Indiana Laborers Welfare Fund

Combination Plan Document and Summary Plan Description

12/1/2014 Edition

Este folleto está disponible en español. Si desea una versión en español, Favor de communicarse con la oficina del Fondo.

Indiana Laborers Welfare Fund
P.O. Box 1587
Terre Haute, IN 47808
(812) 238-2551
(800) 962-3158

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 may contact the Fund Office at:

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For further information or forms visit our website or call or write:

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INTRODUCTION

The Indiana Laborers Welfare Fund (Plan) is a valuable benefit provided through the Local Union 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 eligible Dependents.

The Plan is self-funded. When Employees work in covered employment, the Employer makes contributions to the Plan 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 eligible 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.

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

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Administrator. 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.

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. You 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.

- When your Physician recommends a Hospital stay, out-patient surgery or other treatment listed in Section 8.16, it is a requirement to call the medical care review program (see Section 8.16 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, out-patient surgery or other treatment listed in Section 8.16, (see Section 8.16 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 Benefit (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 each service listed on the claim was provided. 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 8.16 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 (Booklet) is intended to describe the life, dental, eye care, hearing, prescription and health care benefits adopted by the Trustees. Only the full Board of Trustees has the authority to interpret the Benefits described in this Booklet. Their interpretation will be final and binding on all persons dealing with the Plan or claiming a Benefit 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 eligible Dependents. Benefits under this Plan will be paid only if the Plan Administrator 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 health 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 Booklet.

MEDICAL CARE REVIEW PROGRAM

The Plan's chosen medical care review firm is

American Health Holding (AHH)

You may contact AHH at 866-440-2723

The Plan has entered into an agreement with a professional medical care review firm to pre-certify all in-patient 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 pre-certification by the medical care review firm. The medical care review firm pre-approves Hospital and other treatment plans which helps the Eligible Person and the Plan avoid unnecessary medical costs. Hospital admissions on a non-emergency basis for treatment or surgery should be pre-certified 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 they have been contacted**. Refer to Section 8.16 for program information and Section 9.15 for contact information.

PREFERRED PROVIDER ORGANIZATION

The Plan's Preferred Provider Organization is Anthem Blue Access. For up-to-date provider information, visit Anthem's website at www.bcbs.com, click on "Find a Doctor", choose your state and "Blue Access (PPO) plan"

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 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.

Notwithstanding any other Plan provision, if for any reason the contracted PPO fee for a covered service is more than the provider's actual charge, then the Plan will pay benefits so that the Participant's copayment amount 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.

For the most up-to-date provider information for Anthem call Anthem at (800) 810-2583 which is available 7 days a week, 24 hours a day, visit Anthem Blue Cross Blue Shield's website at www.bcbs.com or call the Fund Office at (812) 238-2551 or (800) 962-3158.

LIFE EVENTS AT A GLANCE

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, legal separation order, divorce decree, custody agreement).
- **YOU CHANGE YOUR BENEFICIARY.**
- **THE STATUS OF A DEPENDENT CHANGES.**
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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 Fund Office.

The card requests certain basic information that is needed for Fund Office records. This information includes the Participant and eligible 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 at the Fund Office, contact the 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, 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 certificate, 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 claims for Benefits.

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.

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 eligible Dependents, the Fund Office must know who your Dependents are at all times.

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

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 eligible Dependents, such as their name, address, telephone number and Social Security number, in conjunction with information concerning the Participant and/or their eligible 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 and is also found in Section 8.23 of this Booklet. Please contact the Fund Office to receive another copy of the 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 the Plan to achieve compliance with these federal requirements.

ARTICLE I – ELIGIBLE CLASS DESCRIPTIONS

Section 1.01 – Active

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.

Section 1.02 – Retirees not Eligible for Medicare

Class AS
This class represents retired Employees who are not eligible for Medicare, but would like to keep the Schedule of Benefits for Class A – Active Employees with a few exclusions. Their **Dependents not eligible for Medicare** are also covered under the Schedule of Benefits for Class A – Active Employees with a few exclusions. Their **Dependents who are eligible for Medicare** are covered under the Class CP Benefit structure which is a Supplement to Medicare with prescription coverage.

Class B
This class represents retired Employees who are not eligible for Medicare who have chosen a "low level" coverage. Prescriptions are not covered under this class. Their **Dependents not eligible for Medicare** also have the lower benefit structure and no prescription coverage. Their **Dependents who are eligible for Medicare** are covered under the Class C Benefit structure which is a supplement to Medicare with no prescription coverage.

Class B coverage is no longer available to Employees who retired on or after March 1, 2011.

Section 1.03 – Retirees Eligible for Medicare

Class C
This class represents retired Medicare eligible Employees who want to supplement Medicare but do not want prescription coverage. For retired Medicare eligible Employees who want to supplement Medicare but do not want prescription coverage and have Dependents who are not eligible for Medicare, enrollment must be made through Class D.

Class CP
This class represents retired Medicare eligible Employees who want prescription coverage in addition to the Supplement to Medicare. Their **Dependents who are not eligible for Medicare** are covered under the Schedule of Benefits for Class A – Active Employees with a few exclusions. Their **Dependents who are eligible for Medicare** are covered under this Class CP Supplement to Medicare with prescription coverage.

Class D
This class represents retired Medicare eligible Employees who want Class C Supplement to Medicare (with no prescription coverage) for themselves. Their **Dependents who are not eligible for Medicare** are covered under the Schedule of Benefits for Class A – Active Employees, including prescription coverage, with a few exclusions. Their **Dependents who are eligible for Medicare** are covered under the Class C Supplement to Medicare with no prescription coverage.

Section 1.04 – 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. Their **Dependents not eligible for Medicare** are covered under the Schedule of Benefits for Class A – Active Employees with a few exclusions. Their **Dependents eligible for Medicare** are covered under Class CP Supplement to Medicare with prescription coverage.

ARTICLE II – SCHEDULE OF BENEFITS

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. Please refer to the appropriate Sections of this Booklet or contact the Fund Office for more information.

Class A – Active Employees

Eligible Employee Only

Accidental Death and Dismemberment Benefit *(Non-Occupational Only)*
Loss of:

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

Life Insurance	$ 10,000
Active	

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

Maximum Benefit	13 weeks per injury or sickness
Non-Occupational Injury	
Weekly Benefit Amount (payable every two weeks)	$ 228
Waiting Period	Benefits begin on 1st day of Total Disability
Non-Occupational Sickness	
Weekly Benefit Amount (payable every two weeks)	$ 228
Waiting Period	Benefits begin on 8th day of Total Disability
Occupational Injury	
Weekly Benefit Amount (payable every two weeks)	$ 54
Waiting Period	Benefits begin on 8th day of Total Disability
Occupational Sickness	
Weekly Benefit Amount (payable every two weeks)	$ 54
Waiting Period	Benefits begin on 8th day of Total Disability

Eligible Employee and Eligible Dependents

General Medical Benefit (Plan Year - 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
- 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 ..... N $ 6,000
- Copayment (Fund pays)
  - In-Network (after Deductible) 75%
  - Out-of-Network (after Deductible) 50%

Chiropractic Benefit

- Copayment (Fund pays)
  - In- or Out-of-Network non-surgical services (after Deductible)..... 75%
- Maximum Benefit every Plan Year..... $1,000
  - Services following surgery, if Medically Necessary..... Under General Medical Benefit

Dental Care Benefit

- Individual Dental Deductible Amount (every Calendar Year) ..... $ 25
- Family Maximum Dental Deductible Amount (every Calendar Year)..... $ 75
- Maximum Benefit per individual every Calendar Year..... $500*
- Copayment (Fund pays)
  - Preventative Services ..... 90% of Allowed Amount (not subject to Dental Deductible Amount)
  - Restorative Services (after Deductible)..... 70% of Allowed Amount

* This Calendar Year Maximum does not apply to pediatric dental benefits to Eligible Persons under age 19.

Diabetes Education and Training Benefit

- Copayment (Fund pays)
  - In-Network (after Deductible)..... 75%
  - Out-of-Network (after Deductible)..... 50%
- Maximum Lifetime Benefit per individual ..... $ 200

Eye Care Benefit

- Copayment (Fund pays)
  - Elective Contacts – in lieu of frames and lenses (once every 24 months)
    - In-Network..... 100% up to $105
    - Out-of-Network..... Reimbursement up to $105

Medically Necessary
In-Network ..... 100% up to $210
Out-of-Network ..... Reimbursement up to $210
Routine Eye Exam (once every 12 months)
In-Network 100%
Out-of-Network ..... Reimbursement up to $35
Frames (once every 24 months)
In-Network (private practice providers) ..... 100% up to $50 at wholesale price
In-Network (retail providers) ..... 100% up to $130 at retail price
Out-of-Network ..... Reimbursement up to $80 at retail price
Lenses (once every 24 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

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

Hospice Care Benefit
Copayment (Fund pays)
In-Network (after Deductible) 75%
Out-of-Network (after Deductible) 50%

Mental and Nervous Disorder Benefit
Benefits are subject to the General Medical Benefit provisions for In and Out-of-Network deductibles, copayments and maximums, as applicable.

Prescription Drug Card Benefit – In-Network Benefits Only
Copayments (Participant pays)
Mail Order Participating Pharmacies (90 day supply)
(see Section 4.12 C for approved walk-in pharmacies that allow a 90 supply)
15% of drug cost with a $25 minimum and $50 maximum ..... Generic
25% of drug cost with a $50 minimum and $100 maximum ..... Brand Formulary
35% of drug cost with a $100 minimum and $200 maximum ..... Brand Non-Formulary
Retail Participating Pharmacies (up to 30 day supply)
20% of drug cost with a $10 minimum and $20 maximum ..... Generic
30% of drug cost with a $20 minimum and $40 maximum ..... Brand Formulary
40% of drug cost with a $40 minimum and $80 maximum ..... Brand Non-Formulary
Mail Order Specialty Drugs (up to 30 day supply)

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

Routine Preventive Care Benefit

Routine Physical Exam (Age 2 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 50 and over: 1 sigmoidoscopy every 5 Plan Years	100%; otherwise under General Medical Benefit
Age 50 and over: 1 colonoscopy every 10 Plan Years	100%; otherwise under General Medical Benefit

Routine Well Child Exam & Immunizations – In-Network Benefits Only

Birth to age 24 months for all exams and immunizations recommended by the Center For Disease Control	100%

Routine Childhood & Adult Immunizations – In-Network Benefits Only

Age 2 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, copayments and maximums, as applicable.

Temporomandibular Joint Dysfunction (TMJ) Benefit

Copayment (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, copayments and maximums, as applicable.

Class AS– Non-Medicare Eligible Retirees and Non-Medicare Spouses and Dependent Children (Spouses and Dependents with Medicare will be covered under Class CP benefits)

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 ..... Same as Class A

Active ....

Eligible Employee and Eligible Dependents

General Medical ..... Same as Class A excluding maternity, newborn and Loss of Time 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

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

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

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

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

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

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

Class B – Non-Medicare Eligible Retirees Ages 55-64, and Spouses Under Age 65 and Dependent Children (Spouses and Dependents with Medicare will be covered under Class C Benefits)

Eligible Participant Only

Life Insurance..... Same as Class A

Participant and Eligible Dependents

Inpatient Hospital charges up to 31 days confinement

Hospital Room and Board every day	$70
Hospital Services and Supplies	$500
Surgical Charges	$600
Anesthetists' Charges	$100
Diagnostic X-Ray and Laboratory Tests (Outpatient – per Plan Year)	$100
Physician Hospital Visits	$15 first visit, $10 thereafter

Any covered charges exceeding the above benefit limits will be paid under the General Medical Benefit provisions for In and Out-of-Network deductibles, copayments and maximums as applicable. The General Medical Benefit's Out of Pocket limit does not apply for Class B coverage.

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
Routine Preventative Care Benefit	Same as Class A

Effective March 1, 2011, the Class B Coverage is no longer available. Anyone previously enrolled in Class B will be allowed to continue coverage in that Class until such time as they become eligible for Medicare and choose Plan C, D or CP.

Class C – Medicare Eligible Retirees, Spouses and Dependents without Prescription Coverage

Eligible Participant Only

Life Insurance	Same as Class A

Participant and Eligible 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
Medical and Physicians' Charges	Medicare deductible and your portion of Medicare approved charges
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
Routine Preventative Care Benefit	Same as Class A

Class CP – Medicare Eligible Retirees, Spouses and Dependents with Prescription Coverage (Spouses and Dependents without Medicare will be covered under Class AS Benefits)

Eligible Participant Only

Life Insurance	Same as Class A

Participant and Eligible Dependents eligible for Medicare

Hospital and Skilled Nursing Facility Benefits	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
Prescription Drug Card	Same as Class A
Routine Preventative Care Benefit	Same as Class A

Class D – Medicare Eligible Retirees, Spouses and Dependents without Prescription Coverage with at least one Dependent not eligible for Medicare (Spouses and Dependents without Medicare will be covered under Class AS Benefits)

Participant and Dependents (Eligible for Medicare)

Life Insurance	Same as Class A
Hospital and Skilled Nursing Facility Benefits	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
Routine Preventative Care Benefit	Same as Class A

Class S – Non-Medicare Eligible Surviving Spouses and Non-Medicare Eligible Dependent Children (Dependent Children eligible for Medicare will be covered under Class CP)

Eligible Participant and Eligible Dependents

General Medical	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
Mental and Nervous Disorder Benefit	Same as Class A
Prescription Drug Card	Same as Class A
Routine Preventative Care Benefit	Same as Class A
Substance Abuse Benefit	Same as Class A
Temporomandibular Joint Dysfunction (TMJ) Benefit	Same as Class A
Transplant Benefit	Same as Class A

ARTICLE III – ELIGIBILITY RULES

THE TRUSTEES OF THE PLAN HAVE 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 IS ENTITLED TO THEM.

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

Section 3.01 – 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 earliest of:

A) the first day of the month following the month in which 600 hours of Employer contributions have been made on his behalf; **or**

B) the first day of the month of the next Coverage Period in which 520 hours of Employer contributions have been made on his behalf in the previous two Qualification Periods (8 months); **or**

C) for an Employee who does not accumulate the required 600 hours within the first six months of employment, the Employee may become a Participant in the Plan during any subsequent Coverage Period if the Employee has accumulated 260 hours of Employer contributions in the associated Qualification Period; **or**

D) for an Employee who has worked for two Qualification Periods and does not meet the requirements above, the Employee may become a Participant in the Plan during the next Coverage Period by making maximum Self-Payments of 260 required hours or the balance remaining after Employer contributions. See limitations on Self-Payments in Section 3.03 of this Booklet.

Definitions

The term “Qualification Period” includes the period for which hours are credited to determine the eligibility of an Employee to participate or the eligibility of a Participant to continue participation in the Plan. 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 3.02 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 of this Booklet.

Notwithstanding the foregoing, if an Employee is absent from active work on account of injury or sickness when his Life Insurance (Section 4.01), Accidental Death and Dismemberment Benefit (Section 4.02) and/or Loss of Time (Section 4.03) coverage would otherwise initially take effect, that coverage shall take effect on the date the Employee is released by his Physician for return to active work, following recovery.

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

Example A – 600 Hours Requirement:

John began work on July 1, 2014 and accumulated 600 hours of work by November 15, 2014. John has not completed 6 work months but had 600 hours of Employer contributions made on his behalf. John’s initial eligibility date for benefits is December 1, 2014 and he will remain eligible through March 31, 2015.

Example B – 520 Hours in Two Qualification Periods Requirement:

John began work on July 1, 2014 and did not accumulate 600 hours by December 31, 2014 but accumulated 520 hours by February 10, 2015. Since John had 520 hours of Employer contributions remitted within the last two Qualification Periods (Jul-Oct and Nov-Feb) his initial eligibility date for benefits is April 1, 2015 and he will remain eligible through July 31, 2015.

Example C – 260 Hours in Associated Qualification Period Requirement:

John began work on July 1, 2014 and did not accumulate 600 hours by December 31, 2014 nor did he accumulate 520 hours within the last two Qualification Periods (Jul-Oct and Nov-Feb). However, John had worked 260 hours in the Qualification Period Nov-Feb. His initial eligibility date for benefits is April 1, 2015 and he will remain eligible through July 31, 2015.

Example D – Self-Payment Requirement:
Same facts in Example C above but instead of 260 hours in the Qualification Period Nov-Feb, John only had 100 hours. John would be eligible to make a Self-Payment of 160 hours at the current contribution rate to become eligible for benefits beginning April 1, 2015 and he will remain eligible through July 31, 2015.

Section 3.02 – Continued Eligibility

A Participant can maintain eligibility in the Plan 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. 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 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 3.03 of this Booklet.

However, if a Participant has worked at least three Qualification Periods and does not meet the requirements above, the Participant may maintain eligibility in the Plan 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 3.03 of this document.

In the event the Employer does not submit contributions to the Plan according to the Agreement, you may submit up to two months of approved paycheck stubs to maintain eligibility. Credit for unreported hours worked in excess of two months will not be approved.

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, 2015. He has continued to work 100 hours each month for the Qualification Period November 2014 through February 2015. Since John has had at least 260 hours in the current Qualification Period (Nov-Feb) he will continue to be eligible for the Coverage Period April 1, 2015 through July 31, 2015.

Example B – 520 Hours in Previous Two Qualification Periods Requirement:
John has met initial eligibility requirements and is currently eligible through March 31, 2015. He has continued to work the following schedule:

Work Months	Hours Worked
November 2014 – February 2015	200
July 2014 – October 2014	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). 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 for the Coverage Period April 1, 2015 through July 31, 2015.

Example C – 780 Hours in Previous Three Qualification Periods Requirement:
John has met initial eligibility requirements and is currently eligible through March 31, 2015. He has continued to work the following schedule:

Work Months	Hours Worked
November 2014 – February 2015	200
July 2014 – October 2014	300
March 2014 – June 2014	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 for the Coverage Period April 1, 2015 through July 31, 2015.

Example D – Self-Payment Requirement:
John has met initial eligibility requirements and is currently eligible through March 31, 2015. He has continued to work the following schedule:

Work Months	Hours Worked
November 2014 – February 2015	0
July 2014 – October 2014	260
March 2014 – June 2014	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, 2015 and remain eligible through July 31, 2015.

Section 3.03 – Continuation of Class A Coverage By Self-Payment

A Participant may make Self-Payments in order to retain his eligibility and his Dependents' eligibility for participation 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.

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. Self-Payments shall also be accepted up to the tenth day of the next Coverage Period and coverage shall be provided starting with the day of the postmark of such Self-Payment; 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 elects to continue coverage with the Plan, the Retiree shall transfer to the Senior Program after eligibility based on work hours terminates.

A) Partial Self-Payments

In the event a Participant does not have enough hours reported on his behalf from a contributing Employer a Participant will be required to make partial Self-Payments in order to maintain continued eligibility.

1. The Participant 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 3.02.

2. There is no limit to the number of Partial Self-Payments a Participant 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.

1. The Participant must have had hours reported in one of the two previous Coverage 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 3.02.

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

4. Once this Total Self-Payment option is exhausted as explained in paragraph 3 above, a Participant may maintain eligibility for Coverage Periods by making Self-Payments in an amount equal to 40 hours of contributions per week at the current contribution rate, payable in full prior to the beginning of the Coverage Period. These payments must be approved by the Administrative Manager.

Once a Participant has exhausted the Total Self-Payments option under this Section, the Participant will be required to meet the Initial Eligibility requirements in Section 3.01 in order to be eligible for benefits under this Plan.

Section 3.04 – Termination of Eligibility

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) retires and switches to another Class of coverage, or

F) the Plan terminates.

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 3.09 – Uniformed Services Employment and Reemployment Rights Act (USERRA).

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

A) the individual no longer qualifies as a Dependent as that term is defined in Section 11.13, or

B) the Participant ceases to be covered by the Plan and the Dependent does not elect Continuation of Coverage, or

C) the Dependent fails to make a required Self-Payment for Continuation of Coverage, or

D) the Dependent exhausts the maximum period of coverage provided under the Continuation of Coverage provisions, or

E) the Plan terminates.

A covered Spouse or Dependent Child of a Participant may opt out of the Plan's coverage due to eligibility under a high deductible health plan (such as a Health Savings Account) through other primary coverage, by completing the Plan's appropriate form with proof that the other primary coverage is a high deductible healthcare plan. A covered Spouse or Dependent Child of a Participant may re-enroll in this Plan by completing the Plan's appropriate form with proof that the Spouse or Dependent Child is no longer being covered under the high deductible healthcare plan providing that the Participant is still eligible under this Plan. Eligibility will commence on the first day of termination under the high deductible plan.

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

A) the look-back for continued eligibility in previous, consecutive Qualification Periods, as explained in Section 3.02, is exhausted (in this case, coverage is continued at no cost to the Dependent); or

B) the last day of the Coverage Period in which the Participant’s death occurred.

This provision applies if the Participant completed all of the minimum hours required in Section 3.02 during the Qualification Period in which the Participant’s death occurred.

Section 3.05 – 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 (dependent Spouses and/or dependent children) 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 who would otherwise lose participation in the Plan as a result of a Qualifying Event may elect, within the applicable election period specified in Section 3.05 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 benefits 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.

Proof of good health is **NOT** required to obtain the Continuation Coverage if the Employee or Eligible Dependent(s) meet the other requirements for the Continuation Coverage. The Employee or Eligible Dependent(s) must, however, 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" means any individual who, on the day before a Qualifying Event, is a Participant or a covered 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 that consists of the termination of employment (other than by reason of the Employee's gross misconduct), reduction of hours of the Employee's employment with an Employer or the Employee's retirement or layoff.

A Qualified Beneficiary who fails to elect extended participation under Section 3.05 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 which 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;

e. an Employee becoming entitled to Medicare; or

f. 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 3.05 C. However, if the Participant will not lose coverage before the end of what would be the maximum period described in Section 3.05 C, the event is not a qualifying event.

B) Electing Continuation Coverage

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 3.05 A and ends on the date that is 60 days after the later 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 an eligible Dependent 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 would lose 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, 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 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 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;

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 by 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 Booklet within this Section 3.05. A Booklet 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 Booklet will be available to the new Spouse at the Fund Office or will be mailed to the new Spouse upon request.

    c. If the Booklet 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 Booklet 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 Booklet 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, the Employee's death or the Employee's becoming entitled to Medicare. In order to make such determinations, the Administrative Manager shall use Plan records to determine loss of eligibility due to termination of employment or 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 Employee (or Retired Participant) and Spouse or a dependent child's ceasing to meet the Plan requirements for Eligible 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 an Eligible Dependent under the terms of the Plan.

   When a Qualifying Event occurs that is the Employee's termination of employment, reduction of hours, death or becoming entitled to Medicare, 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 disability by the Social Security Administration regarding a Covered 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 Administrator's determination that continuation coverage shall terminate.

Section 3.06 – Extension of Benefits in Cases of Death (Class A Only)

If a Participant dies and has completed all of the 260-hour requirements described in Section 3.02 for the Qualification Period in which his death occurred, coverage for his covered 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 3.07 – 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 Disabled as defined in Section 11.15, 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 at no expense to the Fund Office within 120 days of the day such Dependent child turns age 19,

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 the limiting age, 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 3.08 – Family 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 weeks of unpaid leave for his serious sickness, the birth or adoption of a child, or to care for his seriously ill Spouse, parent or child. Effective January 28, 2008, a Spouse, son, daughter, parent, or next of kin 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 is allowed to take up to 26 workweeks of FMLA leave to care for such a family member.

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 a 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 insure 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 3.09 – Uniformed Services Employment and Reemployment Rights Act (USERRA)

A) Effective Date

The Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA") was signed into law on October 13, 1994 to protect the eligibility of an Employee and to offer continuation of coverage (Self-Payment) to the Employee and his dependents after the Employee enters into military service.

B) 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 Eligible Dependents at a cost established by the Trustees.

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

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 Eligible 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 3.10 – 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 the determination of whether a medical child support order is a QMCSO and administration thereto, 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.

ARTICLE IV – DESCRIPTION OF BENEFITS – CLASS A

The Benefits listed in the table below are described in this Section. 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.

NOT ALL BENEFITS ARE AVAILABLE TO ALL ELIGIBLE PERSONS. PLEASE CONSULT THE 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 8.16

Description of Covered Benefit	Plan Copayment Amount (Copayment amounts are based on a percent of Approved Charge) In-Network	Plan Copayment Amount (Copayment amounts are based on a percent of Approved Charge) Out-of-Network	Does your Copayment 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 for Specific Limitations*	75%	75% up to $1,000 per Plan Year	Yes	Yes
Diabetes Education and Training Benefit	75%	50% up to $200 Lifetime Maximum	Yes	Yes
Hospice Care Benefit *See Benefit Description for Specific Limitations*	75%	50%	Yes	Yes
Mental and Nervous Disorder Benefit	75%	50%	Yes	Yes
Routine Preventive Care Benefit *See Benefit Description for Specific Limitations*	100%	50%	No	No (In-Network) Yes (Out-of-Network)

Description of Covered Benefit	Plan Copayment Amount Copayment amounts are based on a percent of Approved Charge In-Network	 Out-of-Network	Does your Copayment amount help meet your Out-of-Pocket Limit?	Do you need to meet your Plan Year Deductible before receiving Benefits?
Substance Abuse Benefit	75%	50%	Yes	Yes
Temporomandibular Joint Dysfunction (TMJ) Benefit *See Benefit Description for Specific Limitations*	75% up to $1,500 Lifetime Maximum	50%	Yes	Yes
Transplant Benefit *See Benefit Description for Specific Limitations*	75%	50%	Yes	Yes

Section 4.01 – Life Insurance Benefit (Eligible Employee Only)

Upon the death of an eligible Employee, 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, unless the death was intentionally self-inflicted unless associated with a medical condition. A medical condition means any condition, whether physical or mental, including, but not limited to any condition resulting from sickness, injury (whether or not the injury is accidental), pregnancy or congenital malformation. However, genetic information is not a medical condition. The complete policy is available to review 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 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 any Life Insurance 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 Registration 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 without specifying their respective interests, the Life Insurance Benefit will be paid in equal shares.

A) <u>Conversion to Individual Insurance Policy</u>

If an eligible Employee no longer meets the eligibility requirements for the Life Insurance Benefit or if employment with the Employer terminates, the Employee may convert the group Life Insurance Benefit coverage to an individual insurance policy with the insurance carrier providing coverage for the Plan within 31 days following the termination of eligibility of employment. No medical examination will be required.

The individual insurance policy will be effective and premiums payable at the end of the 31-day period If an eligible Employee dies during this 31-day period, the Life Insurance coverage will be paid whether or not the Employee has applied for an individual insurance policy.

B) <u>Waiver to Life Insurance Premium</u>

If an Employee becomes Totally Disabled before age 60, the Life Insurance coverage will be continued, without the required Self-Payments for as long as the Employee remains Totally Disabled; provided the group Life Insurance policy remains in force and the Employee has returned a written form to the Fund Office within 12 months after date of disability.

Section 4.02 – Accidental Death and Dismemberment Benefit (Class A or AS Employee Only)

When bodily injury caused solely through non-occupational accidental means (independent of other causes) results in any of the following losses within 355 days after the date of the accident, the Plan will pay the amount specified in the Schedule of Benefits. The amount for loss of life is payable to the designated Beneficiary. The amount for loss of limb(s), eyesight, hearing and/or paralysis 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.

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 Accidental Death and Dismemberment 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 any 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 Registration 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 without specifying their respective interests, the Accidental Death Benefit will be paid in equal shares.

Section 4.03 – Loss of Time Benefit (Class A Employee Only)

When an accident or sickness causes an eligible Class A Employee (who is not retired) to be Totally Disabled and prevents the eligible Class A Employee from engaging in the Employee's regular occupation, the Plan will pay the Loss of Time Benefit as set forth in the Schedule of Benefits.

Each Totally Disabled participant who is under the care of a Physician for an injury or sickness will receive benefits for absence due to injury or sickness which constitutes a period of Total Disability after applying for Benefits and satisfying the Waiting Period set forth in the Schedule of Benefits. Following the applicable Waiting Period, a Totally Disabled Participant will receive Benefits payable every two weeks in an amount specified in the Schedule of Benefits. Non-occupational accident benefits begin on the first day of Total Disability and sickness benefits begin on the eighth day of Total 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 to medical review which will require submission of medical records. The expected recovery time will initially be determined in accordance with the then 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 disability due to the same or related causes shall be considered as the same period of disability, unless separated by a release for return to work, following recovery. 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 disabilities will be considered a Non-occupational Disability.

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

Section 4.04 – General Medical Benefit

Medical expenses included under the General Medical Benefit will be payable for Medically Necessary care and services that are ordered and prescribed by a Physician according to the Schedule of Benefits.

A) <u>Deductible Amount</u>

Before benefits 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 is a separate Deductible Amount 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 $50 per person per visit with no family maximum. The Emergency Room Deductible is a separate deductible 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.

B) Copayment

Certain covered health services require you to pay a "Copayment". The term copayment can refer to the Plan's portion of the Covered Service or your portion. Copayments apply after the Deductible Amount is satisfied, if applicable.

C) Out-of-Pocket Limit

The amount you pay out of your pocket in a Plan Year for Covered Charges is referred to as the Out-of-Pocket Limit. After you reach the maximum amount listed on the Schedules of Benefits in a Plan Year, the Plan pays 100% of your medical Covered Charges up to the annual or lifetime maximums, whichever is applicable.

D) Annual and Lifetime Maximums

There are no annual or lifetime maximums.

E) Covered Expenses

Medical expenses included under the General Medical Benefit will be payable for the following Medically Necessary care and services which are ordered and prescribed by a Physician:

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 and recommended by a Physician.

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 thereof 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's fees, including office and Hospital visits but excluding expenses which are related to surgical procedures.

4. UCR Charges for surgical procedures performed by a Physician and in compliance with Women's Health and Cancer Rights Act, the Plan shall cover UCR Charges incurred by Participants or covered 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 Participant's 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. Treatment by a physiotherapist 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).

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. alveloectomy;
    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 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. Medically necessary airplane travel may be covered if it is approved in advance.

11. Medical supplies, limited to: drugs and medicines 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 iron lung and oxygen and equipment for its administration. 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 mid-wives and birthing centers, the Plan will pay benefits for the pregnancy on the same basis as any other accident or sickness. Loss of Time Benefit payments shall be made to the eligible female Employee in accordance with the Loss of Time provisions explained in Section 4.03 of this Booklet.

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 pre-certification to use certain providers or facilities or to reduce out-of-pocket expenses.

Maternity benefits are **NOT** payable on behalf of eligible Dependent children for expenses incurred due to pregnancy, childbirth or miscarriage.

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. Prescription oral contraceptives are covered under the Prescription Drug Card Benefit in Section 4.12 of this Booklet.

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 (not including the non-customized removable inserts provided with such shoes) per Participant or Dependent per Plan Year.

Section 4.05 – Chiropractic Benefit

When an Eligible Person incurs expenses for non-surgical Chiropractic services and has met the Deductible Amount, the Plan will pay Benefits according to the Schedule of Benefits, up to an annual Plan Year limit of $1,000 in Benefits per Eligible Person. Charges for initial office visits or required x-rays will not apply to the $1,000 Plan Year limit. Chiropractic services following surgery will be paid under the General Medical Benefits, if Medically Necessary.

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. Advance approval of dental treatment plans is not required, but is recommended. If you have questions regarding the status of your dental care provider, 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, once in any Calendar Year;

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

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

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

    f. Sealants, one per tooth per lifetime for occlusal surface of first permanent molars to age nine and second permanent molars to age 15. Surface must be free of decay and restorations.

2. Other Dental Services

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

    b. Restorative services using amalgam material; composite resin and porcelain crowns are not covered on posterior teeth;

    c. Provisional splinting once every three years;

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

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

    f. Stainless steel crowns; and

    g. Antibiotic drug injections.

B) <u>Dental Benefit Limitations</u>

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 a Covered 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 claim involving services that are determined by the Plan to be dentally unnecessary. On reconsiderations of denied dental necessity 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 claims;

4. Up to two additional prophylaxes treatments per Calendar Year may be available 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 with kidney failure or who are undergoing dialysis; or

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

5. An additional fluoride treatment may be available each Calendar Year for patients undergoing head and neck radiation.

C) Dental Benefit Exclusions

The Plan does not cover, in whole or in part, any dental service or benefit 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 an allowable 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 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: Alveolectomy, Apicoectomy, Frenectomy, Gingivectomy, Osseous surgery, Ostectomy, Osteoplasy, Removal of cysts, Surgical Removal of impacted teeth, Torus mandibularis, and Torus palatinus. These services will be paid under the General Medical Benefit at the applicable copayment. The Deductible will not apply; and

9. Orthodontic treatment.

Section 4.07 – Diabetes Education and Training

When an Eligible Person incurs expenses for education and training for management of diabetes, the Plan will pay benefits according to the Schedule of Benefits. The maximum limitation on this benefit will not apply to nutritional counseling. Services for nutritional counseling must be provided by a properly licensed dietician or nutritional therapist and must be medically necessary as ordered by a Physician.

Section 4.08 – Eye Care Benefit

When an Eligible Person incurs expenses for eye care services or supplies, the Plan will pay benefits according to the Schedule of Benefits. The Preferred Provider for eye care is Davis Vision. If you have questions regarding the status of your eye care provider, please contact Davis Vision at (888) 235-3220 or www. davisvision.com. 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, up to a maximum of $60 per Eligible Person per Plan Year.

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, up to a maximum reimbursement of $1,000 per ear ($2,000 total) for any Eligible Person, limited to one reimbursement per ear per rolling 36 months per 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.

Section 4.10 – Hospice Care Benefit
Benefits 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.

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 in-patient 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;

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, the Plan will pay benefits 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 a doctor of medicine (MD).

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 and prescribed by a licensed Physician. The Fund does not participate with Walmart, Walgreen's or Sam's Club Pharmacies. The Plan currently utilizes SavRx as its prescription benefit manager. If you have questions regarding the status of your pharmacy provider, please contact SavRx 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 service provider to provide prescription drugs as described in this Section 4.12.

B) Retail Participating Pharmacies

Retail Participating Pharmacies allow prescriptions for a supply of up to 30 days. Each refill is entitled to 100% Copayment by the Plan **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. Each refill is entitled to 100% Copayment by the Plan **after** payment of the applicable amount by the Eligible Person as listed in the Schedule of Benefits. Mail Order Participating Pharmacies also include the following walk-in pharmacies which allow 90 day prescriptions: CVS, Nations Medicine, Pharmacy of Canterbury, Keltsch Pharmacy and Community Care Center. Specialty Drugs may not be filled or refilled at a Mail Order Participating Pharmacy.

D) Covered Expenses

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

E) Exclusions and Limitations

No benefits shall be payable for any of the following:

1. Any prescription filled at Walgreen's, WalMart or Sam's Club Pharmacy;

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 prescription drug manager 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. Vitamins (prescription and over the counter, except for pre-natal vitamins prescribed during pregnancy);

6. Agents or treatment related to baldness or thinning hair (prescription or over the counter);

7. Fertility drugs;

8. All injectable products except for those that can be self-administered or those pre-approved by the Plan;

9. Therapeutic devices or appliances; or

10. Any expense incurred for Specialty Prescription Drugs that exceeds the 30 day limit.

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

Section 4.13 – Routine Preventative 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 Copayments.

Schedule of Routine Preventative Care

Procedure	Benefit
Routine Physical Exam	Age 2 and over: 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 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.
Routine PSA Test (Prostate Cancer Screening)	1 per Plan Year covered at 100%, otherwise under General Medical Benefit.
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.
Colorectal Cancer Screening	Age 50 and over: 1 sigmoidoscopy every 5 Plan Years at 100% Age 50 and over: 1 colonoscopy every 10 Plan Years at 100% Otherwise under General Medical Benefit.
Well-Child Exam & Immunizations	100% from birth to age 24 months for routine well child visits and all immunizations recommended by the Center for Disease Control.
Routine Adult and Childhood Immunizations	100% excluding those required for occupation or vacation travel, as recommended by the Center for Disease Control (age 2 and over).

Limitations

The Routine Preventative 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 excluded tests *may* be covered under General Medical Benefit in Section 4.04 E 9).

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 benefits according to the General Medical Benefit after the Deductible Amount has been met.

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.

Detoxification Services
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.

Substance Abuse Treatment Conditions
Substance Abuse treatment including detoxification, in-patient rehab, a partial hospital program or intensive out-patient program will be covered provided the services are medically necessary and the attending physician completes and submits a Substance Abuse Claim Form for each level of care. The Substance Abuse Claim Form is available on the Fund's website or by calling the Fund Office at (800) 962-3158.

Contact the Fund's case management provider, AHH at (866)440-2723 to obtain pre-certification for inpatient stays or to receive more information regarding this benefit.

Exclusions
Substance Abuse Benefits will not be paid for expenses incurred from or related to court ordered treatment as excluded under Benefit Exclusions and Limitations number 38.

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 benefits 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 an organ transplant, the Plan will pay benefits under the General Medical Benefit, after the Deductible Amounts have been met as follows:

A) Hospital and Surgery Transplant Recipient Benefit
Covered transplant expenses include the following:

1. The use of temporary mechanical equipment, pending the acquisition of a matched human body part 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 Benefits 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 will not exceed 100% of Covered Expenses.

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.

G) Notification Requirement

Prior to treatment, all potential transplant recipients and donors must contact the Plan's Utilization Review Program, who will assist the recipient and/or donor to receive the most cost-effective treatment. Contact information for the Plan's Utilization Review Program can be found in Section 9.15.

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.**

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

3. Cosmetic or reconstructive surgery, 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;

7. Treatment, services or supplies which are considered Experimental 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 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. Intentionally self-inflicted injuries, sickness or other condition or attempt at self destruction unless the injury or sickness is a result of a "medical condition." A *medical condition* means any condition, whether physical or mental, including, but not limited to, any condition resulting from sickness, injury (whether or not the injury is accidental), pregnancy or congenital malformation. However, genetic information is not a condition.

13. Expenses incurred during confinement in a Hospital owned and operated by the United States government or any agency thereof, except as otherwise required by law;

14. Treatment, services or supplies furnished by or under the direction of the United States government or any of its agencies, including the Veterans' Administration, unless otherwise required by law;

15. Expenses incurred during confinement in a Hospital owned or operated by a state, province or political subdivision, unless there is an unconditional requirement of the part of the individual covered under this Plan to pay such expenses without regard to any liability against others, contractual or otherwise;

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

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

18. Developmental Care, as defined in this Plan, regardless of where or by whom provided;

19. Expenses incurred for orthopedic shoes, orthotics or other supportive devices for the feet, except for Medically Necessary expenses incurred for diabetic shoes and toe-fillers needed as a result of diabetes, as set forth in Section 4.04 E 17;

20. Expenses incurred for sexual transformation or treatments related to sexual dysfunction;

21. Expenses incurred related to mental and nervous disorders which are classified as sexual deviations or disorders;

22. Expenses incurred primarily for the covered individual's education, training or development of skills needed to cope with an injury or sickness, except as provided by the Plan;

23. Expenses incurred related to smoking cessation;

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

25. Personal hygiene and convenience items (for convenience of the covered individual, 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;

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

27. Expenses incurred from breast augmentation or reduction which is not associated with cancer of the breast or another Medically Necessary condition;

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

29. Maternity expenses incurred by dependent children;

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

31. 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;

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

33. Any expense or charge for eye exercises, vision therapy or vision training, unless medically necessary;

34. 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);

35. Any treatment of obesity (including, but not limited to, 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);

36. Dental treatment, except as expressly provided in Section 4.04 E 7 or in Section 4.06;

37. Expenses incurred for marital counseling;

38. Injury, Sickness or expenses incurred from or related to any court ordered evaluations or treatment 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;

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

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

41. Expenses incurred for Specialty Prescription Drugs that exceeds the 30-day limit;

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

43. Maternity charges incurred by a 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.

ARTICLE VI – SENIOR PROGRAM

(Classes AS, C, CP AND D)

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

Section 6.01 – Eligibility to Participate in Senior Program

Each Participant who ceases active full-time employment due to retirement or Total Disability with all Employers will be eligible to register in this portion of the Plan provided contributions have been made on the Participant's behalf by Employers to the Plan or the Participant has made Self-Payments to the Plan 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 –

A) the Participant is Totally Disabled and is currently receiving or previously received a pension benefit from the Indiana Laborers Pension Fund; or

B) the Participant is receiving either a disability or retirement benefit from the Social Security Administration; or

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

Section 6.02 – Termination of Eligibility in Senior Program

A Retiree who becomes eligible to participate under this portion of the Plan will remain eligible to participate until the date that individual fails to make a timely Self-Payment for coverage. A Retiree 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 3.01. Participation may not be regained by Self-Payments.

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

A) the Retiree elects (1) a member-only or (2) member and Spouse or one named Dependent coverage type that does not cover the applicable covered Dependent,

B) the individual no longer qualifies as a Dependent, or

C) the Retiree ceases to be covered by the Plan.

Section 6.03 – Registration of Retirees

A Retiree who meets the eligibility requirements set forth in Section 6.01 must register for coverage in the appropriate Class under this portion of the Plan any time during the 90-day period immediately following the later of –

A) his Total Disability or retirement, or

B) the termination of his coverage under Class A.

At the time of registration, the Retiree must elect one of the Three Tier coverage types described in Section 6.05. If the Retiree registers but does not make an affirmative Three Tier coverage election, the Retiree shall be considered to have elected member-only coverage.

If a Retiree does not register during this period, that individual shall not be allowed to register at any later date except by returning to active work and meeting the requirements for initial eligibility as set forth in Section 3.01.

Section 6.04 – Registration of Dependents

A Retiree who registers for Senior Medical Benefits shall be allowed to register his Dependents during the time period specified in Section 6.03. In addition, if a Retiree is covered by Medicare and has a Spouse or other Dependent who is not covered by Medicare, such Spouse or other Dependent may be registered for coverage in the appropriate Class.

At the time of registration, the Retiree must elect one of the Three Tier coverage types described in Section 6.05. If the Retiree registers Dependents but does not make an affirmative Three Tier coverage election, the Retiree shall be considered to have elected member-only coverage and the registration of Dependents shall be null and void.

Section 6.05 – Three Tier Coverage Structure

Upon approval of eligibility for the Senior Program, the Retiree must elect one of the following tiers of coverage and Self-Payment:

A) member-only, which tier will provide coverage only for the Retiree; or

B) member and Spouse or one named Dependent, which tier will provide coverage only for the Retiree and either (1) their Spouse or (2) one Dependent identified by name; or

C) family, which tier will provide coverage for the Retiree, their Spouse (if any) and any registered Dependents.

The cost of Self-Payment will vary according to the class of coverage applicable under Section 6.09 and the tier of coverage elected. A schedule of Self-Payment rates, which may be amended from time to time, is maintained by the Fund Office.

Except as described in the paragraph below, the election under this Section 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 coverage type. However, except as described in the paragraph below, in no event shall coverage be increased (from A above to B or C above; or from B above to C above) from the coverage elected during the one-time election period. Provided, further, notwithstanding anything to the contrary in this Plan, the Spouse or Dependent

of a Retiree who is not covered after this one-time election or the coverage change allowable under the next paragraph shall not be eligible for survivor benefits under Article VII – Surviving Spouse Program.

In the event of marriage, birth, adoption or placement for adoption occurring after the one-time election, the Retiree may change the coverage type to reflect the addition of the new Spouse or other Dependent, provided that the change is requested within a 30 day period beginning on the date of the marriage, birth, adoption or placement for adoption.

In addition, if a Retiree registers for Senior Medical Benefits and has a Spouse or Dependent who is otherwise eligible for coverage under the terms of the Senior Medical Benefits 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 Medical Benefits coverage if requested by the covered Retiree not later than 30 days after the Spouse or Dependent's loss of coverage under the other plan.

Notwithstanding the foregoing, a 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 Participant re-elects this Plan's prescription drug coverage within two years of first enrolling in Part D coverage.

Section 6.06 – Transfers from Class A Coverage to Senior Medical Benefits

A Retiree may maintain his eligibility for a full Schedule of Benefits, excluding Loss of Time Benefits, as provided in the Class A program until the look back for continued eligibility in previous, consecutive qualification periods as explained in Section 3.02 is exhausted. In addition, a Retiree (but not a former Participant who terminates service with an Employer for other reasons) may transfer to the Senior Medical Benefits 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 the expiration of coverage under the Class A program. However, such a Retiree may not transfer from the Senior Medical Benefits program back to the Class A program unless that individual returns to work and again meets the requirements for initial participation set forth in Section 3.01. Self-Payments for the Senior Medical Benefits program are described in Section 6.07.

Section 6.07 – Self-Payments to Maintain Coverage for Senior Medical Benefits

A Retiree may make Self-Payments for Senior Medical Benefits (Class AS, C, CP or D) in an amount determined by the Board of Trustees, payable in advance. Self-Payments for initial eligibility coverage in the Senior Medical Benefits portion of the Plan shall be due by the tenth day of the month preceding the first month of the next Coverage Period. However, Retirees not eligible for Medicare may exhaust their look-back hours for up to two Coverage Periods before Self-Payments are required. Self-Payments not made in a timely manner will not be accepted and coverage will be terminated. In such a case, the Participant may only again participate in the Plan by returning to active work and meeting the requirements for initial participation set forth in Section 3.01. Self-Payments for coverage in the Senior Medical Benefits may be deducted from the monthly pension check if the Retiree or Spouse is receiving a pension from the Indiana Laborers Pension Fund or Construction Workers Pension Trust Fund Lake County and Vicinity.

Section 6.08 – Cost of Self-Payment

The Plan will subsidize the cost of Senior Medical Benefits at a rate of 2% for each year of service with the Plan up to a maximum 60% subsidy. A Retiree 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 tier of coverage elected under Section 6.05 and the class of coverage applicable under Section 6.09. A schedule of costs, which may be amended from time to time, is maintained by the Fund Office.

Section 6.09 – Coverage Provided by Senior Medical Benefits Portion of the Plan

The Participants and/or Dependents who may be eligible for Senior Medical Benefits coverage and the applicable Classes of coverage are listed in Sections 1.02 and 1.03 of this Booklet. The Class that applies to a Retiree and his Dependents depends on age and dependent status and in some cases, the Retiree's election of an applicable Class. The five Classes provide coverage in the amounts specified in the Schedule of Benefits.

The Senior Medical Benefits for those Participant's eligible for Medicare will supplement Medicare's payment and pay up to 100% of the Medicare Allowed amount for those services eligible under Medicare. No Benefit will be paid for services not covered by Medicare unless the service is specifically listed in the Schedule of Benefits. Those services will be paid under the Class A Schedule of Benefits.

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

The eligible surviving Spouse of a Participant or Retiree may elect to continue for himself or herself and the covered Dependent children of the deceased Participant, Retiree, on a Self-Payment basis –

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

B) if not eligible for Medicare, the survivor can elect Class S benefits.

If there is no eligible 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 who is not covered after the one-time election of a coverage change allowable under Section 6.05 shall not be eligible for survivor benefits under Article VII upon the death of the Retiree.

Eligibility for Survivor Benefits begins immediately upon termination of benefit coverage due to the Retiree's death. A surviving Spouse must elect coverage within 60 days after his or her coverage would otherwise terminate. Dependent children will be covered as long as they meet the definition of Dependent.

Section 7.02 – Class S Benefits

Class S benefits are the same as Class A benefits, but will not include Maternity, Newborn Care or Well-Child Benefits, Loss of Time Benefits or Life 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 covered 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 of this Booklet.

Section 7.03 – Self-Payments to Maintain Coverage for Surviving Spouse Benefits

An eligible survivor under Article VII may make Self-Payments for Surviving Spouse Benefits in an amount determined by the Board of Trustees from time to time, payable in advance. Self-Payments for initial eligibility coverage in the Surviving Spouse portion of the Plan must be made within 60 days after the date your Spouse's coverage expires. Initial coverage shall be provided starting with the first day of the next Coverage Period after your Spouse's coverage expires. For participation during subsequent Coverage Periods, Self-Payments must be made by the tenth day of the month preceding the first month of the next Coverage Period. Coverage will be terminated if Self-Payments are not received.

Section 7.04 – Cost of Self-Payment

The subsidy applicable to the Participant or Retiree for Senior Medical Benefits as described in Section 6.08 will also be applied to an eligible surviving Spouse who elects Class S benefits or elects to continue in Class C, CP or D.

The Plan subsidy is at a rate of 2% for each year of service with the Plan up to a maximum 60% 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 tier of coverage elected (if applicable) and the Class of coverage elected. 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 file with the Board of Trustees, in writing, his post office address and each change of post office address. Any communication, statement or notice addressed to such a person at his latest reported post office address will be binding upon him for all purposes of the Plan and neither the Board of Trustees nor any Employer shall be obligated to search for or ascertain his whereabouts.

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, in which case every 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 – Application for Benefits and Data

All persons claiming benefits under any portion of this Plan must make application and furnish to the Board of Trustees or its designated agent, such documents, evidence or information, written in English, as the Board of Trustees or its designated agent considers necessary or desirable for the purpose of administering the Plan. Such claims for benefits must be submitted no later than 18 months from the date the claim was incurred; provided, however, that in the case of benefits coordinated with Medicare or with any Other Group Plan (as defined in Section 8.12), the claim for benefits must be submitted by no later than 18 months from the date the primary payer paid the benefits.

In addition, each such person claiming benefits must furnish such information promptly and sign such documents as the Board of Trustees or its designated agent may require before any benefits become payable.

Section 8.04 – Submission of Claims

In most cases, the provider will submit claims electronically to the appropriate PPO network. If you need to file your own claim, claim forms and instructions can be obtained from the Fund Office. If possible, call the Fund Office to request a claim form a few days before you or your Dependent will need the form. After the form is completed, submit all claims in writing to the Board of Trustees at the following address: Indiana Laborers Welfare Fund, P.O. Box 1587, Terre Haute, IN 47808-1587.

In addition, each such person claiming benefits must furnish such information promptly and sign such documents as the Board of Trustees or its designated agent may require before any benefits become payable.

Section 8.05 – Claims Procedures

Federal claims regulations categorize all claims into Pre-Service Claims (urgent and non-urgent), Post-Service Claims and Disability Claims. Different time frames for the Plan to make a decision on the claim apply to each type of claim. If your claim is denied, the following time frames apply. Following the table below (which summarizes these time frames) are special definitions applying to benefit claims, the timing of benefit claim denial notices and the manner in which such notices are required to be given and the required content of such notices.

Time Limits	**Type of Claim**			
THE LISTED ACTION MUST OCCUR WITHIN THESE TIME LIMITS	**Urgent health care**	**Pre-service health care (non urgent)**	**Post-service health care**	**Disability**
For Plan to make initial claim determination (either approve or deny claim)	72 hours (depending on medical circumstances)	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 claimant and delay is beyond Plan control)	None	15 days	15 days	30 days, plus another 30 days
For Plan to request missing information from claimant after receipt of claim by Plan	24 hours	15 days	30 days	45 days
For claimant to provide missing information after request for information by Plan	48 hours	45 days	45 days	45 days

DEFINITIONS

The following terms are applicable to the procedures which apply to a Claim Denial and appeals of Claim Denials and shall have the meanings set forth below. You or your Beneficiary making a claim are referred to as a "claimant".

Claim Denial or Denial of Claim

The term **"Claim Denial"** or **"Denial of Claim"** 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 a Participant's or your 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 investigational or not Medically Necessary or appropriate.

Claim Involving Urgent Care

A **"Claim Involving Urgent Care"** is any 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 claim.

Whether a 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 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.

Group Health Plan

The term **"Group Health Plan"** means an employee welfare benefit Plan within the meaning of Section 3(1) of ERISA to the extent that such Plan provides "medical care" within the meaning of Section 733(a) of ERISA. Your health care coverage is considered "Group Health Plan" coverage under this definition.

Health Care Professional

The term **"Health Care Professional"** means a physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with State law.

Notice Or Notification

The term **"Notice"** or **"Notification"** means the delivery or furnishing of information to an individual in a manner that satisfies the standards of 29 CFR 2520.104b-1(b), as appropriate, with respect to material required to be furnished or made available to an individual.

Pre-Service Claim
The term **"Pre-Service Claim"** means any claim for a benefit under a Group Health Plan with respect to which the terms of the Plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

Post-Service Claim
The term **"Post-Service Claim"** means any claim for a benefit under a Group Health Plan that is not a Pre-Service Claim.

Relevant
A document, record, or other information shall be considered **"Relevant"** to a claimant's claim if such document, record, or other information –

A) Was relied upon in making the benefit determination;

B) Was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination;

C) Demonstrates compliance with the administrative processes and safeguards required pursuant to 29 CFR 2560.503-1(m)(b)(5) in making the benefit determination; or

D) In the case of a Group Health Plan or a Plan providing disability benefits, constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

TIMING OF NOTIFICATION OF BENEFIT DETERMINATION

In General – Claims Other Than Group Health Care Or Disability Claims
If a claim is wholly or partially denied, the Plan Administrator 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 Plan Administrator determines that special circumstances require an extension of time for processing the claim. If the Plan Administrator 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.

Health Care Claims
In the case of a claim for health care benefits, the Plan Administrator shall notify a claimant of the Plan's benefit determination, as appropriate as shown below:

A) Urgent Care Claims
In the case of a **Claim Involving Urgent Care**, the Plan Administrator shall notify the claimant of the Plan's benefit determination (whether an approval or denial) as soon as possible, taking into account the medical circumstances, but not later than 72 hours after receipt of the claim by the Plan, 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 Plan Administrator shall notify the claimant as soon as possible, but not later than 24 hours after receipt of the claim by the Plan, of the specific information necessary to complete the

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 Plan Administrator shall notify the claimant of the Plan's benefit determination as soon as possible, but in no case later than 48 hours after the earlier of –

1. The Plan's receipt of the specified information, or

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

B) Concurrent Care Decisions

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 Denial of Claim. The Plan Administrator shall notify the claimant of the 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 Denial before the benefit 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 Plan Administrator shall notify the claimant of the benefit determination, whether an approval or a denial, within 24 hours after receipt of the claim by the Plan, provided that any such 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 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) Other Claims

In the case of a claim not described above, the Plan Administrator shall notify the claimant of the Plan's benefit determination, as appropriate.

1. Pre-Service Claims

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

2. Post-Service Claims

In the case of a Post-Service Claim, the Plan Administrator shall notify the claimant, within a reasonable period of time, but not later than 30 days after receipt of the claim. This period may be extended one time by the Plan for up to 15 days, provided that the Plan Administrator 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 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) Disability Claims

In the case of a claim for disability benefits, the Plan Administrator shall notify the claimant of the Plan's Appeal of Claims Denials Procedures within a reasonable period of time, but not later than 45 days after receipt of the claim by the Plan. This period may be extended by the Plan for up to 30 days, provided that the Plan Administrator 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 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 Plan Administrator 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 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.

E) Calculating Time Periods

For purposes of this Section, the period of time within which a benefit determination is required to be made shall begin at the time a claim is filed in accordance with the procedures of a Plan, without regard to whether all the information necessary to make a benefit 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 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.

MANNER AND CONTENT OF NOTIFICATION OF BENEFIT DETERMINATION

The Plan Administrator shall provide a claimant with a written or electronic Notification of any Denial of Claim. The Notification shall set forth, in a manner calculated to be understood by the claimant –

A) The specific reason or reasons for the 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 claim and an explanation of why such material or information is necessary;

D) A description of the Plan's review 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 ERISA following a Denial on review;

E) In the case of a Denial for health care or disability benefits by a Group Health Plan or a Plan providing disability benefits,

   1. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the 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 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 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 Denial by a Group Health Plan concerning a Claim Involving Urgent Care, a description of the expedited review process applicable to such claims.

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

If your claim for benefits is denied, you should first use the Plan’s appeal procedures found in Section 8.06 before filing suit in court. Failure to file such an appeal under Section 8.06 could result in any court action you may file to be considered premature and could result in your case being dismissed in such a manner as to preclude any further court actions. If your claim for benefits is denied again on appeal under Section 8.06, you may then proceed to court since you will then have exhausted this Plan’s administrative review procedures.

Section 8.06 – Appeals Procedures

APPEAL OF ADVERSE BENEFIT DETERMINATIONS

Federal claims and appeals regulations categorize all claims and appeals of Denials of Claims into Pre-Service Claims (urgent and non-urgent), Post-Service Claims and Disability Claims. Different time frames for the Plan to make a decision on the appeal of a Denial of Claim apply to each type of claim. If your claim is denied, and you file for an appeal or review of the Claim Denial, the following time frames apply. Following the table below (which summarizes these time frames) are sections on: the rules governing an appeal, the timing of benefit Claim Denial notices, the manner such notices are given and the required content of such notices.

Time Limits	**Type of Claim**			
THE LISTED ACTION MUST OCCUR WITHIN THESE TIME LIMITS	**Urgent health care**	**Pre-service health care (non urgent)**	**Post-service health care**	**Disability**
For claimant to request appeal after Denial	180 days	180 days	180 days	180 days
For Plan to make determination on appeal	72 hours (depending on medical circumstances)	30 days	Appeal will be heard at the next quarterly Board of Trustees meeting after the claimant filed the appeal (or if appeal is filed within 30 days of the next scheduled meeting, the appeal will be heard at the second quarterly meeting) Claimant to be notified within 5 days of Plan decision.	Appeal will be heard at the next quarterly Board of Trustees meeting after the claimant filed the appeal (or if appeal is filed within 30 days of the next scheduled meeting, the appeal will be heard at the second quarterly meeting) Claimant to be notified within 5 days of Plan decision.
For Plan to obtain extension of time (if proper notice given to claimant and delay is beyond Plan control)	None	None	Plan may extend the appeal hearing by one additional quarterly meeting if the claimant is notified prior to the meeting determined above.	Plan may extend the appeal hearing by one additional quarterly meeting if the claimant is notified prior to the meeting determined above.

APPEAL OF DENIED CLAIMS

Full And Fair Review Of Claims Other Than Health Care Or Disability Claims

As part of your rights of appeal for a denial of a claim other than a claim for Health Care Benefits or Disability benefits:

A) Claimants shall have 60 days following receipt of a Notification of an Adverse Benefit Determination within which to appeal the determination;

B) Claimants shall have the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;

C) Claimants shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information Relevant to the claimant's claim for benefits.

D) The review on appeal 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.

Health Care Benefits

As part of your rights of appeal of a Denial of a Claim for Health Care Benefits:

A) Claimants shall have at least 180 days following receipt of a notification of a Denial of Claim within which to appeal the Denial;

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

C) In deciding an appeal of any 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 Health Care Professional who has appropriate training and experience in the field of medicine involved in the medical judgment;

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

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

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

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

2. All necessary information, including the Plan's benefit determination on review, shall be transmitted between the Plan and the claimant by telephone, facsimile, or other available similarly expeditious method.

Plans Providing Disability Benefits

The appeals process of a claim for Disability Benefits shall comply with the requirements concerning the appeal of a claim for other than Health Care or Disability Benefits and paragraphs A) through E) of the above section on Health Care Benefit appeals.

TIMING OF NOTIFICATION OF BENEFIT DETERMINATION ON REVIEW

In General, Claims Other Than Health Or 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 Plan's 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 Plan's 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 Plan's receipt of the request for review. If such an extension of time for review is required because of special circumstances, the Plan Administrator 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 Plan Administrator shall notify the claimant of the benefit determination as soon as possible, but not later than five days after the benefit determination is made.

Health Care Claims

In the case of an appeal of a Denial of Claim for Health Care Benefits, the Plan Administrator shall notify a claimant of the Plan's benefit determination on review as set forth below, as appropriate.

A) Urgent Care Claims

In the case of a **Claim Involving Urgent Care**, the Plan Administrator shall notify the claimant of the Plan's 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 Denial by the Plan.

B) Pre-Service Claims

In the case of a Pre-Service Claim, the Plan Administrator shall notify the claimant of the Plan's benefit 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 by the Plan of the claimant's request for review of a Denial.

C) Post-Service Claims

In the case of a Post-Service 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 Plan's 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 Plan's 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 Plan's receipt of the request for review. If such an extension of time for review is required because of special circumstances, the Plan Administrator 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 Plan Administrator shall notify the claimant of the benefit determination as soon as possible, but not later than five days after the benefit determination is made.

Disability Claims

In the case of a Disability 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 Plan's 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 Plan's receipt of the request for review. If special circumstances (such as the need to hold a hearing, if the Plan's procedures provide for 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 Plan's receipt of the request for review. If such an extension of time for review is required because of special circumstances, the Plan Administrator 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 Plan Administrator 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, the period of time within which a benefit determination on review on appeal is required to be made shall begin at the time an appeal is filed with this Plan, 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 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 Denial on review on appeal, the Plan Administrator 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 Plan Administrator shall provide a claimant with written or electronic notification of a Plan's benefit determination on review. In the case of a Denial, the notification shall set forth, in a manner calculated to be understood by the claimant –

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

B) Reference to the specific Plan provisions on which the 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 claim for benefits.

D) A statement describing any voluntary appeal procedures offered by 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 the ERISA; and

E) In the case of a Denial of Health Care Benefits or Disability Benefits –

1. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the 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 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 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.

Section 8.07 – Venue

Any lawsuit filed by a claimant who has exhausted the claims and appeals process set forth in this document, 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 location of the Plan's administrative offices in Vigo County, Indiana.

Section 8.08 – 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 8.09 – 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 months as a Participant prior to July 1, 1996, shall not be Creditable Coverage and provided further 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 or (800) 962-3158.

Section 8.10 – Interest Not Transferable

No right or interest of any Participant in the Loss of Time Benefits portion of the Plan shall be assignable or transferable. Rights under the Medical Benefits, Senior Medical Benefits and Survivor Benefits portions may be assigned to the provider of medical services.

Section 8.11 – 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 8.12 – Coordination Of Benefits

All benefits payable by this Plan shall be coordinated with benefits payable under any Other Group Plan if the covered expenses are for a Participant, Retiree or covered Dependent Spouse and/or Dependent children as defined in Section 11.13 in this Booklet.

If a Participant, Retiree or covered 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 nondependent 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. If the Other Group Plan does not have the rule described in this subparagraph 2 and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

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 claim for a dependent child of divorced or separated parents or the rule described in subparagraph 5 below involving a 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. However, if the Other Group Plan does not contain the rule described in this subparagraph 3 but instead has a rule based on the gender of the parent and if, as a result, the plans do not agree on the order of benefits, the rule in the Other Group Plan will determine the order of benefits.

4. If a 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 for 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 for 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.

   If the Other Group Plan does not have the rule described in this subparagraph 4 and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

5. If a 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.

   If the Other Group Plan does not have the rule described in this subparagraph 6 and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

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.

Definitions

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.

Claim Period
The term "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 incurred which is covered by at least one Other Group Plan during a 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 Claim Period shall also be considered a Covered Expense.

Section 8.13 – Coordination with Medicare

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 Medicare was not elected, the Plan will use the Original Medicare Part A and Part B benefit structure for coordination. For Participants, Retirees and/or their covered Dependents who are eligible for Medicare, the Plan requires the submission of a Medicare explanation of benefits before covered expenses will be paid by the Plan.

Section 8.14 – Subrogation

If an Eligible Person is injured in an accident for which someone else may be liable, that person or their insurance 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 tort-feasor, 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 claims for or receive any Benefit 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 payments and claims. This form will assist the Plan in recovering Benefits paid from a third party who was responsible for the injuries giving rise to the claims. This Agreement must also be executed by the Eligible Person's attorney, if applicable.

   Because Benefit payments are not payable unless you sign a Subrogation Agreement, the Eligible Person's claims will not be paid until the fully signed Agreement is received by the Plan.

   This means that, if an Eligible Person files a claim and a Subrogation Agreement is not received promptly, the 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 Benefits 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 Benefits 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 Benefits 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 Benefits 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 Plan Administrator 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 tort-feasor or any other payments on behalf of the third party tort-feasor.

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.

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. The Eligible Person must 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. The Eligible Person must 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. "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.

O) 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.

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 Benefits and also saves the Plan money (which saves you money too) by making sure that the responsible party pays for the injuries.

Notwithstanding any other provision or Section of this Plan, in the event an Eligible Person is injured in an accident for which someone else is liable, the Plan will pay Benefits as a result of said injuries at 75% of discounted charges for in-network benefits and at 50% of approved charges for out of network benefits. The Deductible Amount and Out-of-Pocket rule will not be applied to these claims.

Section 8.15 – Other Rights of Recovery

Whenever benefit payments are made under the Plan which are in excess of eligible 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 Participant, Retiree or covered Dependent.

In the case of the Participant, Retiree or covered Dependent, the Board of Trustees reserves the right to reduce future benefit payments under the Plan in order to correct a prior overpayment.

Section 8.16 – Medical Care Review Program

The Plan has entered into an agreement with a professional medical care review firm to pre-certify all in-patient 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. The Fund also requires pre-notification when an Eligible Person starts dialysis or hospice care.

The participant'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 Participant The medical care review firm also acts as a patient advocate to assist the Participant in managing their condition.

The pre-certification process is not a guarantee of benefits. Other Plan exclusions may prohibit your claim under the Plan. The following is a list of procedures that are required to be pre-certified, as of the effective date of this Combination Plan Document and Summary Plan Description:

- All inpatient hospital admission, which includes acute inpatient, long term acute care, medical rehabilitation, skilled nursing facilities, inpatient hospice, inpatient and acute residential behavior health

- All surgeries, which includes inpatient and outpatient. This does not include medical doctor's office settings.
- Durable Medical Equipment over $500
- Epidural Spinal Injections
- Growth Hormone Treatment
- Home Health Care / Skilled Nursing Visits
- Infusion Therapy
- Outpatient Chemotherapy and Radiation
- Outpatient Diagnostic Procedures: PET and SPEC scans, CT scans and MRI's
- Speech Therapy
- Therapy: Occupational and Physical after 12 visits
- Varicose Vein procedures

The following services require Pre-notification:

- Dialysis
- Hospice Care

THE BOARD OF TRUSTEES MAY AMEND THE LIST OF SERVICES THAT REQUIRE PRE-CERTIFICATION. PLEASE 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 their 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 Participant 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 will be issued by the medical care review program.

When Surgery is Recommended
When a Physician recommends a non-emergency surgical procedure (inpatient or outpatient), the medical care review program must be contacted. 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 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 8.17 – Preferred Provider Organization
The Board of Trustees reserves the right to enter into agreements for negotiated fee levels with preferred provider organizations. Use of a preferred provider may result in lower Deductible Amounts, higher Plan Copayments, 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 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.

Section 8.18 – 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 with the Fund Office.

Section 8.19 – Amendment and Termination

The Board of Trustees reserves the right to amend, modify or terminate the Plan or any part of the Plan (including but not limited to Senior Benefits) at any time and for any reason, including but not limited to such modifications or amendments to the Plan that are necessary or appropriate to qualify or maintain the Plan as a plan meeting the requirements of any appropriate governmental agency. Such amendment, modification or termination shall be accomplished by a Board Resolution adopted by written consent or by a vote of the Board of Trustees at a board meeting.

Section 8.20 – 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 of Retirees and covered Dependents shall thereafter be null and void.

Section 8.21 – 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 8.22 – Applicable Laws

To the extent state laws are not preempted by the Act 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 8.23 – 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, and 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.

B) Definitions

All terms defined in the Privacy Rule shall have the meaning set forth therein. 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 Plan 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 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 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. Plan Administrator

   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 8.24 – HIPAA Security Rule

The Welfare Fund (as defined in Section 8.24 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 Article 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 8.24 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 8.24.

E) Definitions
Capitalized terms used in this Section 8.24 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

Section 9.01 – Name of Plan
This Plan is known as the Indiana Laborers Welfare Fund.

Section 9.02 – 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
Edward T. Hazledine Chairman 1301 Eagle Street Terre Haute, IN 47807	David Frye Secretary-Treasurer 425 S. 4th Street Terre Haute, IN 47807
Douglas Banning, Jr. P.O. Box 34141 Indianapolis, IN 46234	Jack Baker P.O. Box 38 Richmond, IN 47375
Tom Fleenor P.O. Box 6327 Evansville, IN 47719	James W. Daniels 1520 East Riverside Drive Indianapolis, IN 46202
Francis Gantner 7620 Killarney Drive Indianapolis, IN 46217	Brian Short 425 S. 4th Street Terre Haute, IN 47807
William A. Hasse III P.O. Box 300 Calumet City, IL 60409	Brian Krieg 2015 W. Western Avenue, Ste 140 South Bend, IN 46629
Mike McCann 1850 W. 15th Street Indianapolis, IN 46202	Kevin Roach 550 Superior Avenue Munster, IN 46321
Mark J. Stern P.O. Box 64616 Gary, IN 46401	James Terry 1734 Main St. 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
(800) 962-3158

Section 9.03 – 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 Plan, Plan Documents, 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 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 payments and handling general administrative matters. The Administrative Manager is:

Ms. Janetta England
P.O. Box 1587
Terre Haute, IN 47808
(812) 238-2551
(800) 962-3158

Section 9.04 – Plan Sponsors

Plan Participants and Beneficiaries may write to the Plan Administrator 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.

Section 9.05 – Identification Numbers

The Employer Identification Number assigned to the Board of Trustees by the Internal Revenue Service is 35-0923209. The Plan Number is 501.

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

Board of Trustees
Indiana Laborers Welfare Fund
P.O. Box 1587
Terre Haute, IN 47808-1587

Service may be made on the Board of Trustees collectively or on any individual Trustee at the address of the Fund Office.

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 contractor 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 to eligible individuals 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 death benefits, accidental death and dismemberment benefits, weekly loss of time income, medical benefits, prescription benefits, dental benefits and vision benefits. A detailed written description of the Plan benefits appears in this Booklet.

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

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Administrator. 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 of this Booklet.

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 inactive participants or retirees). This document is not a promise always to provide any particular benefit. In general, if a 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
Janetta England
P.O. Box 1587
Terre Haute, IN 47808
(812) 238-2551
(800) 962-3158

Legal Counsel
Wright, Shagley & Lowery, P.C.
P.O. Box 9849
Terre Haute, IN 47808-8448

Life and AD&D Insurance Carrier
Standard Insurance Company
P.O. Box 2177
Portland, OR 97208-2177

Benefit Consultant / Actuary
United Actuarial Services, Inc.
11590 N. Meridian Street, Suite 610
Carmel, IN 46032

Utilization Review Program
American Health Holding
7400 W. Campus Rd.
New Albany, OH 43054
Precert #: 866-440-2723

Medical PPO Network
Anthem Blue Cross and Blue Shield
220 Virginia Avenue
Indianapolis, IN 46204
(317) 488-6000
www.bcbs.com

Eye Care PPO Network
Davis Vision
175 East Houston Street
San Antonio, TX 78205
(888) 235-3220
www.davisvision.com

Dental PPO Network
Delta Dental of Indiana
P.O. Box 9085
Farmington Hills, MI 48333-9085
(800) 524-0149
www.deltadental.com

Prescription Benefit Manager
SavRx
224 N. Park Avenue
Fremont, NE 68025
(800) 228-3108
www.savrx.com

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 Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Administrator may make a reasonable charge for the copies.

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

Be informed that under the Health Insurance Portability and Accountability Act (HIPAA), 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 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) disability.

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 pre-certification. For information on pre-certification, contact your Plan Administrator.

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.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, Spouse or dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event. You or your dependents may have to pay for such coverage. Review this 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 welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits 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 Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the 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 BOOKLET.

UNLESS OTHERWISE INDICATED, ANY MASCULINE TERMINOLOGY USED INCLUDES THE FEMININE AND ANY DEFINITION USED IN THE SINGULAR ALSO INCLUDES THE PLURAL.

Section 11.01 – Act

"Act" means the Employee Retirement Income Security Act of 1974 (ERISA), as amended.

Section 11.02 – Agreement

"Agreement" means a collective bargaining agreement or 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 – Associations
"Associations" means the Associations of participating Employers who are parties to the Trust Agreement which funds the Plan.

Section 11.04 – Beneficiary
"Beneficiary" means a person designated by a Participant, Retiree, or by the terms of the Plan, who is or may become entitled to a benefit.

Section 11.05 – Benefits
"Benefits" means the General Medical, Chiropractic, Dental Care, Eye Care, Hearing, Hospice Care, Mental and Nervous Disorder, Prescription Drug Card, Routine Preventative Care, Substance Abuse, Temporomandibular Joint Dysfunction (TMJ), Transplant, Life Insurance, Accidental Death and Dismemberment and Loss of Time Benefit to be provided pursuant to the Plan together with any amendments, modifications or interpretations adopted by the Board of Trustees.

Section 11.06 – Board of Trustees
"Board of Trustees" means the Board which maintains and administers the Plan as described in Section 9.03 hereof, constituted of an equal number of Employer Trustees and Employee Trustees collectively appointed under the terms of the Trust Agreement.

Section 11.07 – Certification of Creditable Coverage
"Certification of Creditable Coverage" shall mean the certification described in Section 8.09.

Section 11.08 – 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 11.09 – Coverage Period or Qualification Period
"Coverage Period" or "Qualification Period" mean the periods during which a Participant or Retiree is eligible for coverage, or accrues credited hours to become eligible for coverage, respectively, as described in Section 3.02 of this Booklet.

Section 11.10 – Covered Charges
"Covered Charges" means only those charges made for services and supplies which the Trustees would consider to be reasonably priced (see UCR in Section 11.45 of this Booklet) and Medically Necessary in light of the injury or sickness being treated.

Section 11.11 – Creditable Coverage
"Creditable Coverage" means the period of coverage described in Section 8.09.

Section 11.12 – 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 covered individual with daily living activities, including (but not limited to) –

1) walking, getting in and/or out of bed, exercising and moving the covered individual;

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; or

6) supervising the administration of medications which can usually be self-administered, including reminders of when to take such medications; or

7) provide a protective environment; or

8) 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

9) are provided for convenience or are provided because home arrangements are not appropriate or adequate.

Section 11.13 – Dependent

"Dependent" means the following category of individuals:

A) The Spouse to whom the Participant or Retiree is legally married (not divorced or legally separated).

B) Children of the Participant or Retiree (including stepchildren and legally adopted children and children placed for adoption as of the date they are placed for adoption) who are less than 26 years of age.

C) Children of the Participant or Retiree (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 prior to the attainment of age 19, who live in the Participant's or Retiree's home and who are chiefly dependent upon the Participant or

Retiree for support, provided proof of Disability is submitted from time to time as described in Section 3.07 or as otherwise required by the Board of Trustees.

D) Children described in B or C above for whom a Participant or Retiree 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."

E) A 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 or Retiree for support" means that the Participant or Retiree directly provides 50% or more of the financial support of the child, or that the Participant or Retiree has taken full parental responsibility for and control of the child, or is raising the child as his own. The Participant or Retiree 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.

Dependent shall not include an individual who is in active military service and has medical coverage through that service.

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 or Retiree 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 or Retiree terminates upon the termination of such legal obligation.

Section 11.14 – Developmental Care

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

A) are provided to a covered individual 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 11.15 – Disability or Disabled

"Disability" or "Disabled" means, on the basis of medical evidence satisfactory to the Board of Trustees, a covered Dependent or Retiree 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 11.16 – Durable Medical Equipment

"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.

Section 11.17 – 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.

Section 11.18 – Emergency

"Emergency" means a severe condition which –

A) results from symptoms which occur suddenly and unexpectedly; and

B) requires immediate Physician's care to prevent death or serious impairment of health; or

C) poses an imminent serious threat to the covered individual or to others.

Section 11.19 – Employee
"Employee" means those categories of persons who are designated by the Board of Trustees as employed by an Employer.

Section 11.20 – 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 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 11.21 – 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 on-going phase I, II or III clinical trials or is under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment or diagnosis; or

D) 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.

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 11.22 – 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 confinement in 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 11.23 – Life Insurance

“Life Insurance” means the following insured benefits, as described in Section 4.01 and Section 4.02:

A) **Life Insurance:** those benefits payable as the result of the death of a Participant or Retiree 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:** those benefits payable as the result of the death or other loss of a 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 11.24 – Maternity
“Maternity” means expenses related to pregnancy and childbirth.

Section 11.25 – 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 covered individual’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 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 11.26 – 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 11.27 – 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 11.28 – Participant
The term "Participant" shall mean any Employee, former Employee of an Employer, Retiree, or surviving Spouse, who has met the eligibility requirements for participation in the Plan and is covered by the Plan or whose Beneficiaries may become eligible to receive any such Benefit.

Section 11.29 – Physician
“Physician” means any of the following licensed practitioners who is acting within the scope of their license and who performs a service payable under the Plan:

A) a doctor of medicine (MD), osteopathy (DO), podiatry (DPM) or chiropractic (DC); or

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 11.30 – Plan
"Plan" means the Indiana Laborers Welfare Fund as described herein and as hereafter amended.

Section 11.31 – Plan Year
"Plan Year" means the twelve-month period beginning on December 1 and ending on November 30 of the following year.

Section 11.32 – Retiree
"Retiree" means an individual who has retired from the employ of his Employer or an Employee who is Totally Disabled.

Section 11.33 – Self-Payment
"Self-Payment" means that amount which must be contributed by a Participant, Retiree or Dependent in order to preserve his eligibility to receive Benefits under the Plan.

Section 11.34 – 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 11.35 – Specialty Prescription Drugs
"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. Specialty Prescription Drugs require patient-specific dosing, careful clinical management and are administered to the patient by injection or infusion in the Physician's office, self injection or in some cases, orally. Specialty Prescription Drugs purchased at a retail or mail order pharmacy will be covered under the Prescription Drug Card Benefit. Specialty Prescription Drugs obtained through a Physician or Hospital will be paid under the General Medical Benefit.

Section 11.36 – 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 11.37 – Substance Abuse Treatment Center
"Substance Abuse Treatment Center" means a Hospital or clinic licensed for inpatient or outpatient drug or alcohol abuse treatment. Facilities providing in-patient substance abuse services must be licensed for the level of care, have a physician on staff and have registered nurses on staff 24/7. Facilities providing out-patient services must be licensed for the level of care and services must be performed or supervised by a Physician as defined under this Plan.

Section 11.38 – Total Disability or Totally Disabled
"Total Disability" or "Totally Disabled" 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 11.39 – Totally Disabled Participant
"Totally Disabled Participant" means an individual who became Totally Disabled while a Participant.

Section 11.40 – Trust Agreement or Trust
"Trust Agreement" or "Trust" means any agreement in the nature of a trust established to form a part of the Plan to receive, hold, invest and dispose of the Trust Fund.

Section 11.41 – Trust Fund or Fund
"Trust Fund" or "Fund" means all the assets which are held by the Trustees for the purposes of this Plan.

Section 11.42 – 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 this Plan.

Section 11.43 – 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 11.44 – Usual, Customary and Reasonable Charges or UCR

"Usual, Customary and Reasonable Charges" or "UCR" means the usual, customary and reasonable 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 primary PPO Network, UCR will be the allowed amount as negotiated by the PPO Network.

For providers not in the primary PPO Network but who participate in another secondary PPO network, the UCR will be the lesser of the UCR in the geographic area where such services are rendered or supplies are furnished as described in the first paragraph or the discount obtained through the secondary PPO network.

For providers not in the primary or secondary PPO network, the UCR will be as described in the first paragraph of this Section.

Provided further, in some situations, the covered medical expense will be limited to a specific percentage of the usual, customary and reasonable charge. These situations include, but are not limited to, the following:

A) For multiple or bilateral surgeries performed during the same operative session which are not incidental, or not part of some other procedure and which add significant time or complexity (all as determined by the Board of Trustees) to the complete procedure, the covered medical expense will be –

    1) 100% of the usual, customary and reasonable charge for the primary procedure; and

    2) 50% of the usual, customary and reasonable charge for each additional covered procedure (including any bilateral procedure).

B) For surgical assistance by a Physician, the covered medical expense will be 20% of the usual, customary and reasonable charge for the corresponding surgery.

C) For nonsurgical treatments performed during an office visit, the covered medical expense will be limited to the usual, customary and reasonable charge for the nonsurgical treatment alone.

D) For Dental Benefits, the covered expense will be limited to the usual, customary and reasonable charge as determined by the Fund's Dental PPO provider based on a fee schedule for in network versus out of network providers.

Section 11.45 – Waiting Period

"Waiting Period" means the number of days of sickness or incapacitation which a Participant in the Loss of Time Benefits portion of this Plan must accumulate for each period of Total Disability resulting from an injury or sickness before benefits become payable.

Every effort has been made to assure that the information contained in this Combination Plan Document and Summary Plan Description (Booklet) 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.