Indiana Laborers Welfare Fund

Combination Plan Document and Summary Plan Description

December 1, 2025 Edition

Este folleto está disponible en español en nuestra página web, indianalaborers.org o puedes contactar con la oficina del Fondo.

Indiana Laborers Welfare Fund
P.O. Box 1587
Terre Haute, IN 47808
(812) 238-2551

Important!

There are several significant events that may occur while you are covered under the Plan. Please contact the Fund Office, in writing, if any of the following occurs:

- YOUR ADDRESS OR TELEPHONE NUMBER CHANGES.
- **YOU MARRY, DIVORCE OR OBTAIN A LEGAL SEPARATION FROM YOUR SPOUSE.** You must also submit the appropriate legal documents (for example: marriage certificate, divorce decree, custody agreement).
- YOU CHANGE YOUR BENEFICIARY.
- THE STATUS OF A DEPENDENT CHANGES.
- **YOU BECOME A PARENT.** You must also submit the child's state-certified birth certificate, decree of adoption or a Qualified Medical Child Support Order.
- YOU GO INTO OR RETURN FROM MILITARY SERVICE.
- YOU ARE INJURED ON THE JOB.
- YOU ARE INJURED IN AN ACCIDENT.
- YOU BECOME ELIGIBLE FOR MEDICARE.
- YOU RETIRE.
- YOU CHANGE YOUR ENROLLMENT STATUS IN A MEDICARE PRESCRIPTION DRUG PLAN.
- YOU PERFORM WORK FOR A NON-SIGNATORY EMPLOYER.
- YOU PERFORM WORK AT A DIFFERENT TRADE WITHIN THE CONSTRUCTION INDUSTRY FOR A SIGNATORY OR NON-SIGNATORY EMPLOYER.

You may contact the Fund Office at:
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For further information or forms visit the website or call or write:

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INTRODUCTION

The Indiana Laborers Welfare Fund (Plan) is a valuable benefit provided through the Local Unions and Employers. Generally speaking, Employees may participate in the Plan when they work continuously in employment that's covered under a collective bargaining agreement between their Employer and the Laborers' International Union of North America, State of Indiana District Council.

The Plan is designed to protect Participants from financial hardship in case of serious Sickness or Injury. Health care benefits, including general medical coverage, are provided both to the Participant and Dependents.

The Plan is self-funded for all Benefits except for those with Medicare Advantage Plans with Part D coverage (MAPD), as described in Appendix A, and for the Life and Accidental Death and Dismemberment Benefits, which are fully insured. When an Employee works in covered employment, the Employer makes contributions to the Trust Fund on the Employee's behalf, as required by collective bargaining agreements. These contributions are used to pay Benefits and administer the Plan on the Participant's behalf.

A Board of Trustees, consisting of an equal number of labor and management representatives, is responsible for the financial management and general operation of the Plan. To accomplish these tasks, the Board of Trustees retains the services and advice of various professionals, including certified public accountants, attorneys, actuaries and consultants. The Trustees employ a full-time staff to administer the Plan and maintain a modern, well-equipped office to provide for the daily operation of the Plan.

The Trustees strive to maintain and improve the Benefits available to Participants and their Dependents. However, the Trustees do reserve the right to amend the Plan in any way and at any time they feel necessary or desirable. Proper notice will be given of any changes in the Schedule of Benefits. The Trustees further reserve the right to interpret and apply all provisions of the Plan, including those which relate to eligibility for Benefits and the proper payment of Benefits.

STEPS YOU CAN TAKE TO HOLD DOWN HEALTH CARE COSTS

When health care costs are rising, you can maintain a high level of medical care and save money by being careful about how you use your Benefits. Here are ways you can use your Plan effectively.

- When you need a prescription, ask your Physician or pharmacist about generic drugs. They often can be substituted for brand name drugs – sometimes at less than half the cost.
- Don't substitute the Hospital emergency room for your Physician's office. An emergency room is an expensive place to treat minor ailments. Call your Physician first or utilize Teladoc Online Physician Visits. Teladoc Online Physician Visits are no cost to you. In comparison, you must pay a separate Deductible for visits to an emergency room for conditions other than accidental Injuries, inpatient admissions or serious life-threatening Sicknesses, as verified by Physicians. See Section 4.18 for more information on Teladoc Online Physician Visits.
- When your Physician recommends a Hospital stay, outpatient surgery or other treatment listed in Section 8.15, it is a requirement to call the medical care review program (see Section 8.15 for program information and Section 9.15 for contact information). The staff there can help you identify health care options and obtain the most cost-effective care. They can also answer any questions or concerns you have regarding the procedure and after care.
- Avoid being admitted to a Hospital on Friday or Saturday if your condition isn't likely to be treated until Monday and if there seems to be no practical reason for you to be hospitalized over the weekend. The Plan may not cover weekend admissions if your condition is not treated within 24 hours. You must call the medical care review program with any Hospital admission, outpatient surgery or other treatment listed in Section 8.15 (see Section 8.15 for program information and Section 9.15 for contact information).
- Many Hospitals run a battery of tests simply as a precaution. Some of them may not be necessary. Check with your Physician to see whether or not they're needed.
- Review your Explanation of Benefits (EOB) carefully to be sure you actually received the services and supplies listed. It is not uncommon to find errors in medical bills. Make sure the service date matches the day you incurred the expense and that you received each service listed on the EOB. If you find an error, contact the Fund Office for assistance.
- Become an intelligent consumer. Ask questions. It pays in the long run to ask about treatments you don't understand.
- If you need medical care for an extended period of time, check with your Physician about home health care or other alternatives to hospitalization. You must call the medical care review program with any long-term medical needs (see Section 8.15 for program information and Section 9.15 for contact information).
- If you need an MRI, CAT scan or any other type of imaging, check and see if there is a radiology clinic in your area rather than utilizing a Hospital facility for this service.

IMPORTANT NOTICE

This Combination Plan Document and Summary Plan Description (Document) is intended to describe the Life, Dental, Eye Care, Hearing, Prescription and health care Benefits adopted by the Board of Trustees as set forth in Article II - Schedule of Benefits for Classes A, AS, C, D and S and in Appendix A for Class CP. Only the full Board of Trustees has the authority to interpret the Benefits described in this Document. Their interpretation will be final and binding on all persons dealing with the Plan or filing a Benefit Claim from the Plan. The Plan contains appeal procedures that may be used if you feel that Benefits have been wrongfully denied. The Trustees' decision can be challenged in court only after those procedures are exhausted. No Employer or Union nor any representative of any Employer or Union, in such capacity, is authorized to interpret this Plan nor can any such person act as an agent of the Trustees. Any formal interpretations regarding this Plan must be communicated in writing signed on behalf of the full Board of Trustees either by the Trustees or, if authorized by the Trustees in writing, by the Administrative Manager.

Trustee Authority
The Board of Trustees, as Plan Administrator, has full authority to increase, reduce or eliminate Benefits and to change the Eligibility Rules or other provisions of the Plan at any time. However, the Trustees intend that the Plan terms, including those relating to coverage and Benefits, are legally enforceable and that the Plan is maintained for the exclusive benefit of the Participants and their Dependents. Benefits under this Plan will be paid only if the Plan Administrator (the Board of Trustees) decides, in its discretion, that the applicant is entitled to them.

Notices of Plan changes will be sent to each Participant's last known address. It is extremely important that you notify the Fund Office, in writing, of any address change!

Notice of Plan Changes
Notices of any changes will be sent to each Participant's last-known address within the time required by applicable regulations. Therefore, it is extremely important to keep the Fund Office informed regarding any change of address. Plan changes, however, may take effect before notification is received. Therefore, before receiving non-emergency care, contact the Fund Office to confirm current Benefits if you are unsure what they are.

Defined Terms
Certain words have specific meaning and are capitalized when used in the Plan. These words are listed in Article XI – Definitions. It is important to understand the meanings of the defined terms while using this Document.

MEDICAL CARE REVIEW PROGRAM

The Plan's chosen medical care review firm is Hines & Associates, Inc.

You may contact Hines & Associates, Inc. at (800)559-5257 or visit the website: www.precertcare.com

For Classes A, AS, D, and S, the Plan has entered into an agreement with a professional medical care review firm to precertify all inpatient Hospital stays, surgeries and other procedures and equipment your Physician may recommend. You may contact the Fund Office for a complete list of the procedures, treatments and equipment that require precertification by the medical care review firm. The medical care review firm precertifies Hospital and other treatment plans for Medically Necessary determination which helps the Eligible Person and the Plan avoid unnecessary medical costs. This review is not a guarantee of payment.

It is the Eligible Person's responsibility to contact the Fund Office to determine if Benefits are covered. Hospital admissions on a non-emergency basis for treatment or surgery should be precertified as soon as the decision is made but no less than five days prior to the scheduled admission. Hospital admissions for Emergency treatment must be certified no later than the next business day after the Emergency admission. The medical care review firm can be contacted by the Eligible Person, Physician or Hospital; however, **it is ultimately the Participant's responsibility to make sure Hines & Associates have been contacted**. Refer to Section 8.15 for program information and Section 9.15 for contact information. Class CP medical care review is performed under the fully insured program as described in Appendix A.

PREFERRED PROVIDER ORGANIZATION

The Plan's Preferred Provider Organization is United Healthcare Shared Services.

For up-to-date provider information, visit www.whyuhc.com/uhss.

For Classes A, AS, D, and S, the Plan has negotiated special contracts with an organization of area Physicians and Hospitals ("Preferred Providers") known as a Preferred Provider Organization (PPO). In most cases these Preferred Providers (also called In-Network providers) will render services for fees that are below prevailing prices.

If the Eligible Person uses a Preferred Provider for the Eligible Person's health care needs, the Plan will pay 75% of all Covered Charges, after the annual In-Network Deductible Amount is satisfied. See Article XI for definitions.

Notwithstanding any other Plan provision, if for any reason the contracted PPO fee for a covered service is more than the Preferred Provider's actual charge, then the Plan will pay Benefit Claims so that the Participant's Coinsurance (the amount the Participant pays) is no more than 25% of the provider's actual charge.

The Eligible Person is not required to use a Preferred Provider. The Eligible Person has complete freedom of choice to use any Physician or Hospital. If an individual does not use a Preferred Provider, the Plan will pay 50% of all Covered Charges, after the annual Out-of-Network Deductible Amount is satisfied.

In some instances, certain Out-of-Network services or providers may be covered at the In-Network level. Please contact the Fund Office with any questions at (812) 238-2551.

A provider list is available at www.whyuhc.com/uhss.

The Preferred Provider Network is not applicable to Class C, D and CP as any Physician or Hospital that accepts Medicare will be considered an eligible Provider. See Appendix A for more information regarding Class CP.

If you rely on information in the Plan's provider directory that inaccurately states that an Out-of-Network provider is In-Network, you will only be subject to In-Network cost-sharing amounts. These cost-sharing amounts will be applied toward the In-Network Deductible and/or In-Network Out-of-Pocket maximum in the same manner In-Network cost-share would be applied.

FILING A REGISTRATION CARD

**IF YOU HAVE NOT FILED A REGISTRATION CARD, DO SO NOW!
YOU WILL NOT BE ELIGIBLE TO RECEIVE BENEFITS UNTIL A COMPLETED REGISTRATION CARD IS FILED WITH THE FUND OFFICE.**

When first becoming eligible under the terms of the collective bargaining or participation agreement, Participants should have received a **"REGISTRATION CARD"** from the Local Union or may request one from the Fund Office.

The card requests certain basic information that is needed for Fund Office records. This information includes the Participant and Dependents' full legal names, address, Social Security numbers, dates of birth and the Participant's Beneficiary(ies) in the event of death.

All of this information is vital! Without it, the Fund Office will have difficulty knowing what you and your family are entitled to under the Plan and in keeping you informed about Plan changes.

If you are not sure whether you have a Registration Card on file, contact the Fund Office. The staff will tell you whether you have a card on file and verify that it contains current information. If you do not have current information on file, a card will be sent to you for completion.

NOTIFY THE FUND OFFICE PROMPTLY WITH ANY CHANGE IN ADDRESS, TELEPHONE NUMBER, BENEFICIARY, DEPENDENTS, MARITAL STATUS, PARENTAL STATUS, MILITARY STATUS, EMPLOYMENT STATUS, OTHER PLAN COVERAGE, MEDICARE OR RETIREMENT ELIGIBILITY.

When there are Plan changes, notification is sent to each Participant. This means that, in order to receive notification, the Fund Office must have current address information. **IF YOU MOVE**, make sure to notify the Fund Office of the new address. **IF YOUR MARITAL STATUS CHANGES,** don't forget to notify the Fund Office. The Fund Office must receive a complete, signed and dated copy of your marriage license or certificate of marriage, divorce decree or Order of Legal Separation. These documents will be made a permanent part of your file and will be kept in the Fund Office. Failure to send copies of these documents will delay the processing of Benefit Claims.

If you wish to **CHANGE YOUR BENEFICIARY, DON'T FORGET TO SEND THE CHANGE TO THE FUND OFFICE, IN WRITING.** If you fail to notify the Fund Office of your wishes in writing, the Fund Office can only pay Life Insurance Benefits to the person(s) in your latest **written** notification to the Fund Office prior to the time of your death. See Article XI for the definition of "Beneficiary."

If you need to **ADD OR REMOVE DEPENDENTS,** you must notify the Fund Office, **in writing**. You should be prepared to provide documentation in the form of a birth certificate, decree of adoption, marriage license, divorce decree, etc. Since the Plan provides

Benefits to Dependents, the Fund Office must know who your Dependents are at all times. See Article XI for the definition of "Dependent." An Employee has 30 days after a life event (marriage, adoption, etc.) to add a Dependent, unless the life event is the birth of a child. If an Employee has a child, that child must be added as a Dependent within 120 days of the child's birth. If the new Dependent is added in a timely manner, the new Dependent will be eligible effective the date of the life event. If a Dependent is not added in a timely manner (more than 30 days after the life event or more than 120 days after birth), the new Dependent will be eligible beginning the first of the month after the receipt of all documented proof of dependency.

If the Plan makes any inadvertent, mistaken or excessive payments of Benefit Claims, the Trustees or their representatives shall have the right to recover the payments.

You MUST notify the Fund Office BEFORE you begin work in the construction industry in the geographic jurisdiction of the Plan for an employer that does not have a contractual obligation to contribute to the Trust Fund ("non-signatory employer"). You must also notify the Fund Office BEFORE you begin work at a different trade in the construction industry either for a signatory or non-signatory employer. This information is a material fact of which the Fund Office must be informed. Failure to notify the Fund Office is fraud. Coverage for you and any covered family members will cease the first of the month following the month in which the Fund Office is aware of your work for a non-signatory employer. If the Plan made any Benefit Claims payments on behalf of you or your Dependents during such period, the Plan may seek to recover any such payments from you. The Trustees reserve the right to create equitable exceptions to this rule in cases where the exception would not run contrary to the purposes and intent of providing Benefit Claims under this Plan.

A WORD ABOUT CONFIDENTIAL INFORMATION

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) provides stringent requirements for the Plan, its Trustees and its service vendors concerning the use and disclosure of Participants' personally identifiable Protected Health Information (PHI). Broadly speaking, PHI includes personal information about Participants and/or their Dependents, such as their name, address, telephone number and Social Security number, in conjunction with information concerning the Participant and/or their Dependents, such as: (1) eligibility for Benefits, (2) medical treatment provided or (3) payment for such medical treatment. Specifically, the Plan will use and disclose PHI only for purposes related to health care treatment, payment for health care and health care operations or as otherwise allowed or required by law.

The Plan's use and disclosures of PHI is set out in detail in the Privacy Notice previously mailed to all Participants. Please contact the Fund Office to receive another copy of the Privacy Notice.

The Plan and the Trustees are committed to observing these privacy rules and ensuring the confidentiality of all PHI. The Trustees appreciate cooperation and understanding in working with them to achieve compliance with these federal requirements.

ARTICLE I – ELIGIBLE CLASS DESCRIPTIONS

The following topics are discussed under this Article on Eligibility:

Section 1.01 – Active Participants

Class A

This class represents active Participants who are eligible either by Employer contributions, bank hours or Self-Payments. This class has the Schedule of Benefits for Class A – Active Employees.

Their **Dependents** are also covered under the Schedule of Benefits for Class A.

Section 1.02 – Retirees not Eligible for Medicare

Class AS

This class represents Retirees who are not eligible for Medicare but would like to keep the Schedule of Benefits for Class A – Active Employees (with a few exclusions as explained in Article II – Schedule of Benefits for Class AS). Their **Dependents not eligible for Medicare** are also covered under the Class AS. Their **Dependents who are eligible for Medicare** Parts A & B receive Class CP Benefits under the MAPD Plan as described in Appendix A. Dental, Eye Care and Hearing are self-funded in the same manner as the Schedule of Benefits for Class A.

This class also represents Totally Disabled Participants who are not eligible for Medicare but would like to keep the Schedule of Benefits for Class A, who are unable to work due to a continuing Injury or Sickness who provide medical evidence satisfactory to the Board of Trustees of the continuing Total Disability.

The terms “Injury,” “Sickness,” “Retiree” and “Totally Disabled” are defined in Article XI.

Section 1.03 – Participants Eligible for Medicare

Benefits are payable for services that are covered by Medicare, unless specifically listed as an Exclusion under Article V. Services not covered by Medicare are not payable unless the service is specifically listed in the Schedule of Benefits.

Class C

This class represents Medicare-eligible Employees, Retirees, and Totally Disabled Participants who want to supplement Medicare with this Plan but do not want this Plan’s prescription coverage and have Medicare-eligible Dependents or no Dependents. Their Medicare-eligible Dependents are covered under the Schedule of Benefits for this Class C. If a Medicare-eligible person wants to supplement Medicare with this Plan but does not want this Plan’s prescription coverage, and he has one or more Dependents who are not eligible for Medicare, the Medicare-eligible Participant must enroll through Class D.

Class CP
This class represents Medicare-Parts A & B -eligible Employees, Retirees and Totally Disabled Participants who want medical and prescription coverage under the MAPD Plan as described in Appendix A. Dental, Eye Care, Hearing and Life Insurance are self-funded in the same manner as the Schedule of Benefits for Class A. Their **Dependents who are not eligible for Medicare** are covered under Class AS. Their **Dependents who are eligible for Medicare Parts A & B** are covered under this Class CP except for Life Insurance.

Your medical and prescription claims under the MAPD Plan will still be processed by United Healthcare (UHC). All prescription claims that are not covered under the MAPD but that are eligible for coverage under the self-funded wrap Plan through Sav-Rx will continue to be processed by Sav-Rx.

As a reminder:
Medical Network: Your current In-Network providers and facilities will remain the same. Present your UHC card to your medical provider at the time of service.

Pharmacy Benefits: At the pharmacy, you will still present your UHC card first and your Sav-Rx card second.

If you have any questions regarding your benefits under the MAPD Plan, you will be assigned a member of our Claims Department so that you may contact them directly and speak to the same person each time you call. *Please keep in mind there are times your assigned representative may be on another phone call or out of the office. Don't worry, anyone in our Claims Department will be happy and able to assist you.*

You may also contact UHC and Sav-Rx directly at the phone numbers below:

UHC direct: 1-844-481-8820
Sav-Rx direct on their dedicated Retiree line: 1-800-545-2810

Class D
This class represents Medicare-eligible Employees, Retirees and Totally Disabled Participants who want this Plan's Class C Supplement to Medicare (with no prescription coverage) for themselves. Their **Dependents who are not eligible for Medicare** are covered under the Class AS. Their **Dependents who are eligible for Medicare** are covered under the Class C Supplement to Medicare with no prescription coverage.

Section 1.04 – Non-Medicare-Eligible Surviving Spouses

Class S
This class represents Surviving Spouses who are not eligible for Medicare. The coverage provided under this class is the same as the Schedule of Benefits for Class A – Active Employees with a few exclusions. Life Insurance Benefits are not provided under this class. The Participant's **Dependents not eligible for Medicare** are covered under Class S. the Participant's **Dependents eligible for Medicare Parts A & B** are covered under Class CP, as described above, except for Life Insurance.

ARTICLE II – SCHEDULES OF BENEFITS

The following topics are discussed under this Article on Schedules of Benefits:

Class A	Class AS	Class C	Class CP	Class D	Class S

Once a Participant becomes eligible under the Plan, the Participant qualifies for a variety of Benefits. The following chart highlights the Benefit Plan. Other Plan maximums and limitations may apply to specific Benefits. Benefits will be paid up to the Usual, Customary and Reasonable (UCR) Amount or Allowed Amount. Please refer to the appropriate Sections in this document or contact the Fund Office for more information.

Class A – Active Participants and their Dependents

Active Participant Only

Accidental Death and Dismemberment Benefit

(Non-Occupational Only)

Loss of Life	$ 15,000
Loss of Both Hands, Both Feet, Both Eyes or Combination of any Two	$ 10,000
Loss of One Hand, One Foot or One Eye	$ 5,000

Life Insurance Benefit ..... $ 15,000

Loss of Time (Disability) Benefit

(Subject to Social Security Taxes)
Any Participant receiving Loss of Time will receive a W-2 form at the end of the year.

New Loss of Time Benefit rates will be effective for injuries/illness occurring on December 1, 2025 and after. Those individuals who are already receiving the Loss of Time Benefit or who are injured or sick November 30, 2025 and before will continue to receive the old rate.

Maximum Benefit ..... 13 weeks per Injury or Sickness

Non-Occupational Injury (Benefits begin on 1st day of Total Disability)

Weekly Benefit Amount for Injury incurred before December 1, 2025	$ 456
Weekly Benefit Amount for Injury incurred on or after December 1, 2025	$ 800

Non-Occupational Sickness (Waiting Period: Benefits begin on 8th day of Total Disability)

Weekly Benefit Amount for Sickness incurred before December 1, 2025	$ 456
Weekly Benefit Amount for Sickness incurred on or after December 1, 2025	$ 800

Occupational Injury or Sickness (Waiting Period: Benefits begin on 8th day of Total Disability)

Weekly Benefit Amount for Occupational Injury or Sickness incurred before December 1, 2025	$ 108
Weekly Benefit Amount for Occupational Injury or Sickness incurred on or after December 1, 2025	$ 350

General Medical Benefit

(Plan Year is December 1 to November 30)

Maximum Lifetime Benefit	none
Maximum Annual Benefit	none

Deductible Amount

In-Network

Individual Deductible Amount (every Plan Year)	$ 300
Family Maximum Deductible Amount (every Plan Year)	$ 600

Out-of-Network

Individual Deductible Amount (every Plan Year)	$ 600

This Plan has no Out-of-Network Family Deductible.

Out-of-Pocket Limit

Individual (In-Network only, every Plan Year) Not including Deductible	$ 3,000
Family (In-Network only, every Plan Year) Not including Deductible	$ 6,000

Fund pays

In-Network (after Deductible)	75%
Out-of-Network (after Deductible)	50%

Certain Out-of-Network emergency services, Out-of-Network services at an In-Network facility and Air Ambulance Services are payable at In-Network rates.

Chiropractic Benefit

Fund pays

In-Network non-surgical services (after Deductible)	75%
Out-of-Network non-surgical services (after Deductible)	50%
Maximum Benefit every Plan Year	$ 1,500

Dental Care Benefit

Individual Dental Deductible Amount (every Calendar Year)	$ 25
Family Dental Deductible Amount (every Calendar Year)	$ 75
Maximum Benefit per individual every Calendar Year	$ 1,000*

* Calendar Year Maximum does not apply to Eligible Persons age 18 and under.

Fund pays

Exam, Cleaning, Bitewing X-rays (2 per Calendar Year)	100% of Allowed Amount
(not subject to Dental Deductible Amount; does not count toward annual maximum)	
Other Preventive Services	90% of Allowed Amount
(not subject to Dental Deductible Amount; does not count toward annual maximum)	
Restorative & Other Services	70% of Allowed Amount
(after Dental Deductible)	
Dentures	70%
Implants	70%
Orthodontia for Age 18 and Under ($1,000 lifetime maximum)	50%

Diabetes Education and Training Benefit

Fund pays

In-Network (after Deductible)	75%
Out-of-Network (after Deductible)	50%

Eye Care Benefit

Fund pays (Eye Care maximums listed represent Usual, Customary and Reasonable Charge)

Elective Contact Lenses – in lieu of frames and lenses (once every 12 months)

In-Network	100% up to $250
Out-of-Network	Reimbursement up to $105

Medically Necessary Contact Lenses

In-Network	100%
Out-of-Network	Reimbursement up to $210

Contact Lens Examination

In-Network	Participant pays no more than $60
Out-of-Network	Not covered

Routine Eye Exam

In-Network	100%
Out-of-Network	Reimbursement up to $40

Routine Retinal Screening (once every 12 months)

In-Network	100% after patient copay up to $39

Essential Medical Eyecare

In-Network	100% after $20 copay
Out-of-Network	Not covered

Frames (once every 12 months)

In-Network (retail frame)	100% up to $250 at retail price
In-Network (Visionworks or featured frame brand)	100% up to $300 at retail price
In-Network (Costco frame)	100% up to $135
Out-of-Network	Reimbursement up to $80 at retail price

Lenses (once every 12 months)

In-Network (single vision, lined bifocal or lined trifocal)	100%
Out-of-Network – Single Vision	Reimbursement up to $55
Out-of-Network – Bifocal Vision	Reimbursement up to $80
Out-of-Network – Trifocal Vision	Reimbursement up to $105

Lens Enhancements (once every 12 months)

Standard Progressive Lenses (participant pays)	$0
Premium Progressive Lenses (participant pays)	$95 - $105
Custom Progressive Lenses (participant pays)	$150 - $175

Hearing Benefit

(Deductible does not apply)

Fund pays

Exam (once every Plan Year per individual)	100% UCR
Maximum Exam Benefit	$ 60
Hearing Aid (once every rolling 36 months)	85% UCR Up to $1,000 per ear

Hello Heart

Contact Fund Office to learn about criteria

Monitor and learn about blood pressure with an app and device – see Article IV

Hospice Care Benefit

Fund pays

In-Network (after Deductible)	75%
Out-of-Network (after Deductible)	50%

Member Assistance Program (MAP) ..... No cost

Professional consultations for work or home problems – see Section 4.17

Mental and Nervous Disorder Benefit

Benefits are subject to the General Medical Benefit provisions for Deductibles, coinsurance and maximums, as applicable. Inpatient treatment must be received at an In-Network facility. Inpatient treatment is not covered at an Out-of-Network facility unless approved by Medicare.

Prescription Drug Card Benefit – In-Network Benefits Only

Smoking cessation prescriptions are paid under the Schedule of Benefits below. Physician's office visits are paid under the Schedule of Benefits as any other Physician's office visit.

Coinsurance (Participant pays)

Mail Order Participating Pharmacies (90-day supply)
(see Section 4.12 C for approved walk-in pharmacies that allow a 90-day supply)

Generic	15% of drug cost with a $25 minimum and $50 maximum
Brand Formulary	25% of drug cost with a $50 minimum and $100 maximum
Brand Non-Formulary	35% of drug cost with a $100 minimum and $200 maximum

Retail Participating Pharmacies (up to 30-day supply)

Generic	20% of drug cost with a $10 minimum and $20 maximum
Brand Formulary	30% of drug cost with a $20 minimum and $40 maximum
Brand Non-Formulary.....	40% of drug cost with a $40 minimum and $80 maximum

Mail Order Specialty Drugs

Generic	15% of drug cost with a $8 minimum and $16 maximum
Brand Formulary	25% of drug cost with a $16 minimum and $33 maximum
Brand Non-Formulary.....	35% of drug cost with a $40 minimum and $80 maximum

Routine Preventive Care Benefit

Fund pays

Routine Physical Exam (Age 3 and over) – In-Network Benefits Only

Maximum Exam every Plan Year.....	1 exam
Maximum Benefit every Plan Year.....	100% up to $300; balance under General Medical Benefit

Routine Cervical Cancer Screening (Pap Smear) – In-Network Benefits Only

Maximum Screening every Plan Year.....	1 screening
Maximum Benefit	100%; otherwise under General Medical Benefit

Routine Prostate Cancer Screening (PSA Test) – In-Network Benefits Only

Maximum Screening every Plan Year.....	1 screening
Maximum Benefit	100%; otherwise under General Medical Benefit

Routine Breast Cancer Screening (Mammogram) – In-Network Benefits Only

Age 40-49: 1 every 2 Plan Years	100%; otherwise under General Medical Benefit
Age 50 and over: 1 every Plan Year ...	100%; otherwise under General Medical Benefit

Colorectal Cancer Screening – In-Network Benefits Only – Age 45 and Older

1 sigmoidoscopy every 5 Plan Years	100%; otherwise under General Medical Benefit
1colonoscopy every 5 Plan Years	100%; otherwise under General Medical Benefit
Multi-targeted stool DNA test (Cologuard) every 1-3 years	100%; otherwise under General Medical Benefit

The Plan will pay 100% for one of the above routine preventive colorectal cancer screening services within the recommended screening intervals outlined. Any subsequent colorectal cancer screening services or diagnostic services will then be payable under the General Medical Benefit subject to Deductible and coinsurance.

Lung Screenings by Low-Dose CAT scans – In-Network Only

Age 50 to 80 with history of smoking	100%; otherwise under General Medical Benefit

Routine Well Child Exam & Immunizations – In-Network Only

Birth to age 36 months for all exams and immunizations recommended by the Center For Disease Control	100%

Routine Childhood & Adult Immunizations – In-Network Only

Age 3 and over if recommended by a Physician excluding occupation or vacation travel necessity as recommended by the Center for Disease Control	100%

Substance Abuse Benefit

Benefits are subject to the General Medical Benefit provisions for In- and Out-of-Network Deductibles, Coinsurance and maximums, as applicable. Inpatient treatment must be received at an In-Network facility. Inpatient treatment is not covered at an Out-of-Network facility unless approved by Medicare.

Sword Health..... No cost

Get a Digital Physical Therapy Kit and access to live Physical Therapist – see Article IV

Teladoc Online Physician Visit Benefit for medical and behavioral health services

Deductible or Coinsurance does not apply.

In-Network Benefits through Teladoc Online

Coinsurance	no cost

Temporomandibular Joint Dysfunction (TMJ) Benefit

Fund pays

In-Network (after Deductible)	75%
Out-of-Network (after Deductible)	50%
Lifetime Maximum per individual	$ 1,500
Services that are dental in nature (crowns, bridges, etc.)	Under Dental Benefit

Transplant Benefit

Benefits are subject to the General Medical Benefit provisions for In- and Out-of-Network Deductibles, Coinsurance and maximums, as applicable.

Wig Benefit

Deductible does not apply.

Fund pays

Wigs – one wig per plan year	75% UCR
Maximum Wig Benefit (annual)	$ 2,000

Class AS – Non-Medicare eligible Retirees, Totally Disabled Participants, and Non-Medicare Spouses and Dependent Children (Medicare-Eligible Spouses and Dependents are covered under Class CP)

Non-Medicare-Eligible Participant Only

Accidental Death and Dismemberment Benefit ***(Non-occupational Only)***

Loss of:

Life	Same as Class A
Both Hands, Both Feet, Both Eyes or Combination of any Two	Same as Class A
One Hand, One Foot or One Eye	Same as Class A

Life Insurance Benefit ..... Same as Class A

Non-Medicare-Eligible Participants and Spouses and Non-Medicare-Eligible Dependents

General Medical Benefit..... Same as Class A excluding Maternity and Newborn Benefits

Chiropractic Benefit..... Same as Class A

Dental Benefit..... Same as Class A

Diabetes Education and Training Benefit..... Same as Class A

Eye Care Benefit..... Same as Class A

Hearing Benefit ..... Same as Class A

Hello Heart ..... Contact Fund Office to learn about criteria
Monitor and learn about blood pressure with an app and device – see Article IV

Hospice Care Benefit ..... Same as Class A

Member Assistance Program (MAP)..... Same as Class A
Professional consultations for work or home problems – see Section 4.17

Mental and Nervous Disorder Benefit ..... Same as Class A

Prescription Drug Card Benefit ..... Same as Class A

Routine Preventive Care Benefit..... Same as Class A

Substance Abuse Benefit..... Same as Class A

Sword Health ..... Contact Fund Office to learn about criteria
Get a Digital Physical Therapy Kit and access to live Physical Therapist – see Article IV

Temporomandibular Joint Dysfunction (TMJ) Benefit..... Same as Class A

Transplant Benefit ..... Same as Class A

Teladoc Online Physician Visit Benefit..... Same as Class A

Class C – Medicare-Eligible Retirees, Totally Disabled Participants, Spouses and Dependents Who Want this Plan's Benefits without Prescription Coverage

Medicare-Eligible Participant Only

Life Insurance Benefit ..... Same as Class A

Medicare-Eligible Participants and Dependents eligible for Medicare

Hospital Benefits ..... Medicare deductible and your coinsurance of Medicare-approved charges up to 150 days per Medicare benefit period

Skilled Nursing Facility Benefits ..... Your Medicare coinsurance of Medicare-approved charges up to 100 days per Medicare benefit period

In-patient treatment must be received at an In-Network facility. Inpatient treatment is not covered at an Out-of-Network facility unless approved by Medicare.

Medical and Physicians' Charges ..... Medicare deductible and your portion of Medicare- approved charges

Certain Out-of-Network emergency services, Out-of-Network services at an In-Network facility and Air Ambulance Services are payable at In-Network rates.

Dental Benefit..... Same as Class A

Diabetes Education and Training Benefit..... Same as Class A

Eye Care Benefit..... Same as Class A

Hello Heart ..... Contact Fund Office to learn about criteria
Monitor and learn about blood pressure with an app and device – see Article IV

Hearing Benefit ..... Same as Class A

Member Assistance Program (MAP)..... Same as Class A
Professional consultations for work or home problems – see Section 4.17

Routine Preventive Care Benefit..... Same as Class A

Sword Health ..... Contact Fund Office to learn about criteria
Get a Digital Physical Therapy Kit and access to live Physical Therapist– see Article IV

Teladoc Online Physician Visit Benefit..... Same as Class A
Full cost of visit must be paid at time of service using credit card through the website or smart phone application. Benefit Claim must be submitted to the Fund Office for reimbursement of fees.

Class CP – Medicare-Eligible Retirees, Totally Disabled Participants, Spouses and Dependents with Prescription Coverage Who Want This Plan's Benefits With Some Exclusions (Spouses and Dependents Without Medicare are Covered Under Class AS)

Medicare-Eligible Participant Only

Life Insurance Benefit ..... Same as Class A

Medicare-Eligible Participants and Dependents eligible for Medicare

Medical Benefits..... See Appendix A

Dental Benefit..... Same as Class A

Eye Care Benefit..... Same as Class A

Hearing Benefit
Deductible does not apply.
Fund pays

Exam (once every Plan Year per individual)	100% UCR
Maximum Exam Benefit	$60
Hearing Aid (once every rolling 36 months)	85% UCR Up to $1,500 for both ears combined
If Hearing Aid is purchased through this Plan's MAPD vendor (once every rolling 36 months) Submit a claim to the Fund Office for Reimbursement.	Up to $500 Reimbursement from MAPD vendor, for both ears combined

Hello Heart ..... Contact Fund Office to learn about criteria
Monitor and learn about blood pressure with an app and device – see Article IV

Member Assistance Program (MAP)..... Same as Class A
Professional consultations for work or home problems – see Section 4.17

Prescription Drug Card Benefit ..... See Appendix A
All prescription claims that are not covered by the MAPD vendor but that are eligible for coverage under the self-funded WRAP Plan through Sav-Rx will be processed by Sav-Rx.

Sword Health ..... Contact Fund Office to learn about criteria
Get a Digital Physical Therapy Kit and access to live Physical Therapist– see Article IV

Teladoc Online Physician Visit Benefit..... See Appendix A

Class D – Medicare-Eligible Retirees and Totally Disabled Participants Who Want This Plan's Class C Supplement to Medicare Without the Plan's Prescription Coverage with at Least One Dependent not eligible for Medicare (Spouses and Dependents Without Medicare are Covered Under Class AS. Their Medicare-Eligible Dependents are Covered Under Class D.)

Medicare-Eligible Participant Only

Life Insurance Benefit ..... Same as Class A

Medicare-Eligible Participants and Their Medicare-Eligible Dependents

Hospital ..... Same as Class C

Skilled Nursing Facility ..... Same as Class C

Medical and Physicians' Charges ..... Same as Class C

Dental Benefit..... Same as Class A

Diabetes Education and Training Benefit..... Same as Class A

Eye Care Benefit..... Same as Class A

Hearing Benefit ..... Same as Class A

Hello Heart ..... Contact Fund Office to learn about criteria
Monitor and learn about blood pressure with an app and device – see Article IV

Member Assistance Program (MAP)..... Same as Class A
Professional consultations for work or home problems – see Section 4.17

Routine Preventive Care Benefit ..... Same as Class A

Sword Health ..... Contact Fund Office to learn about criteria
Get a Digital Physical Therapy Kit and access to live Physical Therapist– see Article IV

Teladoc Online Physician Visit Benefit..... Same as Class A
Full cost of visit must be paid at time of service using credit card through the website or smartphone application. Benefit Claim must be submitted to the Fund Office for reimbursement of fees.

Class S – Non-Medicare-Eligible Surviving Spouses and the Deceased Participant's Non-Medicare-Eligible Surviving Dependent Children (The Participant's Medicare-Eligible Surviving Dependent Children are Covered Under Class CP)

General Medical Benefit	Same as Class AS
Chiropractic Benefit	Same as Class A
Dental Benefit	Same as Class A
Diabetes Education and Training Benefit	Same as Class A
Eye Care Benefit	Same as Class A
Hearing Benefit	Same as Class A
Hospice Care Benefit	Same as Class A
Hello Heart Monitor and learn about blood pressure with an app and device – see Article IV	Contact Fund Office to learn about criteria
Teladoc Online Physician Visit Benefit	Same as Class A
Member Assistance Program (MAP) Professional consultations for work or home problems – see Section 4.17	Same as Class A
Mental and Nervous Disorder Benefit	Same as Class A
Prescription Drug Card Benefit	Same as Class A
Routine Preventive Care Benefit	Same as Class A
Substance Abuse Benefit	Same as Class A
Sword Health Get a Digital Physical Therapy Kit and access to live Physical Therapist – see Article IV	Contact Fund Office to learn about criteria
Temporomandibular Joint Dysfunction (TMJ) Benefit	Same as Class A
Transplant Benefit	Same as Class A

ARTICLE III – ELIGIBILITY RULES

THE BOARD OF TRUSTEES, AS PLAN ADMINISTRATOR, HAS THE AUTHORITY AND ALL DISCRETION TO INTERPRET, CONSTRUE AND APPLY THE PROVISIONS OF THE PLAN IN DETERMINING YOUR ELIGIBILITY FOR ENTITLEMENT TO BENEFITS. BENEFITS UNDER THIS PLAN WILL BE PAID ONLY IF THE PLAN ADMINISTRATOR DETERMINES THAT THE PARTICIPANT OR DEPENDENT IS ENTITLED TO THEM.

The following topics are discussed under this Article on Eligibility Rules:

Section 3.01 – Definitions Related to Eligibility

The term "Qualification Period" includes the period for which hours are credited to determine continued eligibility of a Participant for future Coverage Periods. The Plan Year is divided into three equal parts or Qualification Periods of four months each –

- November, December, January, February
- March, April, May, June
- July, August, September, October

The term "Coverage Period" includes the period of coverage under the Plan which begins one month following completion of the required number of hours. The required number of hours may be completed during one or more Qualification Periods, as set forth in the table in Section 3.03 below. The Plan Year is divided into three equal parts or Coverage Periods of four months each–

- April, May, June, July
- August, September, October, November
- December, January, February, March

For purposes of determining hours worked during a Qualification Period, a Participant shall receive 40 hours of credit for each week the Participant receives Loss of Time Benefits in accordance with Section 4.03.

Section 3.02 – Initial Eligibility

Each new Employee or Employee who transfers employment to an Employer under the collective bargaining agreement with the Union or Local Union under the jurisdiction of the Union, must have a completed Registration Card on file with the Fund Office and may become a Participant in the Plan on the first day of the month following the month in which 600 hours of Employer contributions have been made within six months or less. Once eligibility is established, the Participant will remain eligible in Class A until the end of that Coverage Period

In the example below, the Employee has a completed Registration Card on file with the Fund Office.

600 Hours Requirement:

John began work on July 1, 2024 and accumulated 600 hours of work by November 15, 2024. John has not completed six work months but had 600 hours of Employer contributions made on his behalf. John's initial eligibility date for benefits is December 1, 2024 and he will remain eligible through March 31, 2025.

Section 3.03 – Continued Eligibility in the Plan's Class A

A Participant can maintain eligibility in the Plan's Class A as long as the Participant works at least 260 hours in the current Qualification Period. If a Participant does not meet the hours requirement, the Plan will "look-back" to previous consecutive Qualification Periods to maintain continued eligibility for Class A coverage. In the look-back Qualifications Periods, a Participant must have worked 520 hours in the last two Qualification Periods or 780 hours in the last three Qualification Periods prior to each Coverage Period. The Plan does not "bank" any hours in excess of the hour requirements stated in the table below. A Participant will remain eligible under this Plan's Class A as long as the hour requirements are met. In the event a Participant no longer meets these hour requirements, the Participant may be eligible to submit Self-Payments in accordance with Section 3.04.

Alternatively, the Participant may maintain eligibility in the Plan's Class A during the next Coverage Period by making a maximum Self-Payment of 260 required hours or the balance remaining after Employer contributions. See limitations of Self-Payments in Section 3.04.

In the event the Employer does not submit contributions to the Trust Fund according to the Agreement, you may submit a pay statement to maintain eligibility. Upon receipt of the pay information, credit for unreported hours worked will be credited unless and until you are notified otherwise.

Continued Eligibility Requirements

To Be Eligible in this Coverage Period	**An Employee Must Work**				
	260 hours in the current Qualification Period:	**OR**	**520 hours in the previous two Qualification Periods:**	**OR**	**780 hours in the previous three Qualification Periods:**
Apr – Jul	Nov – Feb		Jul – Feb		Mar – Feb
Aug – Nov	Mar – Jun		Nov – Jun		Jul – Jun
Dec – Mar	Jul – Oct		Mar – Oct		Nov – Oct

Example A – 260 Hours Requirement:
John has met initial eligibility requirements and is currently eligible through March 31, 2026. He has continued to work 100 hours each month for the Qualification Period November 2025 through February 2026.

Since John has had at least 260 hours in the current Qualification Period (Nov-Feb) he will continue to be eligible in Class A for the Coverage Period April 1, 2026 through July 31, 2026.

Example B – 520 Hours in Previous Two Qualification Periods Requirement:
John has met initial eligibility requirements and is currently eligible through March 31, 2026. He has continued to work the following schedule:

Work Months	Hours Worked
November 2025– February 2026	200
July 2025 – October 2025	400
Total	600

Since John did not have at least 260 hours in the current Qualification Period (Nov-Feb) the next test is to determine if he worked 520 hours in the previous two Qualification Periods (Jul-Feb).

After reviewing John's work history, it was determined that he worked 600 hours in the previous two Qualification Periods. John will continue to be eligible in Class A for the Coverage Period April 1, 2026 through July 31, 2026.

Example C – 780 Hours in Previous Three Qualification Periods Requirement:
John has met initial eligibility requirements and is currently eligible through March 31, 2026. He has continued to work the following schedule:

Work Months	Hours Worked
November 2025 – February 2026	200
July 2025 – October 2025	300
March 2025 – June 2025	340
Total	840

Since John did not have at least 260 hours in the current Qualification Period (Nov-Feb) the next test is to determine if he worked 520 hours in the previous two Qualification Periods (Jul-Feb). Reviewing John's work history it was determined that he did not work 520 hours in the previous two Qualification Periods, therefore, the next step is to determine if John worked at least 780 hours in the last three Qualification Periods.

Since John did work 840 hours in the last three Qualification Periods he will continue to be eligible in Class A for the Coverage Period April 1, 2026 through July 31, 2026.

Example D – Self-Payment Requirement:
John has met initial eligibility requirements and is currently eligible through March 31, 2026. He has continued to work the following schedule:

Work Months	Hours Worked
November 2025 – February 2026	0
July 2025 – October 2025	260
March 2025 – June 2025	90
Total	350

John continued to work but did not accumulate enough hours as required in one, two or three Qualification Periods. John would be eligible to make a Self-Payment of 260 hours at the current contribution rate to become eligible for Benefits beginning April 1, 2026 and remain eligible in Class A through July 31, 2026.

Section 3.04 – Continuation of Class A Coverage by Self-Payment

Unless coverage is terminated in accordance with Section 3.05 A2, a Participant may make Self-Payments in order to retain eligibility in Class A if the Participant does not work enough hours. However, Self-Payments shall not generate hours of credited employment (which determine eligibility to participate in any subsequent Coverage Period). Self-Payment amounts may be changed at any time and for any reason by the Board of Trustees in its sole discretion.

Coverage through Class A Self-Payment is only available to those Participants who are currently working, or available and actively seeking work under a collective bargaining agreement.

Class A Self-Payments are to be made to the Fund Office and must be submitted by the last day of the last month of the current Coverage Period for full benefit eligibility during the next Coverage Period.

Class A Self-Payments shall be accepted up to the tenth day of the current Coverage Period and coverage shall be provided starting with the first day of the Coverage Period; however, Life Insurance Benefits shall be payable for death occurring from the first to the thirty-first day of that Coverage Period even if a Self-Payment is not received.

If a Retiree (not a Totally Disabled Participant) elects to continue coverage, the Retiree shall continue Class A coverage using bank hours, if available. Once bank hours are depleted, the Retiree shall transfer to the Senior Member Program elected upon retirement.

A) Partial Self-Payments

In the event an Active Employee does not have enough hours reported on his behalf from a contributing Employer, the Participant will be required to make partial Self-Payments in order to maintain continued eligibility. To make Partial Self-Payments a Participant must: a) be working or actively seeking work under a collective bargaining agreement, and b) have worked at least 320 hours in covered employment during the prior 12 months.

1. The Employee makes Partial Self-Payments at the rate of the difference between the hours reported by the Employer and a sum equal to the balance of hours required in Section 3.03.

2. Provided the Participant meets the eligibility standards, there is no limit to the number of Partial Self-Payments an Employee may make to maintain continued eligibility.

B) Total Self-Payments

In the event a Participant does not have any hours reported on his behalf from a contributing Employer, a Participant will be required to make Total Self-Payments in order to maintain continued eligibility. See Section 3.03. Participants who are unable to work due to a continuing Injury or Sickness and provide medical evidence (including an SSA award letter and annual re-examination) satisfactory to the Board of Trustees of the continuing Long-Term Disability shall be moved to the Senior Member Program (Class AS, C, CP or D).

1. The Participant must have had hours reported in one of the two previous Qualification Periods in order to make a Total Self-Payment.

2. The Participant makes Total Self-Payments at the rate of the minimum hours required in Section 3.03.

3. A Participant may only make Total Self-Payments for two consecutive Qualification Periods. The two consecutive Qualification Periods will be deemed used regardless of whether a Total Self-Payment was submitted by the Participant.

4. The Participant must be available and actively seeking work under a collective bargaining agreement.

Once a Participant has exhausted the Total Self-Payments option under this Section, the Participant shall have the option to elect Continuation Coverage under COBRA as described in Section 3.06. If the Participant does not elect Continuation Coverage under COBRA, the Participant will be required to meet the Initial Eligibility requirements in Section 3.02 in order to be eligible for Benefits under this Plan.

Section 3.05 – Termination of Eligibility

A) Termination of an Active Employee's Eligibility

1. Termination of an Active Employee's Eligibility in Class A

An Employee who becomes a Participant in the Plan shall remain covered under Class A until the first day of the Coverage Period in which any of the following occur –

a. the day the Participant fails to meet the eligibility requirements, or

b. chooses not to elect Continuation of Coverage, or

c. fails to make a required Self-Payment for Continuation of Coverage, or

d. exhausts the maximum period of coverage provided under the Continuation of Coverage provisions, or

e. switches to another class of coverage, or

f. retires, or

g. the Plan terminates.

2. An Employee who becomes a Participant in the Plan shall remain covered under Class A until the first day of the month following the month the Fund is aware of either of the following situations –

a. the Participant, without authorization from the Union, works in the construction industry in the geographic jurisdiction of the Plan for an Employer that does not have a contractual obligation to contribute to the Trust Fund ("non-signatory employer") and does not notify the Fund Office as required, or

b. the Participant works in the construction industry in the geographic jurisdiction of the Plan at a different trade in the construction industry for either a signatory or non-signatory employer and does not notify the Fund Office as required.

The Trustees reserve the right to create equitable exceptions to this rule in cases where the exception would not run contrary to the purposes and intent of providing benefits under this Plan. If a Participant's eligibility is terminated according to this Section 3.05 A2, the Participant cannot make Self-Payments as allowed in Section 3.04 to continue eligibility.

Notwithstanding the foregoing, if a Participant's Benefits are terminated due to military service, the Participant shall again be eligible for coverage on the date the Participant returns to active work for a covered Employer. In addition, the Participant shall be covered for Benefits for the remainder of the Coverage Period during which the Participant returned to work for a covered Employer and for the next following Coverage Period. For more information regarding military service, please see Section 3.10 – Uniformed Services Employment and Reemployment Rights Act (USERRA).

B) Termination of a Dependent's Eligibility

A Dependent who is covered under the Plan shall remain covered until the latter of:

1. the last day of the month in which the individual no longer qualifies as a Dependent as that term is defined in Section 11.15, or

2. the last day of the month in which the Participant ceases to be covered by the Plan and the Dependent does not elect Continuation of Coverage, or

3. the last day of the month in which the Dependent fails to make a required Self-Payment for Continuation of Coverage, or

4. the last day of the month in which the Dependent exhausts the maximum period of coverage provided under the Continuation of Coverage provisions, or

5. the last day of the month in which the Plan terminates, or

6. the last day of the month the Dependent is removed from coverage by the Participant under the applicable Opt-Out provisions outlined in subsection C below.

C) Opt-Out Provisions

The following rules will be applicable to Participants who "opt out" (decline coverage) from the Plan for their Spouses or adult Dependent children.

Spouse of Active Participant:

A Spouse of an Employee may have other coverage available and desire to opt out of this Plan's coverage. In order for the Participant to decline coverage for the Spouse , the Participant must provide proof of the Spouse's other coverage (other than Medicare or Medicaid) and must return a signed an acknowledgment regarding return-to-coverage requirements and Medicaid rules.

A Spouse who has opted out of coverage under the Plan may return to coverage on December 1 of each year or if the Spouse experiences a qualifying event. There will be no reduction to the contribution rate or any applicable Self-Payments if the Spouse of an Employee opts out of the Plan.

Adult Dependent Child (Age 18-26)

An adult Dependent child age 18-26 can be removed from Plan coverage by the Participant ("parent"). The adult Dependent child does not have the right to appeal termination of coverage by the Participant. It is the Participant's choice to cover the adult Dependent child under the Plan. If the Participant so chooses to cover the adult Dependent child, then the Plan is required to provide coverage up to age 26.

A Participant may remove coverage for an adult Dependent child if the Plan is provided with proof of other coverage for the adult Dependent child for coverage other than Medicare or Medicaid. The Participant must sign an acknowledgment regarding the return to coverage requirements and Medicaid rules regarding the adult Dependent child. The Plan will provide notice of loss of coverage to the adult Dependent child, but consent from the adult Dependent child is not required to remove the adult Dependent child from coverage under the Plan.

The Participant can reinstate coverage for the adult Dependent child on December 1 each year or if the adult Dependent child experiences a qualifying event.

D) Termination of Dependent Coverage Upon the Death of the Participant

Upon the death of the Participant, Dependent coverage will continue until the latter of:

1. the look-back for continued eligibility in previous, consecutive Qualification Periods, as explained in Section 3.03, is exhausted (in this case, coverage is continued at no cost to the Dependent); or

2. the last day of the Coverage Period in which the Participant's death occurred; or

3. Plan termination.

This provision applies if the Participant completed all of the minimum hours required in Section 3.03 during the Qualification Period in which the Participant's death occurred.

E) Appeal of an Eligibility Decision

If you do not agree with the decision of the Trustees regarding the eligibility of a Dependent or eligibility with Self-Payments, you may appeal the decision by contacting the Fund Office.

Section 3.06 – Continuation Coverage Under COBRA

In compliance with a federal law known as the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), the Plan offers certain Employees and eligible Dependents the opportunity to continue their health, prescription, dental and eye care Benefits, where applicable, by making Self-Payments in certain instances where the eligibility for these Benefits would otherwise terminate. This coverage is "Continuation Coverage." In the event of a conflict between the Plan's COBRA provisions and such statutes, regulations or guidance, such statutes, regulations or guidance shall govern.

Each Qualified Beneficiary (defined in subsection A below) who would otherwise lose participation in the Plan as a result of a Qualifying Event (defined in subsection A below) may elect, within the applicable election period specified in Section 3.06 B, to extend his participation under the Plan immediately before the Qualifying Event by electing Continuation Coverage.

Qualified Beneficiaries electing Continuation Coverage are subject to the same limits as Participants. If a Qualified Beneficiary's eligibility for Continuation Coverage begins before the end of the prescribed period for accumulating amounts toward a maximum Benefit, the Qualified Beneficiary retains credit for Benefit Claims paid or expenses incurred toward that limit before the beginning of Continuation Coverage as though the Qualifying Event had not occurred.

Each Qualified Beneficiary's remaining limit, if any, on the date Continuation Coverage begins is equal to that individual's remaining limit immediately before that date.

The Employee or Dependent(s) must take certain actions within specified time periods in order to effect and maintain the Continuation Coverage.

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

A) COBRA Definitions

"Qualified Beneficiary" for COBRA purposes means any individual who, on the day before a Qualifying Event, is a Participant or a Dependent under the Plan by virtue of being on that day either an Employee or a Dependent of an Employee; provided, however, that a Dependent who is born to or placed for adoption with the Participant during a period of extended participation is a Qualified Beneficiary. An individual is not a Qualified Beneficiary if on the day before the Qualifying Event, the individual –

1. participates in the Plan by reason of another individual's election to extend participation and is not already a Qualified Beneficiary by reason of a prior Qualifying Event, or

2. is entitled to Medicare.

An Employee can become a Qualified Beneficiary only in connection with a Qualifying Event as defined below.

A Qualified Beneficiary who fails to elect extended participation under Section 3.06 B in connection with a Qualifying Event ceases to be a Qualified Beneficiary at the end of the election period specified in that Section.

"Qualifying Event" means an event that would cause a person to lose coverage under this Plan. A "Qualifying Event" satisfies the following paragraphs (1) and (2):

1. An event satisfies this paragraph if it is –

   a. the death of an Employee;

   b. the termination (other than by reason of the Employee's gross misconduct) or reduction in hours of an Employee's employment with an Employer;

   c. an Employee's retirement or layoff;

   d. the divorce or court-ordered legal separation of an Employee from his or her Spouse; or

   e. a Dependent child ceasing to be an eligible Dependent.

2. An event satisfies this paragraph if the event causes the Eligible Person to lose coverage under the Plan. For this purpose, to "lose coverage" means to cease to participate under the same terms and conditions as in effect immediately before the Qualifying Event. If benefit levels are reduced or eliminated in anticipation of a Qualifying Event, the reduction or elimination is disregarded in determining whether the event causes a loss of coverage. Moreover, for purposes of this paragraph, a loss of coverage need not occur immediately after the Qualifying Event, so long as the loss of coverage will occur before the end of the maximum Coverage Period described in Section 3.06 C. However, if the Participant or Dependent will not lose coverage before the end of what would be the maximum period described in Section 3.06 C, the event is not a Qualifying Event.

B) <u>Electing Continuation Coverage</u>

The availability of Continuation Coverage is conditioned upon a Qualified Beneficiary electing such participation during the election period. The election period begins on or before the date that the Qualified Beneficiary would lose participation on account of a Qualifying Event as described in Section 3.06 A and ends on the date that is 60 days after the latter of –

1. the date that the Qualified Beneficiary would lose participation on account of the Qualifying Event, or

2. the date the Qualified Beneficiary is sent Notice of the right to elect extended participation.

Notwithstanding the preceding paragraph, each Participant or Qualified Beneficiary is responsible for notifying the Board of Trustees of a Dependent child ceasing to be a Dependent (as defined in Section 11.15) or of the divorce or court-ordered legal separation of a Participant. This notice must be sent to the Board of Trustees within 60 days after the later of –

1. the date of the Qualifying Event, or

2. the date that the Qualified Beneficiary would lose participation on account of the Qualifying Event.

If more than one Qualified Beneficiary loses participation on account of a divorce of a Participant, notice of the divorce sent by the Participant or any one of those Qualified Beneficiaries will preserve the election rights of all of the Qualified Beneficiaries.

If the Qualified Beneficiary makes an election to extend participation during the election period, participation will be provided during the election period; however, Benefit Claims incurred by a Qualified Beneficiary during the election period will not be paid before the election and payment is made.

A Qualified Beneficiary who, during the election period, waives extended participation can revoke the waiver at any time before the end of the election period. However, if such Qualified Beneficiary later revokes the waiver, Benefits will be provided retroactively to the date the waiver is revoked.

If a Qualified Beneficiary who is a former Employee elects to provide any other Qualified Beneficiary with extended participation, the election shall be binding on that other Qualified Beneficiary. However, an election to waive extended participation by such a Qualified Beneficiary for any other Qualified Beneficiary shall not be binding on the other Qualified Beneficiary.

An election on behalf of a minor child can be made by the child's parent or legal guardian. An election on behalf of a Qualified Beneficiary who is incapacitated or dies can be made by the legal representative of the Qualified Beneficiary or the Qualified Beneficiary's estate, as determined under applicable state law or by the Spouse of the Qualified Beneficiary.

Continuation of Coverage Requirements and Limits

Qualifying Event	Documentation Required	Time Limits
Divorce	• Divorce decree or • Equivalent State court document	Within 60 days after the Qualified Beneficiary would lose coverage as a result of the divorce
Legal Separation	• Legal separation decree or • equivalent State court document	Within 60 days after the Qualified Beneficiary would lose coverage as a result of the legal separation
Death of the Participant	• Death Certificate	Within 60 days after the Qualified Beneficiary would lose coverage as a result of the death
Dependent Child Ceasing to Qualify as a Dependent under the Plan	• Proof of age if turning age 26 or failure to provide proof of continuing eligibility past age 26.	Within 60 days after the Qualified Beneficiary would lose coverage as a result of no longer qualifying as a Dependent child

C) Termination of Continuation Coverage

Elected Continuation Coverage will begin on the date of the loss of eligibility to participate in this Plan and will end on the earliest of the following dates:

1. the last day of the maximum participation period as described below;

2. the first day for which timely payment is not made with respect to the Qualified Beneficiary as described below;

3. the date upon which the Board of Trustees ceases to maintain any group health plan (including successor plans);

4. the date upon which the Qualified Beneficiary first becomes, after the date of the election, covered under any other group health plan that is not maintained by the Board of Trustees, (even if such plan provides benefits that are less valuable than the benefits provided by the Plan) as Participant or otherwise, provided it does not contain any exclusion or limitation with respect to any preexisting condition of such Qualified Beneficiary or with respect to which such period is satisfied by virtue of the Qualified Beneficiary's Creditable Coverage (defined in Section 8.08);

5. the date that the Qualified Beneficiary is entitled to Medicare; or

6. the day before the day on which the Qualified Beneficiary becomes covered under the Plan without regard to COBRA.

The maximum participation period ends –

1. 18 months after the Qualifying Event, if the Qualifying Event that gives rise to extended coverage election rights is a termination of employment (except for gross misconduct), reduction of hours, retirement or layoff;

2. 36 months after the Qualifying Event for any other type of Qualifying Event; and

3. 29 months after the Qualifying Event for Qualified Beneficiaries who are determined (under Title II or XVI of the federal Social Security Act) to have been disabled within 60 days after the Qualifying Event, if the Qualifying Event that gives rise to extended participation election rights is the termination of employment (except for gross misconduct), reduction of hours, retirement or layoff.

The end of the maximum participation period is measured from the date coverage ceases.

In the case of a Qualified Beneficiary who is determined to be disabled under the federal Social Security Act, the Qualified Beneficiary must provide notice of such determination to the Plan Administrator within 60 days from the latter of:

1. the date of determination,

2. the date of the Qualifying Event, and

3. before the end of the original 18 months of extended participation,

in order to obtain the 11-month extension, resulting in a total extended participation of 29 months of COBRA coverage.

Such disabled Qualified Beneficiary's extended participation beyond 18 months shall end in the month that begins more than 30 days after the date the final determination is made under Title II or XVI of the Social Security Act that such person is no longer disabled or, if earlier, the twenty-ninth month after the date on which such termination of employment, reduction in hours, retirement or layoff occurred. Nondisabled covered Dependents of the disabled Qualified Beneficiary are also entitled to the 11-month extension of participation resulting in a total extended participation of 29 months of COBRA coverage.

If a Qualifying Event that gives rise to an 18-month maximum participation period is followed (within that 18-month period) by a second Qualifying Event, such as a death or divorce, the original 18-month period is expanded to 36 months, but only for those individuals who were Qualified Beneficiaries under the Plan as of the first Qualifying Event and participated under the Plan at the time of the second Qualifying Event.

No Qualifying Event can give rise to a maximum participation period that ends more than 36 months after the date of the first Qualifying Event.

D) Costs for Continuation Coverage

Qualified Beneficiaries shall pay, on a timely basis, no more than 102% of the applicable premium for coverage. For disabled individuals entitled to a maximum of 29 months of extended participation, up to 150% of the applicable premium will be charged for months 19 through 29. The first payment is due within 45 days after extended participation is elected. After that, payments are due on the first day of each calendar month of participation, with a 30-day grace period.

Notification Procedures

1. Initial (General) COBRA Notice

   a. The general Notice required by federal law is provided as part of this Document within this Section 3.06, which will be mailed to the home address of each new Participant within 90 days after coverage begins.

   b. If the Participant adds a Spouse to coverage later (such as by getting married after the Participant already has coverage), a separate Document will be available to the new Spouse at the Fund Office or will be mailed to the new Spouse upon request.

   c. If the Document is provided to new Participants in any other fashion, a stand-alone initial COBRA Notice will be mailed to the home of each new Participant within 90 days after coverage begins and it will be addressed to the Participant and all Eligible Dependents. If an Eligible Dependent lives at a different address from the Participant, the Document and the general Notice will be mailed to them at the separate address.

2. Employer Qualifying Event Notice

Under this Plan, Employers are not required to provide notice of Qualifying Events to the Administrative Manager. This Document provides that the Administrative Manager shall determine whether a Qualifying Event has occurred due to the Employee's termination of employment or reduction in hours of employment or the Employee's death. In order to make such determinations, the Administrative Manager shall use Plan records to determine loss of eligibility due to termination of employment or a reduction in employment hours and shall rely on timely notice from the Participant of other Qualifying Events.

3. Employee Qualifying Event Notice

A Participant must give written notice to the Administrative Manager within 60 days after a Qualifying Event, that is a divorce or legal separation of the Participant) and Spouse or a Dependent child's ceasing to meet the Plan requirements for Dependent status.

4. COBRA Election Notice

The Plan has adopted a standard form for the Administrative Manager to use to furnish notice of a Qualified Beneficiary's eligibility for COBRA Continuation Coverage.

The notice will be sent to each Qualified Beneficiary within 14 days after receipt of notice from an Employee of a Qualifying Event that is a divorce or legal separation or a child's ceasing to qualify as a Dependent under the terms of the Plan.

When a Qualifying Event occurs that is the Employee's termination of employment, reduction of hours, or death, the notice will be sent to each Qualified Beneficiary within 44 days after the earlier of:

a. the date on which the Participant or Beneficiary would lose coverage due to a Qualifying Event, or

b. the date of the Qualifying Event (if coverage is to terminate immediately as of the Qualifying Event instead of at the end of the Coverage Period in which the Qualifying Event occurs).

5. Unavailability of COBRA Notice

a. When the Administrative Manager receives a notice from an Employee or Beneficiary relating to a Qualifying Event, second Qualifying Event or determination of long-term disability by the Social Security Administration regarding an Employee, Qualified Beneficiary or other individual and the Administrative Manager determines that the individual is not entitled to COBRA Continuation Coverage, the Administrative Manager shall provide a notice explaining why the individual is not entitled to COBRA Continuation Coverage.

b. The unavailability notice shall be sent within 14 days from receipt of the notice from the Employee or other individual.

6. Early Termination of COBRA Continuation Coverage Notice

a. Whenever COBRA Continuation Coverage is terminated prior to the latest date shown on the Election Notice, notice must be sent to all affected Qualified Beneficiaries explaining the reason for the termination, the date of termination and any rights the Qualified Beneficiary may have under the Plan or under applicable law to elect alternative group or individual coverage, such as a conversion right.

b. The termination notice will be provided as soon as practicable following the Administrative Manager's determination that continuation coverage shall terminate.

Section 3.07 – Extension of Benefits in Cases of Death (Class A Only)

If an Employee dies and has completed all of the 260-hour requirements described in Section 3.03 for the Qualification Period in which his death occurred, coverage for his Dependents shall be continued under this Subsection. The extension of coverage shall last until the earliest of –

A) any hours of credited employment have been used, or

B) the Plan terminates.

Section 3.08 – Continuation of Coverage for Disabled Children

If an unmarried Dependent child is incapable of self-sustaining employment by reason of mental or physical handicap and –

A) meets the definition of Long-Term Disability as defined in Section 11.17, and

B) became Disabled prior to attainment of age 19, and

C) is primarily dependent upon the Participant for support and maintenance, and

D) if the Participant furnishes due proof of such Disability within 120 days of the day after the day such Dependent child turns age 26,

the coverage of such Dependent shall be continued for as long as the coverage of the Participant under the Plan remains in effect and such Dependent remains Disabled.

The Board of Trustees may require, at reasonable intervals during the two years following the Dependent's attainment of age 19, subsequent proof of the Dependent's Disability and dependency. After this two-year period, the Board of Trustees may require subsequent proof of Disability and dependency of such Dependent once each year. As described in Section 8.02, the Board of Trustees may delegate the review of proof of Disability and dependency.

Section 3.09 – Family and Medical Leave Act

The Family and Medical Leave Act of 1996 (FMLA) creates a federal right for a Class A Employee to take up to 12 workweeks of unpaid leave for his serious Sickness, for the birth or adoption of a child or to care for his seriously ill Spouse, parent or child.

An Employee is also allowed to take up to 26 workweeks of FMLA leave to care for a Spouse, son, daughter, parent, or next of kin who is of a member of the Armed Forces, including a member of the National Guard or Reserves, who is undergoing medical treatment, recuperation or therapy,

is otherwise in outpatient status, or is otherwise on the temporary disability retired list, for a serious injury or Sickness

In addition, an Employee may take up to 12 workweeks of FMLA leave for a “qualifying exigency” arising out of the fact that the Employee’s Spouse, son, daughter or parent is on active duty in the Armed Forces or has been notified of an impending call or order to active duty. An “exigency” is a state of affairs that makes urgent demands as defined by the regulation.

The FMLA requires Employers to maintain health care coverage under any health plan on the same terms and conditions as if you were still employed for the length of the leave. In addition, FMLA states that if an Employee takes a family or medical leave the Employee may not lose any Benefits that the Employee had accrued before the leave. The Plan will recognize eligibility for a family medical leave provided the Employer properly grants the leave under the FMLA and the Employer makes the required payments to the Plan. These required contributions shall be based upon the hourly contribution rate set by the applicable collective bargaining agreement between the Union and the Associations, based upon 260 minimum hours required per Qualification Period.

If you take FMLA leave and you fail to return to your Employer for any reason after such absence, your Employer has the right to collect all contributions made on your behalf during such leave of absence. Thus, to ensure your continuing coverage under the Plan and to prevent possible repayment of any such contributions to your Employer, you should return to work at the end of your FMLA leave.

In addition, if you advised the Employer granting your FMLA leave that you do not intend to return to work, then the employer must notify the Fund Office of the date you advised the Employer that you do not intend to return to work.

If you have any questions about the FMLA, you should contact your Employer or the nearest office of the Wage and Hour Division, listed in most telephone directories under the U.S. Government, Department of Labor, Employment Standards Administration. You can also visit the Department of Labor’s FMLA webpage at: www.dol.gov/esa/whd/fmla.

Section 3.10 – Uniformed Services Employment and Reemployment Rights Act (USERRA)

YOU MUST NOTIFY THE FUND OFFICE IMMEDIATELY WHEN YOU KNOW YOU ARE ENTERING MILITARY SERVICE.

- **Effective Date**

  The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) protects the eligibility of an Employee and offers continuation coverage (by Self-Payment) to the Employee and his Dependents after the Employee enters into military service.

- **Provisions**

  1. Return to Work Coverage Guaranteed
     USERRA requires an Employer or a multiemployer health care plan; to protect any health care benefits an Employee has already earned up to the time an Employee enters military service if the Employee re-applies for work within prescribed time periods after an honorable discharge.

     Under that law, future accrued eligibility can be used immediately or can be "frozen" when entering military service. If frozen, it is fully restored when the Employee re-applies for work with the same Employer or, in the case of a multiemployer plan, with any Employer who is signatory to the collective bargaining agreement. If an Employee enters military services, rather than having to make this election, the Trustees have agreed to allow this extension both immediately following this reduction of hours worked and when the Employee returns from active duty and reapplies for work.

     When an Employee returns from service, no exclusion or waiting period may be imposed in connection with the restoration of health care coverage that would not otherwise apply if the Employee had not entered military service.

  2. Continuation of Coverage While in the Military
     USERRA requires a group health care plan to offer identical health care coverage for **up to 24 months** to persons who have coverage in connection with their employment, but who are absent from such employment due to military service. In effect, military service is treated as if it is a "Qualifying Event" for COBRA purposes and continuation coverage is offered to the Participant and Dependents at a cost established by the Trustees.

     If notification to the Fund Office is delayed for several months, the extension of coverage for a maximum of 24 months begins with the initial date of entry into military service and a retroactive payment to that date may be charged. A Participant has an obligation to notify the Fund Office as soon as the Participant knows they are entering military service if the Eligible Person wishes to take advantage of continuation coverage. Failure to notify the Fund Office may be taken as an indication that the Participant does not wish to purchase coverage for themselves or their dependents.

3. Reemployment Requirements When Returning from Service
   The application period for reemployment is based on a time schedule keyed to the length of time spent in military service. *For service of less than 31 days*, an application for reemployment with a signatory Employer must be filed at the beginning of the next regular scheduled work period on the first day after release from service, taking into account safe transportation plus an eight-hour rest period. *For military service of 31 days or more but less than 181 days*, an application for reemployment must be filed within 14 days (calendar days, not work days) after release from the service. *For service over 181 days*, an application for reemployment must be submitted within 90 days (calendar days, not work days) after an honorable discharge.

Section 3.11 – Qualified Medical Child Support Order

The term "Qualified Medical Child Support Order" (QMCSO) means a medical child support order which creates or recognizes the existence of an Alternate Recipient's right to or assigns to an Alternate Recipient the right to receive Benefits under the Plan and which complies with the requirements of a QMCSO. An Alternate Recipient under a QMCSO shall be eligible for Benefits from the Plan only if the Participant is eligible.
Benefits paid to an Alternate Recipient shall be at the level of Benefits available under the Plan at the time the Expense was incurred.

In the event that the Participant loses eligibility and later regains eligibility, the eligibility of an Alternate Recipient under an unexpired QMCSO will automatically be reinstated.

The Plan has established procedures for 1) the determination of whether a medical child support order is a QMCSO and 2) administration of the QMCSO, pursuant to the requirements of federal law.

The procedures followed by the Plan in processing a QMCSO are available from the Fund Office at no charge upon request.

Section 3.12 – Timely Dependent Enrollment

A Participant has 30 days after a life event (marriage, adoption, etc.) to add a Dependent, unless the life event is the birth of a child. If a Participant has a child, that child must be added as a Dependent within 120 days of the child's birth. If the new Dependent is added within these time frames, the new Dependent will be eligible effective the date of the life event. If an Active Participant's Dependents are added after these time frames, coverage will begin the month following the receipt of all applicable enrollment information. If a Retiree's or Totally Disabled Participant's Dependents are added after these time frames, the Plan will not provide coverage for the Dependents.

ARTICLE IV – DESCRIPTION OF BENEFITS

The following topics are discussed under this Article on Description of Benefits:

The Benefits listed in the table below are described in this Article IV. This table is only intended to give you a brief summary of medical Benefits available. Please refer to the Description of Benefits that begins immediately after the table to fully understand the Benefit and any specific maximums or limitations.

Dental Care, Eye Care, Hearing and Prescription Drug Card Benefits are not summarized in this table. For complete information, please refer to the appropriate Section within this Article.

The Plan provides Benefits only for those Medically Necessary covered services and charges expressly described in the Plan. **Any omission of service or charge shall be presumed to be an exclusion even though not expressly stated as such.**

General Medical Benefit note: Certain Out-of-Network emergency services, Out-of-Network services at an In-Network facility and Air Ambulance Services are payable at In-Network rates.

NOT ALL BENEFITS ARE AVAILABLE TO ALL ELIGIBLE PERSONS. PLEASE CONSULT THE ARTICLE II SCHEDULE OF BENEFITS TO DETERMINE IF YOU OR YOUR DEPENDENTS ARE ELIGIBLE FOR ANY PARTICULAR BENEFIT.

IN ADDITION, SOME BENEFITS ARE SUBJECT TO MEDICAL CARE REVIEW AS DESCRIBED IN SECTION 8.15

Description of Covered Benefit	Plan Pays amounts based on a percent of Approved Charge: In-Network	Plan Pays amounts based on a percent of Approved Charge: Out-of-Network	Does your Coinsurance Amount help meet your Out-of-Pocket Limit?	Do you need to meet your Plan Year Deductible before receiving Benefits?
General Medical Benefit	75%	50%	Yes	Yes
Chiropractic Benefit *See Benefit Description in Section 4.05 for Limitations*	75%	50% up to $1,500 per Plan Year	Yes	Yes
Diabetes Education and Training Benefit	75%	50%	Yes	Yes
Hospice Care Benefit *See Benefit Description in Section 4.10 for Limitations*	75%	50%	Yes	Yes
Teladoc Online Physician Visit Benefit *In-Network Benefit Only* *See Benefit Description in Section 4.18 for Limitations*	100%	0%	No	No
Mental and Nervous Disorder Benefit *See Benefit Description in Section 4.11 for Limitations*	75%	50%	Yes	Yes
Routine Preventive Care Benefit *See Benefit Description in Section 4.13 for Limitations*	100%	50%	No	No (In-Network) Yes (Out-of-Network)
Substance Abuse Benefit *See Benefit Description in Section 4.14 for Limitations*	75%	50%	Yes	Yes
Temporomandibular Joint Dysfunction (TMJ) Benefit *See Benefit Description in Section 4.15 for Limitations*	75%	50% up to $1,500 Lifetime Maximum	Yes	Yes
Transplant Benefit *See Benefit Description in Section 4.16 for Limitations*	75%	50%	Yes	Yes

Section 4.01 – Life Insurance Benefit (Participants Only)

Upon the death of a Participant, the Plan will pay a Life Insurance Benefit in the amount set forth in the Schedule of Benefits to the designated Beneficiary of the deceased Employee. The complete policy is available to be reviewed at the Fund Office. The payment of any such Life Insurance Benefit shall be contingent upon the receipt by the Fund Office of proper proof of the eligible Employee's death. Proper proof of the eligible Employee's death includes a Benefit Claim form, original or certified copy of death certificate and the obituary notice.

In the event that the deceased Employee dies without designating a Beneficiary or in the event that the designated Beneficiary has predeceased the Employee, the amount of the Life Insurance Benefit shall be paid to the first applicable of the following surviving individuals in equal shares, in descending order:

> The deceased Employee's Surviving Spouse; child or children; parents; siblings; or failing these, to the deceased Employee's estate.

Benefits payable to minor children may be paid to the minor's legal guardian.

An eligible Employee may designate any natural person or persons or legal entity as the Beneficiary of the Life Insurance Benefit or the Accidental Death Benefit payable from the Plan by filing the designation, in writing, with the Fund Office. An eligible Employee may designate a new Beneficiary at any time by filing a new Beneficiary Designation Card with the Fund Office. Any change shall **NOT** become effective until it is received in the Fund Office, and neither the Plan nor the Trustees shall be liable for any payment made before the change was received in the Fund Office.

If an eligible Employee designates more than one Beneficiary, the Life Insurance Benefit will be paid in equal shares.

Notwithstanding the foregoing, an Employee's designation of his/her spouse as Beneficiary shall become null and void automatically upon divorce. Should the Employee wish to maintain the Beneficiary designation of an ex-spouse, he/she must fill out a new Beneficiary Designation Card dated after the divorce.

Section 4.02 – Accidental Death and Dismemberment Benefit (Class A or AS current or former Employees Only)

When bodily Injury caused solely through non-occupational accidental means (independent of other causes) results in any of the following losses within 365 days after the date of the accident, the Plan will pay the amount specified in the Schedule of Benefits. The amount of the Accidental Death Benefit is payable to the designated Beneficiary. The amount for the Dismemberment (meaning loss of limb(s), loss of eyesight, loss of hearing and/or paralysis) Benefit is payable to the Employee.

The term "Loss" as used in this part with reference to hand or foot means the complete severance through or above the wrist or ankle joint and with reference to the eye means the irrecoverable loss of the entire sight thereof. If more than one loss is suffered the Plan will pay the benefit for the greatest loss.

Benefits will **NOT** be payable for any loss resulting from:

A) A job-related Injury;

B) Suicide or Injuries intentionally self-inflicted while sane;

C) Injuries due to combat during war or as a result of an act of war; declared or undeclared;

D) Military or naval service in any country; or

E) Injuries or loss of life to an Employee residing outside the United States.

Please See section 4.01(A) for the Beneficiary Designation rules that also apply to the Accidental Death Benefit in this Section 4.02.

Section 4.03 – Loss of Time (Short-Term Disability) Benefit (Class A Participant Only)

When an Injury or Sickness causes a Class A Employee (who is not retired) to have a Short-Term Disability (as defined in Article XI) the Plan will pay the Loss of Time (Short-Term Disability) Benefit as set forth in the Schedule of Benefits.

Each Participant who has a Short-Term Disability will receive Benefits for absence due to Injury or Sickness which constitutes a period of Short-Term Disability after submitting a Benefit Claim and satisfying the Waiting Period set forth in the Schedule of Benefits. Following the applicable Waiting Period, the Participant will receive Benefits payable weekly in an amount specified in the Schedule of Benefits. Non-occupational Injury Benefits begin on the first day of Disability and Sickness Benefits begin on the eighth day of Disability. For purposes of this Benefit, if treatment for an Injury is not sought within 72 hours of sustaining the Injury, the Disability will be treated as a Sickness and Benefits will not commence until the eighth day.

If the Disability period exceeds the expected recovery time for that medical condition, your case will be sent for medical review, which will require submission of medical records. The expected recovery time will initially be determined in accordance with the current standard set by the Work Loss Data Institute. An extension will be allowed upon validation of Medical Necessity. In no circumstances will the Benefit be paid for more than the maximum 13 weeks.

Successive periods of Loss of Time (Short-Term Disability) due to the same or related causes shall be considered as the same period of Loss of Time (Short-Term Disability), unless separated by a release for return to work by your Physician. Benefits will be paid for only one period of Total Disability at a time, even if a different or unrelated Injury or Illness resulting in Loss of Time (Short-Term Disability) occurs during a period of Loss of Time (Short-Term Disability). The period of Loss of Time (Short-Term Disability) for the different and unrelated Injury or Illness will not extend to account for any overlap with the initial period of Loss of Time (Short-Term Disability). For the purposes of this Benefit, any Injury which arises out of or in the course of any occupation or employment for wage or profit will be considered an Occupational Disability. All other Total Disabilities will be considered Non-occupational Disabilities.

No Benefit Claims are payable under this Section unless the Class A Employee is under the regular care and attention of a Physician or Surgeon. The Plan requires reasonable proof of initial and continuing Total Disability.

Section 4.04 – General Medical Benefit

Medical expenses included under the General Medical Benefit will be payable for Medically Necessary care and services according to the Schedule of Benefits. Medical expenses will only be covered if the provider or facility is properly licensed and/or certified under state and/or federal law, as applicable, to provide the services rendered. Services must be provided by a Doctor of Medicine (MD) or under the direct supervision of an MD.

Some services require precertification as part of the Plan's Medicare Review Program. See Section 8.15. Contact the Fund's medical care review provider, Hines & Associates, Inc. at (800) 559-5257 or www.precertcare.com to obtain precertification or to receive more information.

A) Deductible Amount

Before Benefit Claims are paid under the Plan, you must satisfy a Deductible Amount. This is the dollar amount of Covered Charges that you pay each Plan Year before the Plan pays any Benefits. There are separate Deductible Amounts for In-Network Services, Out-of-Network Services and Emergency Room Visits.

1. In-Network Deductible Amount

The In-Network Deductible Amount is $300 per person or $600 per family per Plan Year. The In-Network Deductible Amount does not apply to Benefits that are not subject to a Deductible.

2. Out-of-Network Deductible Amount

The Out-of-Network Deductible Amount is $600 per person per Plan Year with no family maximum. The Out-of-Network Deductible Amount does not apply to Benefits that are not subject to a deductible.

3. Emergency Room Deductible Amount

The Emergency Room Deductible Amount is $70 per person per visit with no family maximum. The Emergency Room Deductible is a separate Deductible that applies when you visit an Emergency Room for reasons other than serious life-threatening Sickness (as verified by a Physician), accident (for visits occurring within 72 hours of the accident) or inpatient admission, including observation, if admitted.

B) Coinsurance

Certain covered health services require you to pay Coinsurance. Coinsurance applies after the Deductible Amount is satisfied, if applicable.

C) Out-of-Pocket Limit

The maximum amount that this Plan requires you to pay out of your pocket in a Plan Year for Covered Charges is referred to as the Out-of-Pocket Limit. After you have paid the maximum amount listed on the Schedules of Benefits in a Plan Year, the Plan pays 100% of your General Medical Covered Charges for the remainder of the Plan Year.

D) Annual and Lifetime Benefit Maximums

There are no annual or lifetime maximum Benefits for the General Medical Benefit.

E) Covered Expenses

Medical expenses included under the General Medical Benefit will be payable (up to the UCR or Allowed Amount) for the following Medically Necessary (as defined in Article XI) care and services:

1. Hospital room and board charges (covers the semi-private room rate if a semi-private room is utilized or the average semi-private room rate if a private room is utilized; and covers an Intensive Care Unit or other specialized care unit(s)),

If an Eligible Person is admitted as a Hospital inpatient, and such admission occurs on Friday or Saturday, then the surgical procedure or treatment recommended by a Physician must commence within 24 hours, otherwise, expenses for Hospital room and board and necessary

services and supplies will not be paid by the Plan and will not count toward any Out-of-Pocket maximums. However, this will not apply to a weekend admission that is Medically Necessary (as defined in Article XI)

2. Other Hospital charges provided during inpatient confinement (excluding personal services such as telephone, television, etc.) including: operating room, drugs (excluding drugs purchased using the Prescription Drug Benefit described in Section 4.12), blood and blood plasma (including administration and charges associated with self-donation of blood prior to a planned surgery if recommended by the attending Physician), x-ray examinations, radiation treatment, physiotherapy, laboratory tests, surgical dressings and medical supplies.

3. Physician fees, office visits (in-office or virtual) including office visits associated with Smoking Cessation and Hospital visits.

4. Surgical procedures performed by a Physician. Surgical procedures may be performed in the Hospital, the doctor's office or other Plan-approved facility.

   In compliance with Women's Health and Cancer Rights Act, the Plan shall cover UCR Charges incurred by Participants or Dependents with respect to a mastectomy, including, if the Eligible Person elects breast reconstruction, the following medical care and prosthetic devices in a manner determined in the consultation with the attending Physician and the Eligible Person:

   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 at all stages of mastectomy, including lymphedemas.

5. Services of a licensed graduate nurse or licensed practical nurse, other than a person who ordinarily resides in the Participant's or covered Dependent's home or who is a member of his immediate family (comprising of the Participant's Spouse and the children, siblings and parents of such Participant or Participant's Spouse).

6. Expenses and services for physical, speech or occupational therapy. Treatment must be provided by a physio, speech or occupational therapist other than a person who ordinarily resides in the Participant's or covered Dependent's home or who is a member of his immediate family (comprising of the Participant's Spouse, and the children, siblings and parents of such Participant or Participant's Spouse).

Contact the Fund's medical care review provider, Hines & Associates, Inc. at (800) 559-5257 or www.precertcare.com to obtain precertification or to receive more information regarding this Benefit.

7. Dental treatment by a Physician or a licensed dentist or dental surgeon, for a fractured jaw or for Injury to sound natural teeth as a result of an accident, including replacement of such teeth provided treatment is completed within six months after the date of the accident or for the following procedures:

   a. alveolectomy;

b. apicoectomy;
c. frenectomy;
d. gingivectomy;
e. osseous surgery;
f. ostectomy;
g. osteoplasty;
h. removal of cysts;
i. surgical removal of impacted teeth;
j. torus mandibularis; and
k. torus palatinus.

All Dental expenses paid under the General Medical Benefit are filed through Delta Dental.

8. X-ray or radium treatment.

9. Diagnostic x-ray and laboratory tests (including laboratory tests associated with smoking cessation office visits) that are performed as part of a routine health examination or that are needed to diagnose an apparent Injury or Sickness. Also, dental x-rays shall not be covered, unless associated with a covered oral surgical procedure or rendered within six months after the date of an accident for dental treatment of a fractured jaw or for Injury to natural teeth.

10. Local professional ambulance service and air-ambulance in Emergency situations, except service by railroad, ship, bus, airplane or other common carrier.

11. Medical supplies, limited to: drugs and devices legally requiring a prescription, legally obtained from a licensed pharmacist and prescribed by a currently licensed Physician (but not contraceptive drugs or devices or drugs purchased using the Prescription Drug Card Benefit described in Section 4.12) blood and blood plasma; artificial limbs and eyes and the initial cost and replacement prostheses if required as a result of growth, pathological changes or wear (including external breast prostheses); surgical dressings; casts; splints; trusses; braces; crutches; hoses; masks; wires for TENS units; batteries and rental up to the purchase price of Durable Medical Equipment such as a wheelchair, hospital bed or and oxygen and equipment for its administration. “Durable Medical Equipment” means equipment which a) can withstand repeated use; b) is mainly and customarily used for a medical purpose; c) is not generally useful to a person in the absence of an Injury or Sickness; and d) is suited for use in the home. Durable Medical Equipment does not include diabetic supplies that are available through the Prescription Drug Card Benefit. Requests for Durable Medical Equipment must be accompanied by a Physician’s statement describing the Medical Necessity and length of use. The cost of these items will be limited to the UCR Charge. Rental of Durable Medical Equipment is covered up to the purchase price. Repairs to integral parts of purchased Durable Medical Equipment are covered as long as the equipment continues to be Medically Necessary and the repair costs less than it would to replace the broken equipment.

12. The first pair of contact lenses or eyeglasses prescribed and obtained within one year following cataract surgery.

13. A second opinion when a Physician has recommended elective surgery.

14. Maternity and Newborn Care – Maternity Benefits include all maternity-related medical services for prenatal care, postnatal care, delivery and any other related complications.

When a pregnancy (including resulting childbirth or complications therefrom) causes an eligible Employee or Dependent Spouse to incur expenses, including for licensed midwives and birthing centers, the Plan will pay Benefit Claims for the pregnancy on the same basis as any other Injury or Sickness. Loss of Time (Short-Term Disability) Benefit payments shall be made to the eligible female Employee in accordance with the Loss of Time (Short-Term Disability) provisions explained in Section 4.03.

MATERNITY BENEFITS ARE PAYABLE UNDER THE GENERAL MEDICAL BENEFIT ONLY AND ARE SUBJECT TO THE SAME TERMS, CONDITIONS AND LIMITATIONS GOVERNING THE INDIVIDUAL BENEFITS FOR ANY OTHER SICKNESS OR INJURY UNDER THE PLAN.

The Plan complies with a federal law known as the Newborns' and Mothers' Health Protection Act of 1996 ("Newborns' Act") which requires that the Plan may not restrict any Hospital stay in connection with childbirth for the mother or newborn child to less than 48 hours following vaginal delivery or less than 96 hours following a cesarean. However, the Plan may pay for a shorter stay if the attending provider (e.g., the Physician, nurse midwife or Physician's assistant), after consultation with the mother, agrees to an earlier discharge date for a mother and her newborn.

Under the Newborns' Act, the Plan may **NOT** set the level of Benefits or Out-of-Pocket expenses so that any later portion of the 48 hours (or 96 hours for a caesarean) stay is treated in a manner less favorable to the mother or newborn than any other portion of the stay.

Additionally, under the Newborns' Act, the Plan may not require that a Physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours for a caesarean). However, the Plan may require precertification to use certain providers or facilities or to reduce Out-of-Pocket expenses.

Maternity Benefits are **NOT** payable on behalf of Dependent children for expenses incurred due to pregnancy, childbirth or miscarriage, unless otherwise required by law.

15. Anesthetics and their administration.

16. Expenses for elective surgical sterilization and birth control devices including (but not limited to) IUDs, contraceptive implants and any similar devices or other birth control methods and all related expenses but not including expenses for elective abortions using drugs such as RU-486 or surgical abortions or other abortion drugs, devices, methods or procedures. The Plan will cover abortion-related expenses in the event of a lethal fetal anomaly. Prescription oral contraceptives are covered under the Prescription Drug Card Benefit in Section 4.12.

17. Expenses for diabetic shoes and toe-fillers if the need for such items is Medically Necessary and is the result of diabetes. Coverage is limited to no more than one pair of custom-molded shoes (including inserts provided with the shoes) and three pairs of inserts (the three pairs of inserts do not include the non-customized removable inserts provided with such shoes) per Participant or Dependent per Plan Year.

18. Genetic testing, when Medically Necessary and the required pre-certification is obtained.

19. Expenses and services for vision therapy or vision training.

20. Expenses for In-Network skilled nursing facility (Out-of-Network not covered), including independent ancillary charges from services outside the facility such as Physician's visits, therapy and Durable Medical Equipment even if the skilled nursing facility stay is not covered. Ancillary charges from the non-covered skilled nursing facility are not covered.

Certain Out-of-Network emergency services, Out-of-Network services at an In-Network facility and Air Ambulance Services are payable at In-Network rates.

Section 4.05 – Chiropractic Benefit

When an Eligible Person incurs expenses for chiropractic services (including office visits, required X-rays related to the chiropractic visit, and chiropractic services that are medically necessary following surgery) and has met the Deductible Amount, the Plan will pay Benefits according to the Schedule of Benefits.

Section 4.06 – Dental Care Benefit

When an Eligible Person incurs expenses for dental care, the Plan will pay Benefits according to the Schedule of Benefits, through an agreement with Delta Dental. Precertification of dental treatment plans is not required but is recommended. To confirm whether your dental provider is in this Plan's Network of providers, please contact Delta Dental at (800) 524-0149 or www.deltadental.com.

A) <u>Covered Benefits</u>

Covered dental services consist of the following:

1. Preventive Services

    a. Routine periodic examinations, twice in any Calendar Year;

    b. Bitewing x-rays, twice in any Calendar Year;

    c. Dental prophylaxis (cleaning, scaling and polishing including periodontal maintenance visits), twice in any Calendar Year;

    d. Full mouth x-rays, once in any three-year period;

    e. Topical fluoride application for patients under age 15 twice in any Calendar Year; and

    f. Sealants, one per tooth per lifetime for occlusal surface of first and second permanent molars without age restriction. Surface must be free of decay and restorations.

2. Restorative and Other Dental Services

    a. Fillings using amalgam material and composite resin material;

    b. Composite resin and porcelain crowns and bridges;

    c. Relines and repairs to bridges and dentures, once in any five-year period;

    d. Provisional splinting once every three years;

    e. Space maintainers up to age 14, once per area per lifetime;

f. Antibiotic drug injections; and

g. Emergency palliative treatment as needed (minor procedures to temporarily reduce or eliminate pain).

B) Dental Benefit Limitations

The Dental Benefit has the following limitations:

1. The Plan is liable for not more than the amount it would have been liable for if only one dentist had supplied the service if an Eligible Person transfers from the care of one dentist to that of another dentist during the course of treatment, or if more than one dentist supplies services for one dental procedure;

2. The Plan is liable only for the treatment carrying the lesser allowance in all cases in which there are optional techniques of treatment carrying different allowances;

3. The Plan reserves the right to obtain advisory opinions from a consultant or consultants in the specialty under consideration before reaching its decision regarding a Benefit Claim involving services that are determined by the Plan to be dentally unnecessary. On reconsiderations of denied dental necessity Benefit Claims, the Plan further reserves the right to refer such cases to an appropriate dental review committee for an advisory opinion before the Plan gives its final determination of such Benefit Claims;

4. Up to two additional prophylaxes treatments per Calendar Year may be available at 100% of the allowed amount for patients with certain high-risk medical conditions such as:

    a. People with diabetes and periodontal (gum) disease;

    b. Pregnant women who have periodontal (gum) disease;

    c. People at risk for infective endocarditis;

    d. People with kidney failure or who are undergoing dialysis; or

    e. People with suppressed immune systems due to chemotherapy and/or radiation treatment, HIV positive status, organ transplant and/or stem cell (bone marrow) transplant.

5. An additional fluoride treatment each Calendar Year may be available at 100% of the Allowed Amount for patients with certain high-risk medical conditions, regardless of age, such as:

    a. People with diabetes and periodontal (gum) disease;

    b. Pregnant women who have periodontal (gum) disease;

    c. People at risk for infective endocarditis;

    d. People with kidney failure or who are undergoing dialysis; or

    e. People with suppressed immune systems due to chemotherapy and/or radiation treatment, HIV positive status, organ transplant and/or stem cell (bone marrow) transplant

C) Dental Benefit Exclusions

The Plan does not cover, in whole or in part, any dental service that is not considered Medically Necessary. The fact that a dentist may prescribe, order, recommend or approve a service does not, of itself, make the charge a Covered Expense, even though the service is not specifically listed as an exclusion.

The final authority for determining whether services are covered is determined by the Trustees of the Plan. The following services are not covered under the Dental Benefit:

1. Any services in excess of the stated limitations above;

2. Replacement of lost or stolen appliances of any type;

3. A service not reasonably necessary (based either on medical necessity or a concern for fraud, waste, or abuse) or not customarily performed for the dental care of the Eligible Person;

4. Charges for failure to keep a scheduled appointment;

5. Cosmetic dentistry;

6. A service not furnished by a dentist, unless the service is performed by a licensed dental hygienist under the supervision of a dentist or is an x-ray ordered by a dentist;

7. Removable or maxillofacial prosthodontics;

8. Any dental procedure covered under the General Medical Benefit, including, but not limited to: Alveolectomy, Apicoectomy, Frenectomy, Gingivectomy, Osseous surgery, Ostectomy, Osteoplasty, removal of cysts, surgical removal of impacted teeth, Torus mandibularis and Torus palatinus. These services will be paid under the General Medical Benefit through Delta Dental at the applicable cost share. The Medical Deductible Amount will not apply; and

Section 4.07 – Diabetes Education and Training Benefit

When an Eligible Person incurs expenses for education and training for management of diabetes, the Plan will pay Benefit Claims according to the Schedule of Benefits. Services for nutritional counseling must be provided by a properly licensed dietician or nutritional therapist and must be Medically Necessary.

Section 4.08 – Eye Care Benefit

When an Eligible Person incurs expenses for eye care services or supplies, the Plan will pay Benefit Claims according to the Schedule of Benefits. The Preferred Provider for eye care is listed in Section 9.15. Services provided by Wal-Mart and Sam's Club are not covered under the Plan.

Section 4.09 – Hearing Benefit

When an Eligible Person incurs expenses for a routine hearing examination made by a Physician which the Eligible Person is not confined in a Hospital as an inpatient during the time such examination is being made, the cost of such examination shall be payable according to the Schedule of Benefits.

In addition, if as a result of a routine hearing examination made by a Physician or a qualified technician, the Physician or qualified technician recommends the purchase of a hearing aid, the Plan will reimburse the Participant according to the Schedule of Benefits for any Eligible Person.

Limitations
In no event will reimbursement be provided for the repair of a hearing aid (whether or not it was covered by the Hearing Benefit) or for the purchase of hearing aid batteries.

Please contact Amplifon Hearing Health Care at (866) 349-9051 for locations of a Hearing Network Provider and discounts.

Section 4.10 – Hospice Care Benefit
Benefit Claims on behalf of an Eligible Person for covered services for Hospice Care after the Deductible Amount has been met shall be payable as set forth in the applicable Schedule of Benefits.

Contact the Fund's medical care review provider, Hines & Associates, Inc. at (800) 559-5257 or www.precertcare.com to obtain required precertification for Hospice care or to receive more information regarding this Benefit.

A Hospice program provides care for the terminally ill at home or at a facility where patients are cared for in a comfortable and supportive home-like environment. Often, Hospitals set aside a floor or wing as a Hospice center. The purpose of a hospice care program is to make the patient comfortable, rather than to attempt a cure. The facility design and regulations are less restrictive than in other inpatient facilities.

Hospice services include providing the dying person with palliative and supportive medical, nursing and other health services through home or inpatient care.

Allowed Charges include:

For services provided during confinement in a hospice facility:

1. Room and board;
2. Physician's charges;
3. Nursing care;
4. Medical services and supplies provided by the facility.

For hospice care provided at home:

1. Nursing and other care provided by the hospice agency;
2. Respite care provided at a Medicare-approved facility.

Hospice Care benefits shall only be paid for patients who are not expected to live beyond six months, as determined by the patient's Physician, and for services provided by a hospice program that is accredited by Medicare.

Section 4.11 – Mental and Nervous Disorder Benefit
When a mental or nervous disorder causes an Eligible Person to incur expenses for inpatient Hospital or Physician charges or outpatient Physician charges (in office or virtual), the Plan will

pay Benefit Claims according to the General Medical Benefit after the Deductible Amount has been met. Services must be provided by a Doctor of Medicine (MD) or under the direct supervision of an MD.

Inpatient treatment must be received at an In-Network facility. Inpatient treatment is not covered at an Out-of-Network facility unless approved by Medicare.

Services may also be available through the MAP Assistance Program as explained in Section 4.17.

Precertification is required for intensive outpatient programs, partial hospitalization programs and inpatient treatment. Contact the Fund's medical care review provider, Hines & Associates, Inc. at (800) 559-5257 or www.precertcare.com to obtain required precertification for Mental and Nervous Disorder Benefit or to receive more information regarding this Benefit.

Autism Spectrum Disorder
The Plan will pay benefits according to the Schedule of Benefits for services deemed Medically Necessary to treat the diagnosis of Autism Spectrum Disorder, subject to the Medical Care Review program found in Section 8.15 of this Plan Document and Summary Plan Description as follows:

A) Applied Behavior Analysis (ABA): ABA therapy must be ordered by a qualified Physician and precertification for Medical Necessity prior to start of therapy is required. ABA therapy must be provided by providers certified with the Behavior Analyst Certification Board (https://www.bacb.com).

B) Developmental Therapy: This service must be deemed Medically Necessary and be intended to meet the medical therapy needs of children who require intensive services (those in addition to services available through Early Intervention Programs (EIP) or Individual Educational Plans (IEP). Developmental Therapy services must be ordered by a Physician and provided by licensed pediatric physical therapists, licensed pediatric occupational therapists, and licensed pediatric speech therapists, which may include feeding therapy and communication.

Section 4.12 – Prescription Drug Card Benefit

When a non-occupational Injury or Sickness causes an Eligible Person to need prescription drugs, the Plan will pay Benefits according to the Schedule of Benefits. Prescription drugs must be legally obtained from a licensed pharmacist at a Participating Pharmacy (defined in the next paragraph) and prescribed by a licensed Physician. The Plan does not cover prescriptions with Walmart, Walgreens or Sam's Club pharmacies, as well as some CVS pharmacies. The Plan currently utilizes Sav-Rx as its pharmacy benefit manager (PBM). If you have questions regarding whether your pharmacy provider is in the Sav-Rx Network, please contact Sav-Rx at (800) 228-3108 or www.savrx.com.

A) Definitions

"**Participating Pharmacy**" means a walk-in pharmacy (including a Hospital pharmacy) or mail order pharmacy which has entered into an agreement with the Fund's PBM to provide prescription drugs as described in this Section 4.12. A "walk-in" pharmacy is also called a "retail" pharmacy.

The "**formulary**" is a list of preferred prescription drugs that this Plan covers.

B) Retail Participating Pharmacies

Retail Participating Pharmacies allow prescriptions for a supply of up to 30 days. The Plan covers 100% of each refill **after** payment of the applicable amount by the Eligible Person as listed in the Schedule of Benefits.

C) Mail Order Participating Pharmacies

Mail Order Participating Pharmacies allow prescriptions for a supply of up to 90 days. The Plan covers 100% of each refill **after** payment of the applicable amount by the Eligible Person as listed in the Schedule of Benefits. Some Mail Order Participating Pharmacies also include walk-in pharmacies which allow 90-day prescriptions. Some examples include, but are not limited to: CVS, Nations Medicine, Pharmacy of Canterbury, Keltsch Pharmacy and Community Care Center. Specialty Drugs may be limited to a 30-day or 90-day supply.

D) Cost Savings Programs

The Plan has mandatory programs through the Plan's PBM, Sav-Rx, that could save money for you and the Plan. If you have any questions about the programs, please contact Sav-Rx.

1. High-Impact Advocacy (HIA) Program
   The HIA Program includes specialty medications in certain classes that have a manufacturer's coupon or other financial assistance available. Current prescription drug classes included are TNF and related prescription drugs (typically prescribed to treat migraines), multiple sclerosis and Hepatitis C. These prescription drug classes and supply limits are subject to change. The HIA Program utilizes manufacturer's coupons and other financial assistance to lower costs to you and the Plan. You may contact Sav-Rx with any questions about this program. If you choose to not participate, your prescription drugs will not be covered under the Plan.

2. Mandatory Generic Program
   The Mandatory Generic Program encourages the use of generic prescription drugs equivalents whenever available. If the Eligible Person or his Physician requests a brand name prescription drug instead of its generic equivalent, the Eligible Person will be charged the brand name prescription drug Copayment PLUS the difference between the brand name prescription drug and the generic alternative. If you require the brand name prescription drug for Medically Necessary reasons, your Physician may request a waiver of the difference in cost, to be reviewed and considered, by submitting a Letter of Medical Necessity to Sav-Rx. If you choose to not participate, your prescription drug at issue (with the biosimilar equivalent) will not be covered under the Plan.

3. Prior Authorization Program
   The Prior Authorization Program targets prescription drugs that are not specialty drugs but do benefit from additional clinical management. This program helps to ensure that Eligible Persons are receiving an appropriate prescription drug for the treatment of specific conditions and in quantities as approved by the U.S. Food and Drug Administration (FDA). If chemotherapy (including oral), infusion therapy, prescription drugs over $5,000, oncology and transplant-related therapy prescription drugs cannot be obtained through Sav-Rx, they must be precertified through the Medical Care Review Program as described in Section 8.15. If you choose to not participate, your prescription drugs will not be covered under the Plan.

4. Step Therapy Program
   The Step Therapy Program requires Eligible Persons to use a more cost-effective prescription drug prior to the approval of a less cost-effective brand name prescription drug. Prescription drugs that qualify for Step Therapy are often high priced and largely

advertised. The goal of the Step Therapy Program is to use the most cost-effective sequence – beginning with Step 1 prescription drugs and moving to Step 2 prescription drugs, based on accepted medical guidelines and standards.

Prescription drug classes that qualify for the Step Therapy Program include, but are not limited to, cholesterol-lowering statins, ARB antihypertensives, SSRI/SNRI antidepressants, oral osteoporosis, migraine, Cox 2 and Non-Steroidal Anti-Inflammatory Agents, steroid nasal sprays, Proton Pump Inhibitors, Beta and Calcium Channel Blockers and Glaucoma Eye Drop. This list is subject to change. If you choose to not participate, your prescription drugs will not be covered under the Plan.

5. Therapeutic Quantity Limits Program
   The Therapeutic Quantity Limits Program ensures proper dosing and dispensing of certain prescription drugs based on FDA and manufacturer's guidelines. The program monitors prescription utilization and helps identify potential overuse or misuse of prescription drugs such as narcotic pain relievers and sedative hypnotics, migraine treatments, respiratory and nasal prescription drugs. If you choose to not participate, your prescription drugs will not be covered under the Plan.

6. Specialty Prescription Drug Program
   "Specialty Prescription Drugs" means a category of drugs created through advances in research, technology and design. They are made up of complex molecules and include bioengineered proteins and blood derivatives. Specialty Prescription Drugs target and treat specific complex conditions or Sicknesses including, but not limited to: cancer, rheumatoid arthritis, multiple sclerosis, hepatitis C and HIV/AIDS.

   The Specialty Prescription Drug Program includes prior authorization and patient assistance for certain specialty prescription drugs and is mandatory. The purpose of this program is to:

   a. ensure that these often high-cost prescription drugs are being prescribed for an appropriate patient and condition at an acceptable dose and quantity, and

   b. ensure that the high-cost prescription drugs are provided through the PBM pricing program only. Certain specialty prescription drugs are required to be obtained through Sav-Rx, the Plan's PBM. Medical buy and bill will not be allowed in the event that you or your provider refuse to participate in this program. Obtaining these specialty prescription drugs through Sav-Rx is the only available option. A list of these certain specialty prescription drugs can be provided by calling the Sav-Rx directly.

7. Mandatory Biosimilar Program
   The Mandatory Biosimilar Program encourages the use of biosimilar prescription drug equivalents whenever available. If the Eligible Person or his Physician requests a brand name prescription drug instead of its biosimilar equivalent, the Eligible Person must submit a Letter of Medical Necessity, written by the Physician, to Sav-Rx, subject to review by Sav-Rx. If you choose to not participate, your prescription drug at issue (with the biosimilar equivalent) will not be covered under the Plan.

E) <u>Covered Prescription Drug Card Expenses</u>

1. All Federal Legend drugs;

2. Self-administered injectables;

3. Syringes for self-administered injectables;

4. Compound medication containing at least one Federal Legend ingredient;

5. Pre-natal vitamins prescribed during pregnancy and other prescribed vitamins;

6. Diabetic supplies available through the Prescription Drug Card Benefit. The cost of such supplies is only payable through this Prescription Drug Card Benefit and will not be payable under any other part of the Plan;

7. Smoking Cessation prescriptions;

8. Weight loss medications:
   The Plan will provide coverage for certain weight loss medications included in the closed formulary for Eligible Persons subject to the following:

   - Mandatory prior authorization review by the Plan's PBM clinical team,
   - Mandatory step therapy clinical review,
   - Closed formulary of medications under this program to include Phentermine, Contrave, Qsymia, Xenical, Saxenda, and Wegovy, and Zepbound,
   - The Eligible Person's initial body mass index (BMI) must be greater than 30 when starting the medication,
   - Mandatory clinical management review with prescribing Physician and patient on regular intervals set by the Plan's PBM clinical team,
   - Copayments will be the same under the current Schedule of Benefits for other prescription benefits, and
   - Corresponding Physician's office visits regarding compliance and efficacy of the prescribed weight loss medication will be covered as a Physician's office visit subject to cost sharing as detailed in the Schedule of Benefits.

F) Exclusions and Limitations

No benefits shall be payable for any of the following:

1. Any prescription filled at Walmart, Walgreens or Sam's Club pharmacies or at certain CVS pharmacies. If you have questions regarding the status of your pharmacy provider, please contact Sav-Rx at (800) 228-3108 or www.savrx.com;

2. The Plan will not pay more for a brand name drug (when a generic equivalent is available) than the Plan would pay for the generic equivalent, unless the Physician or Surgeon indicates "dispense as written" on the prescription and the Plan's PBM determines that the prescription is Medically Necessary, after contacting your Physician or Surgeon. If you wish to purchase the brand name drug when it is not determined to be Medically Necessary, you will be responsible for the brand Copayment plus the cost of the difference between the generic and the brand cost;

3. Investigational or Experimental drugs;

4. Over-the-counter drugs;

5. Over-the-counter vitamins. (prescription vitamins and prescription pre-natal vitamins prescribed during pregnancy are covered);

6. Agents or treatment related to baldness or thinning hair (prescription or over the counter) when used for cosmetic purposes;

7. Fertility drugs;

8. Therapeutic devices or appliances;

9. Any expense incurred for Specialty Prescription Drugs or that are not obtained through the mandatory Specialty Prescription Drug Program as explained in Section 4.12 D 6;

10. Sexual Dysfunction medications, except for with a diagnosis of BPH; or

11. Abortifacients that are not for lethal fetal anomaly.

NOTWITHSTANDING ANY OTHER PLAN PROVISIONS, THE PRESCRIPTION DRUG BENEFIT IS NOT AVAILABLE TO PERSONS ENROLLED IN MEDICARE PART D.

Section 4.13 – Routine Preventive Care Benefit

When an Eligible Person incurs expenses for In-Network covered services as listed below, Benefits will be paid according to the Schedule of Benefits. Out-of-Network services will be paid under the General Medical Benefit and will be subject to the applicable Deductible Amount and cost sharing.

Limitations

The Routine Preventive Care Benefit does not include the cost of physical examinations made in connection with employment or transportation; except that examinations in connection with obtaining or maintaining a Commercial Driver's License (CDL) will be covered for the Eligible Employee and Spouse.

Also, this Benefit does not include physical examinations with a diagnosis other than a well exam (such tests that may be excluded tests under the Routine Preventive Care Benefit *may* be covered under General Medical Benefit in Section 4.04 E9).

Schedule of Routine Preventive Care

Procedure	Benefit
Colorectal Cancer Screening	Age 45 and over: 1 sigmoidoscopy every 5 Plan Years at 100% Age 45 and over: 1 colonoscopy every 5 Plan Years at 100% Age 45 and over: Multi-targeted stool DNA test (Cologuard) every 1-3 years at 100% Otherwise under General Medical Benefit.
Lung Screening by Low-Dose CAT scans	100% age 50-80 with history of smoking
Mammogram (Breast Cancer Screening)	Age 40-49: 1 every 2 Plan Years at 100% Age 50 and over: 1 per Plan Year at 100% Otherwise under General Medical Benefit.
Routine Adult and Childhood Immunizations	100% excluding those required for occupation or vacation travel, as recommended by the Center for Disease Control (age 3 and over).
Routine Cervical Cancer Screening (Pap Smear Test)	1 per Plan Year covered at 100% if performed by your primary care physician or GYN, otherwise under General Medical Benefit. If additional testing is required as a result of a Pap Smear, the additional testing will also be covered under General Medical Benefit
Routine Physical Exam	Age 3 and over, includes all associated lab work: Maximum 1 visit per Plan Year at 100% up to $300, balance under General Medical Benefit. (one additional routine GYN visit will be allowed, subject to the same $300 maximum)
Routine PSA Test (Prostate Cancer Screening)	1 per Plan Year covered at 100%, otherwise under General Medical Benefit.
Well-Child Exam & Immunizations	100% from birth to age 36 months for routine well child visits and all immunizations recommended by the Center for Disease Control.

Section 4.14 – Substance Abuse Benefit

When alcoholism, chemical dependency or substance abuse causes an Eligible Person to incur expenses for inpatient or outpatient treatment at a Hospital or Substance Abuse Treatment Center, the Plan will pay Benefit Claims according to the General Medical Benefit after the Deductible Amount has been met. Substance abuse is also called substance use disorder.

Certain participating Local Unions have an employee assistance program available through the Union at no cost to the Eligible Person.

Please contact your Local Union for more information regarding these programs.

A) <u>Detoxification Services</u>

Treatment for detoxification will be covered if performed in a Hospital or Substance Abuse Treatment Center that is licensed for this level of care, has a Physician on staff and has registered nurses on staff 24/7.

Precertification is required for intensive outpatient programs, partial hospitalization programs and inpatient treatment.

Contact the Fund's medical care review provider, Hines & Associates, Inc. at (800) 559-5257 or visit www.precertcare.com to obtain precertification for the Substance Abuse Benefit or to receive more information regarding this Benefit.

B) Exclusions

Substance Abuse Benefits will not be paid for:

1. Inpatient treatment received at an Out-of-Network facility (unless approved by Medicare) as excluded under Article V - Benefit Exclusions and Limitations.

2. Full panel drug screenings unless deemed Medically Necessary.

C) Clinical Utilization Management Medical Policy Guidelines

Presumptive urine drug testing (UDT) to verify compliance with treatment, identify undisclosed drug use or abuse or evaluate aberrant* behavior is considered Medically Necessary, beginning at the start of treatment, as part of a monitoring program tailored to the unique needs of Eligible Persons who are:

1. Receiving treatment for chronic pain with prescription opioid or other potentially abused medications; or

2. Undergoing treatment for, or monitoring for relapses of, opioid addiction or substance use disorder.

Presumptive UDT is also considered Medically Necessary for the following:

1. To assess an Eligible Person when clinical evaluation suggests use of non-prescribed medications or illegal substances; or

2. On initial entrance into a pain management program or substance use disorder recovery program.

Definitive UDT to verify compliance with treatment, identify undisclosed drug use or abuse or evaluate aberrant* behavior is considered Medically Necessary, beginning at the start of treatment, as part of a monitoring program tailored to the unique needs of Eligible Persons whose requests meet criteria *both* A) and B) below:

A) Testing indications - *either* 1 or 2 below must be present:

    1. Receiving treatment for chronic pain with a prescription opioid or other potentially abused medications; or

    2. Undergoing treatment for, or monitoring for relapses of, opioid addiction or substance use disorder;

and

B) Testing scenarios - *either* 1 or 2 below have been met:

    1. Definitive testing following prior presumptive testing:

        a. The *presumptive* UDT was done for a Medically Necessary reason; and

        b. The *presumptive* test was positive for an illegal drug (for example, but not limited to, methamphetamine or cocaine), positive for a prescription drug

with abuse potential which was not prescribed, or negative for prescribed medications; and

i. The specific *definitive* test(s) ordered are supported by documented rationale for each test ordered; and

ii. Clinical documentation reflects how the results of the test(s) will be used to guide clinical care;

or

2. Definitive testing without prior presumptive testing:

a. *Presumptive* UDTs are not available for the drug in question (examples may include opioids and their metabolites such as fentanyl, meperidine, tramadol and tapentadol; muscle relaxants and their metabolites such as carisoprodol; synthetic cannabinoids and their metabolites; as well as cathinones ["Bath Salts"] and their metabolites); and

b. The specific *definitive* test(s) ordered are supported by documented rationale for each test ordered; and

c. Clinical documentation reflects how the results of the test(s) will be used to guide clinical care.

* Aberrant behavior includes, but is not limited to, lost prescriptions, repeated requests for early refills, prescriptions from multiple providers, unauthorized dose escalation and apparent intoxication.

Section 4.15 – Temporomandibular Joint Dysfunction (TMJ) Benefit

If an Eligible Person incurs expenses in conjunction with temporomandibular joint dysfunction (TMJ), the Plan will pay Benefit Claims according to the Schedule of Benefits, up to a lifetime limit of $1,500 per person after the Deductible Amount has been met. Treatment of TMJ includes services associated with TMJ, excluding services considered dental in nature (such as modification or moving of teeth using crowns, bridges, dentures or braces).

Section 4.16 – Transplant Benefit

If an Eligible Person incurs expenses in conjunction with a Medically Necessary organ, tissue, or body part transplant, the Plan will pay Benefit Claims under the General Medical Benefit, after the Deductible Amounts have been met as follows:

A) <u>Hospital and Surgery Transplant Recipient Benefit</u>

Covered transplant expenses include the following:

1. The use of temporary mechanical equipment, pending the acquisition of a matched human body part, tissue or organ.

2. Multiple transplants during one operative session.

3. Replacement or subsequent transplants.

Hospital and surgery transplant recipient Benefits begin on the day evaluation starts and end when discharged from the Hospital and/or acute rehabilitation facility.

B) Second Opinion

A second opinion may be obtained prior to the transplant procedure. The second opinion must be rendered by a Physician who is:

1. Qualified to give such an opinion either through experience, specialist training or education; and

2. Not affiliated in any way with the Physician who will perform the actual transplant surgery.

C) Transplant Follow-up Expense Benefit

Charges for routine after-care of the transplant recipient will be covered, including but not limited to immune suppressant therapy and Physician's visits.

D) Transplant Donor Benefit

When the transplant recipient is covered by the Plan, charges for the following expenses of the transplant donor will be covered:

1. Testing to identify a suitable donor(s);

2. Expenses for the acquisition of body organ(s)/tissue(s) from the donor(s);

3. Expenses for life support of a donor(s) pending the removal of a usable body organ(s)/tissue(s); and

4. Transportation of a body organ(s)/tissue(s) or a donor(s) on life support.

E) Limitations

Transplant Donor Benefits are contingent upon the recipient being covered by the Plan. The Transplant Donor Benefit does not apply when the donor, but not the recipient, is covered by the Plan. In the event both the donor and recipient are covered by the Plan, the Benefit Claims payable and the applicable limits are Benefits for and Limits of the recipient, not the donor.

Services and supplies for the donor when donor benefits are available through Other Group coverage (see Section 8.11 – Coordination of Benefits) will not exceed 100% of Covered Expenses.

Contact the Fund's medical care review provider, Hines & Associates, Inc. at (800) 559-5257 or www.precertcare.com to obtain precertification for transplant benefits or to receive more information regarding this Benefit.

F) Transplant Benefit Exclusions

Notwithstanding anything to the contrary in this Plan, the Plan does not cover the following expenses:

1. Experimental services or supplies.

2. Expenses when government funding of any kind is provided.

3. Lodging, food or transportation cost.

4. Recipient, donor and procurement services and costs incurred outside the United States.

5. Any animal organ or tissue or mechanical device or equipment that is not considered Medically Necessary as determined by the Plan.

Section 4.17 – Member Assistance Program (MAP)

The Trustees have implemented a program to provide professional consultations for a variety of problems that may affect your personal well-being and your job performance. There are many services available to you, and they are provided at no cost. This program is called AllOne Health and is available to all Participants and members of their household.

Accessing the AllOne Health MAP Program

To access the AllOne Health MAP program, Participants and members of their household may call in by phone or visit the internet portal 24 hours a day, seven days a week.

- Call the program's toll-free number at (800) 456-6327
- For web-based services, visit perspectivesltd.com. The username is: **INLAB** and the password is: **Perspectives**

AllOne Health Counseling Services

AllOne Health Case Managers, all of whom are licensed masters- or doctorate-level behavioral health clinicians, are available to assist with a variety of concerns, including (but not limited to):

- Alcohol/Addictions/ Abuse
- Anger
- Budgeting
- Child Custody
- Depression
- Family Issues
- Grief/Loss
- Mood Swings
- Parenting
- Relationship Issues
- Stress
- Work-Life Balance

At the time of the initial call, the AllOne Health Case Manager will gather some preliminary information and assess your situation. After the assessment, the Case Manager will then coordinate an appointment for you to meet with a local counselor, who will work with you to develop a solution-focused plan of action. Short-term counseling, **up to eight sessions** per issue, can be provided by the counselor to assist in resolving the problem. If long-term or specialized care is indicated during either the assessment or through the course of face-to-face counseling, a referral will be made to a resource or facility that meets your needs. The AllOne Health MAP will coordinate with this Plan and make every effort to provide referrals to treatment providers within the PPO Network. If these referrals are necessary, the objective is to recommend the most appropriate level of care for your unique situation.

AllOne Health Legal and Financial Services

AllOne Health Legal and Financial Services provides a cost-effective solution to help Participants and members of their household who have legal concerns. The program provides you with phone access to specialists who can help you understand your options and point you in the right direction for the help you need. If you do require an attorney, you will be given a referral to their network that includes a FREE 30-minute consultation and 25% reduction in attorney's fees. The following services are included in the AllOne Health Legal and Financial Services program:

- College Planning
- Debt Counseling
- Retirement Planning
- Separation/Divorce
- Tax Consultation
- Will Preparation

AllOne Health WorkLife Online

AllOne Health WorkLife Online provides Participants and members of their household with online access to services that help with various areas of life and productivity. The following services are included in AllOne Health WorkLife Online:

- Career Development/ Training
- Elder Care/ Child Care
- Financial Calculators
- Legal Forms
- Self-Assessments

AllOne Health WorkLife Services AllOne Health WorkLife Services provides Participants and members of their household with access to the relocation center and FREE phone consultations with specialists who assist families with child and eldercare issues, as well as convenience services. Our national network of pre-screened child and eldercare providers offer a time-saving service for you and the people you care about. The following services are included in AllOne Health WorkLife Services:

- Adoption
- Day Care
- Nursing Home Care
- Pet Services
- Summer Camps

AllOne Health SPARK Mobile Application
Available on most smart phone and tablet devices, SPARK provides Participants and members of their household with mobile access to secure and confidential counseling, as well as helpful resources on a number of wellbeing and productivity-related topics. The application also contains a summary of Indiana Laborers Welfare Fund's MAP, as well as the ability to connect immediately with one of AllOne Health's licensed and experienced behavioral health clinicians.

Section 4.18 – Teladoc Online Physician Visit Benefit
The Teladoc Online Physician Visit Benefit can be accessed at www.teladochealth.com.

Teladoc Health is a virtual healthcare service that offers convenient, confidential access to U.S. board-certified, licensed providers for 24/7 urgent care, dermatology, or behavioral health visits. By scheduling a visit with a Teladoc Health provider you may be diagnosed, treated, and prescribed medication if necessary.

This Benefit is not meant for emergency situations, but it can help in deciding whether a medical situation is an emergency. Benefits for Teladoc Online Physician Visits are payable according to the Schedule of Benefits. If you need technical assistance, you can call toll-free at 800-835-2362.

Section 4.19 – Wig Benefit
When an Eligible Person incurs expenses for a wig, the Plan will pay Benefits according to the Schedule of Benefits for one wig, up to an annual Plan Year limit of $2,000 in Benefits per Eligible Person. The wig must be prescribed by a Physician as a prosthetic for hair loss due to the following injuries or diseases, or due to treatment of the following diseases:

- Burns resulting in permanent alopecia;
- Lupus;
- Alopecia areata, alopecia totalis, alopecia universalis;
- Fungal infections not responding to a course of anti-fungal treatment resulting in complete cranial hair loss;
- Chemotherapy;
- Radiation therapy.

A wig or hairpiece for the diagnosis of androgenetic alopecia (male pattern baldness) is not covered on the basis that this is not considered to be a medical diagnosis.

Section 4.20 – Sword Health Digital Physical Therapy Benefit

Sword Health is a digital physical therapy Benefit provided to Eligible Persons age 13 and older, at no cost. The program helps prevent and treat acute, chronic and post-surgical pain. Sword provides treatment for all musculoskeletal issues, including pain in the back, shoulder, neck, hip, knee, elbow, ankle and wrist. Every Sword kit includes a tablet, motion sensors, and access to a digital physical therapy program with support from a real physical therapist. You get to keep your Sword kit as long as you use it. To get started, visit join.swordhealth.com/indianalaborers/register.

Section 4.21 – Hello Heart

Hello Heart is a blood pressure tracking Benefit provided to you at no cost. Services also include cholesterol management and menopause management. Eligible Persons who meet certain criteria age 18 and older can track their blood pressure with an easy-to-use phone app and device sent to you. Sign up at https://join.helloheart.com/ILWF97.

ARTICLE V – BENEFIT EXCLUSIONS & LIMITATIONS

The Plan provides Benefits only for those Medically Necessary covered services and charges expressly described in the Plan. **Any omission of service or charge shall be presumed to be an exclusion even though not expressly stated as such.** Exclusions, including complications from excluded services, supplies or equipment are not considered covered expenses and will not be payable, except when required to be covered under federal law, including the Consolidated Appropriations Act of 2021 (CAA).

IF YOU ARE UNSURE WHETHER A MEDICAL SERVICE OR PROCEDURE IS COVERED, PLEASE CONTACT THE FUND OFFICE FOR CLARIFICATION. FAILURE TO DO SO COULD RESULT IN YOU BEING RESPONSIBLE FOR ANY NON-COVERED OR EXCLUDED CHARGES YOU INCUR.

In addition to any other limitations, either specific or general, set forth in the Plan, Benefits are **NOT** payable for any loss caused by, incurred for or resulting from:

1. Treatment, services or supplies that are not Medically Necessary, unless specifically covered under the Plan;

2. All charges in excess of the Usual, Customary and Reasonable Charge;

3. Cosmetic or reconstructive surgery or any complications resulting from those surgeries, except: 1) to repair damage caused by or a result of an accident; 2) to repair a Medically Necessary congenital defect; 3) for reconstruction of a breast on which a mastectomy has been performed; 4) for surgery and reconstruction of the non-diseased breast to produce a symmetrical appearance; 5) for coverage for prostheses; and, 6) for physical complications of all states of mastectomy (including lymph edemas) in a manner determined in consultation with the attending Physician and the patient;

4. Duplicative charges for the same service or supply where two or more surgical operations are done through the same incision or during the same operative session;

5. Non-prescription drugs or over-the-counter drugs and medications, even though prescribed by a Physician;

6. Expenses incurred for elective abortions, using drugs, devices, methods or procedures, including, but not limited to, RU-486 or surgical abortions and all related expenses (except in the event of a lethal fetal anomaly);

7. Treatment, services or supplies which are considered Experimental (see Article XI for definitions) or which are not provided in accordance with generally accepted professional medical standards;

8. Expenses incurred for the diagnosis or treatment of fertility or infertility or promotion of fertility including (but not limited to) fertility tests and procedures, reversal of surgical sterilization and any attempts to cause pregnancy by hormone therapy, artificial insemination, in vitro fertilization and embryo transfer or any other treatment or method;

9. Injury or Sickness which arises out of or occurs in the course of any occupation or employment for wage or profit or which would entitle the individual to benefits under a Worker's Compensation or occupational disease law; except under the Loss of Time (Short-Term Disability) Benefits portion of the Plan as provided in Section 4.03 and under the Life Insurance portion of the Plan as described in Section 4.01;

10. Injuries or Sicknesses suffered or contracted while in the Armed Forces of any country;

11. Injuries or Sicknesses suffered or contracted due to war or any act of war, declared or undeclared;

12. Expenses incurred during confinement in a Hospital owned and operated by the United States government, except as otherwise required by law;

13. Treatment, services or supplies furnished by or under the direction of the United States government or any of its agencies, including the U.S. Department of Veterans Affairs, unless otherwise required by law;

14. Treatment, services or supplies provided outside the United States of America, except for Emergencies;

15. Housekeeping or Custodial Care, regardless of where or by whom provided;

16. Developmental Care, as defined in this Plan, regardless of where or by whom provided, except as otherwise provided by the Plan;

17. Expenses incurred for sexual transformation or treatments related to sexual dysfunction or complications arising from treatment of these conditions (prescription drugs for treatment of BPH may be covered; see the Prescription Drug Section of this document);

18. Expenses related to disorders not covered by the Plan;

19. Expenses incurred primarily for the Eligible Person's education, training or development of skills needed to cope with an Injury or Sickness, except as provided by the Plan;

20. Expenses incurred for acupuncture; except when used in lieu of an anesthetic agent for covered surgery;

21. Personal hygiene and convenience items (for convenience of the Eligible Person, their family, caretaker, Physician or other medical provider), such as but not limited to, air conditioners, humidifiers, hot tubs or whirlpools, sunbeds, saunas, steambaths, waterbeds, physical fitness equipment or like items, health club or country club memberships or services by a masseuse or massage therapist, even though a Physician may prescribe them;

22. Charges for failure to keep a scheduled appointment, completion of a claim form or to obtain medical records or other information;

23. Expenses incurred from breast augmentation or reduction which is not associated with cancer of the breast or another Medically Necessary condition, or complications arising from these procedures;

24. Except for Class A, expenses incurred for Maternity and Newborn Care;

25. Maternity expenses incurred by dependent children;

26. Newborn Care expenses or any expense incurred by a child born to, adopted by or placed for adoption with dependent children;

27. An Injury or Sickness which arises out of or in the course of any incident involving a third party where a third party may be liable for the Injury, except as allowed by the Plan's subrogation procedures;

28. Expenses incurred for routine physicals, pre-marital examinations, screenings, studies, checkups or preventive inoculations except as provided by the Plan;

29. Eye exams, refractions or fitting of eyeglasses or cost of visual aids, radial keratotomy or similar surgery done in treating myopia, except for corneal graft (except as allowed under Eye Care Benefit);

30. Any treatment of obesity (including, but not limited to, weight loss surgery or any complications arising from weight loss surgery) or loss, expense or charge which results from appetite control, food addictions, eating disorders (except for documented cases of bulimia or anorexia that meet standard diagnostic criteria as determined by the Board of Trustees and present significant symptomatic medical problems) except as otherwise provided by the Plan. This exclusion does not include treatment for complications arising from a previous weight loss surgery that was covered under the Plan at the time of the original surgery;

31. Dental treatment, except as expressly provided in Section 4.04 E7 or in Section 4.06;

32. Expenses incurred for relationship counseling;

33. Injury, Sickness, treatment or expenses incurred from or occurring during an attempt to commit or the commission of a misdemeanor or felony or the willful participation in a public disturbance or riot and as a direct result of driving while legally impaired, whether or not court-ordered Notwithstanding the foregoing, inpatient or outpatient treatment at a Hospital or Substance Abuse Treatment Center may be covered provided the services are Medically Necessary for the treatment of alcoholism, chemical dependency or substance abuse and would otherwise be covered under the Plan's Section 4.14- Substance Abuse Benefit. HIPAA nondiscrimination provisions do not allow a plan to exclude benefits otherwise provided for treatment of an injury if the injury results from an act of domestic violence or a medical condition. See 29 CFR 2590.702(b)(2)(iii);

34. Expenses incurred for diabetic supplies purchased without using the Prescription Drug Card Benefit when such supplies are available under the Prescription Drug Card Benefit;

35. Weekend (Friday, Saturday or Sunday) Hospital admissions unless due to a medical Emergency or when surgery is scheduled for the following day, or unless Medically Necessary;

36. Expenses incurred for Specialty Prescription Drugs that are not obtained through the Mandatory Specialty Prescription Drug Program;

37. Expenses incurred for a work hardening program which is an individualized treatment program designed to maximize a person's ability to return to work;

38. Maternity charges incurred by an Eligible Person acting as a surrogate mother are not Covered Charges. For the purpose of this Plan, "surrogacy" means that the mother has entered into a contract or other understanding pursuant to which she relinquishes a child or children following birth. All expenses paid by the Plan in such cases may be recovered from the Participant, the Participant's spouse and/or the third party or any related parties. Care, services or treatments required as a result of complications from a surrogate pregnancy by the Participant or Participant's Spouse will not be covered under the Plan;

39. Medical expenses incurred for services provided by a provider or facility that is not properly licensed under state and federal law, if applicable, to provide the services rendered;

40. Services, supplies or treatment required as a result of complications from a medical procedure or treatment not covered by the Plan;

41. Any services, supplies or treatment provided by the following:
    a. Dr. Behzad Aalaei or other providers within any practice associated with Dr. Behzad Aalaei; and
    b. Any additional specific providers which may be added from time to time;

42. Any inpatient services, supplies or treatment provided by an Out-of-Network residential treatment facility or skilled nursing facility;

43. When related to Substance Abuse Benefits and Chronic Pain Management, full panel drug screenings unless deemed Medically Necessary;

44. Gene therapy, including any services, supplies and/or drugs related to gene therapy; and

45. Expenses incurred for breast pumps or breast pump parts.

ARTICLE VI – SENIOR MEMBER PROGRAM

(Classes AS, C, CP AND D)

The following topics are discussed under this Article on Senior Member Program:

Section 6.01 – Eligibility to Participate in Senior Member Program

Each Participant who ceases active employment due to retirement or Long-Term Disability (as defined in Article XI) will be eligible to register in this portion of the Plan,

A) provided contributions have been made on the Participant's behalf by Employers to the Trust Fund or the Participant has made Self-Payments to the Trust Fund for a period of not less than five years immediately preceding the request for Senior Benefits and the Participant has been eligible for at least five Coverage Periods under the Plan during the same five-year period and –

   1. the Participant has a Long-Term Disability and is currently receiving or previously received a pension benefit from the Indiana Laborers Pension Fund, the Industrial Pension Fund for Indiana Quarry Workers or the Construction Workers Pension Trust Fund; or

   2. the Participant is receiving either a disability or retirement benefit from the Social Security Administration; or

   3. the Participant is receiving a pension benefit under the terms of the applicable pension plan of an Employer.

   Or

B) notwithstanding the above, if a Participant becomes Totally Disabled and exhausts the Total Self-Payments option in Section 3.04 B, the Participant will become eligible under the Senior Member Program, upon approval of the Administrative Manager.

A Participant is not eligible for the Senior Member Program while working in the construction industry for an employer that does not have a contractual obligation to contribute to the Trust Fund ("non-signatory employer").

Section 6.02 – Termination of Eligibility in Senior Member Program

A Retiree or Totally Disabled Participant who becomes eligible to participate under this portion of the Plan will remain eligible to participate until 1) the date that individual fails to make a timely

Self-Payment for coverage, 2) works in the construction industry for an employer that does not have a contractual obligation to contribute to the Trust Fund ("non-signatory employer"), or 3) the end of the month in which the Senior Member dies.

A Retiree or Totally Disabled Participant who fails to make a timely Self-Payment for coverage may only again participate in the Plan by returning to active work and meeting the requirements for initial eligibility as set forth in Section 3.02.

A Dependent who is covered under this portion of the Plan shall remain covered until the earlier of –

A) The last day of the month in which the Retiree or Totally Disabled Participant elects (1) a Senior Member-only or (2) Senior Member and Spouse or named Dependent(s) coverage type that does not cover the applicable Dependent,

B) The last day of the month in which the individual no longer qualifies as a Dependent, or

C) The last day of the month in which the Retiree or Totally Disabled Participant ceases to be covered by the Plan.

In addition, coverage shall terminate the day the Retiree or Totally Disabled Participant, without authorization from the Union, works in the construction industry for an employer that does not have a contractual obligation to contribute to the Trust Fund ("non-signatory employer"). If a Retiree or Totally Disabled Participant works for a non-signatory employer without first notifying the Fund Office, coverage will be terminated effective the day the Fund Office finds out about such work. Please contact the Fund Office if you are considering a return to work in any position related to the construction industry.

Section 6.03 – Registration in the Senior Member Program

A Retiree or Totally Disabled Participant who meets the eligibility requirements set forth in Section 6.01 must register for coverage by completing the Plan selection for the appropriate Class under this portion of the Plan.

A Retiree or Totally Disabled Participant must complete the Plan selection form and return it to the Fund Office any time during the 90-day period immediately following the earlier of –

1. His Long-Term Total Disability or retirement, or

2. The termination of his Class A coverage.

A) <u>Class CP</u>
Once a Medicare-eligible Retiree or Totally Disabled Participant is enrolled, they may contact the MAPD Advocacy team using the contact information listed in Section 9.15.

B) <u>Tier Selection at Time of Registration</u>
Upon approval of eligibility for the Senior Member Program, the Retiree or Totally Disabled Participant must elect one of the following tiers of coverage:

1. Member-only – which tier will provide coverage only for the Retiree or the Totally Disabled Participant; or

2. Member and Spouse – which tier will provide coverage only for the Retiree or Totally Disabled Participant and his Spouse; or

3. Member and family – which tier will provide coverage for the Retiree or Totally Disabled Participant, his Spouse (if any) and any Dependent(s) registered as required by this program.

C) No Late Registration

If a Retiree or Totally Disabled Participant does not register during the 90-day period, that individual shall not be allowed to register at any later date except by returning to active employment and meeting the requirements for initial eligibility as set forth in Section 3.02.

D) Self-Payment Cost

The cost of Self-Payment will vary according to the class and tier of coverage elected. A schedule of Self-Payment rates, which may be amended from time to time, is maintained by the Fund Office. See also Section 6.06 – Senior Member Program Self-Payment Subsidy.

E) Changes to Coverage After Registration

Except as described in the paragraphs below, the election made at the time of registration is a one-time election. Changes in future circumstances, such as an individual no longer qualifying as a Dependent or Spouse, will trigger an automatic reduction in tier coverage type. However, except as described in the paragraph below, in no event shall the coverage tier be increased to cover additional dependents from the coverage elected during the one-time election period. In addition, unless otherwise allowed in this Plan, the Spouse or Dependent of a Retiree or Totally Disabled Participant who is not covered after this one-time election or the coverage change allowable under the next paragraphs shall not be eligible for survivor Benefits under Article VII – Surviving Spouse Program.

Retirees and Totally Disabled Participants have 30 days after a life event (marriage, adoption, etc.) to add a Dependent, unless the life event is the birth of a child. If a Retiree or Totally Disabled Participant has a child, that child must be added as a Dependent within 120 days of the child's birth. If the new Dependent is added in a timely manner, the new Dependent will be eligible effective the date of the life event. If a Dependent is not added in a timely manner (more than 30 days after the life event or more than 120 days after birth), the new Dependent will not be eligible for coverage under the Plan, and the benefit coverage type cannot be changed.

In addition, if a Retiree or Totally Disabled Participant registers for the Senior Member Program and has a Spouse or Dependent who is otherwise eligible for coverage under the terms of the Senior Member Program at that time, but declines coverage due to being covered by another health plan, including having Active coverage under this Plan, such Spouse or Dependent may be added to the Senior Member Program if requested by the covered Retiree or Totally Disabled Participant not later than 30 days after the Spouse or Dependent's loss of coverage under the other plan, and if the Spouse or Dependent provides proof of coverage under another health plan that lasted the duration of time of the Retiree's or Totally Disabled Participant's coverage under this portion of the Plan.

Notwithstanding the foregoing, a Retiree or Totally Disabled Participant who drops this Plan's prescription drug coverage to enroll in Medicare Part D prescription drug coverage shall be allowed to terminate the Part D coverage and to re-elect this Plan's prescription drug coverage

once, but only if the Retiree or Totally Disabled Participant re-elects this Plan's prescription drug coverage within two years of first enrolling in Part D coverage.

Section 6.04 – Transfers from Class A Coverage to Senior Member Program

A Retiree may maintain his eligibility for a full Schedule of Benefits, excluding Loss of Time (Short-Term Disability) Benefits, as provided in the Class A Schedule of Benefits, until the look back for continued eligibility in previous, consecutive Qualification Periods, as explained in Section 3.03, is exhausted. In addition, a Retiree (but not a former Participant who terminates service with an Employer for other reasons) or Totally Disabled Participant may transfer to the Senior Member Program (including the Life Insurance portion of the Plan and, in some cases, the Accidental Death and Dismemberment Insurance portion of the Plan, as described in Section 4.02) within 90 days after either the expiration of coverage under Class A or the date of total disability or retirement (whichever is later). However, such Retiree or Totally Disabled Participant may not transfer from the Senior Member Program back to Class A unless that individual returns to work and again meets the requirements for initial eligibility set forth in Section 3.02. Self-Payments for the Senior Member Program are described in Section 6.05.

Benefits shall be payable under this Plan for covered items or services furnished under this Plan without regard to an Eligible Person's entitlement or potential entitlement to Medicare if such individual is covered by the Plan as a Retiree or Totally Disabled Participant who maintains enough hours for continued eligibility (Class A coverage) as explained in Section 3.03 for periods in which the Retiree or Totally Disabled Participant is considered to have current employment status. Such Retiree or Totally Disabled Participant will be deemed to have current employment status as this term is defined under Medicare secondary payer regulations. Subject to the Coordination of Benefits provisions, Plan Benefits shall be payable primary to Medicare.

Plan Coordination of Benefits under this Section 6.04 will terminate for Class A (and the Plan shall pay secondary to Medicare) upon exhaustion of the Retiree's or Totally Disabled Participant's hours worked or exhaustion of self-payments if he no longer meets continued eligibility requirements as explained in Section 3.03.

Section 6.05 – Timing of Senior Member Program Self-Payments

A Retiree or Totally Disabled Participant may make Self-Payments for the Senior Member Program in an amount determined by the Board of Trustees, payable in advance. Self-Payments for the Senior Member Program portion of the Plan shall be due by the last day of the month preceding the first month of the next Coverage Period (March 31, July 31 and November 30). Payments not postmarked by the 10th day of the first month of the Coverage Period will not be accepted and coverage will be terminated. Retirees or Totally Disabled Participants may exhaust their look-back hours for up to two Coverage Periods before Self-Payments are required. In the case of termination, the Retiree or Totally Disabled Participant may only again participate in the Plan by returning to active work and meeting the requirements for initial eligibility set forth in Section 3.02. Self-Payments for coverage in the Senior Member Program may be deducted from the monthly pension check if the Retiree, Totally Disabled Participant or Spouse is receiving a pension from the Indiana Laborers Pension Fund or Construction Workers Pension Trust Fund.

Section 6.06 – Senior Member Program Self-Payment Subsidy

The Plan will subsidize the cost of the Senior Member Program at a rate of 2.33% for each year of service in the Indiana Laborers Pension Fund and/or Construction Workers Pension Trust Fund, Industrial Pension Fund and Quarry Workers Pension Fund up to a maximum of 30 years of service for a maximum of a 70% subsidy. A Retiree or Totally Disabled Participant will make a Self-Payment for the difference between the subsidized cost and the total cost of coverage. The

total cost of coverage will vary according to the class and Dependent coverage elected at the time of registration. A schedule of costs, which may be amended from time to time, is maintained by the Fund Office.

Section 6.07 – Opt Out of Senior Member Program

A Retiree or Totally Disabled Participant may opt out of the Senior Program if the Retiree provides the Board proof that the Retiree's Spouse has Active coverage in the Plan based on the Spouse's employment with a contributing employer under the Plan. This opt-out option is offered only once after the Participant retires or is Totally Disabled. The Participant may opt back into the Senior Member Program at his/her subsidy level with a qualifying event (i.e., once the Participant's Spouse either retires or is no longer an Active participant in the Plan). When the Participant returns to the Senior Member Program, he or she must have continuous creditable coverage under this Plan, or Medicare's Late Enrollment Penalties will apply. Participants must sign an acknowledgment of these return to coverage requirements.

ARTICLE VII – SURVIVING SPOUSE PROGRAM

(CLASS S or the Election of CLASS C, CP or D)

The following topics are discussed under this Article on Surviving Spouse Program:

Section 7.01 – Survivor Election

In lieu of Continuation Coverage under COBRA, as explained in Section 3.06, the Surviving Spouse of a Participant, Retiree or Totally Disabled Participant may elect to continue coverage for himself or herself and the Dependent children of the deceased Participant, Retiree or Totally Disabled Participant, on a Self-Payment basis –

A) if eligible for Medicare, the survivor may elect Class C, CP or D coverage, or

B) if not eligible for Medicare, the survivor may elect Class S coverage.

If there is no Surviving Spouse at the time of death, Dependents shall be ineligible for coverage except as allowed under COBRA.

Survivor Benefits under Class C, CP, D or S will cease for a surviving Dependent if the Self-Payments cease (or are late) or if the surviving Dependent becomes covered under another group health plan.

Notwithstanding anything to the contrary in this Plan, the Spouse or Dependent of a Retiree or Totally Disabled Participant who is not covered after the one-time election of a coverage change allowable under Section 6.03 E shall not be eligible for Survivor Benefits under this Article VII upon the death of the Retiree or Totally Disabled Participant.

Eligibility for Survivor Benefits begins immediately upon termination of Benefit coverage due to the Employee's, Retiree's or Totally Disabled Participant's death. A Surviving Spouse must elect coverage for themselves and the Participant's Dependents within 60 days after the last day of the month in which the Participant dies. For example, if a Participant dies on July 15, the Surviving Spouse has 60 days after July 31 to make their election.

Section 7.02 – Class S Benefits

Class S Benefits are the same as Class A Benefits, but will not include Maternity and Newborn Care Benefits, Loss of Time (Short-Term Disability) Benefits, Life Insurance Benefits or Accidental Death and Dismemberment Insurance Benefits.

In the event that a Class S surviving Spouse is eligible to receive Medicare disability benefits, then such Spouse must transfer to Class C, Class CP or Class D.

Class S coverage will cease for a surviving Spouse and Dependents if:

A) Self-Payments cease (or are late); or

B) The Surviving Spouse becomes covered under another group health plan; or

C) The Surviving Spouse becomes eligible for Medicare and does not transfer to Class C, Class D or Class CP.

The Dependents who may be eligible for Survivor Benefits (Class S) coverage are listed in Section 1.04.

Section 7.03 – Timing of Surviving Spouse Self-Payments

A Surviving Spouse may make Self-Payments for Surviving Spouse Benefits in an amount determined by the Board of Trustees, payable in advance. Self-Payments for the Surviving Spouse portion of the Plan shall be due by the last day of the month preceding the first month of the next Coverage Period (March 31, July 31 and November 30). Payments not postmarked by the 10th day of the month of the Coverage Period will not be accepted and coverage will be terminated.

Section 7.04 – Surviving Spouse Self-Payment Subsidy

The subsidy applicable to the Participant for the Senior Member Program as described in Section 6.06 will also be applied to a Surviving Spouse who elects Class S Benefits or elects to continue in Class C, CP or D. Once a Surviving Spouse elects coverage, they may choose a lower tier of coverage in the future but can never increase coverage.

The Plan subsidy is at a rate of 2.33% for each year of service in the Indiana Laborers Pension Fund and/or Construction Workers Pension Trust Fund up to a maximum 70% subsidy. The Surviving Spouse will make a Self-Payment for the difference between the subsidized cost and the total cost of coverage. The total cost of coverage will vary according to the class and tier of coverage elected at the time of registration. A schedule of costs, which may be amended from time to time, is maintained by the Fund Office.

ARTICLE VIII – MISCELLANEOUS PROVISIONS

The following topics are discussed under this Article on Miscellaneous Provisions:

Section 8.01 – Notice of Address

Each person entitled to benefits under any portion of this Plan must notify the Plan of his mailing address and each change of mailing address to the Fund Office. Since all communication, statements or notices are mailed to the address on file with the Fund Office, it is important to keep your address updated to receive all important communication. You may notify the Plan in writing or by calling the Fund Office.

Section 8.02 – Delegation of Authority

The Board of Trustees may appoint one or more persons, including, but not limited to, attorneys, auditors, preferred provider organizations, investment managers, consultants, utilization review firms or other qualified entities and delegate such of its power and duties as it deems desirable to any such persons. Any reference herein made to the Board of Trustees shall be deemed to mean or include those persons also as to matters within their jurisdiction, whether or not a specific reference to delegation is made herein.

Section 8.03 – Procedures to Submit a Benefit Claim

These procedures apply to all Classes except medical and prescription coverage for Class CP. Please refer to Appendix A for procedures that apply to medical and prescription coverage for Class CP.

This Section 8.03 discusses the procedures to be followed to submit a Benefit Claim from the time the Benefit Claim is incurred through the time of the Board of Trustees' decision with respect to the Benefit Claim. If the Benefit Claim is denied, Section 8.04 provides the procedures to appeal the Board's Benefit Claim Denial.

How to Submit a Benefit Claim

In-Network Providers
If an Eligible Person utilizes an In-Network provider, in most cases, the In-Network provider will submit Benefit Claims electronically to the appropriate PPO Network.

Out-of-Network Providers
If an Eligible Person utilizes an Out-of-Network provider, you may need to file your own Benefit Claim with the Fund Office.

To File Your Own Benefit Claim
All Eligible Persons making a Benefit Claim must submit any required forms to the Board of Trustees or its designated agent. Required forms include documents, evidence or information, written in English, as the Board of Trustees or its designated agent considers necessary or desirable for the purpose of reviewing the Benefit Claim. Such Benefit Claims must be submitted no later than 18 months from the date the Benefit Claim was incurred; provided, however, that in the case of Benefit Claims coordinated with Medicare or with any Other Group Plan (as defined in Section 8.11), the Benefit Claim must be submitted no later than 18 months from the date the primary payer paid the Benefit Claim.

Each Eligible Person making a Benefit Claim must furnish such information promptly and sign such documents as the Board of Trustees or its designated agent may require before any Benefit Claims become payable.

Once you file a Benefit Claim, the Board of Trustees will review in accordance with the appropriate time frames below to determine if the Benefit Claim is payable under the Plan. You will receive a Notification of the determination.

Definitions Related to Benefit Claims
The following terms are applicable to the procedures which apply to the determination of a Benefit Claim and shall have the meanings set forth below.

Benefit Claim Denial
A **"Benefit Claim Denial"** means any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a Benefit, including any such denial, reduction, termination or failure to provide or make payment that is based on a determination of an Eligible Person's or Beneficiary's eligibility to participate in a Plan, including, a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a Benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which Benefits are otherwise provided because it is determined to be Experimental or not Medically Necessary or appropriate, or for any other reason that the Benefit Claim is not covered by the Plan.

Claim Involving Urgent Care
A **"Claim Involving Urgent Care"** is any Pre-Service Benefit Claim for medical care or treatment with respect to which the application of the time periods for making *non-**urgent care*** determinations –

A) Could seriously jeopardize the life or health of the Claimant or the ability of the Claimant to regain maximum function, or,

B) In the opinion of a Physician with knowledge of the Claimant's medical condition, would subject the Claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the Benefit Claim.

Whether a Benefit Claim is a "Claim Involving Urgent Care" is to be determined by an individual acting on behalf of the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. Except, any Benefit Claim that a Physician with knowledge of the Claimant's medical condition determines is a "**Claim Involving Urgent Care**" within the meaning of this Section shall be treated as a "**Claim Involving Urgent Care**" for purposes of this Section.

Claimant
A **"Claimant"** means the Eligible Person. In the event of a Benefit Claim Denial, the term "Claimant" also includes a provider when authorized by the Eligible Person and approved by the Board of Trustees according to Section 8.05. Unless it is a Claim Involving Urgent Care, this authorization must be in writing to the Fund Office.

Notice Or Notification
A **"Notice"** or **"Notification"** means the delivery or furnishing of information to an Eligible Person in a manner that satisfies the standards according to law, with respect to material required to be furnished or made available to an Eligible Person. In the case of Benefit Claims, the Board of Trustees will send an Eligible Person a Notification regarding the determination of the Benefit Claim. This Notification is usually called an "Explanation of Benefits."

Pre-Service Claim
The term **"Pre-Service Claim"** means any Benefit Claim for which the terms of the Plan require that the services a Claimant will receive be reviewed by the Plan or its designated agent prior to the Claimant receiving said services in order for the services received to be an approved Benefit Claim, in whole or in part. A Pre-Service Claim may be urgent or non-urgent.

Post-Service Claim
The term **"Post-Service Claim"** means any Benefit Claim under the Plan that is not a Pre-Service Claim.

Concurrent Care
The term **"Concurrent Care"** means a previously approved course of treatment that occurs over a period of time or a number of treatments.

Types of Benefit Claims
This Plan processes Benefit Claims for the following types of Benefits:

- Medical Benefit Claims (General Medical, Chiropractic, Dental, Diabetes, Hospice, Mental and Nervous Disorder, Prescription Drugs, Routine Preventive Care, Substance Abuse, TMJ, Transplant, Vision, Wig)
- Loss of Time (Short-Term Disability) Benefit Claims
- Other Benefit Claims (Life Insurance, Accidental Death and Dismemberment)

Each type of Benefit Claim has different time requirements to process and to send a Notification to the Claimant of the determination. The table below provides the timing and manner of Medical Benefit Claim Determinations. Please see the subsection above titled "Definitions Related to Benefit Claims" to better understand some of the terms used in this Section.

Medical Benefit Claims
Federal claims regulations categorize all Medical Benefit Claims into Pre-Service Claims (urgent and non-urgent), Concurrent Care Claims, Post-Service Claims and Disability Claims. The Board of Trustees (or the Board's designated agent) has different time frames to make a decision on the different types of Benefit Claims. The table below summarizes these time frames.

<table>
<tr><th>Time Limits</th><th colspan="5">Type of Benefit Claim</th></tr>
<tr><th>THE LISTED ACTION MUST OCCUR WITHIN THESE TIME LIMITS</th><th>Urgent health care</th><th>Concurrent care (Preapproved course of treatment)</th><th>Pre-service health care (non-urgent)</th><th>Post-service health care</th><th>Loss of Time (Short-Term Disability)</th></tr>
<tr><td>For Plan to make initial Benefit Claim determination (either approve or deny Benefit Claim)</td><td>72 hours (depending on medical circumstances)</td><td>Within enough time for Participant to appeal and obtain determination before benefits are not paid</td><td>15 days (depending on medical circumstances)</td><td>30 days (sooner if reasonable)</td><td>45 days</td></tr>
<tr><td>For Plan to obtain extension of time (if proper Notice given to the Claimant and delay is beyond Plan control)</td><td>None</td><td rowspan="3">Follows the guidelines for the type of claim it is (urgent, pre-service, post-service or loss of time (Short-Term Disability))</td><td>15 days</td><td>15 days</td><td>30 days, plus another 30 days</td></tr>
<tr><td>For Plan to request missing information from the Claimant after original receipt of Benefit Claim by Plan</td><td>24 hours</td><td>15 days</td><td>30 days</td><td>45 days</td></tr>
<tr><td>For the Claimant to provide missing information after request for information by the Plan</td><td>48 hours</td><td>45 days</td><td>45 days</td><td>45 days</td></tr>
</table>

Medical Benefit Claim Determination Time Limits

In the case of a Medical Benefit Claim, the Board of Trustees shall notify a Claimant of the benefit determination, as shown below:

A) Urgent Care Benefit Claims Time Limits

In the case of a **Claim Involving Urgent Care**, the Board of Trustees shall notify the Claimant of the benefit determination (whether an approval or Benefit Claim Denial) as soon as possible, taking into account the medical circumstances, but not later than 72 hours after the Benefit Claim is received, unless the Claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. In the case of such a failure, the Board of Trustees shall notify the Claimant as soon as possible, but not later than 24 hours after the Benefit Claim is received, of the specific information necessary to complete the Benefit Claim. The Claimant shall be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. The Board of Trustees shall notify the Claimant of the benefit determination as soon as possible, but in no case later than 48 hours after the earlier of –

1. The specified additional information is received, or

2. The end of the period afforded the Claimant to provide the specified additional information.

B) Concurrent Care Benefit Claims Time Limits

If the Plan has approved an ongoing course of treatment to be provided over a period of time or number of treatments:

1. Any reduction or termination by the Plan of such course of treatment (other than by Plan amendment or termination) before the end of such period of time or number of treatments shall constitute a Benefit Claim Denial. The Board of Trustees shall notify the Claimant of the Benefit Claim Denial at a time sufficiently in advance of the reduction or termination to allow the Claimant to appeal and obtain a determination on review of that Benefit Claim Denial before the Benefit Claim is reduced or terminated.

2. Any request by a Claimant to extend the course of treatment beyond the period of time or number of treatments that is a Claim Involving Urgent Care shall be decided as soon as possible, taking into account the medical circumstances, and the Board of Trustees shall notify the Claimant of the benefit determination, whether an approval or a Benefit Claim Denial, within 24 hours after receipt of the Benefit Claim by the Plan, provided that any such Benefit Claim is made to the Plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments. Notification of any Benefit Claim Denial concerning a request to extend the course of treatment, whether involving urgent care or not, shall be given to the Claimant, and any appeal shall be governed by the procedures under the appeals rules.

C) Pre-Service Benefit Claims Time Limits

In the case of a Pre-Service Benefit Claim, the Board of Trustees shall notify the Claimant of the Plan's benefit determination (whether approval or denial) within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the Benefit Claim by the Plan. This period may be extended one time by the Plan for up to 15

days, provided that the Board of Trustees both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Claimant, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If such an extension is necessary due to a failure of the Claimant to submit the information necessary to decide the Benefit Claim, the Notice of extension shall specifically describe the required information, and the Claimant shall be afforded at least 45 days from receipt of the Notice within which to provide the specified information.

D) Post-Service Benefit Claims Time Limits

In the case of a Post-Service Benefit Claim, the Board of Trustees shall notify the Claimant, within a reasonable period of time, but not later than 30 days after receipt of the Benefit Claim. This period may be extended one time by the Plan for up to 15 days, provided that the Board of Trustees both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Claimant, prior to the expiration of the initial 30 day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If such an extension is necessary due to a failure of the Claimant to submit the information necessary to decide the Benefit Claim, the Notice of extension shall specifically describe the required information, and the Claimant shall be afforded at least 45 days from receipt of the Notice within which to provide the specified information.

Loss of Time (Short-Term Disability) Benefit Claims Time Limits

In the case of a Benefit Claim for Loss of Time (Short-Term Disability) Benefits, the Board of Trustees shall notify the Claimant of the Plan's Appeal of Benefit Claim Denials Procedures within a reasonable period of time, but not later than 45 days after receipt of the Benefit Claim by the Plan. This period may be extended by the Plan for up to 30 days, provided that the Board of Trustees both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Claimant, prior to the expiration of the initial 45 day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If, prior to the end of the first 30 day extension period, the Plan Administrator determines that, due to matters beyond the control of the Plan, a decision cannot be rendered within that extension period, the period for making the determination may be extended for up to an additional 30 days, provided that the Board of Trustees notifies the Claimant, prior to the expiration of the first 30 day extension period, of the circumstances requiring the extension and the date as of which the Plan expects to render a decision. In the case of any extension under this paragraph, the Notice of extension shall specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the Benefit Claim, and the additional information needed to resolve those issues, and the Claimant shall be afforded at least 45 days within which to provide the specified information.

Other (Life Insurance, Accidental Death and Dismemberment, Dental, Eye Care and Prescription) Benefit Claims Time Limits

If a Benefit Claim is wholly or partially denied, the Board of Trustees shall notify the Claimant of the Plan's Appeal Procedures within a reasonable period of time, but not later than 90 days after receipt of the claim by the Plan, unless the Board of Trustees determines that special circumstances require an extension of time for processing the

claim. If the Board of Trustees determines that an extension of time for processing is required, written Notice of the extension shall be furnished to the Claimant prior to the end of the initial 90-day period. In no event shall such extension exceed a period of 90 days from the end of such initial period. The extension Notice shall indicate the special circumstances requiring an extension of time and the date by which the Plan expects to render the benefit determination.

Calculating Time Periods

For purposes of this Section 8.03, the period of time within which a benefit determination is required to be made shall begin at the time a Benefit Claim is filed in accordance with the procedures of the Plan, without regard to whether all the information necessary to make a Benefit Claim determination accompanies the filing. In the event that a period of time is extended as permitted due to a Claimant's failure to submit information necessary to decide a Benefit Claim, the period for making the benefit determination shall be paused or stopped extended from the date on which the Notification of the extension is sent to the Claimant until the date on which the Claimant responds to the request for additional information.

Benefit Claim Determination Notification Requirements

When the Board of Trustees makes a determination on a Benefit Claim, a Notice will be sent to the Claimant that explains the Benefit Claim determination. This Notice will be sent in writing.

Notification Requirements for Benefit Claims other than Loss of Time (Short-Term Disability)

If the **determination is a Benefit Claim Denial other than Loss of Time (Short-Term Disability) Benefits,** the Notification will include the following information, written in a manner to be understood by the Claimant –

A) The specific reason or reasons for the Benefit Claim Denial;

B) Reference to the specific Plan provisions on which the determination is based;

C) A description of any additional material or information necessary for the Claimant to perfect the Benefit Claim and an explanation of why such material or information is necessary;

D) A description of the Plan's appeal procedures and the time limits applicable to such procedures, including a statement of the Claimant's right to bring a civil action under Section 502(a) of the Employee Retirement Income Security Act (ERISA) following an appeal of a Benefit Claim Denial;

E) In the case of a Medical Benefit Claim Denial:

1. If an internal rule, guideline, protocol or other similar criterion was relied upon in making the Benefit Claim Denial, either the specific rule, guideline, protocol or other similar criterion shall be provided to the Claimant; or a statement that such a rule, guideline, protocol or other similar criterion was relied upon in making the Benefit Claim Denial and that a copy of such rule, guideline, protocol or other criterion will be provided free of charge to the Claimant upon request; or

2. If the Benefit Claim Denial is based on a Medical Necessity or Experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances

shall be provided to the Claimant, or a statement that such explanation will be provided free of charge upon request; and

F) In the case of a Benefit Claim Denial by a Group Health Plan concerning a Claim Involving Urgent Care, a description of the expedited review process applicable to such Benefit Claims.

In the case of a Benefit Claim Denial by a Group Health Plan concerning a Claim Involving Urgent Care, the information described above may be provided to the Claimant verbally within the required time frame, provided that a written or electronic Notification is furnished to the Claimant not later than three days after the verbal Notification.

G) If the Benefit Claim Denial is based on a Medical Necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and

H) The specific internal rules, guidelines, protocols, standards or other similar criteria the Plan relied upon in making the Benefit Claim Denial on review or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist; and

I) A statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's Benefit Claim.

J) The notification of a Benefit Claim Denial shall be provided in a culturally and linguistically appropriate manner as described below, if necessary, under the "10% Rule" discussed at the end of this Section.

The Plan is considered to provide relevant Notices in a "culturally and linguistically appropriate manner" if the Plan meets the following requirements:

1. The Plan must provide oral language services (such as a telephone customer assistance hotline) that includes answering questions in any applicable non-English language and providing assistance with filing Benefit Claims and appeals in any applicable non-English language;

2. The Plan must provide, upon request, a Notice in any applicable non-English language; and

3. The Plan must include in the English versions of all Notices; a statement prominently displayed in any applicable non-English language clearly indicating how to access the language services provided by the Plan.

With respect to an address in any United States county to which a Notice is sent, a non-English language is an "applicable non-English language" if 10% or more of the population residing in the county is literate only in the same non-English language, as determined in guidance published by the Secretary of HHS ("10% Rule").

Notification Requirements for Loss of Time (Short-Term Disability) Benefit Claims

If the **determination is a Benefit Claim Denial for a Loss of Time (Short-Term Disability),** the Notification of Benefit Claim Denial will include the following information, in addition to the information provided for other Benefit Claims, written in a manner to be understood by the Claimant:

A) The specific reason or reasons for the Benefit Claim Denial;

B) Reference to the specific Plan provisions on which the Benefit Claim Denial is based;

C) A description of any additional material or information necessary for the Claimant to perfect the Benefit Claim and an explanation of why such material or information is necessary;

D) A discussion of the decision, including an explanation of the basis for disagreeing with or not following:

1. The views of health care professionals treating the Claimant and vocational professionals who evaluated the Claimant presented by the Claimant to the Plan;

2. The views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a Claimant's Benefit Claim Denial, without regard to whether the advice was relied upon in making the benefit determination; and

3. A disability determination regarding the Claimant presented by the Claimant to the Plan made by the Social Security Administration;

E) If the Loss of Time (Short-Term Disability) Benefit Claim Denial is based on a Medical Necessity or Experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and

F) The specific internal rules, guidelines, protocols, standards or other similar criteria the Plan relied upon in making the Benefit Claim Denial on review or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist; and

G) A statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the Claimant's Benefit Claim.

H) The notification of a Benefit Claim Denial shall be provided in a culturally and linguistically appropriate manner as described below, if necessary, under the "10% Rule" discussed at the end of this Section.

The Plan is considered to provide relevant Notices in a "culturally and linguistically appropriate manner" if the Plan meets the following requirements:

1. The Plan must provide oral language services (such as a telephone customer assistance hotline) that includes answering questions in any applicable non-English

language and providing assistance with filing Benefit Claims and appeals in any applicable non-English language;

2. The Plan must provide, upon request, a Notice in any applicable non-English language; and

3. The Plan must include in the English versions of all Notices; a statement prominently displayed in any applicable non-English language clearly indicating how to access the language services provided by the Plan.

With respect to an address in any United States county to which a Notice is sent, a non-English language is an "applicable non-English language" if 10% or more of the population residing in the county is literate only in the same non-English language, as determined in guidance published by the Secretary of HHS ("10% Rule").

If your Benefit Claim is denied, you should first use the Plan's appeal procedures found in Section 8.04 before filing suit in court. If you fail to follow the Plan's appeal procedures found in Section 8.04, the court could consider your case to be premature, and it could result in your case being dismissed in such a manner that would prevent any further court actions. If you follow the Plan's appeal procedures found in Section 8.04 and your Benefit Claim is denied again, you may then proceed to court since you will then have exhausted this Plan's administrative review procedures.

Section 8.04 – Appeals Procedures

These procedures apply to all Classes except medical and prescription coverage for Class CP. Class CP eligible retirees should refer to Appendix A for procedures that apply to medical and prescription coverage for Class CP. Class CP eligible retirees can also call the MAPD Advocacy team using the contact information in Section 9.15 to assist with an appeal.

This Section 8.04 discusses the appeal procedures that must be followed if you want the Board of Trustees to reconsider a Benefit Claim Denial. If you do not first follow these appeal procedures, you may not be able to file a lawsuit.

Appeal of Benefit Claim Denial

If your Benefit Claim is denied, in whole or in part, you can follow the Plan's appeals procedures as explained in this Section 8.04 to have your Benefit Claim reconsidered.

Federal regulations categorize all Benefit Claims and appeal of Benefit Claim Denials into different categories (listed in the table below), depending on the type of Benefit Claim that you filed. See Section 8.03 for definitions.

Each type of Benefit Claim has different time limits for you to file an appeal to a Benefit Claim Denial and also different time limits for the Plan to make a decision on the appeal of a Benefit Claim Denial.

Following the table below (which summarizes these applicable time frames) is information on the rules regarding an appeal, the timing and manner of Benefit Claim Denial Notices and the required content of such Notices.

Time Limits	Type of Medical Benefit Claims				
THE LISTED ACTION MUST OCCUR WITHIN THESE TIME LIMITS	**Urgent health care**	**Concurrent care (Preapproved course of treatment)**	**Pre-service health care (non-urgent)**	**Post-service health care**	**Loss of Time (**Short-Term **Disability)**
For Plan to make initial Benefit Claim determination (either approve or deny Benefit Claim)	72 hours (depending on medical circumstances)	Within enough time for Participant to appeal and obtain determination before benefits are not paid	15 days (depending on medical circumstances)	30 days (sooner if reasonable)	45 days
For Plan to obtain extension of time (if proper Notice given to the Claimant and delay is beyond Plan control)	None	Follows the guidelines for the type of claim it is (urgent, pre-service, post-service or Loss of Time (Short-Term Disability)	15 days	15 days	30 days, plus another 30 days
For Plan to request missing information from the Claimant after original receipt of Benefit Claim by Plan	24 hours		15 days	30 days	45 days
For the Claimant to provide missing information after request for information by the Plan	48 hours		45 days	45 days	45 days

APPEAL PROCEDURES

Appeal Procedures For Medical Benefit Claim Denials

As part of your rights of appeal of a Medical Benefit Claim Denial:

A) Claimants shall have at least 180 days following the date they receive a Notification of a Medical Benefit Claim Denial to appeal the Medical Benefit Claim Denial;

B) The review of the Medical Benefit Claim Denial on appeal shall not rely on any aspect of the initial Medical Benefit Claim Denial and shall be conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the initial Medical Benefit Claim Denial that is the subject of the appeal, nor the subordinate of such individual;

C) In deciding an appeal of any Medical Benefit Claim Denial that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug or other item is experimental, investigational or not Medically Necessary or appropriate, the appropriate named fiduciary shall consult with a Physician who has appropriate training and experience in the field of medicine involved in the medical judgment;

D) The Board of Trustees shall provide to the Claimant the identification of any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a Claimant's Benefit Claim Denial, without regard to whether the advice was relied upon in making the Benefit Claim determination;

E) The appeal review process shall provide that the Physician engaged for purposes of a consultation shall be an individual who is neither an individual who was consulted in connection with the Benefit Claim Denial that is the subject of the appeal, nor the subordinate of any such individual; and

F) Provide, in the case of a Benefit Claim Involving Urgent Care, for an expedited review process pursuant to which:

1. A request for an expedited appeal of a Benefit Claim Denial may be submitted orally or in writing by the Claimant; and

2. All necessary information, including the Benefit Claim determination on review, shall be transmitted between the Board of Trustees and the Claimant by telephone, facsimile or other available similarly expeditious method.

Appeal Procedures For Loss of Time (Short-Term Disability) Benefit Claim Denials

As part of your rights of appeal of a Loss of Time (Short-Term Disability) Benefit Claim Denial, the following will apply:

- the requirements listed below in the paragraph titled "**Appeal Procedures for Benefit Claim Denials Other Than Medical or Loss of Time (Short-Term Disability) Benefit Claim Denial**";
- the requirements listed above in paragraphs A) through E) in the paragraph regarding the **Appeal Procedures for Medical Benefit Claim Denials;** and
- the following requirements:

  Before the Board of Trustees can issue a Benefit Claim Denial on review on a Loss of Time (Short-Term Disability) Benefit Claim, the Board of Trustees shall provide the Claimant, free of charge, with any new or additional evidence considered, relied upon or generated by the Board of Trustees, or other person making the Benefit Claim Denial on review (or at the direction of the Board of Trustees or such other person) in connection with the Benefit Claim. Such evidence must be provided as soon as possible and sufficiently in advance of the date on which the Notice of Benefit Claim Denial on review is required to be provided under the Plan to give the Claimant a reasonable opportunity to respond prior to that date.

  In addition, before the Board of Trustees can issue a Benefit Claim Denial on review on a Loss of Time (Short-Term Disability) Benefit Claim based on a new or additional rationale, the Board of Trustees shall provide the Claimant, free of charge, with the rationale. The

rationale must be provided as soon as possible and sufficiently in advance of the date on which the Notice of Benefit Claim Denial on review is required to be provided under the Plan to give the Claimant a reasonable opportunity to respond prior to that date.

If the Board of Trustees fails to strictly adhere to all the requirements of the Benefit Claims and Appeals Sections of the Plan with respect to a Benefit Claim, the Claimant is deemed to have exhausted the administrative remedies available under the Plan, except for de minimis violations explained below. As such, the Claimant is entitled to pursue any available remedies under Section 502(a) of ERISA on the basis that the Board of Trustees has failed to provide reasonable Benefit Claims procedures that would yield a decision on the merits of the Benefit Claim. If a Claimant chooses to pursue remedies under Section 502(a) of ERISA under such circumstances, the Benefit Claim or Appeal is deemed a Benefit Denial on review without the exercise of discretion by an appropriate fiduciary.

The administrative remedies available under the Plan with respect to Benefit Claims for Loss of Time (Short-Term Disability) Benefits will not be deemed exhausted based on de minimis violations that do not cause, and are not likely to cause, prejudice or harm to the Claimant so long as the Board of Trustees demonstrates that the violation was for good cause or due to matters beyond the control of the Board of Trustees and that the violation occurred in the context of an ongoing, good faith exchange of information between the Board of Trustees and the Claimant. This exception is not available if the violation is part of a pattern or practice of violations by the Board of Trustees. The Claimant may request a written explanation of the violation from the Board of Trustees, and the Board of Trustees must provide such explanation within 10 days, including a specific description of its basis, if any, for asserting that the violation should not cause the administrative remedies available under the Plan to be deemed exhausted. If a court rejects the Claimant's request for immediate review under this section on the basis that the Board of Trustees met the standards for the exception under this paragraph, the Benefit Claim shall be considered as re-filed on appeal upon the Board of Trustees' receipt of the decision of the court. Within a reasonable time after the receipt of the decision, the Board of Trustees shall provide the Claimant with Notice of the resubmission.

Appeal Procedures for Benefit Claim Denials Other Than Medical or Loss of Time (Short-Term Disability) Benefit Claim Denial

As part of your rights of appeal for a Benefit Claim Denial other than a Benefit Claim for Medical Benefits or Loss of Time (Short-Term Disability) Benefits:

A) Claimants shall have 60 days following the date they receive a Notification of a Benefit Claim Denial to appeal the determination;

B) Claimants shall have the opportunity to submit written comments, documents, records and other information relating to the Benefit Claim;

C) Upon request and free of charge, Claimants shall be provided reasonable access to, and copies of, all documents, records and other information relevant to the Claimant's Benefit Claim for benefits; and

D) The review on appeal shall take into account all comments, documents, records and other information submitted by the Claimant relating to the Benefit Claim, without regard to whether such information was submitted or considered in the initial Benefit Claim determination.

TIMING REQUIREMENTS FOR THE PLAN TO NOTIFY THE CLAIMANT OF BENEFIT DETERMINATION ON APPEAL OF BENEFIT CLAIM DENIAL

Timing Requirements for Benefit Claims Other Than Medical Or Loss of Time (Short-Term Disability) Claims

The appropriate named fiduciary shall make a benefit determination no later than the date of the meeting of the committee or board that immediately follows the receipt of a request for review, unless the request for review is filed within 30 days preceding the date of such meeting. In such case, a benefit determination may be made by no later than the date of the second meeting following the receipt of the request for review. If special circumstances (such as the need to hold a hearing) require a further extension of time for processing, a benefit determination shall be rendered not later than the third meeting of the committee or board following the receipt of the request for review. If such an extension of time for review is required because of special circumstances, the Board of Trustees shall provide the Claimant with written Notice of the extension, describing the special circumstances and the date as of which the benefit determination will be made, prior to the commencement of the extension. The Board of Trustees shall notify the Claimant of the benefit determination as soon as possible, but not later than five days after the benefit determination is made.

Timing Requirements for Medical Benefit Claims

In the case of an appeal of a Benefit Claim Denial for Medical Benefits, the Board of Trustees shall notify a Claimant of the benefit determination on review as set forth below.

A) Urgent Care Benefit Claims

In the case of a **Benefit Claim Involving Urgent Care**, the Board of Trustees shall notify the Claimant of the benefit determination on review on appeal as soon as possible, taking into account the medical circumstances, but not later than 72 hours after receipt of the Claimant's request for review on appeal of a Benefit Claim Denial.

B) Pre-Service Benefit Claims

In the case of a Pre-Service Claim, the Board of Trustees shall notify the Claimant of the Benefit Claim determination on review on appeal within a reasonable period of time appropriate to the medical circumstances. Such notification shall be provided not later than 30 days after receipt of the Claimant's request for review of a Benefit Claim Denial.

C) Post-Service Benefit Claims

In the case of a Post-Service Benefit Claim, the appropriate named fiduciary shall make a benefit determination no later than the date of the meeting of the committee or board that immediately follows the receipt of a request for review, unless the request for review is filed within 30 days preceding the date of such meeting. In such case, a benefit determination may be made by no later than the date of the second meeting following the receipt of the request for review. If special circumstances (such as the need to hold a hearing) require a further extension of time for processing, a benefit determination shall be rendered not later than the third meeting of the committee or board following the receipt of the request for review. If such an extension of time for review is required because of special circumstances, the Board of Trustees shall notify the Claimant in writing of the extension, describing the special circumstances and the date as of which the benefit determination will be made, prior to the commencement of the extension. The Board of Trustees shall notify the Claimant of the benefit determination as soon as possible, but not later than five days after the benefit determination is made.

Timing Requirements for Loss of Time (Short-Term Disability) Benefit Claims
In the case of a Loss of Time (Short-Term Disability) Benefit Claim, the appropriate named fiduciary shall instead make a benefit determination no later than the date of the meeting of the committee or board that immediately follows the receipt of a request for review, unless the request for review is filed within 30 days preceding the date of such meeting. In such case, a benefit determination may be made by no later than the date of the second meeting following the receipt of the request for review. If special circumstances (such as the need to hold a hearing) require a further extension of time for processing, a benefit determination shall be rendered not later than the third meeting of the committee or board following the receipt of the request for review. If such an extension of time for review is required because of special circumstances, the Board of Trustees shall notify the Claimant in writing of the extension, describing the special circumstances and the date as of which the benefit determination will be made, prior to the commencement of the extension. The Board of Trustees shall notify the Claimant of the benefit determination as soon as possible, but not later than five days after the benefit determination is made.

Calculating Time Periods
For purposes of this Section 8.04, the period of time within which a Benefit Claim determination on review is required to be made shall begin at the time an appeal is filed with the Fund Office, without regard to whether all the information necessary to make a benefit determination on review accompanies the filing. In the event that a period of time is extended as permitted due to a Claimant's failure to submit information necessary to decide a Benefit Claim, the period for making the benefit determination on review shall be paused or stopped from the date on which the notification of the extension is sent to the Claimant until the date on which the Claimant responds to the request for additional information.

Furnishing Documents
In the case of a Benefit Claim Denial on review on appeal, the Board of Trustees shall provide the Claimant such access to, and copies of, documents, records and other information as is appropriate.

MANNER AND CONTENT OF NOTIFICATION OF BENEFIT DETERMINATION ON REVIEW
The Board of Trustees shall provide a Claimant with written or electronic Notification of the Benefit Claim determination on review. In the case of a Benefit Claim Denial other than a Benefit Claim Denial of a Benefit Claim for Disability Benefits (Loss of Time), the notification shall set forth, in a manner calculated to be understood by the Claimant –

A) The specific reason or reasons for the Benefit Claim Denial on appeal;

B) Reference to the specific Plan provisions on which the Benefit Claim Denial is based;

C) A statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the Claimant's Benefit Claim.

D) A statement describing any voluntary appeal procedures outlined in the Plan and the Claimant's right to obtain the information about such procedures, and a statement of the Claimant's right to bring an action under Section 502(a) of ERISA; and

E) In the case of a Benefit Claim Denial of Medical Benefits –

1. If an internal rule, guideline, protocol or other similar criterion was relied upon in making the Benefit Claim Denial, either the specific rule, guideline, protocol or other similar criterion shall be provided to the Claimant; or a statement that such rule, guideline, protocol or other similar criterion was relied upon in making the Benefit Claim Denial and that a copy of the rule, guideline, protocol or other similar criterion will be provided free of charge to the Claimant upon request;

2. If the Benefit Claim Denial is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances shall be provided to the Claimant, or a statement that such explanation will be provided free of charge upon request.

In the case of a Benefit Claim Denial of a Disability Benefit on review, the Notification of the Benefit Claim Denial shall set forth, in a manner calculated to be understood by the Claimant:

1. the specific reason or reasons for the Benefit Claim Denial on review;

2. reference to the specific Plan provisions on which the Benefit Claim Denial on review is based;

3. a statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant, to the Claimant's Benefit Claim for Loss of Time (Short-Term Disability) Benefits;

4. a discussion of the decision, including an explanation of the basis for disagreeing with or not following:

    a. the views presented by the Claimant of health care professionals treating the Claimant and vocational professionals who evaluated the Claimant;

    b. the views of medical or vocational experts whose advice was obtained in connection with a Claimant's Benefit Claim Denial on review, without regard to whether the advice was relied upon in making the Benefit Claim Denial on review; and

    c. a disability determination regarding the Claimant made by the Social Security Administration.

5. if the Benefit Claim Denial on review is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided free of change upon request; and

6. the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the Benefit Claim Denial on review.

7. a statement of the Claimant's right to bring an action under Section 502(a) of ERISA; which lawsuit must be filed within three years from the date of the Benefit Claim Denial on appeal to be considered timely. The statement shall include the calendar date the three-year period would run out.

   In the case of a Benefit Claim Denial after the review on appeal, the notification shall be provided in a culturally and linguistically appropriate manner as described below. The Board of Trustees is considered to provide relevant Notices in a "culturally and linguistically appropriate manner" if they meet the requirements under the "10% Rule," if necessary, discussed below.

   The Board of Trustees must:

   a. provide oral language services (such as a telephone customer assistance hotline) that includes answering questions in any applicable non-English language and providing assistance with filing Benefit Claims and appeals in any applicable non-English language;

   b. provide, upon request, a Notice in any applicable non-English language; and

   c. include in the English versions of all Notices, a statement prominently displayed in any applicable non-English language clearly indicating how to access the language services provided by the Board of Trustees.

With respect to an address in any United States county to which a Notice is sent, a "non-English language" is an "applicable non-English language" if ten percent or more ("10% Rule") of the population residing in the county is literate only in the same non-English language, as determined in guidance published by the Secretary of HHS.

External Review of No Surprises Act Claims

A Claimant may request an external appeal review after an initial Benefit Claim Denial and subsequent internal review appeal denial to dispute determinations that involve whether the Plan complied with the surprise billing and cost-sharing protections under the No Surprises Act. The process for an external review is as follows:

Request for External Review

An external appeal must be allowed if the Claimant requests an external appeal within four months after receipt of notice of Benefit Claim Denial or appeal denial. An immediate external review must also be allowed if the Plan has failed to adhere to the appeals regulations unless the violation was: 1) de minimis; 2) non-prejudicial; 3) attributable to good cause or matters beyond the Plan's control; 4) in the context of an ongoing good-faith exchange of information; and 5) not reflective of a pattern or practice of non-compliance. If the Plan asserts an exception, the claimant is entitled, upon written request, to an explanation of the Plan's basis for asserting the exception. If the external reviewer rejects the claimant's request for immediate review on the basis that the Plan has met the five-element exception, the claimant is permitted to resubmit and pursue an internal appeal.

Preliminary Review

The preliminary review of the external appeal must be completed within five business days after receipt of request to determine whether:

- The Claimant was covered under the Plan at the time the health care item or service was provided;
- The initial Benefit Claim Denial or internal review Benefit Claim Denial did not relate to the Claimant's failure to meet eligibility requirements for eligibility under the Plan;
- The Claimant has exhausted the Plan's internal appeal process unless the Claimant is not required to exhaust the internal appeals process under the regulations; and
- The Claimant has provided all the information and forms required to process an External Review.

Within one business day after completion of preliminary review, the Plan must issue notification in writing to the Claimant. If the request is complete but not eligible for external review, such notification must include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (call toll-free (866) 444-EBSA (3272)). If the request is not complete, such notification must describe the information and materials needed to make the request complete and the Plan must allow the Claimant to perfect the request for external review within the four-month filing period or within the 48 hour period following the receipt of notification, whichever is later. Note that for an urgent care issue, the preliminary review must be done immediately and the claimant must be notified of the decision immediately.

Referral to Independent Review Organization (IRO)
The Plan must utilize an independent review organization (IRO) that is accredited by URAC or by a similar nationally recognized accrediting organization to conduct the external review. Moreover, the Plan must take action against bias and ensure independence.
Accordingly, the Plan must contract with at least three IROs for assignments under the Plan and rotate claims assignments among them (or incorporate other independent unbiased methods for selection of IROs, such as random selection). The IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits. The IRO process may not impose any costs, including filing fees, on the claimant requesting the external review.

Within five business days after assignment to an IRO, the Plan must provide all documents and information considered in denying the appeal to the IRO. The IRO must provide written notice of its decision within 45 days of assignment. For urgent care issues, the IRO must provide notice of its decision as soon as possible but in no event more than 72 hours after receipt of the request for expedited external review.

Implementation of Reversal
Upon receipt of notice of final external review decision reversing an adverse benefit determination, the Plan must immediately provide coverage or payment (including immediately authorizing or immediately paying benefits for claim).

Section 8.05 – Assignment of Benefits or Rights Not Permitted
Your right to receive Benefits (or Plan payments for Benefit Claims) is personal to you so you cannot assign it or any of your rights or Benefits as a Participant or Beneficiary to a third party. This anti-assignment rule prohibits assigning any legal or equitable rights under the Plan, or state or federal law, including the Employee Retirement Income Security Act (ERISA), to anyone else without the consent of the Board of Trustees (except as required by a Qualified Medical Child Support Order or National Medical Child Support Notice, or as otherwise may be required by applicable law). A direction to pay a provider is not an assignment of any right under this Plan or of any legal or equitable right to institute any court proceeding.

You may designate a representative to represent you in the Benefit Claims and Appeals Process. However, your representative is not an assignee of your rights and benefits and does not have standing to file suit against the Plan or Board of Trustees. Nothing contained in this Document or any other written description of the Plan for medical coverage shall be construed to make the Plan or Board of Trustees liable to any third party to whom a Participant may be liable for medical care, treatment or services.

Section 8.06 – Venue

Any lawsuit filed by a Claimant who has exhausted the Claims and Appeals Process set forth in Section 8.04, which lawsuit names the Plan, the Board of Trustees or any administrator connected with the Plan, shall be filed in a court of competent jurisdiction in the venue of the Fund Office in Vigo County, Indiana.

Section 8.07 – Indemnity for Liability

The Plan shall indemnify each member of the Board of Trustees against any and all claims, losses, damages, expenses, including counsel fees, incurred by the Board of Trustees and any liability, including any amounts paid in settlement with the Board of Trustees' approval, arising from the Trustee's or Board of Trustees' action or failure to act in connection with the Trustees' duties and responsibilities under this Plan, except as provided by law. The Plan, at all times and at its own expense shall purchase and keep in effect sufficient liability insurance for each Trustee on the Board of Trustees to cover all claims, losses, damages and expenses arising from any action or failure to act in connection with the execution of his duties as a Trustee of the Board of Trustees.

Section 8.08 – Certificate of Creditable Coverage

If requested, upon the occurrence of any of the events described which result in a termination of coverage under the Plan or an Eligible Person otherwise becoming covered under COBRA coverage, the Board of Trustees shall issue a Certification of Creditable Coverage to the Participant or Qualified Beneficiary. Creditable Coverage shall be the number of months, not in excess of 18, during which such individual was covered under the Plan and, if COBRA coverage was elected, a Qualified Beneficiary under the Plan, without regard to the specific Benefits covered during such months; provided, however, that any months as a Participant or Qualified Beneficiary that occur prior to a period of at least 63 days where there has been a continuous lapse in any Creditable Coverage shall not be Creditable Coverage. To request a Certificate of Creditable Coverage, please contact the Fund Office at P.O. Box 1587, Terre Haute, IN 47808-1587 or at (812) 238-2551.

Section 8.09 – Interest Not Transferable

No right or interest of any Participant in the Loss of Time (Short-Term Disability) Benefits portion of the Plan shall be assignable or transferable. Benefits payable under the Medical Benefits, Senior Member Program and Survivor Benefits portions may be assigned to the provider of medical services. A direction to pay a provider is not an assignment of any right under this Plan or of any legal or equitable right to institute any court proceeding.

Section 8.10 – Employment Rights

The establishment of the Plan shall not be construed as conferring any legal rights upon any Employee or any other person for continuation of employment, nor shall it interfere with the rights of any Employer to discharge any Employee and/or to treat him without regard to the effect which such treatment might have upon him as a Participant.

Section 8.11 – Coordination Of Benefits

These Coordination of Benefits provisions do not apply to benefits provided under the MAPD plan for Class CP Retirees. If you and your eligible Dependents are covered under the MAPD plan, benefits will not be coordinated between the fully insured MAPD policies. See Appendix A for more details.

The Coordination of Benefits provisions provided for in this Section 8.11 apply to an Eligible Person who is covered by more than one group health plan (this Plan and another plan (or plans)), or an insurance policy which provides for the payment of medical benefits. If this applies to you or your Dependents, please read this Section carefully to understand how Benefits will be paid. You may contact the Fund Office

Coordination with Other Group Plans

All Benefits payable under this Plan shall be coordinated with benefits payable under any Other Group Plan if the Covered Expenses are for a Participant, Retiree or Dependent.

If a Participant, Retiree or Dependent is covered by an Other Group Plan, the Benefits under this Plan and the Other Group Plan shall be coordinated. This means that one plan pays its full benefits first, then the other plan pays up to its full benefit; provided, however, that total benefits from this Plan and the Other Group Plan(s) shall not be more than 100% of Covered Expenses incurred.

Benefits paid under this Section shall be paid in the following order:

A) If the Other Group Plan does not have a coordination of benefits provision, the Other Group Plan shall pay its benefits first.

B) When the Other Group Plan does have a coordination of benefits provision, the following rules shall be applied:

1. The plan which covers the person as an employee, member or non-dependent shall pay its benefits first.

2. If the rule described in subparagraph 1 above is not determinative because one or more plans cover the person as an employee, the plan which covers the person as an active worker at the time the expense is incurred shall pay its benefits first.

3. If the rule described in subparagraph 1 above does not apply, the plan which covers the person as a dependent of the parent whose birthday falls earlier in a year will pay its benefits before the plan of the parent whose birthday falls later in the year, except as described under the rule explained in subparagraph 4 below involving a Benefit Claim for a dependent child of divorced or separated parents or the rule described in subparagraph 5 below involving a Benefit Claim for a dependent child that is covered under an Other Group Plan as a result of their spouse's employment. If both parents have the same birthday, the benefits of the plan which covered the parent longer are paid before those of the plan which covered the parent for a shorter period of time. The word "birthday" refers only to the month and day in a calendar year, not the year in which the person was born.

4. If a Benefit Claim is made for a dependent child of divorced or separated parents, the plan which covers a child as a dependent of a parent who by court decree must provide for health care shall pay its benefits first.

   If there is no court decree which requires a parent to provide health care for a dependent child:

   a. The plan covering the parent that is not remarried and who has custody of the child shall pay its benefits first.

   b. If a parent who has custody of the child has remarried, such parent's plan will pay its benefits first; the stepparent's plan shall pay its benefits next; and the plan of the parent without custody shall pay its benefits third.

   If a court decree requires both parents to provide health care for a dependent child, the birthday rule, as described in subparagraph 3 above, will be used to determine primary and secondary coverage. If the parent with custody has re-married, the plan of the stepparent with custody shall pay its benefits next; and the plan of the stepparent without custody shall pay its benefits last.

5. If a Benefit Claim is made for a dependent child who is covered under an Other Group Plan as a result of their spouse's employment, benefits will be paid in the following order:

   a. If the dependent child is covered under an Other Group Plan as an employee, that Other Group Plan shall pay its benefits first.

   b. If the dependent child is married and is covered under an Other Group Plan through the spouse's employment, that Other Group Plan will pay its benefits second.

   c. After applying the rules in subparagraphs 5a and 5b, then the rules in subparagraphs 3 or 4, as applicable, shall apply to determine the order of remaining plans.

6. If a person whose coverage is provided under a right of continuation pursuant to federal law (COBRA) or state law is also covered under any Other Group Plan, the plan which covers the person as an employee or member (or as that person's Dependent) shall pay its benefits first and the plan which provides benefits under the continuation coverage shall pay its benefits second.

7. If none of the preceding rules in subparagraphs 1 through 6 apply, the plan which has covered the person for a longer period of time shall pay its benefits first.

Where part of an Other Group Plan coordinates benefits and part does not, each part shall be treated like a separate plan.

Notwithstanding the order listed above, when the Other Group Plan is an insured product (such as certain vision benefits) provided by this Plan, the Other Group Plan shall pay its benefits first.

If benefits which this Plan should have paid are instead paid by an Other Group Plan, this Plan may reimburse the Other Group Plan. Amounts so reimbursed shall be treated like any other Plan benefits in satisfying this Plan's obligations.

If this Plan pays more for a Covered Expense than is required by this Section, then this Plan may recover such excess payment from –

A. any person to whom the payment was made; or

B. any insurance company, service plan or any other organization which should have made payment.

Coordination with Insurance
A homeowners', event, premises, or automobile policy of insurance which provides for the payment of medical benefits (such as no-fault, personal injury protection or medical payments coverage) shall always pay on a primary basis before the Plan.

Definitions Related to Coordination of Benefits
For purposes of this Section, the following terms shall have the following meanings –

Other Group Plan
The term "Other Group Plan" means programs which provide benefit payments or services to a Participant, Retiree or covered Dependents for hospital, medical, surgical, dental, prescription drug, vision, hearing or any other health care under –

- group insurance;
- group Blue Cross and/or Blue Shield and other prepayment coverage on a group basis, including Health Maintenance Organizations;
- coverage under labor-management trusteed plans, union welfare plans, employer organization plans or employee benefit plans;
- coverage under government programs and any other coverages required by law;
- other arrangements of insured or self-insured group coverage; or
- COBRA coverage.

Provided, however, that –

- individually purchased health insurance plans are not treated as an "Other Group Plan" for coordination of benefits purposes; and
- where both the Employee and one or more of his Dependents are eligible to participate because of employment with an Employer, this Plan shall also be treated as an "Other Group Plan" for coordination of benefits purposes.
- In the event this Plan provides an insured product in addition to noninsured coverage, the insured product shall also be treated as an "Other Group Plan" for coordination of benefits purposes.

Benefit Claim Period
The term "Benefit Claim Period" means part or all of a Calendar Year during which the Participant, Retiree or covered Dependent is eligible for Benefits under the Plan.

Covered Expense
The term "Covered Expense" means any Usual, Customary and Reasonable expense (See Article XI definitions) incurred which is covered by at least one Other Group Plan during a Benefit Claim Period and where an Other Group Plan provides benefits in the form of a service rather than cash payments, the reasonable cash value of the service during a Benefit Claim Period shall also be considered a Covered Expense.

Section 8.12 – Coordination with Medicare

These Coordination of Benefits provisions do not apply to benefits provided under the MAPD plan for Class CP retirees. If you and your eligible Dependents are covered under the MAPD plan, benefits will not be coordinated between the fully insured MAPD policies. See Appendix A for more details.

> The Coordination with Medicare provisions provided for in this Section 8.12 apply to an Eligible Person who is covered by this Plan and Medicare. If this applies to you or your Dependents, please read this Section 8.12 carefully to understand how Benefits will be paid. You may contact the Fund Office with any questions.

Notwithstanding any provision to the contrary in this Plan, the Plan shall pay Benefits secondary to Medicare to the full extent allowed by Section 1862(b) of the Social Security Act. In no event shall Covered Expenses under the Plan, when added to Medicare benefits, exceed the amount the Plan would have paid had the individual covered by this Plan not been entitled to Medicare benefits. For purposes of this Section, such individual will be presumed to be covered by Medicare to the extent the individual has met all of the eligibility rules and is otherwise entitled to Medicare regardless of whether the individual has actually enrolled in Medicare. For situations where the individual is not enrolled in Medicare, the Plan will use the Original Medicare Part A and Part B benefit structure for coordination. For Medicare-enrolled Eligible Persons, the Plan requires the submission of a Medicare Explanation of Benefits before Covered Expenses will be paid by the Plan.

Section 8.13 – Subrogation

These Subrogation provisions do not apply to benefits provided under the MAPD plan for Class CP Retirees or Totally Disabled Participants. Class CP Participants should refer to Appendix A for the applicable Subrogation provisions.

> **The Subrogation provisions provided for in this Section 8.13 apply to an Eligible Person who receives treatment or services due to an accident or injury for which someone else may be liable. If this applies to you or your Dependents, please read this Section carefully to understand how Benefits will be paid. Also, there is specific paperwork that you must fill out and return to the Fund Office prior to any Benefits being paid. You may contact the Fund Office with any questions.**

If an Eligible Person is injured in an accident for which someone else may be liable, that person or an insurer may be responsible for paying the related medical expenses and these expenses would not be covered under the Plan. However, waiting for a third party to pay for these Injuries may be difficult; recovery from a third party may take a long time (you may have to go to court), and your creditors may not wait patiently. Because of this, as a service to the Participant, the

Plan will advance Benefit payments related to such an accident based on the Plan's rights of restitution and subrogation. This means, the Participant must reimburse the Plan if recovery is obtained from any person or entity.

The Plan will receive restitution for all Benefit payments made as the result of the Injuries or Sicknesses which are caused by the actions of a third=party and which give rise to a court-ordered financial award or out-of-court settlement to the Eligible Person from a third-party tortfeasor, person or entity. This Plan will provide Benefits, otherwise not payable under this Plan, to or on behalf of the Eligible Person, only on the following terms and conditions:

A) In the event of any payment under this Plan, the Plan shall be subrogated to all of the Eligible Person's rights of recovery against any person or organization.

   This means that the Plan has an independent right to bring an action in connection with such Injury or Sickness in the Eligible Person's name and also has a right to intervene in any such action brought by the Eligible Person, including any action against an insurance carrier under any uninsured or underinsured motor vehicle policy.

B) Consistent with the Plan's rights set forth in this Section, if the Eligible Person submits Benefit Claims for or receives any Benefit Claims payments from the Plan for an Injury or Sickness that may give rise to any claim against any third-party, the Eligible Person's representative will be required to execute a "Subrogation Assignment of Rights, and Restitution Agreement" affirming the Plan's rights of restitution and subrogation with respect to such Benefit Claims payments and claims. This form will assist the Plan in recovering Benefit Claims paid from a third party who was responsible for the Injuries giving rise to the Benefit Claims. This Agreement must also be executed by the Eligible Person's attorney, if applicable.

   Because Benefit Claims payments are not payable unless you sign a Subrogation Agreement, the Eligible Person's Benefit Claims will not be paid until the fully signed Agreement is received by the Plan.

   This means that, if an Eligible Person files a Benefit Claim and a Subrogation Agreement is not received promptly, the Benefit Claim will not be paid.

C) The Eligible Person shall do whatever is necessary to secure the Plan's subrogation rights and shall do nothing after the loss to prejudice such rights. The Eligible Person must do nothing to impair or prejudice the Plan's rights. For example, if the Eligible Person chooses not to pursue the liability of a third party, the Eligible Person may not waive any rights covering any conditions under which any recovery could be received. Where the Eligible Person chooses not to pursue the liability of a third party, the acceptance of Benefit Claims from the Plan authorizes the Plan to litigate or settle your claims against the third party. If the Plan takes legal action to recover what it has paid, the acceptance of Benefit Claims obligates the Eligible Person (and their attorney, if applicable) to cooperate with the Plan in seeking its recovery, and in providing relevant information with respect to the accident.

D) The Eligible Person shall agree to cooperate with the Plan and/or any representatives of the Plan in completing such forms and in giving such information surrounding any accident as the Plan or its representatives deem necessary to fully investigate the incident. Failure to execute the necessary forms will result in no Benefit Claims being paid.

E) The Plan is also granted a right of restitution from the proceeds of any settlement, judgment or other payment obtained by the Eligible Person. This right of restitution is cumulative with and not exclusive of the subrogation right granted in paragraph A above, but only to the extent of the Benefit Claims paid by the Plan.

F) The Plan's rights of restitution and subrogation provide the Plan with first priority to any and all recovery in connection with the Injury or Sickness, whether such recovery is full or partial and no matter how such recovery is characterized, why or by whom it is paid or the type of expense for which it is specified. Such recovery includes amounts payable under the Eligible Person's own uninsured motorist insurance, underinsured motorist insurance or any medical pay or no-fault benefits payable.

This right of subrogation is specifically and unequivocally pro tanto subrogation, that is, subrogation from the first dollar received by the Eligible Person, and the pro tanto subrogation is to take effect before the entire debt is paid to the Eligible Person. In addition to its pro tanto rights, the Plan is entitled to restitution of the full amount of Benefits paid, regardless of whether the Eligible Person is made whole by the third party for all damages.

G) The Plan's rights of restitution and subrogation apply regardless of the terms of the claim, demand, right of recovery, cause of action, judgment, award, settlement, compromise, insurance or order, regardless of whether the third party is found responsible or liable for the Injury or Sickness, and regardless of whether the Eligible Person actually obtains the full amount of such judgment, award, settlement, compromise, insurance or order.

The Plan, by payment of any proceeds, is granted an equitable lien on the proceeds of any settlement, judgment or other payment received by the Eligible Person, and the Eligible Person consents to said lien and agrees to take all steps necessary to help the Board of Trustees secure such lien.

The Plan shall have a lien on any amount received by the Eligible Person or a representative of the Eligible Person (including your attorney) that is due to the Plan under this Section, and any such amount shall be deemed to be held in trust by the Eligible Person for the Benefit of the Plan until paid in full to the Plan.

H) The subrogation and restitution rights and liens apply to any recoveries made by the Eligible Person as a result of the Injuries sustained or Sickness suffered, including but not limited to the following:

1. Payments made directly by the third-party tort-feasor or any insurance company on behalf of the third-party tortfeasor or any other payments on behalf of the third-party tortfeasor.

2. Any payments, settlements, judgments or arbitration awards paid by any insurance company under an uninsured, underinsured motorist policy or medical pay provisions on the insured's behalf; and

3. Any payments from any source designed or intended to compensate an insured for Sickness, Injury, disease or Disability sustained as the result of the negligence or wrongful action or alleged negligence or wrongful action of another person.

4. Any payments from an employer or worker's compensation insurer.

5. Any payments or donations due made by or through a charitable organization or online fundraising, social media, or crowdfunding platform (for example, GoFundMe).

I) It is the obligation of the Eligible Person to:

1. Notify the Plan within ten days of any accident or Injury for which someone else may be liable;

2. Notify the Plan in writing of any Injury, Sickness, disease or disability for which the Plan has paid medical expenses on behalf of the Eligible Person that may be attributable to the wrongful or negligent acts of another person;

3. Notify the Plan in writing if the Eligible Person retains services of an attorney, and of any demand made or lawsuit filed on behalf of the Eligible Person, and of any offer, proposed settlement, acceptance settlement, judgment or arbitration award;

4. Notify the Plan before accepting any payment prior to the initiation of a lawsuit. If the Eligible Person does not notify the Plan and accepts payment that is less than the full amount of the Benefits that the Plan has advanced, the Eligible Person will still be required to repay the Plan, in full, for any Benefits it has paid on the Eligible Person's behalf;

5. Notify the Plan within ten days of the initiation of any lawsuit arising out of the accident and of the conclusion of any settlement, judgment or payment relating to the accident in any lawsuit initiated to protect the Plan's claims;

6. Provide the Plan or its agents with information it requests concerning circumstances that may involve subrogation, provide any reasonable assistance requested in assimilating such information and cooperate with the Plan or its agents in defining, verifying or protecting its right of subrogation and restitution; and

7. Promptly provide restitution to the Plan for Benefits paid on behalf of the Eligible Person attributable to Sickness, Injury, disease or disability, once the Eligible Person has obtained money through settlement, judgment, award or other payment.

J) The Eligible Person will not make any settlement which specifically excludes or attempts to exclude the medical expenses paid by the Plan.

K) The Plan's right of recovery shall be a prior lien against any proceeds recovered by the Eligible Person, which right shall not be defeated nor reduced by the application of any so-called "Made-Whole Doctrine," "Rimes Doctrine" or any other such doctrine purporting to defeat the Plan's recovery rights by allocating the proceeds exclusively to non-medical expense damages.

L) The Eligible Person shall not incur any expenses on behalf of the Plan in pursuit of the Plan's rights, specifically, no court costs nor attorney's fees may be deducted from the Plan's recovery without the prior expressed written consent of the Plan. This right shall not be defeated by any so-called "Fund Doctrine," "Common Fund Doctrine," "Attorney's Fund Doctrine," or any other such doctrine purporting to reduce the Plan's recovery amount.

M) If the Eligible Person fails to notify the Plan, as required herein, then upon recovery made, whether by suit, judgment, settlement, compromise or otherwise, by the Eligible Person, the Plan shall be entitled to restitution to the extent of the Benefits paid by the Plan, immediately upon demand, and shall have the right to recovery thereof, by suit or otherwise.

N) If the Eligible Person refuses to provide restitution to the Plan from any recovery or refuse to cooperate with the Plan regarding its subrogation or restitution rights, the Plan has the right to recover the full amount of all Benefits paid by methods which include, but are not necessarily limited to, offsetting the amounts paid against the Eligible Person's future Benefit payments under the Plan or contributions made to the Plan by, or on behalf of, the Eligible Person. "Non-cooperation" includes the failure to execute a Subrogation, Assignment of Rights, and Restitution Agreement and the failure of any party to respond to the Plan's inquiries concerning the status of any claim or any other Injury relating to the Plan's rights of restitution and subrogation.

If the Eligible Person is compensated for their Injury or Sickness, the Eligible Person is responsible for any and all future medical benefits that are a result of this Injury or Sickness, unless the Trustees, in their sole discretion, approve the payment of such benefits.

Failure to comply with any of these requirements may result in:

A) The Plan's withholding payment of future Benefits;

B) An obligation by the Eligible Person to pay costs, attorney's fees and other expenses incurred by the Plan in obtaining the required information or restitution.

This restitution and subrogation program is a service to the Eligible Person. It provides for the early payment of Benefit Claims and also saves the Plan money (which saves you money too) by making sure that the responsible party pays for the Injuries.

Section 8.14 – Other Rights of Recovery

Whenever Benefit Claims payments are made under the Plan which are in excess of Covered Expenses or other Plan limits (including mistaken payments), the Board of Trustees shall have a right to recover the mistaken or excess amount from either –

A) the person or agency who received it, or

B) the Eligible Person.

In the case of excess Benefit Claims payments made to a Participant or Dependent, the Board of Trustees reserves the right to reduce future benefit payments under the Plan in order to correct a prior overpayment.

Section 8.15 – Medical Care Review Program

This Medical Care Review Program applies to Classes A, AS, D and S. Class CP medical care review is performed under the fully insured program as described in Appendix A.

The Plan has entered into an agreement with a professional medical care review firm to pre-certify all inpatient Hospital stays, surgeries and other procedures and equipment your Physician may

recommend. The contracted professional medical care review firm pre-approves treatment plans and assists the Eligible Person to avoid unnecessary medical costs.

Medical Care Review is sometimes called utilization review. This program includes:

- Precertification of the Medical Necessity for non-emergency services before certain Behavioral Health, Medical and/or Surgical services are provided:

- Retrospective review of the Medical Necessity of the listed services provided on an emergency basis;

- Concurrent review, based on the admitting diagnosis, of the listed services requested by the attending Physician; and

- Certification of services and planning for discharge from a Health Care Facility or cessation of prescribed treatment.

The Eligible Person's cooperation is essential to the success of this medical cost management partnership. Failure to contact the medical care review firm when a Physician recommends hospitalization or surgery may result in longer than necessary Hospital stays or unnecessary medical treatment which might not be covered and therefore resulting in higher medical costs to the Eligible Person. The medical care review firm also acts as a patient advocate to assist the Eligible Person in managing the condition.

The precertification process is not a guarantee of benefits. Other Plan exclusions may prohibit your Benefit Claim under the Plan. The following is a list of service categories and items that are required to be precertified, as of the effective date of this Combination Plan Document and Summary Plan Description. Contact the Fund Office for a current list.

- ABA Therapy
- Advanced diagnostic laboratory tests
- Behavioral Health (Mental Health and Substance Abuse) including intensive outpatient programs (IOP) and partial hospitalization programs (PHP)
- Biopsies
- Dialysis, such as: AV fistula creation, AV graft creation, tunneled dialysis catheter, non-tunneled CVC dialysis session
- Durable medical equipment (DME), such as: electric/motorized scooters or wheelchairs, pneumatic compression devices, Bone Growth Stimulators, Continuous Passive Motion (CPM) devices, hospital beds and accessories, speech generating devices, feeding pump and nutrition supplies CPAP and BIPAP, unclassified DME
- Ear, nose and throat (ENT) procedures, such as: rhinoplasty, sinuplasty, septoplasty, submucous resection (SMR)
- Foot orthotics
- Genetic or genomic testing
- Home health care, such as nursing, therapy, and home hospice
- Hyaluronan Injections
- Inpatient facility admissions
- Interventional Cardiology – Cardiac Catheterization and Percutaneous Coronary Intervention (PCI)

- Outpatient surgery including all reconstructive surgery, breast removal and reconstruction, cartilage implants, spine surgery (please contact the fund office to find out if your specific surgery requires precertification)
- Pain management
- Radiation therapy
- Spinal cord stimulators
- Therapeutic agents over $5,000 (drugs / biologics / infusions including chemotherapy / oncology drugs) that are not obtained through Sav-Rx
- Transcranial Magnetic Stimulation (TMS)
- Transplant of tissues and organs
- Vein procedure
- Vascular access devices

THE BOARD OF TRUSTEES MAY AMEND THE LIST OF SERVICES THAT REQUIRE PRE-CERTIFICATION. PLEASE READ SECTION 8.15 AND CONTACT THE FUND OFFICE IF YOU ARE UNSURE IF PRE-CERTIFICATION IS REQUIRED FOR YOUR PROPOSED TREATMENT

How the Medical Care Review Program Works
The medical care review program is designed to work with the Eligible Person and his Physician to keep medical care costs as low as possible, consistent with good medical care. In many instances, review of the need for hospitalization and exploration of available alternatives will indicate that admission to the Hospital can be avoided and that quality treatment can better be provided in a less stressful environment. This program is included in the Plan to help the Eligible Person and the Physician to use alternatives effectively, to avoid the inconvenience of a Hospital stay entirely or spend some recovery time in a less restrictive setting.

To achieve the best result for the Eligible Person and the Plan, you must use the program properly.

When Hospitalization is Recommended for Non-Emergency Cases
If a Physician recommends a Hospital admission on a non-emergency basis for treatment or surgery, the medical care review program should be contacted as soon as the decision for hospitalization is made and no less than seven days prior to the scheduled admission. The medical care review program must review all proposed (non-emergency) hospitalizations prior to Hospital admission.

The medical care review program staff will review the clinical information submitted by the Physician and will work with the Physician throughout the Hospital stay to ensure that continuing care needs are met in the most effective way possible.

When Hospitalization is Recommended for Emergency Cases

IN CASE OF AN EMERGENCY, SEEK MEDICAL ATTENTION AND CALL THE MEDICAL CARE REVIEW PROGRAM NO LATER THAN THE NEXT BUSINESS DAY.

If an Eligible Person is hospitalized for Emergency treatment, the medical care review program should be contacted by the Eligible Person, Physician or Hospital within 48 hours of Emergency admission or on the first business day following a weekend (Friday, Saturday or Sunday) or holiday admission. **In an Emergency situation, the Eligible Person should seek appropriate medical treatment first** and then contact the medical care review program within the timeframe given.

Extensions of Time

If complications arise and it becomes Medically Necessary for an Eligible Person to stay in the Hospital longer than the time originally authorized, an extension of the authorization may be issued by the medical care review program after further review.

When Surgery is Recommended

If a Physician recommends a non-emergency surgical procedure (inpatient or outpatient), it may require you to contact the medical care review program. You may contact the Fund Office to find out if your recommended procedure requires the medical care review program. If required, the request for non-emergency surgery must be reviewed and authorized at least five days prior to the scheduled surgery. Upon completion of the review process, the Eligible Person, Physician and the surgical facility will receive written authorization for the length of stay and the appropriate setting (inpatient, outpatient facility or Physician's office). Any surgical procedures performed on an Emergency basis will not require prior written authorization from the medical care review program.

When Other Care is Recommended

When a Physician recommends Home Health Care or Durable Medical Equipment, the Eligible Person or Physician should contact the medical care review program prior to arranging the visits or purchasing the equipment.

ALTHOUGH THE ELIGIBLE PERSON, PHYSICIAN OR HOSPITAL MAY CONTACT THE MEDICAL CARE REVIEW PROGRAM, THE PARTICIPANT IS ULTIMATELY RESPONSIBLE TO ENSURE THE MEDICAL CARE REVIEW PROGRAM HAS BEEN CONTACTED WITHIN THE APPROPRIATE TIME FRAME.

SEE SECTION 9.15 FOR CONTACT INFORMATION.

Section 8.16 – Preferred Provider Organization (PPO)

The Preferred Provider Organization Network applies to Classes A, AS, and S. Any Physician or Hospital that accepts Medicare will be treated as an In-Network, Preferred Provider for Class CP. See Appendix A for more information.

The Board of Trustees reserves the right to enter into agreements for negotiated fee levels with PPOs. Use of a Preferred Provider may result in lower Deductible Amounts, lower cost sharing amounts, application of the Out-of-Pocket Limit and other favorable features. However, usage is voluntary and shall be initiated by the Participant.

The Board of Trustees may amend these agreements at any time, including but not limited to terminating any agreement and entering into new agreements. All such agreements are on file with the Fund Office.

Notwithstanding any other Plan provision, if for any reason the contracted PPO fee for a covered service is more than the Preferred Provider's actual charge, then the Plan will pay benefits so that the Participant's Copayment amount is no more than what it would have been had the covered amount been the actual charge.

Protections From Surprise Medical Bills
Under a federal law called the No Surprises Act, you have protection against surprise medical bills from Out-of-Network providers and facilities. This law mainly applies to Out-of-Network Emergency Services, services provided by Out-of-Network providers at In-Network facilities, and Out-of-Network Air Ambulance Services.

Out-of-Network Emergency Services
Covered Emergency Services are treated as In-Network for determining all cost-sharing amounts, including the Coinsurance, Copayments, Deductible and the Out-of-Pocket Limit, even if the services were received from an Out-of-Network Emergency facility. This means you will be responsible for the In-Network cost-share amount. The Plan will count any cost-sharing payments toward the In-Network Deductible and/or the In-Network Out-of-Pocket Limit in the same manner it would count cost-sharing payments made for In-Network Emergency Services.

Your cost-sharing will be based on the Recognized Amount payable for these services.

If you receive Emergency Services from an Out-of-Network provider, the provider is not permitted to "balance bill" you for the difference between what the provider charges and the total amount collected by the provider, which include payments paid by the Plan and Copayments, coinsurance or Deductible amounts paid by you.

Out-of-Network Providers at In-Network Facilities
Unless you consent to receiving services from the Out-of-Network provider (as described in this section), covered services performed by Out-of-Network providers at In-Network hospitals or ambulatory surgical centers are treated as In-Network for determining all cost-sharing amounts, including the Coinsurance, Copayments, Deductible and the Out-of-Pocket maximum. This means you will be responsible for the In-Network cost-share amount, and the Plan will count any cost- sharing payments incurred for these services toward the In-Network Deductible and/or the In-Network Out-of-Pocket maximums under the Plan in the same manner it would count cost-sharing payments made for In-Network services.

Your cost-sharing will be based on the Recognized Amount payable for these services.

If you receive services from an Out-of-Network provider at an In-Network facility, the provider is not permitted to "balance bill" you for the difference between what the provider charges and the total amount collected by the provider, which include payments paid by the Plan and Copayments, coinsurance or Deductible amounts paid by you.

Out-of-Network Air Ambulance Providers
Covered Air Ambulance Services are treated as In-Network for determining all cost-sharing amounts, including coinsurance, Copayments, Deductible and the Out-of-Pocket maximum. This means you will be responsible for the In-Network cost-share amount and the Plan will count any

cost-sharing payments incurred for covered Air Ambulance Services toward the In-Network Deductible and/or the In-Network Out-of-Pocket maximums in the same manner it would count cost-sharing payments made for In-Network services.

Your cost-sharing will be based on the lesser of the amount billed by the provider or facility or the Qualifying Payment Amount.

If you receive Air Ambulance Services from an Out-of-Network provider, the provider is not permitted to "balance bill" you for the difference between what the provider charges and the total amount collected by the provider, including payments paid by the Plan and Copayments, coinsurance or Deductible Amounts paid by you.

Waiving Surprise Medical Bill Protections

In certain limited circumstances, you can waive the balance billing and cost-sharing protections provided under the No Surprises Act. You may be able to waive these protections for (1) services from an Out-of-Network Provider at an In-Network Facility or (2) services from an Out-of-Network emergency facility or provider after you are stabilized. This can occur if you are notified by the Out-of-Network Provider that the provider does not participate with the Plan and you provide informed consent to be treated by the provider and waive the protections.

If you give informed consent to be treated by the Out-of-Network provider, then the Plan will treat these services as Out-of-Network. This means you will be subject to Out-of-Network cost-sharing, the provider can bill you for the balance directly and the provider can balance bill you for the difference between what the provider charges and the amount paid by the Plan and the cost-sharing amounts paid by you.

You may not waive No Surprises Act protections for ancillary services provided by an Out-of-Network Provider in an In-Network facility. Ancillary services include items and services related to emergency medicine, anesthesiology, pathology, radiology and neonatology; items and services provided by assistant surgeons, hospitalists and intensivists; diagnostic services, including radiology and laboratory services, and items and services provided by an Out-of-Network Provider if there is no In-network Provider who can furnish such item or service at such facility.

Plan Payment to Out-of-Network Providers at In-Network Facilities, Out-of-Network Air Ambulance Providers, and Out-of-Network Emergency Facilities

For claims subject to the No Surprises Act from Out-of-Network Providers at In-Network Health Care Facilities, Out-of-Network Air Ambulance Providers, and Out-of-Network Emergency Facilities, the Plan will pay the provider or facility the Out-of-Network Rate minus any cost-sharing amounts (Copayments, Coinsurance and/or amounts paid towards Deductible) you paid.

Continuing Care

If you are receiving care from an In-Network provider that becomes Out-of-Network, you may have certain rights to continue your course of treatment if you are a "continuing care patient."

A continuing care patient is a patient that

- Is undergoing a course of treatment for a serious and complex condition from the provider or facility;
- Is undergoing a course of institutional or inpatient care from the provider or facility;
- Is scheduled to undergo nonelective surgery from the provider, including receipt of postoperative care from such provider or facility with respect to such a surgery;

- Is pregnant and undergoing a course of treatment for the pregnancy from the provider or facility; or
- Is or was determined to be terminally ill (as determined under Social Security Act) and is receiving treatment for such illness from such provider or facility.

A serious and complex condition means a condition that

- In the case of an acute illness, is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or
- In the case of a chronic illness or condition, a condition that
  - is life-threatening, degenerative, potentially disabling or congenital; and
  - requires specialized medical care over a prolonged period of time.

If the Plan terminates its contract with your In-Network provider or facility or your Benefits are terminated because of a change in terms of the providers' and/or facilities' participation in the Plan, you will be notified of the change and informed of your right to elect to receive transitional care from the provider. You may choose to continue your course of treatment under the same terms and conditions as would have applied for an In-Network provider for up to 90 days after the notice is provided or until you no longer qualify as a continuing care patient (whichever is earlier). These providers cannot balance bill you during this time.

Termination of a contract includes the expiration or nonrenewal of the contract but does not include a termination of the contract for failure to meet applicable quality standards or for fraud.

Section 8.17 – Insured Benefits

The Board of Trustees reserves the right to enter into agreements for insured benefits with outside vendors or providers. Use of the benefit offered under this type of arrangement is voluntary and shall be initiated by the Participant.

The Board of Trustees may amend these agreements at any time, including but not limited to terminating any agreement and entering into new agreements.

All such agreements are incorporated by reference into this Plan and are on file at the Fund Office.

Section 8.18 – Termination of the Plan by an Employer

Upon termination of the Plan with respect to any individual Employer, the coverage of that Employer's Participants and Dependents shall thereafter be null and void.

Section 8.19 – Illegality of Particular Provision

The illegality of any particular provision of this Plan shall not affect the other provisions thereof, but the Plan shall be construed in all respects as if such invalid provision were omitted.

Section 8.20 – Applicable Laws

To the extent state laws are not preempted by ERISA or any other federal law, the Plan shall be governed by and construed according to the laws of the State of Indiana. Should any Trust Agreement be entered into by the Board of Trustees, any such Trust Agreement shall be governed by and construed according to the laws of the state in which the Trust is located.

Section 8.21 – HIPAA Privacy Rule

A) Plan's Designation of Person/Entity to Act on its Behalf

The Plan has determined that it is a "group health plan" within the meaning of the HIPAA Privacy Rule. For HIPAA purposes, the Plan designates the Plan Sponsor, the Board of Trustees, to take all actions required to be taken by the Plan in connection with the Privacy Rule *(e.g.,* entering into Business Associate contracts; accepting certification from the Plan Sponsor). Such responsibility may be delegated by the Board to the Plan's Administrator (which, for this Plan, is the Board of Trustees).

B) Definitions

All terms defined in the Privacy Rule shall have the meaning set forth in the Privacy Rule. The following additional definitions apply to the provisions set forth in this Section.

1. "Plan" means this Plan.

2. "Plan Documents" mean the Plan's governing documents and instruments (i.e., the documents under which the Plan was established and is maintained), including but not limited to this Document.

3. "Plan Sponsor" means the Board of Trustees of this Plan.

C) The Plan's Disclosure of Protected Health Information to the Plan Sponsor-Required Certification of Compliance by Plan Sponsor

Except as provided below with respect to the Plan's disclosure of summary health information, the Plan will: (i) disclose Protected Health Information to the Plan Sponsor or (ii) provide for or permit the disclosure of Protected Health Information to the Plan Sponsor with respect to the Plan, *only if* the Plan has received a certification (signed on behalf of the Plan Sponsor) that:

1. The Plan Documents have been amended to establish the permitted and required uses and disclosures of such information by the Plan Sponsor, consistent with 45 CFR §164.504 (the "504" provisions);

2. The Plan Documents have been amended to incorporate the Plan provisions set forth in this Section; and

3. The Plan Sponsor agrees to comply with the Plan provisions as modified by this Section.

D) Permitted Disclosure of Individuals' Protected Health Information to the Plan Sponsor

1. The Plan (and any Business Associate acting on behalf of the Plan, or any health insurance issuer, HMO, PPO, health care provider, etc., as applicable, servicing the Plan) will disclose individuals' Protected Health Information to the Plan Sponsor only to permit the Plan Sponsor to carry out Plan administration functions. Such disclosure will be consistent with the provisions of this Section.

2. All disclosures of the Protected Health Information of the Plan's individuals by the Plan's Business Associate, health insurance issuer, HMO, PPO, health care provider, etc., as applicable, to the Plan Sponsor will comply with the restrictions and requirements set forth in this Section 8.16 and in the "504" provisions.

3. The Plan (and any Business Associate acting on behalf of the Plan) may not permit a health insurance issuer, HMO, PPO, health care provider, etc., as applicable, to disclose individuals' Protected Health Information to the Plan Sponsor for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor, unless authorized by the individual or as allowed by law.

4. The Plan Sponsor will not use or further disclose individuals' Protected Health Information other than as described in the Plan Documents and permitted by the "504" provisions.

5. The Plan Sponsor will ensure that any agent(s), including a subcontractor, to whom it provides individuals' Protected Health Information received from the Plan (or from the Plan's health insurance issuer, HMO, PPO, health care provider, etc., as applicable), agrees to the same restrictions and conditions that apply to the Plan Sponsor with respect to such Protected Health Information.

6. The Plan Sponsor will not use or disclose individuals' Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor, unless authorized by the individual or as allowed by law.

7. The Plan Sponsor will report to the Plan any use or disclosure of Protected Health Information that is inconsistent with the uses or disclosures provided for in the Plan Documents (as amended) and in the "504" provisions, of which the Plan Sponsor becomes aware.

E) Disclosure of Individuals' Protected Health Information - Disclosure by the Plan Sponsor

1. The Plan Sponsor will make the Protected Health Information of the individual who is the subject of the Protected Health Information available to such individual in accordance with 45 C.F.R. §164.524.

2. The Plan Sponsor will make individuals' Protected Health Information available for amendment and incorporate any amendments to individuals' Protected Health Information in accordance with 45 C.F.R. §164.526.

3. The Plan Sponsor will make and maintain an accounting so that it can make available those disclosures of individuals' Protected Health Information that it must account for in accordance with 45 C.F.R. §164.528.

4. The Plan Sponsor will make its internal practices, books and records relating to the use and disclosure of individuals' Protected Health Information received from the Plan available to the U.S. Department of Health and Human Services for purposes of determining compliance by the Plan with the HIPAA Privacy Rule.

5. The Plan Sponsor will, if feasible, return or destroy all individuals' Protected Health Information received from the Plan (or a health insurance issuer, HMO, PPO, health care

provider, etc., as applicable, with respect to the Plan) that the Plan Sponsor still maintains in any form after such information is no longer needed for the purpose for which the use or disclosure was made. Additionally, the Plan Sponsor will not retain copies of such Protected Health Information after such information is no longer needed for the purpose for which the use or disclosure was made. If, however, such return or destruction is not feasible, the Plan Sponsor will limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

6. The Plan Sponsor will ensure that the required adequate separation, described in paragraph F below, is established and maintained.

F) Required Separation between the Plan and the Plan Sponsor

1. In accordance with the "504" provisions, this section describes the employees or classes of employees of workforce members under the control of the Plan Sponsor who may be given access to individuals' Protected Health Information received from the Plan or from a health insurance issuer, HMO, PPO, etc., as applicable, servicing the Plan.

    a. Board of Trustees

    b. Claims supervisors, processors and clerical support staff

    c. Information Technology personnel

2. This list reflects the employees, classes of employees or other workforce members of the Plan Sponsor who receive individuals' Protected Health Information relating to payment, health care operations of or other matters pertaining to Plan administration functions that the Plan Sponsor provides for the Plan. These individuals will have access to individuals' Protected Health Information solely to perform these identified functions, and they will be subject to disciplinary action and/or sanctions (including termination of employment or affiliation with the Plan Sponsor) for any use or disclosure of individuals' Protected Health Information in violation of or noncompliance with the provisions of this Section.

3. The Plan Sponsor will promptly report any such breach, violation or noncompliance to the Plan and will cooperate with the Plan to correct the violation or noncompliance, to impose appropriate disciplinary action and/or sanctions, and to mitigate any harmful effect of the violation or noncompliance.

Section 8.22 – HIPAA Security Rule

The Welfare Fund (as defined in Section 8.23 E) shall implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the Electronic Protected Health Information that it creates, receives, maintains or transmits on behalf of the Plan, consistent with the requirements of the Standards for the Security of Electronic protected Health Information as set forth in 45 CFR Parts 160 and 162 and Part 164, Subpart C (the "Security Standards"). For this purpose, the Welfare Fund shall be deemed a hybrid entity under the Security Standards, and the provisions of this Section 8.23 shall be administered and interpreted to apply only to that portion of the Welfare Fund that constitutes a Covered Entity under the Security Standards.

A) Support of Adequate Separation Requirement by Security Measures

The Welfare Fund shall ensure that the adequate separation requirement set forth in 45 CFR §164.504(f)(2)(iii) is supported by reasonable and appropriate security measures, consistent with the requirements of the Security Standards.

B) Agents and Subcontractors
The Welfare Fund shall take reasonable steps to ensure that any agent, including a subcontractor, to whom it provides the Electronic Protected Health Information, agrees to implement reasonable and appropriate security measures to protect such information.

C) Reporting Obligation
The Union and Associations shall report to the Welfare Fund any Security Incident of which it becomes aware.

D) Policy
The Plan and this Section 8.23 shall be interpreted and administered in accordance with the Security Standards, any applicable Federal or State law and any other applicable regulation or other official guidance issued thereunder. In the event of a conflict between this Article of the Plan and the Security Standards, statute, regulation or guidance, such Security Standards, statute, regulation or guidance shall govern. The Welfare Fund shall adopt written policies and procedures to implement the provisions of this Section 8.23.

E) Definitions
Capitalized terms used in this Section 8.22 and not defined in the Plan shall have the meaning set forth in the Security Standards. Notwithstanding any provisions to the contrary, for purposes of this Article, Welfare Fund refers to the Plan and Trust Fund and related administration.

ARTICLE IX – IMPORTANT PLAN INFORMATION

The following topics are discussed under this Article on Important Plan Information:

Section 9.01 – Name of Plan

This Plan is known as the Indiana Laborers Welfare Fund.

Section 9.02 – Plan Administrator

The Plan is administered by a joint Board of Trustees, one-half of whom are appointed by the Union and one-half of whom are appointed by the Association.

As Plan Administrator, the Board of Trustees shall have the absolute and sole discretionary authority to construe and interpret the provisions of the Trust Agreement, this Combination Plan Document and Summary Plan Description, as well as any communications related to the Plan. The Board of Trustees will make all factual determinations, including determining the rights or eligibility of Employees or Participants, Dependents and any other persons and the amounts of their Benefits under the Plan. The Board of Trustees will remedy ambiguities, inconsistencies or omissions and such determinations shall be binding on all parties. Benefits will only be paid if the Board of Trustees, in its sole discretion, determines that the Participant or Beneficiary is entitled to them.

The Board of Trustees has the authority to delegate any of its powers under the Plan (including, without limitation, its power to administer Benefit Claims and appeals) to any other person or committee. Such person or committee may further delegate its powers to another person or committee. Any delegation or subsequent delegation shall include the same sole, discretionary and final authority that the Board of Trustees has, as described in this paragraph, and any decisions, actions or interpretations made by any delegate shall have the same ultimate binding effect as if made by the Board of Trustees. No Employer, Union or representative of any Employer or Union is authorized to interpret the provisions of either the Plan or the Trust Agreement.

The Trustees have hired an Administrative Manager to perform the day-to-day operations of the Plan, such as maintaining records, making Benefit Claims payments and determinations and handling general administrative matters.

The Administrative Manager is: Somer Taylor, Indiana Laborers Welfare Fund, P.O. Box 1587 Terre Haute, IN 47808, (812) 238-2551.

Section 9.03 – Board of Trustees

The Board of Trustees is responsible for the operation of the Plan. The Board of Trustees consists of an equal number of Employer and Union representatives who have entered into the collective bargaining agreements that relate to this Plan.

Employer Trustees	Employee Trustees
Jeremy Ayres, Chairman F.A. Wilhelm Construction Co., Inc. 3914 Prospect Street Indianapolis, IN 46203	Brian Short, Secretary-Treasurer LIUNA State of Indiana District Council 425 S. 4th Street Terre Haute, IN 47807
Jeffrey Chapman Tonn & Blank Construction, LLC 1623 Greenwood Avenue Michigan City, IN 46360	Andrew Angel LIUNA Local Union #561 951 North Park Drive Evansville, IN 47710
William A. (Bill) Hasse III Hasse Construction Co., Inc. P.O. Box 300 Calumet City, IL 60409	James Ward Daniels LIUNA State of Indiana District Council 2611 Waterfront Parkway East Drive, Ste 225 Indianapolis, IN 46214
Butch McAreavy Miller Pipeline, LLC 8850 Crawfordsville Road Indianapolis, IN 46234	Murray Miller LIUNA Local Union #645 23698 Western Avenue South Bend, IN 46619
Dave Podlogar Pepper Construction Co of Indiana, LLC 1850 W 15th Street Indianapolis, IN 46202	William Kevin Roach LIUNA Local Union #41 550 Superior Avenue Munster, IN 46321
Randall Wilkinson Milestone Contractors, LP 5757 Decatur Blvd, Ste 250 Indianapolis, IN 46241	Danny Stults LIUNA Local Union #795 1213 State Street New Albany, IN 47150
	James (Jim) Terry LIUNA Local Union #274 1734 Main Street Lafayette, IN 47904

The Board of Trustees may be contacted at the following Fund Office address and phone number:

Indiana Laborers Welfare Fund
P.O. Box 1587
Terre Haute, IN 47808-1587
(812) 238-2551

Section 9.04 – Plan Sponsors
"Plan Sponsors" are the parties that created this group health care Plan. Plan Sponsors include Employers, Unions and the Board of Trustees. Plan Participants and Beneficiaries may write to the Plan Administrator (the Board of Trustees) at the address in Section 9.03 to find out if a particular Employer or Union is a sponsor of this Plan and, if so, to find out that Plan sponsor's address. For purposes of HIPAA, the Plan Sponsor is the Board of Trustees.

Section 9.05 – Identification Numbers
The Federal Employer Identification Number assigned to the Board of Trustees by the Internal Revenue Service is 35-0923209. The Plan Number is 501. The State Employer Identification Number is 00018259840012

Taken together, the Plan's name and number and the Employer Identification Number identify the Plan with the federal agencies governing employee benefits plan operation.

Section 9.06 – Agent for Service of Legal Process

Service may be made on the Board of Trustees collectively or on any individual Trustee at the address of the Fund Office:

Indiana Laborers Welfare Fund
P.O. Box 1587
Terre Haute, IN 47808-1587

Section 9.07 – Collective Bargaining Agreement
The Plan is maintained under Agreements between the Laborers International Union of North America State of Indiana District Council and participating Associations. You may review the Agreements at your Local Union Office, or you may request a copy by writing to the Fund Office.

Section 9.08 – Source of Contributions
The Plan's Benefits for eligible Employees are provided through Employer contributions. Employers are required to make a contribution to the Trust Fund for each hour worked by each Employee. The hourly contribution rate is set by the collective bargaining agreements between the Union and the Associations.

Section 9.09 – Funding Medium for the Accumulation of Plan Assets
All contributions and investment earnings of the Plan are accumulated in a Trust Fund that is utilized to pay Benefits for Eligible Persons and to defray reasonable costs of administration.

Section 9.10 – Plan and Fiscal Year
The fiscal records of the Plan are kept on a December 1 to November 30 basis.

Section 9.11 – Type of Plan
This Plan is maintained for the purpose of providing Life, Accidental Death and Dismemberment, Loss of Time (Short-Term Disability), Medical, Prescription, Dental, Eye Care and other Benefits. A detailed written description of the Plan Benefits appears in Article IV.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Administrator (the Board of Trustees).

You may also contact the Employee Benefits Security Administration, US Department of Labor at (866) 444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

Section 9.12 – Eligibility Rules

The rules regarding eligibility for coverage, termination of eligibility and direct payment of contributions are found in the applicable Sections.

Section 9.13 – Reciprocity Agreements

The Plan has entered into reciprocity agreements with various other funds. If you work under more than one fund and are not eligible under your home fund, you should check with the Fund Office to see if eligibility can be established under reciprocity.

Please contact the Fund Office for further information.

Section 9.14 – If the Plan Is Terminated or Modified

The Board of Trustees reserves the right to change, suspend or end the Plan at any time and for any reason, in whole or in part.

In addition, Benefits may be discontinued at any time for any group of Participants (including Retirees).

This document is not a promise always to provide any particular Benefit. In general, if the Plan (or any portion of the Plan) is ended you will not be vested in any Plan Benefits or have any rights.

In the event that the Plan is discontinued or terminated, in whole or in part, Benefits will be paid only for services received up to the date of Plan termination.

However, the amount and form of any final Benefit you may receive will depend on Plan assets, any contract or insurance provisions affecting the Plan and decisions made by the Board of Trustees.

You will be notified if the Plan is amended.

Section 9.15 – Fund Service Providers

Administrative Manager
Somer Taylor
P.O. Box 1587
Terre Haute, IN 47808
(812) 238-2551

Legal Counsel
Ledbetter Partners LLC
2449 North Delaware Street
Indianapolis, IN 46205

Life and AD&D Insurance Carrier
MetLife
200 Park Ave.
New York, NY 10166

Benefit Consultant / Actuary
United Actuarial Services, Inc.
11590 N. Meridian Street, Suite 610
Carmel, IN 46032

Medical Care Review Program
Hines & Associates, Inc.
115 East Highland Avenue
Elgin, IL 60120
Precert: (800) 559-5257
www.precertcare.com

General Medical PPO Network
United Healthcare Shared Services
www.whyuhc.com/uhss

Eye Care PPO Network
VSP
3333 Quality Drive
Rancho Cordova, CA 95670
(800) 877-7195
www.vsp.com

Dental PPO Network
Delta Dental of Indiana
P.O. Box 9085
Farmington Hills, MI 483339085
(800) 524-0149
www.deltadental.com

Pharmacy Benefit Manager
Sav-Rx
224 N. Park Avenue
Fremont, NE 68025
(800) 228-3108
www.savrx.com

Member Assistance Program (MAP)
AllOne Health MAP
20 N. Clark Street Suite 2650
Chicago, IL 60602
(800) 866 7556
www.AllOne Health.com

Hearing Network
Amplifon Hearing Health Care
(866) 349-9051
www.amplifonusa.com/indianalaborers

Telehealth Provider
Teladoc Online
www.teladochealth.com
800-835-2362

Sword Health
join.swordhealth.com/indianalaborers/register

Hello Heart
https://join.helloheart.com/ILWF97

MAPD Advocacy Team
for questions regarding medical and prescription benefits, medical providers and pharmacies.
(812) 238-2551, Option 2

MAPD Plan Insurance Company
UnitedHealthcare
P.O. Box 31362
Salt Lake City, UT 84131-0362
(844) 481-8820 (TTY 711)

Administrator for MAPD Self-Payment
Somer Taylor
P.O. Box 1587
Terre Haute, IN 47808
(812) 238-2551

ARTICLE X – STATEMENT OF ERISA RIGHTS

Your Rights
As a Participant in Indiana Laborers Welfare Fund, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan Participants shall be entitled to:

Receive Information About Your Plan and Benefits

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

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

Receive a summary of the Plan's annual financial report. The Board of Trustees is required by law to furnish each Participant with a copy of the summary annual report.

Be informed that under the Health Insurance Portability and Accountability Act (HIPAA), upon request, the Plan must provide you with a "Certificate of Creditable Coverage" if you lose health care coverage under the Plan for any reason. This Certificate reports data on prior periods of health coverage under the Plan compiled in accordance with federal regulations. Participants should retain this "Certificate of Creditable Coverage" and submit it to a new employer if the new employer maintains a group health care plan. The new employer may be required under federal law to credit such coverage toward any waiting period for coverage of pre-existing conditions under the new employer's plan.

Be informed that the Plan is in compliance with the non-discrimination requirements set forth in Section 2590.701-2 of the DOL's HIPAA regulations. These regulations state that a group health care plan may NOT establish Eligibility Rules based on any of the following factors: (1) health status; (2) medical condition (including both physical and mental illness); (3) prior Benefit Claims experience; (4) actual receipt of health care; (5) medical history; (6) genetic information; (7) evidence of insurability (including conditions arising out of domestic violence); or, (8) short-term disability (Loss of Time).

Be informed that under the Newborns' and Mothers' Health Protection Act, group health plans and health insurance issuers offering group health insurance coverage generally may NOT restrict benefits for any Hospital stay in connection with childbirth for the mother or newborn child to less than 48 hours following vaginal delivery or less than 96 hours following a delivery by cesarean section. However, the Plan, or issuer, may pay for a shorter stay if the attending provider (e.g., your Physician, nurse midwife or Physician Assistant), after consultation with the mother, discharges the mother or newborn earlier. Under federal law, plans and issuers may not set the level of benefits or Out-of-Pocket costs so that any later portion of the 48-hour or 96-hour stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay. In addition, a plan or issuer may not, under federal law, require that a Physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours or 96 hours,

as applicable. However, to use certain providers or facilities, or to reduce your Out-of-Pocket costs, you may be required to obtain precertification. For information on precertification, See Section 8.15 or contact the Fund Office.

Be informed that under the Women's Health and Cancer Rights Act, group health plans and health insurance issuers offering group health insurance coverage that includes medical and surgical benefits with respect to mastectomies shall include medical and surgical benefits for breast reconstructive surgery as part of a mastectomy procedure. Breast reconstructive surgery benefits in connection with a mastectomy shall at a minimum provide coverage for: (1) reconstruction of the breast on which the mastectomy has been performed; (2) surgery and reconstruction of the other breast to produce a symmetrical appearance; (3) prostheses; and, (4) physical complications for all stages of mastectomy, including lymphedemas. Such surgery shall be in a manner determined in consultation with the attending Physician and the patient. As part of the Plan's Schedule of Benefits, such Benefits are subject to the Plan's appropriate cost control provisions, such as Deductibles and Copayments.

The Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, religion, national origin, age (40 or older), disability, sex (including pregnancy, sexual orientation or gender identity) or genetic information (including family medical history).

Continuing 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 Combination Plan Document and Summary Plan Description 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 pre-existing 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 employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan Participants and Beneficiaries. No one, including your Employer, your Union or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a Benefit or exercising your rights under ERISA.

Enforce Your Rights

If your Benefit 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 Benefit Claim 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 Fund Office 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 Board of Trustees 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 Benefit Claim that is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Fund Office. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Fund Office, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, 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 at (866) 444-3272.

ARTICLE XI – DEFINITIONS

THE FOLLOWING WORDS HAVE SPECIFIC MEANINGS WHEN USED IN THE PLAN. IT IS IMPORTANT TO UNDERSTAND THE MEANINGS OF THESE DEFINED TERMS WHILE USING THIS DOCUMENT.

UNLESS OTHERWISE INDICATED, ANY MASCULINE TERMINOLOGY USED INCLUDES THE FEMININE AND ANY DEFINITION USED IN THE SINGULAR ALSO INCLUDES THE PLURAL.

The following topics are discussed under this Article on Definitions:

Section 11.01 – Air Ambulance Service
Medical transport by helicopter or airplane for patients.

Section 11.02 – Agreement
"Agreement" means either a collective bargaining agreement or a participation agreement between the Union, or a subordinate body thereof, and an Employer or Association of Employers, which requires contributions to the Indiana Laborers Welfare Fund.

Section 11.03 – Allowed Amount
The "Allowed Amount" is the maximum amount this Plan will pay for a Covered Expense. "Allowed Amount" may also be called "Allowable Expense," "Eligible Expense," "Payment Allowance," "Negotiated Rate," "Recognized Amount," "Approved Amount" or "Approved Charge."

Section 11.04 – Associations
"Associations" means the Associations of participating Employers who are parties to the Trust Agreement which funds the Plan.

Section 11.05 – Beneficiary
"Beneficiary" means a natural person or legal entity designated by a Participant or by the terms of the Plan, who is or may become entitled to a Benefit.

Section 11.06 – Benefit Claim
"Benefit Claim" means a request for payment of Benefits from the Fund in accordance with the procedures outlined in Section 8.03. This request can be submitted in either a paper or HIPAA-compliant electronic format. If a Benefit Claim is denied, in whole or in part, an Eligible Person can appeal the Benefit Claim Denial in accordance with the procedures outlined in Section 8.04.

A Benefit Claim **does not** include any of the following:

A) A casual inquiry about whether a specific service is a covered Benefit.

B) A voluntary pre-service determination of whether a treatment, service or product is covered.

C) An inquiry regarding eligibility to receive a treatment, service or product. However, after service is incurred, a determination of eligibility will be made by the Fund.

D) An attempt to purchase or receive a prescription drug at the counter. However, any denial of such purchase or receipt entitles the Eligible Person to file a Benefit Claim after the denial.

Section 11.07 – Benefits
"Benefits" means services, supplies, charges, and losses that this Plan covers, as shown in this Plan's Schedule of Benefits, together with any amendments, modifications or interpretations adopted by the Board of Trustees.

Section 11.08 – Board of Trustees
"Board of Trustees" means the Board which maintains and administers the Plan as described in Section 9.03, constituted of an equal number of Employer Trustees and Employee Trustees collectively appointed under the terms of the Trust Agreement.

Section 11.09 – Coinsurance and Copay

"Coinsurance" means the percentage the Eligible Person must pay of the covered services and items after the Deductible is met. "Copay" means the dollar amount the Eligible Person must pay of the covered services after the Deductible is met. Coinsurance and Copays are types of Cost Sharing.

Section 11.10 – Cosmetic

"Cosmetic" means any procedure or service 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.

Section 11.11 – Coverage Period

"Coverage Period" means the period during which an Eligible Person may participate in this Plan's Benefits.

Eligibility for Active Employees is further defined in Section 3.02 with examples in Section 3.03. Eligibility for Retirees is further explained in Section 6.01.

Section 11.12 – Covered Charges

"Covered Charges" means only those dollar amounts charged for services and supplies which the Trustees would consider to be priced as Usual, Customary, and Reasonable (see definition in this Article) and Medically Necessary in light of the Injury or Sickness being treated.

Section 11.13 – Cost Sharing

"Cost Sharing" means the share of Covered Charges that you pay out of your own pocket. The Deductible, Coinsurance, and Copays are types of Cost Sharing.

Section 11.14 – Custodial Care

"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; or

B) are provided mainly to help the Eligible Person with daily living activities, including (but not limited to) –

1) walking, getting in and/or out of bed, exercising and moving the Eligible Person;

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;

6) supervising the administration of medications which can usually be self-administered, including reminders of when to take such medications;

C) provide a protective environment;

D) are part of a maintenance treatment plan or are not part of an active treatment plan intended to or reasonably expected to improve Injury, Sickness or functional ability; or

E) are provided for convenience or are provided because home arrangements are not appropriate or adequate.

Section 11.15 – Dependent

"Dependent" means a person registered with the Trust Fund to receive Plan Benefits. A "Dependent" is an Eligible Person by way of fitting one of the following categories of individuals:

A) The Spouse to whom the Participant is legally married (not divorced or legally separated).

B) Children of the Participant (including stepchildren, legally adopted children and children placed for adoption as of the date they are placed for adoption) until the end of the month in which the child turns age 26. A person of any age who is not your child and for whom you have legal guardianship is NOT a Dependent.

C) Children of the Participant (including stepchildren and legally adopted children and children placed for adoption as of the date they are placed for adoption) who became physically or mentally incapable of self-support (meeting the definition of "Disabled' in Section 11.16) prior to the attainment of age 19, who live in the Participant's home and who are chiefly dependent upon the Participant for support, provided proof of Disability is submitted from time to time as described in Section 3.08 or as otherwise required by the Board of Trustees.

D) Children described in B or C above for whom a Participant is ordered by a United States court of competent jurisdiction to provide medical coverage in accordance with a court-issued Qualified Medical Child Support Order (QMCSO).

"Dependent" shall not include the child carried and born of an Eligible Person acting as a surrogate mother and will not be considered a Dependent of such surrogate mother or her spouse. For the purpose of this Plan, "surrogate mother" means that the mother has entered into a contract or other understanding pursuant to which she relinquishes a child or children following the birth of the child.

"Chiefly dependent on the Participant for support" means that the Participant directly provides 50% or more of the financial support of the child, or that the Participant has taken full parental responsibility for and control of the child or is raising the child as his own. The Participant shall provide such proof of dependency as is requested by the Board of Trustees, including but not limited to tax returns or written affidavits.

Such Dependents shall be covered in accordance with the Plan provisions established for each class of coverage.

As used in this Plan, “child(ren) placed for adoption” means an individual who has not yet attained the maximum age of adoption, as of the date of the assumption and retention by a Participant of a legal obligation for total or partial support of such child in anticipation of adoption of such child. The child’s placement with a Participant terminates upon the termination of such legal obligation.

Section 11.16 – Developmental Care

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

A) are provided to an Eligible Person who has not previously reached the level of development expected for his 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; or

B) are not rehabilitative in nature (restoring fully developed skills that were lost or impaired due to Injury or Sickness); or

C) are educational in nature.

Section 11.17 – Disability (Long-Term)

“Long-Term Disability” means, on the basis of medical evidence satisfactory to the Board of Trustees, a person is prevented by Injury or Sickness, from engaging in almost or substantially all of the normal activities of a person of like age and sex in good health.

Section 11.18 – Disability (Short-Term)

For the purpose of Loss of Time (Short-Term Disability) Benefits, “Short-Term Disability” means, on the basis of evidence satisfactory to the Board of Trustees (unless delegated as described in Section 8.02), a Participant is –

A) under the care of a Physician,

B) prevented, by Injury or Sickness, from engaging in his regular or customary occupation and

C) performing no work of any kind for compensation or profit.

Section 11.19 – Eligible Person
The term "Eligible Person" means any person who is presently or may become eligible for Benefits under this Plan in accordance with the Eligibility Rules adopted by the Trustees. An Eligible Person is one of the following: a Participant (as defined in Section 11.36, including an Active Employee, Retiree or Totally Disabled Participant), a Dependent (as defined in Section 11.15, including a Spouse, Surviving Spouse, Dependent Child or Alternate Recipient under a QMCSO), or a Beneficiary (as defined in Section 11.04) currently receiving Benefits.

Section 11.20 – Emergency or Emergency Medical Condition or Medical Emergency
A medical condition, including a mental health condition or substance use disorder, manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in (i) 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, (ii) serious impairment to bodily functions or (iii) serious dysfunction of any bodily organ or part.

Section 11.21 – Emergency Services
With respect to an Emergency Medical Condition, "Emergency Services" include:

- An appropriate medical screening examination that is within the capability of the emergency department of a hospital or of an Independent Freestanding Emergency Department, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition

- Such further medical examination and treatment to stabilize the patient within the capabilities of the staff and facilities available at the hospital or the Independent Freestanding Emergency Department

- Further services that are furnished by an Out-of-Network provider or Out-of-Network Emergency Facility after the patient is stabilized and as part of outpatient observation or an inpatient or outpatient stay (regardless of the department of the hospital in which such further examination or treatment is furnished).

Section 11.22 – Employee
"Employee" means a person who is designated by the Board of Trustees as employed by an Employer.

Section 11.23 – Employer
"Employer" means –

A) An Employer who is a member of, or is represented by, the Association and who is bound by a collective bargaining agreement with the Union providing for the establishment and maintenance of a Welfare Fund Plan and Trust Fund and for the payment of contributions to such Trust Fund.

B) An Employer who is not a member of the Association (see definition in Article XI) but whose Employees are represented by the Union and who satisfies the requirements for participation in the Plan as established by the Board of Trustees. Such Employer shall, by

the making of a payment to the Trust Fund on behalf of an Employee, be deemed to have become a party to an agreement between the Union and the Association.

C) The Union, which shall be considered as the Employer of the Employees of the Union for whom the Union contributes to the Trust Fund.

D) The Board of Trustees, which shall be considered as the Employer of the Employees of the Plan for whom the Board of Trustees contributes to the Trust Fund.

Section 11.24 – Experimental

"Experimental" means a service or supply that the Board of Trustees (unless delegated as described in Section 8.02) determines meets one or more of the following criteria:

A) a drug or device 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 or device is furnished; or

B) a drug, device, treatment or procedure 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) a drug, device, treatment or procedure which Reliable Evidence shows is the subject of ongoing phase I, II or III clinical trials or is under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or

D) a drug, device, treatment or procedure 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; or

E) A drug, device, treatment or procedure for a condition or treatment not specifically approved by the FDA unless it is determined by the Plan's medical professionals to be an appropriate standard of care for that condition.

For purposes of this definition, "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. For purposes of this paragraph, "authoritative" means that the prevailing opinion within the appropriate specialty of the United States medical profession is that the medical and scientific literature is entitled to credit and acceptance, as is, for example, The New England Journal of Medicine.

Section 11.25 – Hospital

"Hospital" means an institution which is licensed as a hospital and operated pursuant to law and is primarily and continuously engaged in providing or operating, either on its premises or in facilities controlled by the hospital, under the supervision of a staff of Physicians, medical,

diagnostic and major surgery for the medical care and treatment of sick and injured persons on an inpatient basis for which a charge is made, with 24-hour nursing service by or under the supervision of registered graduate professional nurses (R.N.s).

For the purpose of paying Benefits for mental/nervous disorders, "Hospital" also means either –

A) a hospital licensed by a Board of Health or Department of Mental Health, or

B) a hospital owned or operated by a state, which is especially intended for the use in the diagnosis, care and treatment of psychiatric, mental/nervous disorders.

The term "Hospital" shall not include any military or veteran's hospital or soldier's home unless otherwise legally required to pay. The term "Hospital" also shall not include a hospital or institution or part of a hospital 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 or primarily affording Custodial, educational or rehabilitative care.

Section 11.26 – Independent Freestanding Emergency Department

A health care facility that (i) Is geographically separate and distinct and licensed separately from a hospital under applicable State law; and (ii) Provides any "Emergency Services" as defined in this Document.

Section 11.27 – Injury

"Injury" means any accidental bodily injury which requires treatment by a Physician, and which results in loss independent of Sickness or other causes. **Intentionally self-inflicted Injuries are excluded.**

Section 11.28 – Insurance (Life Insurance, Accidental Death and Dismemberment Insurance)

A) **Life Insurance** means, as described in Section 4.01, those Benefits payable as the result of the death of a Participant which occurs as the result of an accidental bodily Injury or Sickness for any reason. Life Insurance Benefits shall be paid to a Beneficiary in such form or forms as provided in Section 4.01.

B) **Accidental Death and Dismemberment Insurance** means, as described in Section 4.02, those Benefits payable as the result of the death or other loss of an Active Participant or Class AS Retiree which occurs within 90 days of an accidental bodily Injury as the result of a non-occupational accident. "Loss of a hand and/or foot" means severance at or above the wrist or ankle. "Loss of sight" means total and permanent loss of sight.

Section 11.29 – Maternity

"Maternity" means expenses related to pregnancy and childbirth.

Section 11.30 – Medically Necessary

"Medically Necessary" means a service or supply which is ordered by a Physician and is –

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 Eligible Person's Injury or Sickness;

C) provided in accordance with generally accepted medical practice on a national basis; 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 one type of care vs. other types of care).

The fact that a Physician prescribes services or supplies does not automatically mean such services or supplies are Medically Necessary and covered by the Plan. Whether a particular service or supply is Medically Necessary shall be determined by the Board of Trustees (unless delegated as described in Section 8.02).

Section 11.31 – Medicare

"Medicare" means the federally-sponsored health insurance program for aged and disabled individuals, as set forth in Title XVIII of the Social Security Act, as amended.

Section 11.32 – Newborn Care

"Newborn Care" means routine expenses incurred by a well, but Hospital-confined, Dependent newborn child but only while the mother is Hospital-confined as the result of giving birth to such child, including expenses incurred for room and board provided by a Hospital for such newborn child and expenses incurred for routine medical examination and "check-up" purposes. "Newborn Care" does not mean expenses incurred as a result of premature birth, Injury suffered, Sickness contracted or a congenital birth defect.

Section 11.33 – Network Health Care Facility

In the context of non-Emergency Services, an In-Network Hospital, Hospital outpatient department, critical access Hospital or ambulatory surgical center (as defined in the Social Security Act).

Every effort has been made to ensure that the information contained in this Combination Plan Document and Summary Plan Description (Document) is accurate and up to date as of the time of its printing. You will be notified, in writing, of any changes in the Plan that may affect your benefits or rights under the Plan.

Section 11.34 – Out-of-Network Emergency Facility

An emergency department of a Hospital, or an Independent Freestanding Emergency Department (or a Hospital, with respect to Emergency Services as defined), that does not have a contractual relationship directly or indirectly with the Plan, with respect to the furnishing of an item or service.

Section 11.35 – Out-of-Network Rate

"Out-of-Network Rate" means the total amount this Plan pays for each service an Eligible Person receives.

The Out-of-Network Rate will be determined in the following order:

- the amount that the state approves under an All-Payer Model Agreement, if applicable;
- the amount determined by a state law, if applicable;
- the payment amount agreed to by the Plan and provider or facility, if applicable;
- the amount approved under the independent dispute resolution (IDR) process.

Section 11.36 – Participant
The term "Participant" shall mean any Employee, Retiree, or Totally Disabled Participant who has met the eligibility requirements for Benefit coverage in the Plan and is covered by the Plan

Section 11.37 – Physician
"Physician" means any of the following licensed practitioners who act within the scope of their license to perform a service payable under the Plan:

A) a Doctor of Medicine (MD), osteopathy (DO), podiatry (DPM) or chiropractic (DC);

B) where required to cover by law, a licensed doctoral clinical psychologist, a Master's level counselor and licensed or certified social worker, a licensed physician's assistant (PA) or any other licensed practitioner who –

1. is acting under the supervision of a Doctor of Medicine (MD); and

2. performs a service which is payable under the policy when performed by a Doctor of Medicine (MD)

Section 11.38 – Plan
"Plan" means the employee welfare benefit plan with assets in the Indiana Laborers Welfare Fund as described in this Combination Plan Document and Summary Plan Description and as hereafter amended.

Section 11.39 – Plan Year
"Plan Year" means the 12-month period beginning on December 1 and ending on November 30 of the following year.

Section 11.40 – Qualification Period
"Qualification Period" means the period during which a Participant accrues credited hours.

Eligibility for Active Employees is further defined in Section 3.02 with examples in Section 3.03.

Section 11.41 – Qualifying Payment Amount (QPA)
Generally, the median amount the Plan has contractually agreed to pay In-Network providers, facilities or providers of Air Ambulance Services for a particular covered service. This amount is updated annually to account for inflation.

Section 11.42 – Recognized Amount
For items and services furnished by an Out-of-Network provider or Emergency Facility, the Recognized Amount will be determined in the following order:

- An amount determined by an All-Payer Model Agreement, if applicable;
- An amount determined by a specified state law, if applicable;
- The lesser of the amount billed by the provider or facility or the Qualifying Payment Amount (QPA).

Section 11.43 – Retiree
"Retiree" means an Employee who has retired from the employ of his Employer.

Section 11.44 – Self-Payment
"Self-Payment" means that amount which must be contributed by a Participant or Dependent in order to preserve his eligibility to receive Benefits under the Plan.

Section 11.45 – Sickness
"Sickness" means a disease, disorder or condition which requires treatment by a Physician. For a female Employee or Dependent wife, "Sickness" includes childbirth, pregnancy or related condition. The term "Sickness" shall also include an illness not caused by an accident.

Section 11.46 – Spouse
"Spouse" means a legal spouse. A Spouse includes a same-sex spouse where the Participant and Spouse were legally married in a state that recognizes same-sex marriages.

Section 11.47 – Substance Abuse Treatment Center
"Substance Abuse Treatment Center" means a Hospital, licensed clinic, or other entity certified by the State (or otherwise meeting state-mandated requirements) for inpatient or outpatient drug or alcohol abuse treatment. Facilities providing inpatient substance abuse services must be licensed or certified for the level of care, have a Physician on staff and have registered nurses on staff 24/7. Facilities providing outpatient services must be licensed or certified for the level of care and services must be performed or supervised by a Physician as defined under this Plan.

Section 11.48 – Summary Plan Description
The "Summary Plan Description," or SPD, is the document that explains the benefits, rights, and obligations under a health plan.

Section 11.49 – Totally Disabled Participant
"Totally Disabled Participant" means an individual with a Long-Term Disability who became Totally Disabled while a Participant.

Section 11.50 – Trust Agreement or Trust
"Trust Agreement" or "Trust" means any agreement in the nature of a trust established to receive, hold, invest and dispose of the Trust Fund in accordance with this Plan.

Section 11.51 – Trust Fund or Fund
"Trust Fund" or "Fund" means all the assets which are held by the Board of Trustees for the purposes of this Plan. It also means the Indiana Laborers Welfare Fund. In this Document, "Fund" also means this Plan.

Section 11.52 – Trustee
"Trustee" means the Employer Trustees and the Employee Trustees, as appointed under the Trust Agreement, to act as Trustee or Trustees of the assets of the Trust Fund.

Section 11.53 – Union
"Union" means the Laborers' International Union of North America, State of Indiana District Council or Local Unions under the jurisdiction of the State of Indiana District Council, who have, in effect with the Associations or with other participating Employers, welfare agreements or collective bargaining agreements providing for the establishment of a Welfare Fund Plan and Trust Fund and for the payment of contributions to such Fund.

Section 11.54 – Usual, Customary and Reasonable Charge or UCR

"Usual, Customary and Reasonable Charge" or "UCR" means the provider's charge for the services or procedures rendered and the supplies furnished based upon data collected from the health plans, insurance carriers and third-party administrators for the geographic area where such services are rendered or supplies are furnished.

For providers within the PPO Network, UCR will be the allowed amount as negotiated by the PPO Network.

For providers not in the primary PPO Network, the UCR will be 140% of the Medicare allowable rate.

Provided further, in some situations, the covered medical expense will be limited to a specific percentage of the usual, customary and reasonable charge.

For Dental, Eye Care, Transplant and Hearing Benefits, the Covered Expense will be limited to the Usual, Customary and Reasonable charge as determined by the Fund's Dental, Eye Care, Transplant and Hearing PPO providers, respectively, based on a fee schedule for In-Network versus Out-of-Network providers. The Fund's providers are listed in Section 9.15.

Section 11.55 – Waiting Period

"Waiting Period" means the number of days of Sickness or Injury which a Participant in the Loss of Time (Short-Term Disability) Benefits portion of this Plan must accumulate for each period of Total Disability resulting from an Injury or Sickness before Benefits become payable.

APPENDIX A – MEDICARE ADVANTAGE PRESCRIPTION DRUG PLAN

This Appendix A only applies to Class CP Participants covered under the Medicare Advantage Prescription Drug Plan (MAPD).

(Placeholder for UHC Certificate)