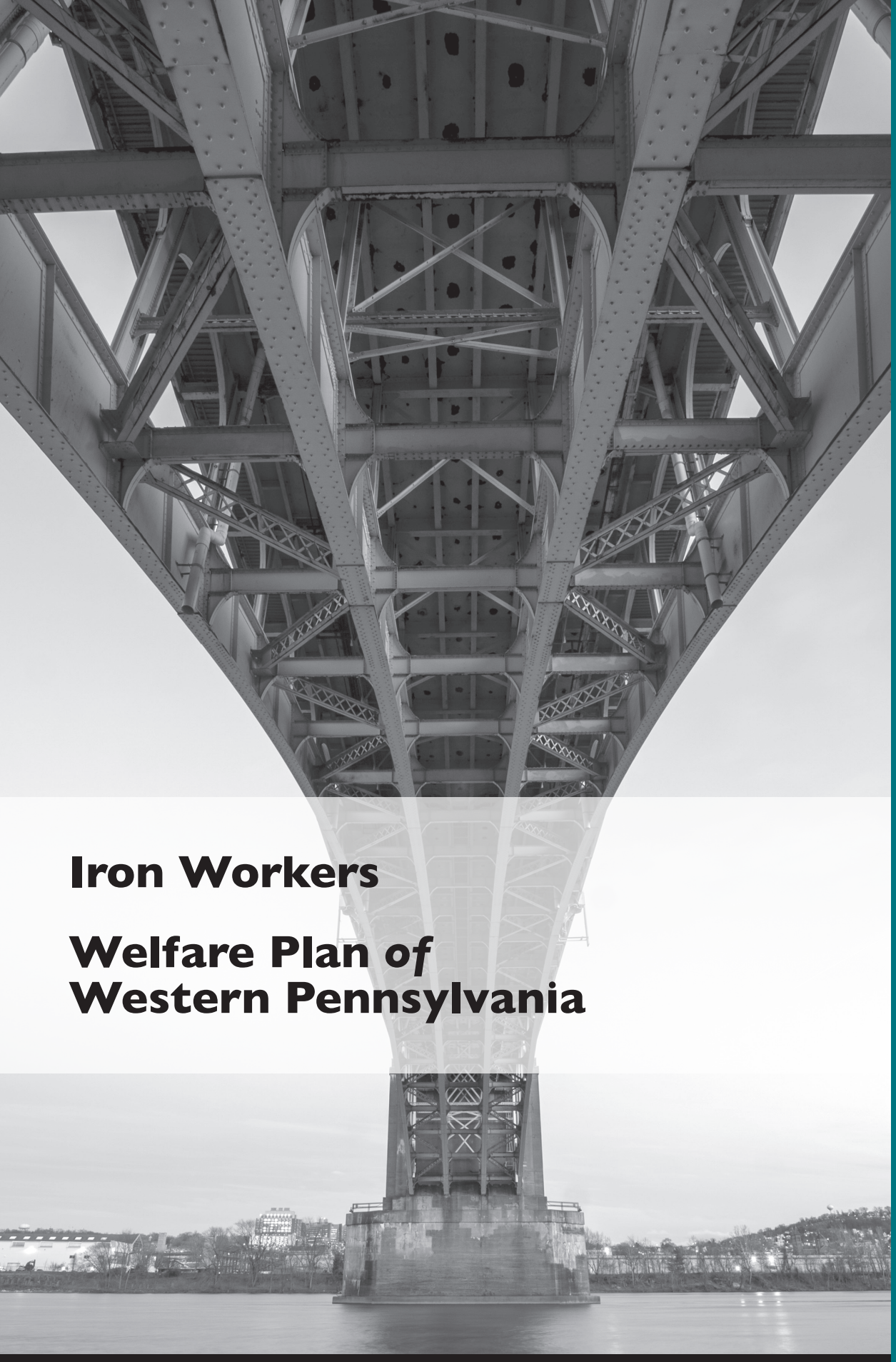
(3) Services are limited to those listed on the Highmark Preventive Schedule. Gender, age and frequency limits may apply.

(4) 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. If ASD benefit period dollar maximum applies only non-essential health benefits will accumulate.

(5) Treatment includes coverage for the correction of a physical or medical problem associated with infertility. Infertility drug therapy may or may not be covered depending on your group's prescription drug program.

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

(7) Prescriptions are covered as long as they are listed on the prescription drug formulary applicable to your plan. Your plan has coverage for both formulary and non-formulary medications at the applicable copayments. The member is responsible for the payment differential when a generic drug is authorized by the physician and the patient elects to purchase a brand drug. The member 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.



Iron Workers

Welfare Plan *of* Western Pennsylvania

VALUE BANK

The collective bargaining agreement between your employer and the union requires your employer to make contributions to the Welfare Plan on your behalf to cover welfare benefits. These contributions will be credited to your **Value Bank**.

Contributions made on your behalf to the Value Bank will first be credited to your Eligibility Account under the Value Bank. The balance in this account will be used to determine your eligibility for benefits under the Welfare Plan. Once you meet the eligibility requirements set forth in the next section of this booklet, an amount equivalent to the premium charge for the coverage level and tier for which you are enrolled will be deducted from your Eligibility Account each month. The maximum amount that may be credited to your Eligibility Account is an amount that is the equivalent of three months of premium at the coverage level and tier for which you are enrolled.

If your Eligibility Account is at the maximum amount, any employer contributions received on your behalf will then be credited to your Health Reimbursement Account under the Value Bank. There is no limit to the amount that can accumulate in your Health Reimbursement Account, and you may be able to earn additional contributions to your Health Reimbursement Account by participating in certain wellness activities offered by the Plan on occasion.

Your Health Reimbursement Account may be used for the following:

- Paying for any voluntary dental and vision premiums for benefits offered through the Plan, if you so choose;
- Reimbursing you for copayments, deductibles, and coinsurance that you and your Eligible Dependents incur under the Welfare Plan;
- If you or your spouse, or both, have attained age 65 and enrolled in Medicare, reimbursing you for Medicare Part B premiums for you or your spouse, or both;
- If you or your spouse, or both, are enrolled in Medicare because of a disability, reimbursing you for any related Medicare Part B premiums; and
- Reimbursing you for the following additional medical expenses that you incur for yourself and your Eligible Dependents covered by the medical insurance (e.g. Community Blue):
  - Dental treatment and artificial teeth;
  - Vision exams;
  - Glasses and contacts needed for medical reasons;
  - Eye surgery to treat defective vision;
  - Hearing aids;
  - Hearing tests;

- Expenses to obtain a breast pump and for supplies to assist lactation;
- Prescription drugs that are not covered by the medical insurance under the Welfare Plan;
- Smoking cessation programs;
- Fertility enhancement programs, such as in vitro fertilization (including temporary storage of eggs and sperm), for you or your spouse; and
- Insurance premiums that have not already been paid with pre-tax dollars.

With the exception of reimbursement for Medicare Part B premiums, in order to be reimbursed for eligible medical expenses from your Health Reimbursement Account, while still eligible for Welfare Plan coverage, you must have an amount equal to three months of premiums credited to your Eligibility Account at the coverage level and tier for which you are enrolled. Proper documentation of all expenses must be provided to the Plan Office. After termination from Welfare Plan coverage, you may be reimbursed for eligible expenses incurred by you or your Eligible Dependents who were enrolled at the time of termination with proper documentation until your Health Reimbursement Account balance is depleted. You, as the participant, are the only individual who may submit requests for reimbursement. However, if you are deceased and you have an Eligible Dependent enrolled in this Welfare Plan who survives you, such Eligible Dependent may request reimbursement from the Welfare Plan.

Claims for reimbursement of copayments, deductibles, coinsurance, Medicare Part B premiums and eligible medical expenses must be submitted to the Plan Office within 24 months of the date the expense was incurred. Claims submitted more than 24 months after they have been incurred will not be reimbursed.

If you submit a claim for reimbursement under the Health Reimbursement Account which is determined by the Plan Office, after diligent review, to be fraudulent, no reimbursement will be made to you and the value of the fraudulent claim will be deducted from your balance in your Health Reimbursement Account. This action will be deemed a denial of benefits and will be subject to the appeals procedures described later in this booklet.

Voluntary Forfeiture of Balance in Value Bank

If your Welfare Plan coverage has terminated, you may be eligible for a premium tax credit if you enroll in insurance coverage offered through the Health Care Marketplace. However, in order to qualify for the tax credit, you must permanently forfeit the balance in your Value Bank. Any employer contributions that are made on your behalf to the Welfare Plan while you are receiving a premium tax credit will be used only to determine your future eligibility under the Welfare Plan and may not be used for reimbursement of medical expenses or premiums. Please contact the Plan Office for more information and to request a form to forfeit your Value Bank.

ELIGIBILITY RULES

These eligibility rules provide a means by which a member covered under a collective bargaining agreement requiring contributions to the Welfare Plan can maintain health coverage during periods of:

- **active employment;**
- **temporary, total or partial disability;**
- **involuntary or voluntary unemployment (including vacation); and**
- **time prior to actual voluntary retirement.**

The eligibility rules do not provide extended coverage if you voluntarily leave covered employment to work in another industry or to become self-employed. "Covered employment" means work for which a collective bargaining agreement requires contributions to be made to this Welfare Plan on your behalf.

If you voluntarily leave covered employment to work in another industry or to become self-employed (including ironwork not covered by the collective bargaining agreement), your coverage will terminate at the end of the third (3rd) month after you last worked in covered employment, provided your Value Bank is sufficient to continue eligibility.

Initial Eligibility

You become eligible for coverage on the first day of the month after your Value Bank has sufficient contributions, within a 12-month period, to cover the cost of three months of coverage at the Deluxe Plan Family Rate.

Contact the Plan Office for the current year's requirements.

Lag Month

In order that there is sufficient time for employer contributions to be received and processed by the Plan Office, a **lag month** will be used in determining your initial eligibility.

Benefits **will not** be paid for days of hospitalization, medical or surgical services received before the initial eligibility date. This includes expenses incurred during the lag month.

ELIGIBILITY RULES

Delinquent Employer Contributions

If you worked for an employer who is delinquent in remitting its required contributions to the Welfare Plan on your behalf, and the amount of the contributions that are owed (when combined with other contributions made on your behalf for that 12-month period) is at least equal to the amount needed to meet the initial eligibility requirements, you may elect to self-pay the amount needed to meet the eligibility requirements.

You must provide proof to the Plan Office that you worked for the delinquent employer and that contributions are owed to the Welfare Plan on your behalf.

The amount you may elect to self-pay under this provision may be more than the amount needed to meet the initial eligibility requirement; however, you may not self-pay more than the total amount that was required to be contributed by the delinquent employer on your behalf.

If the delinquent employer later pays the required contributions to the Welfare Plan on your behalf, the Welfare Plan will refund you an equivalent portion of the amount that you self-paid to gain initial eligibility. For example, if the employer contributes 50% of what it owes, you will be refunded 50% of the amount that you self-paid.

Continued Eligibility

You will remain eligible as long as you have enough Welfare Plan contributions in your Value Bank to meet the current month's premium charge.

If your Value Bank does not contain enough money to cover the premium for a month of Welfare Plan coverage, you will be given the option to self-pay the balance.

You may continue to make self-payments to maintain coverage as long as your Value Bank is credited with at least three months of the cost of the premium coverage you have elected in a rolling 12-month period.

Once your right to self-pay terminates, you will be eligible for COBRA continuation coverage. You may also reinstate your eligibility through covered employment under the **Reinstatement of Eligibility** rules explained below.

For retirees over age 60, the following rules apply:

- **If a retiree's pension is not suspended, the dollars accrued do not count towards the Value Bank.**
- **If a retiree's pension is suspended, the dollars do count towards the Value Bank.**

ELIGIBILITY RULES

Reinstatement of Eligibility

Once you lose eligibility, you must meet the initial eligibility requirements in order to regain coverage. If there is a balance in the Value Bank at the time of termination of coverage, this balance can be used to satisfy the reinstatement of eligibility requirement if reinstatement occurs within twelve months of the termination of coverage. Once you are reinstated, you will have full and complete use of your existing balance.

Eligibility Status for Members Employed by Certain Entities

If you are eligible to participate in the Welfare Plan and you elect to work for a political subdivision, a signatory employer in a management role, or the International Association of Bridge, Structural, Ornamental and Reinforcing Iron Workers, your right to participate in the Welfare Plan (for benefit coverage and for reimbursement purposes) can be suspended on an elective basis, and your Value Bank account can be frozen on the first day of the month in which you elect to participate in the health plan of the other entity. Once your Value Bank is frozen, all Welfare Plan coverage will be suspended until reinstatement of eligibility occurs.

A political subdivision includes a municipality, water authority, board of education, or other public entity within the geographic jurisdiction of the Union, in employment of the type covered under a collective bargaining agreement with a contributing employer.

Proof of insurance through a separate collective bargaining agreement or a letter from the employer must be submitted to the Plan Office for verification.

Reinstatement of Eligibility for Members Employed by Certain Entities

If your eligibility was suspended due to your employment status (as discussed above), you may be reinstated into the Welfare Plan for benefit coverage and for Value Bank reimbursement purposes on the first day of the month after you lose eligibility for coverage in the health plan of the other entity.

Proof of termination of insurance must be submitted to the Plan Office for verification.

Reciprocal Contributions

The Welfare Plan is signatory to the International Reciprocal Agreement for Welfare Plans.

The Welfare Plan has also entered into a number of agreements where this Welfare Plan will accept or transfer contributions on a member's behalf.

If you become eligible under another welfare plan that is not a signatory to the International Reciprocal Agreement for Welfare Plans or if the other welfare plan does not have an agreement to transfer contributions, your Value Bank under this Welfare Plan will be frozen. Your coverage may be reinstated when you lose eligibility under the other plan.

Participation Agreements

If you are not covered by a collective bargaining agreement requiring contributions to the Welfare Plan, you are eligible for coverage under the Welfare Plan if your employer has entered into a written participation agreement with the Trustees requiring your employer to make contributions to the Welfare Plan on your behalf for 40 hours per week and 52 weeks per year.

Agreements with the International

If you are covered by an agreement with the International Association of Bridge, Structural and Ornamental Iron Workers requiring contributions to the Welfare Plan, you are eligible for coverage under the Welfare Plan in accordance with the terms of that agreement.

Limitation on Participation for Owners and Management Employees

If you have any type of direct or indirect financial interest in an employer, or if you perform any type of work or service for an employer in the ironworking industry that is not covered by the collective bargaining agreement, whether as an employee, owner or independent contractor, you will not be eligible for any coverage under the Welfare Plan for work with that employer, unless that employer enters into a written participation agreement with the Trustees requiring the employer to make contributions to the Welfare Plan on your behalf for 40 hours per week and 52 weeks per year (referred to as a "40/52 agreement"). This limitation applies even if you work sufficient hours for the employer under the collective bargaining agreement to be otherwise eligible for coverage under the Welfare Plan.

The determination of whether you have a direct or indirect financial interest in an employer is made by applying constructive ownership of stock rules from the Internal Revenue Code (§ 318) modified for non-corporate employers to apply to ownership of capital or profits interests of such an employer (and to reduce the 50% stock threshold to 5%). Under these rules, for example, you are deemed to own the stock owned by your spouse. Thus, if you work for an employer owned by your spouse, this limitation will apply, and you will not be eligible for coverage for work with this employer unless the employer enters into a 40/52 agreement on your behalf.

Employer for this purpose includes any related employer (i.e., the parent company of the employer, any subsidiary company of the employer, and any trade or business under common control with the employer as determined by applying the controlled group and affiliated service group rules from the Internal Revenue Code (§414(b), (c), (m) and (o)). Thus, for example, if you work for a subsidiary controlled by a corporation you own, this limitation will apply, and you will not be eligible for coverage for work with this employer unless the employer enters into a 40/52 agreement on your behalf.

Employer, however, does not include any employer if its securities are listed on the New York Stock Exchange, the American Stock Exchange or a regional stock exchange with daily price quotations or if its securities are traded on NASDAQ. This includes most publicly traded companies. Thus, your ownership of stock of such an employer will not trigger the application of this limitation, and your eligibility for coverage under the Welfare Plan for work for such an employer will be determined under the regular eligibility rules.

Also, this limitation does not apply to your work for an employer that is not related to the employer in which you have a financial interest or for which you perform non-bargaining work or service. Thus, if you work sufficient hours for the unrelated employer, you will be provided with coverage under the Welfare Plan if otherwise eligible, even if you also work for an employer in which you have a financial interest or for which you perform non-bargaining work or service.

Continued Eligibility During Disability Periods

If you are unable to work because of a certified disability, your Value Bank will be credited for each full week of disability. The credit will be calculated by taking your current monthly premium divided by 4.33.

A **certified disability** is one for which the member:

- is being paid Weekly Accident and Sickness Benefits through the Welfare Plan; or
- submits evidence of receiving Workers' Compensation benefits as the result of a disability incurred while performing work normally under the jurisdiction of Iron Workers Local Unions.

You can receive disability hours for a maximum of 52 weeks per illness or accident in a 24-month period up to a lifetime maximum of 104 weeks of benefits for a recurring disability.

However, as discussed in the Weekly Accident & Sickness Benefit section, you will receive no disability credit if it is determined that you fraudulently applied for the Weekly Accident & Sickness Benefit or misrepresented your entitlement to the benefit, or if it is determined that you received Weekly Accident & Sickness Benefit payments as the result of your fraud or misrepresentation.

Notwithstanding the above, for any week you are using an Apprentice Credit to maintain eligibility, as described later in this Eligibility section, you will not receive a disability credit. Apprentice Credits shall be used before any disability credits are used.

Family and Medical Leave Act (FMLA)

The Family and Medical Leave Act of 1993 (FMLA) creates a right for certain members to take up to twelve (12) weeks of unpaid leave for their own serious illness, after the birth or adoption of a child, to care for their seriously ill spouse, parent or child, or for certain circumstances arising out of their spouse's, son's or daughter's, or parent's military duty. FMLA also allows certain members to take up to twenty-six (26) weeks of unpaid leave in a single 12-month period to care for a spouse, parent, son or daughter, or next of kin who is a military service member with a serious illness or injury. The Family and Medical Leave Act requires certain employers to maintain health care coverage during the leave period. Your benefits are protected and your Value Bank is frozen if your employer approves your family and medical leave. Contact the Plan Office for more information concerning the requirements for an FMLA leave.

Members in Military Service

If you are on active duty for 90 days or less, you and your dependents will continue to receive health care coverage for up to 90 days. At the end of this 90-day period, the Trustees, in their discretion, may review the situation in order to determine whether to further extend benefits.

After this extended period of coverage, if you return to covered employment (or make yourself available for covered employment) within 90 days of your discharge from active duty, your Value Bank will be reinstated at the same amount as when you were called to active duty. Essentially, this means that all of your welfare contributions will be as they were when you were called to active duty.

If you remain on active duty after 90 days and the Trustees do not extend the period of coverage as described above, USERRA (Uniformed Services Employment and Reemployment Rights Act of 1994) permits you to continue medical coverage for you and your dependents at your own expense while you are on active duty for up to 24 months from the date your active duty began. You may choose to use your Value Bank to pay for this coverage, or you may self-pay. If you exhaust your Value Bank while still on active duty, you must self-pay to continue coverage. When you return from active duty and are once again receiving employer contributions to your Value Bank, you may continue to self-pay for coverage until you have enough employer contributions to your Value Bank to maintain eligibility.

If you and your dependent(s) are covered under TRICARE (the health care system for members of U.S. Armed Forces), this Welfare Plan will coordinate coverage with TRICARE.

ELIGIBILITY RULES

Coverage will not be offered for any illness or injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, performance of service in the uniformed services. The uniformed services and the Department of Veterans Affairs will provide care for service-connected disabilities.

Definition of Eligible Dependents

Eligible Dependents are your spouse, and each of your children who has not reached his or her 26th birthday. A "child" is your biological child, adopted child, stepchild, or a child named in a Qualified Medical Child Support Order (QMSCO).

You may be required to provide proof to the Plan Office that the dependent meets the definition of an Eligible Dependent.

If your unmarried dependent child is incapable of self-sustaining employment because of physical handicap or mental retardation and he/she is dependent upon you for support and maintenance, his/her coverage will continue provided his/her incapability began prior to attaining age 26. You must submit proof of the dependent child's incapability to the Plan Office within the 31-day period following the day he/she attains age 26. You may be requested to provide proof of the continued existence of such incapability to the Plan Office from time to time.

A Qualified Medical Child Support Order (QMCSO) is a court order that requires an employee to provide medical coverage for his or her children (called alternate recipients) in situations involving divorce, legal separation or a paternity dispute. A QMCSO requires the Welfare Plan to cover an alternate recipient who might not otherwise be eligible for coverage. This Welfare Plan provides benefits according to the requirements of the QMCSO. The Plan Office will notify affected participants and alternate recipients if a QMCSO is received. You may request a copy of the Welfare Plan's QMCSO procedures, free of charge, if you need additional information.

Benefits for Dependents of Deceased Members

If a member dies while eligible under the Welfare Plan, the surviving spouse and eligible dependent children will be credited with six full months of the required premium to maintain existing coverage. The remaining Value Bank may be utilized to either extend coverage beyond the six months or be used for reimbursement of out-of-pocket medical and prescription drug expenses in accordance with the Value Bank reimbursement rules.

Continued Eligibility During Apprenticeship Training

Effective July 1, 2008, members in the Apprentice Program will receive a credit for each hour of school attended, up to 40 hours per week, for a maximum of seven weeks per year. This "Apprentice Credit" will only be used to maintain eligibility if the apprentice's Welfare Plan coverage is being terminated due to insufficient hours. The Apprentice Credit will equate to one hour of work and will be valued (for determining eligibility of the apprentice only) as if a contribution was made to the Value Bank for such hour. However, no actual contribution or credit to the Value Bank shall be made. Once a member leaves the Apprentice Program, all Apprentice Credits shall be forfeited.

Notwithstanding any of the provisions of this Welfare Plan to the contrary, if your participation in the Apprentice Program is voluntarily or involuntarily terminated prior to your successful completion of the Apprentice Program, your participation in this Welfare Plan will terminate as of the end of the month in which your participation in the Apprentice Program terminates, and all amounts credited to the Value Bank on your behalf will be forfeited. See the section called "COBRA Continuation Coverage" for benefits that may be available to you after your termination of coverage.

Special Continuation of Coverage in June 2020

Due to the COVID-19 pandemic and the work stoppages beginning in March 2020, if you were eligible for coverage under the Plan as of May 31, 2020, coverage will be extended through June 2020 for your and your eligible Dependents, with no deduction from your Value Bank and no self-payment required.

Initial Eligibility

you want to enroll - the Deluxe Plan, the Premier Plan, the Standard Plan, the Core Plan, or the Value Plan. You also will need to elect your coverage level (yourself only, yourself and your spouse, yourself and your children, or yourself and your family). The monthly premium amount that will be deducted from your Value Bank will depend on your plan option and your coverage level. You will also have the option of enrolling in the Voluntary Vision and/or Voluntary Dental programs.

When you first become eligible, the Plan Office will send you enrollment materials. These materials must be completed and returned by the end of the month in which you become eligible. If they are not received by the end of the month, you will automatically be defaulted into the Premier Plan option with family coverage (unless you have beneficiary/dependent information on file with the Plan Office which indicates that single coverage is appropriate because you have no dependents), and you will not be eligible for dental and vision until the next Open Enrollment period. If your enrollment materials are received by the end of the month, your medical coverage will be effective as of the first of the month in which you became eligible. Any dental or vision coverage you elect will be effective the first of the month following the month in which you became eligible.

> **As an example,** *if you are eligible on December 1st, your enrollment materials must be received by the Plan Office by December 31st. Your medical coverage will be effective December 1st and your dental and vision coverage will be effective on January 1st.*

The choices you make when you first become eligible are effective for the remainder of the calendar year in which you first become eligible, unless you have a mid-year Change in Status Event (see below).

You are required to enroll in medical coverage; however, you are not required to cover your spouse or dependents (unless the Welfare Plan receives a Qualified Medical Child Support Order).

Open Enrollment

Each year, you will be given the opportunity to review the available benefits and make elections regarding plan options and coverage levels for the following calendar year. This period is called "Open Enrollment." Elections that you make during Open Enrollment remain in effect for the entire year. This means that you will not be able to change plan options or coverage levels until the next annual "Open Enrollment" period, unless you have a mid-year Change in Status Event.

Change in Status Event

Generally speaking, you may only change your choices of plan option, coverage levels and participation in the voluntary benefits during Open Enrollment for the following Plan Year. However, in certain situations you may modify your choices mid-year upon a "change in status." Events that constitute a change in status under the Welfare Plan are listed below. Please note that there are several conditions and/or limitations that apply to the events listed below. Please contact the Plan Office if you have any questions or believe that you may qualify for an election change.

A **change in status** is:

- A change in your marital status including marriage, death of a spouse, divorce, legal separation, or annulment.
- A change in the number of your dependents, including birth, death, adoption, and placement for adoption.
- A change in your employment status, or that of your spouse or your dependent, that results in gaining or losing eligibility under a group health plan; this includes a termination or commencement of employment, a strike or a lockout, a commencement or return from an unpaid leave of absence, or a change in worksite.
- A change in election by your spouse under a group health plan offered by your spouse's employer.
- When your dependent meets or ceases to meet the definition of Eligible Dependent.
- When the Welfare Plan receives a judgment, decree, or order resulting from a divorce, legal separation, annulment, or change in legal custody (including a Qualified Medical Child Support Order) that requires health coverage for your child or foster child, or cancels coverage if the order requires your spouse, former spouse or other individual to provide coverage.
- When you, your spouse, or dependent are entitled to Medicare or Medicaid.
- When your spouse or dependent becomes eligible to participate in a financial assistance program through Medicaid or a State Children's Health Insurance Program ("SCHIP"); or when your spouse or dependent loses coverage under Medicaid or SCHIP.

Your request to make an election change due to a Change in Status Event must be received by the Plan Office within 30 days of the event. As an exception, in the case of eligibility for financial assistance through Medicaid or SCHIP, or a loss of coverage under Medicaid or SCHIP, the request must be received by the Plan Office within 60 days.

If the request is timely received, the change will be effective the first day of the month following the date the Plan Office received your request. As an exception, in the case of birth, adoption, or placement for adoption, if the request is timely received, the change will be effective retroactive to the date of birth, adoption, or placement for adoption.

If your request is not timely received, the change will not be effective and you will have to wait until the next Open Enrollment period to make the change. As an exception, in the case of birth, adoption, or placement for adoption, if the request is not received within 30 days, but is received in the same Plan Year as the birth, adoption or placement for adoption, the change will be effective the first day of the month following the date the Plan Office received your request.

LIFE INSURANCE BENEFIT

(Provided through MetLife)

If you die from any cause - on the job or off - while you are insured for this Life Insurance Benefit, your named beneficiary will receive the applicable benefit amount.

Benefit Amount

The amount payable to beneficiaries of active members who were insured under this Life Insurance Benefit for twelve (12) consecutive months or more is $50,000. The amount payable to beneficiaries of active members who were insured under this Life Insurance Benefit for less than twelve (12) consecutive months is $25,000.

If you become terminally ill, you may be eligible for an accelerated benefit of up to 50% of your Life Insurance Benefit before you die. If you receive this benefit, the amount paid upon your death is reduced.

Beneficiary

You may name anyone you wish as your beneficiary for life insurance and you may change your beneficiary at any time by filling out the proper form obtained from/and returned to the Plan Office.

If you have not designated a beneficiary or if your beneficiary predeceases you, payment of the Life Insurance Benefit will be made equally to the members of the first (1st) of the following categories that applies:

- spouse
- children
- parents
- brothers and sisters

Alternatively, the Life Insurance Benefit may be paid to your estate. If your beneficiary is a minor, the benefit will be paid to the beneficiary's legal guardian or otherwise distributed in accordance with applicable law.

The Life Insurance Benefit will be paid to your beneficiary or beneficiaries as a single lump sum. Your beneficiary must submit a certified copy of the death certificate.

LIFE INSURANCE BENEFIT

Total and Permanent Disability

If, prior to attaining age 62, while insured under the group policy, you become permanently and totally disabled from any gainful employment, the Welfare Plan will pay the premiums necessary to provide you with life insurance coverage. You will be required to provide proof that you obtained a Social Security disability award showing that you were totally disabled from any gainful employment.

The Life Insurance Benefit will be continued until you:

- attain age 62; or, if sooner,
- are no longer considered to be permanently and totally disabled.

If you die during the time your life insurance is continued by the Welfare Plan, your beneficiaries will be paid the appropriate benefit amount.

If Social Security does not determine that you are totally and permanently disabled from gainful employment, you will be offered the opportunity to convert your life insurance.

Conversion Privilege Feature

If your Life Insurance Benefit terminates, you may convert to an individual life insurance policy within 31 days of termination. No medical examination is required. The benefit amount of the converted policy cannot exceed the amount provided under the group plan. You may choose any type of individual policy being written by MetLife, except term insurance or any insurance that provides disability or other supplemental benefits. Your premium cost for the conversion policy will be based on your class of risk and attained age at the time of conversion.

If you die within the 31-day period following termination, your beneficiary will receive the Life Insurance Benefit amount as though you were still insured under the Group Policy.

Note: *This is just a summary of the benefits provided under the insurance contract with MetLife. If any terms of the contract conflict with this summary, the contract will govern.*

ACCIDENTAL DISMEMBERMENT & LOSS *of* SIGHT INSURANCE BENEFIT

(Provided through MetLife)

If you sustain any of the losses described below solely as a direct result of an accidental injury — on the job or off — the Accidental Dismemberment and Loss of Sight Insurance Benefit will be paid by MetLife in addition to any other benefits payable under the Welfare Plan.

Benefit Amount

The amount payable if you sustain any of the following losses is:

A hand	$10,000
A foot	$10,000
An arm	$15,000
A leg	$15,000
Sight of one eye	$10,000
Any combination of a hand, a foot, or sight of an eye	$20,000
Thumb and index finger on same hand	$5,000
Speech and hearing in both ears	$20,000
Speech	$10,000
Hearing in both ears	$10,000
Paralysis of both arms and legs	$20,000
Paralysis of both legs	$10,000
Paralysis of an arm **and** a leg on either side of the body	$10,000
Paralysis of one arm **or** leg	$5,000
Brain damage	$20,000
Coma	$2,000 monthly for up to 60 months

The amount for loss of limb(s), eyesight, hearing and/or paralysis is payable to you. The loss must be a direct result of bodily injury sustained from an accident, independent of other causes. In addition to the benefits listed above, if you are confined to a hospital due to your accident, you may receive a benefit of $2,000 per month for up to 12 months of continuous confinement.

ACCIDENTAL DISMEMBERMENT & LOSS *of* SIGHT INSURANCE BENEFIT

General Exclusions and Limitations

These General Exclusions and Limitations do not apply to any Life Insurance Benefits provisions.

MetLife does not pay under the Accidental Dismemberment Benefits provisions for any loss which is caused or contributed to by:

1) Physical or mental illness or infirmity, or the diagnosis or treatment of such illness or infirmity;
2) Infection, other than infection occurring in an external accidental wound;
3) Suicide or attempted suicide;
4) Intentionally self-inflicted injury;
5) Service in the armed forces of any country or international authority, except the United States National Guard;
6) Any incident related to:
    a) Travel in an aircraft as a pilot, crew member, flight student or while acting in any capacity other than as a passenger;
    b) Travel in an aircraft for the purpose of parachuting or otherwise exiting from such aircraft while it is in flight;
    c) Parachuting or otherwise exiting from an aircraft while such aircraft is in flight, except for self-preservation;
    d) Travel in an aircraft or device used:
        i) For testing or experimental purposes;
        ii) By or for any military authority; or
        iii) For travel, or designed for travel, beyond the earth's atmosphere;
7) Committing or attempting to commit a felony;
8) The voluntary intake or use by any means of;
    a) Any drug, medication or sedative, unless it is:
        i) Taken or used as prescribed by a physician, or
        ii) An "over the counter" drug, medication, or sedative; or
    b) Poison, gas or fumes;
9) War, whether declared or undeclared; or act of war, insurrection, rebellion or riot; or
10) Operation of a vehicle or other device while intoxicated.

Note: *This is just a summary of the benefits provided under the insurance contract with MetLife. If any terms of the contract conflict with this summary, the contract will govern.*

IRONWORKER MANAGEMENT PROGRESSIVE ACTION TRUST (IMPACT) OFF-THE-JOB ACCIDENT PLAN

The IMPACT Off-the-Job Accident Plan is a benefit provided in addition to this Welfare Plan by an outside party. Please contact the Plan Office for additional information regarding the coordination of this benefit with the Welfare Plan.

WEEKLY ACCIDENT & SICKNESS BENEFIT (LOSS *of* WAGES)

The Weekly Accident and Sickness Benefit provides benefits as a partial replacement for lost wages if you are totally and temporarily disabled from work due to a non-occupational accident or sickness. This benefit is not available if you would not be available for work in Covered Employment for some reason other than the fact that you are disabled. **The benefit is not payable if you continue to receive hourly wages, including paid vacation, salary, or when collecting unemployment compensation during a disability period.**

On the first (1st) day of the month following the onset of total and permanent disability, you may choose to receive an immediate disability pension as opposed to drawing this Weekly Accident and Sickness Benefit from the Welfare Plan.

The weekly benefit begins on the first (1st) day of the disability resulting from an accident and the eighth (8th) day of disability caused by a sickness. However, if you are hospital confined for a sickness, this Weekly Accident and Sickness Benefit will begin on the first (1st) day of hospital confinement due to a sickness if sooner than the eighth (8th) day of the sickness. You must be under the care of a legally qualified physician, licensed physician assistant, or certified nurse practitioner. If your disability due to sickness lasts for a period of at least 15 consecutive days, benefits will be paid for the first seven (7) days of the disability. **Remember**, the Welfare Plan reserves the right to request physical examinations for any claim under this Weekly Accident and Sickness Benefit. However, all initial claims for benefits that are retroactive for more than five (5) weeks will require an examination by a physician selected by the Welfare Plan (unless the member has returned to work in which case the Welfare Plan needn't require an examination by a physician). Claims must be submitted within 90 days of the onset of the disability.

You do not need to be confined to your home to collect benefits, but you must be under the care of a medical doctor (M.D.) or doctor of osteopathy (O.D.), or a licensed physician assistant (PA), or a certified nurse practitioner. Such care must be professional medical care received on a regular basis, in the hospital, a physician's office or in your home.

WEEKLY ACCIDENT & SICKNESS BENEFIT (LOSS *of* WAGES)

IMPORTANT: If it is determined that you fraudulently applied for the Weekly Accident and Sickness Benefit or misrepresented your entitlement to the Benefit, or if it is determined that you received Weekly Accident and Sickness Benefit payments as the result of your fraud or misrepresentation:

- you will be responsible for the repayment of all Weekly Accident and Sickness Benefit payments you received as the result of your fraud or misrepresentation;
- you will not be entitled to the weekly disability credit used to determine your eligibility under the Welfare Plan (and your vesting, eligibility and benefits under the Pension Plan) for those weeks of payment; and
- you will lose all eligibility to receive the Weekly Accident and Sickness Benefit during the 24-month period that begins on the later of the date of the determination of your fraud or misrepresentation or the date you repay all of the Weekly Accident and Sickness Benefit payments you received as the result of your fraud or misrepresentation.

This determination will be made by the Trustees (or their designee). You should note that if you receive Weekly Accident and Sickness Benefit payments and unemployment compensation payments (or wages and salary) for the same week or weeks, it will be presumed that you have received the Weekly Accident and Sickness Benefit payments as the result of your fraud or misrepresentation.

A determination under these provisions can be reviewed under the claims and appeal procedures for a denied Weekly Accident and Sickness Benefit.

You are limited to a lifetime maximum of 104 weeks of benefits for recurring disabilities combined, regardless of how often you become temporarily disabled.

Non-Occupational Injury or Sickness

If you are unable to work due to a non-occupational injury or sickness, this Weekly Accident and Sickness Benefit will pay $490 per week for a maximum period of 52 weeks in any 24-month period for all related disabilities. You are limited to a lifetime maximum of 104 weeks of benefits for **recurring** disabilities combined, regardless of how often you become temporarily disabled.

You are not entitled to benefits if you continue to receive hourly wages, salary, paid vacation or unemployment compensation while disabled or during the period you are receiving payments.

If you recover from a disability for which benefits have been paid and again become disabled for the same or related cause within 24 months, both disabilities will be considered one period of disability.

WEEKLY ACCIDENT & SICKNESS BENEFIT (LOSS *of* WAGES)

If you recover from a disability for which benefits have been paid and immediately become disabled due to an unrelated cause, a new, consecutive, period of disability will commence. After you have incurred two consecutive periods of unrelated disabilities, a new period of disability for a claim not related to the previous disability cannot begin until you have recovered from your current disability and returned to work for at least two (2) full weeks, with a minimum of eighty (80) hours in covered employment. This is true whether benefits have been paid to you for the full 52-week period or not.

Occupational Injury

If you are unable to work due to an occupational injury, you must apply for Workers' Compensation. The Welfare Plan will pay benefits for the first seven (7) days of your disability if you recover before completing the waiting period for payment of the first week of Workers' Compensation benefits.

Exclusions

You are not entitled to Weekly Accident and Sickness Benefit if:

1. you are entitled to receive benefits for any week under the IMPACT Off-the-Job Accident Plan;
2. you continue to receive hourly wages, salary, Workers' Compensation or unemployment compensation while disabled;
3. you would not be available for work for any reason other than your disability;
4. you are not under the care of a medical doctor (M.D.), doctor of osteopathy (O.D.), licensed physician assistant (PA), or a certified nurse practitioner; or
5. your disability started before you became covered for this benefit.

MEMBERSHIP ASSISTANCE PROGRAM

(Provided through Lytle EAP Partners)

The Welfare Plan, through Lytle EAP Partners, provides the Membership Assistance Program (MAP). This program provides you and your family with confidential help in dealing with personal problems. The MAP staff will help you and your family with the following kinds of problems:

- Marital or family problems
- Financial or legal difficulties
- Emotional or stress-related problems
- Drug or alcohol abuse
- Parenting or aging
- Problems related to work

For confidential help call: 1-888-877-8997.

MEDICAL BENEFITS UNDER COMMUNITY BLUE

(Provided through Highmark Blue Cross Blue Shield Community Blue Program)

This section of the booklet, provided by Highmark, gives you the information you need to understand your Highmark Blue Cross Blue Shield Community Blue program. We encourage you to take the time to review this information so you understand how your health care program works.

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

- **Your health care program gives 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 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, log onto your Highmark member website, **www.highmarkbcbs.com**.

- **Your health care program gives 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 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 SPD.

If you have any questions on your health care program, please call the Member Service toll-free telephone number on the back of your ID card. For TTY/TDD hearing impaired service, please dial 711 and the number on the back of your ID card.

Information for Non-English-Speaking Members

Non-English-speaking members have access to clear benefits information. They can call the toll-free Member Service telephone number on the back of their ID card to be connected to a language services interpreter line. Highmark Member Service representatives are trained to make the connection.

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 beginning of this SPD. For specific amounts, refer to your Summary of Benefits.

Benefit Period

The specified period of time during which charges for covered services must be incurred in order to be eligible for payment by Highmark. A charge shall be considered incurred on the date you receive the service or supply for which the charge is made.

Medical and Prescription 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 your 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 your Summary of Benefits for the copayment amounts.

Deductible

The deductible is a specified dollar amount you must pay for covered services each benefit period before the program begins to provide payment for benefits. See your 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.

If your group changes group health care expense coverage during your benefit period, the amount you paid toward your deductible during the last partial benefit period for services covered under the prior Highmark coverage will be applied to the network and out-of-network deductible of the initial benefit period under this program.

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 your 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.

Out-of-Pocket Limit

The out-of-pocket limit refers to the specified dollar amount of expense incurred for covered services in a benefit period. When the specified dollar amount is attained, the level of benefit increases as specified in the Summary of Benefits. See your 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 benefit period. When the specified individual dollar amount is attained by you, or the specified family dollar amount is attained by you or your covered family members, your program begins to pay 100% of all covered expenses and no additional coinsurance, copayments and deductible will be incurred for network covered services and covered medications in that benefit period. 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.

Out-of-Pocket Credit

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

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.

Value-Based Benefits

Value-Based benefits are available when specific covered services are received in connection with the treatment of the following chronic conditions. These services must be provided by a network provider.

Chronic Condition	Covered Services
Asthma	Condition-related outpatient visits Antibody inhibitor Asthma spacers
Coronary Artery Disease	Condition-related outpatient visits Lipid panel test Liver function test
Congestive Heart Failure	Condition-related outpatient visits Liver function test
Chronic Obstructive Pulmonary Disease (COPD)	Condition-related outpatient visits
Depression	Condition-related outpatient mental health visits
Diabetes	Condition-related outpatient visits Basic metabolic panel Diabetic education (up to 10 hours) Dilated retinal exam (performed by a physician or specialist) Glucometer/test strips Hemoglobin A1c tests Hospital-based nutrition counseling visits Lipid panel test Liver function test Microalbumin urine test Needles/syringes
High Cholesterol	Condition-related outpatient visits Lipid panel test Liver function test
Hypertension	Condition-related outpatient visits

Covered Services - Medical Program

Community Blue provides 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. For specific covered services, refer to your 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. To make sure that a provider is in the network, call Member Service at the number on the back of your member ID card or visit **www.highmarkbcbs.com**.

Ambulance Service

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

- **from your home, the scene of an accident or medical emergency to a hospital or**
- **skilled nursing facility;**
- **between hospitals; or**
- **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. Refer to the Terms You Should Know section for a definition of emergency care services.

Use of an ambulance as transportation to an emergency room for an injury or condition that does not satisfy the criteria of 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:

- **from a hospital to your home, or**
- **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 initially rendered by a physician which are required as a result of accidental injury to the jaws, sound natural teeth, mouth or face. 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.

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:

- **Equipment and supplies:** Blood glucose monitors, monitor supplies, and insulin infusion devices
- **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:
  - Visits medically necessary and appropriate upon the diagnosis of diabetes
  - 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:

- 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).
- Basic Diagnostic Services
  - **Standard Imaging Services** - procedures such as skeletal x-rays, ultrasound and fluoroscopy
  - **Laboratory and Pathology Services** - procedures such as non-routine Papanicolaou (PAP) smears, blood tests, urinalysis, biopsies and cultures
  - **Diagnostic Medical Services** - procedures such as electrocardiograms (ECG), electroencephalograms (EEG), echocardiograms, pulmonary studies, stress tests, audiology testing
  - **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 is a liquid source of nutrition equivalent to a prescription drug that is administered orally or enterally and which may contain some or all nutrients necessary to meet minimum daily nutritional requirements. Enteral foods are intended for the specific dietary management of a disease or condition for which distinctive nutritional requirements are identified through medical evaluation.

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

- 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
- nutritional supplements administered under the direction of a physician for the therapeutic treatment of phenylketonuria, branched-chain ketonuria, galactosemia and homocystinuria and;
- enteral formulae prescribed by a physician, when administered on an outpatient basis, considered to be your sole source of nutrition and provided:
  - through a feeding tube (nasogastric, gastrostomy, jejunostomy, etc.) and utilized instead of regular shelf food or regular infant formulas; or
  - orally and identified as one 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 **excludes** the following:

- 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

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

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:

- Skilled nursing services of a Registered Nurse (RN) or Licensed Practical Nurse (LPN), excluding private duty nursing services
- Physical medicine, speech therapy and occupational therapy
- Medical and surgical supplies provided by the home health care agency or hospital program for home health care or hospice care
- Oxygen and its administration
- Medical social service consultations
- Health aide services when you are also receiving covered nursing services or therapy and rehabilitation services
- 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. Benefits for certain infusion therapy prescription drugs as identified by Highmark and which are appropriate for self-administration, will be provided only when received from a participating pharmacy provider.

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 room with two or more beds;
- a private room. Private room allowance is the average semi-private room charge; or
- 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:

- use of operating, delivery and treatment rooms and equipment;
- drugs and medicines provided to you while you are an inpatient in a facility provider;
- whole blood, administration of blood, blood processing, and blood derivatives;
- anesthesia, anesthesia supplies and services rendered in a 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;
- medical and surgical dressings, supplies, casts and splints;
- diagnostic services; or
- therapy and rehabilitation services.

Outpatient Services

Ancillary Services

Hospital services and supplies including, but not restricted to:

- use of operating, delivery and treatment rooms and equipment;
- drugs and medicines provided to you while you are an outpatient in a facility provider. However, benefits for certain therapeutic injectables as identified by Highmark and which are appropriate for self-administration will be provided only when received from a participating pharmacy provider;
- whole blood, administration of blood, blood processing, and blood derivatives;
- 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;
- medical and surgical dressings, supplies, casts and splints.

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 may be subject to a copayment, which is waived if you are admitted as an inpatient. Refer to the Summary of Benefits section for your program's specific amounts.

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.

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.

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

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 state law, entities such as Highmark which issue health insurance to your employer or union, are generally prohibited from restricting 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, state law does not prohibit the mother's or newborn's attending provider from discharging the mother or newborn earlier than 48 hours (or 96 hours as applicable) if the mother and newborn meet the medical criteria for a safe discharge contained in guidelines which recognize treatment standards used to determine the appropriate length of stay; including those of the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists. In any case, health insurance issuers like Highmark 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. Refer to the General Information section for further eligibility information.

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 program provides 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 or approved telemedicine provider via an audio and video telecommunications system.

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, telemedicine services 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. However, benefits for certain therapeutic injectables as identified by Highmark and which are appropriate for self-administration will be provided only when received from a participating pharmacy provider.

Pediatric Extended Care Services

Benefits are provided for care received from a pediatric extended care facility that is licensed by the state and is primarily engaged in providing basic non-residential services to infants and/or young children who have complex medical needs requiring skilled nursing and therapeutic care and who may be technologically dependent.

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

- Skilled nursing services of a Registered Nurse (RN) or Licensed Practical Nurse (LPN)
- Physical medicine, speech therapy and occupational therapy
- Respiratory therapy
- Medical and surgical supplies provided by the pediatric extended care facility
- Acute health care support
- Ongoing assessments of health status, growth and development

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

A prescription from the child's attending physician is necessary for admission to such facility. No benefits are payable after the child has reached the maximum level of recovery possible for his or her particular condition and no longer requires definitive treatment other than routine supportive care.

Preventive Care Services

Benefits will be provided for covered services. Refer to the Summary of Benefits for your program's specific level of coverage.

Adult and Pediatric Care

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

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

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 network 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.

Mammographic Screening

Benefits are provided for the following:

- **An annual routine mammographic screening pursuant to the 2002 recommendations by the United States Preventive Services Task Force.**
- **Mammographic screenings for all members when such services are prescribed by a physician.**

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

Pediatric Immunizations

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 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.

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. Benefits will be provided for an assistant at surgery only if a house staff member, intern or resident is not available.

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

Sterilization

- Sterilization and its reversal 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.

Therapy and Rehabilitation Services

Benefits will be provided for 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. Benefits for certain infusion therapy prescription drugs as identified by Highmark and which are appropriate for self-administration, will be provided only when received from a participating pharmacy provider.
- 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 your member website, log in and choose **Prescriptions** or call Member Service at the number on the back of your ID card.

Your program includes a mandatory generic penalty (MGP) provision. The MGP provision provides that if you receive a brand name drug when a generic equivalent is available you must pay the price difference between the brand and generic prices in addition to the applicable copayment or coinsurance amount.

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;"
- egend drugs under applicable state law and dispensed by a licensed pharmacist;
- prescription drugs listed in your program's prescription drug formulary;
- preventive drugs that are offered in accordance with a predefined schedule and are prescribed for preventive purposes. 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 your member website, or call Member Service at the toll-free telephone number listed on the back of your ID card;
- prescribed injectable insulin;
- diabetic supplies, including needles and syringes; and
- certain drugs that may require prior authorization

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 your toll-free Member Service number. 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

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

Key Word	Exclusion
Acupuncture	For acupuncture services.
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 a cosmetic or reconstructive procedure or surgery done to improve the appearance of any portion of the body, and from which no improvement in physiological function can be expected, except: a) as otherwise provided herein, b) when required to correct a condition resulting from an accident; c) when necessary to correct a functional impairment which directly results from a covered disease or injury, or d) to correct a congenital birth defect.
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, 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.
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.
Foot Care	For palliative or cosmetic foot care including flat foot conditions, supportive devices for the foot, corrective shoes, the treatment of subluxations of the foot, care of corns, bunions, (except capsular or bone surgery), calluses, toe nails (except surgery for ingrown toe nails), fallen arches, weak feet, chronic foot strain, and symptomatic complaints of the feet, except when such devices or services are related to the treatment of diabetes.
Healthcare Management Program	For any care, treatment, prescription drug or service which has been disallowed under the provisions of Healthcare Management program.
Hearing Care Services	For hearing aid devices, tinnitus maskers, or examinations for the prescription or fitting of hearing aids.
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 intellectual disability, 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.
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 group 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.
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.

MEDICAL BENEFITS UNDER COMMUNITY BLUE

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

Any over-the-counter drug obtained without presentation of a written prescription order, 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.

Topical antifungals.

Antitussives (cough/cold products).

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.

Any drugs and supplies which can be purchased without a prescription order, including, but not limited to blood glucose monitors and injection aids, except as provided herein.

Compounded medications.

Any drugs which are experimental/investigative.

Any prescription drugs or supplies purchased at a non-participating pharmacy provider, except in connection with emergency care described herein.

Any prescription drug purchased through mail order but not dispensed by a designated mail order pharmacy provider.

Any selected diagnostic agents.

MEDICAL BENEFITS UNDER COMMUNITY BLUE

How Your Health Care Program Works

Your program is 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 program works 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 your 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 your program's network.

Out-of-network providers are not in the program'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 program's 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 your Summary of Benefits for your coverage details.

Even though a hospital may be in our 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.

YMCA Diabetes Prevention Eligible Providers

When provided by a YMCA Diabetes Prevention Eligible Provider, the Diabetes Prevention Program shall be available at the network level of benefits.

Provider Reimbursement and Member Liability

Highmark uses the Plan Allowance to calculate the benefit payable and the financial liability of the member for Medically Necessary and Appropriate Services covered under this plan. Refer to the Terms You Should Know section for the definition of Plan Allowance.

Highmark's payment is determined by first subtracting any deductible and/or copayment liability from the Plan Allowance. The coinsurance percentage set forth in the Summary of Benefits is then applied to that amount. This amount represents Highmark's payment. Any remaining coinsurance amount is the member's responsibility. The member's total cost-sharing liability is the sum of the coinsurance plus any deductible and/or copayment obligations.

When a member receives covered services from an out-of-network provider, in addition to the member's cost-share liability described above, the member is responsible for the difference between Highmark's payment and the provider's billed charge. If a member receives services which are not covered under this plan, the member is responsible for all charges associated with those services.

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 section of this booklet.

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. The method of claims payment by Host Blues is taken into account by Highmark in determining your premiums.

Special Cases: Value-Based Programs

Highmark has included a factor for bulk distributions from Host Blues in your premium for Value-Based Programs when applicable under your program. Additional information is available upon request.

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.

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 the Member Service toll-free telephone number on the back of your ID card, or log onto **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 program, 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 your member 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 Member Service at the toll-free telephone number on the back of your ID card.

Eligible Providers

Eligible network providers include facilities, general practitioners, internists, obstetricians/gynecologists and a wide range of specialists.

Facility Providers

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

Professional Providers

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

Ancillary Providers:

- Ambulance service
- Clinical laboratory
- Diabetes prevention provider
- Home infusion therapy provider
- Independent diagnostic testing facility (IDTF)
- Suite infusion therapy provider
- Suppliers

Contracting Suppliers (for the sale or lease of):

- Durable medical equipment
- Supplies
- Orthotics
- Prosthetics

**Excluded from eligibility are registered nurses employed by a health care facility or by an 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 Member Service for help. They can help you find a network pharmacy near the area you are visiting. You also can use the member website to find a pharmacy. Once you have the name and address of the network pharmacy, take the prescription bottle to that pharmacy. The pharmacist will contact your home pharmacy to start the refill 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 Member Service 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.

Health Care 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 the toll-free number listed on the back of your ID card 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 toll-free Member Service telephone number located on the back of your ID card.

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 prior to the receipt of services.

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. You will be financially responsible for the difference between what is covered by the plan and the full amount of the out-of-network provider's charge. 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 toll-free Member Service telephone number located on the back of your ID card.

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 Member Services at the telephone number listed on the back of your ID card.

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 Member Service at the number on your member ID card for help. You will need a copy of the report from the fire department, police department or other agency.

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

Traveling Abroad

If you will be out of the country when it is time to refill your prescription, call Member Service 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 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 is not included in the formulary, or to request prior authorization for a managed care prescription drug, 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.

To print a copy of the "Prescription Drug Medication Request Form" for your physician to complete:

- Log onto Highmark's website
- Click on the Prescriptions tab
- Scroll down the page to Pre-Approval Process
- Click on "Prescription drug medication request form"
- Print the form and give it to your physician
- Or, you can submit an online request

Once a decision is made, a letter documenting the decision 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 the toll-free Member Service telephone number appearing on your ID card.

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's 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.

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:
  - Until the maximum amount of benefits has been paid; or
  - Until the inpatient stay ends; or
  - Until you become covered, without limitation as to the condition for which you are receiving inpatient care, under another group program; whichever occurs first.
- If you are pregnant on the date coverage terminates, no additional coverage will be provided.

Coordination of Benefits

Most health care programs, including your health care program, 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:

- 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.
- 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.
- 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

Subrogation means that if you incur health care expenses for injuries caused by another person or organization, the person or organization causing the accident may be responsible for paying these expenses.

For example, if you or one of your dependents receives benefits through your program for injuries caused by another person or organization, Highmark has the right, through subrogation, to seek repayment from the other person or organization or any applicable insurance company for benefits already paid.

Highmark will provide eligible benefits when needed, but you may be asked to show documents or take other necessary actions to support Highmark in any subrogation efforts.

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 Member Service 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:

- Your name and your dependent's name, if applicable
- Identification number
- Group number
- Copayment for physician office visits and emergency room visits
- Pharmacy network logo (when applicable)
- Member Service toll-free number (on back of card)
- Toll-free telephone number for Out-of-network facility admissions (on back of card)
- 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.

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 via the toll-free Member Service telephone number located on the back of your ID card 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 Member Service at the number on your member ID card.

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.

Member Service

When you have questions about a claim, benefits or coverage, our Member Service Representatives are here to help you. Just call Member Service at the toll-free number on your member ID card or log in to you 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.

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 all your online offerings. 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 online tools and resources.

Go to **www.highmarkbcbs.com**. Then click on the Members tab and log in to your home page to take advantage of all kinds of programs and resources to help you understand your health status, including an online Wellness Profile. Then, take steps toward real health improvement.

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.

Member Rights and Responsibilities

Your participation in your health care program 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 Highmark, its products and its services, 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. Highmark Blue Cross Blue Shield 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 Highmark Blue Cross Blue Shield or the care provided and receive a reply within a reasonable period of time.
6. Make recommendations regarding the Highmark Blue Cross Blue Shield 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.

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.

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 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.

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 by Highmark Inc. to be medically effective for the condition being treated. Highmark will consider an intervention 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.

Highmark believes that 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 our 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.

Highmark recognizes that 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.

Highmark Blue Shield Service Area - The geographic area, within Pennsylvania, in which Highmark Blue Shield operates as a hospital plan corporation consisting of the following counties in central Pennsylvania:

Adams	Franklin	Lehigh	Perry
Berks	Fulton	Mifflin	Schuylkill
Centre (part)	Juniata	Montour	Snyder
Columbia	Lancaster	Northampton	Union
Cumberland	Lebanon	Northumberland	York
Dauphin			

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.

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.
- **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 – In this section of the document, refers to Highmark, which is an independent licensee of the Blue Cross Blue Shield Association. Any reference to the plan may also include its designated agent as defined herein and with whom the plan has contracted, either directly or indirectly, to perform a function or service in the administration of this program.

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

Plan 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			

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.

Prescription Drugs - Any drugs or medications ordered by a professional provider by means of a valid prescription order, bearing the federal legend: "Caution: Federal law prohibits dispensing without a prescription," or legend drugs under applicable state law and dispensed by a licensed pharmacist. Also included are prescribed injectable insulin and disposable insulin syringes, as well as compounded medications, consisting of the mixture of at least two ingredients other than water, one of which must be a legend drug.

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.

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.

Totally Disabled (or Total Disability) - A condition resulting from illness or injury as a result of which, and as certified by a physician, for an initial period of 24 months, you are continuously unable to perform all of the substantial and material duties of your regular occupation. However: (i) after 24 months of continuous disability, "totally disabled" (or total disability) means your inability to perform all of the substantial and material duties of any occupation for which you are reasonably suited by education, training or experience; (ii) during the entire period of total disability, you may not be engaged in any activity whatsoever for wage or profit and must be under the regular care and attendance of a physician, other than your immediate family. If you do not usually engage in any occupation for wages or profits, "totally disabled" (or total disability) means you are substantially unable to engage in the normal activities of an individual of the same age and sex.

You or Your - Refers to individuals who are covered under the program.

SUPPLEMENTAL HOME HEALTH CARE BENEFITS PROVIDED UNDER THE WELFARE PLAN

If you or your eligible dependent can be treated for an illness or injury under a Home Health Care Plan which is designed by your doctor as an alternative to hospital confinement, and you have exhausted your Highmark Blue Cross Blue Shield benefit, or your claim is denied by Highmark Blue Cross Blue Shield, the Welfare Plan will pay the reasonable and customary charges for necessary medical services and supplies provided under the Home Health Care Plan up to the following limits:

- **$60 per visit/per day (limited to one visit per day);**
- **$6,000 calendar year maximum; and**
- **$30,000 lifetime maximum (while covered by this Welfare Plan).**

A Home Health Care Plan is a program for continued care and treatment in a private residence (not necessarily your home) for an injury or illness that would otherwise require hospital confinement as an inpatient.

In order to be covered under this benefit, the Home Health Care Plan must be established and approved in writing by the eligible person's physician, and the physician must certify that proper treatment of the injury or illness would require confinement as a hospital inpatient in the absence of the services and supplies provided as part of the Home Health Care Plan.

The following services are covered under the benefit:

1. **Following hospitalization, up to 100 visits of the cost of a licensed practical nurse or another approved party;**
2. **Physical therapy, occupational therapy, and speech therapy provided by the home health care agency; and**
3. **Medical supplies, drugs and medications, prescribed by a physician and laboratory services by or on behalf of a hospital, to the extent such items would have been covered under the Welfare Plan if the individual were an inpatient.**

SUPPLEMENTAL HOME HEALTH CARE BENEFITS PROVIDED UNDER THE WELFARE PLAN

No payment will be made for:

1. Services provided by an immediate relative or a person who ordinarily resides in the household;
2. Custodial care;
3. Charges made by the owner of the residence;
4. Transportation service;
5. Charges for housekeeping services or maid services, unless they are necessary in conjunction with services to provide medical treatment to the eligible person;
6. Charges incurred for services that exceed the per visit, calendar year or lifetime maximums;
7. Services or supplies furnished due to sickness resulting from occupational disease, or for occupational injuries;
8. Services or supplies not included in the Home Health Care Plan; or
9. Any period during which the individual is not under the continuing care of a physician.

OTHER COVERED SERVICES

The following services are covered under the Welfare Plan, although they are not covered under the Community Blue program:

1. Dental surgeries including:
   a. Alveolectomy;
   b. Osseous surgery; and
   c. Gingevectomy / curretage
2. Hair prosthesis for hair loss caused by chemotherapy or radiation, up to a lifetime maximum of $500 per person.
3. Corrective work boots, up to an annual maximum of $400 per person.

SUPPLEMENTAL MEDICAL BENEFIT

The Supplemental Medical Benefit, or Cash Bank, is an additional benefit provided by the Welfare Plan to reimburse out-of-pocket medical expenses and premiums not reimbursed under your medical benefits. This benefit is designed to assist active members in paying healthcare expenses for themselves and their dependents.

While contributions to the Cash Bank have ceased as of January 1, 2010, any remaining balance in your Cash Bank can be used to pay for certain eligible health care expenses not reimbursed by your medical plan or any other benefit or insurance plan, including:

1. Medical and dental expenses over those covered by any medical plan covering you or your dependents, except that expenses for over the counter medications may only be reimbursed if they are for insulin or you have a doctor's prescription;
2. Deductibles;
3. Copayments;
4. COBRA Continuation Coverage premium;
5. Other health insurance premiums; and
6. Self-payment for extension of eligibility if a lack of work causes ineligibility.

Coverage under the Supplemental Medical Benefit will end when you permanently leave the trade and are not available for future work. If you have no hours credited for 36 months, it will be presumed that you have permanently left the trade and are no longer available for future work unless you become employed by a political subdivision, such as a municipality, water authority, board of education, or other public entity, within the geographic jurisdiction of the Union, in employment of the type covered under a collective bargaining agreement with a contributing employer.

If your eligibility for the Supplemental Medical Benefit terminates and the remaining balance is forfeited, reinstatement of that balance can occur if you return to work in covered employment, regain eligibility, and remain eligible as indicated below. If your eligibility in the Welfare Plan has been reinstated, any unused balance of a Cash Bank which was previously forfeited shall be restored if you remain eligible for full Welfare Plan benefits for the number of months which equals the period commencing with the date the Cash Bank benefit was forfeited and the date you returned to work in covered employment.

Expenses paid or incurred after you leave the trade will not be reimbursed. Retirees who have funds in their Cash Bank are exempt from the termination rule and will have no further benefits when the benefit has been exhausted.

SUPPLEMENTAL MEDICAL BENEFIT

The surviving spouse or dependent children of a deceased member can be provided with any remaining benefits under the Supplemental Medical Benefit.

Call the Plan Office if you have any questions concerning this benefit.

VOLUNTARY DENTAL PROGRAM

(Provided through United Concordia)

The Welfare Plan offers a voluntary dental expense program through United Concordia, a subsidiary of Highmark Blue Cross Blue Shield. Open enrollment to this program is available to all active participant members and their eligible dependents as well as retirees each January 1st. New members are offered enrollment at the time they become eligible for medical coverage.

You have a choice between two dental programs: Concordia Plus, a Dental Maintenance Organization program similar to an HMO; or Concordia Flex, a Preferred Provider Organization, which has a broader network of providers and provides a deductible and coinsurance arrangement along with an out-of-network benefit.

The Board of Trustees will act as the intermediary, collecting an annual self-payment and making premium payments to United Concordia.

THIS PROGRAM IS PURELY VOLUNTARY. United Concordia establishes participation rules. Detailed information is available through the Plan Office regarding this program, the dentists who participate, and the benefits that are available. As this is a personally purchased insured program, the Board of Trustees has not negotiated a contract nor is the Board of Trustees responsible for claims payments, limitations and exclusions from dental care or a participant's right to appeal.

United Concordia establishes renewal rates. Any individual who is participating will have the right at that time to continue at the new premium rate.

VOLUNTARY VISION PROGRAM

(Provided through Highmark, Inc.)

The Welfare Plan offers a voluntary vision expense program through Highmark, Inc. Open enrollment to this program is available to all active participant members and their eligible dependents as well as retirees each January 1st. New members are offered enrollment at the time they become eligible for medical coverage.

Highmark provides you with savings on eye exams and eyewear, and discounts on laser vision correction. There is a broad network of providers and coverage is also provided through an out-of-network benefit. The Board of Trustees will act as the intermediary, collecting an annual self-payment and making premium payments to Highmark.

THIS PROGRAM IS PURELY VOLUNTARY. Highmark establishes participation rules. Detailed information is available through the Plan Office regarding this program, the doctors who participate, and the benefits that are available. As this is a personally purchased insured program, the Board of Trustees has not negotiated a contract nor is the Board of Trustees responsible for claims payments, limitations and exclusions from vision care or a participant's right to appeal.

Highmark establishes renewal rates. Any individual who is participating will have the right at that time to continue at the new premium rate.

BENEFITS *for* CERTAIN RETIRED MEMBERS

RETIREE DEATH BENEFITS

If you are a Retired Member, your beneficiaries will be eligible for the Death Benefit when you die if:

- Your employment has been primarily in the jurisdiction of a local union which has specifically negotiated the contribution necessary to support this coverage; and
- You retired in accordance with the Rules and Regulations of the Iron Workers Pension Plan of Western Pennsylvania, based on employment primarily in the jurisdiction of the local union where employers are contributing a sum necessary to support this coverage, or you were receiving the 48-Month Extended Disability Benefit when you died; and

- You were eligible to retire from the Iron Workers Pension Plan of Western Pennsylvania without the benefit of the provisions of the International Pro-Rata Agreement. You must have earned at least ten (10) pension credits under the Pension Plan if you retire at age 65 or older, or at least 15 pension credits, if you retire before age 65. If you are disabled, you must have at least ten (10) pension credits. If you retire with less than 15 pension credits, you must have earned at least ten (10) full pension credits based on actual contributions.

Benefit Amount

Upon submission of proof of your death, the Trustees will pay a $7,500 Death Benefit to your eligible beneficiary(ies).

Beneficiary

You may name whoever you want as your beneficiary(ies). If no beneficiary is named, or if such beneficiary has predeceased you or is not entitled, by law or otherwise, to receive the benefit, the Trustees will pay the Death Benefit equally to the members of the first category that applies who survive you:

- spouse
- children
- parents
- brothers and sisters

If none of the above persons survives you, the Board of Trustees will set aside an amount not to exceed the amount of the Death Benefit for payment of funeral, burial and gravesite expenses (collectively called Funeral Services). The Trustees will pay such amount to any one or more of the following persons:

- your personal representative;
- the Provider(s) of the Funeral Services (i.e., funeral director, cemetery company or association or gravemarker company); or
- any other such person(s) who will have paid the Funeral Services.

Payment under such circumstances will be made upon presentation of the original receipt, bill or bills to the Trustees. The Trustees will not pay the difference between the Death Benefit and the amount paid for Funeral Services to your estate or to any other person.

If the Trustees, in good faith, pay the Death Benefit or the Funeral Services as described above, the Trustees will be released from any liability whatsoever to any person whose interest is or may be affected by such payment. Any person to whom payment is made will be answerable to anyone prejudiced by an improper distribution.

As previously noted, the Board of Trustees reserves the right to amend all benefits under the Welfare Plan at any time, including decreasing or eliminating this Death Benefit.

RETIREE HEALTH INSURANCE REIMBURSEMENT BENEFIT

When you retire, you may continue to use any balance in your Value Bank to maintain coverage under the Welfare Plan.

If you retire prior to age 65 and choose to purchase your own medical coverage, the Welfare Plan provides a partial reimbursement if you meet the eligibility requirements below. Reimbursement is currently your cost for coverage up to a maximum of $800 per month ($1,000 per month effective July 1, 2020) toward an insurance contract for family coverage or $400 per month ($500 per month effective July 1, 2020) for an insurance contract for your individual coverage (and for individual coverage for your spouse or Eligible Dependent).

As a retiree, you may not be reimbursed for any income-related monthly adjustment amounts applied to your Medicare premium. You may only be reimbursed for the standard Medicare premium.

If you are purchasing insurance through an outside carrier, you must submit a paid receipt for your health coverage before receiving the reimbursement. This reimbursement is then made on a quarterly basis.

If you are purchasing insurance under the COBRA Continuation Coverage or under the special early retiree group coverage, this reimbursement will be applied towards your premium(s) due each month.

For Early Retirees

In order to be entitled to this monthly reimbursement, you must have at least 5,000 hours of employer contributions made on your behalf in a period of five (5) consecutive years (60 consecutive months) within the seven (7) year period (84 months) immediately prior to your pension effective date. Further, you must be entitled to an early retirement pension from the Iron Workers Pension Plan of Western Pennsylvania on the basis of employment in the jurisdiction of the Unions participating in this Welfare Plan.

If you do not meet the above requirements because you do not have sufficient employment (5,000 hours) within the 60 consecutive month period, you may still be eligible for reimbursement if the Welfare Plan determines you had been eligible for at least 24 consecutive months immediately prior to retirement and had been eligible for at least 60 months as an active employee during the past 84 months.

If you leave Covered Employment when you are eligible for Early Retirement and meet the requirements above, but choose to wait until a later date to begin your pension, you will be entitled to the reimbursement once you start receiving your pension.

This reimbursement is only available to you for a limited period of time as follows:

- **For retirements after January 1, 2010, until the earlier of your reaching age 65 or 10 years;**
- **For retirements after January 1, 2011, until the earlier of your reaching age 65 or 9 years;**
- **For retirements after January 1, 2012, until the earlier of your reaching age 65 or 8 years;**
- **For retirements after January 1, 2013, until the earlier of your reaching age 65 or 7 years;**
- **For retirements after January 1, 2014, until the earlier of your reaching age 65 or 6 years; and**
- **For retirements after January 1, 2015, until the earlier of your reaching age 65 or 5 years.**

If your spouse is younger than you, he or she is eligible for the reimbursement until the later of your reimbursement period or 5 years. If your spouse is older than you, he or she is eligible for the reimbursement until the earlier of your reimbursement period or your spouse's reaching age 65.

If you have met the eligibility requirements above and are receiving reimbursement under this section and then return to active work, you and your spouse, if receiving benefits at the time you returned to work, will again be eligible to receive reimbursement under this section when you later cease actively working. The total period of time that you and your spouse are eligible for reimbursement will be based on the timeframes set forth above using your original retirement date. For example, if you first retired on June 1, 2012 at age 55 and received retiree reimbursements form that date until you retuned to work on June 1, 2016 (for a total of 4 years), when you again retire, you will be eligible for retiree reimbursements for 4 more years, or until you reach age 65, if earlier.

For Retirees Eligible for the 48-Month Extended Disability Benefit

If you become eligible for the 48-Month Extended Disability Benefit from the Welfare Plan and are under the age of 55, you will be entitled to the retiree health insurance reimbursement for a maximum of 24 months if you meet the eligibility requirements above. However, if you become entitled to Medicare, you may continue to receive the retiree health insurance reimbursement benefit for the length of time as indicated in the bullet points above for early retirees.

If you received the retiree health insurance reimbursement while you were eligible for the 48-Month Extended Disability Benefit, the amount of time you received the reimbursement will be counted towards the maximum time period listed in the bullet points above. So, for example, if you received two years of retiree reimbursement while you were on the 48-Month Extended Disability Benefit and your maximum period under the bullet points above is 5 years, you will only be able to receive an additional three years of reimbursement.

Death Prior to Retirement

If you die while still an active employee, but you would have been eligible for this benefit if you had retired immediately prior to your death, your spouse will be eligible for reimbursement under this section as if you had retired on your date of death and continued receiving the benefit for the reimbursement period calculated using the date you would have reached age 65.

As previously noted, there is no guarantee that any benefits under the Welfare Plan will be maintained in the future. The Board of Trustees reserves the right to amend or eliminate any benefit, including this benefit, at any time.

CONTINUATION OF HEALTH COVERAGE FOR CERTAIN DISABLED MEMBERS (AND THEIR DEPENDENTS) WHO HAVE BEEN AWARDED A DISABILITY PENSION FROM THE IRON WORKERS PENSION PLAN OF WESTERN PENNSYLVANIA

Effective for disabilities commencing on or after January 1, 2007 (as determined by the Social Security Administration), if you are awarded a disability pension from the Iron Workers of Western Pennsylvania Pension Plan and meet the eligibility rules under the Welfare Plan, you will be provided with the retiree reimbursement to purchase medical coverage. This reimbursement is only available to you for the same limited period of time that is described in the Retiree Health Insurance Reimbursement benefit rules mentioned above. This reimbursement will continue to your spouse for a minimum of five years, unless your spouse reaches age 65 prior to the end of that five-year period. If your spouse is younger than you, your spouse will be provided with this reimbursement for as long you are provided the reimbursement, but no less than five years.

48-MONTH EXTENDED DISABILITY BENEFIT

Effective January 1, 2007, the Welfare Plan provides a 48-Month Extended Disability Benefit to an eligible Iron Worker who applies for a disability benefit on or after that date for a disability that prevents employment as a construction worker. This 48-Month Extended Disability Benefit replaces the similar Extended Disability Benefit provided by the Iron Workers of Western Pennsylvania Pension Plan (the "Pension Plan").

Eligibility for the 48-Month Extended Disability Benefit

You are eligible for the 48-Month Extended Disability Benefit under the Welfare Plan if:

1. You are unable to work as a construction worker due to a physical or mental condition which has continued for at least one month and which is reasonably expected to continue indefinitely into the future;
2. You have been credited with five or more years of vesting service under the Pension Plan; and
3. You worked for 400 or more hours in Covered Employment under the Pension Plan (work for which contributions are payable to the Pension Plan) during the two-year period consisting of the calendar year in which you became disabled and the prior calendar year.

If you meet the above eligibility requirements, you are eligible for the 48-Month Extended Disability Benefit under the Welfare Plan even if you are not eligible for other benefit coverage (such as medical coverage) under the Welfare Plan.

You must be under the care of a physician in order to be eligible for the 48-Month Extended Disability Benefit. You will be required to submit satisfactory medical evidence of your disability to establish your eligibility for the 48-Month Extended Disability Benefit, and you must be examined by a physician selected by the Board of Trustees to confirm your disability.

There is a lifetime maximum of 48 monthly premium payments under the 48-Month Extended Disability Benefit. This includes any monthly payments of the Extended Disability Benefit you may have received from the Pension Plan for an eligible disability incurred before January 1, 2007. Thus, if you have received a total of 48 payments of the 48-Month Extended Disability Benefit under the Welfare Plan and/or of the Extended Disability Benefit under the Pension Plan, you will not be eligible for any further payment of the 48-Month Extended Disability Benefit under the Welfare Plan.

If you recover from your disability and return to covered employment before receiving the lifetime maximum of 48 monthly payments, you may again receive a 48-Month Extended Disability Benefit under the Welfare Plan if you later become disabled and satisfy the eligibility requirements for the 48-Month Extended Disability Benefit. However, because of the 48-month lifetime maximum, the number of monthly payments you may receive in that case is limited to 48 months **less** the number of months for which you previously received a 48-Month Extended Disability Benefit payment (including any monthly payments of the Extended Disability Benefit you may have received from the Pension Plan for an eligible disability incurred before January 1, 2007).

Amount of the 48-Month Extended Disability Benefit

The monthly amount of the 48-Month Extended Disability Benefit under the Welfare Plan is calculated in the same manner as your Regular Pension under the Pension Plan and is equal to the monthly amount of Regular Pension you could receive under the Pension Plan at age 65 assuming payment in the form of a Single Life Annuity.

However, the monthly amount of your 48-Month Extended Disability Benefit will not be less than $200, regardless of the amount of your Regular Pension under the Pension Plan.

Payment of the 48-Month Extended Disability Benefit

Payment of the 48-Month Extended Disability Benefit will begin after payment of your Weekly Accident and Sickness Benefits under the Welfare Plan ends. If you are not eligible for, or choose not to receive, Weekly Accident and Sickness Benefits, payment of the 48-Month Extended Disability Benefit can begin as early as the second month of your disability.

However, if you are entitled to Workers' Compensation Benefits, payment of the 48-Month Extended Disability Benefit will begin on the first of the month after the earliest of the following occurs: (a) the expiration of twelve (12) consecutive months of Workers' Compensation Benefits; (b) the expiration of fifty-two (52) weeks of Workers' Compensation Benefits in any 24-month period for all related injuries; or (c) the expiration of one hundred and four (104) weeks of Workers' Compensation Benefits.

In all cases, you must file a written application for payment of the 48-Month Extended Disability Benefit with the Plan Office and provide satisfactory medical evidence of your disability.

Termination of the 48-Month Extended Disability Benefit

Payment of the 48-Month Extended Disability Benefit will end once you receive a total of 48 monthly payments. This includes any Extended Disability Benefit monthly payments you may have received from the Pension Plan for an eligible disability incurred before January 1, 2007, and all 48-Month Extended Disability Benefit monthly payments you receive under the Welfare Plan for an eligible disability incurred on or after January 1, 2007.

Payment of the 48-Month Extended Disability Benefit will end earlier if you recover from your disability or you fail to provide proof of your disability. For this purpose, the Board of Trustees may require that you be examined by a physician selected by the Board to confirm your continuing disability.

You may also choose to stop payment of your 48-Month Extended Disability Benefit at any time by filing a written request to stop payment with the Plan Office.

Coordination with Pension Plan

If you begin to receive payment of any other type of pension under the Pension Plan while receiving payment of the 48-Month Extended Disability Benefit under the Welfare Plan, the monthly amount of your 48-Month Extended Disability Benefit will be reduced by the monthly amount of your pension under the Pension Plan. If you are **eligible, but have not applied**, for any type of disability benefit or an unreduced pension under the Pension Plan while receiving payment of the 48-Month Extended Disability Benefit under the Welfare Plan, the monthly amount of your 48-Month Extended Disability Benefit will be reduced by the monthly amount that you would be eligible to receive under the Pension Plan, had you applied for it. For this purpose, the amount of your pension will be determined as if paid in the form of a Single Life Annuity, regardless of the actual form of payment.

This means that the payment of a pension to you from the Pension Plan, or your eligibility for a disability benefit or an unreduced pension benefit under the Pension Plan, can result in the complete offset of your 48-Month Extended Disability Benefit under the Welfare Plan. For example, assume that you become disabled and entitled to a 48-Month Extended Disability Benefit when your Regular Pension under the Pension Plan is equal to $1,200. The amount of your 48-Month Extended Disability Benefit would also be equal to $1,200. Assume further that you receive a Social Security Disability Award and become eligible for a Regular Disability Pension under the Pension Plan equal to $1,200. Payment of your $1,200 48-Month Extended Disability Benefit under the Welfare Plan will be completely offset by the $1,200 from your Regular Disability Pension, whether you are receiving the Regular Disability Pension or not.

The months that your 48-Month Extended Disability Benefit is offset by reason of a pension payment (or eligibility for a pension payment) count against the lifetime 48-monthly payment limit. For this reason, you may want to consider stopping payment of your 48-Month Extended Disability Benefit under the Welfare Plan when you become eligible for a disability pension or an unreduced pension under the Pension Plan. You may stop payment of your 48-Month Extended Disability Benefit by filing a written request to stop payment with the Plan Office.

Occupational 48-Month Extended Disability Benefit

You are eligible for an Occupational 48-Month Extended Disability Benefit under the Welfare Plan if:

1. You are unable to work as a construction worker due to an occupational accident that occurs while employed in the jurisdiction of the Union, and your inability to work is reasonably expected to continue indefinitely into the future;
2. You have been credited with at least three but less than five Pension Credits under the Pension Plan based on actual hours of Covered Employment for which employer contributions have been made to the Pension Plan; and
3. You worked for 400 or more hours in Covered Employment under the Pension Plan (work for which contributions are payable to the Pension Plan) during the two-year period consisting of the calendar year in which you became disabled and the prior calendar year.

The amount of the Occupational 48-Month Extended Disability Benefit is $100 per month, or, if greater, the retirement benefit you have accrued under the Pension Plan through the date you become eligible for the Occupational 48-Month Extended Disability Benefit, and payment is made under the same conditions and requirements for the regular 48-Month Extended Disability Benefit under the Welfare Plan.

COBRA CONTINUATION COVERAGE

Federal Law requires the Welfare Plan to offer covered employees and their families the opportunity for a temporary extension of health coverage (called COBRA Continuation Coverage) at group rates in certain instances where coverage under the Welfare Plan would otherwise end. You do not have to show that you are in good health to choose COBRA Continuation Coverage.

This section summarizes your rights and obligations under the continuation coverage provisions of the law. You, your spouse and your dependent child(ren) should take the time to read this information carefully.

Qualifying Events

If you are a covered member under the Welfare Plan, you have the right to choose COBRA Continuation Coverage if you lose health coverage for a **qualifying event**.

A qualifying event for a member occurs when group health coverage under the Welfare Plan is lost because of:

1. Reduction of hours;
2. The termination of employment; or
3. Retirement

If you do not elect to continue this group health coverage for your spouse or eligible dependents, they each have an individual right to elect to continue coverage under the Welfare Plan on their own.

IT IS IMPORTANT THAT YOU, YOUR SPOUSE AND ALL OF YOUR ELIGIBLE DEPENDENTS ARE AWARE OF THESE RULES.

Your spouse has the right to choose COBRA Continuation Coverage if he/she loses group health coverage under the Welfare Plan for any of the following reasons:

1. Your death;
2. Your reduction of hours;
3. Your termination of your employment, including your retirement or military service;
4. Divorce or legal separation from you; or
5. Your termination of coverage because of entitlement to Medicare.

COBRA CONTINUATION COVERAGE

PLEASE NOTE: Entitlement to Medicare does not necessarily mean that your coverage under this Welfare Plan is lost. You are only eligible for COBRA Continuation coverage if you lose your coverage under this Welfare Plan.

Your dependent child has the right to elect COBRA Continuation Coverage if he/she loses group health coverage under the Welfare Plan for any of the following reasons:

1. Your death;
2. Your reduction of hours;
3. Your termination of your employment including your retirement;
4. Your divorce or legal separation;
5. Your coverage under the Welfare Plan terminates; or
6. He/she ceases to be a dependent child as defined in the Welfare Plan.

Notice Requirements

Under the law, you or a member of your family has the responsibility of informing the Plan Office, in writing, of a divorce (including a copy of your divorce decree), legal separation, or a child losing dependent status under the Welfare Plan within 60 days of the later of:

1. The date of the event; or
2. The date coverage would be lost because of the event.

If written notice of the qualifying event is not given within the 60-day period, your spouse and/or dependent (as applicable) will not be eligible to elect COBRA Continuation Coverage.

Although the Welfare Plan will determine if one of the following qualifying events has occurred:

1. Your death;
2. Your reduction of hours;
3. Your termination of your employment; or
4. Loss of coverage because of Medicare entitlement,

you or a member of your family should also notify the Plan Office (in writing) of any of these qualifying events. This will assure timely notification of eligibility for COBRA Continuation Coverage and for processing COBRA Continuation Coverage election forms.

When the Plan Office is notified in writing that a qualifying event has occurred, you (or spouse or dependent) will be notified of the right to elect COBRA Continuation Coverage. Under the law, you must elect COBRA Continuation Coverage by filing the COBRA election form with the Plan Office within 60 days from the later of:

1. The date your Welfare Plan coverage terminated (or will terminate); or
2. The date of the notice advising you of your rights to COBRA Continuation Coverage.

COBRA Continuation Coverage

If you or your spouse or your dependents do not file the COBRA election form with the Plan Office within this 60-day period, you, your spouse and dependents will not be eligible to elect COBRA Continuation Coverage for that qualifying event.

If you choose COBRA Continuation Coverage, the Welfare Plan is required to give you group health coverage which, at the time coverage is being provided, is identical to the coverage provided to covered members and their families under the Welfare Plan. This coverage does not include:

1. Life Insurance;
2. Accidental Dismemberment and Loss of Sight Insurance; or
3. Weekly Accident and Sickness Benefits.

SEE THE LIFE INSURANCE SECTION ABOUT CONVERTING TO AN INDIVIDUAL LIFE INSURANCE POLICY.

Premium Cost

You, your spouse and/or your dependents must pay the entire cost of COBRA Continuation Coverage at group rates. At the time your election is required to be made, the Plan Office will advise you of the cost of coverage for the various medical options and coverage elections.

COBRA CONTINUATION COVERAGE

Length of COBRA Continuation Coverage

You may continue COBRA Continuation Coverage for up to eighteen (18) months for you and/or your dependents if your group health coverage terminates because of your:

1. Reduction of hours;
2. Termination of employment; or
3. Retirement.

The 18-month period may be extended to 36 months if a second qualifying event occurs (i.e. divorce, legal separation, death, or Medicare entitlement) during the 18-month period and if you have notified the Plan Office in writing of the second qualifying event. In addition, the18-month period may be extended to 29 months for you and your dependents if:

1. You, your spouse, or one of your dependents were disabled at the time of the qualifying event or within the first 60 days after the qualifying event; and
2. You, your spouse or one of your dependents met the Social Security disability requirements; and
3. You have notified the Plan Office (in writing) of that determination within 60 days of the determination, and before the end of the 18-month period of COBRA Continuation Coverage.

Please note that if Social Security determines that you or your dependent has recovered from the disability before the end of the 29 months, you must notify the Plan Office within 30 days of such determination.

For qualifying events other than your reduction in hours, termination of employment or retirement (such as divorce, loss of dependent status, etc.), your dependents may continue COBRA Continuation Coverage for up to 36 months.

Adding New Dependents to Your COBRA Continuation Coverage

If you acquire a new dependent through marriage, birth, or placement for adoption while you are enrolled in COBRA Continuation Coverage, you may add that dependent to your coverage for the balance of your COBRA coverage period. For example, if you have five months of COBRA Continuation coverage left and you get married, you can enroll your new spouse for five months of COBRA Continuation Coverage. To enroll your new dependent for COBRA Continuation Coverage, you must notify the Plan Office **within 31 days** of acquiring the new dependent. If you are paying the family rate for coverage, there will be no change in your COBRA premium amount. If you are paying for single coverage, adding your dependent will increase your COBRA premium amount.

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

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

You may enroll your spouse or dependent for coverage for the balance of the period of COBRA Continuation Coverage if your spouse or dependent loses coverage under another group health plan. Your spouse or dependent must have been eligible but not enrolled for coverage under the terms of the Welfare Plan when enrollment was previously offered under the Welfare Plan and declined. Your spouse or dependent is only eligible if they were covered under another group health plan or had other health insurance coverage.

You must enroll your spouse or dependent within 31 days after the termination of the other coverage. Adding a spouse or dependent child will cause an increase in the amount you must pay for COBRA Continuation Coverage if you are paying at a single rate. If you are paying the family rate, there will be no change in your COBRA premium amount.

To enroll your new dependent for COBRA Continuation Coverage, you must notify theWelfare Plan Office within 31 days of acquiring the new dependent.

COBRA CONTINUATION COVERAGE

Termination of COBRA Continuation Coverage

COBRA Continuation Coverage may be cut short for any of the following five reasons:

1. The Welfare Plan no longer provides group health coverage;
2. Your payment for COBRA Continuation Coverage is not paid on time;
3. The individual becomes covered under another group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition the individual may have;
4. The individual becomes entitled to Medicare; or
5. The individual was entitled to extended coverage for up to 29 months due to Social Security disability, and there has been a final determination that the individual is no longer disabled.

Conversion Privilege

If you do not elect to pay for COBRA Continuation Coverage or if the maximum continuation period (18, 29 or 36 months) has been reached, you may apply for conversion of your coverage to an individual policy directly through the medical insurance carrier. You will not be required to provide evidence of good health. You may not convert if:

1. You are eligible for another group health care benefits program through your place of employment; or
2. The medical program that had been offered by the Welfare Plan is replaced by another health care benefits program immediately upon termination of the medical program.

Please note that conversion coverage is not the same as COBRA Continuation Coverage. Conversion coverage usually costs more because coverage is provided at individual rates. The coverage provided is usually at a reduced level.

You should note that if you enroll in an individual conversion policy, you lose your rights under federal law to purchase individual health insurance that does not impose any pre-existing condition limitations after your conversion policy coverage ends.

If you have any questions concerning your rights, election or obligations relating to COBRA Continuation Coverage or the conversion privilege, please contact the Plan Office.

FOR THIS TYPE OF CLAIM	YOU SHOULD
Precertification of your benefits	Generally, network providers are responsible for any required precertification of your benefits. If you are using a non-network provider, call Healthcare Management Services at the number listed on your Identification Card.
For benefits provided by **Highmark Blue Cross Blue Shield - Community Blue and Prescription Drug benefits**	Generally, your provider will file a claim for you. If your provider does not file a claim form for you, call Member Services at **1-800-871-0391** (also listed on the back of your Identification Card) for information about filing a claim form.
For **Supplemental Home Health Care** benefits, provided under Other Covered Services	Call the Plan Office at **412-227-6740** or toll free at **1-800-927-3199** to obtain a claim form and for information about these benefits.
For **Weekly Accident** and **Sickness** and and **48-Month Extended Disability Benefit** Claims	Call the Plan Office at **412-227-6740** or toll free at **1-800-927-3199** to obtain a claim form and for information about these benefits.
For **Life Insurance** benefits or **Dismemberment** benefits	Call the Plan Office at **412-227-6740** or toll free at **1-800-927-3199** to obtain a MetLife Life Insurance Company claim form and for information about these benefits.

Member Inquiries

You should contact the Highmark Blue Cross Blue Shield Member Services Department at **1-800-871-0391** for all member inquiries about benefits provided through Highmark Blue Cross Blue Shield, including questions concerning your eligibility for coverage and benefits available to you through your Highmark Blue Cross Blue Shield program. The Highmark Blue Cross Blue Shield Member Services Department telephone number is also shown on your Identification Card.

You should contact the Plan Office at **412-227-6740** or toll free at **1-800-927-3199** for all member inquiries about benefits that are provided directly by the Fund and not through Highmark Blue Cross Blue Shield, including questions concerning your eligibility for coverage and benefits available to you through the Welfare Plan.

CLAIMS AND APPEALS PROCEDURES

Filing Benefit Claims

This section describes the procedures for filing claims for benefits from the Welfare Plan that are provided through Highmark Blue Cross Blue Shield and directly by the Welfare Plan. It also describes the procedure for you to follow if your claim is denied in whole or in part and you wish to appeal the decision.

For Healthcare Benefits Covered Under Community 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:

- **Know Your Benefits.** Review this information to see if the services you received are eligible under your medical program.
- **Get an Itemized Bill.** Itemized bills must include:
  - The name and address of the service 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.*

- **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.
- **Complete a Claim Form.** Make sure all information is completed properly, and then sign and date the form. *Claim forms can be downloaded from the member website by entering "forms" in the search box. Claim forms are also available from the Plan Office, or call the Member Service telephone number on the back of your ID card.*
- **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.

If you file the claim yourself, your claim must be submitted within 90 days of the date of service, but in no event will it be accepted later than one year from the 90-day timeframe.

Your Explanation of Benefits Statement

When you submit a claim, you will receive an Explanation of Benefits (EOB) statement that lists: the provider's charge; allowable amount; copayment; deductible and coinsurance amounts, if any, you are required to pay; total benefits payable; and 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 your member website. Your EOB can also be mailed to you. If you do not owe a payment to the provider, you may not receive an EOB.

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 Member Service Department using the telephone number on your ID card.

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 Healthcare 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 Healthcare 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, see the Appeal Procedure subsection below.

Appeal Procedure

Internal Appeal Process

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

At any time during the appeal process, you may choose to designate an authorized representative to participate in the appeal process on your behalf. You or your authorized representative shall notify Highmark in writing of the designation. For purposes of the appeal process, "you" includes designees, legal representatives and, in the case of a minor, parents entitled or authorized to act on your behalf. 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 a physician or other health care provider with knowledge of your medical condition to act as your authorized representative.

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

If you receive notification that your coverage has been rescinded or that a claim has been denied by Highmark, in whole or in part, you may appeal the decision. Your appeal must be submitted within 180 days from the date of your receipt of notification of the adverse decision.

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

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

- **When the appeal involves a non-urgent care pre-service claim, within a reasonable period of time appropriate to the medical circumstances involved not to exceed 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 or a decision by Highmark to rescind coverage, within a reasonable period of time not to exceed 30 days following receipt of the appeal.**

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

In the event Highmark renders an adverse decision on your internal appeal, the notification shall include, among other items, the specific reason or reasons for the adverse decision and a statement regarding your right to request an external review and/or pursue any applicable legal action.

External Review Process

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

- 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
- a determination made by Highmark to rescind your coverage.

In the case of a denied claim, the request for external review may be filed by either you or your 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 reasonable necessary supporting information as part of the external review filing.

Preliminary Review and Notification

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

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

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

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

In the event that the external review request is complete but not eligible for external review, notification by 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.

Final Review and Notification

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

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

Expedited External Review (applies to urgent care claims only)

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

Member Assistance Services

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

Autism Spectrum Disorders Expedited Review and Appeal Procedures

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

CLAIMS AND APPEALS PROCEDURES

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

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

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

For Healthcare Benefits Not Covered Under Community Blue

When you have a claim for Supplemental Home Health Care Benefits or benefits provided by the Welfare Plan under Other Covered Services, you should file a written claim with the Plan Office for those benefits within 90 days from the date you receive the services. In no event will claims be honored that are filed later than one year after the date you receive the covered services.

The Trustees, acting by majority decision or through the Chair and Co-Chair, will make an initial determination on your claim and provide you with a notice of their initial determination within 30 days after they receive your claim. If the Trustees require an extension of time due to matters beyond their control, the Trustees may extend the 30 day period for an additional 15 days. You will be notified of the reason for the extension and when the decision will be made. This notification will occur before the expiration of the 30-day period. If an extension of time is necessary because you have failed to submit information necessary for the Trustees to make a decision on your benefit claim, the notice of extension sent to you by the Plan Office will specifically describe the information that you must submit and will give you at least 45 days in which to submit that information. In that case, the Trustees will decide your claim within a reasonable period of time after the earlier of the date you submit the required information or the date the period to submit the information ends, but not later than 15 days after that date.

If your request for benefits is denied, you will receive written notification of that denial which will include:

1. The specific reason or reasons for the denial of benefits or other adverse benefit determination;
2. A specific reference to the pertinent provisions of the Welfare Plan upon which the decision is based;
3. A description of any additional material or information that is needed to process your claim and an explanation of why the information is needed;
4. A copy of the Welfare Plan's review procedures and time periods to appeal your claim, plus a statement that you may bring a lawsuit under ERISA following the review of your claim;
5. A copy of any internal rule, guideline, protocol or similar criteria that was relied on or a statement that a copy is available to you at no cost upon request;
6. A copy of the scientific or clinical judgment or statement that it is available to you at no cost upon request for benefit claims that are denied due to:
    a. Medical necessity;
    b. Experimental treatment; or
    c. Similar exclusion or limit.

You have the right to review documents relevant to your claim and receive copies free of charge.

Your Right to Request a Review of a Denied Healthcare Benefit Claim

You have the right to a full and fair review if your claim for healthcare benefits not covered by Community Blue is denied by the Trustees. You must file your appeal in writing. You must make your request to the Plan Office within 180 days after you receive notice of denial. Your application for appeal must be in writing and it must include the specific reasons you feel denial was improper. You may submit any document you feel appropriate, as well as submitting your written issues and comments.

Review Process for Healthcare Benefit Claims

The review process for healthcare benefits not covered by Community Blue works as follows:

You have the right to review documents relevant to your claim and receive copies free of charge. A document, record or other information is relevant if:

1. It was relied upon by the Trustees in making the decision;
2. It was submitted, considered or generated in the course of making the benefit determination (regardless of whether it was relied upon);
3. It demonstrates compliance with the Welfare Plan's administrative processes for ensuring consistent decision-making; or
4. It constitutes a statement of Welfare Plan policy regarding the denied treatment or service.

Upon request, you will be provided with the identification of medical or vocational experts, if any, that gave advice to the Trustees on your claim, without regard to whether their advice was relied upon in deciding your claim.

A different person will review your claim than the one who originally denied the claim. The reviewer will not give deference to the initial adverse benefit determination. The decision will be made on the basis of the record, including such additional documents and comments that may be submitted by you.

If your claim was denied on the basis of a medical judgment (such as a determination that the services or prescription drugs were not Medically Necessary, or were investigational or experimental), a health care professional who has appropriate training and experience in a relevant field of medicine will be consulted.

You have the right to review documents relevant to your claim and receive copies free of charge.

Timing of Notice of Decision on Appeal of Healthcare Benefit Claims

Ordinarily, decisions on appeals involving healthcare benefit claims not covered by Community Blue will be made at the next regularly scheduled meeting of the Board of Trustees following receipt of your request for review. However, if your request for review is received within 30 days of the next regularly scheduled meeting, your request for review will be considered no later than the second regularly scheduled meeting following receipt of your request. In special circumstances, a delay until the third regularly scheduled meeting following receipt of your request for review may be necessary. You will be advised in writing in advance if this extension will be necessary. Once a decision on review of your claim has been reached, you will be notified of the decision as soon as possible, but no later than 5 days after the decision has been reached.

For Weekly Accident and Sickness Benefits and 48-Month Extended Disability Benefits

You must file your claim for Weekly Accident and Sickness benefits or 48-Month Extended Disability Benefits within 90 days from the date of the accident or the date of onset of the sickness or disability. In no event will claims be honored that are filed later than one year after the date of the accident or the date of onset of the sickness or disability.

The Trustees, acting by majority decision or through the Chair and Co-Chair, will make a decision on the claim and notify you of the decision within 45 days. If the Trustees require an extension of time due to matters beyond their control, the Trustees may extend the 45-day period for an additional 30 days. You will be notified of the reason for the extension and when the decision will be made. This notification will occur before the expiration of the 45-day period. The period for making a decision may be delayed an additional 30 days, provided the plan administrator notifies you, prior to the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date as of which the Trustees expect to render a decision.

If your claim for Weekly Accident and Sickness Benefits or 48-Month Extended Disability Benefits is denied, your denial notice must provide you with the following information:

1. The specific reason or reasons for the denial of benefits or other adverse benefit determination;
2. A specific reference to the pertinent provisions of the Welfare Plan upon which the decision is based;
3. A description of any additional material or information that is needed to process your claim and an explanation of why the information is needed;
4. A copy of the Welfare Plan's review procedures and time periods to appeal your claim, plus a statement that you may bring a lawsuit under ERISA following the review of your claim;

5. A copy of any internal rule, guideline, protocol or similar criteria that was relied on;
6. A copy of the scientific or clinical judgment, or statement that it is available to you at no cost upon request, for Welfare Plan claims that are denied due to:
    a. Medical necessity;
    b. Experimental treatment; or
    c. Similar exclusion or limit.
7. A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim for benefits; and
8. A discussion of the decision, including an explanation of the basis for disagreeing with or not following:
    a. The views you presented to the Welfare Plan of health care professionals treating you and vocational professionals who evaluated you;
    b. The views of medical or vocational experts whose advice was obtained on behalf of the Welfare Plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and
    c. A disability determination made by the Social Security Administration regarding you presented by you to the Welfare Plan.

Your Right to Request a Review of a Denied Weekly Accident and Sickness or 48-Month Extended Disability Claim

You have the right to a full and fair review if your claim for benefits is denied by the Trustees. You must file your appeal in writing. You must make your request to the Plan Office within 180 days after you receive notice of denial. Your application for appeal must be in writing and it must include the specific reasons you feel the denial was improper. You may submit any document you feel appropriate, as well as submitting your written issues and comments.

Review Process for Weekly Accident and Sickness and 48-Month Extended Disability Claims

The review process works as follows:

You have the right to review documents relevant to your claim and receive copies free of charge. A document, record or other information is relevant if:

1. It was relied upon by the Trustees in making the decision;
2. It was submitted, considered or generated in the course of making the benefit determination (regardless of whether it was relied upon);
3. It demonstrates compliance with the Welfare Plan's administrative processes for ensuring consistent decision-making; or
4. It constitutes a statement of Welfare Plan policy regarding the denied treatment or service.

Upon request, you will be provided with the identification of medical or vocational experts, if any, that gave advice to the Trustees on your claim, without regard to whether their advice was relied upon in deciding your claim.

A different person will review your claim than the one who originally denied the claim. The reviewer will not give deference to the initial adverse benefit determination. The decision will be made on the basis of the record, including such additional documents and comments that may be submitted by you.

If your claim was denied on the basis of a medical judgment (such as a determination that the treatment or service was not Medically Necessary, or was investigational or experimental), a health care professional who has appropriate training and experience in a relevant field of medicine will be consulted.

Before the Welfare Plan can issue an adverse benefit determination on appeal, the Welfare Plan must provide you, automatically and free of charge:

1. Any new or additional evidence considered, relied upon, or generated by the Welfare Plan in connection with your claim; and
2. Any new or additional rationale that is the basis for an adverse benefit determination.

The evidence and rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided, so as to give you a reasonable opportunity to respond prior to that date.

Timing of Notice of Decision on Appeal of Weekly Accident and Sickness and 48-Month Extended Disability Claims

Ordinarily, decisions on appeals involving Weekly Accident and Sickness Benefit or 48-Month Extended Disability Claims will be made at the next regularly scheduled meeting of the Board of Trustees following receipt of your request for review. However, if your request for review is received within 30 days of the next regularly scheduled meeting, your request for review will be considered no later than the second regularly scheduled meeting following receipt of your request. In special circumstances, a delay until the third regularly scheduled meeting following receipt of your request for review may be necessary. You will be advised in writing in advance if this extension will be necessary. Once a decision on review of your claim has been reached, you will be notified of the decision as soon as possible, but no later than 5 days after the decision has been reached.

For Life Insurance and Accidental Dismemberment and Loss of Sight Insurance

Claims for life insurance should be sent to MetLife as soon as is reasonably possible after the death of the Member. Claims for Accidental Dismemberment and Loss of Sight insurance must be sent to MetLife within 90 days of the date of a loss.

Claim Review Procedures

After MetLife receives your claim for benefits, MetLife will review the claim and notify you of its decision to approve or deny the claim. This notification will be given within a reasonable period, not to exceed 90 days from the date MetLife receives the claim, unless MetLife notifies you within that period that there are special circumstances requiring an extension of time of up to 90 additional days.

Claim Denials

If MetLife denies your claim in whole or in part, the notification of the claims decision will state the reason why your claim was denied and reference the specific Welfare Plan provisions on which the denial is based. If the claim is denied because MetLife did not receive sufficient information, the claims decision will describe the additional information needed and explain why such information is needed. The notification will also include a description of the Welfare Plan review procedures and time limits, including a statement of your right to bring a civil action if your claim is denied after an appeal.

Appealing the Initial Determination

In the event a claim has been denied in whole or in part, you or, if applicable, your beneficiary can request a review of your claim by MetLife. This request for review should be sent in writing to Group Insurance Claims Review at the address of MetLife's office which processed the claim within 60 days after you or, if applicable, your beneficiary received notice of denial of the claim. When requesting a review, please state the reason you or, if applicable, your beneficiary believe the claim was improperly denied and submit in writing any written comments, documents, records or other information you or, if applicable, your beneficiary deem appropriate. Upon your written request, MetLife will provide you free of charge with copies of relevant documents, records and other information.

MetLife will re-evaluate all the information, will conduct a full and fair review of the claim, and you or, if applicable, your beneficiary will be notified of the decision. Such notification will be provided within a reasonable period not to exceed 60 days from the date MetLife receives your request for review, unless MetLife notifies you within that period that there are special circumstances requiring an extension of time of up to 60 additional days.

If MetLife denies the claim on appeal, MetLife will send you a final written decision that states the reasons why the claim you appealed is being denied, references any specific Welfare Plan provisions on which the denial is based, any voluntary appeal procedures offered by the Welfare Plan, and a statement of your right to bring a civil action if your claim is denied after an appeal. Upon written request, MetLife will provide you free of charge will copies of documents, records or other information relevant to your claim.

Discretionary Authority to Determine Claims

In carrying out their responsibilities under the Welfare Plan, the Trustees and the insurance carriers shall have discretionary authority to interpret the terms of the Welfare Plan and to determine eligibility for and entitlement to Welfare Plan benefits in accordance with the terms of the Welfare Plan. Any interpretation or determination made using such discretionary authority shall be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

Exhaustion of Remedies

You must follow all of the claims and appeals procedures described in this booklet before you may bring any action for benefits in a court of law or before an administrative agency.

Overpayments or Mistaken Payments

The Welfare Plan has the right to recover directly from you any overpayments or mistaken benefit payments it has made to you or on your behalf. Overpayments and mistaken payments include payments that the Welfare Plan makes while you are waiting for approval or settlement of your workers' compensation benefits, Welfare Plan payments resulting from any failure to provide accurate information to the Welfare Plan, and Welfare Plan payments not otherwise provided for by its terms. Throughout this section, the term "you" refers to you or your spouse, dependent or beneficiary.

The Welfare Plan may appoint an agent to act on its behalf to recover overpayments or mistaken payments.

By accepting benefits from this Welfare Plan, you are automatically authorizing the Welfare Plan to recover any overpayments or mistaken payments made to you. This includes your permission for the Welfare Plan to deduct the amount of the overpayments or mistaken payments from any future amounts due to you under this Welfare Plan.

The Welfare Plan has the option of recovering overpayments or mistaken payments by:

1. Reducing future payments due to you under the Welfare Plan; and/or
2. Bringing a legal action against you.

Subrogation/Reimbursement

Subrogation is the substitution of one person for another; that is, one person is allowed to stand in the shoes of another and assert that person's rights against another party. The Welfare Plan will require you to execute a subrogation and reimbursement agreement with regards to the payment of any accident and sickness benefits paid to you under this Welfare Plan.

INFORMATION REQUIRED BY THE EMPLOYEE RETIREMENT INCOME SECURITY ACT *of* 1974

The original plan of benefits provided by the Welfare Plan became effective June 1, 1953. This booklet sets forth the plan of benefits, as well as the Eligibility and Termination Rules currently in effect.

Name of Plan. This Welfare Plan is known as the Iron Workers Welfare Plan of Western Pennsylvania.

Board of Trustees. A Board of Trustees is responsible for the operation of this Welfare Plan. The Board of Trustees consists of equal representation by the employers and the unions who have entered into collective bargaining agreements, which relate to this Welfare Plan. If you wish to contact the Board of Trustees, you may use the address and telephone number below (also listed in the front of this booklet):

Board of Trustees
Iron Workers Welfare Plan of Western PA
2201 Liberty Avenue
Pittsburgh, PA 15222
412-227-6740

Plan Administrator. The Board of Trustees is the Plan Administrator. The Plan Administrator has the absolute discretion and authority to determine eligibility for benefits, make legal and factual determinations and interpret Welfare Plan provisions. The decision of the Plan Administrator will be given judicial deference in any court proceeding.

Plan Sponsors. The Board of Trustees is the Plan Sponsor.

Participating Employers. Welfare Plan participants and beneficiaries may write to the Board of Trustees to find out if a particular employer is participating in this Welfare Plan. Iron Workers Local Union No. 3 is the union participating in the Welfare Plan.

Identification Numbers. The number assigned to the Board of Trustees by the Internal Revenue Service is 25-6181473. The number assigned to the Welfare Plan by the Board of Trustees is 501.

Agent for Service of Legal Process. If legal disputes involving the Welfare Plan arise, any legal documents should be served on any of the Plan Trustees, at the following address: 2201 Liberty Avenue, Pittsburgh, Pennsylvania 15222.

Collective Bargaining Agreements. This Welfare Plan is maintained pursuant to collective bargaining agreements. Welfare Plan participants and beneficiaries may examine these collective bargaining agreements and may obtain a copy of any such agreement for a reasonable charge by writing to the Board of Trustees at the address listed in the front of this booklet.

INFORMATION REQUIRED BY THE EMPLOYEE RETIREMENT INCOME SECURITY ACT *of* 1974

Source of Contributions. The Welfare Plan's benefits for eligible employees are provided through employer contributions. The provisions of collective bargaining agreements determine the amount of the employer contributions. Under certain circumstances employee contributions are received by the Welfare Plan.

Insurance Companies. Medical and prescription drug benefits are provided under a group contract issued by Highmark Blue Cross Blue Shield. Life Insurance and Accidental Dismemberment benefits are provided under group policies issued by MetLife. Membership Assistance Program benefits are provided by Lytle EAP Partners. The Weekly Accident and Sickness benefit and the 48-Month Extended Disability Benefit are self-insured by the Welfare Plan. United Concordia provides the voluntary dental program, and Highmark, Inc. provides the voluntary vision program.

Trust Fund. All Welfare Plan assets are held in a Trust Fund. Professional asset managers hired by the Board of Trustees manage the Trust assets. Insurance premiums are paid from the Trust Fund and the Trust Fund pays the self-insured benefits of the Welfare Plan.

Fiscal Year. The fiscal records of the Welfare Plan are kept on a calendar year basis.

Type of Plan. This Welfare Plan is maintained for the purpose of providing life insurance, accidental dismemberment and loss of sight benefit, weekly disability benefit, prescription benefits, hospitalization, medical service and other health care benefits.

Eligibility. The Welfare Plan's requirements with respect to eligibility as well as circumstances that result in disqualification, ineligibility, or denial or loss of any benefits are fully described in this booklet.

Claim Procedure. The procedures to follow for filing a claim for benefits are set forth in this booklet.

Type of Plan Administration. The staff of individuals who are hired by the Board of Trustees handles the Administrative operations of this Welfare Plan.

Procedure for Obtaining Additional Plan Documents. If you wish to inspect or receive copies of additional documents relating to this Welfare Plan, contact the Plan Office at the address or phone number listed in the front of this booklet. You will be charged a reasonable fee to cover the cost of any materials you wish to receive.

Rights of Plan Participants. As a participant in this Welfare Plan, you are entitled to certain rights and protections under ERISA. Although these rights and protections first became a part of federal law with the passage of ERISA, the Trustees have always considered the fair management of this Welfare Plan as their primary objective. The Trustees, therefore, intend to encourage you to first seek assistance from the Plan Administrator when you have questions or problems that involve the Welfare Plan.

STATEMENT *of* ERISA RIGHTS

As a participant in the Welfare 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

1. Examine, without charge, at the Plan's administrative office and at other specified locations, all documents governing the Plan, including insurance contracts, 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.
2. Obtain, upon written request to the Plan Administrator, copies of documents governing 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.
3. Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

1. 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 for the rules governing your COBRA continuation coverage rights.
2. Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided with a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to preexisting condition exclusions for 12 months (18 months for late enrollees) after your enrollment date in your new coverage.

STATEMENT *of* ERISA 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 without charge, and to appeal any denial, all within certain time limits.

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 an 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 without charge, and to appeal any denial, all within certain time limits.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of the Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay 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 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 Pension and Welfare Benefits Administration, U.S. 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, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

STATEMENT *of* GRANDFATHERED STATUS

The Board of Trustees believes this Welfare Plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that the Welfare Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on essential health benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Office. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at **1-866-444-3272** or **www.dol.gov/ebsa/healthreform**. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

HIGHMARK
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 hour 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 choose to opt-out, your information will be sent to the HIE, but providers 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:

A. For marketing purposes

B. If we intent to see your PHI

C. 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 contacting us at the Customer Service phone number on the back of your identification card, 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 contacting us at the Customer Service phone number on the back of your identification card, 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.

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 Web site 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 customer 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 grievance.

HIGHMARK
NOTICE *of* PRIVACY PRACTICES

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

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IRON WORKERS WELFARE PLAN
***of* WESTERN PENNSYLVANIA**
2201 Liberty Avenue, Room 203
Pittsburgh, Pennsylvania 15222

ADDRESS SERVICE REQUESTED