SUMMARY PLAN DESCRIPTION

Labor-Management Healthcare Fund
Medical and Prescription Drug Plan

January 1, 2019

Plan Information

Plan Name:	The Labor-Management Healthcare Fund Medical and Prescription Drug Plan
Plan Sponsor/Plan Administrator Name, Address and Phone Number:	Board of Trustees Labor-Management Healthcare Fund 90 Anderson Road Cheektowaga, NY 14225 (716) 601-7980 The Plan Administrator has authority to control and manage the operation and administration of the Plan.
Employer ID #:	20-0422657
Plan Year:	January 1 to December 31
Agent for Service of Legal Process:	Board of Trustees Labor-Management Healthcare Fund (address and phone above)
Plan Changes or Termination:	The Plan Administrator may terminate, suspend, withdraw, amend or modify the Plan in whole or in part at any time, subject to the applicable provisions of the Insurance Contract.
Accompanying Documents:	**SPD** – This document, together with the appropriate Subscriber Contract and LMHF/PBD Formulary constitutes your Summary Plan Description ("SPD"). A copy of this document is available on the LMHF website, www.lmhf.net. The term "Subscriber Contract" refers to the plan documentation provided by Highmark BlueCross BlueShield of WNY ("BCBS"), which describes your hospital, medical, and durable medical equipment benefits in detail. Subscriber Contracts are sometimes also referred to as Certificates of Coverage, Evidence of Coverage, Plan Booklets, etc. If you do not have a copy of your Subscriber Contract, you may obtain one from the Plan Administrator or on the BCBS website, www.bcbswny.com. The term "Insurance Contract" refers to the group insurance contract between Highmark BCBS and the Plan Administrator. The LMHF/PBD Formulary lists preferred and generic medications and is available (only as a log-in by the member) on the website of PBD, the Plan's pharmacy benefit manager www.pbdrx.com. A copy may also be obtained from the Plan Administrator.

Benefit Information

Plan Name: Labor-Management Healthcare Fund Medical and Prescription Drug Plan

Type of Plan Benefit:

Active Employee:
- Point of service health plan
- Preferred provider organization health plan

Pre-65 Retirees:
- Point of service health plan
- Preferred provider organization health plan

Post-65 Retirees:
- Medicare + Choice HMO
- Medicare + Choice preferred provider organization health plan
- Traditional Indemnity health plan
- Point of service health plan
- Preferred provider organization health plan

Self-insured prescription drug program

Contract Administrators:
Responsible for plan administration and payment of hospital and medical claims

Highmark BlueCross BlueShield of Western New York
257 West Genesee Street
Buffalo, NY 14202

Independent Health Association, Inc.
511 Farber Lakes Drive
Buffalo, NY 14221

Independent Health Association, Inc. is the Contract Administrator for the Medicare HMO and PPO Plans. All other medical plans are administered by BlueCross BlueShield.

Pharmacy Benefits Manager:
Responsible for processing of drug claims

Pharmacy Benefit Dimensions
511 Farber Lakes Drive
Buffalo, NY 14221

Hospital and medical benefits above are provided pursuant to Insurance Contracts between the Plan Sponsor and the Contract Administrators. If the terms of this summary document conflict with the terms of the Insurance Contract or with the Subscriber Contract, the terms of the Insurance Contract or Subscriber Contract will control, unless superseded by applicable law. For further information about these Plan Benefits refer to the Subscriber Contract for each separate benefit or contact the Plan Administrator.

I Introduction

This document is called a "Summary Plan Description." Its purpose is to explain the provisions of your Employer's group health plan, as provided through the Labor-Management Healthcare Fund (the "LMHF" or "Fund"). You are urged to read this Summary Plan Description carefully and to acquaint your family with its provisions.

The Plan is comprised of both insured and self-funded benefits. Your hospital and medical benefits are provided through insurance coverage; your employer is not an insurer of those benefits. The sole source for those benefits is the insurance company.

In most cases, your prescription drug benefits are self-insured through the Fund. Those benefits are paid directly from the Fund, a trust entity that administers these benefits. (There is one program under which prescription drug coverage is provided under the Highmark BCBS Insurance Contract. In that case, the provisions below relating to self-insured drug benefits do not apply.)

This document does not replace the provisions of the Subscriber Contract. In the event of any difference between the Summary Plan Description and the Subscriber Contract, the terms of the Subscriber Contract will control.

If you have any questions about your benefits under the Plan, please contact the Plan Administrator or your Employer.

II Funding Medium and Type of Plan Administration

The LMHF is an Article 44 Welfare Trust under New York State Insurance Law and a multi-employer, collectively bargained Voluntary Employee Benefit Association ("VEBA") for IRS purposes.

The Plan is maintained pursuant to a collective bargaining agreement between your Employer and your Union. Your Employer contributes to the Fund on your behalf. If you are required to contribute toward the cost of coverage, this will be done though your individual Employer as well.

Hospital and medical benefits under the Plan are fully insured. Benefits are provided under group insurance contracts entered into between Highmark Blue Cross Blue Shield of Western New York ("BCBS") or Independent Health Association, Inc. ("IHA") and the Fund, which will own the group contract providing benefits to all eligible participants. Claims for benefits are sent to BCBS or IHA, as applicable. BCBS or IHA (not your Employer or the Fund) is responsible for paying these claims.

Your drug benefits are self-insured by your Employer through the Labor-Management Healthcare Fund. Claims for benefits are sent to the pharmacy benefit manager, Pharmacy Benefit Dimensions ("PBD"). PBD (not your Employer or the Fund) is responsible for paying these claims.

The Fund's Trust Agreement, collective bargaining agreements, and other documents governing the operation of the Plan may be examined, without charge, at the Plan Administrator's office. You may obtain copies of those documents upon written request to the Plan Administrator. The administrator may make a reasonable charge for the copies.

III Insurer Information

If you need specific information regarding the extent of your medical and hospitalization coverage under this Plan, the benefits offered through your insurance, or how to make a claim for benefits, you should contact BCBS or IHA at the following address and telephone numbers:

Highmark BlueCross BlueShield of Western New York

Customer Service:
Local (716) 887-8840
Toll Free 1-877-576-6440
TDD Line (716) 886-7863

Claims Mailing Address:
BlueCross & BlueShield of W.N.Y.
P.O. Box 80
Buffalo, NY 14240-0080

Acupuncture, Massage and Chiropractic Therapy
Toll Free 1-888-774-7601

Mental Health and Substance Abuse
Toll Free 1-877-837-0814
A clinician will assist you with determining the most appropriate type of provider for the services you need and will arrange treatment.

Health Advocate
Toll Free 1-800-359-5465
A 24-hour service to help members navigate through the healthcare system. Health Advocate is a resource to provide medical/clinical information. They will assist you in preparing for physician visits and help you to understand chronic conditions. They also provide assistance with complex claims and billing issues.

Reminder: If you are outside of the service area and you experience an unexpected illness or injury that is not life threatening, you can call your primary care physician or Health Advocate for guidance. If treatment is advised, call 1-800-810-2583 to locate an in-network provider for an appointment.

You can also find out other important information regarding the types of benefits offered by your Insurer at **www.bcbswny.com**.

IV Pharmacy Benefit Manager Information

If you need additional information regarding your prescription drug benefits, you should contact Pharmacy Benefit Dimensions at the following address and telephone numbers:

Pharmacy Benefit Dimensions

Customer Service:
Local (716) 635-7880
Toll-Free 1-888-878-9172
TTY/TDD Line (716) 631-3108 or
1-800-432-1110
Hours: Monday-Friday, 8:00 a.m. – 8:00 p.m.
Website: www.pbdrx.com

Claims Mailing Address:
Pharmacy Benefit Dimensions
Attn: Pharmacy Claims Department
511 Farber Lakes Drive
Buffalo, New York 14221

To obtain prescriptions through the mail, you may call:

Wegmans Mail Order Pharmacy Services

Prescription mail order, customer service or refill requests
Toll Free: 1-888-205-8573
TTY/TDD Line 1-877-409-8711
Website: www.Wegmans.com/Pharmacy

ProAct Pharmacy Services

Prescription mail order customer service or refill requests
Toll Free: 1-888-425-3301
TTY: National 711 Relay Service
Monday - Friday 8:00a.m. -7:00p.m.
Saturday 8:00a.m.- 1:00p.m.
Sunday Closed
Fax: 1-888-880-7714
Online orders: https://secure.proactrx.com/mail-order/
Website: www.proactpharmacyservices.com/PBD

Reliance Rx

Specialty Pharmacy Program
Local (716) 929-1000
Toll Free 1-800-809-4763
Monday – Thursday 8:00 a.m. – 7:00 p.m.
Friday 8:00 a.m. – 5:00 p.m.
Website: www.reliancerxsp.com

V Eligibility and Participation

Eligibility for participation in the Plan is determined according to rules adopted by your individual Employer in accordance with your collective bargaining agreement. You should contact your Employer to see if you are in a job classification eligible for coverage under this Plan. Your Highmark BCBS Plan Booklet sets forth the eligibility rules for your spouse and children.

Upon enrollment and from time to time thereafter, your Employer (or the Plan Administrator or BCBS) may require that you present satisfactory proof of the initial and/or continuing eligibility of your covered spouse or covered dependent children.

VI Enrollment

You must complete an application form (available through your Employer) to enroll yourself and/or your eligible spouse and dependents. New employees must enroll within certain time periods after being hired, as discussed in the Highmark BCBS Plan Booklet. Otherwise, enrollment generally is limited to the annual open enrollment period that generally occurs in November of every year for coverage beginning January 1 of the following year.

If you do not enroll during the open enrollment period, you will generally not be able to reenroll until the next open enrollment period.

However, there are exceptions to that general rule. If you are a current employee and you decline enrollment for yourself or your dependents (including your spouse) because you or your spouse and/or dependent has coverage elsewhere, but you or your spouse or dependent child loses that coverage (or the employer stops contributing towards your or your dependent's other coverage) other than as a result of a failure to pay participant premiums or termination of coverage for cause (such as fraud), you may subsequently enroll yourself and your dependents (including your spouse) in the Plan by submitting a completed enrollment form to your Employer within 30 days after the other coverage ends (or after the Employer stops contributing toward the other coverage). A loss of eligibility for coverage may include, for example, (i) loss of eligibility due to legal separation, divorce, cessation of dependent status (e.g., attaining the maximum age to be eligible as a dependent child), death of the employee, termination of employment, reduction in number of hours of employment; (ii) the individual no longer lives or works in a service area covered by a Plan benefit program (or similar arrangement) that does not provide benefits to individuals who do not reside, live or work in the area, and, in the case of a group market, there are no other benefit packages available; (iii) the plan no longer offers any benefits to a class of similarly situated individuals that includes the individual; and (iv) for other than COBRA coverage, employer contributions toward coverage terminate. If the other coverage was COBRA coverage, this exception only applies after the COBRA coverage is exhausted. In most cases, the coverage will be effective as of the first of the following month.

If you acquire a new dependent during a period of coverage as a result of marriage, birth, adoption or placement for adoption, you may enroll the new dependent in the Plan, but in order to do so you must request enrollment within 30 days of the marriage, birth, adoption or placement for adoption. In the case of a newly acquired dependent child (through birth, adoption or placement for adoption), the enrollment will be effective as of the date of birth, adoption or placement for adoption if you do so within 30 days of the birth, adoption or placement for adoption. A child is considered placed for adoption on the date you first become legally obligated to provide support for the child whom you plan to adopt. If the adoption does not become final, coverage for the child will terminate as of the date you no longer have a legal obligation to support the child. In the case of a newly acquired spouse or another dependent acquired by marriage, coverage is effective on the first day of the month following the date the completed enrollment form is received by the Employer. In the case of a newly acquired dependent child, if you or your spouse were previously eligible to enroll but did not, you may enroll at the same time as the newly acquired child.

If you are an active employee and otherwise eligible for coverage under the Plan, and either (i) you or your dependent's coverage under Medicaid or a State Children's Health Insurance Program (CHIP) is terminated as a result of loss of eligibility for such coverage, or (ii) you or

your dependent becomes eligible for a premium assistance subsidy under Medicaid or CHIP, you may be able to enroll yourself and/or your dependent(s) in the Plan if you request coverage under the Plan sixty (60) days after the date that Medicaid or CHIP coverage ends or the date you (or your dependent) are determined to be eligible for such assistance. If you qualify for this special enrollment opportunity, coverage under the Plan will be effective beginning on the first day of the first calendar month following the month in which a completed request for enrollment is received by your Employer.

If there is an approved change to the health benefit program provided under your collective bargaining agreement outside of the normal open enrollment cycle, you will be provided a special enrollment. You will be notified in advance if that should occur.

To request special enrollment or obtain more information, contact your Employer's personnel or human resources department.

VII Group Insurance Benefits

Your Employer provides hospital, medical, and durable medical equipment group insurance benefits to eligible employees through the Fund. The insurance carrier will provide you with a booklet or certificate describing the insurance benefits provided by that carrier.

The booklet or certificate will contain the following information:

- The eligibility conditions for any dependent coverage
- A summary of benefits
- A description of any deductibles, coinsurance or co-payment amounts
- A description of any annual or lifetime caps or other limits on benefits
- Whether and under what circumstances preventive services are covered
- Whether and under what circumstances prescription drugs are covered
- Whether and under what circumstances coverage is provided for medical tests, devices and procedures
- Provisions governing the use of network providers (if any). If there is a network, the booklet or certificate will contain a general description of the provider network and you will be entitled to obtain a list of providers in the network from the Insurer
- Whether and under what circumstances coverage is provided for out-of-network services
- Any conditions or limits on the selection of primary care physicians or providers of specific specialty medical care
- Any conditions or limits applicable to obtaining emergency medical care
- Any provisions requiring pre-authorization or utilization as a condition to obtaining a benefit service
- A summary of claims procedures

VIII Prescription Drug Benefits

Your Employer provides prescription drug coverage through the Fund on a self-insured basis. Generally, you will access your benefits through participating pharmacies by using your prescription drug card. Your co-pay for a particular drug will depend on whether the drug is a first tier, second tier, or third tier drug on the LMHF/PBD formulary.

You can view the three-tier medication guide on the PBD website at www.pbdrx.com via a member website search. The first-tier drugs are primarily generic medications and require the lowest co-pay. Second-tier drugs are primarily brand-name medications listed on the formulary, and you pay a higher co-pay for these medications. Third tier drugs are not on the formulary, and you pay the highest co-pay for these medications or may not be covered.

The procedure for drug claims and appeals is set forth in Section XIX, below. Additional information regarding your prescription drug benefits is available from the Plan Administrator.

IX Medicare Prescription Drug Benefits

The Plan has contracted with PBD to offer a Medicare Part D plan to you and other Medicare members. This plan is sometimes referred to as the Employer/Union-sponsored Group Waiver Plan or "EGWP" (pronounced "egg-whip").

If you are eligible for Medicare and are enrolled in Part A or B, the Plan will automatically enroll you into the Part D EGWP Plan. Before you are automatically enrolled in the Part D EGWP Plan, you will be given an opportunity to "opt out." However, if you opt out of the Part D EGWP Plan before enrollment or later choose to terminate your enrollment in the Part D EGWP Plan, you will not have any drug coverage under the Plan.

If you "opt out" of the Plan's Part D EGWP Plan, and do not enroll in a different Part D Plan right away, you will likely be responsible for a late enrollment penalty if you do later enroll. If you mistakenly "opt out," you will have the opportunity to re-enroll, and should do so as soon as possible. If you "opt out" of the Plan's Part D Plan and are not enrolled in one of the Plan's Medicare Advantage Prescription Drug (MA-PD) plans, any drug costs you incur will be the responsibility of either you or another plan in which you are enrolled.

The Plan's Part D EGWP Plan formulary can be viewed on the PBD website at www.pbdrx.com.

Because this prescription drug plan is a Medicare Part D plan, high-income retirees may be subject to surcharges based on income. If your income now or prior to retirement was more than $85,000 ($170,000 for those filing jointly), then you may be subject to this surcharge. If you are subject to this surcharge, and your income has fallen due to your retirement or other life-changing event, then you should file Form SSA-44 with your local Social Security office.

X Coordination of Benefits

The coordination of benefits sets out rules for the order of payment of medical benefits when two or more plans—including Medicare—are paying. If you are covered by this Plan and another plan, or your spouse is covered by this Plan and by another plan, or your dependent children are covered by two or more plans, the plans will coordinate benefits when a claim is received. The rules for determining which plan pays first are set forth in the Highmark BCBS insurance booklet.

XI Mental Health Parity & Addiction Equity Act

The Mental Health Parity Act of 1996 (MHPA) is a law that prevents your group health plan from placing annual or lifetime limits on mental health benefits that are lower, or less favorable, than annual or lifetime limits for medical and surgical benefits offered under the Plan. The term "mental health benefits" means benefits for mental health services defined by the health plan or coverage.

The Mental Health Parity & Addiction Equity Act of 2008 (MHPAEA) preserves the MHPA protections and adds significant new protections.

Key changes made by MHPAEA, include the following:

- The financial requirements (e.g., deductibles and co-payments) and treatment limitations (e.g., number of visits or days of coverage) that apply to mental health benefits and substance use disorder benefits (MH/SUD) must be no more restrictive than the predominant financial requirements or treatment limitations that apply to substantially all medical/surgical benefits;

- MH/SUD benefits may not be subject to any separate cost sharing requirements or treatment limitations that only apply to such benefits;

- If your group health plan provides for out of network medical/surgical benefits, it must provide for out of network mental health and substance abuse disorder benefits;

- Standards for medical necessity determinations and reasons for any denial of benefits relating to MH/SUD must be disclosed upon request.

Although these laws require parity with regard to financial and treatment limits, neither law requires group health plans and their health insurance issuers to include mental health coverage in their benefits package. The laws' requirements apply only to group health plans and their health insurance issuers that include mental health benefits in their benefits packages. Therefore, you should contact BCBS for more information as to what extent, if any, mental health benefits are offered.

XII Notice of Patient Protections

Highmark BCBS generally requires the designation of a primary care provider. You have the right to choose any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Highmark BCBS at 1-888-839-5169.

For children, you may select a pediatrician as the primary care provider.

You do not need prior authorization from Highmark BCBS or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Highmark BCBS at 1-888-839-5169.

XIII Qualified Medical Child Support Orders

Notwithstanding any contrary provision in any group health insurance policy under the Plan, an eligible dependent child may include a child for whom an employee is required to provide coverage pursuant to a qualified medical child support order.

XIV Your Rights Under the Newborn's and Mother's Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than forty-eight (48) hours following a vaginal delivery, or less than ninety-six (96) hours following a cesarean section. However, Federal law generally does not prohibit the mother's or the newborn's attending provider, after counseling with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

XV Sources of Contribution and Cost of Benefits

Your Employer will pay the applicable insurance premiums to the Fund on behalf of the employees who participate in the Plan. Employees and retirees may be required to contribute to the cost of coverage. If you are required to contribute to the cost of coverage, your Employer will notify you of the required premiums.

XVI Continuation Coverage/New York's Age 29 Law

COBRA continuation coverage allows you and your dependents an opportunity to temporarily extend your health insurance coverage under the Plan at group rates in certain instances where coverage would otherwise end. New York State continuation coverage, known as "mini-COBRA," provides rights similar to federal COBRA to a member of a group covered by a health insurance contract issued in New York.

Eligibility. You or your dependents that are eligible to purchase continuation coverage are "qualified beneficiaries". If a child is born to or adopted by or placed for adoption with an employee during a period of COBRA continuation coverage, the newborn or newly adopted child's maximum continuation period shall be measured from the date of the initial qualifying event and not from the subsequent date of birth or adoption or placement for adoption.

The events which may entitle you or your dependents (as qualified beneficiaries) to continuation coverage are "qualifying events". The qualifying events, the qualifying beneficiaries, and the maximum continuation period are described in the following chart:

Qualifying Event	Qualified Beneficiary	Continuation Period (Months)
Reduced hours* or termination of employment **	Employee and Dependents	18 or 36 for insured plans***
Employee's death	Dependents	36
Employee's entitlement to Medicare	Dependent not entitled to Medicare	36
Dependent child becomes ineligible for coverage	Ineligible Dependent	36
Employee's divorce/legal separation	Dependents	36

** A reduction in hours due to family or medical leave, as defined by the Family and Medical Leave Act of 1993 ("FMLA"), shall not cause an employee's participation to terminate, to the extent required by FMLA. Thus, a reduction in hours pursuant to an FMLA leave shall not constitute a qualifying event. However, if the employee does not return to work at the end of the FMLA leave, a qualifying event shall occur as of the last day of the FMLA leave.*

*** Continuation coverage is not available if employment if terminated for gross misconduct.*

****Although self-insured benefits, such as the Plan's pharmacy coverage, are not subject to New York's 36 month continuation period, the Plan will permit 36 months of continuation coverage for this benefit.*

Notice Requirements. A qualified beneficiary must inform your Employer of a divorce or of a child losing dependent status under the plan, within sixty (60) days after the later of: the date of the qualifying event or the date the qualified beneficiary loses health coverage on account of that qualifying event. If timely notice is received, the Employer has the responsibility to notify Highmark BCBS of the divorce, legal separation or loss of dependent status. Your employer also has the responsibility to notify Highmark BCBS of your death, termination of employment, reduction in hours, or Medicare entitlement.

Your employer will notify all eligible qualified beneficiaries of their right to elect continuation coverage. If a qualified beneficiary chooses to purchase continuation coverage, the qualified beneficiary must notify your employer in writing within sixty (60) days after the later of: the

date the qualified beneficiary loses health coverage on account of the qualifying event or the date on which the qualified beneficiary is sent notice of his or her eligibility for continuation coverage. If the qualified beneficiary does not choose continuation coverage during the sixty (60) day period, his or her participation will end as otherwise provided in the Plan Booklet.

Coverage. If a qualifying event occurs, you and your dependents who are qualified beneficiaries must be offered the opportunity to elect to receive the group health coverage that is provided to similarly-situated nonqualified beneficiaries. Generally, this means that if you or your dependents purchase continuation coverage, it will be the same as the health coverage provided to you immediately before the qualifying event. Each qualified beneficiary has the right to make an independent election to receive continuation coverage.

Qualified beneficiaries do not have to show that they are insurable in order to purchase continuation coverage. If coverage is subsequently modified for similarly-situated participants, the same modifications will apply to you and your dependents. Qualified beneficiaries who purchase continuation coverage will have the opportunity to elect different types of coverage during an annual open enrollment period in accordance with the opportunity to provide similarly-situated active employees.

Cost. Generally, the qualified beneficiary must pay the total cost of continuation coverage. This cost may be up to 102% of the cost of identical coverage for similarly situated participants. However, for disabled qualified beneficiaries who elect an additional eleven (11) months of continuation coverage, the cost may be 150% of the cost of identical coverage for similarly-situated participants for the additional eleven (11) month period (and for any longer continuation period for which the disabled qualified beneficiary is eligible, as permitted by law). The 150% cost amount shall also apply to the disabled qualified beneficiary's dependents, as long as the disabled qualified beneficiary is in the coverage group receiving COBRA.

The initial premium must be paid within forty-five (45) days after the qualified beneficiary elects continuation coverage. Subsequent premium must be paid monthly, as of the first day of the month, with a thirty (30) day grace period for timely payment. However, no subsequent premium will be due within forty-five (45) days after the qualified beneficiary elects continuation coverage. Payment is considered made on the date on which it is sent to the plan.

Termination. Generally, continuation coverage terminates at the end of the 36-month continuation period. However, continuation coverage for a qualified beneficiary may end before the end of the continuation period for any of the following reasons:

- **Coverage Terminated**
  Employer no longer offers a group health plan to any of its employees;

- **Unpaid Premium**
  The premium for continuation coverage is not timely paid;

- **Other Coverage**
  The date on which a qualified beneficiary first becomes, after the date of the election of continuation coverage, covered under another group health plan. However, this provision does not apply during any time period the other group health plan contains any limitation or exclusion with regard to any pre-existing conditions, other than a limitation or

exclusion which does not apply to the qualified beneficiary or is satisfied by the qualified beneficiary due to the Health Insurance Portability and Accountability Act;

- **Medicare**
  The date on which a qualified beneficiary first becomes, after the date of the election of continuation coverage, entitled to Medicare (Part A or Part B); or

- **Cause**
  The date on which a qualified beneficiary's coverage is terminated for cause on the same basis that the plan terminates for cause the coverage of similarly-situated nonqualified beneficiaries (e.g., for fraud or misrepresentation in a claim for benefits).

New York's Age 29 Law. Your children may have the right to elect coverage under New York's Age 29 Law in lieu of COBRA or state continuation coverage. BCBS will notify you of this right. The Plan will permit your child to continue pharmacy coverage for as long as your child is entitled to BCBS coverage under New York law.

XVII Claims Procedure – Rescission of Coverage

A Rescission of Coverage is a cancellation or discontinuance of medical coverage that is effective **retroactively** and that is not due to a failure to timely pay required contributions toward the cost of coverage. You do not need to file a claim regarding a Rescission of Coverage. If you are notified by your employer or the Plan Administrator or their delegate that your coverage under the Plan is being rescinded, that notification is considered to be a claim denial. You may appeal a Rescission of Coverage within 180 days after your receipt of the notice of Rescission of Coverage. Your appeal will be considered within 60 days after the Plan Administrator receives your appeal, with a 60-day extension permitted if necessary.

Please submit your appeal to the following address:
Labor-Management Healthcare Fund
Attn: Vicki Martino, Executive Director
90 Anderson Road
Cheektowaga, NY 14225
(716) 601-7980

XVIII Claims Procedure – Hospital and Medical Claims

Highmark BCBS is responsible for evaluating all hospital and medical benefit claims under the Plan and will decide your claim in accordance with its own claims procedures. Highmark BCBS has the right to secure independent medical advice and to require such other evidence as it deems necessary in order to decide your claim. If Highmark BCBS denies your claim, in whole or in part, you will receive a written notification setting forth the reasons for the denial. See the Plan Booklet issued by Highmark BCBS for more information about how to file a claim and for details regarding their claims procedures.

If your claim is denied, you may appeal to Highmark BCBS for a review of the denied claim. They will decide your appeal in accordance with their own appeal procedures. See the Plan Booklet issued by Highmark BCBS for more information about how to appeal a denied claim and for details regarding their claims procedures.

XIX Claims Procedure – Prescription Drug Claims

You should present your pharmacy identification card whenever you go to the pharmacy. This will ensure the pharmacy has the correct information to submit your prescription claim. When the pharmacy does not file the claim for you, the charges should be submitted directly to PBD, using the form provided.

In the instance that you are attempting to fill a claim at an out of network pharmacy, you will need to submit a direct claim form. A copy of a direct claim form has been provided in your membership booklet. Your pharmacy network is extensive. If you have any questions regarding whether a specific pharmacy is within your network, please visit PBD at www.pbdrx.com.

Claims are due within 12 months of the date of service. Claims received after the one-year period will be denied unless you can show that it was not possible to provide such notice of claim within the required time and that the claim was filed as soon as reasonably possible.

PBD provides written notice of the appeal procedure to you every time coverage is denied or when it determines that a requested benefit is not covered under the terms of the plan.

This written notice explains the process for filing an appeal, the timeframes within which an appeal decision must be made, what information is necessary to render a decision on an appeal, and your right to designate a representative to file an appeal on your behalf.

Contact information for PBD, together with the address for filing a claim, are set forth in Article IV, above.

The claims procedure is as follows:

For Pharmacy Claim for Benefits

Urgent Care Claim

An "urgent care claim" is a claim for medical treatment or care that, if not provided quickly, could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function or, in the opinion of a physician with knowledge of the case, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment requested.

A decision on an urgent care claim will be made within 72 hours after the request is received. If the request is incomplete, the claimant will be notified within 24 hours of the submission (and will be told of the specific information necessary to complete the claim). The claimant then has 48 hours after the notice is received to provide the additional information. A decision will be made by the later of: a) 48 hours after the additional information is provided; or b) the expiration of the deadline to provide additional information.

An appeal of an adverse benefit determination (denial) regarding an urgent care claim will be decided within 72 hours after the appeal request is filed.

If there is an adverse benefit determination on a claim involving urgent care, a request for an expedited appeal may be submitted orally or in writing by the claimant. All necessary information, including the Plan's benefit determination on review, may be transmitted between the Plan and the claimant by telephone, facsimile, or other similarly expeditious method.

Concurrent Care Claim

A "concurrent care claim" involves a decision by the Plan or PBD to reduce or stop a course of treatment that has already begun.

Any reduction or termination of an ongoing course of treatment to be provided over a period of time or a specified number of treatments shall be treated as an "adverse benefit determination" (unless due to an amendment or termination of the Plan). The claimant will be notified of the decision to reduce or terminate the course of treatment in sufficient time to allow an appeal (and a determination on the appeal) to take place before the benefit is reduced or terminated.

Pre-Service Claims

A "pre-service claim" is any claim for a benefit where the terms of the Plan require approval prior to obtaining medical care.

An initial decision on a pre-service claim must be made in a reasonable time, but no later than 15 days after the submission of the claim. This time period can be extended for an additional 15 days if PBD determines that the extension is necessary due to matters beyond its control and notifies the claimant, before the end of the initial 15-day period, of the circumstances requiring the extension and the date by which a decision is expected.

If an extension is necessary to allow the claimant to submit additional information, the claimant will have 45 days from receipt of the notice to provide the information required.

An appeal of an adverse benefit determination (denial) regarding a pre-service claim will be decided within 30 days after the appeal request is filed.

Post-service Claim

A "post-service claim" is any claim that is not a "pre-service claim" (in other words, you do not need approval before obtaining medical care).

The claimant will be notified of any adverse benefit determination of a post-service claim within a reasonable time, but not later than 30 days after receipt of the claim. The period for a decision may be extended for an additional 15 days if PBD determines that the extension is necessary due to matters beyond its control and notifies the claimant, before the end of the initial 30-day period, of the circumstances requiring the extension and the date by which a decision is expected.

If an extension is necessary to allow the claimant to submit additional information, the claimant will have 45 days from receipt of the notice to provide the information required.

An appeal of an adverse benefit determination (denial) regarding a post-service claim will be decided within 60 days after the appeal request is filed.

Appeals of an Adverse Benefit Determination (when applicable)

When a claimant receives an adverse benefit determination, the claimant has 180 days following receipt of the notification in which to appeal the decision. A claimant may submit written comments, documents, records, and other information relating to the claim. If the claimant so requests, he or she will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim.

The period of time within which a benefit determination on review is required to be made shall begin at the time an appeal is filed in accordance with the procedures of the Plan. This timing is without regard to whether all the necessary information accompanies the filing.

A document, record, or other information shall be considered relevant to a claim if it:

1. was relied upon in making the benefit determination;

2. was submitted, considered, or generated in the course of making the benefit determination, without regard to whether it was relied upon in making the benefit determination;

3. demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that benefit determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all claimants; or

4. constituted a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit.

The review shall take into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination. The review will not afford deference to the initial adverse benefit determination and will be conducted by a fiduciary of the Plan who is neither the individual who made the adverse determination nor a subordinate of that individual.

If the determination was based 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 fiduciary shall consult with a health care professional who was not involved in the original benefit determination. This health care professional will have appropriate training and experience in the field of medicine involved in the medical judgment. Additionally, medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the initial determination will be identified.

Upon receipt of a final adverse benefit determination, a claimant has four months following receipt to request an external review of the claim. This external review will be conducted by an independent review organization in accordance with federal guidance.

Notice to Claimant of Adverse Benefit Determinations

Except with urgent care claims, when the notification may be oral followed by written or electronic notification within 3 days of the oral notification, PBD will provide written or electronic notification of any adverse benefit determination. The notice will state, in a manner calculated to be understood by the claimant:

1. The specific reason or reasons for the adverse determination.

2. Reference to the specific Plan provisions on which the determination was based.

3. A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary.

4. A description of the Plan's review procedures, incorporating any voluntary appeal procedures offered by the Plan, and the time limits applicable to such procedures.

5. 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 Claim.

6. If the adverse benefit determination was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the adverse benefit determination and a copy will be provided free of charge to the claimant upon request.

7. If the adverse benefit determination is based on the medical necessity or experimental or Investigational treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided free of charge, upon request.

8. A description of any available External Review process and how to initiate an External Review.

9. A statement disclosing the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman that can assist you with the internal claims and appeals and External Review processes.

In addition, in accordance with PBD policies and procedures the following steps may also apply:

Rights to New Evidence and Rationale on Appeal

To the extent required by law, in the case of appeals of prescription drug claims:

- If PBD considers, relies upon or generates new or additional evidence in the process of considering your claim, such evidence will be provided to you free of charge as soon as possible in advance of the date by which PBD is required to provide notice of its final decision on appeal.

- If PBD intends to issue an adverse final decision on appeal (deny your appeal in whole or part) based on a new or additional rationale, PBD will provide you, free of charge, with the rationale as soon as possible in advance of the date by which it is required to provide notice of its final decision on appeal.

Miscellaneous

PBD and the Plan do not retaliate or take any discriminatory action against any claimant or provider because he/she files an appeal.

The claimant's rights and remedies under this Plan are cumulative and in addition to any other rights or remedies available under law.

In the event a claimant does not speak English or is hearing impaired, the claimant has full access to appeal a denied claim with the assistance of PBD.

A claimant may request an appeal to be withdrawn because the issue has been resolved prior to any action taken by PBD and the claimant no longer wishes to pursue the appeal. A claimant may also withdraw their appeal with the intent to file it at a later date within the timeframes allowed. All oral and written appeal withdrawals will be sent a confirmation letter.

XX THIRD-PARTY RECOVERY PROVISION

Right Of Subrogation And Refund

When this provision applies. This provision applies to prescription drug or any other medical charges that are self-insured under this Plan. For similar provisions applicable to medical charges paid by insurance, you should refer to the Certificate of Coverage.

You or a covered dependent (a "Covered Person") may incur medical charges due to Injuries which may be caused by the act or omission of a Third Party or a Third Party may be responsible for payment. In such circumstances, the Covered Person may have a claim against that Third Party, or insurer, for payment of the medical charges. Accepting benefits under this Plan for those incurred medical expenses automatically assigns to the Plan any rights the Covered Person may have to Recover payments from any Third Party or insurer. This Subrogation right allows the Plan to pursue any claim which the Covered Person has against any Third Party, or insurer, whether or not the Covered Person chooses to pursue that claim. The Plan may make a claim directly against the Third Party or insurer, but in any event, the Plan has a lien on any amount Recovered by the Covered Person whether or not designated as payment for medical expenses. This lien shall remain in effect until the Plan is repaid in full.

The Covered Person:

(1) automatically assigns to the Plan his or her rights against any Third Party or insurer when this provision applies; and

(2) must repay to the Plan the benefits paid on his or her behalf out of the Recovery made from the Third Party or insurer.

Amount subject to Subrogation or Refund. The Covered Person agrees to recognize the Plan's right to Subrogation and reimbursement. These rights provide the Plan with a 100%, first dollar priority over any and all Recoveries and funds paid by a Third Party to a Covered Person relative to the Injury or Sickness, including a priority over any claim for non-medical or dental charges, attorney fees, or other costs and expenses. Accepting benefits under this Plan for those incurred medical expenses automatically assigns to the Plan any and all rights the Covered Person may have to recover payments from any Responsible Third Party. Further, accepting benefits under this Plan for those incurred medical or dental expenses automatically assigns to the Plan the Covered Person's Third Party Claims.

Notwithstanding its priority to funds, the Plan's Subrogation and Refund rights, as well as the rights assigned to it, are limited to the extent to which the Plan has made, or will make, payments for medical charges as well as any costs and fees associated with the enforcement of its rights under the Plan. The Plan reserves the right to be reimbursed for its court costs and attorneys' fees if the Plan needs to file suit in order to Recover payment for medical or dental expenses from the Covered Person. Also, the Plan's right to Subrogation still applies if the Recovery received by the Covered Person is less than the claimed damage, and, as a result, the claimant is not made whole.

When a right of Recovery exists, the Covered Person will execute and deliver all required instruments and papers as well as doing whatever else is needed to secure the Plan's right of Subrogation as a condition to having the Plan make payments. In addition, the Covered Person will do nothing to prejudice the right of the Plan to Subrogate.

Conditions Precedent to Coverage. The Plan shall have no obligation whatsoever to pay medical benefits to a Covered Person if a Covered Person refuses to cooperate with the Plan's reimbursement and Subrogation rights or refuses to execute and deliver such papers as the Plan may require in furtherance of its reimbursement and Subrogation rights. Further, in the event the Covered Person is a minor, the Plan shall have no obligation to pay any medical benefits incurred on account of Injury or Sickness caused by a responsible Third Party until after the Covered Person or his authorized legal representative obtains valid court recognition and approval of the Plan's 100%, first dollar reimbursement and Subrogation rights on all Recoveries, as well as approval for the execution of any papers necessary for the enforcement thereof, as described herein.

Defined terms: "Covered Person" means anyone covered under the Plan, including minor dependents.

"Recover", "Recovered"", Recovery" or "Recoveries" means all monies paid to the Covered Person by way of judgment, settlement, or otherwise to compensate for all losses caused by the Injury or Sickness, whether or not said losses reflect medical charges covered by the Plan. "Recoveries" further includes, but is not limited to, recoveries for medical or dental expenses, attorneys' fees, costs and expenses, pain and suffering, loss of consortium, wrongful death, lost wages and any other recovery of any form of damages or compensation whatsoever.

"Refund" means repayment to the Plan for medical benefits that it has paid toward care and treatment of the Injury or Sickness.

"Subrogation" means the Plan's right to pursue and place a lien upon the Covered Person's claims for medical or dental charges against the other person.

"Third Party" means any Third Party including another person or a business entity.

Recovery from another plan under which the Covered Person is covered. This right of Refund also applies when a Covered Person Recovers under an uninsured or underinsured motorist plan (which will be treated as Third Party coverage when reimbursement or Subrogation is in order), homeowner's plan, renter's plan, medical malpractice plan or any liability plan.

Rights of Plan Administrator. The Plan Administrator has a right to request reports on and approve of all settlements.

XXI COMPLIANCE WITH HIPAA PRIVACY STANDARDS.

Certain members of the Fund's workforce perform services in connection with administration of the Plan. In order to perform these services, it is necessary for these Employees from time to time to have access to Protected Health Information (as defined below).

Under the Standards for Privacy of Individually Identifiable Health Information (45 CFR Part 164, the "Privacy Standards"), these Employees are permitted to have such access only if the Plan is amended in accordance with the Privacy Standards.

Therefore, the following provisions apply:

(1) **General**. The Plan shall not disclose Protected Health Information to any member of the Fund's workforce unless each of the conditions set out in this HIPAA Privacy section is met. "Protected Health Information" shall have the same definition as set out in the Privacy Standards but generally shall mean individually identifiable health information about the past, present or future physical or mental health or condition of an individual, including information about treatment or payment for treatment.

(2) **Permitted Uses and Disclosures**. Protected Health Information disclosed to members of the Fund's workforce shall be used or disclosed by them only for purposes of Plan administrative functions. The Plan's administrative functions shall include all Plan payment and health care operations. The terms "payment" and "health care operations" shall have the same definitions as set out in the Privacy Standards, but the term "payment" generally shall mean activities taken with respect to payment of premiums or contributions, or to determine or fulfill Plan responsibilities with respect to coverage, provision of benefits, or reimbursement for health care. "Health care operations" generally shall mean activities on behalf of the Plan that are related to quality assessment; evaluation, training or accreditation of health care providers; underwriting, premium rating and other functions related to obtaining or renewing an insurance contract, including stop-loss insurance; medical review; legal services or auditing functions; or business planning, management and general administrative activities.

(3) **Authorized Employees**. The Plan shall disclose Protected Health Information only to members of the Fund's workforce, who are designated and are authorized to receive such Protected Health Information, and only to the extent and in the minimum amount

necessary for these persons to perform duties with respect to the Plan. For purposes of this HIPAA Privacy section, "members of the Fund's workforce" shall refer to all Employees and other persons under the control of the Plan Administrator.

(a) **Updates Required**. The Plan Administrator shall amend this document promptly with respect to any changes in the members of its workforce who are authorized to receive Protected Health Information.

(b) **Use and Disclosure Restricted**. An authorized member of the Fund's workforce who receives Protected Health Information shall use or disclose the Protected Health Information only to the extent necessary to perform his or her duties with respect to the Plan.

(c) **Resolution of Issues of Noncompliance**. In the event that any member of the Fund's workforce uses or discloses Protected Health Information other than as permitted by the Privacy Standards, the incident shall be reported to the privacy official. The privacy official shall take appropriate action, including:

(i) Investigation of the incident to determine whether the breach occurred inadvertently, through negligence, or deliberately; whether there is a pattern of breaches; and the degree of harm caused by the breach;

(ii) Applying appropriate sanctions against the persons causing the breach, which, depending upon the nature of the breach may include, oral or written reprimand additional training, or termination of employment;

(iii) Mitigating any harm caused by the breach, to the extent practicable; and

(iv) Documentation of the incident and all actions taken to resolve the issue and mitigate any damages.

(4) **Certification of Plan Administrator**. The Plan Administrator must provide certification to the Plan that it agrees to:

(a) Not use or further disclose the Protected Health Information other than as permitted or required by the Plan documents or as required by law;

(b) Ensure that any agent or subcontractor, to whom it provides Protected Health Information received from the Plan, agrees to the same restrictions and conditions that apply to the Fund with respect to such information;

(c) Not use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other benefit or Employee benefit plan of the Fund;

(d) Report to the Plan any use or disclosure of the Protected Health Information of which it becomes aware that is inconsistent with the uses or disclosures permitted by this Amendment, or required by law;

(e) Make available Protected Health Information to individual Plan members in accordance with Section 164.524 of the Privacy Standards;

(f) Make available Protected Health Information for amendment by individual Plan members and incorporate any amendments to Protected Health Information in accordance with Section 164.526 of the Privacy Standards;

(g) Make available the Protected Health Information required to provide any accounting of disclosures to individual Plan members in accordance with Section 164.528 of the Privacy Standards;

(h) Make its internal practices, books and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Department of Health and Human Services for purposes of determining compliance by the Plan with the Privacy Standards;

(i) If feasible, return or destroy all Protected Health Information received from the Plan that the Fund still maintains in any form, and retain no copies of such information when no longer needed for the purpose of which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information unfeasible; and

(j) Ensure the adequate separation between the Plan and member of each Employer's workforce, as required by Section 164.504(f) (2) (iii) of the Privacy Standards.

HIPAA NOTIFICATION

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires, among other things, that health plans protect the confidentiality and privacy of individually identifiable health information. A description of a Covered Person's HIPAA Privacy rights are found in the Privacy Notice, which has been distributed to each Employee covered under the health plan.

The Plan and those administering it will use and disclose health information only as allowed by federal law. If a Covered Person has a complaint, questions, concerns or requires a copy of the Privacy Notice, please contact the Privacy Official in the Plan Administrator's office.

XXII Plan Administrator Discretion

Except as specifically provided under this Summary Plan Description, no individuals other than the Plan Administrator or its duly authorized designee(s) has any authority to interpret the Plan documents, including this Summary Plan Description or the official Plan documents, or to make any promises to you about the Plan, or your benefits under the Plan, or to change the provisions of the Plan.

Other than as specifically provided under this Summary Plan Description, the Plan Administrator and its duly authorized designee(s) has the exclusive right, power, and authority, in its sole and absolute discretion, to administer, apply and interpret the Plan, including this booklet, the Trust Agreement, any Collective Bargaining Agreement or membership agreement, and any other Plan documents, and to decide all matters arising in connection with the operation or administration of the Plan or Fund.

All determinations and interpretations made by the Plan Administrator and/or its duly authorized designee(s) shall be final and binding upon all Participants, beneficiaries and any other individuals claiming benefits under the Plan and shall be given deference in all courts of law, to the greatest extent permissible by law.

XXIII Amendment and Termination

The Trustees have established this Plan with the intent that it will be maintained for an indefinite period of time. However, the funding for the Plan is conditioned on a collective bargaining agreement remaining in effect that provides for continued Employer contributions to the Fund. Therefore, the Trustees reserve the right to amend or terminate the Plan, in whole or in part, at any time.