

**PLUMBERS LOCAL UNION NO. 16 HEALTH AND
WELFARE FUND MEDICAL BENEFITS
SUMMARY PLAN DESCRIPTION**

Revised April 1, 2005

NOTICE

This Booklet describes Your benefits under the Plumbers Local Union No. 16 Health and Welfare Fund (the "Plan").

Point of Service benefits are administered in accord with the Plan. Claims are paid in accord with an Administrative Services Agreement between Exclusive Healthcare, Inc. and the Trustees of the Plan for In-Network Benefits and claims are paid in accord with an Administrative Services Agreement between United of Omaha Life Insurance Company and the Trustees of the Plan for Out-of-Network Benefits.

If You have any questions in regards to the Plan, please contact the Plan administration office at: (402) 341-8771.

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appear in the following order.

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SELF FUNDED PLAN COVERAGE

Your benefit program is self funded by participating employers of the Plumbers Local Union No. 16 Health and Welfare Fund. Claims are administered in accord with Administrative Services Agreement which is comprised of Group Identification Number G000A001 and Plan Identification Number MEDPOS, between Exclusive Healthcare, Inc. (In-Network benefits) and Trustees of Plumbers Local Union No. 16 Health and Welfare Fund.

Major Medical Benefits are self funded by Trustees of Plumbers Local Union No. 16 Health and Welfare Fund. Claims are administered in accord with Administrative Services Agreement which is comprised of Group Identification Number G000A001 and Plan Identification Number MEDPOS, between United of Omaha Life Insurance Company (Out-of-Network benefits) and Trustees of Plumbers Local Union No. 16 Health and Welfare Fund.

Coverage is provided for certain members as described in this Booklet.

The coverages described in this Booklet are subject to the terms and conditions of the Plan Document. In the event of any conflict with the provisions outlined in this Booklet and those in the Plan Document, the provisions of the Plan Document will prevail.

The coverage is effective only if You and Your dependent(s) are eligible for the coverage, become covered and remain covered as described in this Booklet.

The Trustees of the Plan reserve the right, at any time, to amend the terms of the Plan.

This Booklet replaces any previous Booklet issued under the Plan.

INTRODUCTION TO POINT OF SERVICE IN-NETWORK

The benefits and provisions of the **In-Network Benefits** option of the Point of Service plan are described in this section.

The Trustees of the Plumbers Local Union No. 16 Health and Welfare Fund offers this coverage (called the **In-Network Benefits**) under the Plan in conjunction with the Self Funded benefits (called the **Out-of-Network Benefits**). This **In-Network Benefits** option and the **Out-of-Network Benefits** option together comprise the Point of Service Plan.

As an enrolled Member/Covered Person in this Point of Service Plan, You and/or Your dependents may access care in two different ways:

- (a) in accordance with the terms and conditions of the Plan for the **In-Network Benefits**. The Member receives a higher level of benefits under the **In-Network Benefits** option. For **In-Network Benefits**, the Member may receive Covered Services provided by any Physician who is a Participating Provider without a referral from the Member's Primary Care Physician. **However, Covered Services must always be provided by Participating Providers, except as otherwise provided in the Plan.** The Member must always verify the Physician, Hospital or any other provider is currently a Participating Provider. From time to time, the participation status of a provider may change. The Member may verify if the provider is currently a Participating Provider by calling Us. If a Participating Provider is not used, benefits will be considered for payment under the **Out-of-Network Benefits** option; or
- (b) in accordance with the terms and conditions of the Plan for the **Out-of-Network Benefits**. The Covered Person receives a lower level of benefits under the **Out-of-Network Benefits** option; **however, the Covered Person may receive Covered Services from any provider that is not a Participating Provider.**

Reminder: The **In-Network Benefits** option provides a higher benefit level. If services are received under the **Out-of-Network Benefits** option, Covered Services may be subject to higher Copayments and/or a higher Calendar Year Deductible and Coinsurance.

Both **In-Network Benefits** and **Out-of-Network Benefits** options include Utilization Management Provisions which affect the way benefits are paid to You and Your covered dependents.

THIS SCHEDULE DESCRIBES THE COPAYMENTS, COINSURANCE, MAXIMUM BENEFITS AND CERTAIN OTHER REQUIREMENTS AND LIMITATIONS APPLICABLE TO BENEFITS FOR COVERED SERVICES. OUR OBLIGATION TO CONSIDER BENEFITS IS SUBJECT TO ALL TERMS AND CONDITIONS OF THE PLAN, INCLUDING, BUT NOT LIMITED TO, ALL DEFINITIONS, GENERAL EXCLUSIONS AND LIMITATIONS, AND PLAN CHANGES. PLEASE REFER TO THE TABLE OF CONTENTS IN THE BOOKLET TO LOCATE THESE PROVISIONS OF THE PLAN.

**IN-NETWORK SCHEDULE OF BENEFITS AND COVERED SERVICES
(SCHEDULE)**

OBTAINING COVERED SERVICES

If a Member incurs Expense for Medically Necessary Covered Services described in this Schedule, the Plan will pay benefits, as set forth in this Schedule, obtained in accordance with the provisions of the Plan.

1. Upon enrollment, each Member will designate (or You will designate on behalf of Your eligible dependents) a Primary Care Physician. You may designate a different Primary Care Physician for yourself and each of Your dependents. If the Member fails to designate a Primary Care Physician, Exclusive Healthcare, Inc. will assign a Primary Care Physician for the Member. The names and addresses of the Primary Care Physicians from which the Member may choose will be provided to You upon enrollment. Services are provided or coverage arrangements are available 24 hours per day, seven days a week by calling the telephone number for the Primary Care Physician provided on the Member's identification (I.D.) card.
2. Subject to Exclusive Healthcare, Inc.'s approval, a Member may change his or her Primary Care Physician by contacting their Customer Service Department.

You may contact the Customer Service Department in writing or by phone as shown below:

Exclusive Healthcare, Inc.
Mutual of Omaha Insurance Companies - F
Attn: Customer Service Department
Mutual of Omaha Plaza
Omaha, NE 68175-5300

Call Toll Free: 1-800-467-4917

Exclusive Healthcare, Inc. reserves the right to limit the number of Primary Care Physician changes. Such change will be effective on the first day of the month following the month in which Exclusive Healthcare, Inc. receives the change request.

In the event that a Member's Primary Care Physician ceases to be a Participating Provider, the Member will be given the opportunity to designate a new Primary Care Physician. If the Member fails to designate a Primary Care Physician, Exclusive Healthcare, Inc. will assign a Primary Care Physician for the Member.

The Member's designated Primary Care Physician can help determine if a Member needs a visit to a Specialist, find one who meets the Member's needs, and/or coordinate the Member's overall health care plan. However, the Member may choose to receive Covered Services from:

- (a) any of the Primary Care Physicians and Specialists who are Participating Providers without an authorization/referral from the designated Primary Care Physician and still receive In-Network Benefits as described in this group Plan; or
 - (b) any Other Providers as Out-of-Network Benefits provided by Exclusive Healthcare, Inc.'s affiliate, United of Omaha Life Insurance Company, issued in conjunction with this Plan.
3. Except in cases of a Medical Emergency, only those Covered Services provided by a Participating Provider will be considered for payment under the In-Network Benefits Schedule.
 4. The Member must always verify that the Physician, Hospital or any other provider is currently a Participating Provider. From time to time, the participation status of a provider may change. The Member may verify if the provider is currently a Participating Provider by calling the Customer Service Department.

Exclusive Healthcare, Inc. will publish an updated list of Participating Providers periodically. Your Plan Administrator will automatically furnish You with a copy of the current list of Participating Providers, without charge, as a separate document. The Participating Provider information is also available through the website at www.mutualofomaha.com.

All Participating Providers are independent contractors; they are not Exclusive Healthcare, Inc. employees or agents. Exclusive Healthcare, Inc. does not supervise, control or guarantee the outcome or results of any health care services furnished by a Participating Provider. Your and Your dependent's relationship with a Participating Provider is that of provider and patient. The Participating Provider is solely responsible for the health care services provided to You and Your dependents.

DISCOUNTED CHARGES

Exclusive Healthcare, Inc. has contractual arrangements with Participating Providers and other health care providers, provider networks and other vendors of health care services and supplies ("Providers"). In accordance with these arrangements, certain Providers have agreed to Discounted Charges.

A "Discounted Charge" is the amount that a Provider has agreed to accept as payment in full for covered health care services or supplies. A "Discounted Charge" does not include rebates or any other reductions, fees or credits a Provider may periodically give Exclusive Healthcare, Inc. Exclusive Healthcare, Inc. will retain those amounts that are not "Discounted Charges." However, Exclusive Healthcare, Inc. has estimated the amount of such rebates, reductions, fees and credits and have taken those into consideration in setting the fees charged to provide coverage under this Plan.

Claims under the Plan and any Deductible, Copayment (based upon percentage of charge), Coinsurance and benefit maximums as described in this Schedule will be determined based on the Discounted Charge.

SCHEDULE

All of the following Covered Services are subject to any required Percentage Payable, Copayments, General Exclusions and Limitations, and other terms and conditions described in this Plan.

When more than one service from the same health care provider is received by a Member in the same day, only one Copayment will apply. It will be the highest Copayment applicable to the services received by the Member. All other Copayments for that health care provider will be waived. This provision does not apply to outpatient prescription drugs.

If You or Your dependents are required to make a Copayment (not based on a percentage of charges) in order to receive a Covered Service, You or Your dependent will pay the lowest of (a) the Copayment; (b) the Discounted Charge; or (c) the provider's billed charge, subject to any applicable Usual and Customary Charge or Allowable Charge limitation.

Benefits under this Plan for You and Your dependents will be in accordance with Your classification in this Schedule.

Classifications

All eligible active employees

All eligible retired employees under age 65

All eligible retired employees age 65 or over

Percentage Payable

After the Calendar Year Deductible and/or any Copayment requirements are satisfied, the Plan will pay:

Physician Office Visit Services

90% of the Expense incurred for Covered Office Visit Services as specified in the Covered Physician Office Visit Services section of this Schedule.

Covered Routine Physical Exam Services, Covered Preventive Health Care Services and Covered Childhood Immunization Services

100% of the Expense incurred for Covered Services for routine physical exams, preventive health care and childhood immunizations as shown in the Covered Routine Physical Exam Services, Covered Preventive Health Care Services and Covered Childhood Immunization Services sections of this Schedule.

Covered Routine Mammography Services

100% of the Expense incurred for Covered Services for a Routine Mammography as specified in the Covered Routine Mammography Services section of this Schedule.

In-Network Schedule

Covered Ambulance Services

90% of the Expense incurred for ambulance services as shown in the Covered Ambulance Services section of this Schedule.

Covered Independent Radiology and Pathology Services

90% of the Expense incurred for Covered Services provided by an Independent Radiology and Pathology Center as shown in the Covered Independent Radiology and Pathology Services section of this Schedule.

Covered Urgent Care Center and Hospital Emergency Room Services

90% of the Expense incurred for Covered Services provided by an Urgent Care Center and Hospital emergency room as shown in the Covered Urgent Care Center Services and Covered Hospital Services sections of this Schedule.

Covered Outpatient Facility Services

90% of the Expense incurred for Covered Services provided by an Outpatient Facility as shown in the Covered Outpatient Facility Services section of this Schedule.

Outpatient Mental or Nervous Disorder Treatment Services and Outpatient Alcohol and Drug Abuse and/or Substance Abuse Treatment Services

90% of the Expense incurred or the Maximum Allowable Amount, whichever is less, for Covered Services for outpatient mental or nervous disorder treatment services and outpatient alcohol and drug abuse and/or substance abuse treatment services as shown in the Covered Mental or Nervous Disorder Treatment Services and Covered Alcohol and Drug Abuse and/or Substance Abuse Treatment Services sections of this Schedule.

All Remaining Services

90% of the Expense incurred for the services listed below.

- (a) Covered Physician Surgical Services;
- (b) Covered Maternity Services;
- (c) Covered Hospital Services;
- (d) Other Covered Services;
- (e) Covered Radiologist, Anesthesiologist, Pathologist and Hospital Emergency Room Physician Services;
- (f) Covered Durable Medical Equipment;
- (g) Covered Prosthetics;
- (h) Covered High End Radiology Services;

In-Network Schedule

- (i) Covered Home Health Care Services;
- (j) Covered Hospice Care Services;
- (k) Covered Inpatient Mental or Nervous Disorder Treatment Services;
- (l) Covered Inpatient Alcohol and Drug Abuse and/or Substance Abuse Treatment Services;
- (m) Covered NonSurgical Spinal Treatment Services;
- (n) Covered Qualified Organ(s)/Tissue Transplant Services;
- (o) Covered Outpatient Therapy Services;
- (p) Covered Skilled Nursing Care Facility Services; and
- (q) Covered Specialty Pharmacy Drug Services;

as shown in those sections of this Schedule.

Covered Routine Vision Care Services

100% of the Expense incurred for Covered Services for Routine Vision Care as shown in the Covered Routine Vision Care Services section of this Schedule.

Covered Outpatient Prescription Drug Services

100% of the Expense incurred for Covered Services for Outpatient Prescription Drugs as shown in the Covered Outpatient Prescription Drug Services section of this Schedule.

You are responsible for paying the percentage of the cost of Covered Services which the Plan does not pay.

Out-of-Pocket Limit

Individual Limit

After the Out-of-Pocket Eligible Expense by a Member reaches \$3,000, the Plan will pay 100% of the Expense for Covered Services incurred by such Member during the rest of the Calendar Year.

Family Limit

After the Out-of-Pocket Eligible Expense for You and Your covered dependents combined reaches \$9,000, the Plan will pay 100% of the Expense incurred by You and Your covered dependents during the rest of the Calendar Year.

Out-of-Pocket Eligible Expense means Expense which the Member incurs for Covered Services during each Calendar Year and must pay:

- (a) to satisfy any Copayments; and
- (b) as Coinsurance (the percentage the Member must pay in accordance with the Percentage Payable provision).

Exceptions

Expense for the following will not be used to satisfy the Individual or Family Limit and will not be paid at 100% after the Individual or Family Limit is reached:

- (a) any Copayment which an Insured Person must pay;
- (b) Mental or Nervous Disorder treatment;
- (c) Alcohol and Drug Abuse and/or Substance Abuse treatment; or
- (d) Nonsurgical Spinal Treatment.

CALENDAR YEAR DEDUCTIBLE

Individual Deductible

\$500 of Expense incurred for Covered Services of Participating Providers. The Member must satisfy the Individual Deductible once each Calendar Year.

Family Deductible

After \$1,000 of Expense for Covered Services of Participating Providers has been incurred by You and Your covered dependents during each Calendar Year, no other Individual Deductible requirement will apply.

Copayments and/or any Coinsurance percentage which the Member pays may not be used to satisfy the Individual Deductible or Family Deductible. The same Expense may be used to satisfy both the Individual Deductible and Family Deductible for the In-Network Benefits option and the Deductible for the Out-of Network Benefit option.

Individual and Family Deductible Exceptions

The Individual and Family Deductibles are waived for:

- (a) Covered Routine Physical Exam Services;
- (b) Covered Preventive Health Care Services;
- (c) Covered Childhood Immunization Services;
- (d) Covered Routine Mammography Services;
- (e) Routine newborn care for any bassinet or nursery charges for any days on which both mother and child are receiving Inpatient Treatment; and
- (f) Covered Independent Radiology and Pathology Services.

Covered Physician Office Visit Services

Primary Care Physician Office Visit Services Copayment:

None

Specialist Office Visit Services Copayment:

None

Covered Office Visit Services

Benefits will be payable for Expense incurred for Covered Services received in the Physician's office, including but not limited to the following:

- (a) office visits (other than office surgery);
- (b) consultations;
- (c) maternity services, including prenatal and postnatal care;
- (d) ophthalmology exam;
- (e) Medical Emergency office visits;
- (f) injections (excluding Specialty Pharmacy Drugs and Medicines);
- (g) allergy testing;
- (h) radiation therapy; and
- (i) x-ray and laboratory services (excluding high end radiology, such as MRIs, CT Scans, PET Scans, SPECT Scans, Arteriograms and other nuclear medical scans). Refer to the Covered High End Radiology Services section of this Schedule.

The Covered Office Visit Services does not include:

- (a) services performed by any other provider, including a Participating Provider;
- (b) office surgery;
- (c) supplies provided by a Physician;
- (d) drugs supplied by a Physician;
- (e) outpatient physical therapy, occupational therapy and speech therapy;
- (f) treatment of Mental or Nervous Disorder and Alcohol and Drug Abuse and/or Substance Abuse;
and
- (g) Nonsurgical Spinal Treatment.

Refer to the applicable sections of this Schedule for these Covered Services.

Any office visit Copayment is waived for the following services:

- (a) allergy injections;
- (b) office visits related to maternity services if the mother's pregnancy is covered under the Plan, except for the initial diagnosis of pregnancy (Maternity Services will be subject to any Percentage Payable as shown in this Schedule); or
- (c) Routine Mammography.

Covered Routine Physical Exam Services (for Members age 18 or older)

Routine Physical Exam Copayment:

None

Benefits will be payable for a routine physical exam, including routine gynecological exam and immunizations, performed by a Physician in a:

- (a) Hospital outpatient department; or
- (b) Physician's office or clinic;

but not to exceed one exam each Calendar Year.

The Plan will not pay benefits for a routine physical exam performed during a Hospital Confinement.

**Covered Preventive Health Care Services
(for dependent children through age 17)**

Preventive Health Care Copayment:

None

Benefits will be payable for preventive health care services (other than childhood immunization services) performed by a Physician in a:

- (a) Hospital outpatient department; or
- (b) Physician's office or clinic.

The Plan will not pay benefits for a preventive health care services performed during a Hospital Confinement.

Covered Childhood Immunization Services (for dependent children up to age 7)

Childhood Immunization Copayment:

None

Benefits will be payable for childhood immunization services consisting of the complete set of vaccinations for children up to age seven as recommended by the American Academy of Pediatrics. The vaccinations include (but are not limited to) immunizations against:

- (1) measles;
- (2) mumps;
- (3) rubella;
- (4) poliomyelitis;
- (5) diphtheria;
- (6) pertussis;
- (7) tetanus;
- (8) haemophilus influenza type B; and
- (9) hepatitis-b.

Covered Routine Mammography Services

Routine Mammography Copayment:

None

Benefits will be payable for a Routine Mammography for a Member who is age 35 or over, but not to exceed one mammogram each Calendar Year.

Routine Mammography means a routine x-ray examination of the breast.

Covered Physician Surgical Services

Benefits will be payable for Expense incurred for Covered Services provided by a Physician for inpatient, outpatient or office surgery, including the services of an assisting surgeon.

Covered Radiologist, Anesthesiologist, Pathologist And Hospital Emergency Room Physician Services

Benefits will be payable for Expense incurred for Covered Services provided by a Physician who is a radiologist, anesthesiologist, pathologist or Hospital emergency room Physician.

Covered Hospital Services

Inpatient Hospital Confinement Copayment:

None

Hospital Emergency Room Services Copayment:

None

The Hospital Emergency Room Services Copayment will be waived if the Member receives Inpatient Treatment immediately after receiving the Hospital emergency room services. However, any applicable Copayment related to the Hospital Confinement and Coinsurance must then be satisfied.

Covered Hospital Services

Benefits will be payable for Expense incurred for the following Covered Hospital Services:

- (a) Hospital room and board. Benefits are provided for a semiprivate room unless a private room is Medically Necessary;
- (b) Hospital services and supplies used when benefits are provided for Hospital room and board under item (a) above;

Hospital charges for the services of a Physician or other practitioner are not covered under item (a) above or under this item (b);

- (c) Inpatient Rehabilitation Therapy Services, up to 60 days each Calendar Year;
- (d) Preadmission tests only if:
 - (1) the Member's Physician determines before the tests are performed that Hospital Confinement is required;
 - (2) the tests are performed:
 - a. on an outpatient basis; and
 - b. in connection with a Hospital Confinement which is a Covered Service;
 - (3) the tests would be covered if performed during Hospital Confinement; and
 - (4) the Hospital where the Member is confined:
 - a. accepts the tests in lieu of tests which would have been performed during Hospital Confinement; and
 - b. does not repeat the tests upon admission (unless the Member's medical record shows both the results of the preadmission tests and that repeated tests are Medically Necessary);

- (e) Hospital emergency services:

If a Member, while covered under this provision, receives Medically Necessary Covered Services for treatment and stabilization of a Medical Emergency, the Plan will provide In-Network Benefits as shown in this Schedule, including benefits for any medical screening

In-Network Schedule

examination or other evaluation required by state or federal law performed in the emergency room of a Hospital to determine if an emergency medical condition exists.

Post-stabilization care of a Medical Emergency is **not** payable under this section, but will be paid in the same manner and subject to the same limitations and conditions as any other Covered Service.

For post-stabilization care of a Medical Emergency, a Participating Provider must provide the Covered Services for In-Network Benefits to be considered for payment.

Covered Services for an out-of-area Emergency Services Benefit are those which:

- (1) are rendered while the Member is temporarily outside the Service Area;
- (2) are required to prevent a serious deterioration in the Member's health;
- (3) cannot be delayed until the Member returns to the Service Area; and
- (4) are otherwise covered under the Plan.

The Plan will not pay In-Network Benefits for unauthorized services or supplies received out of the Service Area if, in the judgment of Our Medical Director, the need for such services or supplies could have been reasonably foreseen before leaving the Service Area;

- (f) routine newborn care (if the mother's pregnancy is covered under the Plan) for any bassinet or nursery charges for Covered Hospital Services for any days on which both mother and child receive Inpatient Treatment. Any Inpatient Hospital Confinement Copayment will not apply. No benefits will be payable for Expense incurred by the child if the child is not eligible under the Plan.

Expense for Covered Hospital Services incurred by a sick newborn will be paid in the same manner and subject to the same limitations and conditions as any other Sickness.

- (g) 48-Hour Maternity Benefits: If, while covered under this provision, a Member is confined to a Hospital as a resident inpatient for childbirth, benefits are payable in the same manner and subject to the same conditions and limitations as any other Sickness, but, in no event, will benefits be provided for less than:
- (1) 48 hours following a vaginal delivery; or
 - (2) 96 hours following a cesarean section;

for the mother and the newborn infant(s), unless the attending Physician, in consultation with the mother, recommends an earlier discharge.

In the event such earlier discharge occurs, a follow-up visit by a registered nurse will be available to the mother, and payable in the same manner and subject to the same conditions and limitations as any other covered service.

- (h) Breast Reconstruction Benefits. If, while covered under this provision, a Member is receiving benefits in connection with a mastectomy, the Plan will pay the expense incurred for the following service in the same manner as subject to the same conditions and limitations as any other covered service:
- (1) reconstruction of the breast on which the mastectomy has been performed;

In-Network Schedule

- (2) surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- (3) prostheses and physical complications of all stages of the mastectomy, including lymphedemas.

Such services are to be provided in a manner determined in consultation with the attending physician and the patient.

Any exclusion for cosmetic or reconstructive surgery will not apply to services covered under this provision.

Birthing Center Benefits

Definitions

Birthing Center means a facility which is equipped and operated solely to provide prenatal care; to perform uncomplicated, spontaneous deliveries; and to provide immediate post-partum care. A Birthing Center must either be licensed by the state or must satisfy all of the following:

- (i) be directed by at least one (1) Physician specializing in obstetrics or gynecology;
- (j) have a Physician or Nurse Midwife present during each birth;
- (k) provide skilled nursing services in the delivery and recovery rooms (under the direction of an RN or Nurse Midwife);
- (l) have at least two (2) birthing rooms or beds, diagnostic x-ray and lab equipment (or a contract to use that of an area medical facility), and emergency equipment;
- (m) admit only patients with low-risk pregnancies (and contract with an area Hospital for transfer of emergency cases); and
- (n) regularly charge patients for services and supplies.

Nurse Midwife means a person who is:

- (a) certified by the American College of Nurse Midwives; or
- (b) licensed as such by the state where services are rendered.

Benefits

If a Member incurs Expense for Birthing Center services, the Plan will pay the Expense incurred in the same manner and subject to the same conditions and limitations as any other Covered Service.

Other Covered Services

Other Covered Services include:

- (a) Physician services for medical care (other than surgery);
- (b) dental services by a Physician or Dentist for the treatment of a Dental Injury to Sound Natural Teeth (including the initial replacement of the injured teeth and any necessary dental X-rays), provided the treatment plan begins within 90 days of the Injury and is completed within one year after the Injury.
- (c) diagnostic x-ray and laboratory service except:
 - (1) x-ray and laboratory services performed in a Physician's office; and
 - (2) other diagnostic imaging services (refer to the Covered High End Radiology Services section of this Schedule);
- (d) radium, radioactive isotopes and x-ray therapy;
- (e) the purchase of ostomy supplies;
- (f) oxygen and the rental of equipment (up to the purchase price) for its administration;
- (g) blood, blood products or blood plasma and its administration;
- (h) initial placement of contact lenses required because of cataract surgery and lens implant required because of cataract surgery;
- (i) casts, splints, braces, trusses and crutches; and
- (j) any other covered supply or service.

Covered Ambulance Services

Ambulance Services Copayment:

None

Benefits will be payable for Expense incurred for the following ambulance services:

- (a) professional ambulance service when:
 - (1) transportation is Medically Necessary; and
 - (2) transportation is to the nearest Hospital equipped to furnish the services; and
- (b) transportation within the United States by a professional ambulance or on a regularly scheduled flight on a commercial airline when:
 - (1) such transportation is Medically Necessary; or
 - (2) special and unique Covered Hospital Services are required which are not provided by a local Hospital.

Covered High End Radiology Services

Benefits will be payable for Expense incurred for Covered High End Radiology Services performed on an outpatient basis, including:

- (a) magnetic resonance imaging (MRIs);
- (b) CT Scans;
- (c) PET Scans;
- (d) SPECT Scans;
- (e) Arteriograms; and
- (f) other nuclear medical scans.

Covered Durable Medical Equipment

Benefits will be payable for Expense incurred for purchase or rental up to the purchase price (except for oxygen and its administration) of Durable Medical Equipment.

Covered Home Health Care Services

Benefits will be payable for Expense incurred for home health care services up to a maximum of 100 visits each Calendar Year.

Covered Home Health Care Services

Covered home health care services consist of:

- (a) nursing care provided on a part-time basis (less than an eight-hour shift) by:
 - (1) a registered nurse (RN); or
 - (2) a licensed practical nurse; and
- (b) part-time or intermittent Home Health Aide services provided:
 - (1) by a Home Health Aide; and
 - (2) under the supervision of a registered nurse.

One home health care visit will consist of:

- (a) one visit for the services listed under item (a) above; or
- (b) up to four consecutive hours for the Home Health Aide services shown under item (b) above.

Conditions

Home health care services must be provided by a person other than You, or a person who lives in Your home or is a part of Your family (Your spouse; or a child, brother, sister or parent of You or Your spouse); and home health care services must be ordered and directed by a Physician and furnished:

- (a) in a private home;
- (b) by a Home Health Agency; and
- (c) in accordance with a Home Health Care Plan.

Exceptions

The Plan will not provide Covered Home Health Care Services for:

- (a) services and supplies which are not part of a Home Health Care Plan;
- (b) services of a Caregiver or person who lives in Your home or is a part of Your family (Your spouse; or a child, brother sister or parent of You or Your spouse);
- (c) domestic or housekeeping services that are unrelated to the patient’s care;
- (d) services that provide a protective environment when no skilled service is required (such as companionship or sitter services); and
- (e) services which are not directly related to the Member’s medical conditions, including but not limited to:
 - (1) estate planning, drafting of wills and other legal services;
 - (2) pastoral counseling or funeral arrangements or services;
 - (3) nutritional guidance or food services such as “meals on wheels”; and
 - (4) transportation services.

Covered Hospice Care Services (Inpatient and Outpatient)

Benefits will be payable for Expense incurred for both inpatient treatment and outpatient treatment for Hospice Care Services up to 185 days or visits while the Member is covered under the Plan. Inpatient Respite Care is limited each time to a stay of no more than five days in a row.

Hospice Care Services can provide the physical, psychological, spiritual or social support needed to help Terminally Ill Members cope with their Sickness. Hospice Care Services include services provided in a private home, Hospital or Hospice Care Facility.

Benefits are payable as long as they are prescribed or ordered by a Physician who is a Participating Provider, and the Member is Terminally Ill.

Inpatient Hospice Care Services

Benefits for Expense incurred for inpatient Hospice Care Services will be payable:

- (a) when Medically Necessary;

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- (b) when there are no suitable Caregivers;
- (c) when it is determined by the Hospice Agency that Hospice Care in a home is impractical because the patient is unmanageable by the persons who regularly assist with home care; or
- (d) for Respite Care.

Outpatient Hospice Care Services

Benefits for Expense incurred for outpatient Hospice Care Services will be payable:

- (a) when Medically Necessary;
- (b) for nursing care provided on a part-time basis (less than an eight-hour shift) by:
 - (1) a registered nurse (RN); or
 - (2) a licensed practical nurse; and/or
- (c) for part-time or intermittent Home Health Aide services provided:
 - (1) by a Home Health Aide; and
 - (2) under the supervision of a registered nurse (RN).

One home Hospice care visit will consist of:

- (a) one visit for the services listed under item (b) above; or
- (b) up to four consecutive hours for the Home Health Aide services shown under item (c) above.

Hospice Care Services must be provided by a person other than a Caregiver, You, or a person who lives in Your home or is a part of Your family (Your spouse; or a child, brother, sister or parent of You or Your spouse).

Covered Counseling and Bereavement Services

When benefits for Hospice Care Services are payable, The Plan will also pay benefits for the Expense incurred for:

- (a) counseling of the Member and his or her Immediate Family, but not to exceed \$500; and
- (b) Bereavement Counseling of the Member's Immediate Family, but not to exceed \$250.

Exceptions

Covered Hospice Care Services do not include:

- (a) services and supplies which are not part of a Hospice Care Plan;
- (b) services of a Caregiver or other person who lives in Your home or is a part of Your family (Your spouse; or a child, brother, sister or parent of You or Your spouse);
- (c) domestic housekeeping services that are unrelated to the Member's care;
- (d) services that provide a protective environment when no skilled service is required (such as companionship or sitter services); or

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- (e) services which are not directly related to the Member's medical condition, including but not limited to:
- (1) estate planning;
 - (2) pastoral counseling or funeral arrangements or services;
 - (3) nutritional guidance or food services such as "meals on wheels"; or
 - (4) transportation services.

Covered Independent Radiology And Pathology Services

Independent Radiology and Pathology Services Copayment:

None

Benefits will be payable for Expense incurred for Covered Services received from an Independent Radiology and Pathology Center, except for any services shown in the Covered High End Radiology Services section of this Schedule.

Covered Alcohol And Drug Abuse And/Or Substance Abuse Treatment Services

Inpatient Services Copayment:

None

Maximum Inpatient Benefit

If a Member incurs Expense for Inpatient Treatment of Alcohol and Drug Abuse and/or Substance Abuse, The Plan will provide benefits for Covered Services for up to 30 days each Calendar Year, but not more than 60 days while the Member is covered under the Plan. Benefits for visits by a Physician are payable only during the period of time that Inpatient Treatment benefits are payable.

Maximum Outpatient Benefit

If a Member incurs Expense for Outpatient Treatment of Alcohol and Drug Abuse and/or Substance Abuse, The Plan will provide benefits for Covered Services for Outpatient Treatment for up to a Maximum Allowable Amount of \$70 each visit and 50 outpatient visits each Calendar Year.

The maximum amount of benefits under the Plan for Alcohol and Drug Abuse and/or Substance Abuse Treatment Services will be \$20,000, and not more than \$10,000 will be payable during any one Calendar Year.

Covered Mental Or Nervous Disorder Treatment Services

Inpatient Services Copayment:

None

Maximum Inpatient Benefit

If a Member incurs Expense for Inpatient Treatment of a Mental or Nervous Disorder, The Plan will provide benefits for Covered Services for Inpatient Treatment for up to 30 days each Calendar Year but not more than 60 days while the Member is covered under the Plan. Benefits for visits by a Physician are payable only during the period of time that Inpatient Treatment benefits are payable.

Maximum Outpatient Benefit

If a Member incurs Expense for Outpatient Treatment of a Mental or Nervous Disorder, the Plan will provide benefits for Covered Services for Outpatient Treatment for up to 50 outpatient visits each Calendar Year.

Exceptions

The Plan will not pay benefits for Expense incurred for treatment of a Mental or Nervous Disorder for:

- (a) the following conditions, diagnoses or therapies:
 - (1) conduct disturbances unless related to a coexisting condition or diagnosis otherwise covered;
 - (2) educational, vocational and/or recreational services;
 - (3) biofeedback for treatment of diagnosed medical conditions;
 - (4) treatment for learning disabilities; and
 - (5) pervasive developmental disorders including, but not limited to, autistic disorders, Rett's Disorder and Asperger's Disorder, other than diagnostic evaluation;
- (b) treatment which is determined by Our Medical Director to be for the Member's personal growth or enrichment; or
- (c) court ordered placements when such court ordered placements are determined by Our Medical Director to not be Medically Necessary.

Covered Nonsurgical Spinal Treatment Services

Benefits will be payable for Expense incurred for Nonsurgical Spinal Treatment up to a Maximum Allowable Amount of \$25 each visit and up to 30 visits each Calendar Year. Covered Nonsurgical Spinal Treatment Services do not include x-ray and laboratory services.

Covered Qualified Organ(s)/Tissue Transplant Services

Benefits are payable in the same manner as any other Covered Service subject to the Maximum Recipient Benefit and Maximum Donor Benefit shown below.

Maximum Recipient Benefit

Up to the maximum amount shown in the Maximum section of this Schedule.

Maximum Donor Benefit

For each period of Hospital Confinement in connection with Transplant Surgery, the Plan will pay:

Medical specialty Network Providers: \$25,000

Participating Providers: \$10,000

Qualified Organ(s)/Tissue Transplant Services

If a Member incurs Expense for a Qualified Organ(s)/Tissue Transplant, the Plan will pay benefits for the following:

- (a) **Recipient:** Expense incurred by a Recipient up to the Maximum Recipient Benefit shown above for:
 - (1) the use of temporary mechanical equipment, pending the acquisition of “matched” human organ(s)/tissue;
 - (2) multiple transplants during one operative session;
 - (3) replacement(s) or subsequent transplant(s); and
 - (4) follow-up Expense for items (1) through (3) above (including immunosuppressant therapy).
- (b) **Donor:** Expense incurred by a Donor(s) up to the Maximum Donor Benefit shown above for:
 - (1) testing to identify suitable Donor(s);
 - (2) the acquisition of human organ(s)/tissue from a Donor;
 - (3) life support of a Donor pending the removal of a usable human organ(s)/tissue;
 - (4) transportation for a living Donor; and
 - (5) transportation of human organ(s)/tissue or a Donor on life support.

Benefits under (b) are payable only when the Recipient is a Member.

Qualified Organ(s)/Tissue Transplants means transplants for any of the following:

- (a) cornea;
- (b) heart;
- (c) lung;
- (d) heart/lung;
- (e) liver;
- (f) kidney;

- (g) pancreas;
- (h) kidney/pancreas; and
- (i) bone marrow/peripheral stem cell transplants.

Medical Specialty Network

Exclusive Healthcare, Inc. provides a program for Qualified Organ(s)/Tissue Transplants called the **Medical Specialty Network (MSN)**.

MSN consists of certain providers throughout the United States with whom Exclusive Healthcare, Inc. has contracted or made arrangements with to provide Transplant Surgery for Qualified Organ(s)/Tissue Transplant services.

Exclusive Healthcare, Inc. will work with You and Your Physician to determine which of the MSN providers is available for Your or Your dependent's type of transplant.

If Transplant Surgery for a Qualified Organ(s)/Tissue Transplant is Medically Necessary and performed at an MSN, You may be eligible for benefits related to Expenses for travel, lodging and meals for the transplant Recipient and one family member or Caregiver. Exclusive Healthcare, Inc. may assist the Member and one family member or Caregiver with travel and lodging arrangements.

Conditions

Exclusive Healthcare, Inc. must be notified at least seven working days before the scheduled Transplant Surgery date or as soon as reasonably possible prior to such date for any of the following:

- (a) the evaluation of the Recipient; and
- (b) testing to identify suitable Donors.

Exceptions

The Plan will not pay Expense for:

- (a) any charge when approved alternative remedies are available;
- (b) any animal organ;
- (c) any mechanical organ(s) except as provided under Recipient item (a) (1) above;
- (d) any financial consideration to the Donor other than for a Covered Service which is Medically Necessary in the performance of or in relation to Transplant Surgery; or
- (e) anything excluded under the General Exclusions and Limitations.

Covered Outpatient Facility Services

Outpatient Facility Copayment:

None

Benefits will be payable for Expense incurred for non-emergency services and supplies received in an Outpatient Facility, including a Hospital or a surgical center setting. Any Covered Physician Surgical Services may be subject to a separate Coinsurance amount as described in the Percentage Payable section of this Schedule.

Services of an Independent Radiology and Pathology Center, Urgent Care Center or Hospital Emergency Room are not covered under this provision. Refer to the applicable section of this Schedule for the benefits payable.

Covered Outpatient Therapy Services

Benefits will be payable for Expense incurred for outpatient therapy, including physical, occupational, speech, cardiac rehabilitation and pulmonary rehabilitation.

Benefits for Expense incurred for physical and occupational therapy are payable for up to 60 total visits each Calendar Year. Physical therapy includes aquatic therapy. Benefits for Expense incurred for speech therapy are payable for up to 30 visits each Calendar Year.

Nonsurgical Spinal Treatment is **not** covered under this section. For the benefits payable for Nonsurgical Spinal Treatment, refer to the Covered Nonsurgical Spinal Treatment Services provision of this Schedule.

Covered Prosthetics

Benefits will be payable for Expense incurred for artificial limbs and eyes to restore or replace mobility or function of natural limbs and eyes, including replacement when damaged or worn out while the Member is covered under this Plan.

Covered Skilled Nursing Care Facility Services

Benefits will be payable for Expense incurred for services provided to a Member while confined in a Skilled Nursing Care Facility for up to 100 days each Calendar Year, provided:

- (a) the confinement is under the supervision of a Physician who is a Participating Provider;
- (b) Hospital Confinement would be Medically Necessary in the absence of Skilled Nursing Care Facility confinement; and
- (c) the confinement is not considered to be Custodial Care.

Covered Specialty Pharmacy Drugs And Medicines

Benefits will be payable for Expense incurred for specialty Pharmacy Drugs and Medicines provided by Participating Providers (excluding Specialty Pharmacy Providers) until the Member is notified. **If a Specialty Pharmacy is utilized, the Plan will pay benefits in the same manner as any other Covered Drug.**

When Your Physician prescribes one of the drugs or medicines which are required to be purchased through a Specialty Pharmacy Provider, You will be notified.

Specialty Pharmacy Drugs and Medicines means drugs or injectables included on Exclusive Healthcare, Inc. list of Specialty Pharmacy Drugs and Medicines for patients who have received an organ transplant or have conditions such as HIV/AIDS, diabetes, growth hormone deficiencies and other conditions which may qualify for the Case Management Program.

NOTE: The current list of Specialty Pharmacy Drugs and Medicines may be obtained by calling 1-800-467-4917. This list is subject to periodic review and modification.

Covered Urgent Care Center Services

Urgent Care Center Services Copayment:

None

Benefits will be payable for Expense incurred for Urgent Care Center Covered Services in a non-Hospital-based facility. Any Hospital-based facility will be subject to the Emergency Room Services Copayment as shown in the Covered Hospital Services section of this Schedule.

Urgent Care Center Services means health services which are required in order to prevent serious deterioration of a Member's health and that are required as a result of an unforeseen Sickness, Injury or onset of threatening symptoms.

Covered Routine Vision Care Services

Routine Vision Care Services Copayment:

None

Benefits will be payable for Expense incurred for a complete Spectacle Exam provided by a Participating Provider shown in the "Vision Care - Routine" section of the HMO/POS Provider Directory.

Exceptions

The Plan will not provide benefits for Covered Routine Vision Care Services for:

- (a) more than one Spectacle Exam each Calendar Year; or
- (b) Spectacle Exams which are provided by a non-Participating Provider or performed in a Physician's office.

Definition

Spectacle Exam means a refraction and assessment of a Member's vision for the purposes of corrective lenses.

Covered Outpatient Prescription Drug Services

**Outpatient Prescription Drug Copayment:
For Covered Drugs (other than Diabetic Supplies)**

\$15 for each prescription or refill for a Generic Drug

\$30 for each prescription or refill for a Brand Name Drug which is included on the Drug Formulary

\$60 for each prescription or refill for a Brand Name Drug which is not included on the Drug Formulary

For Diabetic Supplies

None

Outpatient Prescription Drug Retail Program

The Plan will provide benefits for a Covered Drug subject to the Copayment shown above, for up to a 30-day supply for the Covered Drug, provided the prescription for the Covered Drug is:

- (a) written by a Participating Provider;
- (b) filled by a pharmacy which is a Participating Provider; and
- (c) obtained by the use of a valid identification card (except for a Member who has not yet received a valid identification card).

Generic Drugs will be used to fill prescriptions through Our pharmacies which are Participating Providers unless the prescribing Physician specifies that a Brand Name Drug be dispensed. Any time the Member or the prescribing Physician requests a Brand Name Drug when a Food and Drug Administration (FDA) approved, chemically equivalent Generic Drug is available, the Member will be charged the difference in cost between the Generic Drug and Brand Name Drug in addition to the Copayment.

If there is no FDA approved, chemically equivalent Generic Drug available, the Plan will pay the total Expense for the Brand Name Drug after the Copayment is satisfied. However, with the prescribing Physician's approval, We may, at Our discretion, substitute one Brand Name Drug for another Brand Name Drug.

If the Member purchases more than a 30-day supply of a Covered Drug on the same day, any Expense exceeding the supply limit will not be covered.

In-Network Schedule

Prescription refills will be covered when no more than 25% of the days' supply remains based on the Physician's written order.

Medical Emergency Exception

When a Member is issued a prescription for a Covered Drug as a result of a covered Medical Emergency and such prescription cannot reasonably be filled by a Participating Pharmacy, such prescription will be covered by Us to the same extent it would have been covered if filled by a Participating Pharmacy, subject to the Copayments shown above. To be eligible for reimbursement by Us, the Member must submit a written proof of loss as described in the Payment of Claims provision of the Member's Plan.

Exceptions

The Plan will not provide benefits for Covered Outpatient Prescription Drug Services for:

- (a) drugs (in whole or in part) obtained through the following facilities while the Member is confined in a:
 - (1) Hospital;
 - (2) Skilled Nursing Care Facility or convalescent home;
 - (3) rest home or nursing home; or
 - (4) sanitarium or treatment facility;
- (b) prescription refills in excess of the number specified by the Physician;
- (c) drugs or medicines dispensed more than one year after the date of the prescription;
- (d) drugs or medicines dispensed in a quantity which (when taken as the Physician directs) exceeds a 30-day supply;
- (e) Experimental or Investigational drugs or medicines;
- (f) fertility drugs or medicines;
- (g) diet or appetite suppressant drugs or medicines;
- (h) dietary supplements;
- (i) drugs or medicines used for cosmetic purposes or beauty aids;
- (j) drugs or medicines provided by a non-Participating Provider (except for Medical Emergency or when provided by a Dentist);
- (k) drugs or medicines whose primary purpose is to treat tobacco addiction;
- (l) drugs or medicines that have been determined under the internal standards of the Food and Drug Administration to be less-than-effective in accordance with the Drug Efficacy Study Implementation (DESI) or where the same prescription drug item or an equivalent is also available over-the-counter (OTC) or can lawfully be obtained without a Physician's prescription;
- (m) injectable drugs and medicines (except for Medically Necessary self-administered drugs and medicines, such as insulin); or

- (n) drugs or medicines obtained without the use of a valid identification card (except for a covered Member who has not yet received a valid identification card).

Mail-Order Prescription Drug Program

Prescription-By-Mail (Mail-Order Program) Copayment:

The Plan will provide benefits for up to a 100 day supply of a Covered Drug subject to:

For Covered Drugs (other than Diabetic Supplies)

\$30 for each prescription or refill for a Generic Drug

\$60 for each prescription or refill for a Brand Name Drug which is included on the Drug Formulary

\$120 for each prescription or refill for a Brand Name Drug which is not included on the Drug Formulary

For Diabetic Supplies

None

The prescription must be:

- (a) written by a Participating Provider; and
- (b) filled by Our Participating Provider for Our Prescription-By-Mail (Mail Order) Program.

Order Your Covered Drug by mail when:

- (a) the Participating Provider orders more than a 30 day supply of medication; or
- (b) You are taking the same medication on a regular basis (including, but not limited to, medications for the treatment of high cholesterol, high blood pressure, diabetes, congestive heart failure and arthritis).

The maximum amount dispensed will be up to a **100-day supply**.

To receive Your Covered Drug by mail, have the Participating Provider write two prescriptions:

- (a) the first for Your immediate needs (30 days or less) to have filled by a Participating Pharmacy in accord with our Outpatient Prescription Drug Services provision; and
- (b) the second prescription (up to 100 day supply with up to 3 refills) for You to submit to the Prescription-By-Mail Program.

Complete the Registration and Prescription Order Form, attach Your prescription (with Your first order of a medication), include the copayment for each prescription or refill.

Forms needed for refills and future prescription orders will be provided each time You receive a supply of medication from this program, or You may call the toll free number to refill Your subscription.

In-Network Schedule

Generic Drugs and Medicines will be used to fill prescriptions unless the prescribing Physician specifies that a Brand Name Drug be dispensed. Anytime the Member or the prescribing Physician requests a Brand Name Drug when a Food and Drug Administration (FDA) chemically equivalent Generic Drug is available, the Member will be charged the difference in cost between the Generic Drug and Brand Name Drug in addition to the Copayment.

If there is no FDA approved, chemically equivalent Generic Drug, the Plan will pay the total expense for the Brand Name Drug, after the Copayment is satisfied. However, with the prescribing Physician's approval, We may, at Our discretion, substitute one Brand Name Drug for another Brand Name Drug.

If the Member is purchasing more than a 100 day-supply on the same day, any expense exceeding the supply limit will not be covered.

Prescription refills will be covered when no more than 25% of the days' supply remains based on the Physicians' written order.

Note: Mail-Order Prescription Drug Benefits are subject to all other terms, conditions and limitations of the Plan, including, but not limited to, the:

- (a) "Exceptions" to the Covered Outpatient Prescription Drug Services shown in the Schedule (however, the exception for drugs and medicines dispensed in a quantity which exceeds a 30-day supply will not apply); and
- (b) the General Exclusions and Limitations.

Diabetes Benefit

If You or Your dependent, while covered under this provision, requires equipment, supplies, medication, and outpatient self-management training and Patient Management, including medical nutritional therapy for the treatment of:

- (a) insulin-dependent diabetes;
- (b) insulin-using diabetes;
- (c) gestational diabetes; and
- (d) non-insulin using diabetes,

benefits will be paid as described in the Conditions below.

Conditions

1. The following equipment, supplies and medications will be paid in the same manner and subject to the same conditions and limitation as any other Covered Service:
 - (a) blood glucose monitors;
 - (b) blood glucose monitors for the legally blind;
 - (c) injection aids;
 - (d) insulin pumps and all supplies for the pump;

In-Network Schedule

- (e) insulin infusion devices;
 - (f) insulin measurement and administrative kits for the visually impaired;
 - (g) Patient Management material that provide essential diabetes self-management information; and
 - (h) podiatric appliances for the prevention of complications associated with diabetes.
2. The following equipment, supplies and medications will be paid in the same manner and subject to the same conditions and limitations as any other outpatient prescription drug:
- (a) test strips for glucose monitors;
 - (b) urine test strips;
 - (c) insulin;
 - (d) lancet and lancet devices;
 - (e) syringes;
 - (f) oral agents for controlling blood sugars; and
 - (g) glucose agents and glucagon kits.
3. Benefits will be paid:
- (a) upon the diagnosis of diabetes;
 - (b) when a significant change occurs in symptoms or condition that necessitates a change in self-management; or
 - (c) when refresher Patient Management is necessary.
- Benefits include Medically Necessary home visits and Patient Management conducted individually or in a group setting.
4. Diabetes self-management training and Patient Management, including medical nutrition therapy, must be provided by:
- (a) an American Diabetes Association Recognized Diabetes Self-Management Education Program; or
 - (b) a health care professional that is a diabetes educator certified by the National Certification Board for Diabetes Educators.
5. Diabetes self-management training and Patient Management is covered:
- (a) at diagnosis;
 - (b) when symptoms or conditions change; and
 - (c) when new medications or treatments are prescribed.

In-Network Schedule

Benefits for diabetes self-management education shall not exceed \$500 in any two year calendar period.

Exceptions

The Plan will not pay for:

- (a) any Expense which is paid under any other provision of the Plan; or
- (b) anything excluded under the Exclusions and Limitations, except that, for the purposes of this provision, any exclusion for charges for orthopedic shoes, orthotics or other supportive devices for the feet will not apply.

Colorectal Cancer Screening Benefits

If a Member undergoes a colonoscopy or sigmoidoscopy, the Plan will pay the Expense incurred in the same manner and subject to the same conditions and limitations as any other Covered Service.

Maximum

\$1,000,000 for Active Members and \$250,000 for Retired Members is the maximum amount of benefits payable under the Plan for all Covered Services. (The maximum amount of benefits payable under this Plan is referred to herein as the “Maximum.”)

Benefits are payable only for Expense incurred while You or Your eligible dependents are covered under the Plan.

Exceptions

If You or Your dependents:

- (a) were covered under any group health plan (insured or self-insured) provided through the Plan immediately preceding the effective date of this Plan; and
- (b) become covered under this Plan on June 1, 2002;

the Maximum benefits payable under this Plan will be reduced by the amount of benefits immediately preceding Our coverage that have been paid or that are payable under any prior group health plan (whether insured or self-insured) that was maintained by Us.

The Maximum will be reduced by the amount of benefits that have been paid, or that are payable under:

- (a) any prior group plan (insured or self-insured); or
- (b) any Alternate Health Benefit(s) Plan(s);

maintained by Us.

Cross Allocation Provisions

Benefit Limitations and Maximums

Unless otherwise specifically shown in this Plan or the group Plan issued by United of Omaha Life Insurance Company in conjunction with this Plan to provide Out-of-Network Benefits, Covered Services received under either the In-Network Benefit or the Out-of-Network Benefit options will be used to satisfy benefit limitations or maximums under each of the benefit options. In no event will coverage be provided for the same services or supplies under more than one benefit option.

Copayments and Out-of-Pocket Expenses

Any In-Network Benefit Copayment will only apply to Expense incurred for an In-Network Covered Service.

However, when the In-Network Benefits and Out-of Network Benefits are both subject to Deductibles and Coinsurance, the same Expense may be used to satisfy any In-Network and Out-of-Network Deductibles and Coinsurance.

INTRODUCTION TO POINT OF SERVICE OUT-OF-NETWORK

The benefits and provisions of the **Out-of-Network** Benefits option of a Point of Service Plan are described in this Plan.

Trustees of Plumbers Local Union No. 16 Health and Welfare Fund offers this coverage (called the **Out-of-Network** Benefits) under this Plan in conjunction with the Health Maintenance Organization (HMO) benefits (called the **In-Network** Benefits). The **In-Network** Benefit option and this **Out-of-Network** Benefits option together comprise the Point of Service Plan.

As an enrolled Covered Person/Member in this Point of Service health Plan, You and/or Your dependents may access care in two different ways:

- (a) in accordance with the terms and conditions of the Plan for the **In-Network** Benefits. The Member receives a higher level of benefits under the **In-Network** Benefits option. For **In-Network** Benefits, the Member may receive Covered Services provided by any Physician who is an HMO Participating Provider without a referral from the Member's Primary Care Physician.
- (b) **However, Covered Services must always be provided by HMO Participating Providers, except as otherwise provided in the Plan.** The Member must always verify the Physician, Hospital or any other provider is currently an HMO Participating Provider. From time to time, the participation status of a provider may change. The Member may verify if the provider is currently an HMO Participating Provider by calling Us. If an HMO Participating Provider is not used, benefits will be considered for payment under the **Out-of-Network** Benefit option; or
- (c) in accordance with the terms and conditions of this Plan for the **Out-of-Network** Benefits. The Covered Person receives a lower level of benefits under the **Out-of-Network** Benefits option; **however, the Covered Person may receive Covered Services from any provider that is not a Participating Provider.**

Reminder: The **In-Network** Benefits option provides a higher benefit level. If Covered Services are received under the **Out-of-Network** benefits option, Covered Services may be subject to higher Copayments and/or a higher Calendar Year Deductible and Coinsurance.

The **Out-of-Network** Benefits option includes Utilization Management Provisions which affect the way benefits are paid to You and Your covered dependents.

For purposes of the Coordination of Benefits provision, the **In-Network** Benefits underwritten by Exclusive Healthcare, Inc. and the **Out-of-Network** Benefits underwritten by United will be considered one Plan.

SCHEDULE

THIS SCHEDULE DESCRIBES THE DEDUCTIBLE, COPAYMENTS, COINSURANCE, MAXIMUM BENEFITS AND CERTAIN OTHER REQUIREMENTS AND LIMITATIONS APPLICABLE TO BENEFITS FOR COVERED SERVICES. OUR OBLIGATION TO CONSIDER BENEFITS IS SUBJECT TO ALL TERMS AND CONDITIONS OF THE PLAN, INCLUDING, BUT NOT LIMITED TO, ALL DEFINITIONS, GENERAL EXCLUSIONS AND LIMITATIONS, AND PLAN CHANGES. PLEASE REFER TO THE TABLE OF CONTENTS IN THE BOOKLET TO LOCATE THESE PROVISIONS.

Benefits under the Plan for You and Your dependents will be in accordance with Your classification in this SCHEDULE.

Classifications

All eligible active employees

All eligible retired employees under age 65

All eligible retired employees age 65 or over

UTILIZATION MANAGEMENT PROVISIONS

In order to provide cost-effective health coverage, the Plan contains the following Utilization Management Provisions:

Utilization Review
Partial Hospitalization Benefits
Mental and Nervous Disorders, Alcohol and Drug Abuse and/or
Substance Abuse Outpatient Review
Case Management Program

NOTE: A complete description of these provisions can be found in the Utilization Management Provisions section of this Booklet. United of Omaha urges You to read these provisions thoroughly. Some of the provisions provide more favorable benefits if the requirements and procedures described in the provisions are followed.

IN SOME INSTANCES, LESS FAVORABLE BENEFITS ARE PROVIDED IF THE REQUIREMENTS OR PROCEDURES DESCRIBED IN THE UTILIZATION MANAGEMENT PROVISIONS ARE NOT FOLLOWED.

DISCOUNTED CHARGES

United of Omaha has contractual arrangements with Preferred Providers and other health care providers, provider networks and other vendors of health care services and supplies (“Providers”). In accordance with these arrangements, certain Providers have agreed to Discounted Charges.

A “Discounted Charge” is the amount that a Provider has agreed to accept as payment in full for covered health care services or supplies. A “Discounted Charge” does not include rebates or any other reductions, fees or credits a Provider may periodically give United. United will retain those amounts that are not “Discounted Charges.” However, United has estimated the amount of such rebates, reductions, fees and credits and have taken those into consideration in setting the fees charged to provide services for this Plan.

Claims under the Plan and any Deductible, Copayment (based upon percentage of charge), Coinsurance and benefit maximums as described in this Schedule will be determined based on the Discounted Charge.

For You and Your Dependents
HEALTH COVERAGE
MAJOR MEDICAL BENEFITS

Deductible

Individual Deductible

\$500 of Expense incurred by You and each of Your dependents for Covered Services. The Covered Person must satisfy the Individual Deductible once each Calendar Year.

Family Deductible

After \$1,000 of Expense has been incurred by You and Your dependents for Covered Services during a Calendar Year, no other Individual Deductible requirement shall apply.

Exceptions

Waiver of the Deductible. The Deductible is waived for Covered Services in connection with:

- (a) Routine Mammography services; and
- (b) Childhood Immunization for eligible dependent children through age six.

Percentage Payable

For Covered Services

After the applicable Deductible is satisfied, the Plan will pay 80% of the Expense which You or Your dependents incur for Covered Services (and the Covered Person pays 20%) until the out-of-pocket limit is reached.

Allergy Injections

After the applicable Deductible is satisfied, the Plan will pay 80% of the Expense which You or Your dependents incur for Covered Services.

Out-of-Pocket Limit

Individual Out-of-Pocket Limit

After the Out-of-Pocket Expense by one Covered Person reaches \$3,000, the Plan will pay 100% of the Expense for Covered Services incurred by such person during the rest of the Calendar Year.

Family Out-of-Pocket Limit

After the Out-of-Pocket Expense by You and Your dependents combined reaches \$9,000, the Plan will pay 100% of the Expense which You and Your dependents incur for Covered Services during the rest of the Calendar Year.

Exceptions

Expense for the following will not be used to satisfy the Individual or Family out-of-pocket limit and will not be paid at 100% after the Individual or Family out-of-pocket limit is reached:

- (a) Mental and Nervous Disorders;
- (b) Alcohol and Drug Abuse and/or Substance Abuse;
- (c) Spinal Treatment (nonsurgical); and
- (d) any amount which the Covered Person must pay as a result of failure to comply with the Utilization Management Provisions.

Out-of-Pocket Expense means Expense which the Covered Person incurs for Covered Services provided during the Calendar Year and must pay:

- (a) as Coinsurance; and
- (b) as Deductibles, except for Covered Services that apply to the Deductible, but do not apply toward the Out-of-Pocket Expense.

Maximum

Maximum Benefits under the Plan

\$1,000,000 for Active Members and \$250,000 for Retired Members is the maximum amount of benefits payable under the Plan for Covered Services for treatment of all Injuries and Sicknesses of each Covered Person (the “Maximum”).

Benefits are payable only for Expense incurred while You or Your dependents are covered under the Plan.

Exceptions

If You or Your dependents:

- (a) were covered under any group health plan (insured or self-insured) provided through Us immediately preceding the effective date of the Plan; and
- (b) become covered under the Plan on June 1, 2002;

the Maximum benefits payable under the Plan will be reduced by the amount of benefits immediately preceding Our coverage that have been paid or that are payable under any prior group health plan (whether insured or self-insured) that was maintained by Us.

The Maximum will be reduced by the amount of benefits that have been paid, or that are payable under:

- (a) any prior group plan (insured or self-insured); or
- (b) any Alternative Health Benefits Plan(s);

maintained by Us.

Alternative Health Benefits Plan(s) means any group health coverage, (HMO) or other forms of group or group type health coverage provided by the Plan.

Bassinet, Nursery and Well Newborn Delivery Services

The Plan will pay benefits for the Expense incurred by a Covered Person who is a well newborn dependent child for bassinet or nursery charges in the same manner as any other Covered Service. Benefits will be payable for Covered Services incurred during the Hospital Confinement of such child. No Deductible will apply.

Expense for Physician services incurred by such child during the Hospital Confinement will be considered the child’s own Expense and will be paid in the same manner as any other Covered Service.

Benefits for Expense incurred by a covered sick newborn will be paid the same manner as any other Sickness.

Other Covered Services

This applies to Other Covered Services shown in the Major Medical Benefits provision and not listed elsewhere in this SCHEDULE.

After the applicable Deductible is satisfied, the Plan will pay 80% of the Expense incurred for Covered Services.

Hospital Confinement Services

The Plan will pay benefits for Expense incurred in the same manner as any other Covered Service, subject to the following limitations:

After the applicable Deductible is satisfied, the Plan will pay 80% of the Expense incurred for Covered Services received for each Hospital Confinement.

Room Limit

Semiprivate Room: The semiprivate room charge of the Hospital where the Covered Person is confined.

Ward Accommodation: The ward accommodation charge of the Hospital where the Covered Person is confined.

Private Room: The average semiprivate room charge of the Hospital where the Covered Person is confined.

Intensive Care Unit/Cardiac Care Unit: The intensive care unit/cardiac care unit charge of the Hospital where the Covered Person is confined.

Hospital Emergency Room Treatment Services

The Plan will pay benefits for Expense incurred in the same manner as any other Covered Service, subject to the following limitations:

After the applicable Deductible is satisfied, the Plan will pay 80% of the Expense incurred for Covered Services received in a Hospital emergency room.

Urgent Care Center Services

The Plan will pay benefits for Expense incurred in the same manner as any other Covered Service, subject to the following limitations:

After the applicable Deductible is satisfied, the Plan will pay 80% of the Expense incurred for Covered Services provided in an Urgent Care Center.

Ambulance Services

The Plan will pay benefits for Expense incurred in the same manner as any other Covered Service, subject to the following limitations:

After the applicable Deductible is satisfied, the Plan will pay 80% of the Expense incurred for Covered Services provided by a Professional Ambulance service.

Outpatient Facility Services

The Plan will pay benefits for Expense incurred in the same manner as any other Covered Service, subject to the following limitations:

After the applicable Deductible is satisfied, the Plan will pay 80% of the Expense incurred for Covered Services provided in an outpatient facility.

Independent Radiology and Pathology Center Services

The Plan will pay benefits for Expense incurred in the same manner as any other Covered Service, subject to the following limitations:

After the applicable Deductible is satisfied, the Plan will pay 80% of the Expense incurred for Covered Services provided by an Independent Radiology and Pathology Center.

Inpatient Rehabilitation Facility Services

The Plan will pay benefits for Expense incurred in the same manner as any other Covered Service, subject to the following limitations:

Maximum Inpatient Rehabilitation Facility Benefits

After the applicable Deductible is satisfied, the Plan will pay 80% of the Expense incurred for Covered Services received for inpatient rehabilitation services each Calendar Year.

The Maximum Number of Days Payable will not exceed 60 days each Calendar Year.

Outpatient Therapy Services

The Plan will pay benefits for Expense incurred in the same manner as any other Covered Service, subject to the following limitations:

After the applicable Deductible is satisfied, the Plan will pay 80% of the Expense incurred for Covered Services received for outpatient therapy visits, including physical, occupational, speech, cardiac rehabilitation and pulmonary rehabilitation. Physical, occupational and speech therapies are subject to the Maximum Number of Outpatient Therapy Visits shown.

Out-of-Network Schedule

Maximum Number of Outpatient Therapy Visits

Physical Therapy and Occupational Therapy:

60 visits each Calendar Year for Physical Therapy and Occupational Therapy combined

Speech Therapy:

30 visits each Calendar Year

NOTE: Physical Therapy includes Aquatic Therapy

Anesthesiologist, Radiologist, Pathologist and Hospital Emergency Room Physician Services

The Plan will pay benefits for Expense incurred in the same manner as any other Covered Service, subject to the following limitations:

After the applicable Deductible is satisfied, the Plan will pay 80% of the Expense incurred for Covered Services provided by an anesthesiologist, radiologist and Hospital emergency room Physician.

High End Radiology Services

The Plan will pay benefits for Expense incurred in the same manner as any other Covered Service, subject to the following limitations:

After the applicable Deductible is satisfied, the Plan will pay 80% of the Expense incurred for Covered Services received for High End Radiology performed on an outpatient basis.

Durable Medical Equipment

The Plan will pay benefits for the purchase or rental of Durable Medical Equipment in the same manner as any other Covered Service, subject to the following limitations:

Maximum Durable Medical Equipment Benefit

After the applicable Deductible is satisfied, the Plan will pay 80% of the Expense incurred for Covered Services received for Durable Medical Equipment each Calendar Year.

The Maximum Durable Medical Equipment Benefit for Other Providers will not exceed \$5,000 while You or Your dependents are covered under the Plan.

Out-of-Network Schedule

Prosthetics

The Plan will pay benefits for the purchase of Prosthetics in the same manner as any other Covered Service, subject to the following limitations:

Out-of-Network Schedule

Maximum Prosthetic Benefit

After the applicable Deductible is satisfied, the Plan will pay 80% of the Expense incurred for Covered Services received for prosthetics each Calendar Year.

The Maximum Prosthetic Benefit for Other Providers will not exceed \$5,000 while You or Your dependents are covered under the Plan.

Specialty Pharmacy Drugs and Medicines

The Plan will pay benefits for Expense incurred in the same manner as any other Covered Service, subject to the following limitations:

After the Deductible is satisfied, the Plan will pay 80% of the Expense which You and Your Dependent incurred for Specialty Pharmacy Drugs and Medicines.

Specialty Pharmacy Drugs and Medicines means drugs or injectables included on United of Omaha's list of Specialty Pharmacy Drugs and Medicines for patients who have received an organ transplant or have conditions such as HIV/AIDS, diabetes, growth hormone deficiencies and other conditions which may qualify for Case Management Program.

Skilled Nursing Facility Services

The Plan will pay benefits for Expense incurred in the same manner as any other Covered Service, subject to the following limitations:

Room Limit:

After the Deductible is satisfied, the Plan will pay 80% of the Expense incurred each Calendar Year for the daily room charges of the Skilled Nursing Facility where the Covered Person is Confined, up to a Maximum Allowable Amount of \$200 per day.

Maximum Number of Days: The Maximum Number of Days payable will not exceed 100 days each Calendar Year.

Home Health Care Services

The Plan will pay benefits for Expense incurred in the same manner as any other Covered Service, subject to the following limitations:

Home Health Care

Each Visit Payment: After the applicable Deductible is satisfied, the Plan will pay 80% of the Expense incurred, up to a Maximum Allowable Amount of \$55 for Each Visit Payment.

The Maximum Number of Visits for which benefits are payable each Calendar Year will not exceed 100 each Calendar Year.

Hospice Care Services (inpatient and outpatient)

The Plan will pay benefits for Expense incurred in the same manner as any other Covered Service, subject to the following limitations:

Hospice Care

Inpatient

After the applicable Deductible is satisfied, the Plan will pay 80% of the Expense incurred, up to a Maximum Allowable Amount of \$55 per day.

Inpatient Daily Limit: The daily room charge of the Hospice Care Facility or other facility where the Covered Person is confined.

Outpatient

After the applicable Deductible is satisfied, the Plan will pay 80% of the Expense incurred, up to a Maximum Allowable Amount of \$55 for each visit.

Maximum Number of Days and Visits

The combined Maximum Number of Days and Visits for which benefits are payable will not exceed 185.

Covered Counseling and Bereavement Services

Maximum Counseling Benefit: \$500 for all members of the Covered Person's Immediate Family combined.

Maximum Bereavement Counseling Benefit: \$250 for all members of the Covered Person's Immediate Family combined.

Spinal Treatment (nonsurgical) Services

The Plan will pay benefits for Expense incurred in the same manner as any other Covered Service, subject to the following limitations:

Maximum Spinal Treatment (nonsurgical) Benefit

After the applicable Deductible is satisfied, the Plan will pay 80% of the Expense incurred for Covered Services for nonsurgical Spinal Treatment, but not to exceed:

- (a) the Maximum Allowable Amount of \$25 each visit; and
- (b) a maximum of 30 visits each Calendar Year.

Qualified Organ(s)/Tissue Transplant Services

The Plan will pay benefits for Expense incurred in the same manner as any other Covered Service, subject to the following limitations:

Maximum Recipient Benefit

For the Medical Specialty Network Providers (**MSN**): Not Covered. Refer to the In-Network Schedule of Benefits.

For Other than a Medical Specialty Network provider: After the applicable Deductible is satisfied, the Plan will pay 80% of the Expense incurred for Covered Services.

Maximum Donor Benefit

For each period of Hospital Confinement in connection with Transplant Surgery the Plan will pay \$5,000.

United of Omaha's program for Organ(s)/Tissue transplants is called the **Medical Specialty Network**.

The **MSN** consists of certain providers throughout the United States with whom United has contracted or made arrangements with to provide Organ(s)/Tissue Transplants.

The Plan will work with You and Your Physician to determine which of the **MSN** providers is available for Your or Your dependent's type of transplant.

If a Qualified Organ/Tissue Transplant is Medically Necessary and performed at a **MSN** You may be eligible for benefits related to Expenses for travel, lodging and meals for the transplant Recipient and one family member or Caregiver. United of Omaha may also assist You and one family member or Caregiver with travel and lodging arrangements.

Routine Physical Exam Services (For Covered Persons age 18 or older)

The Plan will pay benefits for Expense incurred in the same manner as any other Covered Service, subject to the following limitations:

Maximum Exam Benefit

After the applicable Deductible is satisfied, the Plan will pay 80% of the Expense incurred for Covered Services for a routine physical exam, up to \$200 each Calendar Year.

Routine Mammography Benefit

The Plan will pay benefits for Expense incurred in the same manner as any other Covered Service, subject to the following limitations:

Maximum Routine Mammography Benefit

The Plan will pay 100% of the Expense incurred for Covered Services.

Preventive Health Care Services (For Dependent Children through age 17)

The Plan will pay benefits for Expense incurred in the same manner as any other Covered Service, subject to the following limitations:

Maximum Medical Benefit

After the applicable Deductible is satisfied, the Plan will pay 80% of the Expense incurred for preventive health care, up to \$200 each Calendar Year.

Covered Childhood Immunization Services (For Dependent Children through age six)

The Plan will pay benefits for Expense incurred in the same manner as any other Covered Service, subject to the following limitations:

Maximum Inoculation Benefit

The Plan will pay 100% of the Expense incurred for Covered Services received for Childhood Immunizations.

Mental and Nervous Disorders Benefits

The Plan will pay benefits for Expense incurred in the same manner as any other Covered Service, subject to the following limitations:

Mental and Nervous Disorders

Maximum Inpatient Benefit (for Hospital Confinement)

Covered Hospital Services:

After the applicable Deductible is satisfied, the Plan will pay 80% of the Expense incurred.

All Other Covered Services:

After the applicable Deductible is satisfied, the Plan will pay 80% of the Expense incurred each Calendar Year. Benefits for visits by a Physician are payable only during the period of time that benefits for the Hospital Confinement are payable.

Maximum Inpatient Benefits will not be payable for more than 30 days each Calendar Year. Benefits will not be payable for more than 60 days while You or Your dependents are covered under the Plan.

Maximum Outpatient Benefit

After the applicable Deductible is satisfied, the Plan will pay 80% of the Expense incurred each Calendar Year.

Maximum Outpatient Benefits will not exceed 50 visits during any Calendar Year.

Alcohol and Drug Abuse and/or Substance Abuse Benefits

The Plan will pay benefits for Expense incurred in the same manner as any other Covered Service, subject to the following limitations:

Maximum Inpatient Benefit (for Hospital Confinement)

Covered Hospital Services:

After the applicable Deductible is satisfied, the Plan will pay 80% of the Expense incurred.

All Other Covered Services:

After the applicable Deductible is satisfied, the Plan will pay 80% of the Expense incurred.

Maximum Inpatient Benefits will not be payable for more than 30 days each Calendar Year. Benefits will not be payable for more than 60 days while You or Your dependents are covered under the Plan.

Maximum Outpatient Benefit

After the applicable Deductible is satisfied, the Plan will pay 50% of the Expense incurred each Calendar Year. The Maximum Allowable Amount for an Outpatient Treatment visit is \$70.

Maximum Outpatient Benefits will not exceed 50 visits each Calendar Year.

Maximum Alcohol and Drug Abuse and/or Substance Abuse Benefit

Maximum inpatient and outpatient benefits will not exceed \$20,000 while covered under the Plan, and not more than \$10,000 each Calendar Year for each Covered Person.

Cross Allocation Provision

Benefit Limitations and Maximums

Unless otherwise specifically shown in this Plan, Covered Services received under any of the benefit options (the **In-Network** Benefit option underwritten by Exclusive Healthcare, Inc. and the **Out-of-Network** Benefit option underwritten by United) will be used to satisfy benefit limitations or maximums under each of the benefit options. In no event will coverage be provided for the same services or supplies under more than one benefit option.

Copayments and Out-of-Pocket Expenses

Only the Expense incurred for a **In-Network** Covered Service will satisfy the **In-Network** Benefit option copayments; only the Expense incurred for an **Out-of-Network** Benefit Covered Service may be used to satisfy any **Out-of-Network** Benefit option Deductibles and coinsurance and/or copayments.

However, when the In-Network Benefits and **Out-of Network** Benefits are both subject to Deductibles and Coinsurance, the same Expense may be used to satisfy any **In-Network** and **Out-of-Network** Deductibles and Coinsurance.

MAJOR MEDICAL BENEFITS

For You and Your Dependents

Benefits

If You or Your dependent, while covered under this provision, incurs Expense for Covered Services described in this provision because of an Injury or Sickness, the Plan will pay a percentage of that Expense (Percentage Payable) after the applicable Deductible and Copayments are satisfied. Consideration of benefits is subject to all terms of the Plan including, but not limited to, all Definitions and General Exclusions and Limitations. Please refer to the Table of Contents in the Booklet to locate these provisions. The Plan will pay up to the Maximum for each Covered Person. The **Percentage Payable, Deductible and Maximum** are shown in the **Schedule** included in this Booklet.

Covered Services

1. Covered Hospital Services

- (a) Hospital room and board, up to the **Room Limit** shown in the **Schedule**;
- (b) Hospital services and supplies used when benefits are payable under (a) above;

Hospital charges for the services of a Physician, private duty nurse or other practitioner are not covered under (a) or (b) above.

- (c) inpatient rehabilitation therapy services, up to the **Maximum Inpatient Rehabilitation Facility Benefits** shown in the **Schedule**;
- (d) Hospital outpatient services in connection with:
 - (1) a surgical operation; or
 - (2) emergency treatment after an Injury; and
- (e) preadmission tests only if:
 - (1) the Covered Person's Physician determines before the tests are performed that Hospital Confinement is required;
 - (2) the tests are performed:
 - a. on an outpatient basis; and
 - b. in connection with a Hospital Confinement which is a Covered Service;
 - (3) the tests would be Covered Services if performed during Hospital Confinement; and
 - (4) the Hospital where the Covered Person is confined:
 - a. accepts the tests in lieu of tests which would have been performed during Hospital Confinement; and
 - b. does not repeat the tests upon admission (unless the Covered Person's medical record shows both the results of the preadmission tests and that repeated tests are Medically Necessary).

2. Covered Surgical Services

- (a) Physician's services for a surgical operation, or the repair of a dislocation or fracture, including the services of an assisting surgeon;
- (b) administration of anesthesia by persons not employed by the Hospital; or
- (c) second opinion on the need for surgery when:
 - (1) the opinion is given by a Physician who:
 - a. is certified by the American Board of Medical Specialties, or another specialty board acceptable to Us, in a field related to the proposed surgery; and
 - b. is not the same Physician who first advised or recommended the surgery;
 - (2) the Physician makes a personal exam of the Covered Person; and
 - (3) the Physician sends Us a written description of his/her opinion.

3. Other Covered Services (if not included in 1 or 2 above)

- (a) Hospital outpatient services;
- (b) Physician's services for medical care;
- (c) outpatient therapy services for physical, occupational or speech therapy provided by a licensed therapist are payable up to the **Maximum Number of Outpatient Therapy Visits** shown in the **Schedule**;
- (d) ambulance services for:
 - (1) professional ambulance service when:
 - a. transportation is Medically Necessary; and
 - b. transportation is to the nearest Hospital equipped to furnish the services; and
 - (2) transportation within the United States by a professional ambulance or on a regularly scheduled flight on a commercial airline when:
 - a. such transportation is Medically Necessary; or
 - b. special and unique Hospital Covered Services are required which are not provided by a local Hospital; and
- (e) the following services and supplies:
 - (1) drugs and medicines requiring a Physician's written prescription, including Specialty Pharmacy Drugs and Medicines;
 - (2) x-ray and laboratory service;
 - (3) oxygen and the rental of equipment for its administration;
 - (4) blood, blood products or blood plasma and its administration;
 - (5) radium, radioactive isotopes and x-ray therapy, casts, splints, braces, trusses and crutches;
 - (6) purchase or rental, not to exceed the purchase price (except for oxygen and its administration) of Durable Medical Equipment used for the treatment of an Injury or Sickness, up to the **Maximum Durable Medical Equipment Benefit** shown in the **Schedule**;
 - (7) artificial limbs and eyes to restore or replace mobility of natural limbs and eyes up to the **Maximum Prosthetic Benefit** shown in the **Schedule**;
 - (8) initial placement of contact lenses required because of cataract surgery and lens implant required because of cataract surgery; and

- (9) dental services by a Physician or Dentist for the treatment of a Dental Injury to Sound Natural Teeth (including the initial replacement of the injured teeth and any necessary dental x-rays), provided the treatment plan begins within 90 days of the Injury and is completed within one year after the Injury.

Definitions (applicable to Other Covered Services)

Dental Injury means an accidental Injury to Sound Natural Teeth which is the direct result of a sudden, unexpected and unintended external force, such as a blow or fall, that requires treatment by a Physician or Dentist. It must be independent of Sickness or any other causes. It does not include tooth breakage while biting or chewing.

Durable Medical Equipment means Medically Necessary equipment that is:

- (a) able to withstand repeated or prolonged use;
- (b) primarily and customarily used to serve a medical purpose;
- (c) not generally useful to a person in the absence of Injury or Sickness; and
- (d) is suited for use in the home.

Durable Medical Equipment includes supplies that are necessary for use with the equipment.

Durable Medical Equipment does not include motor vehicles or any modifications that do not serve a direct medical purpose in treating an Injury or Sickness, including but not limited to:

- (a) modifications/assistive devices for motor vehicles (not including motorized wheelchairs or scooters used in lieu of wheelchairs); or
- (b) internal or external structural modifications to buildings, widening of doorframes, replacement doors, ramps, modifications to walkways, stairs or non-bathroom hand-rails.

High End Radiology means a magnetic resonance imaging (MRIs) CT Scans, PET Scans, SPECT Scans, ultrasounds and other nuclear radiology.

Sound Natural Teeth means teeth which:

- (a) are whole or properly restored;
- (b) are without impairment or periodontal disease; and
- (c) are not in need of the treatment provided for reasons other than Dental Injury.

Specialty Pharmacy Drugs and Medicines means drugs or injectables included on United of Omaha's list of Specialty Pharmacy Drugs and Medicines for patients who have received an organ transplant or have conditions such as HIV/AIDS, diabetes, growth hormone deficiencies and other conditions which may qualify for Our Case Management Program.

NOTE: The current list of Specialty Pharmacy Drugs and Medicines may be obtained by calling United's Care Review Unit at 1-800-467-4917. This list is subject to periodic review and modification.

4. **Covered Skilled Nursing Facility Services**

Room and board, up to the **Room Limit** and **Maximum Number of Days** shown in the **Schedule** for a period of confinement in a Skilled Nursing Facility.

Conditions

The Plan will pay benefits for Skilled Nursing Facility services only if:

- (a) the confinement is under the supervision of a Physician;
- (b) Hospital Confinement would be necessary in the absence of Skilled Nursing Facility confinement; and
- (c) the confinement is not considered to be Custodial Care by Us.

Skilled Nursing Facility means a facility licensed or certified by the jurisdiction in which it is located, or eligible for payment under Medicare, that provides continuous inpatient skilled nursing care.

5. **Covered Home Health Care Services**

Covered home health care services consist of:

- (a) nursing care provided on a part-time basis (less than an eight-hour shift) in a home by:
 - (1) a registered nurse (RN); or
 - (2) a licensed practical nurse; and
- (b) part-time or intermittent Home Health Aide services provided in a home:
 - (1) by a Home Health Aide; and
 - (2) under the supervision of a registered nurse.

Benefits for home health care services are payable up to the **Maximum Number of Visits**, but not to exceed the **Each Visit Payment**, for each home health care visit. The **Maximum Number of Visits** and **Each Visit Payment** are shown in the **Schedule**.

One home health care visit consists of:

- (a) one visit for the services listed; or
- (b) up to four consecutive hours for Home Health Aide services.

Conditions

Home health care services must be provided by a person other than You, a person who lives in Your home or a member of Your family (Your spouse; or a child, brother, sister or parent of You or Your spouse); and covered home health care services and supplies must be ordered and directed by a Physician and furnished:

- (a) in a private home;
- (b) by a Home Health Agency; and
- (c) in accordance with a Home Health Care Plan.

6. Covered Hospice Care Services

Hospice Care Services can provide the physical, psychological, spiritual or social support needed to help Terminally Ill Covered Persons cope with their Sickness. Hospice Care Services include services provided in accordance with a Hospice Care Plan in a private home, a Hospital or Hospice Care Facility. Benefits are payable as long as they are prescribed or ordered by a Physician and the Covered Person is Terminally Ill.

Benefits for inpatient Hospice Care Services will be payable:

- (a) when Medically Necessary; and
- (b) when there are no suitable Caregivers; or
- (c) when it is determined by the Hospice Agency that Hospice care in a home is impractical because the patient is unmanageable by the persons who regularly assist with home care; or
- (d) for Respite Care.

Benefits for outpatient Hospice Care Services will be payable:

- (a) when Medically Necessary;
- (b) for nursing care provided on a part-time basis (less than an eight-hour shift) by:
 - (1) a registered nurse (RN); or
 - (2) a licensed practical nurse; and/or
- (c) for part-time or intermittent Home Health Aide services provided:
 - (1) by a Home Health Aide; and
 - (2) under the supervision of a registered nurse.

Hospice Care Services are payable up to the **Maximum Number of Days and Visits** shown in the **Schedule**.

Condition

Hospice Care Services must be provided by a person other than You, a person who lives in Your home or a member of Your family (Your spouse; or a child, brother, sister or parent of You or Your spouse).

7. Covered Counseling and Bereavement Services

When benefits for Hospice Care Services are payable, the Plan will also pay benefits for the Expense incurred for:

- (a) counseling of the Covered Person and his or her Immediate Family, but not to exceed the **Maximum Counseling Benefit** shown in the **Schedule**; and
- (b) Bereavement Counseling of the Covered Person's Immediate Family, but not to exceed the **Maximum Bereavement Counseling Benefit** shown in the **Schedule**.

Benefits for counseling and Bereavement Counseling for the Covered Person's Immediate Family members are payable whether or not the family members are covered under the Plan.

Benefits for Bereavement Counseling will be paid even if coverage ends before the counseling is received.

Condition

Counseling and Bereavement Counseling must be rendered by a Physician, psychologist or social worker.

Definitions (applicable to Home Health Care and/or Hospice Care Services)

Bereavement Counseling means counseling for the social, psychological and spiritual needs of the Immediate Family to cope with the loss of a Terminally Ill Covered Person.

Caregiver means a person not associated with the Hospice Agency who resides in the Covered Person's home and provides nonmedical services and companionship. This may not be a family member.

Home Health Agency means a public or private agency or organization appropriately licensed, qualified and operated under the law of the jurisdiction in which it is located.

Home Health Aide means a person who:

- (a) provides care of a therapeutic nature; and
- (b) reports to and is under the direct supervision of a Home Health Agency.

Home Health Care Plan means a written plan, approved in writing by a Physician, for continued care and treatment of a Covered Person:

- (a) who is under the care of a Physician; and
- (b) who would need continued Hospital Confinement or Skilled Nursing Facility confinement without the home health care.

Hospice means a program that:

- (a) provides care to the Terminally Ill;
- (b) is licensed/certified by the jurisdiction in which it operates;
- (c) is supervised by a staff of Physicians with at least one Physician on call 24 hours a day;
- (d) provides 24-hour a day nursing services under the direction of a registered nurse (RN) and has a full time administrator; and
- (e) provides an ongoing quality assurance program.

Hospice Agency means a public or private agency or organization which administers and provides Hospice Care Services or operates a Hospice.

Hospice Care Facility means a facility providing Hospice Care Services which is appropriately licensed or certified as such under the law of the jurisdiction in which it is located, and which:

- (a) is certified (or is qualified and could be certified) under Medicare;
- (b) is accredited by the Joint Commission on the Accreditation of Healthcare Organizations; or
- (c) meets the standards established by the National Hospice Organization.

Hospice Care Plan means a coordinated, interdisciplinary program to meet the physical, psychological and social needs of Terminally Ill Covered Persons and their families:

- (a) by providing palliative (pain controlling) and supportive medical, nursing and other health services; and
- (b) through home, Hospice, Hospice Care Facility or inpatient Hospital care during the Sickness or bereavement.

Hospice Care Services means any services provided:

- (a) under a Hospice Care Plan; and
- (b) by a Hospital, Hospice Agency, Hospice Care Facility or other facility licensed by the proper authority in the jurisdiction to operate the Hospice.

Immediate Family means the Covered Person's:

- (a) spouse and children; or
- (b) parents, brothers and sisters, in the case of a Terminally Ill dependent child.

Respite Care means a short-term inpatient stay which is necessary for the Covered Person in order to give temporary relief to a Caregiver who regularly assists the Covered Person with home health care. Inpatient Respite Care is limited each time to a stay of no more than five days in a row.

Terminally Ill means a Covered Person is:

- (a) determined by a Physician to have a terminal Sickness with no reasonable prospect of cure; and
- (b) expected by a Physician to have less than six months to live.

Exceptions (applicable to Home Health Care Services and/or Hospice Care Services)

The Plan will not pay benefits for:

- (a) services and supplies which are not part of a Home Health Care Plan or Hospice Care Plan;
- (b) services of a Caregiver or other person who lives in Your home or is a member of Your family (Your spouse; or a child, brother, sister or parent of You or Your spouse);
- (c) domestic or housekeeping services that are unrelated to the Covered Person's care;
- (d) services that provide a protective environment when no skilled service is required (such as companionship or sitter services); or
- (e) services which are not directly related to the Covered Person's medical condition, including, but not limited to:
 - (1) estate planning, drafting of wills or other legal services;
 - (2) pastoral counseling or funeral arrangements or services;
 - (3) nutritional guidance or food services such as "meals on wheels"; or
 - (4) transportation services.

8. Covered Spinal Treatment (nonsurgical) Services

If You or Your dependent incurs Expense for nonsurgical Spinal Treatment by a Physician, the Plan will pay benefits up to the **Maximum Spinal Treatment (nonsurgical) Benefit** shown in the **Schedule**.

Spinal Treatment means detection or nonsurgical correction (by manual or mechanical means) of a condition of the vertebral column including:

- (a) distortion;
- (b) misalignment; or
- (c) subluxation;

to relieve the effects of nerve interference which results from or relates to any such condition of the vertebral column.

9. Covered Qualified Organ(s)/Tissue Transplant Services

If You or Your dependent incurs Expense for a Qualified Organ(s)/Tissue Transplant, the Plan will pay benefits for the following:

- (a) **Recipient:** Expense incurred by a Recipient up to the **Maximum Recipient Benefit** shown in the **Schedule** for:
 - (1) the use of temporary mechanical equipment, pending the acquisition of “matched” human organ(s)/tissue;
 - (2) multiple transplants during one operative session;
 - (3) replacement(s) or subsequent transplant(s); and
 - (4) follow-up Expense for items (1) through (3) above (including immunosuppressive therapy).
- (b) **Donor:** Expense incurred by a Donor(s) up to the **Maximum Donor Benefit** shown in the **Schedule** for:
 - (1) testing to identify suitable Donor(s);
 - (2) acquisition of human organ(s)/tissue from a Donor;
 - (3) life support of a Donor pending the removal of a usable human organ(s)/tissue;
 - (4) transportation for a living Donor; and
 - (5) transportation of human organ(s)/tissue or a Donor on life support.

Benefits under item (b) are payable only when the Recipient is a Covered Person.

- (c) **Medical Specialty Network Option (MSN):** Additional benefits for Covered Services provided by the MSN are shown in the **Schedule**.

Conditions

The Plan must be notified of the transplant at least seven days before the scheduled transplant date, or as soon as reasonably possible prior to the transplant date for any of the following:

- (a) the evaluation of the Recipient; and
- (b) testing to identify suitable Donors.

Definitions (applicable to Covered Qualified Organ(s)/Tissue Transplant Services)

Donor means a person who undergoes a surgical operation for the purpose of donating a human organ(s)/tissue for Transplant Surgery to a Recipient.

Qualified Organ(s)/Tissue Transplants means transplants for any of the following:

- (a) cornea;
- (b) heart;
- (c) lung;
- (d) heart/lung;
- (e) liver;
- (f) kidney;
- (g) pancreas;
- (h) kidney/pancreas; and
- (i) bone marrow/peripheral stem cell transplants.

Recipient means a Covered Person who undergoes a surgical operation to receive a human organ(s)/tissue transplant.

Transplant Surgery means transfer of a human organ(s)/tissue from the Donor to the Recipient.

Exceptions (applicable to Covered Qualified Organ(s)/Tissue Transplant Services)

The Plan will not pay benefits for:

- (a) any Expense for Transplant Surgery when approved alternative remedies are available;
- (b) any animal organ;
- (c) any mechanical organ(s) except as provided under Section 9. Covered Qualified Organ/Tissue Transplant Services, item (a) (1) above; or
- (d) any financial consideration to the Donor other than benefits for Expense which is necessary in the performance of or relation to Transplant Surgery.

10. Covered Routine Physical Exam Services

If You or Your dependent has a routine physical exam, including diagnostic tests and immunizations performed in:

- (a) a Hospital outpatient department; or
- (b) a Physician's office or clinic;

the Plan will pay benefits for the Expense incurred for such exam, but not to exceed the **Maximum Exam Benefit** shown in the **Schedule**.

Exception (Applicable to Covered Routine Physical Exam Services)

The Plan will not pay benefits for a routine physical exam performed during a Hospital Confinement.

11. Covered Routine Mammography Services

If, a Covered Person who is age 35 or over incurs Expense for Routine Mammography, the Plan will pay the **Maximum Routine Mammography Benefit** as shown in the **Schedule**, but not to exceed one mammogram each Calendar Year.

Definition

Routine Mammography means a routine x-ray examination of the breast.

12. Breast Reconstruction Benefits

If You or Your dependent is receiving benefits in connection with a mastectomy, the Plan will pay the expense incurred for the following services in the same manner and subject to the same condition and limitations any other covered service:

- (a) reconstruction of the breast on which the mastectomy has been performed;
- (b) surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- (c) prostheses and physical complications of all stages of the mastectomy, including lymphedemas.

Such services are to be provided in a manner determined in consultation with the attending physician and the patient.

Exception

The Plan will not pay for anything excluded under the General Exclusion and Limitations; however, any exclusion for cosmetic or reconstructive surgery will not apply to services covered under this provision.

13. Covered Preventive Health Care Services

(For Dependent Children Through the Age Limit Shown in the Schedule)

If Your dependent child receives preventive health care services from a Physician (other than Childhood Immunization Services) in:

- (a) a Hospital outpatient department; or
- (b) a Physician's office or clinic;

the Plan will pay benefits for the Expense incurred for such services, but not to exceed the **Maximum Medical Benefit** shown in the **Schedule**.

Exception (applicable to Preventive Health Care Services Benefits)

The Plan will not pay benefits for preventive health care services performed during a Hospital Confinement.

14. Covered Childhood Immunization Services

(For Dependent Children Through the Age Limit Shown in the Schedule)

If Your dependent child receives Childhood Immunization Services, the Plan will pay benefits for the Expense incurred for such services, but not to exceed the **Maximum Inoculation Benefit** shown in the **Schedule**. No Deductible will apply.

Definition

Childhood Immunization Services means the complete set of vaccinations for children as recommended by the American Academy of Pediatrics or the Advisory Committee on Immunization Practices. The vaccinations include (but are not limited to) immunizations against measles, mumps, rubella, poliomyelitis, diphtheria, pertussis, tetanus, haemophilus influenzae type b and hepatitis-B.

15. Mental And Nervous Disorders Benefits:

Definitions

For purposes of this provision, the following terms have the following meanings:

Inpatient Treatment means Covered Services provided by a Physician for treatment of a Mental and Nervous Disorder during Hospital Confinement and while under 24-hour Physician supervision.

Outpatient Treatment means any Covered Service for treatment of a Mental and Nervous Disorder of less than 24-consecutive-hours, regardless of how it is classified.

Mental and Nervous Disorders Benefits

If You or Your dependent, while covered under this provision, is treated for a Mental and Nervous Disorder, the Plan will pay benefits as follows:

- (a) up to the **Maximum Inpatient Benefit** shown in the **Schedule** for Expense incurred for Inpatient Treatment; or
- (b) up to the **Maximum Outpatient Benefit** shown in the **Schedule** for Expense incurred for Outpatient Treatment based on a written plan approved and supervised by a Physician.

Exceptions

The Plan will not pay Mental and Nervous Disorder benefits for:

- (a) the following conditions, diagnoses or therapies:
 - (1) conduct disturbances unless related to a coexisting condition or diagnosis for which benefits are payable;
 - (2) educational, vocational and/or recreational services;
 - (3) biofeedback for treatment of diagnosed medical conditions;
 - (4) treatment for learning disabilities;
 - (5) pervasive developmental disorders (other than diagnostic evaluation), including but not limited, to:
 - a. autistic disorders;
 - b. Rett's Disorder; and
 - c. Asperger's Disorder;
- (b) treatment which We determine to be for the Covered Person's personal growth or enrichment; or

(c) court ordered placements when such placements are not determined to be Medically Necessary.

16. Alcohol And Drug Abuse And/Or Substance Abuse Benefits

Definitions

For the purposes of this provision, the following terms have the following meanings:

Inpatient Treatment means Covered Services for the treatment of Alcohol and Drug Abuse, and/or Substance Abuse that are provided during Hospital Confinement and while under 24-hour Physician supervision.

Outpatient Treatment means any Covered Service for treatment of Alcohol and Drug Abuse and/or Substance Abuse of less than 24-consecutive-hours, regardless of how it is classified.

Alcohol and Drug Abuse and/or Substance Abuse

If You or Your dependent, while covered under this provision, is treated for Alcohol and Drug Abuse and/or Substance Abuse, the Plan will pay benefits as follows:

- (a) up to the **Maximum Inpatient Benefit** shown in the **Schedule** for Expense incurred for Inpatient Treatment; or
- (b) up to the **Maximum Outpatient Benefit** shown in the **Schedule** for Expense incurred for Outpatient Treatment based on a written plan approved and supervised by a Physician.

Exception

The Plan will not pay Alcohol and Drug Abuse and/or Substance Abuse benefits for court ordered placements when such orders are not determined to be Medically Necessary.

17. 48-Hour Maternity Benefits

If, while covered under this provision, You or Your dependent are confined to a hospital as a resident inpatient for childbirth, the Plan will pay benefits in the same manner and subject to the same conditions and limitations as any other sickness, but, in no event, will benefits be provided for less than:

- (a) 48 hours following a vaginal delivery; or
- (b) 96 hours following a cesarean section;

for the mother and the newborn infant(s), unless the attending physician, in consultation with the mother, recommends an earlier discharge.

In the event such earlier discharge occurs, a follow-up visit by a registered nurse will be available to the mother, and payable in the same manner and subject to the same conditions and limitations as any other covered service.

Exception

The Plan will not pay for anything excluded under the General Exclusions and Limitations.

18. Birthing Center Benefits

Definitions

Birthing Center means a facility which is equipped and operated solely to provide prenatal care; to perform uncomplicated, spontaneous deliveries; and to provide immediate post-partum care. A Birthing Center must either be licensed by the state or must satisfy all of the following:

- (a) be directed by at least one (1) Physician specializing in obstetrics or gynecology;
- (b) have a Physician or Nurse Midwife present during each birth;
- (c) provide skilled nursing services in the delivery and recovery rooms (under the direction of an RN or Nurse Midwife);
- (d) have at least two (2) birthing rooms or beds, diagnostic x-ray and lab equipment (or a contract to use that of an area medical facility), and emergency equipment;
- (e) admit only patients with low-risk pregnancies (and contract with an area Hospital for transfer of emergency cases); and
- (f) regularly charge patients for services and supplies.

Nurse Midwife means a person who is:

- (a) certified by the American College of Nurse Midwives; or
- (b) licensed as such by the state where services are rendered.

Benefits

If a Covered Person incurs Expense for Birthing Center services, the Plan will pay the Expense incurred in the same manner and subject to the same conditions and limitations as any other Covered Service.

19. Breast Reconstruction Benefits

If, while covered under this provision, a Member is receiving benefits in connection with a mastectomy, the Plan will pay the expense incurred for the following service in the same manner as subject to the same conditions and limitations as any other covered service:

- (a) reconstruction of the breast on which the mastectomy has been performed;
- (b) surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- (c) prostheses and physical complications of all stages of the mastectomy, including lymphedemas.

Such services are to be provided in a manner determined in consultation with the attending physician and the patient.

Any exclusion for cosmetic or reconstructive surgery will not apply to services covered under this provision.

20. **Diabetes Benefit**

If You or Your dependent, while covered under this provision, requires equipment, supplies, medication, and outpatient self-management training and Patient Management, including medical nutritional therapy for the treatment of:

- (a) insulin-dependent diabetes;
- (b) insulin-using diabetes;
- (c) gestational diabetes; and
- (d) non-insulin using diabetes,

benefits will be paid as described in the Conditions below.

Conditions

The following equipment, supplies and medications will be paid in the same manner and subject to the same conditions and limitation as any other Covered Service:

- (a) blood glucose monitors;
- (b) blood glucose monitors for the legally blind;
- (c) injection aids;
- (d) insulin pumps and all supplies for the pump;
- (e) insulin infusion devices;
- (f) insulin measurement and administrative kits for the visually impaired;
- (g) Patient Management material that provide essential diabetes self-management information; and
- (h) podiatric appliances for the prevention of complications associated with diabetes.

The following equipment, supplies and medications will be paid in the same manner and subject to the same conditions and limitations as any other outpatient prescription drug:

- (a) test strips for glucose monitors;
- (b) urine test strips;
- (c) insulin;
- (d) lancet and lancet devices;
- (e) syringes;
- (f) oral agents for controlling blood sugars; and
- (g) glucose agents and glucagon kits.

Benefits will be paid:

- (a) upon the diagnosis of diabetes;
- (b) when a significant change occurs in symptoms or condition that necessitates a change in self-management; or

(c) when refresher Patient Management is necessary.

Benefits include Medically Necessary home visits and Patient Management conducted individually or in a group setting.

Diabetes self-management training and Patient Management, including medical nutrition therapy, must be provided by:

- (a) an American Diabetes Association Recognized Diabetes Self-Management Education Program; or
- (b) a health care professional that is a diabetes educator certified by the National Certification Board for Diabetes Educators.

Diabetes self-management training and Patient Management is covered:

- (a) at diagnosis;
- (b) when symptoms or conditions change; and
- (c) when new medications or treatments are prescribed.

Benefits for diabetes self-management education shall not exceed \$500 in any two year calendar period.

Exceptions

The Plan will not pay for:

- (a) any Expense which is paid under any other provision of the Plan; or
- (b) anything excluded under the Exclusions and Limitations, except that, for the purposes of this provision, any exclusion for charges for orthopedic shoes, orthotics or other supportive devices for the feet will not apply.

21. Colorectal Cancer Screening Benefits

If a Covered Person undergoes a colonoscopy or sigmoidoscopy, the Plan will pay the Expense incurred in the same manner and subject to the same conditions and limitations as any other Covered Service.

Exceptions (applicable to all Major Medical Benefits)

The Plan will not pay benefits for:

- (a) any treatment, service or supply unless it is shown under Covered Services;
- (b) extraction of teeth or other dental work or surgery for any reason which involves any tooth or tooth structure, alveolar process, abscess or periodontal disease or disease of the gingival tissue, except as provided under Other Covered Services;
- (c) contact lenses, except as provided under Other Covered Services;
- (d) routine eye refractions or the fitting or cost of visual aids, eyeglasses, vision therapy, radial keratotomy or similar surgery done for the correction of any refraction error or astigmatism, except for corneal graft;

- (e) the fitting or cost of hearing aids and related supplies;
- (f) services provided by a person who lives with You in Your home or is a member of Your family (Your spouse; or a child, brother, sister or parent of You or Your spouse);
- (g) nonsurgical Spinal Treatment, except as specifically provided in the Plan;
- (h) Alcohol and Drug Abuse and/or Substance Abuse, except as specifically provided in the Plan;
- (i) Mental and Nervous Disorders, except as specifically provided in the Plan;
- (j) body organ(s)/tissue transplants, except as specifically provided in the Plan;
- (k) any Expense which is paid under any other provision of the Plan; and
- (l) anything excluded under the General Exclusions and Limitations provision in this Booklet.

UTILIZATION MANAGEMENT PROVISIONS

UTILIZATION REVIEW

Utilization Review Procedures are only intended to determine if health care services or supplies are Medically Necessary under the terms of the Plan.

Before the services or supplies are received, all Hospital Confinements, Outpatient Surgical Procedures and Specialized Services and Supplies identified in these provisions must be pre-certified by United as Medically Necessary. **You, not Your Physician, are responsible for making sure pre-certification occurs.** However, You, Your representative or Your Physician may initiate the pre-certification.

Pre-certification of a proposed service or supply as Medically Necessary through the Utilization Review process does not necessarily mean that benefits are payable. Confirmation of a person's eligibility for Plan coverage for a particular service or supply, and fulfillment of all other Plan requirements, are also necessary for benefits to be payable.

Definitions

Care Review Unit means United of Omaha's Care Review Unit staff or a qualified party or entity named by them. For the Care Review Unit's toll-free phone number, refer to Your identification card or contact Your Plan Administrator.

Outpatient Surgical Procedures means the outpatient surgical procedures listed below which are performed:

- (a) in an ambulatory surgical facility;
- (b) in a Physician's office or clinic; or
- (c) on an outpatient basis in a Hospital.

Outpatient surgical procedures include:

- (a) carpal tunnel release - surgery to relieve a pinched nerve in the hand;
- (b) cochlear implants - insertion of small computer device to transmit to the auditory nerve;
- (c) endometrial ablations - complete removal of the lining of the uterus;
- (d) hysterectomy - surgical removal of the uterus;
- (e) knee arthroscopy - (diagnostic only) an examination of the inside of the knee;
- (f) pelvic laparoscopy - examination of the female organs by a scope;
- (g) tonsillectomy with/without adenoidectomy - surgical removal of the tonsil and adenoids;
- (h) tympanostomy tube insertion - an operation to place drainage tubes in the ear; and
- (i) UPP (uvulopalatopharyngoplasty) or laparoscope aided UPP - removal of a portion of the uvula and soft palate.

Specialized Services and Supplies means the services or supplies listed below:

- (a) skilled nursing facility confinements;
- (b) home health care;
- (c) hospice care (inpatient and outpatient);
- (d) durable medical equipment: any single piece of durable medical equipment with a purchase price of \$1,000 or more; and
- (e) prosthetics.

Pre-certification Requirements

You must pre-certify the following:

- 1. Hospital Confinement due to a Sickness or Injury;
- 2. Hospital Confinement and partial hospitalization for Mental and Nervous Disorders or Alcohol and Drug Abuse and/or Substance Abuse;
- 3. Outpatient Surgical Procedures; and
- 4. Specialized Services and Supplies.

You, Your representative or Your Physician must request pre-certification from the Care Review Unit. The Care Review Unit will advise You and Your Physician of the review decision.

United recommends pre-certification be initiated at least seven (7) days before the Hospital Confinement, Outpatient Surgical Procedure or Specialized Services and Supplies begin or are received. If not pre-certified at least one (1) business day prior, a penalty will apply.

Within two (2) business days, or as soon as reasonably possible for a Medical Emergency, You, Your representative or Your Physician must notify the Care Review Unit of the Hospital Confinement, the Outpatient Surgical Procedures and/or the Specialized Services or Supplies. If not pre-certified within this time frame, a penalty will apply. The Care Review Unit will advise You and Your Physician of the review decision.

If a visit to a Hospital Emergency room exceeds 24 hours, any additional observation in the emergency room must be pre-certified. This is applicable even if the visit does not result in a Hospital Confinement.

Effect on Benefits

The following penalties will apply if services are not properly pre-certified by United.

- 1. For Hospital Confinement:
 - (a) If a Covered Person incurs Expense for Hospital Confinement or for additional observation in the emergency room exceeding 24 hours without first initiating the required pre-certification, **any benefits payable for the room and board will be reduced by \$500.**

If United's subsequent review determines the additional services were Medically Necessary and United had pre-certified the initial days of confinement or observation, the \$500 penalty will not apply to the additional days of Hospital Confinement.

- (b) For a Hospital Confinement for which pre-certification is requested but which United determined to not be Medically Necessary, room and board will not be payable. Expense for other Covered Services provided during the Hospital Confinement (including x-ray and laboratory services, etc.) will be considered in accordance with applicable Plan provisions.
 - (c) If a Covered Person receives pre-certification from United for a specified number of days of Hospital Confinement and You, Your representative or Your Physician requests additional days, the additional days must be approved by United through the pre-certification procedure as described in the **Pre-certification Requirements** section of this provision. If the additional days are not pre-certified, and a subsequent review by United determines the additional days were not Medically Necessary, the claim will be handled as shown in item (b) above.
2. For Outpatient Surgical Procedures or Specialized Services or Supplies: If a Covered Person undergoes an Outpatient Surgical Procedure or receives a Specialized Service or Supply without first obtaining the required pre-certification, **any benefits payable will be reduced by \$500.**

When benefits are reduced in accordance with this Effect on Benefits section, the reduction will not be used to satisfy any Deductible or Out-of-Pocket Limit shown in the Schedule.

Exceptions

1. Pre-certification is **not** required when the Covered Person has Medicare coverage which:
 - (a) has primary responsibility for the Covered Person's claim; and
 - (b) must pay its full benefits before Plan benefits are paid in accordance with the Medicare Coordination of Benefits provision of the Plan.
2. Pre-certification is **not** required for the initial 48-hour inpatient Hospital Confinement for a vaginal delivery or the 96-hour inpatient Hospital Confinement for a Cesarean section delivery.
3. Pre-certification is **not** required for services or supplies performed or provided, outside the United States, Mexico and Canada or any state, district, province, territory or possession thereof.

Request for an Appeal of the Utilization Review Decision

You, Your representative or Your provider of health care have the right to request an appeal regarding the Utilization Review decisions. The request should be submitted in writing and should include any additional information that may have been omitted from United's review or that should be considered by them. Requests should be sent to:

Mutual of Omaha Companies
Mutual of Omaha Plaza
Medical Management Division
Omaha, Nebraska 68175-5820

You may also call the Care Review Unit's toll-free phone number listed on Your identification card for additional information regarding United's appeal process.

**MENTAL AND NERVOUS DISORDERS, ALCOHOL AND
DRUG ABUSE AND/OR SUBSTANCE ABUSE OUTPATIENT REVIEW**

Outpatient review is required for Outpatient Treatment of a Mental and Nervous Disorder, or Alcohol and Drug Abuse and/or Substance Abuse.

It is Your responsibility to initiate outpatient review. The lack of such a review will result in a reduction of Your benefits as described in this provision.

Pre-certification of Outpatient Treatment as Medically Necessary through the Utilization Review process does not necessarily mean that benefits are payable. Confirmation of a person's eligibility, of Plan coverage for a particular service or supply, and fulfillment of all other Plan requirements are also necessary for benefits to be payable.

Definitions

Care Review Unit means United of Omaha's Care Review Unit staff, or a qualified party or entity named by them. For the Care Review Unit's toll-free number, refer to Your identification card or contact Your Plan Administrator.

Outpatient Treatment means any service for the treatment of a Mental and Nervous Disorder or Alcohol and Drug Abuse and/or Substance Abuse of less than 24-consecutive-hours, regardless of how it is classified.

Treatment Information means the following information, which the attending Physician must provide to the Care Review Unit before treatment may be certified as Medically Necessary under the Plan:

- (a) the diagnosis and reason for the treatment;
- (b) any proposed treatment;
- (c) the expected number and frequency of proposed Outpatient Treatment services; and
- (d) any related information regarding the patient's history, condition and proposed Outpatient Treatment.

Rules for Outpatient Review

- (a) If You or Your dependent is advised by a Physician or voluntarily elects to receive Outpatient Treatment You, Your representative or Your Physician must notify the Care Review Unit by phone at least one (1) business day prior to the third Outpatient Treatment.
- (b) After the Care Review Unit receives the required notice and obtains necessary Treatment Information from the attending Physician, You, the Physician and the provider of the services (if other than the Covered Person's Physician) will be notified of United's review decision.
- (c) Expense incurred for Outpatient Treatment which is certified by the Care Review Unit (or by the Covered Person's primary plan, if any, as determined in accordance with the Coordination of Benefits (COB) provision) as Medically Necessary, will be considered by United for payment of benefits in accordance with applicable Plan provisions.

Effect on Benefits

The following penalties will apply if services are not pre-certified by United.

- (a) For Expense incurred for Outpatient Treatment for which review does not first occur, any benefits payable will be reduced by \$500 for each unreviewed Outpatient Treatment.
- (b) For Expense incurred for Outpatient Treatment for which review does occur but which is not certified as Medically Necessary, benefits for such treatment will not be payable.

When benefits are reduced in accordance with this Effect on Benefits section, the reduction will not be used to satisfy any Deductible or Out-of-Pocket Limit shown in the Schedule.

Exception

1. Pre-certification is **not** required when the Covered Person has Medicare coverage which:
 - (a) has primary responsibility for the Covered Person's claim; and
 - (b) must pay its full benefits before Plan benefits are paid in accordance with the Medicare Coordination of Benefits provision of the Plan.
2. Pre-certification is **not** required for services or supplies performed or provided outside the United States, Mexico and Canada or any state, district, province, territory or possession thereof.

CASE MANAGEMENT PROGRAM

Our **Case Management Program** is a voluntary program intended to provide assistance to Members with certain short-term or catastrophic Injuries or Sicknesses. If a Member participates in the Case Management Program, the Plan will coordinate with the Member's family members and health care providers in the development of a health care treatment plan that is intended to:

- (a) respond to the Member's health care needs; and
- (b) be cost-effective and promote efficient use of Plan benefits.

The proposed health care treatment plan must be approved by Us to ensure that any care provided pursuant to the plan is Medically Necessary, cost-effective and involves efficient use of Plan benefits. The health care treatment plan is also subject to approval by the Member and his or her Physician.

The Case Management Program may be initiated by:

- (a) the Member;
- (b) the Member's family members;
- (c) the Member's Physician; or
- (d) Us.

It is the Member's decision whether or not to participate in Our Case Management Program.

Our Case Management Program does not replace the care received from the Member's Physician. The Member and his or her Physician remain in charge of the Member's health care treatment plan.

Effect on Benefits

Benefits payable for services or supplies provided in accordance with the Case Management Program shall be at least equal to benefits otherwise payable under the Plan. Any such benefits will be subject to the Maximum shown in the Schedule.

Eligible for the Case Management Program

Members with the following Injuries or Sicknesses may participate in Our Case Management Program:

- (a) Acquired Immune Deficiency Syndrome;
- (b) amputations;
- (c) burns;
- (d) central nervous system inflammatory diseases;
- (e) chemotherapy;
- (f) chronic cardiac disease and conditions;
- (g) chronic infections;

- (h) chronic liver disease;
- (i) chronic pulmonary diseases and conditions;
- (j) coagulation defects;
- (k) coma;
- (l) diabetes mellitus and related conditions;
- (m) demyelinating diseases of the central nervous system;
- (n) immune system disorders;
- (o) intestinal disorders;
- (p) intra cranial hemorrhage or occlusion;
- (q) multiple fractures, with or without other system involvement;
- (r) myoneural disorders;
- (s) paralytic disorders;
- (t) radical surgeries;
- (u) renal diseases;
- (v) spinal cord injuries;
- (w) transplants; and
- (x) tumors, malignant or unspecified; or
- (y) any other condition approved by Us to be eligible for the Case Management Program.

PARTIAL HOSPITALIZATION BENEFITS

Definition

For the purposes of this provision, the following term has the following meaning:

Partial Hospitalization means a Hospital stay:

- (a) for a child (a person under age 13) or adolescent (a person age 13 but under age 18): for a minimum of four hours per day or 16 hours over a seven-consecutive-day period; or
- (b) for an adult (a person age 18 or over): for a total of at least 20 hours over a five-consecutive-day period.

Benefits

If, while covered under this provision, You or Your dependent incurs Expense for Partial Hospitalization as a result of a Mental and Nervous Disorder or Alcohol and Drug Abuse and/or Substance Abuse, the Plan will pay benefits for Partial Hospitalization, as follows:

- (a) benefits payable are subject to the same limitations and conditions as for Hospital Confinement for a Mental and Nervous Disorder or Alcohol and Drug Abuse and/or Substance Abuse treatment; and
- (b) two days of Partial Hospitalization for which benefits are payable will be considered as one day of Hospital Confinement.

Partial Hospitalization must be a Medically Necessary alternative to Hospital Confinement.

DEFINITIONS

The capitalized terms defined in this section are used in, or apply to, many provisions throughout the Plan and any Plan Changes. Definitions of other terms may be found in other provisions.

Acupuncture means the practice of insertion of needles into specific exterior body locations to relieve pain, to induce surgical anesthesia or for therapeutic purposes.

ADEA employer means an employer which:

- (a) is subject to the federal Age Discrimination in Employment Act (ADEA); and
- (b) has 20 or more employees each working day in 20 or more calendar weeks during the current or preceding calendar year.

Allowable Charge for In-Network provisions, means the amount otherwise payable under the Plan, adjusted as follows:

- (a) **Charges of Professional Service Providers for Multiple and Bilateral Surgeries:** For multiple or bilateral surgeries performed during the same operative session, the Allowable Charge for charges of Professional Service Providers will be:
 - (1) 100% of the Usual and Customary Charge for the primary procedure;
 - (2) 50% of the Usual and Customary Charge for the secondary procedure; and
 - (3) 25% of the Usual and Customary Charge for each additional procedure.
- (b) **Surgical Assistants:** For surgical assistance by a Physician, the Allowable Charge will be 20% of the Usual and Customary Charge for the surgery for which the assistance is provided.
- (c) **Covered Services Billed Separately or Together:** The Plan will determine whether services and supplies should appropriately be billed together as a single service or supply or billed separately. For example, Exclusive Healthcare, Inc. may determine that the evaluation, treatment, management and supplies normally furnished before, during and after surgical and medical procedures should be billed together. Or, Exclusive Healthcare, Inc. may determine that services or supplies that were billed together should be billed separately. The Allowable Charge will not exceed the amount payable in accordance with Exclusive Healthcare, Inc.'s determination of which services or supplies should appropriately be billed separately or together.

Allowable Charge for Out-of-Network provisions, means the amount otherwise payable under the Plan, adjusted as follows:

- (a) **Charges of Professional Service Providers for Multiple and Bilateral Surgeries:** For multiple or bilateral surgeries performed during the same operative session, the Allowable Charge for charges of Professional Service Providers will be:
 - (1) 100% of the Usual and Customary Charge for the primary procedure;
 - (2) 50% of the Usual and Customary Charge for the secondary procedure; and
 - (3) 25% of the Usual and Customary Charge for each additional procedure.
- (b) **Surgical Assistants:** For surgical assistance by a Physician, the Allowable Charge will be 20% of the Usual and Customary Charge for the surgery for which the assistance is provided.

- (c) **Covered Services Billed Separately or Together:** The Plan will determine whether services and supplies should appropriately be billed together as a single service or supply, or billed separately. For example, United of Omaha may determine that the evaluation, treatment, management and supplies normally furnished before, during and after surgical and medical procedures should be billed together. Or, United of Omaha may determine that services or supplies that were billed together should be billed separately. The Allowable Charge will not exceed the amount payable in accordance with Our determination of which services or supplies should appropriately be billed separately or together.

Alternate Health Benefits Plan means any health coverage, or health service plan or health maintenance organization (HMO) plan, which the Trustees of Plumbers Local Union No. 16 Health and Welfare Fund may designate as an alternate health care plan to the coverage provided by this Plan.

Booklet means the document that describes coverage under the Plan and is made a part of the Plan.

Brand Name Drugs means covered proprietary drugs approved by the Federal Food and Drug Administration.

Calendar Year means January 1 through December 31 of the same year.

Caregiver means a person not associated with a Hospice Agency who resides in Your home and provides nonmedical services and companionship. This person may not be part of Your family (Your spouse; or a child, brother, sister or parent of You or Your spouse).

COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Coinsurance means the percentage payable for Covered Services by You in accord with the Percentage Payable provision in the Schedules.

Copayment means a fixed dollar amount (or fixed percentage of cost) which You must pay before benefits are payable and which are required from You on the date the service or supply is received.

Cosmetic Surgery means any surgical procedure performed primarily:

- (a) to improve physical appearance or to change or restore bodily form without materially correcting a bodily malfunction; or
- (b) to prevent or treat a Mental or Nervous Disorder through a change in bodily form.

Covered Drugs means either of the following which require a Physician's written prescription:

- (a) drugs and medicines which are needed for the treatment of an Injury or Sickness, including insulin and certain diabetic supplies (needles, syringes, test tablets, sticks, tapes, strips and lancets); or
- (b) oral contraceptives and/or diaphragms.

Covered Person/Member means You and/or Your dependents who are covered under the Plan.

Covered Service means any Medically Necessary service or supply described in the Plan for which benefits may be payable in accordance with the terms of the Plan.

Custodial Care means services or supplies, regardless of where or by whom they are provided, which:

- (a) a person without medical skills or background could provide or could be trained to provide;
- (b) are provided primarily to help the Member with daily living activities, including (but not limited to):
 - (1) walking, getting in and/or out of bed, exercising and moving the Member;
 - (2) bathing, using the toilet, administering enemas, dressing and assisting with any other physical or oral hygiene needs;
 - (3) assistance with eating by utensil, tube or gastrostomy;
 - (4) homemaking, such as preparation of meals or special diets, and house cleaning;
 - (5) acting as a companion or sitter; and/or
 - (6) supervising the administration of medications which can usually be self-administered, including reminders of when to take such medications;
- (c) primarily provide a protective environment;
- (d) are primarily part of a maintenance treatment plan or are not part of an active treatment plan intended to or reasonably expected to improve the Member's Sickness, Injury or functional ability;
- (e) are primarily provided for the convenience or comfort of the Member or the Member's companion, sitter or family member; or
- (f) are primarily provided because the Member's home arrangements are not appropriate or adequate to accommodate his or her needs.

Exclusive Healthcare, Inc. and/or United of Omaha Life Insurance Company, or a qualified party or entity selected by them, determines what services or supplies are Custodial Care. When a Hospital Confinement, a visit to a Physician or other service or supply is found to be primarily for Custodial Care, some services (such as prescription drugs, X-rays and lab tests) may still be considered Covered Services if Medically Necessary and benefits are otherwise payable for such service or supplies in accordance with the Plan.

Deductible for Out-of-Network provisions, means the amount payable for Covered Services by You each Calendar Year before benefits are payable by United of Omaha Life Insurance Company.

Dental Injury means an accidental Injury to Sound Natural Teeth which is the direct result of a sudden, unexpected and unintended external force, such as a blow or fall that requires treatment by a Physician or Dentist. It must be independent of Sickness or any other causes. It does not include tooth breakage while biting or chewing.

Dentist means a person who is:

- (a) appropriately licensed and qualified to practice dentistry under the law of the jurisdiction in which the dental procedure is performed; and
- (b) operating within the scope of his or her license.

A Dentist does not include a person who lives with You or is a part of Your family (You; Your spouse; or a child, brother, sister or parent of You or Your spouse).

Developmental Care means services or supplies, regardless of where or by whom they are provided which:

- (a) are provided to a Member who has not previously reached the level of development (i.e., developmental delay) expected for the Member's age in the following areas of major life activity:
 - (1) intellectual;
 - (2) physical;
 - (3) receptive and expressive language;
 - (4) learning;
 - (5) mobility;
 - (6) self-direction;
 - (7) capacity for independent living; or
 - (8) economic self-sufficiency;
- (b) are not primarily rehabilitative in nature (restoring fully developed skills that were lost or impaired due to Injury or Sickness); or
- (c) are primarily educational.

Exclusive Healthcare, Inc. and/or Untied of Omaha Life Insurance Company, or a qualified party or entity selected by them, determines what services or supplies are Developmental Care. When a Hospital Confinement, a visit to a Physician or other service or supply is found to be primarily for Developmental Care, some services or supplies (such as prescription drugs, X-rays and lab tests) may still be considered Covered Services if they are Medically Necessary and benefits are otherwise payable for such services and supplies in accordance with the Plan.

Donor means a person who undergoes a surgical operation for the purpose of donating a human organ(s)/tissue for Transplant Surgery to a Recipient.

Drug Formulary means the current listing of Covered Drugs preferred by Us for dispensing to a Member when appropriate. This list is subject to periodic review and modification.

Durable Medical Equipment means Medically Necessary equipment that is:

- (a) able to withstand repeated or prolonged use;
- (b) primarily and customarily used to serve a medical purpose;
- (c) not generally useful to a person in the absence of Injury or Sickness; and
- (d) is suited for use in the home.

Durable Medical Equipment includes supplies that are necessary for use with the equipment.

Durable Medical Equipment does not include motor vehicles or any modifications that do not serve a direct medical purpose in treating an Injury or Sickness, including but not limited to:

- (a) modifications/assistive devices for motor vehicles (not including motorized wheelchairs or scooters used in lieu of wheelchairs); or
- (b) internal or external structural modifications to buildings, widening of doorframes, replacement doors, ramps, modifications to walkways, stairs or non-bathroom hand-rails.

Expense means the charge incurred by a Member for a Covered Service which has been ordered, prescribed or rendered by a Physician, Dentist or Hospital. Expense is considered incurred on the date the Covered Service is received. Expense does not include any charge:

- (a) for a service or supply otherwise excluded under the Plan;
- (b) which is in excess of the charge which the Physician, Dentist or Hospital has agreed to accept as payment in full;
- (c) for a service or supply which is not Medically Necessary;
- (d) **for In-Network provisions**, which is in excess of the Usual and Customary Charge or the Allowable Charge for a service or supply; or
- (e) **for Out-of-Network provisions**, which is in excess of the Usual and Customary Charge, the Facility Charge Allowance or the Allowable Charge for a service or supply.

Experimental or Investigational Drug or Treatment means a drug, device, treatment or procedure:

- (a) which cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and which has not been so approved for marketing at the time the drug, device, treatment or procedure is furnished; or
- (b) which was reviewed and approved (or which is required by federal law to be reviewed and approved) by the treating facility's Institutional Review Board or other body serving a similar function, or a drug, device, treatment or procedure which is used with a patient informed consent document which was reviewed and approved (or which is required by federal law to be reviewed and approved) by the treating facility's Institutional Review Board or other body serving a similar function; or
- (c) which Reliable Evidence shows is the subject of on-going phase I, II or III clinical trials or is under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or
- (d) for which the prevailing opinion among experts as shown by Reliable Evidence is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

Reliable Evidence means only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, treatment or procedure.

Facility Charge Allowance for Out-of-Network provisions, means the maximum amount payable under the Plan for certain Facility charges related to inpatient and outpatient services at an Out-of-Network Provider, as determined as follows:

- (a) **Charges for Inpatient Services.** The facility charge allowance for services provided by a Facility who is an Out-of-Network Provider, which exceed a minimum dollar amount of \$1500 and are associated with any inpatient stay at a Facility in which confinement is more than 24 hours, will be limited to the amount calculated by using the Facility Charges Database. In no

event will the facility charge allowance exceed the amount billed to United of Omaha Life Insurance Company or the amount for which the Covered Person is responsible.

- (b) **Charges for Outpatient Services.** The facility charge allowance for services provided by a Facility who is an Out-of-Network Provider, which exceed a minimum dollar amount of [\$250] and are associated with any outpatient service at a Facility in which confinement is less than 24 hours, will be limited to the lesser of:
- (1) the 75th percentile identified by the Outpatient Charges Database; or
 - (2) the amount calculated by using the Facility Charges Database.

In no event will the facility charge allowance exceed the amount billed to United of Omaha Life Insurance Company or the amount for which the Covered Person is responsible.

For multiple or bilateral outpatient surgeries performed during the same operative session, the facility charge allowance will be further adjusted as follows:

- (1) 100% of the facility charge allowance for the highest cost procedure;
- (2) 25% of the facility charge allowance for the second highest cost procedure; and
- (3) 10% of the facility charge allowance for each additional procedure.

The Covered Person may be responsible for amounts that exceed the facility charge allowance. If the facility charge allowance is less than the amount charged by the Out-of-Network Provider, or less than the amount the Covered Person is responsible for, the Covered Person may be responsible for the difference. If the Covered Person is asked to pay this difference by the Out-of-Network Provider, and if requested, United of Omaha Life Insurance Company will attempt to reduce the amount the Covered Person may owe to the Out-of-Network Provider. If United of Omaha Life Insurance Company's attempts are unsuccessful, the Covered Person may still be responsible for the difference.

Facility or Facilities mean, for purposes of determining the Facility Charge Allowance and for use in the Facility Charges Database and Outpatient Charges Database definitions, a Hospital, Birthing Center, Hospice Care Facility, Skilled Nursing Facility, or any other free standing facility.

Facility Charges Database means a commercially available database and software program selected by United of Omaha Life Insurance Company that provides information about the inpatient and outpatient costs and charges for Facilities. The database supplier uses the cost accounting method for Facilities established and used by Medicare as the basis to calculate cost to charge ratios for various inpatient and outpatient services provided by Facilities. Those ratios are then used as the basis for the formula to calculate the Facility Charge Allowance for certain services provided by Out-of-Network Providers that are Facilities. Expenses may not exceed the Facility Charge Allowance charge as determined in accordance with the facility charges database. The facility charges database will be updated by the database supplier, up to twice each year. United of Omaha Life Insurance Company may discontinue use of, or substitute or replace the database with one of comparable purpose, with or without notice.

Outpatient Charges Database means commercially available charge information databases selected by United of Omaha Life Insurance Company which use charge information databases that provide historical information about charges billed by Facilities on an outpatient basis by selected procedure codes and geographic categories, all as determined and adjusted by the database supplier. The outpatient charges database will be updated by the database supplier, up to twice each year. United of Omaha Life Insurance Company may discontinue use of, or substitute or replace any database with one of comparable purpose, with or without notice.

Generic Drugs means Covered Drugs which are chemically equivalent to Brand Name Drugs whose patent has expired and which are approved by the Federal Food and Drug Administration. Not all Brand Name Drugs have a generic equivalent.

Healthcare Charges Database means a commercially available charge information database selected by Exclusive Healthcare, Inc. and/or United of Omaha Life Insurance Company that provides historical information about the charges of Physicians and other Professional Service Providers by procedure code and geographic categories, all as determined and adjusted by the database supplier. The Healthcare Charges Database will be updated by Exclusive Healthcare, Inc. and/or United of Omaha Life Insurance Company as information becomes available from the database supplier, up to twice each year. Exclusive Healthcare, Inc. and/or United of Omaha Life Insurance Company may also modify the database, at their discretion, to reflect their experience. Exclusive Healthcare, Inc. and/or United of Omaha Life Insurance Company has the right, at their discretion, to substitute or replace the selected database with a database or databases of comparable purpose, with or without notice.

Health Coverage means benefits consisting of medical care (provided directly, through coverage or reimbursement, or otherwise and including items and services paid for as medical care) under any hospital or medical service policy or certificate, hospital or medical service plan contract or health maintenance organization contract offered by a health insurance issuer.

Health Status-Related Factor means any of the following:

- (a) Health status;
- (b) Medical condition (including both physical and mental sickness);
- (c) Claims experience;
- (d) Receipt of health care;
- (e) Medical history;
- (f) Evidence of insurability (including conditions arising out of acts of domestic violence);
- (g) Disability; or
- (h) Genetic information.

Home Health Agency means a public or private agency or organization appropriately licensed, qualified and operated under the law of the jurisdiction in which it is located.

Home Health Aide means a person who:

- (a) provides care of a therapeutic nature; and
- (b) reports to and is under the direct supervision of a Home Health Agency.

Home Health Care Plan means continued care and treatment of a Member:

- (a) who is under the care of a Physician; and
- (b) who would need continued Hospital or Skilled Nursing Care Facility confinement without the home health care.

Hospice means a program that:

- (a) provides care to the Terminally Ill;
- (b) is licensed/certified by the jurisdiction in which it operates;
- (c) is supervised by a staff of Physicians with at least one Physician on call 24 hours a day; and
- (d) provides 24-hour a day nursing services under the direction of a registered nurse (RN) and has a full time administrator.

Hospice Agency means a public or private agency or organization which administers and provides Hospice Care Services or operates a Hospice.

Hospice Care Facility means a facility providing Hospice Care Services which is appropriately licensed or certified as such under the law of the jurisdiction in which it is located, and:

- (a) is certified (or is qualified and could be certified) under Medicare; or
- (b) is accredited by the Joint Commission on the Accreditation of Healthcare Organizations, or meets the standards established by the National Hospice Organization.

Hospice Care Plan means a coordinated, interdisciplinary plan to meet the physical, psychological and social needs of Terminally Ill persons and their families by providing palliative (pain controlling) and supportive medical, nursing and other health services through home, Hospice, Hospice Care Facility or inpatient Hospital care during the Sickness or bereavement.

Hospice Care Services means any services provided under a Hospice Care Plan by a:

- (a) Hospital;
- (b) Hospice Agency;
- (c) Hospice Care Facility; or
- (d) other facility;

licensed or certified by the proper authority in the jurisdiction in which they are located to operate the Hospice.

Hospital means any of the following facilities which are licensed by the proper authority in the jurisdiction in which they are located:

- (a) a facility which:
 - (1) provides services for the care and treatment of patients;
 - (2) has a Physician and a registered graduate nurse (RN) always on duty;
 - (3) has a laboratory and X-ray facility; and
 - (4) as a regular practice, charges the patient for its services; or
- (b) a facility which is accredited by the Joint Commission on the Accreditation of Healthcare Organizations, American Osteopathic Association or the Commission on the Accreditation of Rehabilitative Facilities if the function of such facility is primarily to provide rehabilitation specifically for treatment of a physical disability. Rehabilitative facilities need not have major surgical facilities.

When treatment is needed for Mental or Nervous Disorders/Alcohol and Drug Abuse and/or Substance Abuse, Hospital can also mean a facility which is licensed by the proper authority of the jurisdiction in which it is located and:

- (a) provides inpatient services for the care and treatment of patients;
- (b) is equipped to treat Mental or Nervous Disorders/Alcohol and Drug Abuse and/or Substance Abuse;
- (c) has a resident Physician on duty or on call at all times;
- (d) has a registered nurse (RN) always on duty; and
- (e) as a regular practice, charges the patient for its services.

A Hospital does not include a Hospital or institution or part of a Hospital, facility or institution which is licensed or used principally as a clinic, convalescent home, rest home, nursing home, home for the aged, halfway house or board and care facility, residential treatment center, “wilderness” program, treatment group home or “boot camp.”

Hospital Confinement means a Medically Necessary Hospital inpatient stay of 24-consecutive-hours or more in any single or multiple departments or parts of a Hospital for the purpose of receiving any type of medical service. These requirements apply even if the Hospital does not charge for daily room and board and does not classify the confinement as inpatient. How the Hospital classified the stay is irrelevant.

Any Hospital Confinement satisfying this definition will be subject to all Plan provisions relating to inpatient Hospital services or admissions, including any applicable preadmission review requirements. Hospital stays or services not satisfying this definition will be considered under the Plan provisions for outpatient services.

Immediate Family means a Member’s:

- (a) spouse and children; or
- (b) parents, brothers and sisters in the case of a Terminally Ill dependent child.

Independent Radiology and Pathology Center means a freestanding facility offering radiology and pathology service which:

- (a) is not part of a Hospital; and
- (b) is licensed by the proper authority in the jurisdiction in which it is located.

Injury means an accidental Injury which is a direct result of a sudden, unexpected and unintended external force or element such as a blow or fall that requires treatment by a Physician. It must be independent of Sickness and other causes, including but not limited to, complications from medical care.

Inpatient Treatment means Covered Services that are being provided during Hospital Confinement.

Jaw Joint Disorder means any misalignment, dysfunction or other disorder of the jaw joint (or of the complex of muscles, nerves and tissues related to that joint). It includes temporomandibular joint dysfunction (TMJ), arthritis or arthrosis; other craniomandibular joint disorders; and myofacial or orofacial pain syndrome. It does not include a fracture or dislocation which results from an Injury.

Large group plan means a plan which covers employees of at least one employer that normally employed at least 100 employees on a typical business day during the previous calendar year.

Late Enrollee means an eligible person who requests enrollment under the plan sponsor's group health plan **other than:**

- (a) during the person's first or any subsequent enrollment periods contained in the group health plan;
or
- (b) during the periods provided under the **Special Enrollment Provisions**.

Maximum Allowable Amount for In-Network provisions, means the charge considered for Covered Services before the applicable Percentage Payable are applied. In cases where the Usual and Customary Charge is less than the Maximum Allowable Amount, the Usual and Customary Charge would apply.

Maximum Allowable Amount for Out-of-Network provisions, means the total charge considered for Covered Services before the applicable Deductible and Coinsurance are applied. In cases where the Usual and Customary Charge is less than the Maximum Allowable Amount, the Usual and Customary Charge would apply.

Medical Director means a Physician, or his/her designee, employed, appointed by or under contract to Exclusive Healthcare, Inc. to review Quality Assurance and Utilization Review programs, standards and procedures and perform any other duties as directed by Exclusive Healthcare, Inc.

Medical Emergency means a medical condition or behavioral condition of sudden onset that manifests itself by acute symptoms of sufficient severity (including severe pain), such that a person who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:

- (a) placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- (b) serious impairment to bodily functions;
- (c) serious disfigurement of the individual;
- (d) serious impairment of any bodily organ or part; or

- (e) in the case of a behavioral condition, placing the health of the individual or other persons in jeopardy.

Medically Necessary means a service or supply that is ordered, prescribed or rendered by a Physician or Hospital, and is determined by Exclusive Healthcare, Inc. and/or United of Omaha Life Insurance Company or a qualified party or entity selected by them to be:

- (a) provided for the diagnosis or direct treatment of an Injury or Sickness;
- (b) appropriate and consistent with the symptoms and findings or diagnosis and treatment of the Member's Injury or Sickness;
- (c) provided in accord with generally accepted professional standards and/or medical practice; and
- (d) the most appropriate supply or level of service which can be provided on a cost effective basis (including, but not limited to, inpatient vs. outpatient care, electric vs. manual wheelchair, surgical vs. medical or other types of care).

Services or supplies which may be Medically Necessary are not covered by the Plan if they are specifically excluded or limited in the General Exclusions and Limitations provision.

The fact that the Member's Physician or Primary Care Physician orders, prescribes or renders services does not mean such services are Medically Necessary and a Covered Service.

Medicare benefits means service and supplies which the Member receives or is eligible for under Medicare Part A or B, (whether or not the Member has applied for or is enrolled in Medicare).

Mental or Nervous Disorder/Alcohol and Drug Abuse and/or Substance Abuse means a condition or disease, regardless of its cause, listed in the most recent edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders.

Nonsurgical Spinal Treatment means detection or nonsurgical correction (by manual or mechanical means) of a condition of the vertebral column including:

- (a) distortion;
- (b) misalignment; or
- (c) subluxation;

to relieve the effects of nerve interference which results from or relates to such conditions of the vertebral column.

Our, We, Us means Trustees of Plumbers Local Union No. 16 Health and Welfare Fund.

Out-of-Network Provider or Other Provider for Out-of-Network provisions, means a provider of Covered Services who is not currently participating in United of Omaha Life Insurance Company's Preferred Provider network.

Out-of-Pocket Expense for Out-of-Network provisions, means Expense which the Covered Person incurs for Covered Services provided during the Calendar Year and must pay:

- (a) as Coinsurance; and
- (b) as Deductibles.

Outpatient Facility for In-Network provisions, means a facility providing nonemergency medical services other than during a Hospital Confinement.

Outpatient Facility for Out-of-Network provisions, means a facility providing nonemergency services other than an Independent Radiology and Pathology Center, Urgent Care Center or Hospital Emergency Room.

Outpatient Treatment means any Covered Service of less than 24-consecutive-hours provided by an Outpatient Facility that does not constitute a Hospital Confinement.

Participating Provider means a health care professional, Hospital, facility, institution, agency pharmacy and practitioner that:

- (a) participates in Exclusive Healthcare, Inc.'s network; and
- (b) with whom Exclusive Healthcare, Inc. contracts to provide Covered Services and supplies to Members.

Patient Management means educational and training services furnished to a Member with diabetes in an outpatient setting by an individual or entity with experience in diabetes, in consultation with the Physician who is managing the Member's condition, which Physician certifies that such services are needed under a comprehensive plan of care related to the Member's condition to ensure therapy or compliance or to provide the Member with necessary skills or knowledge, including skills related to self-administration of injectable drugs which participate in the management of the Member's condition.

Physician means any of the following practitioners who is appropriately licensed and qualified under the law of the jurisdiction in which treatment is rendered, and operating within the scope of his/her license:

- (a) a doctor of medicine (MD), osteopathy (DO), podiatry (DPM) or chiropractic (DC);
- (b) a behavioral health care practitioner (such as a social worker, psychologist, etc.);
- (c) a Physician's assistant (PA);
- (d) a nurse practitioner; or
- (e) any other provider as required by applicable law.

A Physician does not include You, a person who lives with You or is a member of Your family (You; Your spouse; or a child, brother, sister or parent of You or Your spouse).

Plan means Trustees of Plumbers Local Union No. 16 Health and Welfare Fund's.

Plan Change means a document that is added to and made a part of the Plan. A Plan Change amends, limits, restricts or otherwise changes the provisions of the Plan.

Primary Care Physician for In-Network provisions, means a Physician who provides Covered Services who participates in Exclusive Healthcare, Inc. network as a Primary Care Physician and practices in the field of:

- (a) family practice;
- (b) internal medicine;
- (c) general practice;
- (d) pediatrics; or
- (e) obstetrics/gynecology.

Primary Care Physician for Out-of-Network provisions, means a Physician who provides Covered Services in any of the fields of:

- (a) family practice;
- (b) internal medicine;
- (c) general practice; and
- (d) pediatrics.

Prior group plan means the group plan providing similar benefits (whether insured or self-insured including HMO's and other prepayment plans provided by Trustees of the Plumbers Local Union No. 16 Health and Welfare Fund) in effect immediately prior to the effective date of this Plan.

Professional Service Provider means any category of Physician or other health care provider that typically bills on the basis of the CPT-4 code system.

Recipient means a Member who undergoes a surgical operation to receive a human Qualified Organ(s)/Tissue Transplant.

Reconstructive Surgery means any surgical procedure which repairs an abnormal body structure.

Respite Care means a short-term inpatient stay which is necessary for the Member to give temporary relief to a Caregiver who regularly assists the Member with home care.

Serious Health Condition is defined as stated in the FMLA.

Service Area means the geographical area approved by the appropriate state regulatory agency in the state in which Exclusive Healthcare, Inc. does business. The counties representing their Service Area are shown on the current list of Participating Providers.

Service in the uniformed services means the performance of duty on a voluntary or involuntary basis in a uniformed service under competent authority and includes active duty, active duty for training, initial active duty for training, inactive duty training, full-time National Guard duty, and a period for which a person is absent from a position of employment for the purpose of an examination to determine the fitness of the person to perform any such duty.

Sickness means a disease, disorder or condition, which requires treatment by a Physician.

1. For a female employee or dependent wife, Sickness **includes** childbirth pregnancy. It **does not include** elective abortion; but it **does include** complications which are the result of an elective abortion.
2. For a dependent child, Sickness **does not include** normal pregnancy or normal childbirth, but it **does include** complications of pregnancy.

Elective Abortion means any abortion other than one where the mother's life would be endangered if the fetus were carried to term.

Normal Pregnancy or **Normal Childbirth** means pregnancy or childbirth which is free of complications of pregnancy.

Complications of Pregnancy means:

- (a) any condition resulting in hospital confinement, the diagnosis of which is distinct from pregnancy but is adversely affected or caused by pregnancy; or
- (b) a nonelective cesarean section, an ectopic pregnancy which is terminated, a spontaneous termination of pregnancy when a viable birth is not possible, a puerperal infection, eclampsia and toxemia.

False labor, occasional spotting, physician prescribed rest, morning Sickness, hyperemesis gravidarum, preeclampsia and similar conditions associated with a difficult pregnancy are not complications of pregnancy.

Skilled Nursing Care Facility means a facility licensed or certified by the jurisdiction in which it is located or eligible for payment under Medicare, that provides continuous inpatient skilled nursing care.

Sound Natural Teeth means teeth which:

- (a) are whole or properly restored;
- (b) are without impairment or periodontal disease; and
- (c) are not in need of the treatment provided for reasons other than Dental Injury.

Specialist for In-Network provisions, means any other Physician other than a Primary Care Physician who:

- (a) is participating in Exclusive Healthcare, Inc.'s network; and
- (b) is shown on Exclusive Healthcare, Inc.'s current list of Participating Providers.

Specialist for Out-of-Network provisions, means a Physician who provides Covered Services in a field other than:

- (a) family practice;
- (b) internal medicine;
- (c) general practice; and
- (d) pediatrics.

Specialty Pharmacy for In-Network means a Participating Provider which provides specified drugs. Specialty Pharmacies are listed on the website at www.mutualofomaha.com or You may call 1-800-467-4917 to receive more information regarding Specialty Pharmacies.

Subrogation Rights, as used in this provision, means the Plan's right to enforce recovery of any Plan benefits paid for You or Your dependent because of an injury or sickness caused by a third party's act or omission. The Plan is entitled to be paid first out of any recovery, up to the amount of Plan benefits paid.

United/United of Omaha means United of Omaha Life Insurance Company.

Terminally Ill means a Member is:

- (a) determined by a Physician to have a terminal Sickness with no reasonable prospect of cure; and
- (b) expected by a Physician to have less than six months to live.

Third Party means another person or organization.

Total Disability, Totally Disabled or Disabled means that because of an Injury or Sickness:

- (a) You are completely and continuously unable to perform the material and substantial duties of Your regular occupation and are not engaging in any work or occupation for wages or profit: or
- (b) Your dependent is:
 - (1) either physically or mentally unable to perform all of the usual and customary duties and the normal activities and duties of a person of the same age and sex who is in good health; and
 - (2) not engaged in any work or occupation for wages or profit.

Transplant Surgery means a transfer of a human organ(s)/tissue from the Donor to the Recipient.

Uniformed services means the United States Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or emergency.

Urgent Care Center means a free standing facility offering ambulatory medical service, which:

- (a) is not part of a Hospital; and
- (b) is licensed by the proper authority of the jurisdiction in which it is located.

USERRA means the Uniformed Services Employment and Reemployment Rights Act of 1994 (including any amendments to such ACT and any interpretive regulations or rulings).

Usual and Customary Charge for In-Network provisions, means a charge by a Professional Service Provider for a Covered Service which is no higher than the 90th percentile identified on the Healthcare Charges Database (HCD). When there is, in Exclusive Healthcare, Inc. and/or United of Omaha Life Insurance Company's determination, minimal data available from the HCD for a Covered Service, the Plan will determine the Usual and Customary Charge by calculating the unit cost for the applicable service category using HCD, and multiplying that by the relative value of the Covered Service assigned by the Medicare Resource Based Relative Value Scale (supplemented with a commercially available relative value scale selected by Exclusive Healthcare, Inc. and/or United of Omaha Life Insurance Company's where one is not available from Medicare). In the event of an unusually complex Covered

Service, a Covered Service that is a new procedure, or a Covered Service that otherwise does not have a relative value that is in Exclusive Healthcare, Inc. and/or United of Omaha Life Insurance Company's determination applicable, the Plan will assign one. In no event will the Usual and Customary Charge exceed the amount billed by the Professional Service Provider or the amount for which the Covered Person is responsible. The term "Usual and Customary Charge" may not reflect the actual charges of the Professional Service Provider, and does not take into account the Professional Service Provider's training, experience or category of licensure.

Usual and Customary Charge for Out-of-Network provisions, means a charge by a Professional Service Provider who is an Out-of-Network Provider or Other Provider for a Covered Service which is no higher than the 90th percentile identified on the Healthcare Charges Database (HCD). When there is, in Exclusive Healthcare, Inc. and/or United of Omaha Life Insurance Company's determination, minimal data available from the HCD for a Covered Service, the Plan will determine the Usual and Customary Charge by calculating the unit cost for the applicable service category using HCD, and multiplying that by the relative value of the Covered Service assigned by the Medicare Resource Based Relative Value Scale (supplemented with a commercially available relative value scale selected by Exclusive Healthcare, Inc. and/or United of Omaha Life Insurance Company's where one is not available from Medicare). In the event of an unusually complex Covered Service, a Covered Service that is a new procedure, or a Covered Service that otherwise does not have a relative value that is in Exclusive Healthcare, Inc. and/or United of Omaha Life Insurance Company's determination applicable, the Plan will assign one. In no event will the Usual and Customary Charge exceed the amount billed by the Professional Service Provider or the amount for which the Covered Person is responsible. The term "Usual and Customary Charge" may not reflect the actual charges of the Professional Service Provider, and does not take into account the Professional Service Provider's training, experience or category of licensure.

You, Your means an employee/member who is covered under the Plan.

GENERAL EXCLUSIONS AND LIMITATIONS

NOTE: Services and supplies which may be Medically Necessary are not covered by the Plan if they are specifically excluded or limited in this General Exclusions and Limitations provision.

The Plan does not pay benefits under the Plan for any Expense or loss unless otherwise specifically provided in the Plan:

- (a) for an Injury or Sickness:
 - (1) which arises out of or in the course of any employment with any employer; or
 - (2) for which the Member:
 - a. is entitled to benefits under a workers' compensation or occupational disease law; or
 - b. receives any settlement from a workers' compensation carrier;
- (b) **for In-Network provisions**, which is in excess of the Usual and Customary Charge or the Allowable Charge;
- (c) **for Out-of-Network provisions**, which is in excess of the Usual and Customary Charge, the Facility Charge Allowance or the Allowable Charge;
- (d) for services and supplies not Medically Necessary;
- (e) incurred after coverage under this Plan ends;
- (f) which does not result from an Injury or Sickness;
- (g) for an Injury or Sickness that occurred while committing a felony or participating in a riot;
- (h) incurred by You while incarcerated in a jail, penitentiary, correctional facility or a Hospital;
- (i) which You do not have to pay;
- (j) for Custodial Care, except as part of a Home Health Care Plan approved by the Plan;
- (k) for Developmental Care;
- (l) which results from Reconstructive Surgery, except:
 - (1) for an Injury;
 - (2) for repair of defects which result from surgery; or
 - (3) for the reconstructive (not cosmetic) repair of a congenital defect which materially corrects a bodily malfunction;
- (m) which results from Cosmetic Surgery;
- (n) which relates to appetite control, food addictions, eating disorders (except for documented cases of bulimia or anorexia that meet standard diagnostic criteria as determined by the Plan, and present significant symptomatic medical problems) or any treatment of obesity (including surgery to treat morbid obesity);
- (o) for routine foot care, orthopedic shoes, orthotics or other supportive devices for the feet;

- (p) in connection with dental work, dental surgery, or oral surgery (unless otherwise specifically provided in the Plan), including:
 - (1) treatment or replacement of any tooth or any tooth structure, alveolar process, abscess or disease of the periodontal or gingival tissue; or
 - (2) surgery or splinting to adjust dental occlusion;
- (q) for the treatment of Jaw Joint Disorders (unless otherwise specifically provided in the Plan);
- (r) related to sexual gender identity disorders, including, but not limited to:
 - (1) sexual dysfunctions;
 - (2) paraphilias; or
 - (3) gender transformations;
- (s) for services and supplies for the treatment of impotence/erectile dysfunction;
- (t) for the diagnosis or treatment of the inability to conceive or become pregnant, or the promotion of fertility including, but not limited to:
 - (1) fertility tests and procedures;
 - (2) reversal of surgical sterilization; and
 - (3) any similar method or treatment which attempts to cause pregnancy by hormone therapy, artificial insemination, in vitro fertilization and embryo transfer;
- (u) for birth control drugs or devices including, but not limited to, oral contraceptives, IUDs, contraceptive implants and any similar drugs, devices or other birth control methods and all related expenses unless otherwise specifically provided in the Plan;
- (v) for chelation therapy except for acute arsenic, gold, mercury or lead poisoning;
- (w) for services or supplies which are not provided in accord with generally accepted professional standards and/or medical practice;
- (x) for services or supplies which:
 - (1) are considered an Experimental or Investigational Drug or Treatment; or
 - (2) result from or relate to the application of such Experimental or Investigational Drug or Treatment;
- (y) for services or supplies which are primarily for the Covered Person's education, training or development of skills needed to cope with an Injury or Sickness;
- (z) related to smoking cessation or treatment for nicotine addiction;
- (aa) for Acupuncture Treatment (except when used in lieu of an anesthetic agent for covered surgery);
- (ab) which is primarily for the Covered Person's convenience or comfort or that of the Covered Person's family, Caregiver, companion, sitter, Physician or other person;
- (ac) for bills for telephone calls, mailings, faxes, e-mails or any other communications to or from a Physician, Hospital or other medical provider;
- (ad) which results from breast augmentation or reduction, whether or not Medically Necessary, except for breast reconstruction following a mastectomy as required under state or federal law/regulation;

- (ae) which results from:
 - (1) pervasive developmental disorders;
 - (2) mental retardation;
 - (3) conduct disorders; or
 - (4) developmental disorders;
- (af) for educational testing or educational remediation;
- (ag) for therapies designed to promote personal growth or enhancement absent a diagnosis of a Mental or Nervous Disorder/Alcohol and Drug Abuse and/or Substance Abuse;
- (ah) for exercise equipment;
- (ai) for services or supplies which are provided or paid for by the federal government or its agencies except for:
 - (1) the Veterans Administration, when services are provided to a veteran for a disability which is not service-connected;
 - (2) a military Hospital or facility when services are provided to a retiree (or dependent of a retiree) from the armed services;
 - (3) a group health plan established by a government or its agencies for its own civilian employees and their dependents; or
 - (4) Medicaid, if required by a Medicaid assignment of benefits;
- (aj) which results from an act of declared or undeclared war or armed aggression;
- (ak) which:
 - (1) is incurred while the Member is on active duty or training in the Armed Forces, National Guard or Reserves of any state or country; or
 - (2) any governmental body or its agencies are liable;
- (al) for contact lenses, except as provided under the Other Covered Services section of the Schedule;
- (am) for routine eye refractions or the fitting or cost of visual aids, vision therapy, radial keratotomy or similar surgery done in treating myopia, astigmatic keratotomy or surgery to treat kerataconus (except for corneal graft or as specifically provided under any Covered Routine Vision services’);
- (an) for the fitting or cost of hearing aids and related supplies;
- (ao) for services provided by a person who lives with You in Your home or is a part of Your family (Your spouse; or a child, brother, sister or parent of You or Your spouse);
- (ap) for any treatment, service or supply received before coverage begins or after coverage ends;
- (aq) for treatment received outside our Service Area which could reasonably have been foreseen by a Member prior to departure from our Service Area;
- (ar) for treatment of normal pregnancy and/or delivery outside Our Service Area;
- (as) for services and supplies provided by a Hospital, but not used while confined in a Hospital, including, but not limited to, take home drugs, except as otherwise specifically provided in the Plan;

- (at) for immunizations and/or physical exams required by a third party, or received for travel or employment purposes;
- (au) for Alcohol and Drug Abuse and/or Substance Abuse treatment, except as provided in the Plan;
- (av) for Mental or Nervous Disorders treatment, except as specifically provided in the Plan;
- (aw) for Nonsurgical Spinal Treatment, except as specifically provided in the Plan;
- (ax) for body organ(s)/tissue transplants, except as specifically provided in the Plan;
- (ay) payment of benefits terminates in the event an employee becomes eligible for Benefits under the Plumbers local 16 Pension Plan. Any payments received will be refunded from the plan; or
- (az) for any treatment, service or supply unless it is shown under Covered Services in the Plan.

ELIGIBILITY

For You - Active Employees

Eligible Employees

Initial Eligibility

You will become eligible to participate in the Plan on the first day of the month following Your completion of 1,040 hours of employment with one or more contributing employers. The 1,040 hours must be:

- (a) worked during a period of 12 consecutive months or less; and
- (b) at activities within the jurisdiction of the collective bargaining units represented by the Unions.

Continuation of Eligibility

Once You have fulfilled the initial eligibility requirements, You will remain eligible unless:

- (a) You are absent from covered employment for 180 consecutive days for reasons other than disability or involuntary military service; or
- (b) You work less than 520 hours at covered employment during any 12 consecutive months.

Reinstatement of Eligibility If Your eligibility ends in accordance with the continuation of Eligibility provision. You will again become eligible provided:

- (a) You have not been absent from covered employment for more than 360 consecutive days; and
- (b) You work 520 hours of covered employment during 12 consecutive months or less.

NOTE: If You are absent from covered employment for more than 360 consecutive days, You will not be eligible for benefits until You once again satisfy the Initial Eligibility.

NOTE: If You were eligible for coverage under the prior group plan but did not elect coverage, You may be considered a Late Enrollee. Exclusive Healthcare Inc. and/or United of Omaha will determine the date coverage begins.

Reciprocity with Other Welfare Funds

The Board of Trustees has entered into reciprocity agreements with other Welfare Funds. This means that You will be given credit for hours worked for other reciprocal local unions if You do not meet the hours of work requirements based on contributions to Plumbers Local Union #1B.

It is Your sole responsibility to inquire at each Local Union to determine if reciprocity is available with that Local Union and Plumbers Local Union No. 16 Health and Welfare Fund. You must sign the necessary documents authorizing the transfer of funds, on Your behalf, back to the Plumbers Local Union No. 16 Fund Office.

Reciprocity hours and hours worked within the jurisdiction of Plumbers Local Union No. 16 will be combined to establish and maintain eligibility under this Fund.

Self-Pay Premiums

If You joined Plumbers Local Union No. 16 as a new member from an organized shop, the following rules will apply to self-pay premiums.

- (a) Self-pay premium must be received in the Welfare Office prior to the first month in which You are to be covered.
- (b) Self-pay premiums cannot be accepted to establish initial eligibility, new employee eligibility or reinstate eligibility unless You are a new member of Plumbers Local Union No. 16 and have joined as a result of being organized.
- (c) Once You let the coverage end, You must re-establish eligibility by active employment.
- (d) The premium for self-pay will be based on the cost of the medical coverage submitted to the Insurance Company plus normal administrative expenses.

Late Enrollee Provision

A Late Enrollee may elect coverage under the Plan only during any open enrollment under the Plan. Annual open enrollment periods will be allowed in which You may elect Coverage. The annual open enrollment period is designated by the Trustees of the Plumbers Local Union No. 16 Health and Welfare Fund and agreed to by Exclusive Healthcare, Inc. and/or United of Omaha, but in no event more than 30 calendar days.

If You waived coverage during any enrollment period You may elect coverage during any subsequent enrollment period. You are not considered a Late Enrollee if You were covered by another employer sponsored medical plan immediately preceding selection of Our Plan at open enrollment. You will become covered on the following April 1, provided You are actively at work. If You are not actively at work on that day, Your coverage will begin on the day You return to active work.

Any requirement regarding eligibility, or that an otherwise-eligible person be actively at work before coverage may begin or remain in force is **not** applicable, if the eligibility for the coverage or the absence is due to a Health Status-Related Factor.

Reinstatement of Coverage

If You want to reinstate Your coverage after You have voluntarily let it lapse, You may be considered a Late Enrollee. Exclusive Healthcare Inc. and/or United of Omaha will determine the day Your coverage begins.

Coverage Requirement

To cover Your dependents under this Plan, You must be covered. If at a later date, Your coverage ends, Your dependents' coverage will also end.

Amount of Coverage

The amount of coverage for Your classification is shown in the **Schedule**.

Changes in Your Classification or in the Amount of Your Coverage

Any changes in Your classification or coverage will take effect on the first day of the Plan month which coincides with or follows the day of the change.

Special Enrollment Provisions

(a) For individuals losing other coverage:

A person who:

- (1) is otherwise eligible under the Plan; and
- (2) failed to enroll when he or she first became eligible;

may enroll, but only if **each** of the following conditions is met:

- (1) the person was covered under a group health plan or had other Health Coverage at the time coverage under the Plan was previously offered to the person;
- (2) the person stated in writing that coverage under such group health plan or Health Coverage was the reason for declining enrollment; but only if We required such a statement and provided the person with notice of such requirement (and the consequences of such requirement) at such time;
- (3) if such coverage:
 - a. was under a COBRA continuation provision and the coverage under such provision was exhausted; except this will not apply when the person failed to pay timely premium; or if coverage terminated for cause, (such as making a fraudulent claim or an intentional misrepresentation of a material fact); or
 - b. was not under a COBRA continuation provision and either the coverage was terminated as a result of:
 - (1) loss of eligibility for the coverage, including as a result of legal separation; divorce; death; termination of employment; or reduction in the number of hours of employment; except this will not apply when the person failed to pay timely premium or if coverage terminated for cause (such as making a fraudulent claim or an intentional misrepresentation of material fact); or
 - (2) the current or former employer contributions towards such coverage were terminated; and
- (4) the person requests enrollment under the Plan not later than 30 days after the date such other coverage ended. The coverage will become effective on the first day of the first calendar month following Our receipt of the enrollment request; or on an earlier date, as agreed to by Us.

(b) Any Preexisting Condition provision of the Plan will apply.

When Your Coverage Ends

Your coverage will end at midnight on the earliest of:

- (a) the day the Plan ends;
- (b) the day any premium for Your coverage is due and unpaid;

- (c) the day before You enter the Armed Forces on active duty (except for temporary active duty of two weeks or less);
- (d) the last day of the Plan month in which You are no longer eligible under the Plan; or
- (e) the day before You become covered under any Alternate Health Benefits Plan which is offered by, through or in connection with Trustees of Plumbers Local Union No. 16 Health and Welfare Fund as an option to coverage under the Plan.

You will no longer be eligible when:

- (f) You are no longer in an eligible class; or
- (g) You do not satisfy:
 - (1) the requirements for hours worked; or
 - (2) any other eligibility conditions in the Plan.

However, Your coverage may be continued as specified in the “COBRA Group Health Coverage Continuation” provision found later on in this Booklet.

Continuation Provision

Disabled Employees

If You meet the requirements Your coverage may be continued indefinitely if disabled: You must have worked at least 10 years for one or more contributing employers in order to qualify for the indefinite disability continuation.

(This section applies to In-Network Only)

Termination For Cause

In addition, Your coverage will be terminated for cause if:

- (a) You permit the use of Your identification card by any other person, or if You use another person’s identification card (We have the right of recovery from You for the cost of those services obtained);
- (b) You knowingly misrepresent or give false information on any enrollment form or application which is material to Our acceptance of such enrollment form or application (This does not supersede the “Applications” section shown in the Standard Provisions of the Plan);
- (c) You fail to abide by the terms and conditions of the Plan;
- (d) after reasonable efforts, You are unable to establish and maintain a satisfactory physician - patient relationship with Your Primary Care Physician;
- (e) You repeatedly and unreasonably refuse to follow a prescribed course of treatment;
- (f) You obtain or attempt to obtain services or benefits under this Plan by means of false, misleading or fraudulent information, acts or omissions;
- (g) Your behavior is, in Our opinion disruptive, unruly, abusive or uncooperative to the extent that Our ability, to provide services to the Member or to any other Member is seriously impaired; or
- (h) You threaten the life or well-being of Our personnel, or providers of health care services and benefits, or of any other Member.

ELIGIBILITY

For You - Retired Employees

Eligible Employees

You are eligible if You:

- (a) are at least age 55 and comply with either (b) or (c) below;
- (b) have completed 10 consecutive years of active service with participating employers of the Plumbers Local Union No. 16 Health and Welfare Fund before 1998; or
- (c) have completed 5 consecutive years of active service with participating employers of the Plumbers Local Union No. 16 Health and Welfare Fund after 1998.

You will be eligible for continuation of all benefits provided by the Plan if You are less than normal retirement age and are Totally Disabled.

When Your Coverage Begins

To enroll for coverage under the Plan You must make a written request by submitting completed applications and forms provided by Exclusive Healthcare Inc. and/or United of Omaha .

If Exclusive Healthcare Inc. and/or United of Omaha receives Your signed written request on, before or within 31 days from the day You become eligible, You will become covered on the later of:

- (a) the day You become eligible; or
- (b) the day Exclusive Healthcare Inc. and/or United of Omaha receives Your request.

Reinstatement of Coverage

If You want to reinstate Your coverage after You have voluntarily let it lapse, You may be considered a Late Enrollee. Exclusive Healthcare Inc. and/or United of Omaha will determine the day Your coverage begins.

Coverage Requirement

To cover Your dependents under this Plan, You must be covered. If at a later date, Your coverage ends, Your dependents' coverage will also end.

Amount of Coverage

The amount of coverage for Your classification is shown in the **Schedule**.

Changes in Your Classification or in the Amount of Your Coverage

Any changes in Your classification or coverage will take effect on the first day of the Plan month which coincides with or follows the day of the change.

When Your Coverage Ends

Your coverage will end at midnight on the earliest of:

- (a) the day the Plan ends;
- (b) the day any premium for Your coverage is due and unpaid;
- (c) the day You are no longer eligible under the Plan; or
- (d) the day before You become covered under any Alternate Health Benefits Plan which is offered by, through or in connection with the Trustees of Plumbers Local Union No. 16 Health and Welfare Fund as an option to coverage under the Plan.

You will no longer be eligible when You are no longer in an eligible class.

Your coverage will be continued indefinitely.

Refer to the “COBRA Group Health Coverage Continuation” provision found later on in this Booklet for other circumstances for which Your Health Coverage may be continued.

(This section applies to In-Network Only)

Termination For Cause

In addition, Your coverage will be terminated for cause if:

- (a) You permit the use of Your identification card by any other person, or if You use another person’s identification card (We have the right of recovery from You for the cost of those services obtained);
- (b) You knowingly misrepresent or give false information on any enrollment form or application which is material to Our acceptance of such enrollment form or application (This does not supersede the “Applications” section shown in the Standard Provisions of the Plan);
- (c) You fail to abide by the terms and conditions of the Plan;
- (d) after reasonable efforts, You are unable to establish and maintain a satisfactory physician - patient relationship with Your Primary Care Physician;
- (e) You repeatedly and unreasonably refuse to follow a prescribed course of treatment;
- (f) You obtain or attempt to obtain services or benefits under this Plan by means of false, misleading or fraudulent information, acts or omissions;
- (g) Your behavior is, in Our opinion disruptive, unruly, abusive or uncooperative to the extent that Our ability, to provide services to the Member or to any other Member is seriously impaired; or
- (h) You threaten the life or well-being of Our personnel, or providers of health care services and benefits, or of any other Member.

ELIGIBILITY
For Your Dependents

Eligible Dependents

Only the following are eligible for dependents coverage:

- (a) Your lawful spouse;
- (b) Your natural-born or legally adopted child;
- (c) Your stepchild who is living in Your home and is Your dependent for federal income tax purposes; and
- (d) A foster child.

A foster child is:

- (1) a child You are raising as Your own;
- (2) a child who lives in Your home;
- (3) a child for whom You have taken full parental responsibility and control; and
- (4) a child who is Your dependent for federal income tax purposes.

A foster child is not:

- (1) a child temporarily living in Your home;
- (2) a child placed with You in Your home by a social service agency which retains control of the child; or
- (3) a child whose natural parent is in a position to exercise or share parental responsibility and control.

When both parents of a child are covered under the Plan as employees, the child can be covered only as a dependent of one parent.

NOTE: If Your dependents were eligible for coverage under any prior group plan provided by Us, but did not elect coverage, such dependents may be considered Late Enrollees. The Plan will determine the date coverage begins.

If You transfer into the Service Area Your dependents are eligible to elect coverage under the Plan provided: (1) Your dependents were covered by the Plan's Alternate Health Benefits Plan (if any such plan was available) at the time of such transfer; and (2) You meet the eligibility requirements of the Plan.

Adopted Child (as federally mandated by OBRA 93)

A minor child, under the age of 18, placed with You for the purpose of legal adoption will be covered from the moment the child is placed in Your custody.

Coverage for such child will not continue beyond 31 days of placement unless any required premium has been paid to Us before that 31st day.

The child's coverage will continue subject to any required premium until the earlier of:

- (a) the day the child is removed from Your custody prior to legal adoption; or
- (b) the day coverage would otherwise end in accordance with the Plan provisions.

Definition

Placed with You for the purpose of legal adoption means assumption and retention by the Member of a legal obligation for total or partial support of such child in anticipation of adoption of such child.

This provision is in addition to any other Adopted Child provision contained in the Plan.

Dependents Not Eligible

The following are not eligible for dependents coverage:

- (a) Your divorced spouse or any married child;
- (b) A child who has been legally adopted by another person (Coverage ends on the date custody is assumed by the adoptive parents);
- (c) In the absence of written employer guidelines, anyone eligible for coverage under the Plan as an employee, union member or an association group member;
- (d) A child who has attained the **limiting age**. The limiting age is:
 - (1) the child's **19th birthday**; or
 - (2) the **23rd birthday** if the child is a full-time student in any accredited high school, trade school, college or university and is Your dependent for federal income tax purposes; or
- (e) a dependent who has had coverage under the Plan terminated for cause as specified under the "Termination For Cause" provision.

Handicapped Child

The coverage for a mentally or physically handicapped child who attains the limiting age while covered under the Plan may be continued if the child:

- (a) is chiefly dependent on You for support; and
- (b) is not capable of self-sustaining employment.

The coverage will continue only if You give Us proof of the child's handicap:

- (a) no later than 31 days after the child attains the limiting age; and
- (b) thereafter as We may require, but not more often than once every two years.

When Dependents Coverage Begins

Dependents coverage will begin the later of:

- (a) the day You are covered; or
- (b) the day You first acquire an eligible dependent.

Once You have a dependent covered, any newly acquired eligible dependent will be covered automatically.

**Newborn Exception
(For In-Network)**

You must choose a Primary Care Physician for Your newborn prior to its birth.

To continue coverage beyond the first 31 days of life, You must make a written request for coverage in accordance with the Special Enrollment Provisions, and any required premium must be paid. Coverage will begin the date of the child's birth.

If You make a written request 31 days after the birth of the newborn dependent child, such child will be considered a Late Enrollee. Exclusive Healthcare, Inc. and/or United of Omaha will determine the day the newborn child's coverage will begin.

(For Out-of-Network)

Newborn children. Your newborn child, born while You are covered under the Plan, will automatically be covered; but coverage beyond 31 days for a newborn child will be continued only if any required premium is paid.

Late Enrollee Provision

A late enrollee may elect coverage under the Plan only during any open enrollment under the Plan. Annual open enrollment periods will be allowed in which You may elect Coverage. The annual open enrollment period is designated by Trustees of Plumbers Local Union No. 16 Health and Welfare Fund and agreed to by Exclusive Healthcare, Inc. or United of Omaha, but in no event more than 30 calendar days.

If You waived coverage during any enrollment period You may elect coverage during any subsequent enrollment period. You are not considered a Late Enrollee if You were covered by another employer-sponsored medical plan immediately preceding selection of Our Plan at open enrollment. You will become covered on the following April 1, provided You are actively at work. If You are not actively at work on that day, Your coverage will begin on the day You return to active work.

Any requirement regarding eligibility, or that an otherwise-eligible person be actively at work before coverage may begin or remain in force is **not** applicable, if the eligibility for the coverage or the absence is due to a Health Status-Related Factor.

**Medical Child Support Order
(as federally mandated by OBRA 93)**

If Your eligible child is not covered because You did not enroll Your child for dependents coverage, such child may be enrolled after We: (a) receive a final medical child support order which requires enrollment; and (b) determine that the order is qualified.

Our Procedures for Determining if a Medical Child Support Order is Qualified. When We receive a proposed or final medical child support order, the Plan will notify You and each child named in the order, at the addresses shown in the order, that We have received it. The Plan will then review the order to decide if it meets the definition of a "qualified medical child support order". Within 30 days after We

receive the order (or within a reasonable time thereafter), the Plan will give a written notice of our decision to You and each child named in the order. The Plan will also send Our notices to each attorney or other representative who may be named in the order or in other correspondence filed with Us. If We decide that the order is not qualified, Our notice will provide the specific reasons for Our decision and the opportunity to correct the order or appeal Our decision by contacting Us within 30 days. If We decide that the order is qualified, Our notice will provide instructions for enrolling each child named in the order; and the Plan provisions that apply for other eligible dependents (such as the exceptions for when dependents coverage begins and the rules for determining when dependents coverage ends) will also apply for each child named in the order. The Plan must receive a certified copy for the entire “qualified medical child support order” before enrollment can occur. Also, if the cost of each child’s coverage is to be deducted from Your pay, Trustees of Plumbers Local Union No. 16 Health and Welfare Fund must receive proper authorization in the order or otherwise.

As part of our authority to interpret the Plan, the Plan has the discretion and final authority to decide if an order meets or does not meet the definition of a “qualified medical child support order” so as to require the enrollment of Your child as an eligible dependent; and Our reasonable decision will be binding and conclusive on all persons. If, as a result of an order, benefits are paid to reimburse medical expenses paid by a child or the child’s custodial parent or legal guardian these benefits will be paid to the child or the child’s custodial parent or legal guardian.

The Plan Sponsor will treat each child enrolled because of a “qualified medical child support order” as a participant for purposes of the reporting and disclosure requirements of a federal law known as ERISA.

The Definition of “Qualified Medical Child Support Order”. A “qualified medical child support order” is defined by Section 609 of ERISA. In general, a “qualified medical child support order” means any judgment, decree or order (including approval of a settlement agreement) issued by a court of competent jurisdiction which:

- (a) either: (1) relates to medical benefits under the Plan and provides for Your child’s support or health benefit coverage pursuant to a state domestic relations law (including a community property law); or (2) enforces a law relating to medical child support described in Section 1908 of the Social Security Act;
- (b) creates or recognizes the existence of Your child’s right to be enrolled and receive medical benefits under the Plan;
- (c) states the name and last known mailing address (if any) of You and each child covered by the order;
- (d) reasonably describes the type of medical coverage to be provided by the Plan to each child, or the manner in which this type of coverage is to be determined;
- (e) states the period to which the order applies;
- (f) states each Plan to which the order applies; and
- (g) does not require the Plan to provide any type or form of benefit or any option not otherwise provided by the Plan, except to the extent necessary to meet the requirements of Section 1908 of the Social Security Act for medical child support orders.

Change in the Amount of Dependents Coverage

Any changes in the coverage of a dependent will take effect on the day of the change.

Special Enrollment Provisions

(a) For individuals losing other coverage:

A person who:

- (1) is otherwise eligible under the Plan; and
- (2) failed to enroll when he or she first became eligible;

may enroll, but only if **each** of the following conditions is met:

- (1) the person was covered under a group health plan or had other Health Coverage at the time coverage under the Plan was previously offered to the person;
- (2) the person stated in writing that coverage under such group health plan or Health Coverage was the reason for declining enrollment; but only if We required such a statement and provided the person with notice of such requirement (and the consequences of such requirement) at such time;
- (3) if such coverage:
 - a. was under a COBRA continuation provision and the coverage under such provision was exhausted; except this will not apply when the person failed to pay timely premium; or if coverage terminated for cause, (such as making a fraudulent claim or an intentional misrepresentation of a material fact); or
 - b. was not under a COBRA continuation provision and either the coverage was terminated as a result of:
 - (1) loss of eligibility for the coverage, including as a result of legal separation; divorce; death; termination of employment; or reduction in the number of hours of employment; except this will not apply when the person failed to pay timely premium or if coverage terminated for cause (such as making a fraudulent claim or an intentional misrepresentation of material fact); or
 - (2) the current or former employer contributions towards such coverage were terminated; and
- (4) the person requests enrollment under the Plan not later than 30 days after the date such other coverage ended. The coverage will become effective on the first day of the first calendar month following Exclusive Healthcare, Inc. or United of Omaha's receipt of the enrollment request; or on an earlier date, as agreed to by Exclusive Healthcare, Inc. or United of Omaha.

(b) For individuals otherwise eligible: In addition to the eligibility provisions contained in the Plan, the following also applies:

- (1) If You are covered under the Plan (or have met any waiting period and are eligible to enroll under the Plan, but did not enroll during a previous enrollment period); and a person becomes Your eligible dependent through marriage, birth, or adoption or placement or adoption; the Plan will provide for a special enrollment period described below during which such dependent (and You, if not otherwise enrolled) may be enrolled under the Plan; and in the case of the birth or adoption of a child, Your spouse may also be enrolled as Your dependent if he or she is otherwise eligible for coverage;

- (2) This special enrollment period shall be a period of not less than 30 days, and begins on the later of:
 - a. the date dependent coverage is made available under the Plan; or
 - b. the date of the marriage, birth, or adoption or placement for adoption (as the case may be);
 - (3) If You request to enroll during the first 30 days of such special enrollment period, the coverage shall become effective:
 - a. in the case of marriage, on the first day of the first calendar month following Our receipt of the enrollment request; or on an earlier date as agreed to by Us;
 - b. in the case of a dependent's birth, on the date of such birth; or
 - c. the case of a dependent's adoption or placement for adoption, the date of such adoption or placement for adoption;
- (c) Any Preexisting Condition provision of the Plan will apply.

When Dependents Coverage Ends

A dependent's coverage will end at midnight on the earliest of:

- (a) the last day of the Plan month the dependent is no longer eligible under the Plan;
- (b) the day any dependent premium is due and unpaid;
- (c) the day the Plan ends;
- (d) the day before a dependent enters the Armed Forces on active duty (except for temporary active duty of two weeks or less);
- (e) the day dependents coverage under the Plan ends because of lack of participation;
- (f) the day Your coverage ends; or
- (g) the day before any dependent becomes covered under any Alternate Health Benefits Plan which is offered by, through or in connection with Us as an option to coverage under the Plan.

However, Your dependents coverage may be continued as specified in the "COBRA Group Health Coverage Continuation" provision found later on in this Booklet.

(For In-Network only)

Termination For Cause

In addition, Your dependents coverage will be terminated for cause if:

- (a) Your dependent permits the use of his/her identification card by any other person, or if he/she uses another person's identification card (We have the right of recovery from You for the cost of those services obtained);
- (b) Your dependent knowingly misrepresents or gives false information on any enrollment form or application which is material to our acceptance of such enrollment form or application (This does not supersede the "Applications" section shown in the Standard Provisions of the Plan);
- (c) Your dependent fails to abide by the terms and conditions of the Plan;

- (d) after reasonable efforts, Your dependent is unable to establish and maintain a satisfactory physician - patient relationship with his or her Primary Care Physician;
- (e) Your dependent repeatedly and unreasonably refuses to follow a prescribed course of treatment;
- (f) Your dependent obtains or attempts to obtain services or benefits under this Plan by means of false, misleading or fraudulent information, acts or omissions;
- (g) Your dependents behavior is, in Exclusive Healthcare, Inc. opinion, disruptive, unruly, abusive or uncooperative to the extent that Exclusive Healthcare, Inc.'s ability to provide services to the Member or to any other Member is seriously impaired; or
- (h) Your dependent threatens the life or well-being of Exclusive Healthcare, Inc.'s personnel, or providers of health care services and benefits, or of any other Member.

FAMILY AND MEDICAL LEAVE

as Federally Mandated For Active Members

Family and Medical Leave

If You become eligible for a family or medical leave of absence in accordance with the Family and Medical Leave Act of 1993 (FMLA) (including any amendments to such Act) Your coverage may be continued on the same basis as if You were an actively-at-work employee for up to 12 weeks during the 12 month period, as defined by Us, for any of the following reasons:

- (a) to care for Your child after the birth or placement of a child with You for adoption or foster care; so long as such leave is completed within 12 months after the birth or placement of the child;
- (b) to care for Your spouse, child, foster child, adopted child, stepchild, or parent who has a serious health condition; or
- (c) for Your own serious health condition.

In the event You and Your spouse are both covered as employees of a participating employer of the Plumbers Local Union No. 16 Health and Welfare Fund, the continued coverage allowed under (a) may not exceed a combined total of 12 weeks. In addition, if the leave is taken to care for a parent with a serious health condition, the continued coverage may not exceed a combined total of 12 weeks.

Conditions:

- (a) If, on the day Your coverage is to begin, You are already on an FMLA leave of absence You will be considered actively at work. Coverage for You and any eligible dependents will begin in accordance with the terms of the Plan. However, if Your leave of absence is due to Your own or any eligible dependents' serious health condition, benefits for that condition will not be payable to the extent benefits are payable under any prior group plan.
- (b) You are eligible to continue coverage under FMLA if:
 - (1) You have worked for Us for at least one year;
 - (2) You have worked at least 1,250 hours over the previous 12 months;
 - (3) We employs at least 50 employees within 75 miles from Your worksite; and
 - (4) You continue to pay any required premium for yourself and any eligible dependents in a manner determined by Us.
- (c) In the event You choose not to pay any required premium during Your leave, Your coverage will not be continued during the leave. You will be able to reinstate Your coverage on the day You return to work, subject to any changes that may have occurred in the Plan during the time You were not covered. You and any covered dependents will not be subject to any evidence of good health requirement provided under the Plan. Any partially-satisfied waiting periods, including any limitations for a preexisting condition, which are interrupted during the period of time premium was not paid will continue to be applied once coverage is reinstated.

- (d) You and Your dependents are subject to all conditions and limitations of the Plan during Your leave, except that anything in conflict with the provisions of the FMLA will be construed in accordance with the FMLA.
- (e) If requested by us, You or Plumbers Local Union No. 16 Health and Welfare Fund must submit proof acceptable to Exclusive Healthcare, Inc. and United of Omaha that Your leave is in accordance with FMLA.
- (f) This FMLA continuation is concurrent with any other continuation option except for COBRA, if applicable. You may be eligible to elect any COBRA continuation available under the Plan following the day Your FMLA continuation ends.
- (g) FMLA continuation ends on the earliest of:
 - (1) the day You return to work;
 - (2) the day You notify Your employer that You are not returning to work;
 - (3) the day Your coverage would otherwise end under the Plan; or
 - (4) the day coverage has been continued for 12 weeks.

Important Notice:

Contact Your employer or the Plan's administration office for additional information regarding FMLA.

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS

as Federally Mandated
For Active Members

Continuation of Group Health Coverage

1. **For You and Your eligible dependents:** If Health Coverage ends because of Your service in the uniformed services, You may elect to continue such Health Coverage, if required by USERRA, until the earlier of:
 - (a) the end of the period during which You are eligible to apply for reemployment in accordance with USERRA; or
 - (b) 24 consecutive months after coverage ended.
2. To continue coverage, You or Your dependent must pay the required premium, (including Your former employer's share and any retroactive premium), unless Your service in the uniformed service is for fewer than 31 days, in which event You must pay Your share, if any, of the premium. The Plan Administrator will inform You or Your dependent of procedures to pay premiums.
3. **End of Continuation.** A member's continued Health Coverage will end at midnight on the earliest of:
 - (a) the day Your former employer ceases to provide any group health plan to any employee;
 - (b) the day premium is due and unpaid;
 - (c) the day a member again becomes covered under the Plan;
 - (d) the day Health Coverage has been continued for the period of time provided in part 1.(a) or (b) above (or any longer period provided in the Plan); or
 - (e) the day the Plan terminates.

Any Health Coverage for an eligible dependent will also end as provided in the "When Dependents Coverage Ends" provision of the Plan.

4. **Other Continuation Provisions.** In the event Health Coverage is continued under any other continuation provision of the Plan, the periods of continued coverage will run concurrently. If another continuation provision provides a shorter continuation period for which premium is paid in whole or in part by Your employer, then the premium You are required to pay may increase for the remainder of the period provided above.

Reemployment (following service in the uniformed services)

Following Your discharge from such service, You may be eligible to apply for reemployment with Your former employer in accord with USERRA. Such reemployment includes Your right to elect reinstatement in any then existing Health Coverage provided by Your employer.

Other Benefits

Our leave of absence policy will determine Your right to participate in any group life or other coverage.

After reemployment, credit will be given, if applicable, for the period of such service, if required to determine Your benefit amounts, eligibility, or costs.

Important Notice

In the event of a conflict between this provision and USERRA, the provisions of USERRA, as interpreted by Us or former employer, will apply.

COORDINATION OF BENEFITS (COB)

NOTE: Regardless of whether We are the primary or secondary Plan, this provision is subject to the terms and conditions of the Plan.

Coordination of Benefits (COB)

If the Claimant is covered by another Plan or Plans, the benefits under the Plan and the other Plan(s) will be coordinated. This means one Plan pays its full benefits first, then the other Plan(s) pay(s).

1. The Primary Plan (which is the Plan that pays benefits first) pays the benefits that would be payable under its terms in the absence of this provision.
2. The Secondary Plan (which is the Plan that pays benefits after the Primary Plan) will limit the benefits it pays under its terms, so that the sum of its benefits and all other benefits paid by the Primary Plan will not exceed the greater of:
 - (a) 100% of total Covered Expense; or
 - (b) the amount of benefits it would have paid had it been the Primary Plan.

The Order of Benefit Determination paragraph below explains the order in which Plans must pay.

This COB provision will not apply to a claim when the Covered Expense for a Claim Period is \$50 or less; but if:

- (a) additional expense is incurred during the Claim Period; and
- (b) the total Covered Expense exceeds \$50;

then this COB provision will apply to the total amount of the claim.

Order of Benefit Determination

When another Plan **does not** have a COB provision, that Plan must determine benefits first.

When another Plan **does** have a COB provision, the first of the following rules which applies governs:

- (a) If a Plan covers the Claimant as an employee, member or nondependent, then that Plan will pay its benefits first.
- (b) If the Claimant is a dependent child whose parents **are not** divorced or separated then the Plan of the parent whose birthday anniversary is earlier in the calendar year will pay first; except:
 - (1) If both parents' birthdays are on the same day, rule (d) below will apply.
 - (2) If another Plan does not include this COB rule based on the parents' birthdays, but instead has a rule based on the gender of the parent, then that Plan's COB rule will determine the order of benefits.
- (c) If the Claimant is a dependent child whose parents **are** divorced or separated, then the following rules apply:

- (1) A Plan which covers a child as a dependent of a parent who by court decree must provide health coverage will pay first.
- (2) When there is no court decree which requires a parent to provide health coverage to a dependent child, the following rules will apply:
 - a. When the parent who has custody of the child **has not** remarried, that parent's Plan will pay first.
 - b. When the parent who has custody of the child **has** remarried, then benefits will be determined by that parent's Plan first, by the stepparent's Plan second, and by the Plan of the parent without custody third.
- (d) If none of the above rules apply, the Plan which has covered the Claimant for the longer period of time will pay its benefits first then the Plan which covers the claimant will pay first.

Where part of a Plan coordinates benefits and a part does not, each part will be treated like a separate Plan.

Credit Savings

Where the Plan does not have to pay its full benefits because of COB, the savings will be credited to the Claimant for the Claim Period. These savings would be applied to any unpaid Covered Expense during the Claim Period.

How COB Affects Plan Benefit Limits

If COB reduces the benefits payable under more than one Plan provision, each benefit will be reduced proportionately. Only the reduced amount will be charged against any benefit limit in those Plan provisions.

Right To Collect and Release Needed Information

In order to receive benefits, the Claimant must give Exclusive Healthcare, Inc. any information which is needed to coordinate benefits. With the Claimant's consent, Exclusive Healthcare, Inc. may release to or collect from any person or organization any needed information about the Claimant.

Facility of Payment

If benefits which this Plan should have paid are instead paid by another Plan, this Plan may reimburse the other Plan. Amounts reimbursed are Plan benefits and are treated like other Plan benefits in satisfying Plan liability.

Right of Recovery

If this Plan pays more for a Covered Expense than is required by this provision, the excess payment may be recovered from:

- (a) the Claimant;
- (b) any person to whom the payment was made; or
- (c) any insurance company, service plan or any other organization which should have made payment.

Definitions (for this section only)

Plan means any of the following coverages, including this Plan's coverage and any coverage which is declared to be "excess" to all other coverages, which provide benefit payments or services to a Member for hospital, medical, surgical, dental, prescription drug or vision care:

- (a) Group, blanket or franchise insurance (except student accident insurance);
- (b) Group Blue Cross and/or Blue Shield and other prepayment coverage on a group basis, including HMOs (Health Maintenance Organizations);
- (c) Coverage under a labor-management trustees plan, a union welfare plan, an employer organization plan or an employee benefits plan;
- (d) Coverage under government programs, other than Medicare or Medicaid, and any other coverage required or provided by law;
- (e) Group or individual automobile "no fault" coverage;
- (f) Other arrangements of insured or self-insured group coverage.

If any of the above coverages include group and group-type hospital indemnity coverage, Plan also means that amount of indemnity benefits which exceeds \$100 a day.

Claimant means the Member for whom the claim is made.

Claim Period means part or all of a calendar year during which the claimant is covered under the Plan.

A **Covered Expense** means any medically necessary, usual and customary item of expense which is covered at least in part by any of the Plans involved during a Claim Period. Where a Plan provides benefits in the form of a service rather than cash payments, the reasonable cash value of the service during a Claim Period will also be considered a Covered Expense. The difference in cost of a private hospital room and the cost of a semiprivate room is not considered a covered expense unless the claimants stay in a private room is medically necessary.

MEDICARE COORDINATION OF BENEFITS

Medicare COB

This Medicare COB provision applies when a Member:

- (a) has health coverage under the Plan; and
- (b) is eligible for coverage under Medicare, Parts A and B, (whether or not the Member has applied or is enrolled in Medicare).

It applies before any other COB provision of the Plan.

Effect on Benefits

1. If, in accord with the following rules, We have primary responsibility for the Member's claims, then the Plan will pay Plan benefits first.
2. If, in accord with the following rules, We have secondary responsibility for the Member's claims:
 - (a) first Medicare benefits are determined or paid; and
 - (b) then Plan benefits are paid;but, for services payable under both plans, the combined Medicare benefits and Plan benefits will not exceed 100% of the services payable.

Rules for Determining Order of Benefits

1. **For You.** We have primary responsibility for Your claims if:
 - (a) You are covered under the Plan because of Your current active employment status with an ADEA employer, and You are eligible for Medicare benefits because of age; or
 - (b) the Plan is part of a large group plan, and You are covered under the Plan because of Your current active employment status, and You are eligible for Medicare benefits because of disability.

We have secondary responsibility for Your claims if You are eligible for Medicare benefits and the above conditions do not apply.

2. **For Your Dependent.** We have primary responsibility for Your dependent's claims if:
 - (a) You are covered under the Plan because of Your current active employment status with an ADEA employer, and Your dependent spouse is eligible for Medicare because of age; or
 - (b) the Plan is part of a large group plan, and You are covered under the Plan because of Your current active employment status, and Your dependent is eligible for Medicare benefits because of disability.

We have secondary responsibility for Your dependent's claims if Your dependent is eligible for Medicare benefits and the above conditions do not apply.

3. **Exception for End Stage Renal Disease.** If Medicare does not already have primary responsibility when You or Your dependent becomes eligible for Medicare benefits because of end stage renal disease:
- (a) We have primary responsibility for Your or Your dependent's claims for up to 30 months beginning with the month in which You or Your dependent is first eligible for Medicare benefits because of end stage renal disease; and
 - (b) We have secondary responsibility after the end of this 30-month period.

Important Information About Medicare

Medicare may affect Plan benefits; therefore, You may want to contact Your local Social Security office for information about Medicare. This should be done before Your or Your spouse's 65th birthday.

SUBROGATION

If You recover any charges from a third party for covered expenses, the amount of the benefit payable by the respective plan will be reduced by the amount the You recover, subject to applicable collective bargaining agreements and/or Company policy.

In addition, the Plan shall be subrogated to the extent of any payments made by the Plan to all rights of recovery of You or Your dependent against any individual, organization or entity in connection with any injury, disease, sickness or condition to which the Plan makes payments. You or Your dependent shall do nothing after the loss to prejudice the rights of the Plan and shall do everything necessary to secure such rights. Your refusal or failure to help with the subrogation process will not limit the Plan's rights, but it can be grounds for denial of Your claims. The Plan shall be reimbursed by You or Your dependent, to the extent of payments made by the Plan, from the proceeds of any settlement, judgment or payments made by any individual, organization or other entity to You or Your dependent.

Any amounts recovered in connection with an injury, disease, sickness or condition to which the Plan makes payments shall be apportioned as follows:

- (a) the Plan shall receive the first dollars of any recovery to the extent of the Plan's payments; and
- (b) the remaining balance of any recovery shall be apportioned to You or Your dependent and any other Plan or insurer providing benefits to You or Your dependent.

In the event You or Your dependent receive moneys as the result of injury, sickness, accident or condition, and the Plan is entitled to such moneys and is not reimbursed the full amount it has paid for such injury, sickness, accident or condition, the Plan shall have the right to reduce future payments due to You or Your dependent, by the amount of benefits paid by the Plan. This right of offset shall not, however, limit the rights of the Plan to recover such moneys in any other manner.

COBRA GROUP HEALTH COVERAGE CONTINUATION

As Federally Mandated

Continuation of Group Health Coverage

1. **For You and Your Dependents.** You and/or any covered dependent may elect to continue Health Coverage for as long as 18 months from the day Your coverage ends because of these qualifying events:

- (a) Your employment terminates (other than due to gross misconduct); or
- (b) You no longer satisfy the requirements for hours worked.

If a covered person is determined, in accordance with Title II or XVI of the Social Security Act, to have been disabled at any time during the first 60 days of continued coverage, the reference to 18 months in the preceding sentence is deemed a reference to 29 months. Notice of such determination must be given to the Plan Administrator before the first 18 months of continued coverage ends and within 60 days of the date of the determination. Refer to Part 3 of this provision.

During the period You continue coverage:

- (a) any new eligible dependents You acquire may be added in accord with the Dependents Eligibility provisions; and
- (b) any eligible dependents You declined to cover before Your continued Health Coverage began may be added during any open enrollment period provided by the Plan;

provided any additional premium is paid. However, such dependents, other than a qualified beneficiary, who are added after the qualifying event will not be entitled to continue coverage as qualified beneficiaries after an event occurs as shown in part 2.

Qualified beneficiary means, with respect to a covered employee under a group health plan, any other individual who, on the day before the qualifying event for that employee, is a beneficiary under the plan:

- (a) as the spouse of the covered employee; or
- (b) as the dependent child of the employee.

Qualified Beneficiary also includes a child who is born or is placed for adoption with the covered employee during the period of continued coverage.

2. **For Your Dependents Only.** Your covered spouse and/or each of Your covered dependent children may elect to continue Health Coverage for as long as 36 months from the day coverage ends because of these qualifying events:

- (a) You die;
- (b) You become entitled to Medicare benefits;

- (c) You and Your spouse are legally separated;
- (d) Your marriage is ended by divorce; or
- (e) a child is no longer an eligible dependent.

If Your dependent is already continuing coverage under part 1 when an event shown in part 2 occurs, that second event will not entitle Your dependent to continue coverage beyond 36 months under parts 1 and 2 combined.

If Your dependent becomes entitled to continue Health Coverage under both parts 1 and 2 on the same day, the periods of continued coverage will run concurrently and will not exceed 36 months.

3. **Notice Requirements.** Your employer is required by law to notify the Plan Administrator within 30 days after Your termination of employment, reduction in hours, death or entitlement to Medicare. You must notify the Plan Administrator within 60 days after the day You are legally separated or divorced, or Your child ceases to be an eligible dependent.

If a covered person is determined, in accordance with Title II or XVI of the Social Security Act, to have been disabled at any time during the first 60 days of continued coverage, that person must:

- (a) notify the Plan Administrator within 60 days of the date of the determination and before the first 18 months of continued coverage ends; and
- (b) notify the Plan Administrator within 30 days of the date of any final determination that he or she is no longer disabled. Then, continued coverage ends the month that begins more than 30 days after the date of such final determination.

Within 14 days after receiving notice of a qualifying event, the Plan Administrator will send You or Your dependent written notice of the continuation right. The Plan Administrator must receive Your or Your dependent's written request to continue Health Coverage within 60 days after the day:

- (a) Health Coverage ends; or
 - (b) the covered person is sent notice of the continuation right;
- whichever is later.

To continue coverage, You or Your dependent must pay the required premium, including any retroactive premium. The initial premium must be paid to the Plan Administrator within 45 days after the day continued coverage is elected. The Plan Administrator will inform You or Your dependent of procedures to pay subsequent monthly premiums.

4. **End of Continuation.** A covered person's continued Health Coverage will end at midnight on the earliest of:
- (a) the day Your employer ceases to provide any group health plan to any employee;
 - (b) the day premium is due and unpaid;
 - (c) the day a covered person is covered under group coverage as an employee or otherwise. However this does not apply when the covered person is covered under another group plan which contains any preexisting condition limitations which apply to that person. Then, he or she may continue coverage under this Plan until the earlier of:

- (1) the day the preexisting conditions limitation under the new group plan no longer applies; or
 - (2) the day continued coverage would otherwise end;
 - (d) the day a covered person again becomes covered under the Plan;
 - (e) the day a covered person is entitled to benefits under Medicare;
 - (f) the day Health Coverage has been continued for the period of time provided in Part 1, Part 2 or the first item (b) of Part 3 above (or any longer period provided in the Plan);
 - (g) the day the Plan terminates.
5. **Other Continuation Provisions.** In the event Health Coverage is continued under any other continuation provision of the Plan, the periods of continued coverage will run concurrently. If another continuation provision provides a shorter continuation period for which premium is paid in whole or in part by Your employer, then the premium You are required to pay may increase for the remainder of the 18-month, 29-month, or 36-month period provided above.

(Applicable to In-Network Benefits)

NOTE: For Qualified Beneficiaries Who Leave The Service Area.

If a qualified beneficiary leaves the Service Area, he or she will be allowed to change coverage to an alternate group health plan offered through the employer, for the period of continued coverage if:

- (a) the employer allows active employees to elect an alternate group health plan when transferred to this location; or
- (b) the employer permits active employees to change to an alternate group health plan at any time at this location.

If the employer only allows an active employee to change to an alternate group health plan at open enrollment, a qualified beneficiary who leaves the Service Area may continue his coverage under this Plan (though only Emergency Services Benefits will be payable) until the next open enrollment when the qualified beneficiary may change to one of the employers alternate group health plans (if available at this location) for the remaining period of continued coverage.

A qualified beneficiary may elect to convert to an individual conversion policy in accord with the Health Conversion Provision if an alternate group health plan is not available through the employer at the location to which the qualified beneficiary has moved.

Definition

Health Coverage as used in this provision generally means the hospital, surgical, medical, prescription drugs and HMO Coverage You had on the day before the qualifying event. Health Coverage is subject to change as a result of open enrollments or plan modifications.

PAYMENT OF CLAIMS

Exclusive Healthcare, Inc. contracts with health care providers to provide health care services to eligible Members, therefore filing a claim should normally not be necessary while You or Your dependents are covered under the Plan. However, should You or Your dependent receive a charge for any service which is covered under the Plan (for example, out-of-area emergency care or prescriptions written by a non-participating provider) it will be necessary for You to file a written proof of loss, as described below, before benefits are paid.

(Provisions below apply to In-Network and Out-of-Network Benefits)

Proof of Loss Requirements

1. First, request a claim form from the Plan Administrator or from the Claims Administrator.

This request should be made:

- (a) within 20 days after a loss occurs; or
- (b) as soon as reasonably possible.

When Your request is received, You will be sent a claim form for filing proof of loss. If the claims form is not received within 15 days, You can meet the proof of loss requirement by giving a written statement of what happened. A written statement must be received within the time shown in 3 below.

2. Next, complete and sign the claim form. If a physician must complete part of the claim form, have the physician complete and sign that part.
3. Finally, return the claim form (with any bills) to the Claims Administrator. The claim form is due:
 - (a) within 90 days after the loss occurs; or
 - (b) as soon as reasonably possible, but not later than one year after (a) above, unless the claimant is not legally capable.

When Claims are Paid

All benefits will be paid as soon as the Claims Administrator receives acceptable proof of loss.

Direct Payments

(Applicable to In-Network Benefits)

All benefits will be paid to the provider of the services; however, if You furnish evidence satisfactory to the Claims Administrator that a payment has been made to the provider for the services for which the claim was submitted, the Claims Administrator will pay benefits to You.

Direct Payments

(Applicable to Out-of-Network)

Any benefits for hospital, medical, surgical, dental or vision services which You have assigned will be paid to the hospital or the provider of the services. If You have not assigned the benefits, the Claims Administrator, at their option, will pay You or the hospital or the provider of the services.

Any other benefits will be paid to You except that benefits unpaid at Your death may be paid, at our option, to:

- (a) Your beneficiary; or
- (b) Your estate.

If Your beneficiary is unable to give a valid release or if benefits unpaid at Your death are not more than \$1,000, we may pay up to \$1,000 to any relative of Yours who we find is entitled to the benefit.

Any payment made in good faith will fully discharge us to the extent of the payment.

Examination

The Claims Administrator will sometimes require that a claimant be examined by a physician of their choice. The Plan will pay for these examinations. The Plan will not require more than a reasonable number of examinations.

PRECERTIFICATION AND CLAIM REVIEW PROCEDURES

(as Federally Mandated)

Definitions

Capitalized terms have the same meaning as shown in the Plan.

For the purposes of this provision:

Adverse Benefit Determination means a denial, reduction, or termination of, or a failure to provide or make payment, (in whole or in part), for a benefit, including, without limitation, any such denial, reduction, termination of, or failure to provide or make payment that is based upon:

- (a) the Covered Person's ineligibility for coverage under the Plan;
- (b) United of Omaha's determination that the treatment or service is not a Covered Service under the Plan;
- (c) a utilization review determination;
- (d) United of Omaha's determination that the treatment or service is considered an Experimental or Investigational Drug or Treatment; or
- (e) United of Omaha's determination that the treatment is not Medically Necessary.

Additionally, if United of Omaha has previously approved an ongoing course of treatment to be provided over a period of time or a given number of treatments, any reduction or termination of such course of treatment by United of Omaha (other than by plan amendment or termination) before the end of such period of time or number of treatments is an Adverse Benefit Determination.

Claim or Request Involving Urgent Care means any claim or request for a benefit for medical care or treatment with respect to which the application of time periods for making nonurgent care determinations:

- (a) could seriously jeopardize the life or health of the Covered Person or the ability of the Covered Person to regain maximum function; or
- (b) in the opinion of a Physician with knowledge of the Covered Person's medical condition, would subject the Covered Person to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. Additionally, if a Physician with knowledge of the Covered Person's medical condition determines that a claim is a Claim or Request Involving Urgent Care, the claim shall automatically be treated as a Claim or Request Involving Urgent Care for the purposes of this provision.

Day(s) means calendar day(s).

For the purposes of these Precertification and Claim Review Procedures, the terms **You, Your, Yours** shall include Your authorized representative.

Precertification and Claim Review Procedures

Once United of Omaha receives information necessary to evaluate the precertification request or evaluate the claim, United of Omaha will make a decision within the time periods set forth below. Please refer to the Utilization Management Provisions, if any; and the Payment of Claims provisions of the Plan.

In the event an extension is necessary due to matters beyond the Plan's control, United of Omaha will notify You of the extension and the circumstances requiring the extension. Except where You voluntarily agree to provide United of Omaha with additional time, extensions are limited as set forth below.

If an extension is necessary due to Your failure to submit complete information, United of Omaha will notify You of the additional information required. Such notice of incomplete information will be sent within the time periods set forth below.

In order for United of Omaha to continue processing Your precertification request or claim, the missing information must be provided to United of Omaha within the time periods set forth below.

You may contact United of Omaha at any time for additional details about the processing of the precertification request or claim.

Claims or Requests Involving Urgent Care

Initial review: 72 hours, unless additional information is requested as set forth below.

If additional information is needed, United of Omaha will notify You within 24 hours of receipt of the request. Once You receive the request for additional information, You will be given no less than 48 hours to submit the additional information to United of Omaha. United of Omaha will make their determination within 48 hours of Our receipt of the additional information. If United of Omaha does not receive the additional information within the specified time period, United of Omaha will make their determination based upon the available information.

Claims or Requests For Benefits Requiring Precertification (excluding Claims or Requests Involving Urgent Care)

- (a) Initial review: 15 days unless additional information is requested as set forth below;
- (b) Extension Period: 15 days; and
- (c) Maximum number of extensions: one.

If additional information is needed, United of Omaha will notify You within five days of receipt of the request. Once You receive the request for additional information, You will be given no less than 45 days to submit the additional information to United of Omaha. United of Omaha will make their determination within 15 days of their receipt of the additional information. If United of Omaha does not receive the additional information within the specified time period, United of Omaha will make their determination based upon the available information.

Claims or Requests For Benefits Not Requiring Precertification

- (a) Initial review: 30 days;
- (b) Extension period: 15 days; and
- (c) Maximum number of extensions: one.

If additional information is needed, United of Omaha will notify You within 30 days of receipt of the request. Once You receive the request for additional information, You will be given no less than 45 days to submit the additional information to United of Omaha. United of Omaha will make their determination within 15 days of their receipt of the additional information. If United of Omaha does not receive the additional information within the specified time period, United of Omaha will make their determination based upon the available information.

Claims or Requests for Benefits Involving Concurrent Care

United of Omaha will notify You of an Adverse Benefit Determination regarding a previously-approved ongoing course of treatment or number of treatments sufficiently in advance to allow You to appeal the Adverse Benefits Determination and obtain a determination of Your appeal before such ongoing treatment is terminated or reduced. (Please refer to the Appeal Rights provision for additional information.)

If You request to extend the course of treatment beyond the period of time or number of treatments that were originally approved by Us, and such request is a Claim Involving Urgent Care, United of Omaha will notify You of their determination within 24 hours of receipt of Your request, provided that United of Omaha receives Your request for extension at least 24 hours prior to the expiration of the prescribed period of time or number of treatments. If United of Omaha does not receive Your request within the 24 hour period, United of Omaha will treat Your request as described in the section entitled “Claims Involving Urgent Care.”

If You request to extend the course of treatment beyond the period of time or number of treatments that were originally approved by United of Omaha and such request is not a Claim Involving Urgent Care, United of Omaha will treat Your request as described in the section herein entitled “Claims For Benefits Requiring Precertification” or “Claims For Benefits Not Requiring Precertification,” whichever is applicable to the request.

Precertification Denials and/or Claim Denials

If a request for precertification or a claim is denied or partly denied, You will receive a written or electronic notice of the denial, which will include:

- (a) the specific reason(s) for the denial;
- (b) reference to the specific Plan provisions on which the denial is based;
- (c) if applicable, a description of any additional material or information necessary to complete the claim and the reason We need the material or information;
- (d) a description of the appeal procedures; the applicable time frames, including Your right to request an appeal within 180 days and Your rights to bring a civil action following the appeal process; and

(e) any other information which may be required under state or federal laws and regulations.

Additionally, if United of Omaha made an Adverse Benefit Determination, You will receive a statement of Your right to receive, upon request and free of charge, any internal rule, guideline, protocol or other similar criterion United of Omaha used in making an Adverse Benefit Determination.

Furthermore, if United of Omaha makes an Adverse Benefit Determination based upon their determination that:

(a) the treatment and/or service is considered an Experimental or Investigational Drug or Treatment; or

(b) the treatment and/or service is not Medically Necessary;

United of Omaha will include a statement that an explanation of the scientific or clinical judgment for such determination will be provided to You upon request, free of charge.

Appeals

If a request for precertification or a claim is denied or partly denied, You shall have a reasonable opportunity for an appeal and a right to a full and fair review. Please refer to the Appeal Rights provision.

APPEAL RIGHTS

(as Federally Mandated)

Definitions

Capitalized terms have the same meaning as shown in the Plan and the Precertification and Claim Review Procedures provision.

For the purposes of this Appeal Rights provision, the terms **You, Your, Yours** shall include Your authorized representative.

Opportunity To Request An Appeal

You shall have a reasonable opportunity to appeal United of Omaha's precertification or claim review decisions in accordance with this Appeal Rights provision. As part of the appeal, there will be a full and fair review of the precertification and/or claim review decisions.

The request for an appeal can be written, electronically or orally submitted and should include any additional information You believe may have been omitted from United of Omaha's review or that should be considered by United of Omaha.

United of Omaha will establish and maintain procedures for hearing, researching, recording and resolving any appeal. The notification You receive regarding United of Omaha's precertification or claim review decision will include instructions on how and where to submit an appeal.

You will have no later than 180 days from Your receipt of notification of United of Omaha's precertification or claim review decision to submit a request for an appeal.

The request for an appeal should include:

- (a) the name of the patient;
- (b) the name of the person filing the appeal if different from the patient;
- (c) the Plan number;
- (d) the member number;
- (e) the nature of the appeal; and
- (f) names of all individuals, facilities and/or services involved with the appeal.

By requesting an appeal, You have authorized United of Omaha, or anyone designated by United of Omaha, to review any and all records (including, but not limited to, Your medical records) which United of Omaha determines may be relevant to Your appeal.

United of Omaha's Response To Appeals

Once United of Omaha receives Your request for an appeal, United of Omaha will respond no later than:

- (a) 72 hours for Claims Involving Urgent Care;

- (b) 30 days for claims and services for benefits requiring precertification (excluding Claims Involving Urgent Care); and
- (c) 60 days for claims and services for benefits not requiring precertification.

When United of Omaha makes their determination You will be provided with:

- (a) information regarding the decision; and
- (b) information regarding other internal or external appeal or dispute resolution alternatives, including any required state mandated appeal rights.

Please refer to the Precertification and Claim Review Procedures provision.

STANDARD PROVISIONS

(Applicable To In-Network And Out-Of-Network)

Changes in Plan Benefits

Plan benefits may be changed (including reducing or terminating benefits or increasing contribution) any time.

A change in the Plan benefits:

- (a) does not require the consent of any Member or beneficiary; and
- (b) must be in writing.

A change may affect any class of Members, including retirees if retiree coverage is included in the Plan.

Applications

Any application of a Member may be used to contest the validity of coverage, reduce coverage or deny a claim. We must first furnish You or Your beneficiary with a copy of that application. A Member's application may not be used to contest or reduce coverage which has been in force for two years or more during that person's lifetime. However, if a Member is not eligible for coverage there is no time limit on Our right to contest coverage or deny a claim.

Statements in an application are treated as representations, not as warranties.

(Applicable To In-Network Benefits)

Relationship Between the Parties

The relationship between Us and Primary Care Physicians, Specialist Physicians, Participating Hospitals and any other Participating Provider in Our program is an independent contractor relationship. Neither they, nor any employee of theirs, is an employee or agent of Ours; and neither We, nor any employee of Ours, is an employee or agent of theirs.

Neither the Trustees of the Plumbers Local Union No. 16 Health and Welfare Fund nor any Member is an agent or representative of Exclusive Healthcare, Inc., and neither will be liable for any acts or omissions of Exclusive Healthcare, Inc., their agents or employees, or any other person or organization with which Exclusive Healthcare, Inc., has made, or will make, arrangements for the performance of services under the Plan.

Liability of the Parties

1. Liability of a Member

Members are responsible for payment of all services and supplies which are not authorized, provided, covered or received in accordance with the terms and provisions of the Plan.

2. Our Liability

If, for any reason, a Participating Provider fails or is unable to render the services required under the Plan, We agree to pay for equivalent services provided the member continues to be covered under the Plan.

In the event that We fail to pay any authorized or approved provider for any covered service, the Member will not be liable to any provider for any amount owed by Us.

3. Liability of Trustees of Plumbers Local Union No. 16 Health and Welfare Fund

The Trustees of the Plumbers Local Union No. 16 Health and Welfare Fund is liable to Exclusive Healthcare, Inc. for all premiums due for the period of time the Plan is in force.

4. Liability of Providers

The provider will maintain the physician-patient or professional relationship with the Member. Neither Exclusive Healthcare, Inc., nor any employee of Exclusive Healthcare, Inc. shall be deemed to be engaged in the practice of medicine. Exclusive Healthcare, Inc. will in no way supervise the practice of medicine by any provider nor will Exclusive Healthcare, Inc. in any manner supervise, regulate, or interfere with the usual professional relationship between a provider and a Member.

The providers have the sole responsibility for determining what care is necessary for members and shall remain solely responsible for the quality of medical care provided.

QUALITY ASSURANCE AND QUALITY IMPROVEMENT

In the event of a conflict between this provision and any other provision of the Plan, this provision shall control. This provision shall be subject to all provisions of the Plan not in conflict with this provision.

Exclusive Healthcare, Inc. and United of Omaha Life Insurance Company has developed and maintain quality assurance and quality improvement programs that are intended to:

- (a) measure and evaluate the quality and outcomes of health care provided to Members; and
- (b) help improve the process and outcomes related to provision of health care to Members.

Exclusive Healthcare, Inc.'s and United of Omaha Life Insurance Company's quality assurance and quality improvement programs do not replace the care received from the Member's Physician. The Member and his or her Physician remain in charge of the Member's health care and health care treatment plan.

Exclusive Healthcare, Inc.'s and United of Omaha Life Insurance Company's quality assurance and quality improvement programs provide assistance in managing Members' use of health care services to help attain:

- (a) quality care and service;
- (b) cost-effectiveness; and
- (c) access to qualified providers.

QUALITY IMPROVEMENT DISCLOSURE

Exclusive Healthcare, Inc.'s Quality Improvement (QI) Program illustrates the Plan's commitment to provide comprehensive medical care that maintains high standards. It creates a framework to monitor, evaluate, and maintain the care given. The program will allow the increased likelihood of desired outcomes and improve the process of care delivery. It will provide an ongoing evaluation process that lends itself to improving or correcting identified shortcomings or improper utilization.

The QI Program will focus on the application of preventive health services. Standards will be set and monitoring will be done to ensure these services remain a focus. Preventive health remains the key to the attainment of both a cost effective health plan and improved member health and satisfaction. In addition, the Plan will work with National, State and local public health initiatives to promote the health of members.

The QI Program will ensure that the quality of services supports the maintenance of member's rights and exceeds time service standards in all management functions. In addition, the services provided will have sufficient breadth and range to meet the member's and network's requirements.

Through monitoring and evaluation processes, the QI Program will attain an understanding of the populations served, in terms of age groups, disease categories and special risk status. These processes will also reflect important aspects of care and service including high-volume and high-risk services and the care of acute and chronic conditions. Monitoring will include such sites as institutional settings, primary care and specialist's offices, home care, ancillary providers and mental health/substance abuse settings.

FRAUD NOTICE

Definition

For the purposes of this provision, the following term has the following meaning:

Fraud means an intentional act of deception, misrepresentation or concealment committed in order to obtain or attempt to obtain benefits or services under the Plan.

Stop Health Care Fraud

Fraud increases the cost of health care for everyone. If You suspect that a Physician, pharmacy, Hospital or other health care provider has charged You or Your dependent for services You or Your dependent did not receive, billed You or Your dependent more than once for the same service or misrepresented any information, do the following:

- (a) Call the provider and ask for an explanation. There may be an error.
- (b) If the provider does not resolve the matter, call the Company's at 800-936-9396 and explain the situation; or
- (c) Write to the Company's at:

Special Investigations Department
Exclusive Healthcare, Inc. and/or
United of Omaha Life Insurance Company
Mutual of Omaha Plaza
Omaha, Nebraska 68175

Penalties For Fraud

- (a) Anyone who intentionally falsifies a claim to obtain Plan benefits may be prosecuted for Fraud.
- (b) The Special Investigations Department may investigate anyone who uses an identification card if such person:
 - (1) tries to obtain services for a person who is not an employee; or
 - (2) is no longer covered and tries to obtain benefits.
- (c) The Trustees of the Plumbers Local Union No. 16 Health and Welfare Fund may also take appropriate action against anyone who falsified a claim for benefits under the Plan.
- (d) The following is added to any provision describing when coverage ends for You and/or Your dependents:

Fraud by You or Your dependent is a basis for ending Your or Your dependent's coverage under the Plan.

Applies to In-Network and Out-of-Network

SUMMARY PLAN DESCRIPTION

for the Plumbers Local Union No. 16 Health and Welfare Fund

The Employee Retirement Income Security Act of 1974 (ERISA) requires that certain information be furnished to eligible participants in an employee benefits plan. The Employee benefits plan maintained by the Policyholder shall be referred to herein as the "Plan".

Important Note:

This Booklet is Your ERISA Summary Plan Description for the health benefits described herein.

Contributions are made solely by Your employer. Contributions are based on the amount necessary to provide plan coverage.

This plan provides coverage for more than one class of employees.

EMPLOYER IDENTIFICATION NUMBER/PLAN NUMBER

E.I.N. 47-0403214	P.N. 502
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PLAN ADMINISTRATOR

The Plan is provided through and administered by:

Trustees of Plumbers Local Union No. 16 Health and Welfare Fund
10801 Pacific St., Suite 100
Omaha, NE 68154
Phone: (402) 341-8771

The benefits under the plan are self-funded by your employer; however, certain administrative services are provided by Exclusive Healthcare, Inc.

These services include claims processing and other services related to the administration of the Plan.

CLAIMS ADMINISTRATOR

Claims are paid by:
Exclusive Healthcare, Inc. (For In-Network Benefits)
United of Omaha Life Insurance Company (For Out-of-Network Benefits)

AGENT FOR SERVICE OF LEGAL PROCESS

Trustees of Plumbers Local Union No. 16 Health and Welfare Fund
10801 Pacific St., Suite 100
Omaha, NE 68154
Phone: (402) 341-8771

PLAN YEAR

Each 12-month period beginning on April 1 is a Plan Year for the purposes of accounting and all reports to the United States Department of Labor and other regulatory bodies.

STATEMENT OF ERISA RIGHTS

As a participant in the Plan, You are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

- (a) Receive Information About Your Plan and Benefits
 - (1) Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksite and union halls, all documents governing the Plan, including contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.
 - (2) Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.
 - (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.
- (b) 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 on 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 a certificate of creditable coverage, free of charge, from Your group health plan or Us 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 a preexisting condition waiting period after Your enrollment date in Your coverage.

(c) Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate Your Plan, called “fiduciaries” of the Plan, have a duty to do so prudently and in the interest of You and other Plan participants and beneficiaries. No one, including Your employer, Your union, or any other person, may fire You or otherwise discriminate against You in any way to prevent You from obtaining a benefit or exercising Your rights under ERISA.

(d) Enforce Your Rights

If Your claim for a benefit is denied or ignored, in whole or in part, You have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps You can take to enforce the above rights. For instance, if You request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, You may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay You up to \$110 a day until You receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If You have a claim for benefits which is denied or ignored, in whole or in part, You may file suit in a state or Federal court. In addition, if You disagree with the Plan’s decision or lack thereof concerning the qualified status of a medical child support order, You may file suit in 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.

(e) 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, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about Your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

PLAN DISCLOSURES

You or Your dependent are entitled to request from the Plan Administrator, without charge, information applicable to the Plan's benefits and procedures. In addition, Your Booklet includes, as applicable, a description of:

- (a) Qualified Medical Child Support Orders;
- (b) any cost-sharing provisions, including premiums, deductibles, coinsurance and copayments, maximums, details about the level of benefits, providers, preauthorization and utilization review rules, coverage for medical tests, devices and procedures, out-of-network coverage, limits on emergency care, coverage of existing and new drugs;
- (c) employee and dependent eligibility requirements;
- (d) any participating provider requirements; a current listing of such providers shall be furnished automatically as a separate document;
- (e) when insurance ends;
- (f) when benefits may be denied or reduced, including subrogation or reimbursement, and Coordination of Benefits provisions;
- (g) state or federal continuation rights;
- (h) claims procedures; additional details shall be furnished upon request; and
- (i) maternity hospitalization for the mother and newborn infant.

AUTHORITY TO INTERPRET PLAN

Except as described in the following paragraph, the Plan Administrator shall have full authority and discretion to construe the terms of the Plan and to determine whether a Participant or a beneficiary is eligible for benefits under the Plan. The Plan Administrator's construction of the terms of the Plan and decision as to a Participant's or beneficiary's eligibility for the amount of benefits shall be binding and conclusive on all persons.

PLAN CHANGES

The persons with authority to change, including the authority to terminate, the Plan on behalf of the Plan Sponsor is the Plan Sponsor's Board of Directors or other governing body, or any person or persons authorized by resolution of the Board or other governing body to take such action. Please refer to the provision in Your Booklet entitled "Changes in the Plan Benefit" for additional information about how the Plan can be changed.

Administrative Services Agreement
which is comprised of
Group Identification Number G000A001
and
Plan Identification Number MEDPOS

SELF FUNDED BY

Trustees of Plumbers Local Union No. 16 Health and Welfare Fund
10801 Pacific St., Suite 100
Omaha, NE 68154

CLAIMS ADMINISTERED BY

For In-Network Benefits
Exclusive Healthcare, Inc.

For Out-of-Network Benefits
United of Omaha Life Insurance Company