Unitarian Universalist Organizations Health Plan

Summary Plan Description

Updated July 1, 2012

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Introduction

The Unitarian Univeralist Association Employee Benefits Trust (the "Trust") was established by the Unitarian Universalist Association (the "UUA"). Effective January 1, 2007, the Trust established the Unitarian Universalist Organizations Health Plan (the "Plan") for the exclusive benefit of and to provide health benefits to Eligible Employees and Eligible Retirees (and their eligible Dependents) of Subscribing Employers and Subscribing Individuals.

The Plan's health benefits are provided under insurance contracts and evidence of coverage documents (together or individually referred to as "Coverage Booklets") entered into between the Trust and insurance carriers. These benefits are summarized in this document and in the Coverage Booklets.

The Plan provides benefits in accordance with applicable federal laws including the Consolidated Omnibus Budget Reconciliation Act ("COBRA"), the Health Insurance Portability and Accountability Act ("HIPAA"), the Mental Health Parity Act, the Newborns' and Mothers' Health Protection Act ("MHPA"), the Family and Medical Leave Act ("FMLA") and the Women's Health and Cancer Rights Act ("HCRA").

Disclaimer

This summary should be read in combination with the Coverage Booklets. The Coverage Booklets are intended to describe the benefits available to you, and, when read together with this summary, are intended to meet the Summary Plan Description ("SPD") requirements set forth under the Employee Retirement Income Security Act of 1974 ("ERISA").

This SPD does not include the complete details of the Plan. For example, details regarding covered benefits are contained in the Coverage Booklets. The Coverage Booklets together with this SPD legally govern the administration of the Plan.

Every effort has been made to ensure that the information in this SPD is complete and accurate. However, if there is ever a conflict or a difference between what is written here, and the Coverage Booklets with respect to the specific benefits provided, the Coverage Booklets will govern unless otherwise provided by any federal or state law. If there is a conflict between the Coverage Booklets and this SPD with respect to the legal compliance requirements under ERISA and any other federal law, this SPD will be the controlling document. The Trust reserves the right to amend or terminate the Plan.

THIS SPD IS NOT A CONTRACT FOR, NOR A GUARANTEE OF, PRESENT OR CONTINUED EMPLOYMENT.

This document is intended merely as a summary of the official Plan document. In the event of any disagreement between this SPD and the official Plan document, as they may be amended from time to time, the provisions of the Plan document will govern.

A WORD ABOUT STATE PREMIUM ASSISTANCE PROGRAMS
If you are eligible for coverage under the Plan but unable to afford it, you should be aware that some States have premium assistance programs that can help you pay for coverage. For more information, please review the *Notice Regarding State Premium Assistance Programs* in Appendix B.

Eligibility

Eligible Employees

You are eligible for the health benefits available under the Plan as an employee ("Eligible Employee") if you are employed by a Subscribing Employer, you work at least 750 [1] hours per calendar year and you satisfy any eligibility requirements established by your Subscribing Employer in a subscription agreement. An Eligible Employee may enroll in the Plan pursuant to the requirements in the *Enrollment* section of this SPD.

Eligible Retirees

You are eligible for the health benefits available under the Plan as a retiree ("Eligible Retiree") in either of the following circumstances:

- You are under age 65, and you retire from a Subscribing Employer after performing services as a minister; or

- You are age 65 or older, you are enrolled in Medicare Parts A and B, you retire from a Subscribing Employer after performing services in any capacity and you worked at least 750[2] hours per calendar year for a Subscribing Employer in five of the ten calendar years preceding the year in which you retire.

An Eligible Retiree may enroll in the Plan pursuant to the requirements in the *Enrollment* section of this SPD.

Eligible Dependents

Your eligible Dependents include the following:

- your spouse under a legally valid marriage. If a State has adopted a definition of marriage that includes same sex marriages, the Plan will recognize that state law for individuals residing in that state and for individuals residing in another state if the other state recognizes the law of the state recognizing same sex marriages;

- your natural, step or adopted children who are under age 26 , or of any age if the child or

[1] *A Subscribing Employer in a State that: (A) operates a health insurance purchasing exchange; and (B) provides State-subsidized health insurance coverage for individuals who do not have access to employer-sponsored health insurance coverage, may substitute "1040" for "750".*
[2] *As noted in footnote 1*

children are physically or mentally incapable of caring for themselves due to a physical, mental or developmental disability (the Administrator may require proof of a child's age and/or disability status at any time); and

- your domestic partner. An individual is a domestic partner if he or she meets the requirements of a domestic partner as established by the Trust and (if applicable) an insurer, which requirements may include but are not limited to the following: (i) you and the domestic partner may not be married to or involved in a domestic partnership with any other individual; (ii) you and the domestic partner may not be related by blood closer than what would bar marriage under the law; (iii) you and the domestic partner must share the same permanent residence; you and the domestic partner must have joint responsibility over each other's welfare and other common expenses; (iv) you and the domestic partner must register their domestic partnership with their state of domicile in accordance with state law (if any).

The term "child" or "children" also includes a child designated under a Medical Child Support Order (MCSO) which is determined by the Administrator in accordance with the Plan's written procedures (which are incorporated herein by reference) and ERISA to be a qualified Medical Child Support Order. Upon receipt of a MCSO, the Administrator will promptly inform the Employee and each child who is the subject of the MCSO of its receipt of the MCSO and will explain (in writing) the Plan's procedures for determining if the MCSO is qualified. Within a reasonable time, the Administrator will decide whether the MCSO is qualified and will notify the Employee and the child(ren) of its determination. Coverage cannot be discontinued for any child who is enrolled to comply with a qualified MCSO unless the Employee submits written evidence that the MCSO is no longer in effect.

An Eligible Employee, Eligible Retiree and Subscribing Individual may enroll his or her eligible Dependents in the Plan pursuant to the requirements in the *Enrollment* section of this SPD.

Subscribing Employer

A Subscribing Employer is a UUA Congregation (or other entity that is a related organization of the UUA) that has subscribed to the Plan. As noted above, Eligible Employees and Eligible Retirees (and their eligible Dependents) of a Subscribing Employer are eligible to participate in the Plan.

Subscribing Individual

A Subscribing Individual includes: (i) an individual who is either a self-employed Unitarian Universalist community minister; and (ii) a Unitarian Universalist community minister working in a ministerial capacity for an employer that does not offer a health insurance plan, each of whom has subscribed to the Plan. A Subscribing Individual may enroll in the Plan pursuant to the requirements in the *Enrollment* section of this SPD.

Enrollment

Initial Enrollment Period

If you are an Eligible Employee, Eligible Retiree or Subscribing Individual hired or commencing work on or before November 27, 2006, you and your eligible Dependents will be enrolled in the Plan if you submit a properly completed enrollment form in accordance with the Administrator's instructions on or before November 27, 2006. In this case, the coverage effective date for you and your eligible Dependents is January 1, 2007.

If you are an Eligible Employee, Eligible Retiree or Subscribing Individual hired or commencing work after November 27, 2006, you and your eligible Dependents will be enrolled in the Plan if you submit a properly completed enrollment form in accordance with the Administrator's instructions within 30 days of the eligibility date specified by a Subscribing Employer in its subscription agreement. In this case, the coverage effective date for you and your eligible Dependents is retroactive to the eligibility date. If you do not enroll in the Plan within 30 days of your eligibility date, you may not enroll until the annual open enrollment period.

Annual Open Enrollment Period

If you are an Eligible Employee, Eligible Retiree or Subscribing Individual, you and your eligible Dependents will be enrolled in the Plan, or you may change your existing enrollment under the Plan, if you submit a properly completed enrollment form in accordance with the Administrator's instructions during an annual open enrollment period beginning and ending on the dates specified by the Administrator. In this case, the coverage effective date for you and your eligible Dependents is January 1st of the year following the annual open enrollment period. Aside from the special enrollment events described below, you may not enroll or change your coverage during the year unless you experience a change in status. For more information, see the *Making Changes During the Year* section of this SPD.

Special Enrollment Periods

If you are an Eligible Employee, Eligible Retiree or Subscribing Individual, you may be entitled to enroll yourself and your eligible Dependents during a special enrollment period in the following situations:

- If you previously declined enrollment for yourself or your eligible Dependents because of other health insurance coverage, and if the other health insurance coverage is subsequently terminated due to a loss of eligibility for that coverage or the termination of any employer contributions for that coverage, you and your eligible Dependents will be enrolled in the Plan if you submit a properly completed enrollment form in accordance with the Administrator's instructions within 30 days after your other coverage ends. In this case, the coverage effective date for you and your eligible Dependents is retroactive to the date the other coverage ends.

- If you acquire a new dependent as a result of marriage, birth, adoption, or placement for adoption, you and your Eligible Dependents will be enrolled in the Plan if you submit a properly completed enrollment form in accordance with the Administrator's instructions within 30 days after the marriage, birth, adoption or placement for adoption. If the new dependent is a newborn child, the coverage effective date for you and your eligible

Dependents is the date of birth. If the new dependent is a child adopted or placed for adoption, the coverage effective date for you and your eligible Dependents is the earlier of: (i) the date the adoptive child's birth parent or other legal authority sign a written document granting you, your spouse or your domestic partner the right to control the child's healthcare; or (ii) the date you, your spouse or domestic partner assume a legal obligation for full or partial financial responsibility for the child in anticipation of the child's adoption. If the new dependent is a spouse or domestic partner, the coverage effective date for you and your eligible Dependents is the date the properly completed enrollment form is received by the Administrator.

Keep in mind that your newborn children, your adopted children and children placed with you for adoption are automatically covered under the Plan on their date of birth, adoption or placement for adoption for a period up to 30 days. However, to continue coverage for your newborn or newly adopted child, you must enroll him or her within 30 days from the date of the birth, adoption or placement for adoption. If you don't enroll your newborn or newly adopted child within 30 days from the date of birth, adoption or placement for adoption, you will be required to wait until the next annual open enrollment period to enroll the child.

Special Enrollment Period for Medicaid/CHIP Events

If an Eligible Employee, Eligible Retiree, Subscribing Individual or one or more Dependents is eligible but not enrolled under the Plan, and either:

(i) the Eligible Employee, Eligible Retiree, Subscribing Individual or Dependent is covered under a Medicaid plan or a State Children's Health Insurance Program, and that coverage is terminated due to a loss of eligibility for such coverage, or

(ii) the Eligible Employee, Eligible Retiree, Subscribing Individual or Dependent becomes eligible for employment assistance under a Medicaid plan or State Children's Health Insurance Program,

then the Eligible Employee, Eligible Retiree, Subscribing Individual and his or her Dependents may enroll in the Plan, provided a properly completed enrollment form is received by the Administrator within 60 days of the applicable event and, provided further, that no Dependents may be enrolled in the Plan unless the Eligible Employee, Eligible Retiree or Subscribing Individual is also enrolled. If a properly completed enrollment form is received by the Administrator within 60 days of the applicable event, then the effective date of coverage for Special Enrollment will be retroactive to the date of the applicable event. If a properly completed enrollment form is not received by the Administrator within 60 days of the applicable event, then the Eligible Employee, Eligible Retiree, Subscribing Individual and his or her Dependents may not enroll until the next annual open enrollment period.

Cost of Coverage

If you are an Eligible Employee or Eligible Retiree, you and your Subscribing Employer share the cost of coverage. Your portion of the cost varies based on which coverages you elect. If your

Subscribing Employer has adopted a cafeteria plan, your cost is deducted from your pay on a pre-tax basis.

If you are a Subscribing Individual, you must pay 100% of the cost of coverage. Your cost of coverage varies based on which coverages you elect.

Your cost for Plan coverage does not include your costs for any applicable deductibles, copays, out-of-network charges, or non-covered items.

Making Changes During the Year

General Rules for Mid-Year Changes

In general, the Plan coverage you choose during an initial enrollment period, an annual open enrollment period or a special enrollment period may not be changed until the next annual open enrollment period. However, you may be able to change your coverage election before the next annual open enrollment period in the following situations. Please note that you may be required to show proof to the Administrator verifying these events have occurred. In all cases, the Administrator has discretion to determine if your requested change satisfies these requirements.

- An Eligible Employee, Eligible Retiree or Subscribing Individual will be permitted to change his or her coverage election under the Plan if a judgment, decree or order (including a qualified medical child support order) resulting from divorce, legal separation, annulment or change in legal custody either requires coverage for a child or permits revocation of coverage for a child.

- An Eligible Employee, Eligible Retiree or Subscribing Individual and his or her eligible Dependents will be permitted to revoke his or her coverage election under the Plan if they or their eligible Dependents become entitled to coverage (i.e., enrolled) under Medicare or Medicaid.

- An Eligible Employee, Eligible Retiree or Subscribing Individual will be permitted to change his or her coverage election from standard PPO coverage to high deductible PPO coverage at any time during a Plan Year. However, an Eligible Employee, Eligible Retiree or Subscribing Individual will be permitted to change his or her coverage election from high deductible PPO coverage to standard PPO coverage only during an annual open enrollment period.

If you participate in a cafeteria plan sponsored by your Subscribing Employer, these changes will be made on a pre-tax basis if they qualify as a permissible change under the cafeteria plan. If you do not participate in a cafeteria plan, or if the change does not qualify as a permissible change under your Subscribing Employer's cafeteria plan, then any additional cost of coverage will be made on an after-tax basis.

FMLA Leave

If you return to service with a Subscribing Employer after taking leave under the FMLA and are otherwise eligible to participate in the Plan, you will be reinstated on the same terms that applied

prior to taking such FMLA leave. For more detailed information on the effect of FMLA leave on your benefits, see the *Family and Medical Leave* section of this SPD.

Benefits

Plan Benefits

The health benefits available under the Plan are provided pursuant to an insurance contract with Highmark Blue Cross Blue Shield. The Plan's health benefits (including information about the benefits available, required deductibles, co-payments, maximums, limits and exclusions, as applicable) are summarized in the applicable Coverage Booklets. Please refer to *Appendix A* for a list of the Coverage Booklets.

With respect to the PPOs, a directory of participating network providers in your area will be available. You will receive instructions on how to access provider directories online.

For additional information regarding the benefits provided under the Plan, please contact the Administrator.

Federal Laws Affecting Benefits

Rights for Mothers and Newborn Children

Benefits for any hospital length of stay in connection with childbirth for the mother or newborn child must not under federal law be less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, under federal law the mother's or newborn's attending provider, after consulting with the mother, may agree to discharge the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not under federal law require that a provider obtain authorization for a length of stay that does not exceed 48 hours (or 96 hours as applicable).

Women's Health and Cancer Rights Act

The Plan provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breast, prostheses, and complications resulting from a mastectomy, including lymphedema. Reconstructive benefits are subject to annual Plan deductibles and coinsurance provisions that apply to other medical and surgical benefits covered under the Plan. Contact the Administrator for more information.

Privacy Rights Under HIPAA

HIPAA imposes rules on health plans with respect to the use and disclosure of each participant's protected health information (PHI) in certain situations. In addition, HIPAA provides participants with certain rights with respect to their PHI, including the right to receive a privacy notice. The Trust intends to comply with HIPAA's privacy requirements, as they apply to the Plan.

Grandfathered Plan Status

The Administrator believes the Plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (PPACA). While a health plan remains grandfathered it is subject to many, but not all, of the requirements of PPACA. For example, a grandfathered health plan is

subject to PPACA rules requiring eligibility up to age 26 for adult children who do not have medical plan coverage available from their or their spouse's employer, and PPACA rules prohibiting lifetime limits, pre-existing condition exclusions and retroactive terminations of coverage except in cases of fraud and misrepresentation. At the same time, a grandfathered health plan is not subject to other PPACA mandates, such as the rules requiring external claims review conducted by an approved third party reviewer. In general, grandfathered health plans must comply with all requirements of PPACA when they lose grandfathered status. Questions about which PPACA rules apply to the Plan, and which changes might cause the Plan to cease to be a grandfathered health plan, should be directed to the Administrator. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at **1-866-444-3272** or by visiting **www.dol.gov/ebsa/healthreform**. The EBSA website has a table summarizing the PPACA rules and indicating which PPACA rules apply to grandfathered health plans.

Coordination of Benefits

If you or any of your eligible Dependents have health coverage under any other group plan, the benefits under this Plan are coordinated with the benefits of the other plan. When benefits are coordinated, the plan that pays first is called the "primary" plan and the other plan(s) are called the "secondary" plans. If you or your eligible Dependents have coverage under another group plan that is primary and are also covered under this Plan, this Plan will coordinate benefits up to, but not more than, the amount this Plan would normally pay. This means that if the other plan pays the same as or more than this Plan would pay, no additional benefits are available under this Plan. *Please note that prescription drug benefits are not coordinated with drug coverage under any other plan.*

The following rules describe which plan is primary and which plan is secondary where you and your eligible Dependents have health coverage under more than one plan:

- **Rule #1** – If you or your Eligible Dependents are covered under this Plan and another plan, and the other plan has no coordination of benefits provision, the other plan pays before this Plan.

- **Rule #2** – If you or your Eligible Dependents are covered under this Plan and another plan, the plan that covers the person as an employee pays before the plan that covers the person as a dependent. Thus, if your coverage is based on your status as an Eligible Employee or Subscribing Individual, this Plan is the primary plan. If your coverage is based on your status as an Eligible Retiree, this Plan is the secondary Plan. If your spouse or domestic partner is covered under another plan, the plan covering your spouse or domestic partner as an employee is the primary plan, and this Plan is the secondary plan.

- **Rule #3** – If your dependent children are covered under this Plan and another plan, the plan of the parent with the earlier birthday in the calendar year pays before the plan of the other parent. For example, if one parent's birthday is in May, and the other's birthday is in June, the plan of the parent with the May birthday will be the primary plan for the dependent children. The actual year of birth doesn't matter. If the other plan does not apply this "birthday rule," then the provisions of the other plan will determine the order of benefits determination. If the parents of dependent children are divorced or separated,

then two special rules apply. First, if the parent with custody has not remarried, the plan of the parent with custody pays first. Second, if the parent with custody has remarried, the plans pay in the following order: (i) the plan that covers the child as a dependent of the custodial parent; (ii) the plan that covers the child as a dependent of a stepparent married to the custodial parent; (iii) the plan that covers the child as a dependent of the non-custodial parent; (iv) the plan that covers the child as a dependent of the stepparent married to the non-custodial parent. But these special rules do not apply if a court decree establishes a parent's financial responsibility to provide health coverage for a child – in that case, the plan covering the child as a dependent of that parent pays first.

- **Rule #4** – If you or your eligible Dependents are covered under this Plan and another plan, the plan covering the person as other than a laid-off or retired employee or as a dependent of a laid-off or retired employee pays first. If the other plan does not apply this rule, then rule #6 applies.

- **Rule #5** – If you or your eligible Dependents are covered under this Plan and another plan, the plan covering the person other than under a state or federal continuation of coverage provision pays first. If the other plan does not apply this rule, then rule #6 applies.

- **Rule #6** – If you or your eligible Dependents are covered under this Plan and another plan, and none of the previous rules determines which plan is primary, then the plan under which the person has been enrolled the longest pays first unless the person's effective date of coverage under both plans is the same. In this case, the person's claim will be split equally between the two plans.

If payments under this Plan exceed the maximum benefit payable under this coordination of benefits provision, you will be expected to repay the Plan any amount you were overpaid. land the plan covering the person as a laid-off or retired employee or as a dependent of a laid-off or retired employee pay

The coordination of benefit rules are summarized in each of the applicable Coverage Booklets. Please refer to *Appendix A* for a list of the Coverage Booklets.

Rights of Subrogation and Reimbursement

Coverage for Injuries Caused by You or Other Parties

When you are injured or become ill because of the actions of yourself or a third party, the Plan may cover your eligible medical expenses. However, to receive coverage, you must notify the Plan that your illness or injury was caused by yourself or another party, and you must follow special Plan rules.

Right of Subrogation

The first rule is the **right of subrogation**. Subrogation means the substitution of one person or entity in the place of another with reference to a lawful claim, demand or right. The Plan's right of subrogation provides that if an injury or illness is your or someone else's fault, the Plan has

the right to recover expenses it pays for that illness or injury directly from any of the sources of payment listed later in this section.

To exercise its right of subrogation, the Plan or the Administrator (or any party designated by the Administrator) may, in its discretion:

- place a first-dollar equitable lien or constructive trust for 100% of the benefits paid by the Plan against any responsible party or other third party recovery you receive to the extent the Plan paid benefits for the sickness or injury;
- bring an action on its own behalf or on your behalf against any responsible party or third party involved in the sickness or injury to recover 100% of the benefits paid by the Plan; or
- suspend the payment of any Plan benefits pending receipt from you of any acknowledgement, agreement, authorization, waiver or release it considers necessary to exercise its rights or privileges under the Plan.

Right of Reimbursement

The second rule is the Plan's **right of reimbursement**. If you receive any payment from a responsible party or third party (through a judgment, settlement or otherwise) when an injury or illness is your or someone else's fault, you must pay the Plan back *first*, *in full*, for *100%* of any medical expenses the Plan has paid to you or on your behalf. You must pay the Plan back up to the full amount of the compensation you receive from the responsible party, regardless of whether your settlement or judgment says that the money you receive (all or part of it) is for medical expenses. Furthermore, you must pay the Plan back regardless of whether the responsible party admits liability and regardless of whether you have been made whole. In addition, you are responsible for payment of all of your attorneys' fees and court costs associated with any settlement or judgment you receive from a responsible party or third party, not the Plan. If any money is left over, you may keep it.

If you do not repay the Plan within seven (7) days after you receive a settlement or judgment from a responsible party or third party, the Plan requires you to pay interest in the amount of one and one half percent (1½ %) of the total amount of benefits paid per month. In addition, the Plan will not pay any attorneys' fees or costs associated with a lawsuit without the written permission of the Administrator or any entity designated by the Administrator.

Sources of Payment

The Plan's sources of payment through subrogation or reimbursement are as follows:

- money from a responsible party or third party that you, your dependents, your guardian or other representatives or beneficiaries receive or are entitled to receive;
- any constructive trust that is imposed on the proceeds of any settlement, verdict or other amount that you, your dependents, your guardian or other representatives or beneficiaries receive; and
- any liability or other insurance (for example, uninsured motorist, underinsured motorist,

medical payments, no-fault, school, homeowners, or excess or umbrella coverage) that is paid or payable.

Your Responsibilities

You have the duty to cooperate fully with the Plan, the Administrator and any party designated by the Administrator if the Plan's rights of subrogation or reimbursement are asserted, including the execution and delivery of any documents the Plan may require or to appear in court for a deposition or testimony, if necessary.

Enforcement by the Plan

The Plan may enforce its rights of subrogation or reimbursement by requiring you, your dependents, your guardian or other representatives or beneficiaries to present a claim/lawsuit to any of the sources of payment listed previously to recover expenses that you or they may be entitled to. The Plan, the Administrator and any entity designated by the Administrator may suspend payment of future Plan benefits if you do not cooperate and comply with its rights of subrogation and reimbursement, or if you take any action that prejudices the Plan's rights of subrogation and reimbursement.

The Plan's rights of subrogation and reimbursement for 100% of all benefits paid, first-dollar, will not be reduced by any equitable defenses that may be raised by you or the third party responsible for your injury or illness, including but not limited to liability or other insurance covering the third party; any common fund doctrine; contributory or comparative negligence doctrine or statute; uninsured or underinsured motorist rules or statutes; medical payment; personal injury protection insurance; or no-fault insurance.

If the Plan has not yet paid benefits relating to an injury or illness that was caused by you, a responsible party or a third party, the Plan may reduce or deny future benefits relating to that injury or illness on the basis that you, your dependents, your guardian or other representatives or beneficiaries received compensation from the responsible party or third party. In addition, any amount due the Plan under its rights of subrogation or reimbursement may be off-set in the Administrator's discretion against any other present or future medical expense benefits payable to you or your dependents or beneficiaries.

The Plan has the right to file suit against you to recover 100% of its reimbursement right, and you will be required to pay the Plan's attorneys' fees and court costs related to any such suit.

The Plan is *not* required to pay medical expenses for any past illnesses or injuries that are settled (through a judgment, settlement or otherwise). And, the Plan's rights of subrogation and reimbursement apply even if the original illness or injury happened before your coverage under the Plan commenced.

Additional Information

Any questions related to your duties and responsibilities under the Plan's subrogation and reimbursement rights may be directed to the Administrator.

Claims and Appeals Procedures

Either you or your authorized representative may file claims for health benefits. If your claim is denied, you or an authorized representative may appeal that denial. An "authorized representative" means a person you authorize, in writing, to act on your behalf. The Plan will also recognize a court order giving a person authority to submit claims on your behalf. In the case of an Urgent Care Claim, a health care professional with knowledge of your condition may act as your authorized representative. All communications from the Plan will be directed to your authorized representative unless your written designation provides otherwise.

The discussion below outlines the general claim and appeal procedures that apply to benefit claims under the Plan. If you intend to file a claim for benefits, you should follow the specific claim and appeal procedures described in each Coverage Booklet. Please refer to Appendix A of this SPD for a list of Coverage Booklets.

Filing an Initial Claim

Your initial claim should be filed with the Claims Administrator listed in the *General Information* section of this SPD. All claims are treated as filed on the date they are received. If your claim is denied in whole or in part, you will receive a written notice of the denial directly from the Claims Administrator or Insurer. The notice will explain the reason for the denial and the review procedures. The specific requirements applicable to health claims depend on whether the claim involves an Urgent Care Claim, a Pre-Service Claim, or a Post-Service Claim.

Urgent Care Claims

If the Plan requires advance approval of a service, supply or procedure before a benefit will be payable, and if the Plan or your physician determines that it is an Urgent Care Claim, you will be notified whether the service, supply or procedure is payable under the Plan no later than 72 hours after the claim is received, either orally or in writing.

"Urgent Care Claim" means a claim for services received for an illness, injury or condition that could seriously jeopardize your life or health or your ability to regain maximum function or a condition that, in your treating physician's opinion, could subject you to severe pain that cannot adequately be managed without such care or treatment.

For Urgent Care Claims that name a specific claimant, medical condition, and service or supply for which approval is required, and that are submitted to the Claim Administrator responsible for handling benefit matters, but otherwise fail to follow the Plan's procedures, you will be notified of the failure within 24 hours of receipt of the claim. You also will be informed of the proper procedures to be followed. The notice may be oral unless you or your authorized representative request a written notification.

If there is not sufficient information to decide the claim, your physician will be notified of the specific information necessary to complete the claim as soon as possible, but no later than 24 hours after receipt of the claim. Your physician will be given a reasonable additional amount of time, but not less than 48 hours, to provide the information. Your physician will be notified of the decision no later than 48 hours after the end of the additional time period (or after receipt of the information, if earlier). If the decision is provided to you orally (unless you or your representative request a written notification), your physician will be provided a written or electronic notification no later than three days after you received the oral notification.

Pre-Service and Post-Service Claims

If the Plan requires you to obtain advance approval of a service, supply or procedure before a benefit will be payable, the claim will be considered a Pre-Service Claim. You will be notified of the decision no later than 15 days after receipt of the Pre-Service Claim. All other claims will be deemed to be Post-Service Claims. You will be notified of a Post-Service Claim decision no later than 30 days after receipt of such claim.

For Pre-Service Claims that name a specific claimant, medical condition, and service or supply for which approval is required, and that are submitted to the Claims Administrator, but which otherwise fail to follow the Plan's procedures, you will be notified of the failure within 5 days for Pre-Service Claims. You also will be informed of the proper procedures to be followed. The notice may be provided to you orally unless you or your representative request written notification.

For either a Pre-Service or a Post-Service Claim, the time period in which the decision must be made may be extended up to an additional 15 days due to circumstances beyond the Plan's control. In that case, you will be notified of the extension before the end of the initial 15 or 30 day period.

If there is not sufficient information to decide the claim, the notice of extension will specifically describe the information necessary to complete the claim. You will have at least 45 days from the date you receive the notice to provide the specified information. The Claims Administrator's period for making the determination will exclude the period of time from the date the notification of the extension is sent to you until the date you respond to the request for additional information. If you fail to supply the requested information within the 45-day period, your claim will be denied.

Ongoing Course of Treatment

If you are receiving an ongoing course of treatment, you will be notified in advance if the Plan intends to terminate or reduce previously authorized benefits for the course of treatment so that you will have the opportunity to appeal the decision before the termination or reduction takes effect. If the course of treatment involves an Urgent Care Claim, and you request an extension of the course of treatment at least 24 hours before its expiration, you will be notified of the decision within 24 hours after receipt of the request.

Filing an Appeal

If your claim for benefits is denied, in whole or in part, you or your authorized representative may file an appeal with the Claims Administrator listed in the *General Information* section of this SPD. The Claims Administrator uses a two-level appeal process to review appeals of denied claims, except for urgent care claims where the Claims Administrator uses a single level appeal process. The first level appeal process with the Claims Administrator is mandatory, and must be followed before you may file a lawsuit. The second level appeal process with the Claims Administrator is mandatory for post-service claims, and voluntary for pre-service claims. If the Claims Administrator denies a first level appeal of an urgent care claim, or a second level appeal of a pre-service or post-service claim, you or your authorized representative may file a voluntary appeal with the Trust Committee.

First Level Appeals

You or your authorized representative must file the initial appeal no later than 180 days from the date you receive notice from the Claims Administrator denying the initial claim. Upon request to the Claims Administrator, you may review all documents, records and other information relevant to the claim being appealed. You will have the right to submit any written comments, documents, records, information, data or other material in support of the appeal.

The initial appeal will be reviewed by a representative of the Claims Administrator's appeal review department. The representative will not be a person who was involved in any previous adverse determination regarding the claim that is the subject of the appeal and the representative will not be the subordinate of any individual that was involved in any previous adverse determination regarding the claim that is the subject of the appeal.

In rendering a decision on the initial appeal, the Claims Administrator will take into account all comments, documents, records, and other information you submit without regard to whether the information was previously submitted to or considered by the Claims Administrator. The Claims Administrator will afford no deference to any previous adverse determination on the claim that is the subject of the appeal.

In rendering a decision on an initial appeal that is based, in whole or in part, on medical judgment, including a determination of whether a requested benefit is medically necessary and appropriate or experimental/investigative, the Claims Administrator will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The health care professional will be a person who was not involved in any previous adverse determination regarding the claim that is the subject of the appeal and will not be the subordinate of any person involved in a previous adverse determination regarding the claim that is the subject of the appeal.

The Claims Administrator will provide you with written notification of its decision on the initial appeal within the following time frames:

- When the appeal involves a pre-service claim, within a reasonable period of time appropriate to the medical circumstances not to exceed 30 days following receipt of the appeal;

- When the appeal involves an urgent care claim, as soon as possible taking into account the medical exigencies involved but not later than 72 hours following receipt of the appeal; or

- When the appeal involves a post-service claim, within a reasonable period of time not to exceed 30 days following receipt of the appeal.

If the initial appeal is denied, the Claims Administrator will notify you and the notice will include: (1) the specific reason or reasons for the decision; (2) reference to the specific Plan provisions on which the decision was based; (3) a statement that you are entitled to receive, upon request and free of charge, access to and copies of any relevant document; (4) a statement describing your right to seek binding arbitration or to file the claim in court; (5) if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the decision, then that information will be provided along with a free copy of the rule, guideline, protocol, or other criterion if you request it; and (6) if the decision is based on whether the treatment or service is

experimental and/or investigational or not medically necessary, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation shall be provided free of charge if you request it.

Second Level Appeals

If the initial appeal is denied, in whole or in part, you or your authorized representative may submit a second level appeal requesting that the decision be reviewed by the Claims Administrator. The second level appeal must be submitted to the Claims Administrator in writing (or communicated orally under special circumstances) within 45 days from the date you received the notice denying the initial appeal. Upon request to the Claims Administrator, you may review all documents, records and other information relevant to the claim which is the subject of the appeal. You will have the right to submit any written comments, documents, records, information, data or other material in support of the second-level appeal.

The second level appeal will be reviewed by a representative of the Claim Administrator's appeal review department. The representative will not be a person who was involved in any previous adverse determination regarding the claim that is the subject of the appeal and the representative will not be the subordinate of any individual that was involved in any previous adverse determination regarding the claim that is the subject of the appeal.

In rendering a decision on the second level appeal, the Claims Administrator will take into account all comments, documents, records, and other information submitted by the claimant without regard to whether the information was previously submitted to or considered by the Claims Administrator. The Claims Administrator will afford no deference to any previous adverse determination regarding the claim that is the subject of the appeal.

In rendering a decision on an initial appeal that is based, in whole or in part, on medical judgment, including a determination of whether a requested benefit is medically necessary and appropriate or experimental/investigative, the Claims Administrator will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The health care professional will be a person who was not involved in any previous adverse determination regarding the claim that is the subject of the appeal and will not be the subordinate of any person involved in a previous adverse determination regarding the claim that is the subject of the appeal.

The Claims Administrator will provide you with written notification of its decision on the second level appeal within the following time frames:

- When the appeal involves a pre-service claim, within a reasonable period of time appropriate to the medical circumstances not to exceed 30 business days following receipt of the second level appeal; or

- When the appeal involves a post-service claim, within a reasonable period of time not to exceed 30 days following receipt of the second level appeal.

If the second level appeal is denied, the Claims Administrator will notify you and the notice will include: (1) the specific reason or reasons for the decision; (2) reference to the specific Plan provisions on which the decision was based; (3) a statement that you are entitled to receive, upon

request and free of charge, access to and copies of any relevant document; (4) a statement describing your right to seek binding arbitration or to file the claim in court; (5) if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the decision, then that information will be provided along with a free copy of the rule, guideline, protocol, or other criterion if you request it; and (6) if the decision is based on whether the treatment or service is experimental and/or investigational or not medically necessary, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation shall be provided free of charge if you request it.

Voluntary Appeals to the Trust Committee

If the Claims Administrator denies the first level appeal of an urgent care claim, or the second level appeal of a pre-service or post-service claim, you or your authorized representative may file a voluntary appeal with the Trust Committee. The appeal must be in writing (unless it involves an urgent care claim), and you must file the appeal within 45 days from the date he or she receives the notice from the Claims Administrator denying the second level appeal. If the appeal involves an urgent care claim, all information will be communicated between the Trust Committee and the claimant by telephone, facsimile, or other available similarly expeditious method throughout the appeal process. You may submit written comments, documents, records and other information related to the claim, whether or not such information was submitted in connection with the initial claim request or any previous appeal. You also may request that the Plan provide him or her, free of charge, copies of all documents, records, and other information relevant to the claim.

The voluntary appeal to the Trust Committee will be reviewed by a person different from the person who made any previous adverse determination regarding the claim that is the subject of the appeal, and the individual making the appeal determination will not be a subordinate of an individual who made any previous adverse determination regarding the claim that is the subject of the appeal. The Trust Committee will afford no deference to any previous adverse determination regarding the claim that is the subject of the appeal.

If the claim is denied on appeal by the Trust Committee, the notice to you will include: (1) the specific reason or reasons for the decision; (2) reference to the specific Plan provisions on which the decision was based; (3) a statement that you are entitled to receive, upon request and free of charge, access to and copies of any Relevant document; (4) a statement describing your right to seek binding arbitration or to file the claim in court; (5) if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the decision, then that information will be provided along with a free copy of the rule, guideline, protocol, or other criterion if you request it; and (6) if the decision is based on whether the treatment or service is experimental and/or investigational or not medically necessary, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation shall be provided free of charge if you request it.

Exhaustion of Administrative Remedies

If your claim for benefits is finally denied by the Claims Administrator, then you may bring suit in federal court. You may not commence a suit in federal court for benefits under the Plan until the Plan's claim and appeal process has been exhausted. For urgent care claims and pre-service claims, you have exhausted the Plan's claim and appeal process when the Claims Administrator

denies your first level appeal. For post-service claims, you have exhausted the Plan's claim and appeal process when the Claims Administrator denies your second level appeal.

Your decision to proceed with other appeals is voluntary. If you elect to pursue a voluntary appeal before pursuing court action, the Plan will not later assert that you failed to exhaust the Plan's claim and appeal process, and the Plan will suspend any statute of limitations while your voluntary appeal is pending. Neither the Plan nor the Claims Administrator imposes any fee for filing a voluntary appeal.

When Coverage Ends

Termination of Coverage

Coverage under the Plan for you and your eligible Dependents will terminate on the earliest of the following dates:

- The last day of the month in which the Plan or Trust terminates;
- The last day of the month in which you or your eligible Dependents waive coverage under the Plan or revoke all coverage elections under the Plan;
- The last day of the month for which you or your eligible Dependents fails to pay any required contribution when due;
- The last day of the month in which you or your eligible Dependents cease to satisfy the requirements of an Eligible Employee, an Eligible Retiree, a Subscribing Individual or an eligible Dependent;
- In the case of an Eligible Employee or Eligible Retiree, the last day of the month in which a Subscribing Employer's participation in the Trust is terminated either voluntarily or involuntarily;
- In the case of an eligible Dependent, the date of the Dependent's marriage;
- The date coverage is terminated for fraud, misrepresentation or deceit; or
- The last day of a person's employment if the Subscribing Employer elects date of hire/date of termination on its subscription agreement.

Other circumstances that can result in the termination, reduction, loss or denial of benefits (for instance, exclusions due to preexisting conditions, and exclusions for certain medical procedures) are described in your Coverage Booklets.

Depending on the reason why coverage was terminated, you and your covered eligible Dependents may have the right to continue health coverage temporarily under COBRA or under

a portability plan or conversion right under a particular option. Refer to your Coverage Booklets for more information on portability rights and converting to an individual policy.

COBRA Continuation Coverage

Federal law requires most employers sponsoring group health plans to offer certain individuals (called "Qualified Beneficiaries") the right to continue their health coverage for a limited period of time in certain instances (called "Qualifying Events") where coverage under the Plan would otherwise end. This right is called "COBRA" continuation coverage. The following information is intended to inform you of your COBRA rights and obligations.

Qualified Beneficiaries

Any employee, spouse or dependent child who is covered by the Plan on the day before a Qualifying Event is a Qualified Beneficiary. Also, a child born to or placed for adoption with a former employee who is a Qualified Beneficiary during a period of COBRA continuation coverage is a Qualified Beneficiary. These newly-added children are allowed to continue COBRA coverage for the remainder of the period of coverage available to the former employee/Qualified Beneficiary.

Each Qualified Beneficiary has a separate right to elect COBRA coverage. For example, the employee's spouse may elect COBRA coverage even if the covered employee does not. COBRA coverage may be elected for only one, several, or for all dependent children who are qualified beneficiaries. A parent may elect COBRA coverage on behalf of any dependent children. The covered employee or the employee's spouse can elect continuation coverage on behalf of all the Qualified Beneficiaries.

Although a domestic partner (and his or her dependent children) does not have rights to COBRA coverage under existing federal law, the Trust has decided to offer COBRA coverage rights to domestic partners equivalent to the COBRA coverage rights available to spouses.

Qualifying Events

To be eligible for COBRA continuation coverage, a Qualified Beneficiary must lose coverage under the Plan on account of a Qualifying Event, as follows:

Eligible Employees and Subscribing Individuals. If you are an Eligible Employee or Subscribing Individual and covered by the Plan, you have the right to elect COBRA continuation coverage if you lose group health coverage under the Plan because of a reduction in your hours of employment with a Subscribing Employer (including your failure to return to work after a leave taken under the federal Family and Medical Leave Act) or because your employment is terminated for reasons other than gross misconduct.

Spouses or Domestic Partners. If you are the spouse or domestic partner of an Eligible Employee, Eligible Retiree or Subscribing Individual and you are covered by the Plan, you have the right to elect COBRA continuation coverage for yourself if you lose group health coverage under the Plan for *any* of the following four reasons:

- The death of the Eligible Employee, Eligible Retiree or Subscribing Individual;
- The termination of the Eligible Employee's or Subscribing Individual's employment with

a Subscribing Employer (for reasons other than gross misconduct) or a reduction in his or her hours of employment (including the failure to return to work after a leave taken under the federal Family and Medical Leave Act);

- The divorce, legal separation or termination of a domestic partner relationship from the Eligible Employee, Eligible Retiree or Subscribing Individual; or
- The Eligible Employee, Eligible Retiree or Subscribing Individual becomes entitled to (that is, covered by) Medicare and revokes coverage under the Plan.

Dependent Children. In the case of a dependent child who is covered under the Plan, he or she has the right to elect COBRA continuation coverage if group health coverage under the Plan is lost for *any* of the following five reasons:

- The death of the Eligible Employee, Eligible Retiree or Subscribing Individual;
- The termination of the Eligible Employee's or Subscribing Individual's employment with a Subscribing Employer (for reasons other than gross misconduct) or a reduction in his or her hours of employment (including the failure to return to work after a leave taken under the federal Family and Medical Leave Act);
- The divorce, legal separation or termination of a domestic partner relationship from the Eligible Employee, Eligible Retiree or Subscribing Individual;
- The Eligible Employee, Eligible Retiree or Subscribing Individual becomes entitled to (that is, covered by) Medicare and revokes coverage under the Plan The employee becomes entitled to (that is, covered by) Medicare and revokes coverage under the Plan;
- The dependent ceases to be a "dependent child" under the Plan.

Notification Responsibilities

The Subscribing Employer must notify the Administrator within 30 days of an Eligible Employee's termination of employment, reduction in hours of employment, death or Medicare entitlement.

You or your dependent must notify the Administrator within 60 days of the following Qualifying Events: (i) divorce or legal separation from your spouse, (ii) termination of your domestic partner relationship, (iii) your dependent child's ceasing to be eligible as a dependent child under the Plan or (iv) in the case of a Subscribing Individual, the Subscribing Individual's termination of employment, reduction in hours of employment, death or Medicare entitlement. To inform the Administrator of these Qualifying Events, you must obtain a Qualifying Event form from the Administrator, complete and sign the form, and return the form to the Administrator within 60 days of the Qualifying Event by first-class mail, or other reliable means of delivery, including personal delivery, express mail, or private courier company. *Please note that you will have no right to elect COBRA continuation coverage if the Qualifying Event form is not sent to the Administrator within 60 days of the Qualifying Event.*

COBRA Election Notice

When the Administrator is notified that a Qualifying Event has occurred, the Administrator will provide the Qualified Beneficiary with a COBRA election notice. To elect COBRA continuation coverage, a Qualified Beneficiary must complete and sign the COBRA election notice and return the notice to the Administrator by first-class mail, or other reliable means of delivery, including personal delivery, express mail within the later of 60 days after the date of the notice, or 60 days after the date his health coverage otherwise ends. *Please note that you will have no right to elect COBRA continuation coverage if the COBRA election notice is not sent to the Administrator within 60 days of the later of the date of the notice or the date health coverage otherwise ends.* If an Eligible Employee, Eligible Retiree or Subscribing Individual elects COBRA continuation coverage, the election will be deemed to include all covered eligible Dependents unless the employee asks that it not include them. If the former spouse or former domestic partner of an Eligible Employee, Eligible Retiree or Subscribing Individual elects COBRA continuation coverage, the former spouse or domestic partner may elect to include covered dependents who live with the former spouse or domestic partner.

Payments For COBRA Continuation Coverage

A Qualified Beneficiary who elects COBRA continuation coverage must pay for that coverage. Premiums for the initial period of COBRA continuation coverage (the period that begins on the date of the Qualifying Event through the date a Qualified Beneficiary elects COBRA continuation coverage) must be made and received by the Administrator within 45 days after the day on which the Qualified Beneficiary elected COBRA continuation coverage. Premiums for subsequent months are due on the first day each month (i.e., payment for coverage for the month of January is due on January 1). However, there is a grace period of 30 days following the due date. The covered person's monthly premium must be received by the Administrator within 30 days after the first of each month. If the Qualified Beneficiary fails to pay the required premium by the end of the 30-day grace period, then COBRA continuation coverage will be terminated retroactively to the end of the last month for which payment has been made (for example, if you fail to pay the premium for the month of January by January 30, then your coverage will be terminated retroactively to December 31). The premium charged for COBRA continuation coverage will be 102% of the applicable premium charged by the Plan or, for Social Security disability extensions beyond 18 months (described below), 150% of the applicable premium. Premiums for COBRA continuation coverage are changed annually, and you will be notified of any premium changes.

Type Of Coverage

Generally, COBRA continuation coverage is identical to the coverage provided under the Plan to similarly situated employees or family members. Your COBRA continuation coverage may be changed or modified if the coverage provided under the Plan to employees or family members is changed. You will continue to participate in the Plan's annual open enrollment period for the duration of your COBRA continuation coverage.

Maximum Duration Of COBRA Continuation Coverage

For health coverage, the law provides that the maximum COBRA continuation coverage period is 36 months unless your Qualifying Event is a termination or reduction in hours of employment. In that case, the maximum COBRA continuation coverage period is generally 18 months. There are two ways in which the 18-month period of COBRA continuation coverage can be extended.

Extension for Second Qualifying Events. The 18-month period may be extended to 36 months if a second Qualifying Event occurs during the original 18-month period of COBRA continuation coverage and the affected family member notifies the Administrator within 60 days of the second Qualifying Event. To inform the Administrator of a second Qualifying Event, you must obtain a Qualifying Event form from the Administrator, complete and sign the form, and return the form to the Administrator within 60 days of the second Qualifying Event by first-class mail, or other reliable means of delivery, including personal delivery, express mail, or private courier company. Examples of second Qualifying Events include the employee's divorce or legal separation, a child ceasing to be a "dependent child," the employee becoming entitled to Medicare and revoking coverage under the Plan, or the employee's death. In no event will COBRA continuation coverage last beyond 36 months from the date of the Qualifying Event that originally made an individual eligible to elect coverage.

Extension for Disability Determinations. The 18-month period may also be extended to 29 months if an individual is determined by the Social Security Administration to be disabled (for Social Security purposes) at any time during the first 60 days of COBRA continuation coverage and the individual notifies the Administrator within 60 days of the date of the disability determination by the Social Security Administration and before the end of the original 18-month period of COBRA continuation coverage. To inform the Administrator of the disability determination, you must obtain a Qualifying Event form from the Administrator, complete and sign the form, and return the form to the Administrator within 60 days of the determination of disability and before the end of the 18-month period by first-class mail, or other reliable means of delivery, including personal delivery, express mail, or private courier company. If the individual entitled to the disability extension has non-disabled family members who are entitled to COBRA continuation coverage, these non-disabled family members are also entitled to the extension of the COBRA continuation coverage period from 18 to 29 months. A greater premium amount applies to the 11-month extension period, as explained above. The affected individual(s) also must notify the Administrator within 30 days of any final determination by the Social Security Administration that the individual is no longer disabled. To inform the Administrator of a final determination that the individual is no longer disabled, you must obtain a Qualifying Event form from the Administrator, complete and sign the form, and return the form to the Administrator by first-class mail, or other reliable means of delivery, including personal delivery, express mail, or private courier company. This 29 month period may be extended to 36 months for certain family members if a second Qualifying Event (as explained above) occurs during the original 29-month period and the affected family member notifies the Administrator within 60 days of the second Qualifying Event.

Please note that you will have no right to extend COBRA continuation coverage (either based on a second Qualifying Event or based on disability) if the appropriate notice is not sent to the Administrator within the time periods described above.

Termination Of COBRA Continuation Coverage

COBRA continuation coverage under the Plan will end on the first of these dates:

- The end of the 18, 29, or 36 month COBRA continuation coverage period;
- The end of the last month for which the Qualified Beneficiary has properly paid the required premium for COBRA continuation coverage. Late payments (after the 30-day grace period) will not be accepted;

- The date the Plan terminates;
- The first date, after the date you make your COBRA election, on which you become covered under another group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition you may have. If the exclusions or limitations for pre-existing conditions in the other group health plan would not apply to you (or would be satisfied by you) due to the requirements enacted by the Health Insurance Portability and Accountability Act of 1996, then the Plan may terminate your COBRA continuation coverage;
- The first date, after the date you make your COBRA election, on which you become entitled to Medicare;
- If a disability extension applies, the date of a final determination by the Social Security Administration that the individual is no longer disabled. The disabled individual must notify the Administrator within 30 days of such a determination;
- The date a Qualified Beneficiary covered by an HMO moves out of the HMO's service area, if coverage under the Plan is not available in the area to which the Qualified Beneficiary has moved; or
- The date the Qualified Beneficiary commits fraud or deception in the use of Plan services.

Keep Your Plan Informed Of Address Changes
To protect your family's rights to COBRA continuation coverage, you should keep the Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Administrator.

Administrator
All notices and communications regarding COBRA continuation coverage should be sent to:

UUA Health Plan
25 Beacon Street
Boston, MA 02108

Family and Medical Leave
The FMLA allows eligible employees to take up to 12 weeks of leave each year for serious illness, the birth or adoption of a child, or to care for a spouse, child, or parent who has a serious health condition.

If your request for a leave is approved, group health coverage for you and any covered dependents continues as long as you continue to pay your portion of the cost for your benefits during the leave. If you take a paid leave of absence, the cost of group health coverage will continue to be deducted from your pay on a before tax basis. If you take an unpaid leave of absence that qualifies under FMLA, your participation continues as long as you contribute your share of the cost of group health coverage during the leave on an after-tax basis. For additional information on FMLA leaves, please contact the Administrator.

If you lose any group health coverage during an FMLA leave because you did not make the required contributions, you may reenroll when you return from your leave and you will be reinstated on the same terms that applied prior to taking such FMLA leave. Your group health coverage will start again on the first day after you return to work and make your required contributions.

When you take an FMLA leave, the entire amount you elected under your Health FSA will be available to you during your leave period, less any prior reimbursement, as long as you continue to make your contributions during your leave of absence. If you stop making contributions, your coverage under the Health FSA will terminate while you are on FMLA leave. In that case, you may not receive reimbursement for any health care expenses you incurred after your coverage terminated.

Military Leave

If you take a military leave, whether for active duty or for training, you are entitled to extend your health coverage for up to 24 months as long as you give your Subscribing Employer advance notice of the leave (with certain exceptions). Your total leave, when added to any prior periods of military leave from your Subscribing Employer, cannot exceed five years (with certain exceptions).

If the entire length of the leave is 30 days or less, you will not be required to pay any more than the amount you paid before the leave. If the entire length of the leave is 31 days or longer, you may be required to pay up to 102% of the full amount necessary to cover an employee who is not on military leave.

If you take a military leave, but your coverage under the Plan is terminated, for instance, because you do not elect the extended coverage, you will be treated as if you had not taken a military leave upon reemployment when determining whether an exclusion or waiting period applies.

Certificates of Coverage

You and your eligible Dependents that lose group health coverage must receive certification of your coverage under the Plan. You may need this certification in the event you later become covered by a new plan under a different employer, or under an individual policy.

You and your eligible Dependent(s) will receive a coverage certification (i) when your Plan coverage terminates, (ii) when COBRA coverage terminates (if you elected COBRA), and (iii) upon your request (if the request is made within 24 months following either termination of coverage).

Your should keep a copy of the coverage certification(s) you receive, as you may need to prove you had prior coverage when you join a new health plan. For example, if you obtain new employment and your new employer's plan has a pre-existing condition limitation (which delays coverage for conditions treated before you were eligible for the new plan), the employer may be required to reduce the duration of the limitation by one day for each day you had prior coverage (subject to certain requirements). If you are purchasing individual coverage, you may need to present the coverage certification to your insurer at that time as well.

ERISA Rights

As a participant in the Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all participants shall be entitled to:

Receive Information about Your Plan and Benefits

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

Obtain, upon written request to the Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated SPD. The administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event. You or your dependents may have to pay for such coverage. Review this SPD and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

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 health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

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 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 the Trust or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a Plan benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the 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 after you exhaust the Plan's claim and appeal procedures. 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.

No action at law or in equity may be brought to recover under the Plan until the appeal rights herein provided have been exercised and the Plan benefits requested in such appeal have been denied in whole or in part.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the 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 Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or contact the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Plan Administration

Power and Authority of Administrator

The Trust is responsible for the general administration of the Plan, and is the named fiduciary of the Plan. The Trust has the discretionary authority to construe and interpret the provisions of the Plan and make factual determinations regarding all aspects of the Plan and its benefits, including the power to determine the rights or eligibility of employees and any other persons, and the amounts of their benefits under the Plan, and to remedy ambiguities, inconsistencies or omissions, and such determinations shall be conclusive and binding on all parties. A misstatement or other mistake of fact will be corrected when it becomes known, and the Trust will make such adjustment on account of the mistake as it considers equitable and practicable, in light of applicable law. The Trust has the discretionary authority to delegate fiduciary functions to other entities, including the Trust Committee and Claims Administrators. The Trust, the Trust Committee and any Claims Administrators will be liable in any manner for any determination made in good faith.

The Trust has designated one Claims Administrator – Highmark Blue Cross Blue Shield – and may designate other organizations or persons, to carry out specific fiduciary responsibilities of the Trust in administering the Plan including, but not limited to, the following:

- pursuant to an administrative services or claims administration agreement, if any, the responsibility for administering and managing the Plan, including the processing and payment of claims under the Plan and the related recordkeeping,

- the responsibility to prepare, report, file and disclose any forms, documents and other information required to be reported and filed by law with any governmental agency, or to be prepared and disclosed to employees or other persons entitled to benefits under the Plan, and

- the responsibility to act as Claims Administrator and to review claims and claim denials under the Plan to the extent an Insurer or administrator is not empowered with such responsibility.

The Trust will administer the Plan on a reasonable and nondiscriminatory basis and will apply uniform rules to all persons similarly situated.

All benefits and administrative expenses of the Plan are paid from the Trust. The Trust is funded by contributions from Subscribing Employers, Eligible Employees, Eligible Retirees and Subscribing Individuals.

Questions

If you have any general questions regarding the Plan, please contact the Administrator. If you have specific questions concerning eligibility for and/or the amount of any benefits payable under the Plan, please refer to your Coverage Booklets or contact the Claims Administrator.

Plan Amendment and Termination

The Trust reserves the right to amend the Plan and any Coverage Booklets in whole or in part or to completely discontinue the Plan at any time. For example, the Trust reserves the right to amend or terminate benefits, covered expenses, benefit co-pays, lifetime maximums, and reserves the right to amend the Plan to require or increase participant contributions. The Trust also reserves the right to amend the Plan to implement any cost control measures that it may deem advisable.

Any amendment, termination or other action by the Trust with respect to the Plan shall be by a duly adopted resolution of the Trustees or delegated to a committee or persons authorized to take such action on behalf of the Trustees. Amendments may be retroactive to the extent necessary to comply with applicable law. No amendment or termination shall reduce the amount of any benefit otherwise payable under the Plan for charges incurred prior to the effective date of such amendment or termination.

In the event of the dissolution, merger, consolidation or reorganization of a Subscribing Employer, participation in the Plan shall terminate as to that Subscribing Employer unless the participation in the Plan is continued by a successor to that Subscribing Employer with the

Trust’s consent. In the event of the dissolution, merger, consolidation or reorganization of the Trust, the Plan shall be terminated.

General Information

Plan Name	Unitarian Universalist Organizations Health Plan
Plan Number	501
Plan Sponsor	Unitarian Universalist Association Employee Benefits Trust 25 Beacon Street Boston, MA 02108 617-948-6405
Employer Identification Number	
Administrator	Unitarian Universalist Association Employee Benefits Trust 25 Beacon Street Boston, MA 02108 617-948-6405
Agent for Service of Legal Process	Administrator
Plan Year	July 1st through June 30th
Plan Type	Welfare benefit plan providing the following types of benefits: Medical, including prescription drug (self-funded)
Source of Contributions	Both Subscribing Employers and Plan participants share in the cost of contributions for the benefits offered under the Plan. The Trust determines the amount of participant contributions each year.
Claims Administrator	
• Medical (including Prescription Drug)	Highmark Blue Cross Blue Shield 5th Avenue Place 120 Fifth Avenue Pittsburgh, PA 15222-3099 800-796-6502

Appendix A – Coverage Booklets

This SPD should be read in combination with the insurance contracts, evidence of coverage documents (together and individually referred to as "Coverage Booklets") provided by Highmark Blue Cross Blue Shield. The Coverage Booklets describe the benefits available under the Plan, and when read with this SPD, are intended to meet ERISA's SPD requirements.

Please see the Coverage Booklets for details of Plan benefits. For additional information or for copies of the Coverage Booklets, please contact the Administrator.

List of Coverage Booklets

Highmark Blue Cross Blue Shield Standard PPO Benefit Booklet

Highmark Blue Cross Blue Shield High Deductible PPO Benefit Booklet (HSA eligible)

Highmark Blue Cross Blue Shield High Deductible PPO Benefit Booklet (non-HSA eligible)

Highmark Blue Cross Blue Shield Medicare Supplement Booklet

APPENDIX B

Notice Regarding State Premium Assistance Programs

If you are eligible for health coverage under the Plan, but are unable to afford the premiums, some states have premium assistance programs that can help pay for coverage. These states use funds from their Medicaid or Children's Health Insurance Programs (CHIP) to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

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

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

Once it is determined that you or your children are eligible for premium assistance under Medicaid or CHIP, the Plan is required to permit you and your children to enroll – as long as you and your children are eligible, but not already enrolled in the Plan. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**.

If you live in one of the following states, you may be eligible for assistance paying your Plan premiums. You should contact your state for further information on eligibility.

ALABAMA – Medicaid	**ALASKA** – Medicaid
Website: http://www.medicaid.alabama.gov Phone: 1-855-692-5447	Website: http://health.hss.state.ak.us/dpa/programs/medicaid/ Phone (Outside of Anchorage): 1-888-318-8890 Phone (Anchorage): 907-269-6529
ARIZONA – CHIP	**COLORADO** – Medicaid
Website: http://www.azahcccs.gov/applicants Phone (Outside of Maricopa County): 1-877-764-5437 Phone (Maricopa County): 602-417-5437	Website: http://www.colorado.gov/ Phone (In state): 1-800-866-3513 Phone (Out of state): 1-800-221-3943
FLORIDA – Medicaid	**GEORGIA** - Medicaid
Website: https://www.flmedicaidtplrecovery.com/ Phone: 1-877-357-3268	Website: http://dch.georgia.gov/ (Click on Programs, then Medicaid, then Health Insurance Premium Payment - HIPP) Phone: 1-800-869-1150
IDAHO – Medicaid and CHIP	**INDIANA** – Medicaid
Medicaid Website: www.accesstohealthinsurance.idaho.gov Medicaid Phone: 1-800-926-2588 CHIP Website: www.medicaid.idaho.gov CHIP Phone: 1-800-926-2588	Website: http://www.in.gov/fssa Phone: 1-800-889-9949
IOWA – Medicaid	**KANSAS** – Medicaid

Website: www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562	Website: http://www.kdheks.gov/hcf/ Phone: 1-800-792-4884
KENTUCKY – Medicaid Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	**LOUISIANA** – Medicaid Website: http://www.lahipp.dhh.louisiana.gov Phone: 1-888-695-2447
MAINE – Medicaid Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-977-6740 TTY: 1-800-977-6741	**MASSACHUSETTS** – Medicaid and CHIP Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120
MINNESOTA – Medicaid Website: http://www.dhs.state.mn.us/ (Click on Health Care, then Medical Assistance) Phone: 1-800-657-3629	**MISSOURI** – Medicaid Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid Website: http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml Phone: 1-800-694-3084	**NEBRASKA** – Medicaid Website: www.ACCESSNebraska.ne.gov Phone: 1-800-383-4278
NEVADA – Medicaid Website: http://dwss.nv.gov/ Phone: 1-800-992-0900	**NEW HAMPSHIRE** – Medicaid Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218
NEW JERSEY – Medicaid and CHIP Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 1-800-356-1561 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	**NEW YORK** – Medicaid Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100	**NORTH DAKOTA** – Medicaid Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-800-755-2604
OKLAHOMA – Medicaid and CHIP Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	**OREGON** – Medicaid and CHIP Website: http://www.oregonhealthykids.gov http://www.hijossaludablesoregon.gov Phone: 1-877-314-5678

PENNSYLVANIA – Medicaid	**RHODE ISLAND** – Medicaid
Website: http://www.dpw.state.pa.us/hipp Phone: 1-800-692-7462	Website: www.ohhs.ri.gov Phone: 401-462-5300
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA** – Medicaid
Website: http://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH** – Medicaid and CHIP
Website: https://www.gethipptexas.com/ Phone: 1-800-440-0493	Website: http://health.utah.gov/upp Phone: 1-866-435-7414
VERMONT – Medicaid	**VIRGINIA** – Medicaid and CHIP
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Medicaid Website: http://www.dmas.virginia.gov/rcp-HIPP.htm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.famis.org/ CHIP Phone: 1-866-873-2647
WASHINGTON – Medicaid	**WEST VIRGINIA** – Medicaid
Website: http://hrsa.dshs.wa.gov/premiumpymt/Apply.shtm Phone: 1-800-562-3022 ext. 15473	Website: www.dhhr.wv.gov/bms/ Phone: 1-877-598-5820, HMS Third Party Liability
WISCONSIN – Medicaid	**WYOMING** – Medicaid
Website: http://www.badgercareplus.org/pubs/p-10095.htm Phone: 1-800-362-3002	Website: http://health.wyo.gov/healthcarefin/equalitycare Phone: 307-777-7531

This list of states is current as of July 31, 2012. To see if any more states have added a premium assistance program since July 31, 2012, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor Employee Benefits Security Administration **www.dol.gov/ebsa** **1-866-444-EBSA (3272)**	U.S. Department of Health and Human Services Centers for Medicare & Medicaid Services **www.cms.hhs.gov** **1-877-267-2323, Ext. 61565**