# Indiana Laborers Welfare Fund

## Combination Plan Document and Summary Plan Description

12/1/2019 Edition

**Este folleto contiene un resumen en inglés de los derechos y beneficios de su plan bajo Indiana Laborers Welfare Fund. Si tiene dificultades para entender alguna parte de este folleto, póngase en contacto con el administrador del plan en 413 Swan Street, Terre Haute, Indiana, 47807. El horario de oficina es de 8:00 a.m. a 5:00 p.m. de lunes a viernes. También puede llamar a la oficina del administrador del plan al (812) 238-2551 o al teléfono gratuito 1-800-962-3158 para obtener ayuda.**

## Important!

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

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

**You may contact the Fund Office at:**

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

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# Plan Document / Summary Plan Description

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

**Indiana Laborers Welfare Fund**
P.O. Box 1587
Terre Haute, IN 47808
Telephone: (812) 238-2551 or (800) 962-3158
www.indianalaborers.org

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# INTRODUCTION

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

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

The Plan is self-funded. When Employees work in covered employment, the Employer makes contributions to the Trust Fund on the Employee's behalf, as required by collective bargaining agreements. These contributions are used to pay Benefits and administer the Plan on the Participant's behalf.

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

The Trustees strive to maintain and improve the Benefits available to Participants and their 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 Board of Trustees 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 Board of Trustees. You may also contact the Employee Benefits Security Administration, US Department of Labor at (866) 444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

# STEPS YOU CAN TAKE TO HOLD DOWN HEALTH CARE COSTS

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

- When you need a prescription, ask your Physician or pharmacist about generic drugs. They often can be substituted for brand name drugs – sometimes at less than half the cost.

- Don't substitute the Hospital emergency room for your Physician's office. An emergency room is an expensive place to treat minor ailments. Call your Physician first or utilize LiveHealth Online Doctor Visits. LiveHealth Online Doctor Visits are no cost to you in comparison to the separate deductible you must pay for visits to an emergency room for conditions other than accidental Injuries, inpatient admissions or serious life-threatening Sicknesses, as verified by Physicians. See Section 4.18 for more information on LiveHealth Online Doctor Visits.

- When your Physician recommends a Hospital stay, out-patient surgery or other treatment listed in Section 8.15, it is a requirement to call the medical care review program (see Section 8.15 for program information and Section 9.15 for contact information). The staff there can help you identify health care options and obtain the most cost-effective care. They can also answer any questions or concerns you have regarding the procedure and after care.

- Avoid being admitted to a Hospital on Friday or Saturday if your condition isn't likely to be treated until Monday and if there seems to be no practical reason for you to be hospitalized over the weekend. The Plan may not cover weekend admissions if your condition is not treated within 24 hours. You must call the medical care review program with any Hospital admission, out-patient surgery or other treatment listed in Section 8.15 (see Section 8.15 for program information and Section 9.15 for contact information).

- Many Hospitals run a battery of tests simply as a precaution. Some of them may not be necessary. Check with your Physician to see whether or not they're needed.

- Review your Explanation of 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 you received each service listed on the EOB. If you find an error, contact the Fund Office for assistance.

- Become an intelligent consumer. Ask questions. It pays in the long run to ask about treatments you don't understand.

- If you need medical care for an extended period of time, check with your Physician about home health care or other alternatives to hospitalization. You must call the medical care review program with any long-term medical needs (see Section 8.15 for program information and Section 9.15 for contact information).

- If you need an MRI, CAT-scan or any other type of imaging, check and see if there is a radiology clinic in your area rather than utilizing a Hospital facility for this service.

# IMPORTANT NOTICE

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

## Trustee Authority

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

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

## Notice of Plan Changes

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

## Defined Terms

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

## MEDICAL CARE REVIEW PROGRAM

**The Plan's chosen medical care review firm is**

**Hines & Associates, Inc.**

**You may contact Hines & Associates, Inc. at 1-800-559-5257 or visit the website: www.precertcare.com**

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-certifies Hospital and other treatment plans for Medically Necessary determination which helps the Eligible Person and the Plan avoid unnecessary medical costs. This review is not a guarantee of payment. It is the Eligible Person's responsibility to contact the Fund Office to determine if Benefits are covered. Hospital admissions on a non-emergency basis for treatment or surgery should be 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 8.15 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" or download the MyBlue App on your smartphone.**

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 Benefit Claims 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.

In some instances, certain out-of-Network services or providers may be covered at the In-Network level. Please contact the Fund Office with any questions.

For the most up-to-date provider information for Anthem call Anthem at (800) 810-2583 which is available seven 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.

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

**NOTIFY THE FUND OFFICE PROMPTLY WITH ANY CHANGE IN ADDRESS, TELEPHONE NUMBER, BENEFICIARY, DEPENDENTS, MARITAL STATUS, MEDICARE OR RETIREMENT ELIGIBILITY.**

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

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

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 Benefit Claims, the Trustees or their representatives shall have the right to recover the payments.

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

## A WORD ABOUT CONFIDENTIAL INFORMATION

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) provides stringent requirements for the Plan, its Trustees and its service vendors concerning the use and disclosure of Participants' personally identifiable 'Protected Health Information' (PHI). Broadly speaking, PHI includes personal information about Participants and/or their 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 8.22. Please contact the Fund Office to receive another copy of the Privacy Notice.

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

# ARTICLE I – ELIGIBLE CLASS DESCRIPTIONS

## *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.

This class also represents Participants who are unable to work due to a continuing Injury or Sickness who provide medical evidence satisfactory to the Board of Trustees of the continuing Total Disability.

**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. Retired Medicare eligible Employees who want to supplement Medicare but do not want prescription coverage and have Dependents who are not eligible for Medicare, must enroll 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 hereafter 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 |

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 | $ 456 |
| Waiting Period | Benefits begin on 1st day of Total Disability |
| **Non-Occupational Sickness** | |
| Weekly Benefit Amount | $ 456 |
| Waiting Period | Benefits begin on 8th day of Total Disability |
| **Occupational Injury** | |
| Weekly Benefit Amount | $ 108 |
| Waiting Period | Benefits begin on 8th day of Total Disability |
| **Occupational Sickness** | |
| Weekly Benefit Amount | $ 108 |
| 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 ..... $ 6,000

Copayment (Fund pays)
In-Network (after Deductible) ..... 75%
Out-of-Network (after Deductible) ..... 50%

Chiropractic Benefit
Copayment (Fund pays)
In-Network non-surgical services (after Deductible)..... 75%
Out-of-Network non-surgical services (after Deductible)..... 50%
Maximum Benefit every Plan Year..... $1,000
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..... $750*
Copayment (Fund pays)
Preventive 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%

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

Eye Care maximums listed represent Usual, Customary and Reasonable Charges.

Hearing Benefit
Deductible does not apply.
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%

LiveHealth Online Doctor Visit Benefit
In-Network Benefits through LiveHealth Online
Coinsurance (no Deductible or Co-Payment)..... 100%

Member Assistance Program (MAP) ..... No cost
(professional consultations for work or home problems – see Section 4.17).

Mental and Nervous Disorder Benefit
Benefits are subject to the General Medical Benefit provisions for In and Out-of-Network deductibles, copayments and maximums, as applicable. In-patient treatment must be received at an In-Network facility. In-patient treatment is not covered at an Out-of-Network facility unless approved by Medicare.

Prescription Drug Card Benefit – In-Network Benefits Only
Copayments (Participant pays)
<u>Mail Order Participating Pharmacies (90-day supply)</u>
(see Section 4.12 C for approved walk-in pharmacies that allow a 90 supply)
Generic ..... 15% of drug cost with a $25 minimum and $50 maximum
Brand Formulary ..... 25% of drug cost with a $50 minimum and $100 maximum
Brand Non-Formulary ..... 35% of drug cost with a $100 minimum and $200 maximum

<u>Retail Participating Pharmacies (up to 30-day supply)</u>
Generic 20% of drug cost with a $10 minimum and $20 maximum
Brand Formulary ..... 30% of drug cost with a $20 minimum and $40 maximum
Brand Non-Formulary ..... 40% of drug cost with a $40 minimum and $80 maximum

<u>Mail Order Specialty Drugs (up to 30-day supply)</u>
Generic 15% of drug cost with a $8 minimum and $16 maximum
Brand Formulary ..... 25% of drug cost with a $16 minimum and $33 maximum

Brand Non-Formulary ..... 35% of drug cost with a $40 minimum and $80 maximum

Smoking Cessation Prescriptions ..... 50% of drug cost
(up to two 90-day treatments per Plan Year)

Routine Preventive Care Benefit

Routine Physical Exam (Age 3 and over) – In-Network Benefits Only
Maximum Exam every Plan Year ..... 1 exam
Maximum Benefit every Plan Year..... 100% up to $300; balance under General Medical Benefit

Routine Cervical Cancer Screening (Pap Smear) – In-Network Benefits Only
Maximum Screening every Plan Year..... 1 screening
Maximum Benefit..... 100%; otherwise under General Medical Benefit

Routine Prostate Cancer Screening (PSA Test) – In-Network Benefits Only
Maximum Screening every Plan Year..... 1 screening
Maximum Benefit..... 100%; otherwise under General Medical Benefit

Routine Breast Cancer Screening (Mammogram) – In-Network Benefits Only
Age 40-49: 1 every 2 Plan Years..... 100%; otherwise under General Medical Benefit
Age 50 and over: 1 every Plan Year..... 100%; otherwise under General Medical Benefit

Colorectal Cancer Screening – In-Network Benefits Only
Age 50 and over: 1 sigmoidoscopy every 5 Plan Years..... 100%; otherwise under General Medical Benefit
Age 50 and over: 1 colonoscopy every 5 Plan Years..... 100%; otherwise under General Medical Benefit

Lung Screenings by Low-Dose CAT scans – In-Network Benefits Only
Age 55 – 80 with history of smoking ..... 100%; otherwise under General Medical Benefit

Routine Well Child Exam & Immunizations – In-Network Benefits Only
Birth to age 36 months for all exams and immunizations recommended by the Center For Disease Control..... 100%

Routine Childhood & Adult Immunizations – In-Network Benefits Only
Age 3 and over if recommended by a Physician excluding occupation or vacation travel necessity as recommended by the Center For Disease Control ..... 100%

Substance Abuse Benefit

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

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, Totally Disabled Participants 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 |

**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 |
| LiveHealth Online | Same as Class A |
| Member Assistance Program (MAP) (professional consultations for work or home problems – see Section 4.17). | Same as Class A |
| Mental and Nervous Disorder Benefit | Same as Class A |
| Prescription Drug Card | Same as Class A |
| Routine Preventive 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, except for in-patient treatment at an out-of-network Skilled Nursing Facility or Residential Treatment Center. In-patient treatment at an out-of-network Skilled Nursing Facility or Residential Treatment Center is not covered unless approved by Medicare. 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

LiveHealth Online..... Same as Class A

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

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

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<br>In-patient treatment must be received at an In-Network facility. In-patient treatment is not covered at an Out-of-Network facility unless approved by Medicare. | 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 |
| LiveHealth Online<br>*Full cost of visit must be paid at time of service using credit card through the website or smartphone application. Benefit Claim must be submitted to the Fund Office for reimbursement of fees.* | Same as Class A |
| Member Assistance Program (MAP)<br>(professional consultations for work or home problems – see Section 4.17). | Same as Class A |
| Routine Preventive 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 Benefits ..... Same as Class C

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

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

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

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

Routine Preventive 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 Benefits | Same as Class C |
| 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 |
| LiveHealth Online | Same as Class A |

*Full cost of visit must be paid at time of service using credit card through the website or smartphone application. Benefit Claim must be submitted to the Fund Office for reimbursement of fees.*

| | |
|---|---|
| Member Assistance Program (MAP) (professional consultations for work or home problems – see Section 4.17). | Same as Class A |
| Routine Preventive 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 |
| LiveHealth Online | Same as Class A |
| Member Assistance Program (MAP) (professional consultations for work or home problems – see Section 4.17). | Same as Class A |

| | |
|---|---|
| Mental and Nervous Disorder Benefit | Same as Class A |
| Prescription Drug Card | Same as Class A |
| Routine Preventive 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 BOARD OF TRUSTEES, AS PLAN ADMINISTRATOR, 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 OR DEPENDENT IS ENTITLED TO THEM.**

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



### *Section 3.01 – Definitions Related to Eligibility*

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

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

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

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

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

### *Section 3.02 – Initial Eligibility*

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

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

600 Hours Requirement:

John began work on July 1, 2020 and accumulated 600 hours of work by November 15, 2020. 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, 2020 and he will remain eligible through March 31, 2021.

### *Section 3.03 – 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 3.04.

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 3.04.

In the event the Employer does not submit contributions to the Trust Fund 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, 2020. He has continued to work 100 hours each month for the Qualification Period November 2019 through

February 2020. 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, 2020 through July 31, 2020.

Example B – 520 Hours in Previous Two Qualification Periods Requirement:
John has met initial eligibility requirements and is currently eligible through March 31, 2020. He has continued to work the following schedule:

| Work Months | Hours Worked |
|---|---|
| November 2019 – February 2020 | 200 |
| July 2019 – October 2019 | 400 |
| Total | 600 |

Since John did not have at least 260 hours in the current Qualification Period (Nov-Feb) the next test is to determine if he worked 520 hours in the previous two Qualification Periods (Jul-Feb). After reviewing John's work history, it was determined that he worked 600 hours in the previous two Qualification Periods. John will continue to be eligible for the Coverage Period April 1, 2020 through July 31, 2020.

Example C – 780 Hours in Previous Three Qualification Periods Requirement:
John has met initial eligibility requirements and is currently eligible through March 31, 2020. He has continued to work the following schedule:

| Work Months | Hours Worked |
|---|---|
| November 2019 – February 2020 | 200 |
| July 2019 – October 2019 | 300 |
| March 2019– June 2019 | 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, 2020 through July 31, 2020.

Example D – Self-Payment Requirement:
John has met initial eligibility requirements and is currently eligible through March 31, 2020. He has continued to work the following schedule:

| Work Months | Hours Worked |
|---|---|
| November 2019 – February 2020 | 0 |
| July 2019 – October 2019 | 260 |
| March 2019 – June 2019 | 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, 2020 and remain eligible through July 31, 2020.

### *Section 3.04 – Continuation of Class A Coverage By Self-Payment*

Unless coverage is terminated in accordance with Section 3.05 A.2., a Participant may make Self-Payments in order to retain eligibility 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.

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

If a Retiree elects to continue coverage, the Retiree shall continue Class A coverage using bank hours, if available. Once bank hours are depleted, the Retiree shall transfer to the Senior Member Program.

**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 3.03.

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. Participants who are unable to work due to a continuing Injury or Sickness and provide medical evidence (including an annual re-examination) satisfactory to the Board of Trustees of the continuing Total Disability shall be moved to the Senior Member Program (Class AS).

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

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

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

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

## *Section 3.05 – Termination of Eligibility*

**A) Participant**

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

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

   b. chooses not to elect Continuation of Coverage, or

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

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

   e. switches to another class of coverage, or

   f. retires, or

   g. the Plan terminates.

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

   a. the Participant, without authorization from the Union, works in the construction industry in the geographic jurisdiction of the Plan for an Employer that does not have

a contractual obligation to contribute to the Trust Fund ("non-signatory employer") and does not notify the Fund Office as required, or

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

The Trustees reserve the right to create equitable exceptions to this rule in cases where the exception would not run contrary to the purposes and intent of providing benefits under this Plan. If a Participant's eligibility is terminated according to this Section 3.05 A.2, the Participant cannot make Self-Payments as allowed in Section 3.04 to continue eligibility.

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

**B) Dependent**

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

1. the individual no longer qualifies as a Dependent as that term is defined in Section 11.14, or

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

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

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

5. the Plan terminates.

A covered Dependent 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 Dependent may re-enroll in this Plan by completing the Plan's appropriate form with proof that the Dependent 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.

**C) Dependent Coverage Upon the Death of the Participant**

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

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

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

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

**D) Appeal of an Eligibility Decision**

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

### *Section 3.06 – Continuation Coverage Under COBRA*

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

Each Qualified Beneficiary 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 3.06 B, to extend his participation under the Plan immediately before the Qualifying Event by electing Continuation Coverage.

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

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

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) <u>COBRA Definitions</u>**

**"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 as defined below.

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

**"Qualifying Event"** means an event 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 3.06 C. However, if the Participant will not lose coverage before the end of what would be the maximum period described in Section 3.06 C, the event is not a qualifying event.

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

The availability of Continuation Coverage is conditioned upon a Qualified Beneficiary electing such participation during the election period. The election period begins on or before the date that the Qualified Beneficiary would lose participation on account of a Qualifying Event as described in Section 3.06 A and ends on the date that is 60 days after the 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, Benefit Claims incurred by a Qualified Beneficiary during the election period will not be paid before the election and payment is made.

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

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

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

***Continuation Coverage Requirements and Limits***

| Qualifying Event | Documentation Required | Time Limits |
|---|---|---|
| Divorce | • Divorce decree or<br>• 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<br>• 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) <u>Termination of Continuation Coverage</u>**

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 Document within this Section 3.06, which will be mailed to the home address of each new Participant within 90 days after coverage begins.

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

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

2. Employer Qualifying Event Notice

    Under this Plan, Employers are not required to provide notice of Qualifying Events to the Administrative Manager. This Document provides that the Administrative Manager shall determine whether a Qualifying Event has occurred due to the Employee's termination of employment or reduction in hours of employment, 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 Administrative Manager’s determination that continuation coverage shall terminate.

### *Section 3.07 – 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 3.03 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 3.08 – Continuation of Coverage for Disabled Children*

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

A) meets the definition of Disabled as defined in Section 11.16, 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 after the day such Dependent child turns age 26,

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

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

### *Section 3.09 – Family 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 3.10 – Uniformed Services Employment and Reemployment Rights Act (USERRA)*

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

- **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.

- **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.

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 3.11 – Qualified Medical Child Support Order*

The term "Qualified Medical Child Support Order" ("QMCSO") means a Medical Child Support Order which creates or recognizes the existence of an Alternate Recipient's right to or assigns to an Alternate Recipient the right to, receive Benefits under the Plan and which complies with the requirements of a QMCSO. An Alternate Recipient under a QMCSO shall be eligible for Benefits from the Plan only if the Participant is eligible.

Benefits paid to an Alternate Recipient shall be at the level of Benefits available under the Plan at the time the Expense was incurred.

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

The Plan has established procedures for 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.

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 <u>exclusion</u> even though not expressly stated as such.**

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

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

| Description of Covered Benefit | Plan Copayment Amount Copayment amounts are based on a percent of Approved Charge | | Does your Copayment Amount help meet your Out-of-Pocket Limit? | Do you need to meet your Plan Year Deductible before receiving Benefits? |
|---|---|---|---|---|
| | In-Network | Out-of-Network | | |
| General Medical Benefit | 75% | 50% | Yes | Yes |
| Chiropractic Benefit<br>*See Benefit Description in Section 4.05 for Specific Limitations* | 75% up to $1,000 per Plan Year | 50% | Yes | Yes |
| Diabetes Education and Training Benefit | 75% | 50% | Yes | Yes |
| Hospice Care Benefit<br>*See Benefit Description in Section 4.10 for Specific Limitations* | 75% | 50% | Yes | Yes |
| LiveHealth Online Doctor Visit Benefit<br>*In-Network Benefit Only*<br>*See Benefit Description in Section 4.18 for Specific Limitations* | 100% | 0% | No | No |

| Description of Covered Benefit | Plan Copayment Amount<br>Copayment amounts are based on a percent of Approved Charge<br>In-Network | <br><br>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? |
|---|---|---|---|---|
| Mental and Nervous Disorder Benefit<br>*See Benefit Description in Section 4.11 for Specific Limitations* | 75% | 50% | Yes | Yes |
| Routine Preventive Care Benefit<br>*See Benefit Description in Section 4.13 for Specific Limitations* | 100% | 50% | No | No (In-Network)<br>Yes (Out-of-Network) |
| Substance Abuse Benefit Benefit<br>*See Benefit Description in Section 4.14 for Specific Limitations* | 75% | 50% | Yes | Yes |
| Temporomandibular Joint Dysfunction (TMJ) Benefit<br>*See Benefit Description in Section 4.15 for Specific Limitations* | 75% | 50%<br>up to $1,500 Lifetime Maximum | Yes | Yes |
| Transplant Benefit<br>*See Benefit Description in Section 4.16 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. 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 Benefit Claim form, original or certified copy of death certificate and the obituary notice.

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

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

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

An eligible Employee may designate any natural person or persons or legal entity as the Beneficiary of 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.

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

**Conversion to Individual Insurance Policy**

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.

### *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.

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

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

When an Injury or Sickness causes an eligible Class A Employee (who is not retired) to be Totally Disabled, prevents the eligible Class A Employee from engaging in the Employee's regular or customary occupation, and the Class A Employee is not working for any compensation or profit, 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 weekly in an amount specified in the Schedule of Benefits. Non-occupational Injury 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 Total Disability will be treated as a Sickness and Benefits will not commence until the eighth day.

If the Total Disability period exceeds the expected recovery time for that medical condition, your case will be sent for medical review which will require submission of medical records. The expected recovery time will initially be determined in accordance with the 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 Total Disability due to the same or related causes shall be considered as the same period of Total Disability, unless separated by a release for return to work by your Physician. For the purposes of this Benefit, any Injury which arises out of or in the course of any occupation or employment for wage or profit will be considered an Occupational Disability. All other Total Disabilities will be considered a Non-occupational Disability.

No Benefit Claims 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 Total Disability.

### *Section 4.04 – General Medical Benefit*

Medical expenses included under the General Medical Benefit will be payable for Medically Necessary care and services that are ordered and prescribed by a Physician according to the Schedule of Benefits. Medical expenses will only be covered if the provider or facility is properly licensed and/or certified under state and/or federal law, as applicable, to provide the services rendered.

**A) <u>Deductible Amount</u>**

Before Benefit Claims are paid under the Plan, you must satisfy a Deductible Amount. This is the dollar amount of Covered Charges that you pay each Plan Year before the Plan pays any Benefits. There 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 $70 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, including observation, if admitted.

**B) <u>Copayment</u>**

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) <u>Out-of-Pocket Limit</u>**

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 for the remainder of the Plan Year.

**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, office visits (including two office visits per Plan Year associated with Smoking Cessation) and Hospital visits but excluding expenses which are related to surgical procedures.

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

   In compliance with Women's Health and Cancer Rights Act, the Plan shall cover UCR Charges incurred by Participants or 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. Expenses and services for physical, speech or occupational therapy. Treatment must be provided by a physio, speech or occupational therapist other than a person who ordinarily resides in the Participant's or covered Dependent's home or who is a member of his immediate family (comprising of the Participant's Spouse, and the children, siblings and parents of such Participant or Participant's Spouse).

   Physical and occupational therapy:

   - For Eligible Persons age 14 and over, 12 therapy visits are allowed. Additional visits must be reviewed by the Medical Care Review Program as explained in Section 8.15.
   - For Eligible Persons under age 14, all visits must be reviewed by the Medical Care Review Program as explained in Section 8.15.

   Speech therapy:

   - All visits must be reviewed by the Medical Care Review Program as explained in Section 8.15, regardless of age of Eligible Person.

   Contact the Fund's medical care review provider, Hines & Associates, Inc. at 1-800-559-5257 or www.precertcare.com to obtain pre-certification or to receive more information regarding this Benefit.

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

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

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

11. Medical supplies, limited to: drugs and 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 Benefit Claims for the pregnancy on the same basis as any other Injury 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.

**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.

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

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

19. Effective April 1, 2020, expenses and services for vision therapy or vision training, up to 12 visits up to age 18. Ages 18 and over require pre-certification. Contact the Fund's medical care review provider, Hines & Associates, Inc. at 1-800-559-5257 or www.precertcare.com to obtain pre-certification for vision therapy or training over 12 visits or to receive more information regarding this Benefit.

### *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 age 14 and under once in any Calendar Year; and

f. Sealants, one per tooth per lifetime for occlusal surface of first permanent molars for people age 8 and under and second permanent molars for people age 13 and under. 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 and composite resin material; 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 Eligible Person transfers from the care of one dentist to that of another dentist during the course of treatment, or if more than one dentist supplies services for one dental procedure;

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

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

4. Up to two additional prophylaxes treatments per Calendar Year may be available 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 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, but not limited to: 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 Medical Deductible Amount 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 Benefit Claims according to the Schedule of Benefits. Services for nutritional counseling must be provided by a properly licensed dietician or nutritional therapist and must be medically necessary 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 Benefit Claims 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.

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

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

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

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

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

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

Hospice services include providing the dying person with palliative and supportive medical, nursing and other health services through home or 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;
2. Respite care provided at a Medicare approved facility.

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

### *Section 4.11 – Mental and Nervous Disorder Benefit*
When a mental or nervous disorder causes an Eligible Person to incur expenses for inpatient Hospital or Physician charges or outpatient Physician charges, the Plan will pay Benefit Claims

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

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

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

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

### *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 or Sam's Club pharmacies as well as some Walgreen's and CVS 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. Some Mail Order Participating Pharmacies also include walk-in pharmacies which allow 90-day prescriptions. Some examples of those include, but are not limited to: CVS, Nations Medicine, Pharmacy of Canterbury, Keltsch Pharmacy, Walgreens and Community Care Center. Specialty Drugs may not be filled or refilled at a Mail Order Participating Pharmacy.

**D) Cost Savings Programs**

The Plan has implemented programs through SavRx that could save money for you and the Plan. Participation in these programs is voluntary; however, if you choose to not participate, then you may have a higher out-of-pocket cost. If you have any questions about the programs, please contact SavRx.

1. High-Impact Advocacy (HIA) Program
   The HIA Program includes specialty medications in certain classes that have a manufacturer's coupon or other financial assistance available. Current medication classes included are TNF and related medications (typically prescribed to treat migraines), multiple sclerosis and Hepatitis C medications. These classes are subject to change. The HIA Program utilizes manufacturer's coupons and other financial assistance to lower costs to you and the Plan. You may contact SavRx with any questions about this program.

2. Mandatory Generic Program
   The Mandatory Generic Program encourages the use of generic equivalents whenever available. If the Eligible Person or their Physician requests a brand name drug instead of its generic equivalent, the member will be charged the brand name Copayment PLUS the difference between the brand name drug and the generic alternative. If you require the brand name drug for Medically Necessary reasons, your Physician may request a waiver of the difference in cost, to be reviewed and considered, by submitting a Letter of Medical Necessity to SavRx.

3. Prior Authorization Program
   The Prior Authorization Program is an extension of the Specialty Drug Program and targets medications that are not specialty drugs but do benefit from additional clinical management. This program helps to ensure that Eligible Persons are receiving an appropriate drug for the treatment of specific conditions and in quantities as approved by the U.S. Food and Drug Administration (FDA). If chemotherapy (including oral), infusion therapy, medications over $2,000 and oncology and transplant-related therapy medications cannot be obtained through SavRx, they must be pre-certified through the Medical Care Review Program as described in Section 8.15.

4. Specialty Drug Program
   The Specialty Drug Program includes prior authorization and patient assistance for some specialty drugs. The purpose of this program is to ensure that these often high cost medications are being prescribed for an appropriate patient and condition at an acceptable dose and quantity. If chemotherapy (including oral), infusion therapy, medications over $2,000 and oncology and transplant-related therapy medications cannot be obtained through SavRx, they must be pre-certified through the Medical Care Review Program as described in Section 8.15.

5. Step Therapy Program
   The Step Therapy Program requires Eligible Persons to use a more cost-effective drug prior to the approval of a less cost-effective brand name medication. Drugs that qualify for Step Therapy are often high priced and largely advertised. The goal of the Step Therapy Program is to use the most cost-effective sequence – beginning with Step 1 drugs and moving to Step 2 drugs, based on accepted medical guidelines and standards.

   Medication classes that qualify for the Step Therapy Program include, but are not limited of, cholesterol-lowering statins, ARB antihypertensives, SSRI/SNRI antidepressants, oral osteoporosis medications, migraine medications, Cox 2 and Non-Steroidal, Anti-Inflammatory Agents, steroid nasal sprays, Proton Pump Inhibitors, Beta and Calcium Channel Blockers and Glaucoma Eye Drop. This list is subject to change.

6. Therapeutic Interchange Program
   The Therapeutic Interchange Program sends customized letters to Eligible Persons who are utilizing high cost brand name medications to give them a less expensive generic alternative. The letter will encourage Eligible Persons to discuss the therapeutic alternative with their Physician.

7. Therapeutic Quantity Limits Program
   The Therapeutic Quantity Limits Program ensures proper dosing and dispensing of certain medications based on FDA and manufactures guidelines. The program monitors prescription utilization and helps identify potential overuse or misuse of medications such as narcotic pain relievers and sedative hypnotics, migraine treatments, respiratory and nasal medications.

**E) 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.

7. Smoking Cessation prescriptions (limited to two 90-day treatments per Plan Year).

**F) Exclusions and Limitations**

No benefits shall be payable for any of the following:

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

2. The Plan will not pay more for a brand name drug when a generic equivalent is available than the Plan would pay for the generic equivalent, unless the Physician or Surgeon indicates "dispense as written" on the prescription and the Plan's 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 Preventive Care Benefit*

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

***Schedule of Routine Preventive Care***

| Procedure | Benefit |
|---|---|
| Colorectal Cancer Screening | Age 50 and over: 1 sigmoidoscopy every 5 Plan Years at 100%<br>Age 50 and over: 1 colonoscopy every 5 Plan Years at 100%<br>Otherwise under General Medical Benefit. |
| Lung Screenings by Low-Dose CAT scans | 100% age 55-80 with history of smoking |
| Mammogram<br>(Breast Cancer Screening) | Age 40-49: 1 every 2 Plan Years at 100%<br>Age 50 and over: 1 per Plan Year at 100%<br>Otherwise under General Medical Benefit. |
| **Procedure** | **Benefit** |
| Routine Adult and Childhood Immunizations | 100% excluding those required for occupation or vacation travel, as recommended by the Center for Disease Control (age 3 and over). |
| Routine Cervical Cancer Screening<br>(Pap Smear Test) | 1 per Plan Year covered at 100% if performed by your primary care physician or GYN, otherwise under General Medical Benefit. If additional testing is required as a result of a Pap Smear, the additional testing will also be covered under General Medical Benefit |
| Routine Physical Exam | Age 3 and over, includes all associated lab work: Maximum 1 visit per Plan Year at 100% up to $300, balance under General Medical Benefit. (one additional routine GYN visit will be allowed, subject to the same $300 maximum) |
| Routine PSA Test<br>(Prostate Cancer Screening) | 1 per Plan Year covered at 100%, otherwise under General Medical Benefit. |
| Well-Child Exam & Immunizations | 100% from birth to age 36 months for routine well child visits and all immunizations recommended by the Center for Disease Control. |

**Limitations**

The Routine Preventive Care Benefit does not include the cost of physical examinations made in connection with employment or transportation; except that examinations in connection with obtaining or maintaining a Commercial Driver's License (CDL) will be covered for the Eligible Employee and Spouse. Also, this Benefit does not include physical examinations with a diagnosis other than a well exam (such tests that may be excluded tests under the Routine Preventive Care Benefit *may* be covered under General Medical Benefit in Section 4.04 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 Benefit Claims 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 medical care review provider, Hines & Associates, Inc. at 1-800-559-5257 or www.precertcare.com to obtain pre-certification for substance abuse benefits or to receive more information regarding this Benefit.

**Exclusions**
Substance Abuse Benefits will not be paid for:

1. Expenses incurred from or occurring during an attempt to commit or the commission of a misdemeanor or felony or the willful participation in a public disturbance or riot and as a direct result of driving while legally impaired.

2. Inpatient treatment received at an out-of-network facility unless approved by Medicare as excluded under Benefit Exclusions and Limitations.

3. More than two full panel drug screenings each Plan Year, after the initial baseline test.

## *Section 4.15 – Temporomandibular Joint Dysfunction (TMJ) Benefit*
If an Eligible Person incurs expenses in conjunction with temporomandibular joint dysfunction (TMJ), the Plan will pay Benefit Claims according to the Schedule of Benefits, up to a lifetime limit of $1,500 per person after the Deductible Amount has been met. Treatment of TMJ includes services associated with TMJ, excluding services considered dental in nature (such as modification or moving of teeth using crowns, bridges, dentures or braces).

## *Section 4.16 – Transplant Benefit*
If an Eligible Person incurs expenses in conjunction with an organ transplant, the Plan will pay Benefit Claims 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 Benefit Claims payable and the applicable limits are Benefits for and Limits of the recipient, not the donor.

Services and supplies for the donor when donor benefits are available through other group coverage will not exceed 100% of Covered Expenses.

Contact the Fund's medical care review provider, Hines & Associates, Inc. at 1-800-559-5257 or www.precertcare.com to obtain pre-certification for transplant benefits or to receive more information regarding this Benefit.

**F) Transplant Benefit Exclusions**

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

1. Experimental services or supplies.
2. Expenses when government funding of any kind is provided.
3. Lodging, food or transportation cost.
4. Recipient, donor and procurement services and costs incurred outside the United States.
5. Any animal organ or tissue or mechanical device or equipment that is not considered Medically Necessary as determined by the Plan.

## *Section 4.17 – Member Assistance Program (MAP)*

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

**Accessing the Perspectives MAP Program**

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

- Using your telephone, call the program's toll-free number at 1-800-456-6327
- For web-based services, visit perspectivesltd.com. The username is: **INLAB** and the password is: **perspectives**

**Perspectives Counseling Services**

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

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

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

**Perspectives Legal and Financial Services**

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

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

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

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

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

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

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

## *Section 4.18 – LiveHealth Online Doctor Visit Benefit*

The LiveHealth Online Doctor Visit Benefit utilizes Anthem's LiveHealth Online program to give Eligible Persons the capability to speak with a certified Physician online (with a webcam) or through a smartphone in order to get quick access to certain prescriptions or other advice regarding a medical situation. This online doctor visit Benefit is available 24 hours a day, seven days a week and can be accessed at www.livehealthonline.com. If you need technical assistance you can call toll-free at 1-888-LiveHealth (1-888-548-3432). This Benefit is not meant for emergency situations, but it can help in deciding whether a medical situation is an emergency. Benefits for LiveHealth Online Doctor Visits are payable according to the Schedule of Benefits. No Benefits will be payable for any other online program.

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

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

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

6. Expenses incurred for elective abortions, using drugs, devices, methods or procedures, including, but not limited to, RU-486 or surgical abortions and all related expenses;

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 or complications arising from treatment of these conditions;

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

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

23. Expenses incurred related to smoking cessation; except for two office visits per Plan year and associated labs covered under the General Medical Benefit provided in Section 4.04 E 3 and under the Prescription Drug Card Benefit portion of the Plan provided in Section 4.12 E 7;

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

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, or complications arising from these procedures;

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 preventive inoculations except as provided by the Plan;

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

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

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, treatment or expenses incurred from or occurring during an attempt to commit or the commission of a misdemeanor or felony or the willful participation in a public disturbance or riot and as a direct result of driving while legally impaired, whether or not court-ordered;

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.

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

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

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

47. Any in-patient services, supplies or treatment provided by an Out-of-Network residential treatment facility or skilled nursing facility.

48. When related to Substance Abuse Benefits, after one initial baseline test, no more than two full panel drug screenings will be payable each Plan Year.

# ARTICLE VI – SENIOR MEMBER PROGRAM

(Classes AS, C, CP AND D)

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



### *Section 6.01 – Eligibility to Participate in Senior Member Program*

Each Participant who ceases active employment due to retirement or 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 Trust Fund or the Participant has made Self-Payments to the Trust Fund for a period of not less than five years immediately preceding the request for Senior Benefits and the Participant has been eligible for at least five Coverage Periods under the Plan during the same five year period and –

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

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

### *Section 6.02 – Termination of Eligibility in Senior Member Program*

A Retiree or Totally Disabled Participant who becomes eligible to participate under this portion of the Plan will remain eligible to participate until the date that individual fails to make a timely Self-Payment for coverage. A Retiree or Totally Disabled Participant who fails to make a timely Self-Payment for coverage may only again participate in the Plan by returning to active work and meeting the requirements for initial eligibility as set forth in Section 3.02.

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

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

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

C) the Retiree or Totally Disabled Participant ceases to be covered by the Plan.

In addition, coverage shall terminate the day the Retiree or Totally Disabled Participant, without authorization from the Union, works in the construction industry in the geographic jurisdiction of the Plan for an employer that does not have a contractual obligation to contribute to the Trust Fund ("non-signatory employer"). If a Retiree or Totally Disabled Participant works for a non-signatory employer without first notifying the Fund Office, coverage will be terminated effective the day the Fund Office finds out about such work.

### *Section 6.03 – Registration of Retirees*

A Retiree or Totally Disabled Participant 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 Class A coverage.

At the time of registration, the Retiree or Totally Disabled Participant must elect one of the three tier coverage types described in Section 6.05.

If a Retiree or Totally Disabled Participant does not register during the required 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 3.02.

### *Section 6.04 – Registration of Dependents*

A Retiree or Totally Disabled Participant who registers for Senior Member Program shall be allowed to register his Dependents during the time period specified in Section 6.03. In addition, if a Retiree or Totally Disabled Participant 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 or Totally Disabled Participant must elect one of the three tier coverage types described in Section 6.05.

### *Section 6.05 – Three Tier Coverage Structure*

Upon approval of eligibility for the Senior Member Program, the Retiree or Totally Disabled Participant 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 Totally Disabled Participant; or

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

C) family, which tier will provide coverage for the Retiree or Totally Disabled Participant, their Spouse (if any) and any registered Dependents (more than one Dependent).

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 paragraphs 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. In addition, unless otherwise allowed in this Plan, the Spouse or Dependent of a Retiree or Totally Disabled Participant who is not covered after this one-time election or the coverage change allowable under the next 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 or Totally Disabled Participant 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 or Totally Disabled Participant registers for the Senior Member Program and has a Spouse or Dependent who is otherwise eligible for coverage under the terms of the Senior Member Program at that time, but declines coverage due to being covered by another health plan, including having Active coverage under this Plan, such Spouse or Dependent may be added to the Senior Member Program if requested by the covered Retiree or Totally Disabled Participant not later than 30 days after the Spouse or Dependent’s loss of coverage under the other plan.

Notwithstanding the foregoing, a Retiree or Totally Disabled Participant who drops this Plan's prescription drug coverage to enroll in Medicare Part D prescription drug coverage shall be allowed to terminate the Part D coverage and to re-elect this Plan's prescription drug coverage once, but only if the Retiree or Totally Disabled Participant re-elects this Plan's prescription drug coverage within two years of first enrolling in Part D coverage.

### *Section 6.06 – Transfers from Class A Coverage to Senior Member Program*

A Retiree or Totally Disabled Participant 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 3.03, is exhausted. In addition, a Retiree (but not a former Participant who terminates service with an Employer for other reasons) or Totally Disabled Participant may transfer to the Senior Member Program (including the Life Insurance portion of the Plan and, in some cases, the Accidental Death and Dismemberment Insurance portion of the Plan, as described in Section 4.02) within 90 days after the expiration of coverage under the Class A program. However, such Retiree or Totally Disabled Participant may not transfer from the Senior Member Program back to the Class A program unless that individual returns to work and again meets the requirements for initial eligibility set forth in Section 3.02. Self-Payments for the Senior Member Program are described in Section 6.07.

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

Plan Coordination of Benefits under this Section 6.06 will terminate (and the Plan shall pay secondary to Medicare) upon exhaustion of the Retiree's or Totally Disabled Participant's hours worked if he no longer meets continued eligibility requirements as explained in Section 3.03.

### *Section 6.07 – Self-Payments to Maintain Coverage for Senior Member Program*

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

### *Section 6.08 – Cost of Self-Payment*

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

The Retirees, Totally Disabled Participants and Dependents who may be eligible for Senior Member Program coverage and the applicable Classes of coverage are listed in Sections 1.02 and 1.03. 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 Member Program for those Retirees, Totally Disabled Participant and Dependents 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*

In lieu of Continuation Coverage under COBRA, as explained in Section 3.06, the eligible surviving Spouse of a Participant, Retiree or Totally Disabled Participant may elect to continue coverage for himself or herself and the covered Dependent children of the deceased Participant, Retiree or Totally Disabled Participant, 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 coverage.

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 or Totally Disabled Participant 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 this Article VII upon the death of the Retiree or Totally Disabled Participant.

Eligibility for Survivor Benefits begins immediately upon termination of benefit coverage due to the Retiree's or Totally Disabled Participant's death. A surviving Spouse must elect coverage for themselves and their Dependents within 60 days after his or her coverage would otherwise terminate. After election, Dependent children will be covered as long as they meet the definition of Dependent and timely self-payments are made.

## *Section 7.02 – Class S Benefits*

Class S Benefits are the same as Class A Benefits, but will not include Maternity, Newborn Care, 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.

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

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

### *Section 7.04 – Cost of Self-Payment*

The subsidy applicable to the Participant or Retiree for the Senior Member Program as described in Section 6.08 will also be applied to an eligible surviving Spouse or Totally Disabled Participant who elects Class S Benefits or elects to continue in Class C, CP or D. Once a Participant or Retiree elects coverage, they may choose a lower tier of coverage in the future but can never increase coverage.

The Plan subsidy is at a rate of 2.33% for each year of service in the Indiana Laborers Pension Fund and/or Construction Workers Pension Trust Fund up to a maximum 70% subsidy. The surviving Spouse or Totally Disabled Participant will make a Self-Payment for the difference between the subsidized cost and the total cost of coverage. The total cost of coverage will vary according to the 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 notify the Plan of his mailing address and each change of mailing address to the Fund Office. Since all communication, statements or notices are mailed to the address on file with the Fund Office, it is important to keep your address updated to receive all important communication. You may notify the Plan in writing or by calling the Fund Office.

### *Section 8.02 – Delegation of Authority*

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

### *Section 8.03 – Procedures to Submit a Benefit Claim*

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

<u>How to Submit a Benefit Claim</u>

*In-Network Providers*

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- Medical Benefit Claims
- Loss of Time Benefit Claims
- Other Benefit Claims (Life Insurance, Accidental Death and Dismemberment, Dental and Vision, Prescription)

Each type of Benefit Claim has different time requirements to process and to send a Notification to the Claimant of the determination. The table below is language to provide you with information regarding: the timing and manner of Benefit Claim Determinations and the timing and required content of Notices of Benefit Determinations. Please see the subsection above titled "Definitions Related to Benefit Claims" to better understand some of the terms used in this Section.

*Medical Benefit Claims*
Federal claims regulations categorize all Benefit Claims into Pre-Service Claims (urgent and non-urgent), Post-Service Claims and Disability Claims. The Board of Trustees (or the Board's

designated agent) has different time frames to make a decision on the different types of Benefit Claims. The table below summarizes these time frames.

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

Medical Benefit Claim Determination Time Limits

In the case of a Benefit Claim for health care benefits, the Board of Trustees shall notify a Claimant of the benefit determination, as shown below:

A) Urgent Care Benefit Claims
In the case of a **Claim Involving Urgent Care**, the Board of Trustees shall notify the Claimant of the benefit determination (whether an approval or Benefit Claim Denial) as soon as possible, taking into account the medical circumstances, but not later than 72 hours after the Benefit Claim is received, unless the Claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. In the case of such a failure, the Board of Trustees shall notify the Claimant as soon as possible,

but not later than 24 hours after the Benefit Claim is received, of the specific information necessary to complete the Benefit Claim. The Claimant shall be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. The Board of Trustees shall notify the Claimant of the benefit determination as soon as possible, but in no case later than 48 hours after the earlier of –

1. The specified additional information is received, or

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

B) Concurrent Care 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 Benefit Claim Denial. The Board of Trustees shall notify the Claimant of the Benefit Claim Denial at a time sufficiently in advance of the reduction or termination to allow the Claimant to appeal and obtain a determination on review of that Benefit Claim Denial before the Benefit Claim is reduced or terminated.

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

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

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

of Trustees both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Claimant, prior to the expiration of the initial 30 day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If such an extension is necessary due to a failure of the Claimant to submit the information necessary to decide the Benefit Claim, the Notice of extension shall specifically describe the required information, and the Claimant shall be afforded at least 45 days from receipt of the Notice within which to provide the specified information.

*Loss of Time (Disability) Benefit Claims*

Loss of Time (Disability) Benefit Claim Determination Time Limits

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

*Other (Life Insurance, Accidental Death and Dismemberment, Dental, Vision and Prescription) Benefit Claims*

Other Benefit Claim Determination Time Limits

If a Benefit Claim is wholly or partially denied, the Board of Trustees shall notify the Claimant of the Plan's Appeal Procedures within a reasonable period of time, but not later than 90 days after receipt of the claim by the Plan, unless the Board of Trustees determines that special circumstances require an extension of time for processing the claim. If the Board of Trustees determines that an extension of time for processing is required, written Notice of the extension shall be furnished to the Claimant prior to the end of the initial 90-day period. In no event shall such extension exceed a period of 90 days from the end of such initial period. The extension Notice shall indicate the special circumstances requiring an extension of time and the date by which the Plan expects to render the benefit determination.

Calculating Time Periods

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

Claimant responds to the request for additional information.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Notification Requirements for Loss of Time (Disability) Benefit Claims

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

If your Benefit Claim is denied, you should first use the Plan’s appeal procedures found in Section 8.04 before filing suit in court. If you fail to follow the Plan’s appeal procedures found in Section 8.04, the court could consider your case to be premature and it could result in your case being dismissed in such a manner that would prevent any further court actions. If you follow the Plan’s

appeal procedures found in Section 8.04 and your Benefit Claim is denied again, you may then proceed to court since you will then have exhausted this Plan's administrative review procedures.

### *Section 8.04 – Appeals Procedures*

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

Appeal of Benefit Claim Denial

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

Federal regulations categorize all Benefit Claims and appeals of Benefit Claim Denials into different categories (listed in the table below), depending on the type of service that you received.

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

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

| **Time Limits** | | **Type of Benefit Claim** | | | |
|---|---|---|---|---|---|
| **THE LISTED ACTION MUST OCCUR WITHIN THESE TIME LIMITS** | **Urgent health care** | **Pre-service Medical Benefit Claim (non-urgent)** | **Post-service Medical Benefit Claim (other than those associated with work-related Injuries)** | **Post-service Medical Benefit Claim associated with work-related Injuries** | **Loss of Time (Disability)** |
| **For Claimant to request an appeal after a Benefit Claim Denial** | 180 days | 180 days | 180 days | 36 months | 180 days |
| **For Plan to make a determination on the Claimant's 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 will be heard at the next quarterly Board of Trustees meeting after the Claimant filed the | 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 (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 (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 is given to the Claimant and the 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. | Plan may extend the appeal hearing by one additional quarterly meeting if the Claimant is notified prior to the meeting determined above. |

**APPEAL PROCEDURES**

**Appeal Procedures for Medical Benefit Claim Denials**
As part of your rights of appeal of a Medical Benefit Claim Denial:

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

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

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

D) The Board of Trustees shall provide to the Claimant the identification of any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a

Claimant's Benefit Claim Denial, without regard to whether the advice was relied upon in making the Benefit Claim determination;

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

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

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

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

**Appeal Procedures for Loss of Time (Disability) Benefit Claim Denials**

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

- the requirements listed below in the paragraph titled "**In General, Benefit Claims Other than Health or Disability Benefit Claims";**
- the requirements listed above in paragraphs A) through E) in the paragraph regarding the **Appeal Procedures for Medical Benefit Claim Denials;** and
- the following requirements:

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

  In addition, before the Board of Trustees can issue a Benefit Claim Denial on review on a Disability Benefit Claim based on a new or additional rationale, the Board of Trustees shall provide the Claimant, free of charge, with the rationale. The rationale must be provided as soon as possible and sufficiently in advance of the date on which the Notice of Benefit Claim Denial on review is required to be provided under the Plan to give the Claimant a reasonable opportunity to respond prior to that date.

  If the Board of Trustees fails to strictly adhere to all the requirements of the Benefit Claims and Appeals Sections of the Plan with respect to a Benefit Claim, the Claimant is deemed to have exhausted the administrative remedies available under the Plan, except for de minimis violations explained below. As such, the Claimant is entitled to pursue any available remedies under Section 502(a) of ERISA on the basis that the Board of Trustees has failed to provide reasonable Benefit Claims procedures that would yield a decision on

the merits of the Benefit Claim. If a Claimant chooses to pursue remedies under Section 502(a) of ERISA under such circumstances, the Benefit Claim or Appeal is deemed a Benefit Denial on review without the exercise of discretion by an appropriate fiduciary.

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

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

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

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

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

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

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

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

**Timing Requirements for Benefit Claims Other Than Medical or Loss of Time (Disability) Claims**

The appropriate named fiduciary shall make a benefit determination no later than the date of the meeting of the committee or board that immediately follows the receipt of a request for review, unless the request for review is filed within 30 days preceding the date of such meeting. In such case, a benefit determination may be made by no later than the date of the second meeting following the receipt of the request for review. If special circumstances (such as the need to hold

a hearing) require a further extension of time for processing, a benefit determination shall be rendered not later than the third meeting of the committee or board following the receipt of the request for review. If such an extension of time for review is required because of special circumstances, the Board of Trustees shall provide the Claimant with written Notice of the extension, describing the special circumstances and the date as of which the benefit determination will be made, prior to the commencement of the extension. The Board of Trustees shall notify the Claimant of the benefit determination as soon as possible, but not later than five days after the benefit determination is made.

**Health Care Claims**

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

**A) Urgent Care Benefit Claims**

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

**B) Pre-Service Benefit Claims**

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

**C) Post-Service Benefit Claims**

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

**Loss of Time Benefit Claims**

In the case of a Loss of Time Benefit Claim, the appropriate named fiduciary shall instead make a benefit determination no later than the date of the meeting of the committee or board that immediately follows the receipt of a request for review, unless the request for review is filed within 30 days preceding the date of such meeting. In such case, a benefit determination may be made by no later than the date of the second meeting following the receipt of the request for review. If special circumstances (such as the need to hold a hearing,) require a further extension of time for processing, a benefit determination shall be rendered not later than the third meeting of the committee or board following the receipt of the request for review. If such an extension of time for review is required because of special circumstances, the Board of Trustees shall notify the

Claimant in writing of the extension, describing the special circumstances and the date as of which the benefit determination will be made, prior to the commencement of the extension. The Board of Trustees shall notify the Claimant of the benefit determination as soon as possible, but not later than five days after the benefit determination is made.

**Calculating Time Periods**

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

**Furnishing Documents**

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

**MANNER AND CONTENT OF NOTIFICATION OF BENEFIT DETERMINATION ON REVIEW**

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

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

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

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

D) A statement describing any voluntary appeal procedures outlined in the Plan and the Claimant's right to obtain the information about such procedures, and a statement of the Claimant's right to bring an action under Section 502(a) of the ERISA; and

E) In the case of a Benefit Claim Denial of Health Care Benefits –

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

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

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

F) In the case of a Benefit Claim Denial of a Disability Benefit on review, the Notification of the Benefit Claim Denial shall set forth, in a manner calculated to be understood by the Claimant:

1. the specific reason or reasons for the Benefit Claim Denial on review;

2. reference to the specific Plan provisions on which the Benefit Claim Denial on review is based;

3. a statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant, to the Claimant's Benefit Claim for Disability Benefits;

4. a discussion of the decision, including an explanation of the basis for disagreeing with or not following:

   a. the views presented by the Claimant of health care professionals treating the Claimant and vocational professionals who evaluated the Claimant;

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

   c. a disability determination regarding the Claimant made by the Social Security Administration.

5. if the Benefit Claim Denial on review is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided free of change upon request; and

6. the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the Benefit Claim Denial on review.

7. a statement of the Claimant's right to bring an action under Section 502(a) of ERISA; which lawsuit must be filed within three years from the date of the Benefit Claim Denial on appeal to be considered timely. The statement shall include the calendar date the three-year period would run out.

   In the case of a Benefit Claim Denial on review, the notification shall be provided in a culturally and linguistically appropriate manner as described below. The Board of Trustees is considered to provide relevant Notices in a “culturally and linguistically appropriate manner” if they meet the requirements under the “10% Rule”, if necessary, discussed below.

   The Board of Trustees must:

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

b. provide, upon request, a Notice in any applicable non-English language; and

c. include in the English versions of all Notices, a statement prominently displayed in any applicable non-English language clearly indicating how to access the language services provided by the Board of Trustees.

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

### *Section 8.05 – Assignment of Benefits or Rights Not Permitted*

Your right to receive Benefits (or Plan payments for Benefit Claims) is personal to you so you cannot assign it or any of your rights or Benefits as a Participant or Beneficiary to a third party. This anti-assignment rule prohibits assigning any legal or equitable rights under the Plan, or state or federal law, including the Employee Retirement Income Security Act (ERISA), to anyone else without the consent of the Board of Trustees (except as required by a Qualified Medical Child Support Order or National Medical Child Support Notice, or as otherwise may be required by applicable law). A direction to pay a provider is not an assignment of any right under this Plan or of any legal or equitable right to institute any court proceeding.

You may designate a representative to represent you in the Benefit Claims and Appeals Process. However, your representative is not an assignee of your rights and benefits and does not have standing to file suit against the Plan or Board of Trustees. Nothing contained in this Document or any other written description of the Plan for medical coverage shall be construed to make the Plan or Board of Trustees liable to any third-party to whom a Participant may be liable for medical care, treatment or services.

### *Section 8.06 – Venue*

Any lawsuit filed by a Claimant who has exhausted the Claims and Appeals Process set forth in Section 8.04, which lawsuit names the Plan, the Board of Trustees or any administrator connected with the Plan, shall be filed in a court of competent jurisdiction in the venue of the Fund Office in Vigo County, Indiana.

### *Section 8.07 – Indemnity for Liability*

The Plan shall indemnify each member of the Board of Trustees against any and all claims, losses, damages, expenses, including counsel fees, incurred by the Board of Trustees and any liability, including any amounts paid in settlement with the Board of Trustees' approval, arising from the Trustee's or Board of Trustees' action or failure to act in connection with the Trustees' duties and responsibilities under this Plan, except as provided by law. The Plan, at all times and at its own expense shall purchase and keep in effect sufficient liability insurance for each Trustee on the Board of Trustees to cover all claims, losses, damages and expenses arising from any action or failure to act in connection with the execution of his duties as a Trustee of the Board of Trustees.

### *Section 8.08 – Certificate of Creditable Coverage*

If requested, upon the occurrence of any of the events described which result in a termination of coverage under the Plan or an Eligible Person otherwise becoming covered under COBRA coverage, the Board of Trustees shall issue a Certification of Creditable Coverage to the Participant or Qualified Beneficiary. Creditable Coverage shall be the number of months, not in excess of 18, during which such individual was covered under the Plan and, if COBRA coverage was elected, a Qualified Beneficiary under the Plan, without regard to the specific Benefits covered during such months; provided, however, that 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 8.09 – 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. Benefits payable under the Medical Benefits, Senior Member Program and Survivor Benefits portions may be assigned to the provider of medical services. A direction to pay a provider is not an assignment of any right under this Plan or of any legal or equitable right to institute any court proceeding.

### *Section 8.10 – Employment Rights*

The establishment of the Plan shall not be construed as conferring any legal rights upon any Employee or any other person for continuation of employment, nor shall it interfere with the rights of any Employer to discharge any Employee and/or to treat him without regard to the effect which such treatment might have upon him as a Participant.

## *Section 8.11 – Coordination Of Benefits*

**The Coordination of Benefits provisions provided for in this Section 8.11 apply to an Eligible Person who is covered by more than one group health plan (this Plan and another plan (or plans). If this applies to you or your Dependents, please read this Section carefully to understand how Benefits will be paid. You may contact the Fund Office with any questions.**

All Benefits payable under this Plan shall be coordinated with benefits payable under any Other Group Plan if the Covered Expenses are for a Participant, Retiree or Dependent.

If a Participant, Retiree or Dependent is covered by an Other Group Plan, the Benefits under this Plan and the Other Group Plan shall be coordinated. This means that one plan pays its full benefits first, then the other plan pays up to its full benefit; provided, however, that total benefits from this Plan and the Other Group Plan(s) shall not be more than 100% of Covered Expenses incurred.

Benefits paid under this Section shall be paid in the following order:

A) If the Other Group Plan does not have a coordination of benefits provision, the Other Group Plan shall pay its benefits first.

B) When the Other Group Plan does have a coordination of benefits provision, the following rules shall be applied:

1. The plan which covers the person as an employee, member or 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.

3. If the rule described in subparagraph 1 above does not apply, the plan which covers the person as a dependent of the parent whose birthday falls earlier in a year will pay its benefits before the plan of the parent whose birthday falls later in the year, except as described under the rule explained in subparagraph 4 below involving a Benefit Claim for a dependent child of divorced or separated parents or the rule described in subparagraph 5 below involving a Benefit Claim for a dependent child that is covered under an Other Group Plan as a result of their spouse's employment. If both parents have the same birthday, the benefits of the plan which covered the parent longer are paid before those of the plan which covered the parent for a shorter period of time. The word "birthday" refers only to the month and day in a calendar year, not the year in which the person was born.

4. If a Benefit Claim is made for a dependent child of divorced or separated parents, the plan which covers a child as a dependent of a parent who by court decree must provide for health care shall pay its benefits first.

   If there is no court decree which requires a parent to provide 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.

5. If a Benefit Claim is made for a dependent child who is covered under an Other Group Plan as a result of their spouse's employment, benefits will be paid in the following order:

   a. If the dependent child is covered under an Other Group Plan as an employee, that Other Group Plan shall pay its benefits first.

   b. If the dependent child is married and is covered under an Other Group Plan through the spouse's employment, that Other Group Plan will pay its benefits second.

   c. After applying the rules in subparagraphs 5a and 5b, then the rules in subparagraphs 3 or 4, as applicable, shall apply to determine the order of remaining plans.

6. If a person whose coverage is provided under a right of continuation pursuant to federal law (COBRA) or state law is also covered under any Other Group Plan, the plan which covers the person as an employee or member (or as that person's Dependent) shall pay its benefits first and the plan which provides benefits under the continuation coverage shall pay its benefits second.

7. If none of the preceding rules in subparagraphs 1 through 6 apply, the plan which has covered the person for a longer period of time shall pay its benefits first.

Where part of an Other Group Plan coordinates benefits and part does not, each part shall be treated like a separate plan.

Notwithstanding the order listed above, when the Other Group Plan is an insured product (such as certain vision benefits) provided by this Plan, the Other Group Plan shall pay its benefits first.

If benefits which this Plan should have paid are instead paid by an Other Group Plan, this Plan may reimburse the Other Group Plan. Amounts so reimbursed shall be treated like any other Plan benefits in satisfying this Plan's obligations.

If this Plan pays more for a Covered Expense than is required by this Section, then this Plan may recover such excess payment from –

A. any person to whom the payment was made; or

B. any insurance company, service plan or any other organization which should have made payment.

**Definitions Related to Coordination of Benefits**
For purposes of this Section, the following terms shall have the following meanings –

*Other Group Plan*
The term "Other Group Plan" means programs which provide benefit payments or services to a Participant, Retiree or covered Dependents for hospital, medical, surgical, dental, prescription drug, vision, hearing or any other health care under –

- group insurance;
- group Blue Cross and/or Blue Shield and other prepayment coverage on a group basis, including Health Maintenance Organizations;
- coverage under labor-management trusteed plans, union welfare plans, employer organization plans or employee benefit plans;
- coverage under government programs and any other coverages required by law;
- other arrangements of insured or self-insured group coverage; or
- COBRA coverage.

Provided, however, that –

- individually purchased health insurance plans are not treated as an "Other Group Plan" for coordination of benefits purposes; and
- where both the Employee and one or more of his Dependents are eligible to participate because of employment with an Employer, this Plan shall also be treated as an "Other Group Plan" for coordination of benefits purposes.
- In the event this Plan provides an insured product in addition to noninsured coverage, the insured product shall also be treated as an "Other Group Plan" for coordination of benefits purposes.

*Benefit Claim Period*
The term "Benefit Claim Period" means part or all of a Calendar Year during which the Participant, Retiree or covered Dependent is eligible for benefits under the Plan.

*Covered Expense*
The term "Covered Expense" means any Usual, Customary and Reasonable expense incurred which is covered by at least one Other Group Plan during a Benefit Claim Period and where an Other Group Plan provides benefits in the form of a service rather than cash payments, the reasonable cash value of the service during a Benefit Claim Period shall also be considered a Covered Expense.

## *Section 8.12 – Coordination with Medicare*

**The Coordination with Medicare provisions provided for in this Section 8.12 apply to an Eligible Person who is covered by this Plan and Medicare. If this applies to you or your Dependents, please read this Section 8.12 carefully to understand how Benefits will be paid. You may contact the Fund Office with any questions.**

Notwithstanding any provision to the contrary in this Plan, the Plan shall pay benefits secondary to Medicare to the full extent allowed by Section 1862(b) of the Social Security Act. In no event shall covered expenses under the Plan, when added to Medicare benefits, exceed the amount the Plan would have paid had the individual covered by this Plan not been entitled to Medicare benefits. For purposes of this Section, such individual will be presumed to be covered by Medicare to the extent the individual has met all of the eligibility rules and is otherwise entitled to Medicare regardless of whether the individual has actually enrolled in Medicare. For situations where 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 8.13 – Subrogation*

**The Subrogation provisions provided for in this Section 8.13 apply to an Eligible Person who receives treatment or services due to an accident or injury that someone else may be liable. If this applies to you or your Dependents, please read this Section carefully to understand how Benefits will be paid. Also, there is specific paperwork that you must fill out and return to the Fund Office prior to any Benefits being paid. You may contact the Fund Office with any questions.**

If an Eligible Person is injured in an accident for which someone else may be liable, that person or 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 Benefit Claims for or receives any Benefit Claims payments from the Plan for an Injury or Sickness that may give rise to any claim against any third-party, the Eligible Person's representative

will be required to execute a "Subrogation Assignment of Rights, and Restitution Agreement" affirming the Plan's rights of restitution and subrogation with respect to such Benefit Claims payments and claims. This form will assist the Plan in recovering Benefit Claims paid from a third party who was responsible for the Injuries giving rise to the Benefit Claims. This Agreement must also be executed by the Eligible Person's attorney, if applicable.

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

This means that, if an Eligible Person files a Benefit Claim and a Subrogation Agreement is not received promptly, the Benefit Claim will not be paid.

C) The Eligible Person shall do whatever is necessary to secure the Plan's subrogation rights and shall do nothing after the loss to prejudice such rights. The Eligible Person must do nothing to impair or prejudice the Plan's rights. For example, if the Eligible Person chooses not to pursue the liability of a third party, the Eligible Person may not waive any rights covering any conditions under which any recovery could be received. Where the Eligible Person chooses not to pursue the liability of a third party, the acceptance of Benefit Claims from the Plan authorizes the Plan to litigate or settle your claims against the third party. If the Plan takes legal action to recover what it has paid, the acceptance of Benefit Claims obligates the Eligible Person (and their attorney, if applicable) to cooperate with the Plan in seeking its recovery, and in providing relevant information with respect to the accident.

D) The Eligible Person shall agree to cooperate with the Plan and/or any representatives of the Plan in completing such forms and in giving such information surrounding any accident as the Plan or its representatives deem necessary to fully investigate the incident. Failure to execute the necessary forms will result in no Benefit Claims being paid.

E) The Plan is also granted a right of restitution from the proceeds of any settlement, judgment or other payment obtained by the Eligible Person. This right of restitution is cumulative with and not exclusive of the subrogation right granted in paragraph A above, but only to the extent of the Benefit Claims paid by the Plan.

F) The Plan's rights of restitution and subrogation provide the Plan with first priority to any and all recovery in connection with the Injury or Sickness, whether such recovery is full or partial and no matter how such recovery is characterized, why or by whom it is paid, or the type of expense for which it is specified. Such recovery includes amounts payable under the Eligible Person's own uninsured motorist insurance, underinsured motorist insurance, or any medical pay or no-fault benefits payable.

This right of subrogation is specifically and unequivocally pro tanto subrogation, that is, subrogation from the first dollar received by the Eligible Person, and the pro tanto subrogation is to take effect before the entire debt is paid to the Eligible Person. In addition to its pro tanto rights, the Plan is entitled to restitution of the full amount of Benefits paid, regardless of whether the Eligible Person is made whole by the third party for all damages.

G) The Plan's rights of restitution and subrogation apply regardless of the terms of the claim, demand, right of recovery, cause of action, judgment, award, settlement, compromise, insurance or order, regardless of whether the third party is found responsible or liable for the

Injury or Sickness, and regardless of whether the Eligible Person actually obtains the full amount of such judgment, award, settlement, compromise, insurance or order.

The Plan, by payment of any proceeds, is granted an equitable lien on the proceeds of any settlement, judgment or other payment received by the Eligible Person, and the Eligible Person consents to said lien and agrees to take all steps necessary to help the Board of Trustees secure such lien.

The Plan shall have a lien on any amount received by the Eligible Person or a representative of the Eligible Person (including your attorney) that is due to the Plan under this Section, and any such amount shall be deemed to be held in trust by the Eligible Person for the Benefit of the Plan until paid in full to the Plan.

H) The subrogation and restitution rights and liens apply to any recoveries made by the Eligible Person as a result of the Injuries sustained or Sickness suffered, including but not limited to the following:

1. Payments made directly by the third-party tort-feasor or any insurance company on behalf of the third-party 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 Benefit Claims 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 Benefit Claims as a result of said Injuries at 75% of discounted charges for In-Network Benefit Claims and at 50% of approved charges for Out of Network Benefit Claims. The Deductible Amount and Out-of-Pocket rule will not be applied to these Benefit Claims.

### *Section 8.14 – Other Rights of Recovery*

Whenever Benefit Claims 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 Dependent.

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

### *Section 8.15 – Medical Care Review Program*

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 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 Benefit 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:

- **Behavioral Health (Mental Health and Substance Abuse)** including outpatient therapy, intensive outpatient programs (IOP) and partial hospitalization programs (PHP),
- **Dialysis**,
- **Diagnostic Services for capsule endoscopy and genetic testing**,
- **Durable medical equipment** limited to electric/motorized scooters or wheelchairs, pneumatic compression devices, TENS, Bone Growth Stimulator, Neuromuscular Stimulator, Home Ventilator, Respiratory Assist Device, External Defibrillator Device (VEST), Traction Equipment, Phototherapy Light, Continuous Passive Motion (CPM), CPAP and BIPAP),

- **Home health care**,
- **Hospice**, Inpatient and Home
- **Hyperbaric oxygen**,
- **Long-term acute** care,
- Inpatient **Medical, Surgical and Behavioral Health**, including acute inpatient medical, surgical and behavioral health (mental health and substance abuse)
- **Outpatient surgery** (please contact the fund office for to find out if your specific surgery requires pre-certification),
- Services referred by the Plan's **Prescription Benefit Manager** including chemotherapy (including oral), infusion therapy, medications over $2,000 and oncology and transplant-related therapy,
- **Prosthetics** for limbs,
- **Radiation**,
- **Rehabilitation facility**,
- **Residential treatment facility**, In-Network (Out-of-Network not covered)
- **Skilled nursing facility**, In-Network (Out-of-Network not covered)
- **Therapy**
  - Occupational and Physical after 12 visits for Eligible Persons age 14 and over, and from the first visit for Eligible Persons under age 14
  - Speech from the first visit for Eligible Persons
  - Vision after 12 visits for Eligible Persons under age 18, and from first visit for Eligible Persons age 18 and over
- **Transplant services**

**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 may be issued by the medical care review program after further review.

**When Surgery is Recommended**

If a Physician recommends a non-emergency surgical procedure (inpatient or outpatient), it may require you to contact the medical care review program. You may contact the Fund Office to find out if your recommended procedure requires the medical care review program. If required, he 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 8.16 – Preferred Provider Organization (PPO)*
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 8.17 – Insured Benefits*
The Board of Trustees reserves the right to enter into agreements for insured benefits with outside vendors or providers. Use of the benefit offered under this type of arrangement is voluntary and shall be initiated by the Participant.

The Board of Trustees may amend these agreements at any time, including but not limited to terminating any agreement and entering into new agreements.

All such agreements are incorporated by reference into this Plan and are on file at the Fund Office.

### *Section 8.18 – 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 8.19 – 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 Dependents shall thereafter be null and void.

### *Section 8.20 – 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 8.21 – 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 8.22 – 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 Document.

3. "Plan Sponsor" means the Board of Trustees of this Plan.

C) The Plan's Disclosure of Protected Health Information to the Plan Sponsor - Required Certification of Compliance by Plan Sponsor

Except as provided below with respect to the Plan's disclosure of summary health information, the Plan will: (i) disclose Protected Health Information to the Plan Sponsor or (ii) provide for or permit the disclosure of Protected Health Information to the Plan Sponsor with respect to the Plan, *only if* the Plan has received a certification (signed on behalf of the Plan Sponsor) that:

1. The Plan Documents have been amended to establish the permitted and required uses and disclosures of such information by the Plan Sponsor, consistent with 45 CFR §164.504 (the "504" provisions);

2. The Plan Documents have been amended to incorporate the Plan provisions set forth in this Section; and

3. The Plan Sponsor agrees to comply with the Plan provisions as modified by this Section.

D) Permitted Disclosure of Individuals' Protected Health Information to the Plan Sponsor

1. The Plan (and any Business Associate acting on behalf of the Plan, or any health insurance issuer, HMO, PPO, health care provider, etc., as applicable, servicing the Plan) will disclose individuals' Protected Health Information to the Plan Sponsor only to permit the Plan Sponsor to carry out Plan administration functions. Such disclosure will be consistent with the provisions of this Section.

2. All disclosures of the Protected Health Information of the Plan's individuals by the Plan's Business Associate, health insurance issuer, HMO, PPO, health care provider, etc., as applicable, to the Plan Sponsor will comply with the restrictions and requirements set forth in this Section 8.16 and in the "504" provisions.

3. The Plan (and any Business Associate acting on behalf of the Plan) may not permit a health insurance issuer, HMO, PPO, health care provider, etc., as applicable, to disclose individuals' Protected Health Information to the Plan Sponsor for employment-related actions and decisions or in connection with any other benefit or employee

benefit plan of the Plan Sponsor, unless authorized by the individual or as allowed by law.

4. The Plan Sponsor will not use or further disclose individuals' Protected Health Information other than as described in the Plan Documents and permitted by the "504" provisions.

5. The Plan Sponsor will ensure that any agent(s), including a subcontractor, to whom it provides individuals' Protected Health Information received from the Plan (or from the Plan's health insurance issuer, HMO, PPO, health care provider, etc., as applicable), agrees to the same restrictions and conditions that apply to the Plan Sponsor with respect to such Protected Health Information.

6. The Plan Sponsor will not use or disclose individuals' Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor, unless authorized by the individual or as allowed by law.

7. The Plan Sponsor will report to the Plan any use or disclosure of Protected Health Information that is inconsistent with the uses or disclosures provided for in the Plan Documents (as amended) and in the "504" provisions, of which the Plan Sponsor becomes aware.

E) Disclosure of Individuals' Protected Health Information - Disclosure by the Plan Sponsor

1. The Plan Sponsor will make the Protected Health Information of the individual who is the subject of the Protected Health Information available to such individual in accordance with 45 C.F.R. §164.524.

2. The Plan Sponsor will make individuals' Protected Health Information available for amendment and incorporate any amendments to individuals' Protected Health Information in accordance with 45 C.F.R. §164.526.

3. The Plan Sponsor will make and maintain an accounting so that it can make available those disclosures of individuals' Protected Health Information that it must account for in accordance with 45 C.F.R. §164.528.

4. The Plan Sponsor will make its internal practices, books and records relating to the use and disclosure of individuals' Protected Health Information received from the Plan available to the U.S. Department of Health and Human Services for purposes of determining compliance by the Plan with the HIPAA Privacy Rule.

5. The Plan Sponsor will, if feasible, return or destroy all individuals' Protected Health Information received from the Plan (or a health insurance issuer, HMO, PPO, health care provider, etc., as applicable, with respect to the Plan) that the Plan Sponsor still maintains in any form after such information is no longer needed for the purpose for which the use or disclosure was made. Additionally, the Plan Sponsor will not retain copies of such Protected Health Information after such information is no longer needed for the purpose for which the use or disclosure was made. If, however, such return or destruction is not feasible, the Plan Sponsor will limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

6. The Plan Sponsor will ensure that the required adequate separation, described in paragraph F below, is established and maintained.

F) Required Separation between the Plan and the Plan Sponsor

1. In accordance with the "504" provisions, this section describes the employees or classes of employees of workforce members under the control of the Plan Sponsor who may be given access to individuals' Protected Health Information received from the Plan or from a health insurance issuer, HMO, PPO, etc., as applicable, servicing the Plan.

   a. Board of Trustees

   b. Claims supervisors, processors and clerical support staff

   c. Information Technology personnel

2. This list reflects the employees, classes of employees, or other workforce members of the Plan Sponsor who receive individuals' Protected Health Information relating to payment, health care operations of, or other matters pertaining to Plan administration functions that the Plan Sponsor provides for the Plan. These individuals will have access to individuals' Protected Health Information solely to perform these identified functions, and they will be subject to disciplinary action and/or sanctions (including termination of employment or affiliation with the Plan Sponsor) for any use or disclosure of individuals' Protected Health Information in violation of, or noncompliance with, the provisions of this Section.

3. The Plan Sponsor will promptly report any such breach, violation, or noncompliance to the Plan and will cooperate with the Plan to correct the violation or noncompliance, to impose appropriate disciplinary action and/or sanctions, and to mitigate any harmful effect of the violation or noncompliance.

### *Section 8.23 – HIPAA Security Rule*

The Welfare Fund (as defined in Section 8.23 E) shall implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the Electronic Protected Health Information that it creates, receives, maintains or transmits on behalf of the Plan, consistent with the requirements of the Standards for the Security of Electronic protected Health Information as set forth in 45 CFR Parts 160 and 162 and Part 164, Subpart C (the "Security Standards"). For this purpose, the Welfare Fund shall be deemed a hybrid entity under the Security Standards and the provisions of this Section 8.23 shall be administered and interpreted to apply only to that portion of the Welfare Fund that constitutes a Covered Entity under the Security Standards.

A) Support of Adequate Separation Requirement by Security Measures
   The Welfare Fund shall ensure that the adequate separation requirement set forth in 45 CFR §164.504(f)(2)(iii) is supported by reasonable and appropriate security measures, consistent with the requirements of the Security Standards.

B) Agents and Subcontractors
   The Welfare Fund shall take reasonable steps to ensure that any agent, including a subcontractor, to whom it provides the Electronic Protected Health Information, agrees to implement reasonable and appropriate security measures to protect such information.

C) Reporting Obligation
The Union and Associations shall report to the Welfare Fund any Security Incident of which it becomes aware.

D) Policy
The Plan and this Section 8.23 shall be interpreted and administered in accordance with the Security Standards, any applicable Federal or State law and any other applicable regulation or other official guidance issued thereunder. In the event of a conflict between this Article of the Plan and the Security Standards, statute, regulation or guidance, such Security Standards, statute, regulation or guidance shall govern. The Welfare Fund shall adopt written policies and procedures to implement the provisions of this Section 8.23.

E) Definitions
Capitalized terms used in this Section 8.23 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 |
|---|---|
| Francis Gantner<br>Chairman<br>PO Box 1587<br>Terre Haute, IN 47808 | David Frye<br>Secretary-Treasurer<br>LIUNA State of Indiana District Council<br>425 S. 4th Street<br>Terre Haute, IN 47807 |
| Jeremy Ayres<br>F.A. Wilhelm Construction Co., Inc.<br>3914 Prospect Street<br>Indianapolis, IN 46203 | Jack Baker<br>LIUNA Local Union #1112<br>P.O. Box 38<br>Richmond, IN 47375 |
| Douglas Banning, Jr.<br>Miller Pipeline Corp<br>P.O. Box 34141<br>Indianapolis, IN 46234 | James W. Daniels<br>LIUNA Local Union #120<br>1520 East Riverside Drive<br>Indianapolis, IN 46202 |
| Jeffrey Chapman<br>Tonn & Blank Construction<br>1623 Greenwood Avenue<br>Michigan City, IN 46360 | Murray Miller<br>LIUNA Local Union #645<br>23698 Western Avenue<br>South Bend, IN 46619 |
| Tom Fleenor<br>Empire Contractors, Inc.<br>P.O. Box 6327<br>Evansville, IN 47719 | Kevin Roach<br>LIUNA Local Union #41<br>550 Superior Avenue<br>Munster, IN 46321 |
| William A. Hasse III<br>Hasse Construction Co., Inc.<br>P.O. Box 300<br>Calumet City, IL 60409 | Brian Short<br>LIUNA State of Indiana District Council<br>425 S. 4th Street<br>Terre Haute, IN 47807 |
| James McDonald<br>White Construction<br>PO Box 249<br>Clinton, IN 47842 | James Terry<br>LIUNA Local Union #274<br>1734 Main St.<br>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
toll free (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 Trust, Plan Document and Summary Plan Description, as well as any communications related to the Plan. The Board of Trustees will make all factual determinations, including determining the rights or eligibility of Employees or Participants, Dependents and any other persons and the amounts of their Benefits under the Plan. The Board of Trustees will remedy ambiguities, inconsistencies or omissions and such determinations shall be binding on all parties. Benefits will only be paid if the Board of Trustees, in its sole discretion, determines that the Participant or Beneficiary is entitled to them. The Board of Trustees has the authority to delegate any of its powers under the Plan (including, without limitation, its power to administer Benefit Claims and appeals) to any other person or committee. Such person or committee may further delegate its powers to another person or committee. Any delegation or subsequent delegation shall include the same sole, discretionary and final authority that the Board of Trustees has, as described in this paragraph and any decisions, actions or interpretations made by any delegate shall have the same ultimate binding effect as if made by the Board of Trustees. No Employer, Union or representative of any Employer or Union is authorized to interpret the provisions of either the Plan or the Trust Agreement.

The Trustees have hired an Administrative Manager to perform the day-to-day operations of the Plan, such as maintaining records, making Benefit Claims payments and determinations and handling general administrative matters. The Administrative Manager is:

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

### *Section 9.04 – Plan Sponsors*

Plan Participants and Beneficiaries may write to the Plan Administrator (the Board of Trustees) at the address in Section 9.03 to find out if a particular Employer or Union is a sponsor of this Plan and, if so, to find out that Plan sponsor's address.

### *Section 9.05 – Identification Numbers*

The Federal Employer Identification Number assigned to the Board of Trustees by the Internal Revenue Service is 35-0923209. The Plan Number is 501. The State Employer Identification Number is 00018259840012

Taken together, the Plan's name and number and the Employer Identification Number identify the Plan with the federal agencies governing employee benefits plan operation.

### *Section 9.06 – Agent for Service of Legal Process*

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, Accidental Death and Dismemberment, Loss of Time, Medical, Prescription, Dental and Vision Benefits. A detailed written description of the Plan Benefits appears in Article IV.

The Board of Trustees 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 (the Board of Trustees). You may also contact the Employee Benefits Security Administration, US Department of Labor at (866) 444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

### *Section 9.12 – Eligibility Rules*
The rules regarding eligibility for coverage, termination of eligibility and direct payment of contributions are found in the applicable Sections.

### *Section 9.13 – Reciprocity Agreements*
The Plan has entered into reciprocity agreements with various other funds. If you work under more than one fund and are not eligible under your home fund, you should check with the Fund Office to see if eligibility can be established under reciprocity. Please contact the Fund Office for further information.

### *Section 9.14 – If the Plan Is Terminated or Modified*

The Board of Trustees reserves the right to change, suspend or end the Plan at any time and for any reason, in whole or in part. In addition, Benefits may be discontinued at any time for any group of participants (including inactive participants or retirees). This document is not a promise always to provide any particular Benefit. In general, if the Plan (or any portion of the Plan) is ended you will not be vested in any Plan Benefits or have any rights. In the event that the Plan is discontinued or terminated, in whole or in part, Benefits will be paid only for services received up to the date of Plan termination. However, the amount and form of any final Benefit you may receive will depend on plan assets, any contract or insurance provisions affecting the Plan and decisions made by the Board of Trustees. You will be notified if the Plan is amended.

### *Section 9.15 – Fund Service Providers*

*Administrative Manager*
Somer Taylor
P.O. Box 1587
Terre Haute, IN 47808
(812) 238-2551
(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

*Medical Care Program*
Hines & Associates, Inc.
115 East Highland Ave
Elgin, IL 60120
Precert#: (800) 559-5257
www.precertcare.com

*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.deltadentalin.com

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

*Hearing Network*
Amplifon Hearing Health Care
(866) 349-9051
www.amplifonusa.com/indianalaborers

*Member Assistance Program (MAP)*
Perspectives MAP
20 N Clark St, Ste 2650
Chicago, IL 60602
(800) 866 7556
www.perspectivesltd.com

*Telehealth Provider*
LiveHealth Online
www.livehealthonline.com
(888) 548-3432 (technical assistance only)

# ARTICLE X – STATEMENT OF ERISA RIGHTS

## Your Rights

As a Participant in Indiana Laborers Welfare Fund you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan Participants shall be entitled to:

## Receive Information About Your Plan and Benefits

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

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

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

Be informed that under the Health Insurance Portability and Accountability Act (HIPAA), upon request, the Plan must provide you with a "Certificate of Creditable Coverage" if you lose health care coverage under the Plan for any reason. This Certificate reports data on prior periods of health coverage under the Plan compiled in accordance with federal regulations. Participants should retain this "Certificate of Creditable Coverage" and submit it to a new employer if the new employer maintains a group health care plan. The new employer may be required under federal law to credit such coverage toward any waiting period for coverage of pre-existing conditions under the new employer's plan.

Be informed that the Plan is in compliance with the non-discrimination requirements set forth in Section 2590.701-2 of the DOL's HIPAA regulations. These regulations state that a group health care plan may NOT establish Eligibility Rules based on any of the following factors: (1) health status; (2) medical condition (including both physical and mental illness); (3) prior Benefit Claims experience; (4) actual receipt of health care; (5) medical history; (6) genetic information; (7) evidence of insurability (including conditions arising out of domestic violence); or, (8) disability (Loss of Time).

Be informed that under the Newborns' and Mothers' Health Protection Act, group health plans and health insurance issuers offering group health insurance coverage generally may NOT restrict benefits for any Hospital stay in connection with childbirth for the mother or newborn child to less than 48 hours following vaginal delivery or less than 96 hours following a delivery by cesarean section. However, the Plan, or issuer, may pay for a shorter stay if the attending provider (e.g., your Physician, nurse midwife or Physician Assistant), after consultation with the mother, discharges the mother or newborn earlier. Under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48 hour or 96 hour stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay. In addition, a plan or issuer may not, under federal law, require that a Physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours or 96 hours,

as applicable. However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain pre-certification. For information on pre-certification, contact the Fund Office.

Be informed that under the Women's Health and Cancer Rights Act, group health plans and health insurance issuers offering group health insurance coverage that includes medical and surgical benefits with respect to mastectomies shall include medical and surgical benefits for breast reconstructive surgery as part of a mastectomy procedure. Breast reconstructive surgery benefits in connection with a mastectomy shall at a minimum provide coverage for: (1) reconstruction of the breast on which the mastectomy has been performed; (2) surgery and reconstruction of the other breast to produce a symmetrical appearance; (3) prostheses; and, (4) physical complications for all stages of mastectomy, including lymphedemas. Such surgery shall be in a manner determined in consultation with the attending Physician and the patient. As part of the Plan's Schedule of Benefits, such Benefits are subject to the Plan's appropriate cost control provisions, such as deductibles and copayments.

The Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, religion, national origin, age (40 or older), disability, sex (including pregnancy, sexual orientation or gender identity) or genetic information (including family medical history).

## 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 Benefit or exercising your rights under ERISA.

## Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Fund Office and do not

receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Board of Trustees to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a Benefit Claim that is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

### Assistance with Your Questions

If you have any questions about your Plan, you should contact the Fund Office. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Fund Office, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration at (866) 444-3272.

# ARTICLE XI – DEFINITIONS

**THE FOLLOWING WORDS HAVE SPECIFIC MEANINGS WHEN USED IN THE PLAN. IT IS IMPORTANT TO UNDERSTAND THE MEANINGS OF THESE DEFINED TERMS WHILE USING THIS DOCUMENT.**

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



### *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 – Benefit Claim*
"Benefit Claim" means a post-service request for payment of Benefits from the Fund in accordance with the procedures outlined in Section 8.03. This request can be submitted in either a written or HIPAA-compliant electronic format. If a Benefit Claim is denied, in whole or in part, an Eligible Person can appeal the Benefit Claim Denial in accordance with the procedures outlined in Section 8.04.

A Benefit Claim **does not** include any of the following:

A. A verbal inquiry about whether a specific service is a covered Benefit.

B. A voluntary pre-service determination of whether a treatment, service or product is covered.

C. An inquiry regarding eligibility to receive a treatment, service or product. However, after service is incurred, a determination of eligibility will be made by the Fund.

D. An attempt to purchase or receive a prescription drug at the counter. However, any denial of such purchase or receipt entitles the Eligible Person to file a Benefit Claim after the denial.

### *Section 11.06 – Benefits*
"Benefits" means the General Medical, Chiropractic, Dental Care, Eye Care, Hearing, Hospice Care, Mental and Nervous Disorder, Prescription Drug Card, Routine Preventive 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 11.07 – 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 11.08 – Certification of Creditable Coverage*
"Certification of Creditable Coverage" shall mean the certification described in Section 8.08.

### *Section 11.09 – 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 11.10 – Coverage Period*
“Coverage Period” means the period during which a Participant or Retiree is eligible for coverage.

Eligibility for Active Participants is further defined in Section 3.02 with examples in Section 3.03. Eligibility for Retirees is further explained in Section 6.01.

### *Section 11.11 – 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 11.47) and Medically Necessary in light of the Injury or Sickness being treated.

### *Section 11.12 – Creditable Coverage*
“Creditable Coverage” means the period of coverage described in Section 8.08.

### *Section 11.13 – Custodial Care*
“Custodial Care” means services or supplies, regardless of where or by whom they are provided which –

A) a person without medical skills or background could provide or could be trained to provide; or

B) are provided mainly to help the Eligible Person with daily living activities, including (but not limited to) –

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

2) bathing, using the toilet, administering enemas, dressing and assisting with any other physical or oral hygiene needs;

3) assistance with eating by utensil, tube or gastrostomy;

4) homemaking, such as preparation of meals or special diets and house cleaning;

5) acting as a companion or sitter; 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 11.14 – 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) until the end of the month in which the child turns age 26. Children that you have legal guardianship are NOT Dependents.

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 3.08 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 11.15 – Developmental Care*

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

A) are provided to an Eligible Person who has not previously reached the level of development expected for his age in the following areas of major life activity:

   1) intellectual;

   2) physical;

   3) receptive and expressive language;

   4) learning;

   5) mobility;

   6) self-direction;

   7) capacity for independent living; or

   8) economic self-sufficiency; or

B) are not rehabilitative in nature (restoring fully developed skills that were lost or impaired due to Injury or Sickness); or

C) are educational in nature.

### *Section 11.16 – 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 11.17 – 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 11.18 – 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 11.19 – 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 Eligible Person or to others.

### *Section 11.20 – Employee*

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

### *Section 11.21 – 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 11.22 – 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 11.23 – 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 11.24 – Injury*

"Injury" means any accidental bodily injury which requires treatment by a Physician and which results in loss independent of Sickness or other causes. **Intentionally inflicted Injuries are excluded.**

### *Section 11.25 – 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 11.26 – Maternity*

“Maternity” means expenses related to pregnancy and childbirth.

### *Section 11.27 – Medically Necessary*

“Medically Necessary” means a service or supply which is ordered by a Physician and is –

A) provided for the diagnosis or direct treatment of an Injury or Sickness;

B) appropriate and consistent with the symptoms and findings or diagnosis and treatment of the Eligible Person’s Injury or Sickness;

C) provided in accordance with generally accepted medical practice on a national basis; and

D) the most appropriate supply or level of service which can be provided on a cost effective basis (including, but not limited to, inpatient vs. outpatient care, electric vs. manual wheelchair, surgical vs. medical or 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 11.28 – 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 11.29 – 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 11.30 – Participant*
The term "Participant" shall mean any Employee, former Employee of an Employer, Retiree, or surviving Spouse, who has met the eligibility requirements for benefit coverage in the Plan and is covered by the Plan or whose Beneficiaries may become eligible to receive any such Benefit.

### *Section 11.31 – 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);

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

### *Section 11.33 – Plan Year*
"Plan Year" means the twelve-month period beginning on December 1 and ending on November 30 of the following year.

### *Section 11.34 –Qualification Period*
"Qualification Period:" means the period during which a Participant accrues credited hours.

Eligibility for Active Participants is further defined in Section 3.02 with examples in Section 3.03.

### *Section 11.35 – Retiree*
"Retiree" means an individual who has retired from the employ of his Employer or an Employee who is Totally Disabled.

### *Section 11.36 – 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 11.37 – 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 11.38 – 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 11.39 – 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 11.40 – Substance Abuse Treatment Center*
"Substance Abuse Treatment Center" means a Hospital, or licensed clinic, or other entity certified by the State (or otherwise meeting state mandated requirements) for inpatient or outpatient drug or alcohol abuse treatment. Facilities providing in-patient substance abuse services must be licensed or certified for the level of care, have a physician on staff and have registered nurses on staff 24/7. Facilities providing out-patient services must be licensed or certified for the level of care and services must be performed or supervised by a Physician as defined under this Plan.

### *Section 11.41 – 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.

A Totally Disabled Participant will be required to have an annual exam to confirm that he continues to be Totally Disabled.

### *Section 11.42 – Totally Disabled Participant*
"Totally Disabled Participant" means an individual who became Totally Disabled while a Participant.

### *Section 11.43 – Trust Agreement or Trust*
"Trust Agreement" or "Trust" means any agreement in the nature of a trust established to receive, hold, invest and dispose of the Trust Fund in accordance with this Plan.

### *Section 11.44 – Trust Fund or Fund*
"Trust Fund" or "Fund" means all the assets which are held by the Board of Trustees for the purposes of this Plan.

### *Section 11.45 – Trustee*
"Trustee" means the Employer Trustees and the Employee Trustees, as appointed under the Trust Agreement, to act as Trustee or Trustees of the assets of the Trust Fund.

### *Section 11.46 – 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 11.47 – 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, the UCR will be based on the Fair Health Relative Value at the 85$^{th}$ percentile.

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.

E) For Benefit Claims where Medicare pays secondary, an amount based on 150% of the Medicare fee schedule.

### *Section 11.48 – 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 (Document) is accurate and up to date as of the time of its printing. You will be notified, in writing, of any changes in the Plan that may affect your benefits or rights under the Plan.**