BRICKLAYERS AND ALLIED CRAFTWORKERS LOCAL NO. 3 HEALTH AND WELFARE PLAN

FORMAL PLAN RULES
(As revised July 1, 2025)

TABLE OF CONTENTS

This Table of Contents is for reference only and is not part of the Formal Plan Rules.

BRICKLAYERS AND ALLIED CRAFTWORKERS LOCAL NO. 3 HEALTH AND WELFARE PLAN

FORMAL PLAN RULES
(As revised July 1, 2025)

PART 1 - GENERAL PLAN RULES

1. DEFINITIONS (Other Definitions Appear in Section 14)

1.01 "Participant" is someone who meets the eligibility requirements for coverage under the terms of the Plan. You are no longer a Participant if your coverage terminates or you lose eligibility.

1.02 "Union" is the Bricklayers and Allied Craftworkers Union Local No. 3 (California).

1.03 "Employer" is an individual owner, partnership or corporation that employs employees represented by Bricklayers and Allied Craftworkers Union Local No. 3 (the "Union") under a Collective Bargaining Agreement calling for contributions to this Plan.

1.04 "Collective Bargaining Agreement" is an agreement between an Employer and the Union concerning the terms of employment.

1.05 "Covered Employment" is work of the type covered by a Collective Bargaining Agreement.

1.06 "Pensioner" is any person who has retired and is receiving pension benefits from any pension plan administered and established under any trust to which the Union appoints trustees.

1.07 "Non-Signatory Employer" is an employer who is not signed to a collective bargaining agreement.

2. ELIGIBILITY AS AN EMPLOYEE

2.01 **Initial Eligibility Qualifications**

(1) You become eligible for benefits when you complete 360 hours of covered work under a Collective Bargaining Agreement for an Employer who makes all required contributions to the Plan on your behalf. Once eligible for benefits you will be sent an enrollment card that is to be completed and returned to the Plan.

(2) Your eligibility starts on the first day of the second month following the month in which you have completed 360 hours during the previous six-month period (provided your employer has made required contributions). For example, if you start working for a contributing Employer on January 1, and you complete 360 hours of work on March 31, you are eligible to participate as of May 1.

(3) You must work a minimum of one hundred twenty (120) hours per month to maintain eligibility, and your employer must make the required contributions. Any hours over 120 hours that you work during a month are accumulated in a reserve account.

(4) The Board of Trustees may, in its sole discretion, approve entry of newly-organized bargaining units and of the bargaining unit employees of existing Union signatory employers for whom health benefits are newly negotiated, with an advance of hours to Participants' reserve accounts, based on the specific facts and circumstances of each case.

2.02 **Reserve Account, Self-Payment and Short Payment Provisions**

(1) The Plan keeps track of the number of hours you work each month. After you work more than 120 hours in a month, additional hours go into your reserve account. You can have up to 480 hours in your reserve account. During periods when you cannot work, including labor disputes, you can use these hours to maintain eligibility for benefits. Except as provided in subsections (2), (3) or (4) below, if you use up all of your hours in your reserve account, you and your Eligible Dependents will no longer be eligible for benefits and you will have to reestablish your eligibility. If you die as a Plan Participant, your reserve account will continue to provide benefits to your Eligible Dependents until the account is run out.

(2) In the event that a Participant's reserve account is exhausted, and subject to the approval of the Board of Trustees, which may be withheld for any reason, a Participant may be permitted a maximum of 360 hours of eligibility based on reported but unpaid covered hours under the following circumstances: if, commencing 90 days prior to the exhaustion of the Participant's reserve account, the Participant has worked in covered employment for contributing Employers who have reported the Participant's hours to the Trust, but have not yet made payment to the Trust for those hours. The extended eligibility provided in this section may be permitted only once in any 12 month period, must be for a continuous period, and may not be for more than 360 reported but unpaid hours. Unreported hours shall not establish any right to this extended eligibility. When the period of extended eligibility provided in this section terminates, the eligibility of the Participant and the eligibility of any Eligible Dependent of such a Participant shall terminate. In such an event, eligibility may be reestablished as set forth below. Nothing herein shall be construed as excusing an Employer's failure to make payments to the Trust, or as a waiver of the Trust's claims against the Employer for contributions and liquidated damages, or as a right to receive any benefits when contributions are not received by the Trust.

(3) SELF-PAYMENT. If the combination of work hours credited and reserve hours does not equal 120, you may continue your eligibility by making self-payments under the

following rules for a maximum of three months in any 12-month period:

(a) You are eligible to make self-payments only if:

(i) you have at least 60 months of prior active coverage under the BAC Local 3 Health and Welfare Plan over your lifetime; and

(ii) you meet one of the following two requirements:

(A) you are available for work in the Industry, or

(B) you are disabled and have exhausted your Reserve Account after expiration of the maximum period of coverage under the disability coverage provisions in Section 2.03.

"Available for work in the Industry" means that you have maintained registration on the Union's out-of-work list and are actually available for dispatch.

(b) If you lose coverage for cause under Section 2.06, you will not be eligible to make a self-payment to continue coverage.

(c) The self-payment amount is determined from time to time by the Board of Trustees.

(d) The Board of Trustees will review the suitability of this provision on an annual basis.

(4) SHORT PAYMENT. You may continue your eligibility by making a "short payment" under the following rules:

(a) If the combination of work hours credited and reserve hours is at least 80 hours, you may make a short payment to bring your total hours up to the 120 hours required to continue coverage. Your short payment amount will be the number of additional hours you need to bring your total up to 120 hours times the current Master Labor Agreement hourly health and welfare contribution rate.

(b) If you are eligible to make a short payment in a particular month but elect not to do so, your coverage will terminate and you will not be eligible to make a short payment to reestablish or continue coverage in the future until active eligibility is reinstated under Section 2.05.

(c) If you lose coverage for cause under Section 2.06, you will not be eligible to make a short payment to reestablish or continue coverage in the future.

(d) The Board of Trustees will review the suitability of this provision on an annual basis.

2.03 **Coverage During a Period of Disability**

(1) If you are a Participant and you become disabled, you can receive up to 6 months of coverage without withdrawing any hours from your reserve account. The actual number of months of this special disability coverage is equal to the period for which you were continuously covered as a result of hours worked immediately prior to the disability, up to 6 months.

(2) If you exhaust your eligibility for disability coverage and remain disabled, your reserve account hours can be used to continue your coverage. Once your reserve account falls below the minimum number of hours to maintain coverage, or 120, you may be qualified to continue your coverage under the Self-Payment or Short Payment Provisions in Section 2.02. If you do not meet the requirements of the Self-Payment or Short Payment Provisions, you may apply for continuation coverage (COBRA) as provided in Section 6 of these Formal Plan Rules.

(3) To be "disabled," you must meet one of the following requirements:

(a) be receiving State Disability Insurance Benefits; or

(b) be receiving temporary disability indemnity benefits or have been awarded "Qualified Injured Worker" status, under California Workers' Compensation Laws; or

(c) have a disability that would qualify you for SDI benefits but you are not receiving them because, as of the date you became disabled, you hadn't earned enough credits under that program to qualify. You must provide proof to the Plan Administration Office of both your qualifying disability and the reason for your lack of SDI credits. Contact the Administration Office for more information on the type of proof you need to submit.

(4) Disability coverage is not available to retirees; if you become disabled after you retire, you must begin making the required contributions for retiree coverage.

2.04 **Failure to Maintain Eligibility**

Your coverage under the Plan terminates at the end of the month in which your reserve account falls below the 120 hour minimum, or if you enter military service (other than a temporary tour of duty not exceeding 30 days). Thereafter, you will be eligible for coverage again only if you satisfy the requirements for Self-Payment, Short Payment, COBRA Coverage, Reinstatement of Eligibility, or Initial Eligibility.

2.05 **Reinstatement of Eligibility**

(1) You can reinstate eligibility as of the second calendar month following the month in which you work at least 120 hours, if you do so within six calendar months following the end of your coverage, including the end of coverage maintained under the Self-Payment or Short Payment Provision in Section 2.02. If your coverage is not reinstated within this six-month

period, you must complete the initial eligibility qualification rules in order to become covered under the Plan again.

(2) However, if you have been covered under the Plan's disability coverage provisions and you return to work before that coverage expires, your regular Plan coverage is reinstated when the combination of hours you work and your reserve bank totals 120 hours. You will not have to meet the initial eligibility requirements.

2.06 **Loss of Eligibility for Cause**

(1) You and your Eligible Dependents lose eligibility, and your reserve account will be canceled, if you:

(a) accept employment for work in covered employment for a Non-Signatory Employer; or

(b) go into business for yourself in the type of work covered by the Union's Collective Bargaining Agreements without being signed to such an agreement; or

(c) become a partner of or a corporate officer of any Non-signatory Employer who engages in work that is Covered Employment; or

(d) fail to stop working for a delinquent employer, when requested by the Union to do so.

(2) You lose coverage and the hours in your reserve account for the first day of the month after one of the above events occur. If you enter into another trade because you become disabled and are unable to work in Covered employment, you will not lose your reserve account upon approval by the Trustees and proof of your disability.

(3) If the Union asks you to work for a Non-Signatory Employer as part of the Union's organizing activities and makes contributions on your behalf to the Trust, you will not lose any hours in your reserve account because of that employment.

(4) If your coverage ends for cause, you will again be eligible for participation the month when you complete 720 hours of work under the terms of a collective bargaining agreement that requires contributions to the Trust. The work must be performed within a subsequent 12-month period. If your coverage ends for cause, you are not eligible to continue coverage under the Self-Payment or Short Payment Provisions in Section 2.02.

2.07 **When Employee Coverage Ends**

(1) Your coverage ends on the earliest of the following dates:

(a) the last day of the month in which your reserve account falls below 120 hours after

deduction of 120 hours for the current month;

(b) the date the Plan terminates;

(c) the date you terminate your membership in one of the classes eligible for coverage;

(d) the date the class of persons you belong to is no longer covered under the Plan;

(e) the date you terminate your continuation coverage, if any, for any reason listed in Section 6.

(f) the date you fail to make timely payments that you may owe for plan coverage;

(g) the date you become eligible for medical benefits under any other group insurance plan between a local union of the International Union of Bricklayers and Allied Craftsman other than Local 3. However, your reserve account hours will not be canceled for a period of one year requiring contributions to this Trust. If you return within this period and notify the Plan Administration Office that you are no longer covered by any group plan as described above, your coverage will begin on the first of the month following the month in which you give notice to the Plan Administration Office until your reserve account hours are exhausted;

(h) the date you are terminated for cause, as provided in Section 2.06;

(i) the date of your death;

(j) the date you enter full-time active duty in the Armed Forces; or

(k) the date your coverage under the Self-Payment or Short Payment Provisions in Section 2.02 terminates.

(2) After you are covered under the Plan, your coverage will not be rescinded, unless you have performed an act, practice or omission that constitutes fraud, or unless you make an intentional misrepresentation of material fact. For purposes of this rule, a rescission is a retroactive cancellation or discontinuance of coverage, other than for a failure to timely pay required premiums or contributions toward the cost of coverage.

2.08 **Service in the Armed Forces**

(1) No coverage is provided to any individual while he or she is serving in the armed forces of any country. However, if a person is covered as an employee, and is beginning a period of qualified service in any of the Uniformed Services of the United States, and has provided notice to the Administration Office, he or she may elect one of the following options for coverage of his or her Eligible Dependents:

(a) to continue coverage for his or her Eligible Dependents, by payment of a monthly premium equal to the COBRA premium, until the earlier of: 1) the end of the period during which the employee is eligible for reemployment under USERRA, or 2) 24 months after the employee's entry into the Uniformed Services; or

(b) to have his or her reserve of hours applied for coverage of his or her Eligible Dependents until it is exhausted, and thereafter continue coverage for his or her Eligible Dependents under COBRA; or

(c) to waive all coverage for his or her Eligible Dependents while in the Uniformed Services.

(2) If an employee fails to notify the Administration Office of his or her entry into military service, he or she shall be deemed to have elected option (b). If an employee elects option (a) or (c), and returns to, or becomes available for, covered employment within the applicable period under USERRA, then his or her reserve of hours shall be reinstated.

2.09 **During a Leave Under the Family and Medical Leave Act**

If you work for an individual employer which is required to provide health and welfare plan coverage under the Family and Medical Leave Act ("the FMLA") during a qualifying leave under the FMLA, and you are eligible for, and take, such leave, then the following special rules apply:

(1) Your employer must make contributions to this Plan on your behalf for every period of FMLA leave. The amount of the contributions for each month of FMLA leave shall be equal to the hourly rate then in effect for you times 120 hours per month. If your period of FMLA leave is less than a month, the amount of contributions shall be prorated accordingly.

(2) Your employer must report the number of hours of FMLA leave and make the required contributions with its regular monthly reports. Your employer must also provide evidence in a form satisfactory to the Trustees that the leave is one for which contributions to this Plan are required by the FMLA.

(3) Your hour bank reserve account will be credited with the same number of hours as your employer contributes for you under these FMLA rules. All other Plan rules concerning

hour bank reserve accounts remain in effect during FMLA leave.

(4) Crediting of hours for you, and your employer's obligation to contribute, terminates under these rules upon termination of your FMLA leave. Your employer must inform the Plan Administration Office in writing when your FMLA leave terminates. If you do not return to work for the employer at the termination of your FMLA leave, you are eligible for COBRA Continuation as provided elsewhere in this Plan, with the termination of FMLA leave deemed the qualifying event as a termination of employment.

2.10 **Delinquent Contributions from Employers**

(1) Delinquent Contributions Paid Within 12 Months of the Period the Delinquent Hours Were Worked.

(a) If the calendar month during which the delinquent contribution is received is within twelve months of the period you worked the delinquent hours and you were covered by the Plan for a least one month in the six calendar months prior to the work month for which the delinquent contribution is received, then you will receive reimbursement for any COBRA payment you made for the delinquent month. The reimbursement rate shall be the lesser of (1) the amount of the COBRA payment you made or (2) 120 times the hourly contribution rate for work performed during the delinquent month (and any remaining hours worked in the delinquent month in excess of 120 will be added to your reserve account and available for prospective coverage). If you did not make a COBRA payment for the delinquent month, the delinquent payment will be added to your reserve account up to the reserve account maximum of 480 hours.

(b) If the calendar month during which the delinquent contribution is received is within twelve months of the period you worked for delinquent hours and you were not covered by the Plan for a least one month in the six calendar months prior to the work month for which the delinquent contribution is received and you have since established eligibility, the delinquent contributions will be added to your reserve account. If you have not established eligibility, the delinquent contributions will be counted toward initial eligibility.

(2) Delinquent Contributions Paid More Than 12 Months After the Calendar Month the Delinquent Hours Were Worked.

(a) If your employer pays delinquent contributions more than twelve months after the period you worked the delinquent hours and your employer reports that you worked at least 120 hours in covered employment in the 6 calendar months before the receipt of the delinquent contribution, then you will receive reimbursement for any COBRA payment you made for the delinquent month. The reimbursement rate shall be the lesser of (1) the amount of the COBRA payment you made or (2) 120 times the hourly contribution rate for work performed during the delinquent month (and any remaining hours worked in the

delinquent month in excess of 120 will be added to your reserve account and available for prospective coverage). If you did not make a COBRA payment for the delinquent month, the delinquent payment will be added to your reserve account up to the reserve account maximum of 480 hours.

(b) If your employer pays delinquent contributions more than twelve months after the period you worked the delinquent hours and you have not been reported by any employer as having worked in covered employment for at least a total of 120 hours in the 6 calendar months prior to the receipt of the delinquent contribution, then you will not receive credit for the delinquent contribution. However, if the Trust receives 120 hours of contributions for work you perform within the 9 calendar months following the month in which the delinquent contribution is received, you may apply to the Trustees to have the delinquent contribution credited to your reserve account up to a maximum of 480 hours. The Trustees have the discretion to approve or deny your application.

(3) If your employer pays delinquent contributions for a delinquent period of not less than six consecutive months, for eligibility months affected by the delinquency for which your employer reports that you worked at least 120 hours in covered employment, you may receive reimbursement for the medical and dental premiums you paid for coverage for you and your family, up to 120 times the hourly contribution rate for work performed during the delinquent month (and any remaining hours worked in the delinquent month in excess of 120 will be added to your reserve account and available for prospective coverage), provided the following requirements are satisfied:

(a) The employer pays the delinquent contributions in full; and

(b) The medical and dental coverage you enrolled in was a group health plan offered by your Spouse's employer (i.e., not coverage purchased on the individual market); and

(c) The medical coverage provided by your Spouse's employer provides minimum value pursuant to Internal Revenue Code §36B(c)(2)(C)(ii); and

(d) You provide proof of your payment of premiums for the medical and dental coverage.

2.11 Self-Pay Eligibility for Participants Working Out of the Area Under a Lower Contribution Rate

(1) Participants who work in an area that has a lower contribution rate than this Fund will have their hours reciprocated back to the BAC Local 3 Health and Welfare Fund on a pro-rata basis. This means that if you work in an area that has a lower contribution rate, you will only receive credit for a percentage of the hours you work. For example, if you work in an area that has a contribution rate that is 10% lower than the contribution rate for the B.A.C. Local 3 Health and Welfare Fund, you will receive credit for only 90 % of the hours you work out of area.

(2) The Trustees recognize that this system of pro-rata crediting may sometimes make it difficult for traveling Participants to maintain the 120 hours needed for monthly eligibility. Therefore, if your hour bank falls below 120 hours due exclusively to this pro-rata crediting, you will be permitted to self-pay the additional hours needed to maintain eligibility, if you meet all of the following requirements:

(a) You begin self-paying hours for the first month your hour bank falls below 120 hours because of a lower reciprocal contribution rate. This means that in some instances you may have to purchase retroactive coverage because there is often a lag between when you perform work out of the area and the date the reciprocal contributions arrive at the B.A.C. Local 3 Health and Welfare Trust Fund; and

(b) You have had three consecutive years of coverage under the B.A.C. Local No. 3 Health and Welfare Plan; and

(c) Your coverage in at least nine of the most recent twelve months was earned through active hours of work; and

(d) The combination of reciprocal hours credited on a reduced pro-rata basis and the hours in your hour bank is fewer than 120 hours, and, therefore, not sufficient to maintain coverage; and

(e) During the month(s) for which you make self-payments to maintain eligibility, you were working out of the area and having hours reciprocated back to the B.A.C. Local 3 Health and Welfare Trust Fund at a lower contribution rate; and

(f) All of your self-pay contributions are timely. To be considered timely, the initial contribution and all subsequent contributions must be received within 30 days of the date the Fund Office sends out the self-pay balance statement to you.

2.12 Self-Pay Eligibility for Participants Working as Apprentices for Non-Signatory Employers under Division of Apprenticeship Standards (DAS) Rules

If you are eligible for coverage as an active employee under Section 2 of these rules, and are dispatched as an apprentice to work for a non-signatory employer under DAS rules, you may self-pay the hours needed to continue your coverage during such employment. The amount you will be required to pay each month to continue your coverage will be calculated at the number of hours needed to meet the 120-hour requirement multiplied by the hourly contribution rate applicable under the Collective Bargaining Agreement. For example, if you had 70 hours in your reserve account, you would be required to pay for 50 hours at the hourly contribution rate then in effect in order to maintain your coverage for one month.

2.13 COBRA Continuation Coverage

If your coverage terminates under this Plan, you may be eligible to continue your coverage under the federal law known as COBRA. See Section 6 for more information on COBRA.

3. ELIGIBILITY RULES FOR NON-BARGAINING UNIT EMPLOYEES AND OFFICER/SHAREHOLDERS

3.01 Eligibility as a Non-Bargaining Unit Employee

(1) Effective November 22, 2005, the Plan was closed to new non-bargaining unit employees. Prior to March 1, 2012, participants who were non-bargaining unit Participants on November 22, 2005 and have remained Participants continuously since that time, were eligible to continue to receive HMO coverage only under Kaiser or UHC/PacifiCare, unless such coverage was not available in the Participant's geographical area. Eligible non-bargaining unit Participants outside the Kaiser or UHC/PacifiCare service areas were offered the UHC/PacifiCare PPO. Effective March 1, 2012, participants who were non-bargaining unit Participants on November 22, 2005 and have remained Participants continuously since that time, are eligible to receive coverage under Kaiser or the self-funded PPO plan.

(2) Effective July 1, 2014, to remain eligible, non-bargaining unit participants must meet both of the following requirements:

(a) At least 1440 bargaining unit member hours must be reported and paid annually for each non-bargaining unit employee who participates; and

(b) At least 110 hours must be reported and paid for at least one bargaining unit employee each month.

If an employer fails to report at least 110 hours for at least one bargaining unit employee in any month, coverage for all non-bargaining unit employees of that employer will be terminated. The participation of non-bargaining unit employees will be reviewed annually to determine if the minimum number of bargaining unit member hours have been reported.

(3) Effective May 1, 2015, the non-bargaining unit employees of an employer may be reported to the Plan and covered as non-bargaining unit Participants if their employer was reporting to the Plan on November 22, 2005 on behalf of its non-bargaining unit employees. Non-bargaining unit Participants are eligible for coverage under Kaiser or the self-funded PPO plan. For each non-bargaining unit employee reported by an employer the requirements of (2) must be met.

(4) Effective January 1, 2015, an employer previously obligated to contribute to another Taft-Hartley multiemployer health and welfare plan that is now obligated to contribute to this

Plan due to a collective bargaining change, may report its non-bargaining unit employees to this Plan if the employer was making contributions on behalf of its non-bargaining unit employees to the prior health and welfare plan on November 22, 2005. For each non-bargaining unit employee reported by an employer, the requirements of (2) must be met.

3.02 Eligibility as an Officer/Shareholder

If you are a Participant who becomes an officer or shareholder of an Employer, you may continue to participate in the Plan, provided:

(1) the Board of Trustees approves your continued participation;

(2) you are working with the tools of the trade;

(3) your Employer is incorporated and employs at least one bargaining unit employee who has no ownership interest in the Employer and is participating in the Plan under the terms of a Collective Bargaining Agreement or in a plan that benefits workers in the masonry trade under the terms of a Collective Bargaining Agreement;

(4) your Employer signs a participation agreement;

(5) your participation meets the requirements under applicable law; and

(6) you apply for participation within 30 days of becoming eligible for participation as an officer/shareholder.

3.03 COBRA Continuation Coverage

If your coverage terminates under this Plan, you may be eligible to continue your coverage under the federal law known as COBRA. See Section 6 for more information on COBRA.

4. ELIGIBILITY RULES FOR DEPENDENTS OF ACTIVE EMPLOYEES

4.01 Eligible Dependent Coverage

(1) (a) For new participants, your Eligible Dependent's coverage becomes effective on the same date as your coverage, provided he or she has been properly enrolled as a dependent. After initial enrollment, whenever you acquire a new Eligible Dependent through marriage, registration of a Domestic Partner, birth or adoption, you need to advise the Administration Office and properly enroll him/her in your medical plan no later than 30 days (or 60 days, as applicable) after the marriage, registration of Domestic Partnership, birth or placement for adoption. Failure to do this may mean a lapse in your

Eligible Dependent's coverage. Newly-acquired dependents because of birth, adoption, or placement for adoption become eligible on the date of the birth, adoption, or placement for adoption. Newly-acquired dependents because of marriage or registration of a Domestic Partnership become eligible for benefits on the first day of the month after they are properly enrolled as dependents. Unless you terminate coverage for your Eligible Dependents under paragraph (b) below, your Eligible Dependent's coverage ends on the same date your coverage ends or when he or she is no longer an Eligible Dependent. However, if you should die while covered under this Plan, your covered Eligible Dependents will continue to be covered at no charge until the expiration of the coverage available under your reserve account. Thereafter, they may be eligible for Continuation Coverage under the COBRA provisions of the Plan.

(b) (i) If you are eligible for coverage under the Plan as an Employee, and any of your Eligible Dependents are eligible for coverage under an employer-sponsored health plan that meets the Internal Revenue Code definition of a "high deductible health plan" (HDHP) for purposes of allowing tax-deductible contributions to a health savings account, you may opt not to enroll or to terminate coverage of such Eligible Dependents in the medical benefit package under which you are covered. You must provide documentation to the Administration Office that your Eligible Dependents are eligible for coverage under a qualified, employer-sponsored HDHP.

(ii) Your Eligible Dependents will remain eligible for dental, vision, life insurance, and accidental death and dismemberment benefits for any month in which you are eligible for coverage as an Employee under the Plan, provided that such coverage will be effective only after each Eligible Dependent is properly enrolled. All other Plan rules regarding eligibility and coverage of dental, vision, life insurance, and accidental death and dismemberment benefits will continue to apply to your Eligible Dependents. If your Eligible Dependents are covered under the Plan's dental and vision benefit packages under this rule, they may continue such coverage in accordance with the Plan's COBRA provisions.

(2) "Eligible Dependent" means:

(a) your lawful Spouse.

(b) each child until the last day of the calendar year in which he or she attains age 26.

(c) your unmarried dependent child of any age if he or she has a physical or developmental disability which began before coverage would otherwise have ended, and which makes him or her incapable of self-sustaining employment.

(d) your Domestic Partner, if your Domestic Partnership has been registered with a governmental agency pursuant to state or local law authorizing such registration, and children of such Domestic Partner.

As part of this Domestic Partner coverage, this Plan pays the incidental federal employment payroll taxes, in accordance with governing IRS and U.S. Department of Labor rulings.

(3) The term "child" means:

(a) your direct offspring;

(b) a stepchild;

(c) a minor placed with you for the purpose of legal adoption. Such child shall be covered from the date he or she is placed in your physical custody or the date you have assumed a legal obligation to provide the child's support, if earlier. Coverage will end on the date this child is no longer in your custody or the date you no longer anticipate adopting the child;

(d) a foster child or other child for whom you have assumed legal guardianship.

(4) The age limit which applies to dependent children will not apply to any covered child of yours who remains dependent on you for support and maintenance because he or she becomes incapable of working:

(a) due to a physical or developmental disability; and

(b) before reaching the limiting age.

Written proof satisfactory to the Board of Trustees of his or her incapacity and dependency must be furnished to the Plan Administration Office at least 31 days prior to the dependent reaching the limiting age.

(5) The child of an Eligible Dependent shall not be eligible for any benefits provided by this Plan, except as provided above.

(6) If a person has dual coverage under the Plan (a) both as an Employee and an Eligible Dependent, or (b) as the Eligible Dependent of two Employees, the total amount of benefits payable under the Plan will not exceed 100% of the actual eligible charges incurred.

(7) Dependent does not mean anyone who (a) lives outside the United States; or (b) is in the Armed Forces of any country.

4.02 **Qualified Medical Child Support Orders**

The Plan will comply with any Medical Child Support Order ("MCSO") with which it is

properly served and which is a Qualified Medical Child Support Order ("QMCSO") under applicable federal law. Upon service with an MCSO, the Plan Administration Office will review the MCSO under procedures adopted by the Board of Trustees, and determine within a reasonable time whether or not the MCSO is a QMCSO. The determination that an MCSO is not a QMCSO is subject to the Appeals Procedures provided elsewhere in this Plan.

4.03 **Eligibility Date**

(1) Your dependents who meet the Plan's requirements will become eligible for benefits on the date that you become eligible, provided that they have been properly enrolled as dependents.

(2) Newly-acquired dependents become eligible for benefits on the first day of the month after they are properly enrolled as dependents, which must occur no later than 30 days (or 60 days, as applicable) after the marriage, birth or placement for adoption which makes the dependent eligible.

4.04 **Termination of Dependent Coverage**

The coverage of any dependent will terminate on whichever of the following dates occurs first:

(1) the date such dependent ceases to be an Eligible Dependent;

(2) the date your coverage under the Plan terminates;

(3) the date the dependent enters the Armed Forces on full-time active duty;

(4) with respect to life insurance, the date that premium payments for the protected person's life insurance coverage hereunder are discontinued because of disability;

(5) the last day of the month during which you request that coverage of your dependents be terminated because they are eligible for coverage under an employer-sponsored high deductible health plan, as defined in Section 4.01(b) of these Formal Plan Rules; or

(6) if you are an active eligible employee and you die, coverage for your dependents will terminate on the date your coverage would have terminated had you lived.

4.05 **Special Enrollment**

If you decline enrollment for yourself or your Eligible Dependents (including your Spouse) because of other health insurance or group health plan coverage, you may in the future be able to enroll yourself or your Eligible Dependents in this Plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new

dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your Eligible Dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

Eligible Dependents may be enrolled in the Plan if they lose eligibility under Medicaid or a State Sponsored Children's Health Insurance Plan and/or upon becoming eligible for a special premium assistance subsidy under Medicaid or a State Sponsored Children's Health Insurance Plan. You must file your enrollment form with the Administration Office within 60 days of your Eligible Dependent losing coverage under Medicaid or a State Sponsored Children's Health Insurance Plan or within 60 days of your Eligible Dependent becoming eligible for premium assistance under Medicaid or a State Sponsored Children's Health Insurance Plan.

5. ELIGIBILITY RULES FOR RETIREES

5.01 Eligibility

You will be eligible for retiree coverage if you meet the requirements of paragraphs (1) through (6) below:

(1) (a) you were an active Participant as an Employee for five of the eight years immediately preceding your retirement; or

(b) effective for retirements on and after February 1, 2013, you were an active Participant as an Employee for five of the twelve years immediately preceding your retirement, and you are able to demonstrate that you would have met the requirement in subparagraph (a), above, but for lack of work in the Industry; and

(2) you are receiving a pension from a pension plan administered and established under any trust to which either (a) the Union appoints trustees or (b) the Plan has sent reciprocity payments based on your employment within the geographic jurisdiction of the Union; and

(3) (a) you apply for coverage within 60 days of your retirement; or

(b) if you selected COBRA coverage upon your retirement, you apply for retiree coverage within 60 days of the termination of COBRA coverage;

(4) you make the required premium payment;

(5) if eligible for Medicare, you are enrolled in both Part A and Part B of Medicare; and

(6) if eligible for Medicare, you may elect Kaiser coverage only if enrolled in Kaiser Senior Advantage and residing in the Senior Advantage service area.

Retiree medical coverage options are Kaiser and UHC HMO only, for retirees residing within the service areas of Kaiser or UHC. Retirees may also apply for dental and vision

coverage at the time you elect coverage for yourself, for an additional premium. A surviving Spouse or Domestic Partner of an eligible retiree may continue coverage if the surviving Spouse or Domestic Partner maintains coverage continuously be paying the monthly cost determined from time to time by the Board of Trustees and is not remarried or reregistered as a Domestic Partner. Premium payments are due to the Trust Fund no later than the 20th of the month prior to the month of coverage. If you or your surviving Spouse or Domestic Partner fails to make premium payments in a timely manner, coverage will be terminated.

5.02 **Dependent Eligibility**

Eligible Dependents for Retirees are the same as for Active Participants. You must enroll your Eligible Dependents at the time you elect medical coverage for yourself, subject to the following exceptions. Eligible Dependents not enrolled at the time you elect medical coverage for yourself can only be enrolled at a later date under the following rules:

(1) Coverage for Subsequently Acquired Dependents. If you get married or register a Domestic Partnership, or your child is born, placed with you for adoption or foster care, or becomes your step-child after you begin retiree coverage, you can add your Spouse, Domestic Partner, or child by giving notice within 30 days of the applicable event.

(2) Deferred Election of Coverage for Spouses and Domestic Partners. After you begin retiree coverage, if your Spouse or Domestic Partner loses other employment-based coverage, you may enroll your Spouse or Domestic Partner if you provide the following documentation to the Administration Office within 63 days of the loss of other employment-based coverage:

(a) Proof that, on the date of your retirement, your Spouse or Domestic Partner had been employed for at least the prior 12 consecutive months;

(b) Proof that your Spouse or Domestic Partner had been continuously covered under other employment-based coverage from the date of your retirement; and

(c) Documentation that the loss of your Spouse's or Domestic Partner's most recent other employment-based coverage was due to termination of employment, or termination by the employer of employer-sponsored coverage, rather than due to his/her election to discontinue participation in that other coverage.

5.03 **Medicare**

(1) Benefits paid to a Participant, Pensioner, Spouse or Domestic Partner are secondary to Medicare Part A and Part B. In order to receive coverage, all Pensioners and Eligible Dependent Spouses or Domestic Partners who are eligible for Medicare must enroll in both Part A and Part B of Medicare.

(2) The maximum benefits provided by the Plan to Pensioners eligible for Medicare,

because of age, disability, or kidney failure, are the level of benefits that would be paid to a Medicare contracted Hospital or the amount the Plan would have paid for other medical services if Medicare had paid primary benefits.

(3) If the Pensioner, Spouse, Domestic Partner or Eligible Dependent is eligible for Medicare, he/she may elect Kaiser coverage only if enrolled in Kaiser Senior Advantage and residing in the Senior Advantage service area.

5.04 **Loss of Retiree Coverage for Cause**

(1) You and your Eligible Dependents will not be eligible to receive retiree health coverage under this Plan, if you:

(a) accept employment for work in covered employment for a Non-Signatory Employer; or

(b) go into business for yourself in the type of work covered by the Union's Collective Bargaining Agreements without being signed to such an agreement; or

(c) become a partner of or a corporate officer of any Non-signatory Employer who engages in work that is Covered Employment; or

(d) fail to make the required premium payment.

(2) You and your Eligible Dependents lose coverage for the first day of the month after one of the above events occur.

5.05 **Disclaimer**

All retiree benefits are provided under this Plan to the extent that funds are available for such coverage from current contributions by employers and retirees. Retiree coverage is not supported by any long-range funding program. The Board of Trustees reserves the sole right to modify or discontinue entirely the coverage provided to retirees and their dependents, including the right to set the premium rate for retiree coverage, as the financial circumstances of the Fund may warrant.

5.06 **COBRA Coverage Continuation Applicable to Retirees**

The federal law known as COBRA requires that participants and beneficiaries of this Plan who do not elect retiree coverage will be allowed to extend their health coverage by making self-payments. See Section 6 for more information on COBRA.

6. COBRA CONTINUATION COVERAGE

An employee or eligible dependent may elect continued coverage under COBRA as follows whenever his or her coverage would otherwise terminate under the Plan as a result of a qualifying event defined below, unless all medical plan contracts of this Fund are terminated before the person's qualifying event. If an employee is eligible for both COBRA and either Disability Coverage or coverage under the Self-Payment or Short Payment Provisions in Section 2.02, an election of any extended coverage option other than COBRA shall be deemed to be a rejection of COBRA at that time. COBRA coverage may be elected when the period of other extended coverage ends, for the remaining months of the original COBRA Continuation Coverage period measured from the initial qualifying event. However, if an employee elects any of the other extended coverage options, and is disqualified from, or fails to make payments for, his or her chosen coverage, he may not elect COBRA at that time.

6.01 Eligibility for COBRA

(1) A Participant or eligible dependent is eligible for continued coverage for up to 18 months, at 102% of Plan cost, if and when the Participant's coverage has terminated because of termination of employment or low hours, unless the Participant was fired for gross misconduct. A veteran who returns to covered employment after less than 31 days of military service shall only be charged 100% of Plan cost.

(2) A Participant and/or eligible dependent is eligible for an additional 11 months of coverage, for up to a total of 29 months, at 150% of Plan cost, if within the original 18-month period, the Participant or dependent is totally and permanently disabled, and has obtained a Social Security Disability Award which finds that he or she was so disabled within 60 days of the original loss of coverage due to termination of employment or reduction of hours.

(3) An eligible dependent is eligible for continued coverage, for up to 36 months, at 102% of Plan cost, if and when the dependent's coverage has terminated because of one of the following qualifying events:

(a) the death of the Participant;

(b) divorce of the Participant and Spouse, or dissolution of the Participant's domestic partnership;

(c) a child loses eligibility as a dependent; or

(d) the Participant becomes entitled to Medicare.

(4) If a Participant is eligible for and elects one of the Plan's extended coverage options, including but not limited to Disability Coverage and coverage under the Self-Payment or Short Payment Provisions set forth in Section 2.02, at a time when the Participant is also eligible for

COBRA continuation coverage, and then elects COBRA after the expiration of the other extended coverage option, the period for which the Participant and his or her dependent(s) are covered under COBRA Continuation Coverage is reduced by the period in which the Participant or dependent was covered under any of those options.

(5) If a second qualifying event occurs for a dependent, the dependent may then make a new election to receive COBRA coverage. However, the period in which the dependent shall be eligible for COBRA coverage shall not exceed 36 months from the original qualifying event.

(6) Notwithstanding any other provision of this section, no one is eligible for coverage on the grounds of termination of employment if, at the time of the termination of his or her Plan coverage, he or she was still employed by the Individual Employer who formerly made contributions to this Plan on behalf of that person, and the person's coverage has terminated for reasons other than a qualifying event.

(7) Any child born, adopted or placed for adoption after a Participant's COBRA effective date shall be covered from the date of birth or placement for adoption and will be covered as long as the Participant remains eligible and pays for COBRA coverage, subject to timely satisfaction of all applicable enrollment requirements.

6.02 **Procedures of COBRA Coverage**

(1) If a Participant is about to lose coverage because his or her reserve of hours ran out, the Trust Fund Office will notify the Employee of the qualifying event, and of the right to elect COBRA coverage.

(2) A dependent who is about to lose coverage because of divorce, dissolution of Domestic Partnership, death of the Participant, termination of dependent status, or entitlement of the Participant for Medicare, must notify the Trust Fund Office within 60 days of the qualifying event. The Trust Fund Office will then notify the dependent of his or her COBRA rights.

(3) An employee or a dependent who is eligible for COBRA coverage may elect "core coverage" (that is, all Plan benefits except dental care, vision benefits and life insurance and accidental death or dismemberment insurance), or full COBRA coverage (all Plan benefits, including dental and vision benefits, except life insurance and accidental death and dismemberment insurance). The election of one type of coverage by an employee with dependents applies to his or her dependents as well. However, if an employee does not elect COBRA coverage, his or her dependent(s) may elect either form of coverage for themselves. A dependent who, at the time of his or her qualifying event, is not enrolled in one of the Plan's medical benefit packages but is covered by the Plan's dental and vision benefit packages, may elect COBRA for those benefits under these procedures. If elected, the COBRA rate for dental and vision benefits only will be the difference between the full COBRA coverage rate and the "core coverage" rate.

(4) After a person receives notification from the Plan of the right to elect COBRA continuation coverage, he or she has 60 days to submit a written election of such coverage. If an eligible person elects COBRA coverage during this 60-day election period, the coverage shall be made retroactive to the initial termination date of coverage. A person who originally rejects COBRA coverage may rescind that election and elect COBRA coverage within the original 60 days, but in that case coverage will not be retroactive to the initial termination date of coverage.

(5) A person who elects COBRA coverage must make the first payment within 45 days of the election of COBRA coverage, and must also make subsequent payments for COBRA coverage by the 15th of each month for coverage for the next month.

6.03 **Termination of COBRA Coverage**

(1) COBRA coverage will be terminated for all persons if all benefits of this Fund are terminated.

(2) COBRA Coverage for any individual is terminated if any of the following occur:

(a) a payment for that individual is not made by the 15th of each month;

(b) the individual becomes covered under another group health plan either as an employee or dependent, unless the individual has a pre-existing condition that is excluded by the other plan; or

(c) the individual becomes entitled to Medicare.

7. CLAIMS AND APPEAL PROCEDURES FOR MATTERS WITHIN THE DISCRETION OF THE BOARD OF TRUSTEES OF THE BRICKLAYERS AND ALLIED CRAFTWORKERS LOCAL NO. 3 HEALTH AND WELFARE PLAN

7.01 **Applicability**

(1) The following claims and appeals procedures shall apply to all matters within the discretion of the Board of Trustees, including:

- claims and appeals regarding eligibility under this Plan for any type of benefit;
- claims and appeals regarding medical, prescription and vision benefits when the claimant has made a specific claim for medical, prescription or vision care, and the HMO or other provider has denied the claim on the grounds that the claimant or family member is not eligible for the benefit under the terms of this Plan;
- claims and appeals regarding self-funded PPO Plan benefits.

The claimant may appeal any adverse action with regards to compliance with the surprise billing protections under the No Surprises Act to the Plan's PPO provider, currently Anthem Blue Cross.

(2) There are three types of claims for medical benefits, each of which is subject to different rules.

- A **pre-service claim** is a claim for a benefit that requires prior approval under the terms of the Plan, such as inpatient admission pre-certification and other pre-certifications.

- An **urgent care claim** is a type of pre-service claim which, if the regular time periods for handling pre-service claims were followed: (1) could seriously jeopardize your life or health or your ability to regain maximum function or (2) would, in the opinion of a health care provider with knowledge of your condition, subject you to severe pain that could not be adequately managed without the care or treatment that is the subject to the claim.

- A **post-service claim** is a claim for a benefit that does not require prior approval under the terms of the Plan. A post-service claim involves a claim for payment or reimbursement for medical care or supplies that have already been received.

(3) The procedures specified in this Section 7 shall be the sole and exclusive procedures available to any individual who is adversely affected by any action of the Trustees, the Administration Office or any other Plan agent or fiduciary. The Board of Trustees reserves full discretionary authority to interpret Plan language and to decide all claims or disputes regarding right, type, amount or duration of benefits, or claim to any payment from this Trust. The decision of the Board of Trustees on any matter within its discretion shall be final and binding on all parties.

7.02 **Filing a Claim**

Participants, family members and assignees (hereinafter "claimants") may initiate a claim for benefits within 12 months of the date of service by contacting the Administration Office. An authorized representative may submit a claim on behalf of a claimant. In the case of a claim involving urgent care, a health care professional with knowledge of the claimant's medical condition may act as the authorized representative of the claimant.

7.03 **Notification of Failure to Follow Plan Procedures**

If the claimant fails to follow the Plan's procedures for filing a claim for benefits, the Administration Office will notify the claimant as soon as possible, but within 5 days following the failure, or if the claim is for urgent care, within 24 hours of the failure. This notification may be oral, unless the claimant or authorized representative requests it in writing.

7.04 **Notification of Claim Decision**

(1) Time Limits and Requests for Additional Information.

(a) Urgent Care Claims: If a claim is for urgent care, the Administration Office will notify the claimant of its determination as soon as possible, but no later than 72 hours after receipt of the claim by the Administration Office.

If the claimant fails to provide sufficient information to determine whether benefits are payable under the plan, the Administration Office will notify the claimant what information is necessary as soon as possible, but no later than 24 hours after receipt of the claim by the Administration Office. The claimant will have 48 hours to provide the specified information. The Administration Office will notify the claimant of its decision as soon as possible, but no later than 48 hours after the Administration Office's receipt of the specified information.

(b) Pre-service claims: If a claimant makes a claim for benefits before care has been provided to the Participant or family member, but the claim is not urgent, the Administration Office will notify the claimant of its decision as soon as reasonably possible, but no later than 15 days after the Administration Office received the claim.

The above 15-day time period may be extended for up to one additional 15-day period, but only due to matters beyond the Administration Office's control. If the Administration Office needs a 15-day extension, it will notify the claimant of the following: the reason for the delay; the expected date of decision; and any additional information the Administration Office needs to make the decision. If the Administration Office requires additional information, the claimant will have up to 45 days to provide the specified information. Once the specified information is provided, the Administration Office will notify the claimant of its decision within 15 days.

(c) Post-service claims: If a claimant makes a claim after care has been provided, the Administration Office will notify the claimant of its decision as soon as reasonably possible, but no later than 30 days after the Administration Office received the claim.

The 30-day time period may be extended for one additional 15-day period, but only due to matters beyond the Administration Office's control. If the Administration Office needs a 15-day extension, it will, before the end of the first 30-day period, notify the claimant of the following: the reason for the delay; the expected date of decision; and any additional information the Administration Office needs to make the decision. If the Administration Office requires additional information, the claimant will have up to 45 days to provide the specified information. Once the specified information is provided, the Administration Office will notify the claimant of its decision within 15 days.

(2) CONTENTS OF CLAIM DENIAL NOTICE: The Administration Office will provide the claimant with written notice if his or her claim for benefits is denied. If the claim involves urgent care, the information described below may be given orally, so long as a written notification is provided within three days after the oral notification. The notice will include the following information:

(a) a statement of the specific reason(s) for the denial;

(b) reference to the specific Plan provision(s) on which the denial was based;

(c) if the Administration Office's decision relied upon an internal Plan rule, guideline, protocol or similar criterion, either the specific rule, or a statement that the specific rule was relied upon and that a copy of such rule will be provided free of charge upon request;

(d) if the decision 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 decision, applying the Plan's terms to your medical circumstances, or a statement that such explanation will be provided free of charge upon request;

(e) a description of any additional information or documents that the claimant will need to submit if he or she wants the claim to be reconsidered, and an explanation of why that information is necessary;

(f) a description of the Plan's appeal procedures, including any expedited appeal procedures available if it is a claim for urgent care benefits; and

(g) a statement of the claimant's right to bring a civil action under ERISA § 502(a), if the appeal is unsuccessful.

7.05 **Appeal Procedures**

(1) GROUNDS FOR APPEAL: The claimant may appeal any adverse action within the discretion of the Board of Trustees to the Board of Trustees. The Board of Trustees hears all appeals regarding self-funded PPO Plan benefits apart from appeals relating to compliance with surprise billing protections under the No Surprises Act, all appeals regarding eligibility under this Plan for any type of benefit, and appeals regarding medical, prescription and vision benefits when the claimant has made a specific claim for medical, prescription or vision care, and the HMO or other provider has denied the claim on the grounds that the claimant or family member is not eligible for the benefit under the terms of this Plan. The claimant may appeal any adverse action with regards to compliance with the surprise billing protections under the No Surprises Act to the Plan’s PPO provider, currently Anthem Blue Cross.

(2) SUBMISSION OF APPEAL: Appeals must be in writing, and state in detail the matter or matters involved. To submit an appeal, the claimant must send a letter with any

documents and information that he or she wants the Board to consider, to the Administration Office.

(3) TIME LIMITS: Claimants must submit an appeal within 180 days of receiving the denial of the original claim by the Administration Office. If a claimant does not submit an appeal within 180 days of receiving a denial, he or she will be deemed to have waived any objection to the denial.

(4) STANDARD FOR REVIEW: The Board of Trustees has full discretionary authority to decide upon Plan benefits, to interpret the Plan language conclusively and to make a final determination of the rights of any Participant, beneficiary, assignee, or other person with respect to Plan benefits. The Board of Trustees will take into account everything that the claimant submitted, even material that was submitted or considered in the initial benefit determination. The Board of Trustees will not give deference to the initial determination. Neither a person who made the initial determination nor such a person's subordinate shall have a vote in the decision on appeal.

In deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment is Medically Necessary or appropriate, or the Board of Trustees' determination whether the Plan is complying with the non-quantitative treatment limiting provisions of ERISA Section 712 and § 2590.712, the Board of Trustees shall consult with a health care professional. The health care professional shall not have participated in making the initial benefit determination. The Board of Trustees shall, upon claimant's request, identify the health care professional, regardless of whether the Board of Trustees relied on his or her advice in making the decision.

(5) NOTIFICATION

(a) TIME LIMITS FOR NOTIFICATION

(i) Urgent Care Claims: The Administration Office will notify the claimant of the Board of Trustees' determination as soon as possible, but not more than 72 hours after receiving the claimant's request for an appeal.

(ii) Pre-Service Claims: The Administration Office will notify the claimant of the Board of Trustees' determination as soon as possible, but not more than 30 days after receiving the claimant's request for an appeal.

(iii) Post-Service Claims: The Board of Trustees will render a decision on the appeal at the regularly scheduled meeting immediately following the filing of the appeal, unless the appeal is filed within 30 days of the meeting, in which case the decision may be made at the second meeting following the appeal. The claimant shall be notified of the time and place of the meeting. The Board of Trustees does not need to

make a verbatim record, but the Administration Office shall keep any documents deemed pertinent or which the claimant requests to have included in the file.

If special circumstances require further extension, the decision will be made no later than the third meeting following the filing of the appeal. In such cases, the Administration Office will notify the claimant in writing of the extension, describing the special circumstances and the date the determination will be made, before the extension begins.

The Administration Office will notify the claimant of the Board of Trustees' determination as soon as possible, but no later than 5 days after the decision is made. The Board of Trustees' response period will be extended by any additional time it takes for the claimant to provide requested information.

(b) CONTENTS OF NOTICE: The Administration Office will send the claimant written notice of the Board of Trustees' decision on appeal. If the appeal has been denied, the notice will include the following information:

(i) the specific reason(s) for the denial;

(ii) reference to the specific Plan provision(s) on which the denial is based;

(iii) if the decision relied upon an internal Plan rule, guideline, protocol or similar criterion, either the specific rule, or a statement that the specific rule was relied upon and that a copy of such rule will be provided free of charge upon request;

(iv) if the decision 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 decision, applying the Plan's terms to your medical circumstances, or a statement that such explanation will be provided free of charge upon request;

(v) a statement that the claimant may view and receive copies of documents, records or other information relevant to the claim, upon request and free of charge; and

(vi) the claimant's right to bring a civil action under ERISA § 502(a).

(6) TIME LIMIT FOR CIVIL ACTION: A civil action arising from the denial of benefits must be filed within one year from the date on which the Board of Trustees provides notice that the claimant's appeal has been denied, regardless of any state or federal statutes establishing provisions relating to limitations of actions.

7.06 **Appeals to Medical Plan Carriers**

If a claim for medical or vision benefits is denied on grounds other than eligibility under

this Plan by Kaiser, UHC, another HMO, or other provider, the claimant's only appeal is under the appeals procedures provided by the HMO or other provider which rendered the decision to which the claimant objects.

7.07 **Waiver of Class, Collective and Representative Actions**

By participating in the Plan, Participants waive, to the fullest extent permitted by law, whether or not in court, any right to commence, be a party in any way, or be an actual or putative class member of any class, collective, or representative action arising out of or relating to any dispute, claim or controversy relating to the Plan, and Participants agree that any dispute, claim or controversy may only be initiated or maintained and decided on an individual basis.

8. DISCLOSURE OF PROTECTED HEALTH INFORMATION TO THE BOARD OF TRUSTEES AND "MINIMUM NECESSARY" POLICY

8.01 **Definitions**. Whenever used in this section, the following terms shall have the respective meanings set forth below.

(1) Plan means the Bricklayers and Allied Craftworkers Local No. 3 Health and Welfare Plan.

(2) Board means the Board of Trustees of the Bricklayers and Allied Craftworkers Local No. 3 Health and Welfare Plan, which is the plan sponsor as defined in ERISA § 3(16)(B).

(3) Health Information means information (whether oral or recorded in any form or medium) that is created or received by a health care provider, health plan (as defined in 45 CFR § 160.103), employer, life insurer, school or university, or health care clearinghouse (as defined in 45 CFR § 160.103) that relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual.

(4) Summary Health Information means information that summarizes the claims history, expenses, or types of claims by individuals for whom the Plan provides benefits, and from which the following information has been removed:

(a) names;

(b) geographic information more specific than state;

(c) all elements of dates relating to the individual(s) involved (e.g., birth date) or their medical treatment (e.g., admission date) except the year; all ages for those over age 89 and all elements of dates, including the year, indicative of such age (except that ages and elements may be aggregated into a single category of age 90 and older);

(d) other identifying numbers, such as Social Security, telephone, fax, or medical record numbers, e-mail addresses, VIN, or serial numbers;

(e) facial photographs or biometric identifiers (e.g., fingerprints); and

(f) any information the Board does not have knowledge of that could be used alone or in combination with other information to identify an individual.

(5) Protected Health Information ("PHI") means Health Information, including demographic information, that is (a) transmitted or maintained in any form or medium, (b) collected from an individual and created or received by a health care provider, health plan, employer, or health care clearinghouse, and (c) identifies the individual involved or with respect to which there is a reasonable basis to believe the information may be used to identify the individual involved.

(6) Reproductive Health Care means health care, as defined in 45 CFR § 160.103, that affects the health of an individual in all matters relating to the reproductive system and to its functions and processes. This definition shall not be construed to set forth a standard of care for or regulate what constitutes clinically appropriate reproductive health care.

8.02 **Disclosure of Summary Health Information**. Except as prohibited by 45 CFR § 164.502(a)(5)(i), the Plan may disclose Summary Health Information to the Board if the Board requests such information for the purpose of obtaining premium bids for providing health insurance coverage under the Plan or for modifying, amending, or terminating the Plan.

8.03 **Disclosure of Enrollment Information**. The Plan may disclose to the Board information on whether an individual is participating in the Plan, or is enrolled in or has disenrolled from a health insurance issuer or HMO offered by the Plan.

8.04 **Disclosure of PHI**. The Plan will disclose PHI to the Board only in accordance with 45 CFR § 164.504(f) and the provisions of this section.

8.05 **Permitted Uses of PHI by the Board**. PHI disclosed to the Board in accordance with this section may only be used for the Plan administrative functions that the Board performs.

8.06 **Certification**. The adoption of this section shall constitute certification by the Board that this Plan has been amended to include the provisions required under 45 CFR § 164.504(f).

8.07 **Obligations of the Board**. In addition to the requirements stated above, the Board also agrees to:

(1) not use or further disclose PHI other than as permitted in this section or as required by law;

(2) ensure that any of its agents to whom it provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Board with respect to such PHI, including the requirements of 45 CFR Part 164, Subpart D;

(3) not use or disclose PHI for employment-related actions or in connection with any other benefit or employee benefit plan;

(4) report to the Plan any use or disclosure of the information that is inconsistent with the permitted uses and disclosures in this section, including any breach of unsecured PHI as defined in 45 CFR § 164.402;

(5) make PHI available to individuals in accordance with 45 CFR § 164.524;

(6) make PHI available for individuals' amendment and incorporate any amendments in accordance with 45 CFR § 164.526;

(7) make the information available that will provide individuals with an accounting of disclosures in accordance with 45 CFR § 164.528;

(8) make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Department of Health and Human Services for purposes of determining the Plan's compliance with 45 CFR Part 164;

(9) if feasible, return or destroy all PHI received from the Plan that the Board maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, the Board will limit further its uses and disclosures of the PHI to those purposes that make the return or destruction of the information infeasible;

(10) ensure that adequate separation between the Plan and the Board, as required by this section and by 45 CFR § 164.504(f)(2)(iii), is established and maintained;

(11) not to use or disclose PHI, for any of the following activities: (1) To conduct a criminal, civil, or administrative investigation into any person for the mere act of seeking, obtaining, providing or facilitating Reproductive Health Care; (2) to impose criminal, civil, or administrative liability on any person for the mere act of seeking, obtaining, providing or facilitating Reproductive Health Care; and (3) to identify any person for any such purpose described in (1) or (2) of this subsection. This prohibition only applies where the relevant activity is in connection with any person seeking, obtaining, providing, or facilitating Reproductive Health Care, and the covered entity or business associate that received the request for PHI has determined that one or more of the following conditions exist: (a) the Reproductive Health Care is lawful under the law of the state in which such health care is provided under the circumstances in which it is provided; (b) the Reproductive Health Care is protected, required or authorized by Federal law, including the United States Constitution, under the circumstances in which such

health care is provided, regardless of the state in which it is provided; or (c) the presumption under 45 CFR 164.502(a)(5)(iii)(C) applies; and

(12) not use or disclose PHI potentially related to Reproductive Health Care for purposes specified in 45 CFR 164.512(d), (e), (f), or (g)(1), without obtaining an attestation that is valid under 45 CFR 164.509(b)(1) from the person requesting the use or disclosure and complying with all applicable conditions of 45 CFR 164.509.

8.08 **Disclosure Only to Designated Parties**. Pursuant to this section, the Plan will disclose PHI only to the Board and/or to individual Trustees.

8.09 **Disclosure Only for Designated Purposes**. Access to and use of PHI by the parties described in paragraph H shall be restricted to Plan administration functions that the Board performs for the Plan. Such access or use shall be permitted only to the extent necessary for these individuals to perform their respective duties for the Plan.

8.10 **Non-Compliance**. If any person described in paragraph H does not comply with the provisions of this section or the provisions of 45 CFR § 164.504(f), the Board shall provide a mechanism for resolving the issue of non-compliance, which may include disciplinary sanctions.

8.11 **Statement Required in Privacy Notice**. The Plan may not disclose, and may not permit a health insurance issuer or HMO providing services to the Plan to disclose, PHI to the Board except as would be permitted by the Plan in this section, and only if a separate statement describing the disclosure is included in the privacy notice of the Plan, the insurance issuer, or the HMO, as required by 45 CFR § 164.520.

8.12 **Disclosure of ePHI**. The Board will reasonably and appropriately safeguard electronic PHI (ePHI) created, received, maintained or transmitted to or by the Board on behalf of the Plan. Specifically, the Board will:

(1) implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the ePHI that it creates, receives, maintains or transmits on behalf of the Plan,

(2) ensure that adequate separation between the Plan and Board, as required by this section and by 45 CFR § 164.504(f)(2)(iii), is supported by reasonable and appropriate security measures,

(3) ensure that any agent or service provider to whom the Board provides this information agrees to implement reasonable and appropriate security measures to protect the information, including measures required by 45 CFR Part 164, Subpart D, and

(4) report to the Plan any security incident or breach of unsecured ePHI as defined in 45 CFR § 164.402 of which it becomes aware.

8.13 **"Minimum Necessary" Standard**. In accordance with 45 CFR § 164.502(b), as amended from time to time, reasonable efforts will be made to limit any use or disclosure by the Plan of PHI, including ePHI, or request for PHI, to the minimum necessary to accomplish the intended purpose of the use, disclosure, or request.

9. MISCELLANEOUS RULES

9.01 Dual Coverage

(1) When both Spouses or Domestic Partners are eligible under the Plan as employees, they may be covered as:

(a) an employee;

(b) a dependent Spouse or Domestic Partner; or

(c) both an employee and a dependent Spouse or Domestic Partner.

(2) When both parents of a child are covered under the Plan as employees, the child may be covered as a dependent of either or both parents.

(3) When both Spouses or Domestic Partners, or both parents of a child, are covered under the Plan as employees:

(a) benefits will be paid in accordance with the Coordination of Benefits provisions; and

(b) the combined benefits will not exceed 100% of the actual eligible charges incurred.

(4) Either Spouse or Domestic Partner, or parent, may submit a claim.

9.02 Coordination of Benefits

(1) If a covered person is also covered by another plan or plans, the benefits under this Plan and the other plan(s) will be coordinated. This means one plan pays its full benefits first, then the other plan(s) pay(s).

(a) The Primary Plan (which is the plan that pays benefits first) pays the benefits that would be payable under its terms in the absence of this provision.

(b) The Secondary Plan (which is the plan that pays benefits after the Primary Plan) will limit the benefits it pays so that the sum of its benefit and all other benefits paid by the Primary Plan will not exceed the greater of:

(i) 100% of total covered expense; or

(ii) the amount of benefits it would have paid had it been the Primary Plan.

(2) The Order of Benefit Determination paragraph below explains the order in which plans must pay.

(3) This provision will not apply to a claim when the covered expense for a claim period is $50 or less, but if (i) additional expense is incurred during the claim period, and (ii) the total covered expense exceeds $50, then this provision will apply to the total amount of the claim.

(4) Order of Benefit Determination

(a) When another plan does not have a COB provision or if it has a COB provision which differs from these rules, that plan must determine benefits first.

(b) When another plan does have a COB provision in accord with these rules, the first of the following rules which applies govern:

(i) If a plan covers the claimant as an employee, member, subscriber, or non-dependent, then that plan will pay its benefits first; except when (A) one plan covers the claimant as a laid-off or retired employee (or a dependent of such an employee), and (B) the other plan includes this COB rule for laid-off or retired employees (or is issued in a state which requires this COB rule by law), then the plan which covers the claimant as other than a laid-off or retired employee (or a dependent of such an employee) will pay first. If the other plan does not have this laid off or retired employee rule, and if, as a result the plans do not agree on the Order of Benefits, this rule will not apply.

(ii) If the claimant is a dependent child whose parents (A) are not divorced or separated, or (B) are divorced or separated, but the court decree states the parents will share joint custody, without requiring one parent to be responsible for coverage, then the plan of the parent whose birthday anniversary is earlier in the calendar year will pay first; except if both parents' birthdays are on the same day, rule (iv) below will apply. If another plan does not include this COB rule based on the parents' birthdays, but instead has a rule based on the gender of the parent, then that plan's COB rule will determine the order of benefits.

(iii) If the claimant is a dependent child whose parents are divorced or separated (except when sharing joint custody), then the following rules apply:

(A) A plan which covers a child as a dependent of a parent who by court decree must provide health coverage will pay first; providing that plan has actual knowledge

of the court decree.

(B) When there is no court decree which requires a parent to provide health coverage to a dependent child, or when the plan covering the parent has no knowledge of the court decree, the following rules will apply:

1. When the parent who has custody of the child has not remarried, that parent's plan will pay first.

2. When the parent who has custody of the child has remarried, then benefits will be determined by that parent's plan first, by the stepparent's plan second, and by the plan of the parent without custody third.

(iv) If none of the above rules applies, the plan which has covered the claimant for the longer period of time will pay its benefits first. To determine the length of time a person has been covered under a plan, two plans shall be treated as one if the claimant was eligible under the second within 24 hours after the first ended.

(A) The start of a new plan does not include:

1. a change in the amount or scope of a plan's benefits;

2. a change in the entity which pays, provides or administers the plan's benefits; or

3. a change from one type of plan to another.

(B) The claimant's length of time covered under a plan is measured from the claimant's first date of coverage under that plan. If that date is not readily available, the date the claimant first became a member of the group shall be used as the date from which to determine the length of time the claimant's coverage under the present plan has been in force.

(c) Where part of a plan coordinates benefits and a part does not, each part will be treated like a separate plan.

(5) Credit Savings. Where the Plan does not have to pay its full benefits because of COB, the savings will be credited to the claimant for the claim period. These savings would be applied to any unpaid covered expense during the claim period.

(6) How COB Affects Plan Benefit Limits. If COB reduces the benefits payable under more than one Plan provision, each benefit will be reduced proportionately. Only the reduced amount will be charged against any benefit limit in those Plan provisions.

(7) Right to Collect and Release Needed Information. In order to receive benefits, the claimant must give the insurer any information which is needed to coordinate benefits. With the claimant's consent, the insurer may release to or collect from any person or organization any needed information about the claimant.

(8) Facility of Payment. If benefits which this Plan should have paid are instead paid by another Plan, this Plan may reimburse the other Plan. Amounts reimbursed are Plan benefits and are treated like other Plan benefits in satisfying Plan liability.

(9) Right of Recovery. If this Plan pays more for a covered expense than is required by this provision, the excess payment may be recovered from:

(a) the claimant;

(b) any person to whom the payment was made; or

(c) any insurance company, service plan or any other organization which should have made payment.

(10) Definitions

(a) "Plan" means any of the following coverages, including Plan coverage and any coverage which is declared to be "excess" to all other coverages (except those declared to be excess by law), which provide benefit payments or services to a covered person for hospital, medical, surgical, dental, prescription drug or vision care:

(i) group, blanket or franchise insurance (except student accident insurance);

(ii) group Blue Cross and/or Blue Shield and other prepayment coverage on a group basis, including HMOs (Health Maintenance Organizations);

(iii) coverage under a labor-management trusteed plan, a union welfare plan, an employer organization plan or an employee benefits plan;

(iv) coverage under government programs, other than Medicare or Medicaid, and any other coverage required or provided by law;

(v) other arrangements of insured or self-insured group coverage.

If any of the above coverages include group and group-type hospital indemnity coverage, plan also means that amount of indemnity benefits which exceeds $100 a day.

(b) "Claimant" means the covered person for whom the claim is made.

(c) "Claim Period" means part or all of a calendar year during which the claimant is covered under the Plan.

(d) "Covered Expense" means any Medically Necessary, usual and customary item of expense which is covered at least in part by any of the Plans involved during a Claim Period; however, any expense which is not payable by the Primary Plan because of the claimant's failure to comply with cost containment requirements (such as second surgical opinions, pre-admission testing, pre-admission review of Hospital confinement, mandatory Outpatient surgery, etc.) will not be considered a Covered Expense by this Plan if it is the Secondary Plan. Where a Plan provides benefits in the form of a service rather than cash payments, the reasonable cash value of the service during a Claim Period will also be considered a Covered Expense. The difference in cost of a private Hospital room, and the cost of a semiprivate room is not considered a covered expense unless the claimants stay in a private room is Medically Necessary.

9.03 **Continuity of Care**

(1) If a covered person who is currently receiving treatment at a provider or facility for any of the below treatments, and whose provider or facility has a change in their contractual relationship (including, but not limited to, changing from an in-network facility/provider to an out-of-network facility/provider) then the covered person may request to continue to have services provided under that current provider or facility under the same terms and conditions as if no contractual change had occurred:

(a) a Serious and Complex Condition;

(b) the course of treatment for Pregnancy;

(c) the duration of a Terminal Illness;

(d) the performance of a scheduled nonelective surgery (including post-operative care);

(e) course of institutional or inpatient care.

(2) Conditions

(a) Continuity of Care is available only if requested by the covered person. Upon notice to the covered person of the change in contractual relationship, the covered person may elect to continue care at that current provider or facility under the same terms and conditions as if no contractual change had occurred for 90 days from the receipt of notice, or until the covered person no longer qualifies for continuing care, whichever is earlier.

(b) After the required period of Continuity of Care has expired, coverage will be provided in accordance with the terms of the Plan.

(c) In application, such continuity of care is intended to fully comply with Section 113 of the Consolidated Appropriations Act of 2021.

(3) Definitions

(a) "Pregnancy" means the three trimesters of pregnancy and the immediate postpartum period.

(b) "Serious and Complex Condition" means in the case of an acute illness, as a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or in the case of a chronic illness or condition, a condition that is life-threatening, degenerative, potentially disabling, or congenital; and requires specialized medical care over a prolonged period of time.

(c) "Terminal Illness" shall mean as determined under the Medicare hospice benefit and the individual is receiving treatment for such illness.

9.04 **Third-Party Reimbursement**. This provision applies if you or your dependent is injured or sick as a result of the act or omission of a Third Party.

(1) Definitions.

(a) "Reimbursement Rights" means the Plan's right to be reimbursed from any Fund of Money if:

(i) The Plan pays benefits for you or your dependent because of an Injury or Sickness caused or allegedly caused by a Third Party's act or omission; and

(ii) You, your dependent or a legal representative recovers an amount held in any Fund of Money from the Third Party, the Third Party's insurer, an uninsured motorist insurer or anyone else by reason of the Third Party's act or omission. This recovery may be the result of a lawsuit, a settlement or some other act. The Plan is entitled to be paid out of any recovery, up to the amount of benefits paid by the Plan.

(b) "Third Party" means another person, organization or account maintained by any organization.

(c) "Fund of Money" means any amount of money held by you, your agent, your attorney, any Third Party or the agent or attorney of any Third Party or any financial institution acting on behalf of anyone, which has been recovered at any time in connection with an Injury or Sickness caused or allegedly caused by a Third Party's act or omission for which Plan Benefits were paid to or for you or your dependent. The amount held in any Fund of Money shall be the property of the Plan, up to the amount paid out by

the Plan in Plan Benefits subject to the Plan's Reimbursement Rights.

(2) Reimbursement Rights. If you or your dependent has an Injury or Sickness caused or allegedly caused by a Third Party's act or omission:

(a) The Plan will pay benefits for that Injury or Sickness subject to its Reimbursement Rights on the condition that you or your dependent (or the legal representative of you or your dependent) (i) will not take any action which would prejudice the Plan's Reimbursement Rights, and (ii) will cooperate in doing what is reasonably necessary to assist the Plan in enforcing its Reimbursement Rights, including taking the actions detailed in subsection (3) below.

(b) The Plan's Reimbursement Right will be for 100% of benefits paid, regardless of whether or not you or your dependent has received full or any compensation and will not be reduced because (i) the recovery does not fully or partly compensate you or your dependent for all losses sustained or alleged; or (ii) the recovery and/or Fund of Money is not described as being related to medical costs or loss of income.

(c) The Plan may enforce its Reimbursement Rights by filing a lien with the Third Party, the Third Party's insurer or another insurer, a court having jurisdiction in this matter or any other holder of a Fund of Money, or any other appropriate party.

(d) The amount of the Plan's Reimbursement will not be reduced by legal fees or court costs incurred in seeking the recovery, unless the Plan agrees otherwise in writing.

(e) If you or your dependent were in a motor vehicle accident and maintain automobile insurance with medical coverage, then the Plan will pay secondary to the automobile insurance.

(f) The Plan will not enforce its Reimbursement Rights if the covered person’s Injury or Sickness was the result of domestic violence.

(3) Subrogation Agreement: You or your dependent will not be entitled to receive any benefits for such expenses under this Plan unless your or your dependent agree in writing to all of the following conditions:

(a) To reimburse the Plan, to the extent of all benefits paid by this plan as a result of such injuries, immediately upon obtaining any monetary recovery from any Third Party whether by action of law, settlement, or otherwise by the execution of a Subrogation Agreement or Lien Agreement;

(b) To irrevocably assign to the Plan all rights to recover monetary compensation from the Third Party to the extent of all benefits paid by this Plan and to give notice of this assignment directly to such Third Parties, their agents, or insurance carriers, or to any

agent or attorney who may represent you or your dependent. The assignment shall entitle the Plan to reimbursement from any sums held or received by the following Third Parties which are due to you or your dependent prior to any distribution of funds to you or your dependent and shall provide that such parties shall hold such sums in trust as a fiduciary for the benefit of the Plan. The parties who shall be bound by such assignment are:

a. Any party or insurance carriers making payments to or on behalf of you or your dependent; or
b. Any agent or attorney receiving payments for or on behalf of you or your dependent; or
c. Any account holder.

(c) To notify the Plan of any claim or legal action asserted against any Third Party or any insurance carrier(s) for such injuries as well as the name and address of such Third Party, insurance carrier(s), any agent or attorney who is representing or acting on behalf of you or your dependent or estate, or any person claiming a right through you on a form to be supplied by the Plan;

(d) To cooperate fully with the Trustees in the exercise of any assignment or right of subrogation, and not to take any action or refuse to take any action which would prejudice the rights of the Plan; and

(e) To acknowledge that this Plan shall have the right of recovery as provided under this Section should you or your dependent fail to execute an assignment, Subrogation Agreement, Lien Agreement, or any other documents required herein, or breach any of the terms of this Section.

A Subrogation Agreement is not required if the covered person's Injury or Sickness was the result of domestic violence.

(4) Trustee Rights

In addition, the Trust shall have the independent right to bring suit in your name or your dependent's name. The Trust shall also have the right to intervene in any action brought by you or your dependent against any Third Party, to and including you or your dependent's insurance carrier under any uninsured or underinsured motorist provision or policy. You and your dependent further must agree to take no action inconsistent with the requirements of this provision.

The Trustees expect full compliance with this Reimbursement Section. Therefore, the Trustees reserve the right to withhold future medical benefits from you and/or your dependent if you and/or your dependent has obtained a recovery from another source, as described above, and you and/or your dependent has not reimbursed the Plan as required. Future benefits will be withheld in an amount equal to the amount previously owed to the Plan until such time as the Plan's claim for reimbursement has been completely satisfied.

This will not reduce the Plan's right to be paid out of any recovery up to the amount of Plan benefits not yet reimbursed.

The Trustees also reserve the right to file suit against you and/or your dependents if you fail to comply with the terms of the Plan or the Subrogation Agreement.

9.05 **Assignment**

Coverage and a participant or beneficiary's rights under this Plan may not be assigned. A direction to pay a provider is not an assignment of any right under this Plan or any legal or equitable right to instate any court proceeding.

9.06 **Right to Recovery**

(1) If payments for claims made by the Plan are more than the amount payable under the Plan's rules, the Plan may recover the overpayment. The Plan may seek recovery from one or more of: (a) any insured person to or for whom benefits were paid; (b) any other insurers; (c) any institution, physician or other provider of medical care; or (d) any other organization.

(2) The Plan shall be entitled to deduct the amount of any such overpayment from any future claims payable to the Participant or any of his or her dependents.

9.07 **Rights of States**

(1) Payment of benefits with respect to a Participant shall be made in accordance with any assignment of rights made by or on behalf of such Participant or beneficiary of a Participant as required by a state plan for medical assistance approved under title XIX of the Social Security Act pursuant to section 1912(a)(1)(A) of that Act.

(2) In enrolling an individual as a Participant or beneficiary or in determining or making any payments for benefits of an individual as Participant or beneficiary, the fact that the individual is eligible for, or is provided, medical assistance under a state plan for medical assistance under title XIX of the Social Security Act shall not be taken into account.

(3) To the extent that payment has been made under a state plan for medical assistance approved under title XIX of the Social Security Act in any case in which the Plan has a legal liability to make payments for items or service constituting such assistance, payment for benefits under the Plan shall be made in accordance with any state law which provides that the state has acquired rights with respect to a Participant to such payment for such items or services.

9.08 **Coordination with Medicare**

(1) This provision applies when a covered person is (a) covered under this Plan, and (b) eligible for insurance under Medicare Parts A and B, whether or not he or she has applied for or has enrolled in Medicare. This provision applies before any other Coordination of Benefits provision.

(2) This Plan will be secondary with respect to Medicare for a covered person whenever allowed by law.

(3) If this Plan has secondary responsibility for the covered person's claims:

(a) Medicare benefits are determined or paid first; and

(b) then Plan benefits are paid, but, for services payable under both plans, Plan benefits and Medicare benefits combined will not exceed the amount that would have been paid by the Plan in the absence of Medicare.

(4) This Plan has secondary responsibility for the claims of a covered person who is eligible for Medicare, unless:

(a) the covered person is an active employee, or a dependent of an active employee, who is eligible for Medicare benefits because of age or disability; or

(b) the covered person is eligible for Medicare benefits due to end stage renal disease and Medicare does not already have primary responsibility, in which case this Plan has primary responsibility for up to 30 months beginning with the month in which such Medicare eligibility due to end stage renal disease begins.

(5) Small Employer Exception to Medicare Secondary Payer Rules for Working Aged.

(a) This Plan elects treatment under the Small Employer Exception from the "working aged" provision of the Medicare Secondary Payer rules provided for qualified participants and beneficiaries in multiemployer group health plans as set forth in Title XVIII of the Social Security Act of 1965, as amended, codified at 42 U.S.C. §1395y(b)(1)(A)(iii).

(b) Pursuant to the Small Employer Exception, this Plan will not have primary responsibility for claims with respect to an individual who is age 65 or older, and who is enrolled in the Plan, if the coverage of the individual under the Plan is by virtue of current employment status with an employer that does not have 20 or more individuals in current employment status for each working day in each of 20 or more calendar weeks in the current calendar year and the preceding calendar year, provided that a Small Employer Exception has been granted with respect to such individual by the Centers for

Medicare and Medicaid Services (CMS).

9.09 **Authority of the Board of Trustees**

The Board of Trustees reserves the power to revise all rules and procedures related to this Plan, including the power to terminate or change the coverage for any person or class of persons, to change the payment required for coverage, and to change the benefits payable by, or provided by, the Plan or by an insurance company, HMO, or other provider. Nothing in these Rules should be construed to make any benefits under the Plan vested, or as a waiver of any discretion or power conferred upon the Board of Trustees under the Trust Agreement.

The Board of Trustees has sole, full, and final discretionary authority to construe the terms of the Plan and all other documents relevant to the Plan for all purposes, including but not limited to the purposes of determining what benefits should be paid, the meaning and application of eligibility rules, the scope and application of the Plan's right to reimbursement, and the rights of assignees.

9.10 **No Surprises Act**

This Plan is compliant with the No Surprises Act, Title I of Division BB of the Consolidated Appropriations Act, 2021 ("the No Surprises Act"). To the extent any provision of this Plan is inconsistent with the No Surprises Act, the No Surprises Act shall govern. Subject to the definitions and applications of an Emergency Medical Condition, as defined under Part 2, Article 12 Section, 12.30 of the Plan, and Emergency Services as defined under Part 2, Article 12, Section 12.30 of the Plan, and notwithstanding any other provision of the Plan to the contrary, in accordance with the No Surprises Act, the Plan will apply the PPO in-network coinsurance percentage to:

(a) Non-PPO Air Ambulance Services;
(b) Emergency Services for treatment of an Emergency Medical Condition by Non-PPO Providers and Non-PPO emergency facilities (unless the covered person received proper notice and consented to the out-of-network billing rates for certain post-stabilization services as allowed under the No Surprises Act); and
(c) non-emergency services from Non-PPO Providers at PPO facilities (unless the covered person received proper notice and consented to the out-of-network billing rates as allowed under the No Surprises Act).

If a covered person visits a Non-PPO provider or Non-PPO facility in the situations described above, the Non-PPO provider or Non-PPO facility may not balance bill. In addition, the covered person's cost-sharing will be the same as if he or she had visited a PPO provider or facility, meaning that once he or she has met the applicable deductible, his or her coinsurance costs will be applied to the stop-loss limit and the coinsurance percentage will be the same as if

the covered person had visited a PPO provider or facility. For Non-PPO services covered by the No Surprises Act, the in-network coinsurance percentage shall be applied to the lower of the billed charge or the Qualifying Payment Amount. There will be no balance billing for services covered by the No Surprises Act.

For purposes of this Section, a Qualifying Payment Amount means the Plan's median contracted rate for the item or service in the same geographic region, as adjusted under DOL Regulation 2590.716-6(c).

For purposes of this Section, a "visit" with respect to services at a participating facility includes the furnishing of equipment and devices, telemedicine services, imaging services, laboratory services, and preoperative and postoperative services, regardless of whether the provider furnishing such items or services is at the facility. These services are not limited based on whether the provider furnishing the services is physically located at the facility.

For purposes of this Section for services covered under the Plan, the Plan will pay the provider or facility, subject to all applicable Plan limitations and exclusions, an agreed upon amount, and if there is no agreed upon amount, an amount determined by an Independent Dispute Resolution Entity in accordance with 9816(c) or 9817(b) of the Internal Revenue Code, section 716(c) or 717(b) of ERISA, or section 2799A-1(c) or 2799A-2(b) of the PHS Act.

9.11 **Provider Directory**

Anthem Blue Cross, UHC and Kaiser each maintain a provider directory. Anthem Blue Cross, UHC and Kaiser each update their respective provider directory every ninety (90) days and will respond to inquiries about the network status of a provider or facility within one business day. If a covered person receives inaccurate information from Anthem Blue Cross, UHC, Kaiser or the Plan Administration Office about a provider or facility's network status, the covered person will be liable only for in-network coinsurance for the services underlying the inquiry. It is the covered person's responsibility to confirm that the provider or facility selected is in-network at the time the covered person receives services.

PART 2 - SELF-FUNDED MEDICAL BENEFITS

10. BENEFITS PAYABLE

10.01 USING THE PPO PLAN

Covered Plan Participants and dependents have the right to obtain care from the Physician, Hospital or Institution of their choice. However, when you use providers belonging to the Plan's contracted Preferred Provider Organization (PPO), the Plan pays a higher share of your provider's charges. The Plan currently contracts with Anthem Blue Cross as its PPO. (For a current list of preferred providers, visit www.anthem.com/ca/ or call the Plan Administration

Office).

Covered charges for services or treatment rendered by Hospitals, Physicians and Institutions belonging to the Preferred Provider Organization can be calculated with different Covered Percentages. Such differences occur when using a:

PPO Hospital with a PPO Physician;
PPO Hospital with a Non-PPO Physician;
Non-PPO Hospital with a PPO Physician; and
Non-PPO Hospital with a Non-PPO Physician.

The differences in the Covered Percentages payable for covered charges are shown in Section 10.03.

Please note the following rules which apply to coverage under the Self-Funded PPO Plan:

Preferred Provider Discounts
The Plan has contracted with Anthem Blue Cross as its Preferred Provider Organization. Anthem Blue Cross has negotiated Contracted Rates with PPO Physicians and Hospitals. These rates are generally more favorable than the standard rates charged by similar providers for their services. **Therefore, it is always to your advantage, and to the advantage of the Plan, if you use PPO Providers when they are available.**

Office Visits
A co-payment amount will be charged for office visits as shown in the following chart:

	General Office Visit (Including Office Visit for Mental Health and Substance Use Disorder Benefits)	**Specialist Office Visit**
PPO Provider:	$10	$20
Non-PPO Provider:	$20	$40

Office visit co-payments are not subject to the Deductible, and will not be used to meet the Deductible or the Stop-Loss Limit described below. Co-payments for office visits will apply regardless of whether the Deductible has been met and will continue to be charged after the Stop-Loss Limit has been reached.

Virtual office visits will be treated as in-person office visits under the Plan.

Use of the Anthem Blue Cross telemedicine program, LiveHealth Online, will also be treated as an office visit under the Plan. LiveHealth Online provides 24/7 access to medical care through video consultations for minor injuries and illnesses. LiveHealth Online visits will require a co-payment equal to the PPO Provider office visit co-payment.

Utilization Review Program
The Plan requires Utilization Review ("UR") for all Hospital admissions and overnight stays at any medical facility. Utilization Review has proven effective in helping patients avoid unnecessary effort and expense, while still getting quality medical services at the most appropriate level of care.

The responsibility of notifying the UR Program lies with the covered person. Individuals are advised to contact the UR Program directly to verify that the admitting Physician or Hospital has made the required "notification." Utilization Review is provided by Anthem Blue Cross at (800) 274-7767.

Stop-Loss Limit
Another advantage to using PPO Providers is the lower stop-loss limit. The stop-loss limit works as follows:

When you use PPO Providers: After the out-of-pocket expenses for Covered Medical Charges incurred by each insured person reaches $1,250, the Plan pays 100% of the Covered Medical Charges which that insured person incurs for Covered Services of PPO Providers for the rest of the calendar year. For a family using PPO Providers, the stop-loss limit is $3,750.

When you use Non-PPO or Other Providers: After the out-of-pocket expenses for Covered Medical Charges incurred by each insured person reaches $8,500, the Plan pays 100% of the Covered Medical Charges which that insured person incurs for Covered Services of Non-PPO and Other Providers for the rest of the calendar year (excluding services covered by the No Surprises Act, which include: (a) Emergency Services for an Emergency Medical Condition provided by a Non-PPO provider or Non-PPO facility (unless the covered person received proper notice and consented to the out-of-network billing rates for certain post-stabilization services as allowed under the No Surprises Act); (b) non-Emergency Services by a Non-PPO provider at a PPO facility (unless the covered person received proper notice and consented to the out-of-network billing rates as allowed under the No Surprises Act); and (c) Non-PPO air ambulance services. These excluded services shall be covered under the PPO rate). For a family using non-PPO or Other Providers, the stop-loss limit is $25,500.

Certain expenses are not covered by this rule; please see Section 10.05 for complete rules on Stop Loss Limits.

Limitations and Exclusions
Certain covered medical charges are subject to limitations, and some procedures are excluded from coverage under the Plan. See Section 13 for further information.

10.02 DEDUCTIBLES

Benefits are payable for Covered Medical Charges as follows.

(1) For charges that are subject to a Deductible, benefits are payable for such charges that are more than the Deductible in each calendar year. The amount payable after the Deductible will equal the Covered Percentage times such charge in excess of the Deductible.

(2) For such charges that are not subject to a Deductible, the amount payable is equal to the Covered Percentage times the amount of Covered Medical Charges.

(3) The Plan has no general annual maximum benefit.

DEDUCTIBLES (Per Calendar Year)
Per Person:
When you use a PPO Provider.....$250
When you use a Non-PPO Provider.....$500

Per Family:*
When you use a PPO Provider.....$750
When you use a non-PPO Provider $1,500
(*Three family members must each separately satisfy the $250 deductible or the $500 deductible, as applicable.)

The Deductible Per Calendar Year applies to benefits for Covered Medical Charges provided by both PPO or Non-PPO Providers, in the applicable amounts, shown above.

The following rules govern the Deductibles listed above, and apply to each covered person:

Deductible Per Calendar Year
The Deductible per Calendar Year is the amount of Covered Medical Charges that each covered person must incur before benefits are payable each calendar year.

Charges incurred in the months of October, November and December that are used to meet this Deductible (in full or in part) for that calendar year will also be used to meet the Deductible per Calendar Year for the next year.

Deductible For Accidents
Your family is made up of you and your covered dependents. If two or more covered members of your family sustain injuries in the same accident, only one Deductible per Calendar Year must be met for all charges incurred due to these injuries during the rest of the calendar year in which the accident occurred.

Family Deductible
Only three members of your family must meet the Deductible per Calendar Year during any one year. Once the third family member meets that Deductible, no further Deductibles per Calendar

Year must be met during the rest of that year for any charges incurred by any other members of your family.

Office Visits
Office visit co-payments are not subject to the Deductible, and will not be used to meet the Deductible. Co-payments for office visits will apply regardless of whether the Deductible has been met.

Emergency Services and Ambulance and Air-Ambulance Services
Co-payments for Covered Medical Charges provided by Non-PPO emergency providers and ambulance and air-ambulance providers are subject to the PPO Deductible.

10.03 COVERED PERCENTAGES AFTER DEDUCTIBLE, CO-PAYMENT AMOUNTS FOR OFFICE VISITS AND APPLICABLE MAXIMUMS

Physician Charges-
(1) General Office Visits
When you use a PPO Provider.....$10
When you use a Non-PPO Provider.....$20

(2) Specialist Office Visits
When you use a PPO Provider.....$20
When you use a Non-PPO Provider.....$40

(3) Hospital Visits
When you use a PPO Provider..... 80%
When you use a Non-PPO Provider..... 60%

Exception: Charges by a licensed physician which are payable under this Plan shall be covered at the rates stated above, except for the following services by a Non-PPO provider that are covered by the No Surprises Act, which shall be covered at the PPO Provider rate:

(1) A covered person receives Emergency Services for treatment of an Emergency Medical Condition from a Non-PPO Provider or Non-PPO emergency facility (unless he or she consents to out-of-network billing rates for certain post-stabilization services as allowed under the No Surprises Act); and

(2) A covered person receives non-emergency services from a Non-PPO provider at a PPO facility (unless he or she consents to out-of-network billing rates as allowed under the No Surprises Act).

Emergency Services for Treatment of an Emergency Medical Condition (Hospital or Other Emergency Facility Charges)
The Plan covers Emergency Services for treatment of an Emergency Medical Condition in accordance with the No Surprises Act. The Plan pays benefits at the following rates, without

prior authorization and without regard to any other term or condition of the Plan or coverage other than the exclusion or coordination of benefits (to the extent not inconsistent with benefits for an Emergency Medical Condition):

When you use a PPO Provider Facility..... 80%
(counting the covered person's cost-sharing toward the stop-loss limit)
When you use a Non-PPO Provider..... 80%

Exception: Charges will be paid at 60% for Emergency Services at a Non-PPO Provider Facility if any of the following are determined to apply:

(1) A covered person did not have an Emergency Medical Condition; or

(2) A covered person receives Emergency Services for treatment of an Emergency Medical Condition from a Non-PPO Provider or Non-PPO emergency facility and consents to out-of-network billing rates for certain post-stabilization services as allowed under the No Surprises Act; or

(3) A covered person receives non-emergency services from a Non-PPO provider at a PPO facility and consents to out-of-network billing rates as allowed under the No Surprises Act.

If a covered person visits a Non-PPO provider or Non-PPO facility in the situations described above, the Non-PPO provider or Non-PPO facility may not balance bill. In addition, the covered person's cost-sharing will be the same as if he or she had visited a PPO provider or facility, meaning that once he or she has met the applicable deductible, his or her coinsurance costs will be applied to the stop-loss limit and the coinsurance percentage will be the same as if the covered person had visited a PPO provider or facility. The covered person's coinsurance percentage will be applied to the lesser of the billed charge or the Qualifying Payment Amount. For purposes of this Section, a Qualifying Payment Amount means the Plan's median contracted rate for the item or service in the same geographic region, as adjusted under DOL Regulation 2590.716-6(c).

For purposes of this Section, a "visit" with respect to services at a PPO provider facility includes the furnishing of equipment and devices, telemedicine services, imaging services, laboratory services, and preoperative and postoperative services, regardless of whether the provider furnishing such items or services is at the facility. These services are not limited based on whether the provider furnishing the services is physically located at the facility.

Skilled Nursing Facility
A maximum of 60 days are covered for each confinement.
When you use a PPO Provider..... 80%
When you use a Non-PPO Provider..... 60%

Inpatient Hospice
When you use a PPO Provider..... 80%
When you use a Non-PPO Provider..... 60%

Chiropractic Benefits
The Maximum Benefit is $1,000 per calendar year.
When you use a PPO Provider..... 80%
When you use a Non-PPO Provider..... 60%

Kaiser does not provide Chiropractic benefits. However, the self-funded PPO plan will pay for Chiropractic benefits for active employees and their Eligible Dependents enrolled in Kaiser at 80% of UCR charges, up to $1,000 per year per person.

Mental and Emotional Illness Benefits

Note: The provisions of the No Surprises Act and Part 1, Article 9, Section 9.10 of the Plan shall apply here to Emergency Services for Emergency Medical Conditions relating to mental and emotional illness.

(1) Inpatient Treatment:
Inpatient Hospital Services
When you use a PPO Provider..... 80%
When you use a Non-PPO Provider..... 60%

All other covered Inpatient services
When you use a PPO Provider..... 80%
When you use a Non-PPO Provider..... 60%

All other covered Inpatient services (all Providers) 60%

(2) Outpatient Treatment, other than Office Visits:
When you use a PPO Provider..... 80%
When you use a Non-PPO Provider..... 60%

(3) Office Visits:
When you use a PPO Provider.....$10
When you use a Non-PPO Provider.....$20

Home Health Care/Outpatient Hospice
A maximum of 100 visits per person per calendar year are covered.

When you use a PPO Provider..... 80%
When you use a Non-PPO Provider..... 60%

Hospice Care Counseling/Bereavement Counseling

When you use a PPO Provider..... 80%
When you use a Non-PPO Provider..... 60%

Home Private Duty Nursing Services
A maximum of 1000 hours per person per calendar year are covered.

When you use a PPO Provider..... 80%
When you use a Non-PPO Provider..... 60%

Outpatient Surgery Charges
Charges must be incurred on the day of surgery. Surgery must be done in: (a) a Hospital; (b) an Ambulatory Surgical Center; or (c) a Physician's office.

Facility Charges and Surgeon Charges:
When you use a PPO Provider..... 80%
When you use a Non-PPO Provider..... 60%

Note: All arthroscopic surgeries, cataract surgeries, and colonoscopies must be performed at PPO Provider ambulatory surgical centers. The provisions of the No Surprises Act and Part 1, Article 9, Section 9.10 of the Plan shall apply here to Emergency Services for Emergency Medical Conditions relating to outpatient surgery charges.

Inpatient Surgery Charges
Note: The provisions of the No Surprises Act and Part 1, Article 9 Section 9.10 of the Plan shall apply here to Emergency Services for Emergency Medical Conditions relating to inpatient surgery charges

(1) Facility Charges:
When you use a PPO Provider..... 80%
When you use a Non-PPO Provider..... 60%

(2) Surgeon, Assistant Surgeon and Anesthesiologist Charges:
When you use a PPO Provider..... 80%
When you use a Non-PPO Provider..... 60%

Preadmission Testing
Preadmission tests must be made within four days prior to confinement as an Inpatient, and must be (a) related to the condition for which the insured person is or was confined and (b) ordered by a Physician. ..... No charge

Post-release Testing
Post-release testing must be (a) related to the condition for which the insured person is or was

confined and (b) ordered by a Physician.

When you use a PPO Provider..... 80%
When you use a Non-PPO Provider..... 60%

Birthing Centers
When you use a PPO Provider..... 80%
When you use a Non-PPO Provider..... 60%

Other Surgery Limits
Transplant surgeries and bariatric surgeries must be performed at designated Blue Distinction Centers. A maximum of $30,000.00 will be paid for each knee or hip surgery.

Ground Ambulance Charges
When you use a PPO Provider..... 80%
When you use a Non-PPO Provider..... 80%

The Plan will pay all ground ambulance claims at 80% of the billed charge.

Air Ambulance Charges
Where a covered person receives medical transport by a rotary-wing or fixed wing ambulance, the Plan pays in accordance with the No Surprises Act. The Plan pays benefits at the following rates, for covered charges in excess of any then applicable deductible:

When you use a PPO Provider……..80% of the applicable contracted rate, counting the covered person's cost-sharing amount toward the stop-loss limit.
When you use a Non-PPO Provider: ……80% if a covered person receives medical transport by a rotary-wing or fixed wing ambulance

The Plan will pay all air ambulance claims at 80% of the billed charge.

Note: For a Non-PPO Provider, the coinsurance percentage will be applied to the lesser of billed charges or the Qualifying Payment Amount, counting the covered person's cost-sharing amount toward the stop-loss limit. For purposes of this Section, a Qualifying Payment Amount means the Plan's median contracted rate for the item or service in the same geographic region, as adjusted under DOL Regulation 2590.716-6(c).

Note: Providers of Air Ambulance services are generally prohibited from balance billing a covered person. For purposes of this Air Ambulance benefit, a Qualifying Payment Amount means the Plan's median contracted rate for the item or service in the same geographic region, as adjusted under U.S. Department of Labor Regulation 2590.716-6(c).

Podiatry Services
Inpatient Podiatry Services:
When you use a PPO Provider..... 80%
When you use a Non-PPO Provider..... 60%

Outpatient Podiatry Services, other than Office Visits:
When you use a PPO Provider..... 80%
When you use a Non-PPO Provider..... 60%

Office Visits:
When you use a PPO Provider.....$20
When you use a Non-PPO Provider.....$40

COVID-19 Screening and Testing Charges
When you use a PPO Provider ……..80%
When you use a Non-PPO Provider ……..60%

10.04 DAILY ROOM ALLOWANCES

Maximum Hospital Daily Room Allowance
Up to the Most Common Semiprivate Room Rate
When you use a PPO Provider..... 80%
When you use a Non-PPO Provider..... 60%

Intensive Care Unit Daily Allowance
When you use a PPO Provider..... 80%
When you use a Non-PPO Provider..... 60%

10.05 STOP-LOSS LIMIT

Individual Stop-loss Limit:

When you use PPO Providers: After the out-of-pocket expense for Allowable Charges incurred by each insured person reaches $1,250, the Plan pays 100% of the Allowable Expense which that insured person incurs for Covered Services of PPO Providers for the rest of the calendar year. After the out-of-pocket expense for Allowable Charges incurred by a covered family reaches $3,750, the Plan pays 100% of the Allowable Expense which that covered family incurs for Covered Services of Other Providers for the rest of the calendar year.

When you use Non-PPO or Other Providers: After the out-of-pocket expense for Allowable Charges incurred by each insured person reaches $8,500, the Plan pays 100% of the Allowable Expense which that insured person incurs for Covered Services of Other Providers for the rest of the calendar year. After the out-of-pocket expense for Allowable Charges incurred by a covered family reaches $25,500, the Plan pays 100% of the Allowable Expense which that covered

family incurs for Covered Services of Other Providers for the rest of the calendar year. (excluding services covered by the No Surprises Act, which include: (a) Emergency Services for an Emergency Medical Condition provided by a Non-PPO provider or Non-PPO facility (unless the covered person received proper notice and consented to the out-of-network billing rates for certain post-stabilization services as allowed under the No Surprises Act); (b) non-Emergency Services by a Non-PPO provider at a PPO facility (unless the covered person received proper notice and consented to the out-of-network billing rates as allowed under the No Surprises Act); and (c) Non-PPO air ambulance services).

Exception:
Office visit co-payments will not be used to satisfy the stop-loss limit. Co-payments for office visits will continue to be charged after the stop-loss limit has been reached.

"Out-of-Pocket Expense" means expense which the insured person incurs for Covered Services during the calendar year and must pay out-of-pocket:

(a) to satisfy the Deductible; and

(b) as coinsurance (the percentage the insured person must pay in accord with the Covered Percentages provision).

The same out-of-pocket expense may be used to satisfy both the stop-loss limit for PPO Providers and the stop-loss limit for Non-PPO Providers.

The following benefits will not be paid at 100% even though the stop-loss limit has been reached: Chiropractic Charges (Non-Surgical Manipulative Treatment of the Spine), Charges incurred as a result of failure to comply with the Utilization Review provisions of the Plan, and Co-Payments for Office Visits.

Out-of-pocket expenses for services from Non-PPO providers, up to 20% of Covered Medical Expenses, for ground ambulance services will be used to satisfy the stop-loss limit for PPO Providers.

10.06 WELL CHILD CARE

Maximum Number of Exams
Benefits are limited to 19 periodic physical examinations at approximately each of the following age intervals: birth, 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, 18 months, 24 months, 3 years, 4 years, 5 years, 6 years, 8 years, 10 years, 12 years, 14 years, 16 years and 18 years.

A co-payment amount will be charged for Well Child Care Exams as follows:

Primary Physician Office Visits:
When you use a PPO Provider.....$10
When you use a Non-PPO Provider.....$20

Pediatric Specialist Office Visits:
When you use a PPO Provider.....$20
When you use a Non-PPO Provider.....$40

10.07 PREGNANCY BENEFITS

Expenses incurred for prenatal and delivery care, including termination of pregnancy, are paid in the same manner and subject to the same conditions as any other Medically Necessary service or supply.

The Plan will pay any bassinet or nursery charges made by the Hospital for any day on which both mother and child are jointly confined in the Hospital except that no benefits are provided to the grandchild of an insured person if that grandchild does not qualify under the eligibility rules of the Plan.

10.08 ALCOHOL AND DRUG DEPENDENCY TREATMENT

Inpatient Hospital Services
When you use a PPO Provider..... 80%
When you use a Non-PPO Provider..... 60%

All Other Covered Inpatient Services
When you use a PPO Provider..... 80%
When you use a Non-PPO Provider..... 60%

Outpatient Benefits, other than Office Visits
When you use a PPO Provider..... 80%
When you use a Non-PPO Provider..... 60%

Office Visits:
When you use a PPO Provider.....$10
When you use a Non-PPO Provider.....$20

10.09 ROUTINE PHYSICAL EXAMINATIONS

One routine physical examination is covered every two calendar years. Co-payments for routine physicals are not subject to the Deductible and will apply regardless of whether the Deductible has been met. You must use a PPO Provider to receive this benefit.

Routine physical examinations (PPO Providers only).....$10

10.10 ALL OTHER COVERED CHARGES

When you use a PPO Provider..... 80%
When you use a Non-PPO Provider..... 60%

11. COST CONTAINMENT RULES (UTILIZATION REVIEW)

11.01 HOSPITAL CONFINEMENT REVIEW

Review of any Hospital confinements due to any Sickness, Injury, or mental or nervous disorder (when covered by the Plan) is required if you or your dependent is confined for:

(1) a nonemergency admission, or
(2) childbirth, or
(3) Inpatient Mental and Emotional Illness Treatments.

Prior Utilization Review is also required for the following services:

(1) Inpatient Surgery
(2) Preadmission/Post-release Testing
(3) Skilled Nursing Facility/Inpatient Hospice Services
(4) Home Health Care/Private Nursing/Outpatient Hospice Services
(5) Childbirth at a Birthing Center
(6) Jaw Joint Disorder Treatments in excess of $300
(7) Bariatric surgery
(8) Gene Therapy.

Utilization Review for the admissions and services listed above is provided by Anthem Blue Cross. This is not a complete list. For the complete list, please refer to Anthem's Utilization Review department for more information. The telephone number for the Anthem Blue Cross UR Program is (800) 274-7767. See Section 11.02 for more information on how to obtain Utilization Review from Anthem Blue Cross.

The Anthem Blue Cross Utilization Review Program ("UR Program") provides preadmission review, concurrent review and discharge planning on Hospital admissions.

(1) Preadmission Review: review is performed for admissions for scheduled procedures, prior to admission.

(2) Concurrent Review: review is performed for Scheduled and Nonscheduled Admissions during confinement.

(3) Discharge Planning: where necessary, arrangements are made to facilitate earliest dismissal possible which is consistent with the patient's medical condition.

Covered Medical Charges do not include charges which are not Medically Necessary.

Charges which are determined by the UR Program to be not Medically Necessary are not Covered Medical Charges, and no benefits will be paid for such charges. This could include any or all days of Inpatient Hospital confinement.

11.02 NOTIFICATION GUIDELINES

Scheduled Admissions
When an insured person is scheduled for admission to any Hospital, notification must be received by the Anthem Blue Cross UR Program at the appropriate UR Office prior to Hospital admission. This may be done by:

(1) telephoning the UR Program;
(2) completing a Preadmission Review Request Form; or
(3) having the admitting Physician contact the UR Program.

The telephone number for the Anthem Blue Cross UR Program is (800) 274-7767.

The responsibility of notifying the UR Program lies with the covered person. Individuals are advised to contact the UR Program directly to verify that the admitting Physician or Hospital has made "notification."

The following information is necessary for notification.

(1) Trust Fund's Name and Group Number; and
(2) The Employee's Name/Social Security Number; and
(3) Patient's Name and Date of Birth; and
(4) Physician's Name/Phone Number; and
(5) Hospital's Name/Phone Number; and
(6) Date of Admission; and
(7) Diagnosis/Planned Procedure.

Nonscheduled Admissions
When a covered person is admitted to any Hospital on a nonscheduled basis, the UR Program must be notified by the next Working Day following admission, or as soon thereafter as is reasonably possible prior to the date of discharge.

11.03 SECOND SURGICAL OPINIONS

Optional Second Surgical Opinion
When surgery is advised, a covered person may get a second surgical opinion to confirm that surgery is needed. Charges for the second surgical opinion will be covered under Covered Medical Charges on an Outpatient basis, but only for (1) Physician's charges, and (2) related

tests.

The Physician who provides the second opinion must be one who: (1) treats the type of condition for which surgery is advised; (2) is not scheduled to do the surgery; and (3) has no business or financial relationship with the Physician recommending or performing the surgery.

If the second Physician disagrees with the first Physician, benefits will be payable for the cost of a third opinion, subject to the conditions listed above.

12. COVERED MEDICAL CHARGES

12.01 GENERAL

Covered Medical Charges means charges which are:

(1) for Medically Necessary services, supplies, care or treatment;
(2) due to Sickness or Injury;
(3) prescribed, performed, or ordered by a Physician;
(4) Reasonable and Customary Charges;
(5) incurred while you and your dependents are covered under the Plan; and
(6) up to any maximum shown in Section 10.03.

Covered Medical Charges include only the following charges, and are subject to any limits or exclusions as noted:

12.02 HOSPITAL CHARGES for:

(1) Room and Board, including all routine nursing care;
(2) other Inpatient and Outpatient services and supplies. These do not include charges for professional services; and
(3) confinement in an Intensive Care Unit.

Such confinement must be:

(1) ordered by a Physician; and
(2) due to a condition that requires special medical and nursing treatment not generally provided to other Inpatients of the Hospital.

12.03 SKILLED NURSING FACILITY/INPATIENT HOSPICE

Room and Board charges for each day of confinement in a Skilled Nursing Facility if:

(1) the confinement follows Hospital confinement of at least three consecutive days of eligible Hospital Room and Board charges and is for the same illness or Injury; and
(2) the attending Physician certifies that continued Hospital confinement would be necessary in the absence of confinement in the Skilled Nursing Facility.

Hospice care in a freestanding Hospice facility, a Hospital-based Hospice, or extended care Hospice facility for an insured person who is terminally ill and has a life expectancy of six months or less as certified in writing by the Physician in charge of the person's care and

treatment.

The maximum daily Allowable Charge for a Skilled Nursing Facility or Hospice facility is 50% of the Hospital's Most Common Semiprivate Room Rate in the geographic area where the charges are incurred.

Note: Prior approval of the Utilization Review agency must be obtained before admittance to a Skilled Nursing Facility/Inpatient Hospice.

12.04 HOME CARE/PRIVATE NURSING/OUTPATIENT HOSPICE

Private Duty Nursing Service
Full-time (eight-hour shift or more) services of a registered Nurse in the home of a covered person will be covered up to any maximum shown in Section 10.03, only if these services are in lieu of confinement in a Hospital or Skilled Nursing Facility. This benefit covers only those services which require the technical skills of a Nurse and is not meant to cover services which could be provided by a home health aide.

Home Health Care
This benefit provides for the part-time or intermittent services of a registered Nurse, a physical therapist, an occupational therapist, a speech therapist, a respiratory therapist or a home health aide (up to four hours per day) when provided under the direction of an agency licensed by the state as a Home Health Care Agency or Hospice agency up to any maximum shown in Section 10.03. It also covers drugs, supplies and laboratory services provided by such agency to the extent they would otherwise be covered under the Plan. The attending Physician must certify that continued confinement in a Hospital or Skilled Nursing Facility would be necessary in the absence of this benefit.

Custodial Care or other daily living activities assistance are not Covered Services.

Conditions Applying to Private Duty Nursing Services and Home Health Care
Prior approval of the Utilization Review agency must be obtained. Covered Services must begin within three days following discharge from a Hospital or Skilled Nursing Facility. Any visit by a member of a Home Health Care team on any day will be considered as one Home Health Care visit. These benefits are only provided at the patient's own home and do not cover services provided in a home which is primarily a medical or group care facility.

Hospice Care Counseling/Bereavement Counseling
When a terminally ill covered person receives Hospice care, this benefit provides counseling to the covered person's immediate family and bereavement counseling for the covered person's immediate family. The immediate family of the terminally ill covered person includes Spouse and children, or parents, brothers and sisters, in the case of a terminally ill dependent child.

12.05 **AMBULANCE AND AIR-AMBULANCE CHARGES** for transportation of a

covered person by a professional ambulance service to and from the nearest:
(1) Hospital or Skilled Nursing Facility for Inpatient care; or
(2) Hospital for emergency accident care;
but only if the condition of the patient requires paramedic support.

12.06 **AMBULATORY SURGICAL CHARGES** for necessary services and supplies if:
(1) these charges are due to surgery; and
(2) benefits for these charges would have been payable if the surgery had been done in a Hospital.

Arthroscopic surgeries, cataract surgeries, and colonoscopies must be performed at in-network ambulatory surgical centers.

12.07 **SURGEON'S CHARGES** by a Physician for the performance of surgical procedures.

12.08 **PHYSICIAN'S CHARGES** for medical care and treatment, other than:
(1) surgical procedures; and
(2) related postoperative care.

12.09. **ANESTHESIA CHARGES** and its administration when these are not covered as Hospital charges.

12.10 **PHYSIOTHERAPY AND OCCUPATIONAL THERAPY CHARGES** for:
(1) treatment by a licensed physiotherapist; and
(2) treatment by a licensed occupational therapist.
The person providing the care must not live with or be related to the insured person or to his or her Spouse.

12.11 **RADIOLOGICAL AND LABORATORY CHARGES** for:
(1) X-rays;
(2) radiological treatment; and
(3) diagnostic laboratory tests.

12.12 **MENTAL AND EMOTIONAL ILLNESS BENEFITS**
Inpatient or residential benefits are covered only if the admission has been determined by the Utilization Review coordinator at Anthem Blue Cross to be Medically Necessary. The deductible and covered percentage of charges will vary, depending on whether you use a PPO or non-PPO provider. See Sections 10.01, 10.03 and 11.01.

12.13 **SEVERE MENTAL ILLNESS BENEFITS**
If while covered under the Plan, a covered person incurs Expense for the diagnosis and Medically Necessary treatment of a Severe Mental Illness of a person of any age or of Serious Emotional Disturbances of a Child, the Plan will pay benefits in the same manner and subject to the same conditions and limitations as any other covered Sickness.

Definitions

Severe Mental Illness includes any of the following:

(1) schizophrenia;
(2) schizoaffective disorder;
(3) bipolar disorder (manic-depressive illness);
(4) major depressive disorders;
(5) panic disorder;
(6) obsessive-compulsive disorder;
(7) pervasive development disorder or autism;
(8) anorexia nervosa; and
(9) bulimia nervosa.

Serious Emotional Disturbances of a Child applies to a child under the age of 18 years who:

(1) has one or more mental disorders as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, other than a primary substance use disorder or developmental disorder, that result in behavior inappropriate to the child's age according to expected developmental norms, and

(2) meets the following criteria in paragraph (2) of subdivision (a) of section 5600.3 of the Welfare and Institutions Code:

(a) as a result of the mental disorder the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community; and either of the following occur:

(i) the child is at risk of removal from home or has already been removed from the home; or

(ii) the mental disorder and impairments have been present for more than six months or are likely to continue for more than one year without treatment;

(b) the child displays one of the following: psychotic features, risk of suicide or risk of violence due to a mental disorder; and

(c) the child meets special education eligibility requirements under Chapter 26.5 (commencing with section 7570) of Division 7 of Title 1 of the Government Code.

Exceptions

The Plan will not pay for anything excluded under the Exclusions, except any exclusion for eating disorders will not apply.

Covered Services

This benefit is intended to cover Medically Necessary treatment when a patient suffers from the onset of severe behavioral symptoms and impairment of functioning due to a mental disorder which interferes with the patient's daily activities. Examples include severe symptoms of depression, paranoia, anxiety, panic attacks, psychosis, bipolar disorder, or threats of self-harm, violence or damage to persons or property. Examples of conditions which are not covered are passive-aggressive personality and academic underachievement.

Covered services are those which are for the diagnosis and treatment of an active mental disorder as defined in the ICD-9 and are limited to treatment of severe impairment of the patient's mental, emotional or behavioral functioning on a daily basis. The treatment must be generally recognized as appropriate for the diagnosed mental disorder, reasonably expected to result in a significant degree of clinical stability or resolution of significant symptoms, and rendered by a licensed Physician, clinical psychologist, clinical social worker or marriage and family counselor.

Services Not Covered

This benefit is specifically not intended to cover reading, learning or developmental disorders or programs primarily oriented towards treatment of social maladjustment in persons whose functioning on a daily basis is not severely impaired. Examples of services not covered include, but are not limited to, the following: cognitive training, perceptual motor therapy, art therapy, recreational therapy, milieu therapy, experiential therapy, social skills therapy, assertion training, and delinquent children's services.

12.14 **WELL CHILD CARE BENEFITS**

If your covered dependent child is under the age of 19 years and incurs expense for comprehensive preventive care, the Plan will pay benefits in the same manner and subject to the same conditions and limitations as any other covered service, but not to exceed, for periodic physical examinations by a Physician, the Maximum Number of Exams shown in Section 10.06.

Exceptions

The Plan will not pay for any expense which is paid under any other provision of the Plan.

12.15 **MEDICAL SUPPLY CHARGES** for:

(1) oxygen, blood and plasma;
(2) casts, splints, trusses, braces, crutches, and surgical dressings;
(3) purchase of needles and syringes;
(4) artificial eyes and limbs for:
    (a) the initial replacement of natural eyes and limbs severed while insured; and
    (b) replacement of such artificial limbs only if the replacement is due to body growth of an insured child;
(5) purchase of a breast prosthesis to restore and achieve symmetry for the patient, and for the initial replacement of a breast surgically removed while insured;
(6) the initial purchase of eyeglasses or contact lenses due to cataract surgery performed while insured; and
(7) rental of manually operated wheelchairs and Hospital beds, oxygen equipment and other durable medical equipment that is used solely by the insured person for the treatment of his or her Sickness or Injury, and only when there is a clear medical necessity for the equipment, but not just for the patient's convenience. The Plan may, at its discretion, approve purchase of such items. Rental cost in excess of the purchase price is excluded.

12.16 WOMEN'S HEALTH BENEFITS

(1) 48-HOUR MATERNITY BENEFITS

This provision is in accordance with Federal law, and is provided concurrently with any similar provisions required under state law, for maternity and childbirth.

If, while covered under the Plan, you or your dependent are confined to a Hospital as a resident Inpatient for childbirth, the Plan will pay benefits in the same manner and subject to the same conditions and limitations as any other Sickness, but in no event will benefits be provided for less than:
(a) 48 hours following a vaginal delivery; or
(b) 96 hours following a cesarean section;
for the mother and the newborn infant(s), unless the attending Physician, in consultation with the mother, recommends an earlier discharge.

In the event such earlier discharge occurs, a follow-up visit by a registered Nurse will be available to the mother, and payable in the same manner and subject to the same conditions and limitations as any other covered service.

(2) MAMMOGRAPHY BENEFITS

If, while covered under the Plan, a female covered person incurs expense for mammography upon referral of a Physician:
(a) for breast cancer screening, or
(b) for diagnostic purposes, the Plan will pay:
(i) one baseline mammogram for women age 35 through 39;
(ii) one mammogram every two years (or more frequently based on the covered person's Physician's recommendation) for women age 40 through 49; and
(iii) one mammogram each year for women age 50 and over;
in the same manner as any other Sickness.

(3) MASTECTOMY BENEFITS

(a) If, while covered under the Plan, you or your dependent is confined to the Hospital as a resident Inpatient for a Mastectomy, including lymph node dissection, the length of the confinement will be determined by the treating Physician, in consultation with the patient, in accord with sound clinical principles and processes. The Plan will not require prior approval in determining the length of a Hospital stay following the procedure.

(b) If, while covered under the Plan, you or your dependent has a Mastectomy performed, the Plan will pay the Expense incurred in the same manner and subject to the same conditions and limitations as any other covered service for:
(i) Prosthetic Devices or Reconstructive Surgery, including devices or surgery To Restore and Achieve Symmetry following the Mastectomy; and
(ii) all complications from a Mastectomy, including lymphedema.

"Prosthetic Devices or Reconstructive Surgery" means any initial and subsequent reconstructive surgeries or Prosthetic Devices, and follow-up care deemed necessary by the Physician.

"Prosthetic Devices" means and includes the provision of initial and subsequent Prosthetic Devices pursuant to an order of the patient's Physician.

"Mastectomy" means the removal of all or part of the breast for Medically Necessary reasons, as determined by the Physician.

"To Restore and Achieve Symmetry" means that, in addition to coverage of Prosthetic Devices and Reconstructive Surgery for the diseased breast on which the Mastectomy was performed, Prosthetic Devices and Reconstructive Surgery for a healthy breast is also covered if, in the opinion of the Physician, this surgery is necessary to achieve normal symmetrical appearance.

(4) **PAP SMEAR EXAM BENEFITS**
If, while covered under the Plan, you or your dependent incurs expense for a routine PAP smear exam, the Plan will pay benefits in the same manner as any other covered service, but not to exceed one exam and lab charge each calendar year.

(5) **ALPHA FETO PROTEIN**
This provision applies only when the covered person's pregnancy is covered under the Plan. If, while covered under the Plan, you or your dependent participates in the Expanded Alpha Feto Protein program, the Plan will pay the expense incurred in the same manner and subject to the same conditions and limitations as any other covered service. "Expanded Alpha Feto Protein" program means a statewide prenatal testing program administered by the State Department of Health Services.

12.17 CANCER CLINICAL TRIAL BENEFITS

Cancer Clinical Trial means a Phase II, Phase III or Phase IV clinical trial for cancer that:

(1) involves a drug that is exempt under federal regulations from a new drug application; or
(2) is approved by one of the following:
  (a) one of the National Institutes of Health;
  (b) the Federal Food and Drug Administration, in the form of an investigational new drug application;
  (c) the United States Department of Defense; or
  (d) the United States Veterans' Administration.

If a covered person incurs Expense for a Cancer Clinical Trial, benefits will be paid in the same manner and subject to the same conditions and limitations as any other Covered Service.

For the purpose of this provision, a clinical trial's endpoints shall not be exclusively to test toxicity but shall have a therapeutic intent.

Exceptions
Benefits will not be provided for:

(1) drugs or devices associated with the clinical trial but not approved by the Federal Food and Drug Administration;
(2) services other than health care services, such as travel, housing, companion expenses or other non-clinical expenses;
(3) any item or service provided solely to satisfy data collection and analysis needs and that is not used in the clinical management of the patient;
(4) any services specifically excluded from coverage under the Plan;
(5) any services provided by the research sponsors free of charge; or
(6) any services for a Phase I Cancer Clinical Trial.

12.18 CANCER SCREENING BENEFITS

If, while covered under the Plan, you or your dependent incurs Expense for any generally medically accepted cancer screening tests, the Plan will pay benefits in the same manner and subject to the same conditions and limitations as any other covered service.

12.19 CERVICAL CANCER SCREENING BENEFITS

If a covered person incurs Expense for an annual cervical cancer screening test, including a routine PAP test and the option of any cervical cancer screening test approved by the Federal Food and Drug Administration, the Plan will pay benefits in the same manner and subject to the same conditions and limitations as any other Covered Service.

12.20 PROSTATE CANCER SCREENING BENEFITS

If, while covered under the Plan, you or your dependent incurs expense for the screening and diagnosis of prostate cancer, the Plan will pay benefits in the same manner and subject to the same conditions and limitations as any other covered service.

A prostate cancer screening and diagnosis includes, but is not limited to:

(1) a prostate-specific antigen test; and
(2) a digital rectal examination;

when Medically Necessary and consistent with good professional practice.

Exceptions
The Plan will not pay for:

(1) any expense which is paid under any other provision of the Plan; or
(2) anything excluded under the Exclusions.

12.21 DIABETES BENEFITS

If, while covered under the Plan, you or your dependent incurs Expense for the Medically Necessary treatment of:

(1) insulin-using diabetes;
(2) non-insulin-using diabetes; or

(3) gestational diabetes;
benefits will be payable as follows, even if the items are available without a prescription.

For these items, benefits are payable in the same manner and subject to the same conditions and limitations as any other covered service:
(1) blood glucose monitors designed to assist the visually impaired;
(2) insulin pumps and all related necessary supplies;
(3) pen delivery systems for the administration of insulin;
(4) podiatric devices to prevent or treat diabetes-related complications; and
(5) visual aids, excluding eyewear, to assist the visually impaired with proper dosing of insulin.

For these items, benefits are payable in the same manner and subject to the same conditions and limitations as any other prescription drug:
(1) blood glucose monitors and blood glucose testing strips;
(2) ketone urine testing strips;
(3) lancets and lancet puncture devices;
(4) insulin syringes;
(5) insulin;
(6) prescriptive medications for the treatment of diabetes; and
(7) glucagon.

For diabetes Outpatient self-management training, education, and medical nutrition therapy:
(1) necessary to enable a covered person to properly use the equipment, supplies, and medication shown above; or
(2) directed or prescribed by a Physician; and
(3) provided by appropriately licensed or registered health care professionals;
benefits are payable in the same manner and subject to the same conditions and limitations as a Physician's office visit.

Exceptions
The Plan will not pay for:
(1) any Expense which is paid under any other provision of the Plan; or
(2) anything excluded under the Exclusions, except that, for the purposes of this provision, any exclusion for charges for orthopedic shoes, orthotics or other supportive devices for the feet will not apply.

12.22 CONTRACEPTIVES BENEFITS

If, while covered under the Plan, you or your dependent receives outpatient Contraceptives, the Plan will pay the Expense incurred in the same manner and subject to the same conditions and limitations as any covered drug.

"Contraceptives" means a variety of prescription methods, drugs or devices that are approved as contraceptives by the Federal Food and Drug Administration (FDA).

Benefits for voluntary surgical sterilization are payable in the same manner and subject to the same conditions and limitations as any other covered service. Reversal of surgical sterilization is not covered.

12.23 **DIETARY TREATMENT BENEFITS** For Phenylketonuria (PKU)

If, while covered under the Plan, you or your dependent requires testing or treatment for Phenylketonuria (PKU), the Plan will pay the Expense incurred in the same manner and subject to the same conditions and limitations as any other Sickness.

Coverage includes Formula and Special Food Products that are part of a diet prescribed by a Physician and managed by a health care professional in consultation with a Physician who specializes in the treatment of metabolic disease, provided that the diet is deemed Medically Necessary to avert the development of serious physical or mental disabilities or to promote normal development or function as a consequence of Phenylketonuria (PKU).

Definitions

"Formula" means an enteral product or enteral products for use at home that are prescribed by a Physician or Nurse practitioner, or ordered by a registered dietician upon referral by a health care provider authorized to prescribe dietary treatments, as Medically Necessary for the treatment of Phenylketonuria (PKU).

"Special Food Product" means a food product that is:

(1) prescribed by a Physician or Nurse practitioner for the treatment of Phenylketonuria (PKU) and is consistent with the recommendations and best practices of qualified health professionals with expertise germane to, and experience in the treatment and care of Phenylketonuria (PKU). It does not include a food that is naturally low in protein but may include a food product that is specially formulated to have less than one gram of protein per serving; and

(2) used in place of normal food products, such as grocery store foods, used by the general population.

12.24 **GENERAL ANESTHESIA AND ASSOCIATED FACILITY CHARGES FOR DENTAL PROCEDURES**

If, while covered under the Plan, you or your dependent requires a dental procedure that is provided in a Hospital or surgery center setting, the Plan will pay the expense incurred for:

(1) general anesthesia; and

(2) the associated Hospital or surgery center charges;

in the same manner and subject to the same conditions and limitations as any other covered service, when the clinical status or underlying medical condition of the covered person requires dental procedures that would ordinarily not require general anesthesia to be rendered in a Hospital or surgery center.

Conditions

The benefits described above are payable only for a covered person:
(a) who is a child under the age of 7;
(b) who is developmentally disabled, regardless of age; or
(c) whose health is compromised and for whom general anesthesia is Medically Necessary, regardless of age.

Exceptions
The Plan will not pay for:
(a) the dental procedure itself;
(b) the professional fee of the dentist;
(c) anesthesia or related facility charges for dental procedures that ordinarily would require general anesthesia; or
(d) anything excluded under the Exclusions.

See also Dental Benefits.

12.25 JAW JOINT DISORDERS

Benefits for the diagnosis or treatment of a jaw joint disorder will be paid in the same manner as for any other Sickness, except that expense in excess of $300 will be payable only if benefits have been preauthorized in writing under the Plan's Utilization Review program.

"Jaw Joint Disorder" means any misalignment, dysfunction or other disorder of the jaw joint (or of the complex of muscles, nerves and tissues related to that joint). It includes temporomandibular joint dysfunction (TMJ), arthritis or arthrosis, other craniomandibular joint disorders and myofacial or orofacial pain syndrome. It does not include a fracture or dislocation which results from an Accidental Injury.

12.26 BODY ORGAN TRANSPLANT

If you or your dependent incurs expense for transplant surgery, the Plan will pay benefits for the following:

(1) the use of temporary mechanical equipment, pending the acquisition of "matched" human organ(s);
(2) multiple transplant(s) during one operative session;
(3) replacement(s) or subsequent transplant(s); and
(4) follow-up expenses for covered services (including immunosuppressant therapy).

Transplant surgeries must be performed at designated Blue Distinction Centers.

The Plan will pay the expense incurred by a donor(s) up to the Maximum Donor(s) Benefit of $5,000 for:

(1) testing to identify suitable donor(s);
(2) the expense for the acquisition of organ(s) from a donor;
(3) the expense of Life Support of a donor pending the removal of a usable organ(s);
(4) transportation for a living donor; and

(5) transportation of organ(s) or a donor on Life Support.

Benefits for expense incurred by a donor are payable only when the recipient is covered under the Plan.

Definitions
"Transplant Surgery" means transfer of a body organ(s) from the donor to the recipient.

"Donor" means a person who undergoes a surgical operation for the purpose of donating a body organ(s) for transplant surgery.

"Body Organ" means any of the following: (a) kidney, (b) heart, (c) heart/lung, (d) liver, (e)pancreas (when condition not treatable by use of insulin therapy), (f) bone marrow and (g) cornea.

"Recipient" means a covered person who undergoes a surgical operation to receive a body organ transplant.

Exceptions
The Plan will not pay for:

(1) any expenses when approved alternative remedies are available;
(2) any animal organ or mechanical equipment, device, or organ(s), except temporary mechanical equipment pending the acquisition of "matched" human organ;
(3) any financial consideration to the donor other than for a Covered Expense which is incurred in the performance of or in relation to transplant surgery.

12.27 LARYNGECTOMY PROSTHETIC DEVICES BENEFITS

If you or your dependent incurs expense as a result of a laryngectomy, the Plan will pay for a prosthetic device to restore a method of speaking in same manner and subject to the same conditions and limitations as any other covered service.

Definitions
"Laryngectomy" means the removal of the larynx for Medically Necessary reasons.

"Prosthetic Devices" means and includes the provision of initial and subsequent prosthetic devices, including installation accessories, pursuant to an order of the patient's Physician. Prosthetic devices do not include electronic voice producing machines.

12.28 BARIATRIC SURGERY

Bariatric surgery benefits will be provided only in accordance with Medicare national coverage guidelines then in effect. Prior Utilization Review is required for bariatric surgery, whether performed on an in-patient or out-patient basis.

Bariatric surgeries must be performed at designated Blue Distinction Centers.

12.29. KNEE AND HIP SURGERY

A maximum of $30,000.00 is payable for services associated with a single hip joint replacement or a single knee joint replacement surgery. Anthem Blue Cross Value Based Centers provide this procedure for $30,000.00. Procedures performed other than at a Value Based Center will be covered by the Plan at the normal co-insurance rate, with benefits payable by the Plan not to exceed $30,000.00.

12.30. EMERGENCY SERVICES AND EMERGENCY MEDICAL CONDITIONS

The Plan will pay benefits for Emergency Services with respect to Emergency Medical Conditions. Emergency Services means, with respect to an Emergency Medical Condition:

(a) An appropriate medical screening examination that is within the capability of an emergency room of a hospital or independent freestanding emergency department, as applicable, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition;

(b) Such further medical examination and treatment as are required to stabilize the patient within the capabilities of the staff and facilities available at the hospital or the independent freestanding emergency department, as applicable (regardless of the department of the hospital in which such further examination or treatment is furnished); and

(c) Post-stabilization services furnished by out-of-network providers or out-of-network facilities as part of outpatient observation or an inpatient/outpatient stay related to the Emergency Medical Condition (regardless of the department of the hospital in which such further examination or treatment is furnished), until: (1) the treating provider or facility determines that the individual is able to travel using non-medical transportation or non-emergency medical transportation; and (2) the individual is provided with appropriate written notice to consent to out-of-network treatment and gives informed consent to such out-of-network treatment.

Emergency Medical Condition means a medical condition, including a mental health condition or substance use disorder, manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in any of the following conditions described below:

(a) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;

(b) Serious impairment to bodily functions; or

(c) Serious dysfunction of any bodily organ or part.

12.31 **PODIATRY SERVICES**

The Plan will pay benefits for the treatment of Medically Necessary podiatry services to treat conditions related to the foot and ankle. This includes conditions such as plantar fasciitis, bunions, toe and foot deformity, tendonitis, diabetic foot ulcerations and other medical foot and ankle conditions.

12.32 **ADULT IMMUNIZATIONS**

If you or your covered dependent incurs expenses as a result of immunizations for routine use that have in effect a recommendation from the Centers for Disease Control and Prevention, the Plan will pay benefits in the same manner and subject to the same conditions and limitations as any other covered service.

12.33 **GENE THERAPY**

The Plan covers gene therapy, as well as any drugs, procedures, or health care services related to the introduction of genetic material into a person, intended for the purpose of replacing or correcting faulty or missing genetic material. Only gene therapy approved by the Food and Drug Administration, including future products as determined by the Food and Drug Administration, are covered when determined to be Medically Necessary. Prior approval of the Utilization Review agency must be obtained before starting gene therapy.

13. LIMITATIONS AND EXCLUSIONS

13.01 **LIMITATIONS ON BENEFITS**

Certain Covered Medical Charges are limited. These covered charges and their limitations are as follows.

(1) Charges in connection with teeth, gums or alveolar process are covered only for:
(a) Hospital charges for necessary Inpatient care;
(b) treatment of tumors;
(c) surgery to remove an impacted tooth; and
(d) repair to natural teeth or other body tissue due to an Accidental Injury that occurs while covered.

(2) Charges in connection with Cosmetic Surgery are covered only:
(a) as the result of an Injury;
(b) for the correction of a congenital defect of your dependent child; and
(c) for replacement of diseased tissue surgically removed.

(3) Charges in connection with transplants or replacements of tissue or organs are covered only to the extent they are not considered experimental by the Health Care Financing Agency (HCFA) of the federal government.

If both the donor and the donee are covered under the Plan, the donor's and donee's charges are covered. The total of the donor's and donee's charges will not be more than any maximums under the Plan applicable to the donee.

If the donor is not covered under the Plan and the donee is covered under the Plan, the donor's charges will be covered only to the extent that the donor's charges are not covered under any other insurance. The total of the donor's and donee's charges will not be more than any maximums under the Plan applicable to the donee.

If the donor is covered under the Plan and the donee is not covered under the Plan, the donor's charges and the donee's charges are not covered.

13.02 **EXCLUSIONS**

No benefits will be paid for expenses or charges:

(1) for services or supplies for which a covered person is not required to pay or charges made only because coverage exists (subject to the right, if any, of the United States government to recover Reasonable and Customary Charges for care provided in a military or veterans' Hospital but not in excess of the amount the Plan would pay on behalf of a similarly situated active or retired Participant who was not receiving care in a military or veterans' facility). This will not apply if these charges are incurred in a non-governmental charitable research Hospital;

(2) for Sickness or Injury:

(a) for which benefits are paid or payable under workers' compensation or any occupational disease or similar law whether such benefits are insured or self-insured; or

(b) that is caused by, or connected in any way to, employment of the covered person. This includes self-employment or employment by others. It applies whether or not workers' compensation or any occupational disease or similar law covers the charges incurred. It applies whether the charges are covered on an insured or uninsured basis;

(3) for health exams that are not required for treatment of Sickness or Injury unless specifically provided under the Plan;

(4) for any act due to war, if declared or not, or arising out of service in the Armed Forces; or participation in a riot or insurrection; or participation in a felony, unless that Injury resulted from an act of domestic violence or a medical condition;

(5) for eye refractions, except as specifically provided under Covered Medical Charges; eyeglasses or the fitting of eyeglasses; radial keratotomy or other surgical procedure to correct myopia; visual training; and vision therapy;

(6) for speech therapy, unless Medically Necessary due to a covered Sickness or Injury

incurred while covered under the Plan;

(7) for educational testing or training; behavior modification programs; services primarily oriented toward treating a social, developmental or learning problem, except as specifically provided under the Plan;

(8) for Developmental Care or Custodial Care, except as part of approved Home Health Care;

(9) for sleep disorders, except when coordinated through the Utilization Review Program;

(10) which are incurred as a donor of an organ when the donee is not insured under the Plan;

(11) for drugs and medicines that may be obtained without a written prescription (this will not apply to insulin);

(12) which are more than the Reasonable and Customary Charges for the services and supplies furnished;

(13) for Hospital services and supplies when confinement is solely for diagnostic testing purposes;

(14) for comprehensive preventive child care except as specifically provided for;

(15) for sex change operations; or any expense incurred to change the physical characteristics of the covered person to those of the opposite sex; or any charge for treatment of sexual dysfunction;

(16) for "stand-by" services of a Physician or surgeon whether in the Physician's or surgeon's office or a Hospital;

(17) for transportation, except as specifically provided under the Plan; or

(18) for care, treatment, services or supplies:
(a) not prescribed by a Physician;
(b) not Medically Necessary;
(c) which are experimental as recognized in the United States or provided mainly for the purpose of medical or other research;
(d) received from a Nurse which do not require the skill and training of a Nurse;
(e) to the extent that benefits are payable under other provisions of the Plan;
(f) for which benefits are not paid due to the Deductible or Coinsurance provisions of the Plan:
(g) received in a Hospital or Institution owned or operated by the United States

government or any of its agencies (subject to the right, if any, of the United States government to recover Reasonable and Customary Charges for care provided in a military or veterans' Hospital); or

(h) provided by or paid for by any governmental plan or law not restricted to the government's civilian employees and their dependents. (This will not apply to Medicaid or Medi-Cal.)

(19) which are incurred by a covered person while incarcerated in a jail, penitentiary, correctional facility or Hospital;

(20) for Cosmetic Surgery, unless specifically provided under the Plan;

(21) for appetite control, food addictions, eating disorders (except for documented cases of bulimia or anorexia that meet standard diagnostic criteria, and presents significant symptomatic medical problems) or any treatment of obesity (including surgery to treat morbid obesity, except as provided in Section 12.28);

(22) for sexual and gender identity disorders, including but not limited to sexual dysfunctions, paraphilias, or gender transformations;

(23) for services and supplies for the treatment of impotence/erectile dysfunction;

(24) for the diagnosis or treatment of the inability to conceive or become pregnant, or the promotion of fertility, including, but not limited to:

(a fertility tests and procedures;

(b) reversal of surgical sterilization; or

(c) any similar method or treatment which attempts to cause conception or pregnancy by hormone therapy, artificial insemination, in vitro fertilization and/or embryo transfer; for medical procedures involving the in vitro fertilization process (unless otherwise specifically provided for in the Plan).

(25) for chelation therapy, except for acute arsenic, gold, mercury or lead poisoning;

(26) for services or supplies which are not provided in accordance with generally accepted professional standards and/or medical practice;

(27) for services or supplies which are primarily for the covered person's education, training or development of skills needed to cope with an Injury or Sickness;

(28) which are related to smoking cessation or treatment for nicotine addiction;

(29) for acupuncture treatment;

(30) which are primarily for the covered person's convenience or comfort or that of the

covered person's family, caregiver, companion, sitter, Physician or other person;

(31) for bills for telephone calls, mailings, faxes, e-mails or any other communications to or from a Physician, Hospital or other medical provider;

(32) for breast augmentation or reduction, whether or not Medically Necessary, except for breast reconstruction following a mastectomy as required under state and federal laws and regulations;

(33) for developmental disorders or delays, or conduct disorder, except as specifically provided under the Plan, and for medications for attention deficit disorder that are covered with prior authorization under the Prescription Drug Benefits program;

(34) for educational testing or educational remediation;

(35) for therapies designed to promote personal growth or enhancement;

(36) for exercise equipment;

(37) for services or supplies which are provided or paid for by the federal government or its agencies, except for:

(a) the Veterans Administration, when services are provided to a veteran for a disability which is not service-connected;
(b) a military Hospital or facility, when services are provided to a retiree (or dependent of a retiree) from the armed services;
(c) a group health plan established by a government or its agencies for its own civilian employees and their dependents; or
(d) Medicaid, if required by a Medicaid assignment of benefits.

No benefit payment shall be made for charges incurred after the date the Plan is terminated, except as provided under any extended benefits provision of the Plan.

14. DEFINITIONS

14.01 **Accidental Injury** means definite trauma resulting from a sudden, unexpected and unplanned event, occurring by chance, caused by an independent external source.

14.02 **Allowable Charge** means the maximum amount payable for Covered Services and supplies.

14.03. **Birthing Center** and like terms means an Institution which is not a Hospital, but a place where births take place following normal, uncomplicated pregnancies. Such centers must be: (1) constituted, licensed and operated as set forth in the laws that apply, where required; (2) equipped with those items needed to provide low-risk maternity care; (3) adequately staffed with

personnel who are qualified and, where required, licensed, and who: (a) provide care at childbirth; and (b) are practicing within the scope of their training and experience; and (4) equipped and ready to initiate emergency procedures in life-threatening events to mother and baby.

14.04 **Ambulatory Surgical Center** and like terms means an Institution that: (1) is equipped mainly to do surgery; (2) has the services of a Physician and a Nurse (RN) at all times when a patient is present; and (3) is not an office maintained by a Physician for the general practice of medicine or dentistry.

14.05 **Cosmetic Surgery** means surgery that is intended to: (1) improve the appearance of the patient; or (2) preserve or restore a pleasing appearance. It does not mean surgery that is intended to correct normal functions of the body.

14.06 **Covered Service** means any service or supply for which benefits may be payable under the terms of the Plan.

14.07 **Custodial Care** means services or treatment which, regardless of where it is provided:

(1) could be rendered safely by a person without medical skills; and

(2) is designed mainly to help the patient with daily living activities, including (but not limited to):

(a) personal care, such as help in walking and getting in and out of bed; help with bathing; help with eating by spoon, tube or gastrostomy; exercising; dressing; enema and using the toilet;

(b) homemaking, such as preparing meals or special diets;

(c) moving the patient;

(d) acting as companion or sitter;

(e) supervising medication which can usually be self- administered;

(f) oral hygiene; and

(g) ordinary skin and nail care.

Anthem Blue Cross, as the Plan's contracted Utilization Review provider, determines what services are Custodial Care. When a confinement or visit is found to be mainly for Custodial Care, some services (such as prescription drugs, X-rays and lab tests) may still be covered. All bills should be routinely submitted for consideration.

14.08 **Developmental Care** means services or supplies, regardless of where or by whom they are provided which:

(1) are provided to a covered person who has not previously reached the level of development expected for the covered person's age in the following areas of major life activity:

(a) intellectual;

(b) physical;

(c) receptive and expressive language;

(d) learning;
(e) mobility;
(f) self-direction;
(g) capacity for independent living; or
(h) economic self-sufficiency;

(2) are not primarily rehabilitative (restoring skills that were lost or impaired due to Injury or Sickness); or
(3) are primarily educational.

14.09 **Domestic Partner** means a person whose domestic partnership with a participant has been registered with a governmental agency pursuant to state or local law authorizing such registration.

14.10 **Experimental Drug or Treatment** means a drug, device, treatment or procedure:

(1) which cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and which has not been so approved;
(2) which was reviewed and approved (or required by law to be reviewed and approved) by the treating facility's Institutional Review Board or other body serving a similar function, or which was used with a patient informed consent document which was reviewed and approved (or required by law to be reviewed and approved) by the treating facility's Institutional Review Board or other body serving a similar function;
(3) 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, toxicity, safety, or efficacy; or
(4) 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, toxicity, safety, or efficacy.

"Reliable Evidence" means only published reports and articles in peer-reviewed medical and scientific literature; the written protocol used by the treating facility or another facility studying the same drug, device, treatment or procedure; or the patient informed consent document used by the treating facility or another facility studying the same drug, device, treatment or procedure.

14.11 **Home Health Care Agency** means a public or private agency or organization licensed in the state in which it is located, to provide Home Health Care Services.

14.12 **Home Health Care** means services that are Medically Necessary for the care and treatment of a covered Sickness or Injury furnished to a covered person at his or her place of residence.

14.13 **Hospice** means a coordinated plan of home or Inpatient care which treats the terminally ill patient and family as a family unit. It provides care to meet the special needs of the family unit during the final stages of a terminal illness. The Hospice must meet the licensing requirements of the state or locality in which it operates.

14.14 **Hospital** means an Institution constituted, licensed and operated as set forth in the laws that apply to Hospitals, which: (1) provides Room and Board and nursing care for its patients; (2) has a staff with one or more Physicians available at all times; (3) provides 24-hour nursing service; (4) maintains on its premises all the facilities needed for the diagnosis, medical care and treatment of Sickness or Injury; and (e) has organized facilities on its premises for major surgery. No claim for treatment, care or services rendered in a Hospital will be denied solely because the Hospital lacks major surgical facilities.

The term Hospital does not include an Institution, or that part of an Institution, used mainly for: (1) nursing care; (2) rest care; (3) convalescent care; (4) care of the aged; (5) Custodial Care; or (6) educational care.

14.15 **Hospital's Most Common Semiprivate Room Rate** means the rate that is charged by the Hospital for confinement in most of its semiprivate rooms. If the Hospital has no semiprivate rooms, this term will mean the average semiprivate rate in the same Locale.

14.16 **Injury** means an injury to the body that is sustained accidentally.

14.17 **Inpatient** means a covered person who is confined in a Hospital or Skilled Nursing Facility and is charged for Room and Board.

14.18 **Institution** means a facility, operating within the scope of its license, whose purpose is to provide organized health care and treatment to an covered person, such as a Hospital, Skilled Nursing Facility, Ambulatory Surgical Center, Psychiatric Hospital, community mental health center, residential treatment facility, psychiatric treatment facility, alcohol or drug dependency treatment center, Birthing Center, home health center, Hospice, or any other such facility that the Plan approves.

14.19 **Intensive Care Unit** means a separate part of a Hospital that is reserved for critically and seriously ill patients who require highly skilled nursing care and constant or close and frequent audiovisual nursing observation. The Intensive Care Unit must provide its patients with: (1) Room and Board; (2) nursing care by Nurses who work only in the unit; and (3) special equipment and supplies that are primarily for use within the unit.

14.20 **Lifetime** means while covered under any benefit plan sponsored by the Bricklayers and Allied Craftworkers Local No. 3 Health and Welfare Trust Fund or any prior plan, at any time.

14.21 **Locale** means the geographical area represented by the ZIP code which accompanies a given address.

14.22 **Manipulative Therapy of the Spine** means any charges for correction by manual or mechanical means of nerve interference resulting from or related to distortion, misalignment or partial dislocation of or in the vertebral column.

14.23 **Mastectomy** means the removal of all or part of the breasts for Medically Necessary reasons.

14.24 **Medical Necessity or Medically Necessary** means services or supplies received while covered, which are determined by the Plan to be:

(1) appropriate and necessary for the symptoms, diagnosis or treatment of the medical condition;

(2) provided for the diagnosis or direct care and treatment of the medical condition;

(3) within the standards of good medical practice within the organized medical community;

(4) not primarily for the convenience of the covered person, the covered person's Physician or another provider; and

(5) the most appropriate supply or level of service which can safely be provided. For Hospital stays, this means that acute care as an Inpatient is necessary due to the kind of services the covered person is receiving or the severity of the covered person's condition, and that safe and adequate care cannot be received as an Outpatient or in a less intensified medical setting.

The fact that the covered person's Physician prescribes services or supplies does not automatically mean such services or supplies are Medically Necessary or covered by the Plan. The Plan Administration Office will make available the criteria for Medical Necessity or Medically Necessary determinations upon request.

14.25 **Mental and Emotional Illness** means any condition or disease, regardless of cause, listed in the most recent edition of the International Classification of Disease-9.

14.26 **Nonscheduled Admission** means a Hospital admission that is not a Scheduled Admission.

14.27 **Nurse** means: (1) registered nurse (RN); (2) licensed practical nurse (LPN); or (3) Licensed Vocational Nurse (LVN), licensed by the State Board of Nursing.

14.28 **Other Provider and Non-PPO Provider** mean a Hospital, Physician or Other Provider of covered medical services who:

(1) is not participating in Anthem Blue Cross (Preferred Provider Organization); and

(2) is not shown on Anthem Blue Cross's current list of members in that program.

14.29 **Outpatient** means a covered person who receives care in a Hospital or other Institution, including: Ambulatory Surgical Center; Skilled Nursing Facility; or Physician's office for a Sickness or Injury, but who is not confined and is not charged for Room and Board.

14.30 **Outpatient Treatment Facility** means an Institution licensed and approved by the Department of Health and Social Services which provides Outpatient services for: (1) prevention; and (2) treatment of mental disorders, alcoholism or drug dependency.

14.31 **Physician** means: (1) legally licensed doctor of medicine or doctor of osteopathy; or (2) any other legally licensed practitioner of the healing arts rendering services: (a) which are covered under the Plan; (b) for which benefits are required by law to be provided when rendered by such a practitioner; and (c) which are within the scope of his or her license.

This term does not include: (1) you; or (2) your dependent; (3) your Spouse, parent, child, sister or brother; or (4) your dependent's Spouse, parent, child, sister or brother.

Such practitioners shall, upon referral from a Physician, include a licensed or certified: (1) clinical social worker; (2) physical therapist; (3) occupational therapist; (4) speech pathologist; (5) audiologist; (6) marriage, family or child counselor; or (7) acupuncturist.

14.32 **Preferred Provider and PPO Provider** mean a Hospital, Physician or Other Provider of covered medical services who:

(1) is participating in Anthem Blue Cross (Preferred Provider Organization); and
(2) is shown on Anthem Blue Cross's current list of members in that program.

An updated list of Preferred Providers will be published periodically by Anthem Blue Cross. For the current list, you may contact BeneSys Administrators, or visit Anthem Blue Cross's website at www.anthem.com/ca/.

The Preferred Provider Option is administered in accord with an agreement between the Plan and Anthem Blue Cross. The Plan does not contract directly with any Preferred Provider. Anthem Blue Cross contracts with these providers, and the criteria for participation in the network are determined by Anthem Blue Cross. The Plan does not endorse any provider, including any Preferred Provider, nor does the Plan supervise, control or guarantee the health care services of any provider, including any Preferred Provider.

14.33 **Psychiatric Hospital** means an Institution constituted, licensed and operated as set forth in the laws that apply to Hospitals which: (1) is primarily engaged in providing psychiatric services for the diagnosis and treatment of mentally ill persons, either by or under the supervision of a Physician; (2) maintains clinical records on all patients and keeps records as needed to determine the degree and intensity of treatment provided; (3) is licensed as a Psychiatric Hospital; (4) requires that every patient be under the care of a Physician; and (5) provides 24-hour nursing service.

The term Psychiatric Hospital does not include an institution, or that part of an institution, used mainly for: (1) nursing care; (2) rest care; (3) convalescent care; (4) care of the aged; (5) custodial care; (6) educational care; or (7) treatment of alcoholism or drug dependency.

14.34 **Reasonable and Customary Charge(s)** means charges made for medical services and supplies that are required for the care of the covered person that: (1) are normally charged by the provider for these services and supplies; (2) but not to exceed the amount normally charged within the same Locale by most providers of similar services and supplies.

Consideration will be given to: (1) the nature and severity of the condition for which the covered person needs care; and (2) any circumstances for which additional time, skill or experience are required. In any case where a provider of services accepts as full payment an amount less than the Reasonable and Customary Charge that would have been accepted in the absence of coverage, that reduced amount will be the maximum Reasonable and Customary Charge. For covered persons eligible for Medicare, the Reasonable and Customary Charge will be the Limiting Charge established by the Health Care Financing Administration.

14.35 **Room and Board** means: (1) room and meals; and (2) all general nursing services which are required for the care of Inpatients in a Hospital or other Institution.

Charges for Room and Board must: (1) be billed by the Hospital or other Institution on its own behalf; and (2) be made at a daily or weekly rate that is based on the type of room required.

14.36 **Scheduled Admission or Scheduled For Admission** means a Hospital admission of an insured person that a Physician has scheduled in advance by at least 24 hours.

14.37 **Sickness** means illness or disease. It includes pregnancy and the resulting childbirth, miscarriage or termination of pregnancy.

14.38 **Skilled Nursing Facility** means an Institution constituted, licensed and operated as set forth in the laws that apply, which: (1) mainly provides Inpatient care and treatment for covered persons who are receiving rehabilitation or other therapies which are reasonably expected to result in improved physical or functional status of a recovering patient from a Sickness or Injury; (2) provides care supervised by a Physician; (3) provides 24-hour-per-day nursing care by Nurses, that are supervised by a full-time Nurse (RN); (4) keeps a daily clinical record of each patient; (5) is not a place primarily for the aged; and (6) is not a rest, educational or custodial institution or similar place.

14.39 **Spouse** means a person to whom a participant is lawfully married in any jurisdiction.

14.40 **Usual, Customary and Reasonable** or **UCR** shall mean the allowable out-of-network charge, which is based on benchmark data paid at the 90th percentile of what providers typically charge in the geographic region or market.

14.41 **Working Day** means any day Monday through Friday, excluding national legal holidays.

PART 3 - DENTAL BENEFITS

15. DENTAL BENEFITS PAYABLE

You may enroll either in the Delta Dental PPO or the DeltaCare USA HMO. If you do not elect to enroll in the HMO, you and your eligible dependents will be enrolled in the PPO. If you switch from the Delta Dental PPO to the DeltaCare USA HMO, you will receive a $300.00 taxable benefit from the Plan.

15.01 Delta Dental PPO

(1) **Benefits Payable**

The maximum benefit for dental services (other than Orthodontia) per calendar year is $2,000.

The deductible per person per calendar year is $25. The deductible per family per calendar year is $75.

For Diagnostic and Preventive Services:
After the deductible is satisfied, the Plan will pay 100% of the expense for Covered Services received either from an in-PPO network provider or from an out-of-PPO network provider.

For Basic Services, Endodontics, Peridontics, and Oral Surgery:
After the deductible is satisfied, the Plan will pay 100% of the expense for Covered Services received from an in-PPO network provider, and 80% of the expense for Covered Services received from an out-of-PPO network provider.

For Major Services:
After the deductible is satisfied, the Plan will pay 80% of the expense for Covered Services received either from an in-PPO network provider or from an out-of-PPO network provider.

Orthodontia Benefits:
After the deductible is satisfied, the Plan will pay 50% of usual, customary and reasonable orthodontic services received either from an in-PPO network provider or from an out-of-PPO network provider. Orthodontia benefits are only covered if provided to an Eligible Dependent, before his or her 17th birthday, and are limited to payment of periodic charges through completion of treatment or until his or her 19th birthday, whichever occurs first. The Lifetime maximum benefit per person for Orthodontia is $1,500.

(2) **Deductible**

You or your dependents must satisfy the out-of-pocket expense shown before becoming entitled to benefits. The amount of and manner in which the deductible amount is applied are shown in Section 15.01(1).

(3) **Maximum Benefit**

The Maximum Benefit payable for each covered person is shown in Section 15.01(1).

(4) **Predetermination**

The dentist will perform his or her initial examination, including X-rays and study models where necessary, and list all procedures needed to fully complete treatment on the claim form, including his or her fee(s) for the procedures. This method must be followed whenever the total estimated charges for a course of treatment exceed $1,000. Before the treatment begins, unless of an emergency nature, the dentist must submit the form to the Plan Administration Office. Eligibility must be verified, and benefits for the proposed treatment plan shall be determined prior to the commencement of such treatment.

If such predetermination is not filed with the Plan Administration Office, the Plan reserves the right to make a determination of benefits payable, taking into account alternate procedures, services or courses of treatment based upon accepted standards of dental practice.

(5) **Covered Dental Charges**

Covered Dental Charges are those charges made for services, supplies and treatment itemized below when performed by a dentist or oral surgeon for oral examinations and treatment of diseased teeth or supporting bone or tissue. Such services must be reasonably necessary and the charges may not be unreasonably priced, as determined by the charges generally incurred for cases of comparable nature and severity in the particular geographical area concerned. The Plan may, at its discretion, request as supporting proofs of loss, clinical reports, charts and X-rays.

Selection of a more expensive plan of treatment than is customarily provided under the Plan will be reimbursed by the Plan at the applicable percentage of the lesser fee and the covered person will be responsible for the remainder of his or her dentist's fee; for example, crowns where a silver or plastic restoration could restore the tooth. Composite fillings are covered as amalgam. Porcelain crowns are covered as metal.

A charge shall be deemed to have been incurred on the date the applicable care or service is rendered. The "insert" date of an appliance shall be considered the date the charge was incurred.

(a) **Basic Services** consist of:

Diagnostic Services provide the necessary procedures to assist the dentist in determining the required dental treatment. Full mouth x-rays are covered once every 36 months; bitewing x-rays are covered once every 6 months.

Preventative Care provides the necessary procedures to prevent oral disease. These services include prophylaxis once every 6 months. Applications of fluoride solutions are covered once every 6 months for Eligible Dependents up until his or her 15th birthday. Applications of sealants are covered once every 4 years, for Eligible Dependents up until his or her 15th birthday. Sealants applied to non-permanent molars are not covered. Mouthguards for the protection of teeth against grinding are covered. Athletic mouthguards are not covered.

Oral Surgery provides the necessary procedures for extractions and other dental surgery including pre-and post-operative care.

Restorative Dentistry provides for amalgam, synthetic porcelain and plastic restorations. Gold restorations, crowns and jackets will be provided when teeth cannot be restored with the above materials.

Endodontics provides necessary pulpal therapy and root canal filling (treatment of non-vital teeth).

Periodontics provides for treatment of the tissues supporting the teeth. Scaling and root planing is covered once every 24 months.

(b) **Prosthodontic Services** consist of:

(i) Inlays, gold fillings, crowns (including precision attachments for dentures) and initial installation of fixed bridgework (including inlays and crowns to form abutments).

(ii) Initial installation (including adjustments during the six-month period following installation) of partial or full removable denture to replace one or more natural teeth or replacement of an existing partial or full denture or fixed bridgework, or the addition of teeth to an existing partial removable denture or to bridgework to replace extracted natural teeth, but only if satisfactory evidence is presented that:

(A) the replacement or addition of teeth is required to replace one or more additional natural teeth extracted while insured under the Plan;

(B) the existing denture or bridgework was installed at least five years prior to its

replacement and that the existing denture or bridgework cannot be made serviceable; or

(C) the existing denture is an immediate temporary denture and replacement by a permanent denture is required, and takes place within 12 months from the date of installation of the immediate temporary denture.

(iii) Repair or re-cementing of crowns, inlays, bridgework or dentures, or relining of dentures.

(6) **Covered Orthodontia Charges**

Benefits shall be payable for charges incurred for orthodontia care treatment, services and supplies (except for missing primary teeth), including corrections of malocclusion, as shown in Section 15.01(1).

Limitations on Orthodontic Benefits:
The obligation of the Plan to make monthly or other periodic payments for orthodontic treatment ends upon termination of treatment prior to completion of the case.

The Plan will not pay for repair or replacement of any orthodontic appliance furnished under this Plan.

(7) **Exclusions and Limitations - Dental Benefits**
Covered Dental Charges do not include, and no benefits are payable for, the following:

(a) Charges for any dental procedures which are included as Covered Medical Expenses under Medical Expense Benefits (see Section 12.24), and under Limitations on Benefits (Section 13.01), and charges for which benefits are payable under any other Group Medical Expense Benefit plan provided by your employer.

(b) Charges for treatment by other than a dentist or oral surgeon, except that scaling or cleaning of teeth may be performed by a licensed dental hygienist, if the treatment is rendered under the supervision and direction of the dentist.

(c) Charges for services and supplies that are partially or wholly cosmetic in nature, including charges for personalization or characterization of dentures, or with respect to congenital malformations.

(d) Charges for prosthetic devices, including bridges and crowns and the fitting thereof, which were ordered while the individual was covered under the Plan but are finally installed or delivered to such individual more than 90 days after termination of coverage.

(e) Charges for the replacement of a lost or stolen prosthetic device.

(f) No benefits are payable under this provision for the charges listed below, and they are not included as allowable expenses when benefits are determined:

(i) Charges that would not have been made if no coverage existed or charges that you are not required to pay;

(ii) Any expense or charge for services or supplies which are provided or paid for by the federal government or its agencies, except for:

(A) the Veterans Administration, when services are provided to a veteran for a disability which is not service connected;

(B) a military hospital or facility, when services are provided to a retiree (or dependent of a retiree) from the armed services; or

(C) a group health plan established by a government for its own civilian employees and their dependents;

(iii) Any services for injuries or conditions which can be paid under Workers' Compensation or Employer's Liability laws; or services provided by a State Government Agency, or provided without cost to you or your Eligible Dependents by any municipality, county, or other political subdivision;

(iv) Charges for services and supplies which are not necessary for treatment of the Injury or disease, or are not recommended and approved by the attending Physician or oral surgeon, or are unreasonable, or which exceed generally accepted standards; or

(v) Charges which result from a more expensive plan of treatment when a lesser fee may be payable. The Plan shall pay the applicable lesser fee for such plan of treatment and the covered individual shall be responsible for the remainder of the dentist's fee.

(g) for more than one oral examination and preventive service in any six month period;

(h) for replacement of a denture, crown, or bridge for which benefits were paid by the Plan within five years, unless such replacement is made necessary by the initial placement of an opposing full denture or the extraction of natural teeth;

(i) for prosthetic services or devices (including crowns and bridges) which commenced before the date the person became covered under this Plan. X-rays and prophylaxis treatment shall not be deemed to commence a dental procedure.

15.02 **DeltaCare USA HMO**

Under the DeltaCare USA HMO, dental benefits are provided by a contract dentist, who

must be elected at the time of enrollment, or, if necessary, by a specialist through referral by the contract dentist. Out-of-network emergency dental services will be covered up to $100 per emergency. Pre-authorization is required for all other out-of-network dental services.

There is no deductible, maximum benefit per calendar year, or Lifetime maximum benefit under the DeltaCare USA HMO.

Covered benefits and required co-payment amounts are set forth in Schedule A, and limitations and exclusions are set forth in Schedule B of the Benefit highlights booklet provided by DeltaCare USA.

PART 4 - PRESCRIPTION DRUG BENEFITS
for Participants in the Self-Funded PPO Plan ONLY

16. PRESCRIPTION DRUG BENEFITS

16.01 Benefits Payable

The Plan's prescription drug benefits for persons covered under the self-funded PPO Plan are administered by Sav-Rx. To receive these benefits, you must use your Sav-Rx card at a participating pharmacy, and pay the required co-payment as advised by your pharmacy. All prescription drug benefits are for generic drugs, unless a physician specifies the use of a formulary brand name or other non-generic drug.

The Plan utilizes Sav-Rx's Step Therapy Program for new prescriptions. The Step Therapy Program identifies certain prescribed drugs for which there is a less expensive therapeutically equivalent drug. The Step Therapy Program requires that before the more expensive drug be authorized, the less expensive drug be tried.

(1) **Retail pharmacy**
The following co-payments apply at the retail level:
No charge for generic drug
$10 for formulary brand drug
$40 for all other drugs

(2) **Mail Order**
You may also use the Sav-Rx Mail Order system, and pay one co-payment for a 90-day supply, instead of the 30-day supply available from your pharmacist. The mail order co-payments are as follows:
No charge for generic drug
$20 for formulary brand drug
$80 for all other drugs

(3) **Specialty Drugs Subject to Sav-Rx High Impact Advocacy ("HIA") Program**
Specialty drugs identified by Sav-Rx as being eligible for a manufacturer-sponsored coupon program are subject to the HIA program. If you are taking or have been prescribed a specialty drug that is a part of this program Sav-Rx will notify you to facilitate your enrollment in the manufacturer sponsored coupon program. You are required to cooperate with Sav-Rx and enroll in a manufacturer sponsored coupon program subject to the HIA program. Specialty drugs listed in the HIA program are subject to different copayment amounts. Copayment amounts are set at the level determined by the Sav-Rx HIA program and are subject to change. The copayment may be as high as 25%. However your actual out-of-pocket expense under the HIA program will never be greater than the out-of-pocket expense under the Plan's Retail Pharmacy copayment structure. Specialty drugs subject to the HIA program must be processed through a Sav-Rx Specialty Pharmacy.

Specialty drugs are limited to a 30-day supply.

There is no limit on your annual prescription drug benefit. However, there are exclusions, which are listed below in Section 16.03.

Please note: Prescription drug expenses are not counted toward your stop-loss limit, and prescription drug expenses are not payable at 100%, even after you have satisfied the stop-loss limit for other Covered Expenses.

16.02 **Definitions**

(1) Covered prescription drug charges are charges which are:
(a) due to Sickness or Injury;
(b) incurred while you and your dependents are covered under the Plan;
(c) Reasonable and Customary;
(d) for drugs and medicines that require a Physician's written prescription order; and
(e) dispensed by a licensed pharmacist at a participating pharmacy.

(2) "Prescription Legend Drug" means any medicinal substance, the label of which the Federal Food Drug and Cosmetic Act requires to bear the legend, "Caution: Federal Law prohibits dispensing without a prescription."

(3) "Eligible Prescription Drugs" mean: (a) prescription legend drugs; (b) compound medications of which at least one ingredient is a prescription legend drug; (c) injectable insulin and syringes prescribed by a Physician, and (d) diabetic equipment and supplies as provided for under the prescription drug plan design outline.

(4) "Participating Pharmacy" means a pharmacy which is under an appropriate contract with Sav-Rx.

(5) "Nonparticipating Pharmacy" means a pharmacy which is not under an appropriate contract with Sav-Rx.

16.03 **Exclusions - Prescription Drug Benefits**
No benefits will be paid for:

(1) charges a covered person is not required to pay or charges made only because coverage exists (subject to the right, if any, of the United States government to recover Reasonable and Customary Charges for care provided in a military or veterans' Hospital);

(2) a Sickness or Injury:

(a) for which benefits are paid or payable under workers' compensation or any occupational disease or similar law whether such benefits are insured or self-insured; or

(b) that is caused by, or connected in any way to, employment of the covered person. This includes self-employment or employment by others. It applies whether or not workers' compensation or any occupational disease or similar law covers the charges incurred. It applies whether the charges are covered on an insured or uninsured basis;

(3) prescription non-legend drugs, except those listed above;

(4) therapeutic devices or appliances, except diabetic equipment and supplies as described above;

(5) drugs or medicines lawfully obtainable without a prescription order of a Physician, except insulin;

(6) biological sera, blood or blood plasma (this includes the giving of these items);

(7) drugs labeled: "Caution-limited by federal law to investigational use," or Experimental Drugs, even though a charge is made to the insured person;

(8) any charge for the administration of prescription legend drugs or injectable insulin, which is a Covered Charge under the Self-Funded Medical Benefits program;

(9) any medication, legend or not, which is consumed or administered at the place where it is dispensed;

(10) any amount of drugs or medicines dispensed that is more than a 34-day supply or a 100-unit dosage whichever is greater except that three months' supply will be dispensed if the Sav-Rx Mail Order Program is used;

(11) drugs that may be received at no charge under local, state or federal programs (this will not apply to drugs covered by Medicaid);

(12) drugs and medicines to be taken by or given to an insured person while he or she is confined in a Hospital or Institution;

(13) any prescription or refill in excess of the number specified by the Physician, or any refill dispensed after one year from Physician's original order;

(14) drugs prescribed for Sickness or Injury resulting from war or acts of war;

(15) anorectics (any drug used for the purpose of weight loss);

(16) growth hormones, except with prior authorization;

(17) infertility drugs or medications; or

(18) Minoxidil (Rogaine) for the treatment of alopecia.

16.04 **Off-Label Use of Prescription Drugs Benefits**

(1) Definitions

(a) "Chronic and Seriously Debilitating" means diseases or conditions that require ongoing treatment to maintain remission or prevent deterioration and cause significant long-term morbidity.

(b) "Life-threatening" means either or both of the following:
(i) diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted; or
(ii) diseases or conditions with potentially fatal outcomes, where the end point of clinical intervention is survival.

(2) Benefits

(a) If you or your dependent incurs Expense for prescription drugs that are prescribed by a Physician for a use that is different from the use for which that drug has been approved for marketing by the federal Food and Drug Administration (FDA), the Plan will pay benefits on the same basis as any other covered prescription drug.

(b) Any Medically Necessary services associated with the drug's administration will be payable on the same basis as any other Covered Service.

(3) Conditions

(a) Benefits are subject to the following:
(i) the drug is approved by the FDA;
(ii) the drug is prescribed for the treatment of a Life-threatening condition; or
(iii) the drug is prescribed for the treatment of a Chronic and Seriously Debilitating condition, the drug is Medically Necessary to treat that condition, and the drug is on Our formulary, if any; and
(iv) the drug has been recognized for treatment of that condition by one of the following:
(A) the American Medical Association Drug Evaluations;
(B) the American Hospital Formulary Service Drug Information;
(C) the United States Pharmacopoeia Dispensing Information, Volume 1, "Drug Information for the Health Care Professional";
(D) two articles from major peer reviewed medical journals that present data supporting the proposed off label use or uses as generally safe and effective unless

there is clear and convincing contradictory evidence presented in a major peer reviewed medical journal.

(b) The Plan may request the Physician to submit documentation needed to support compliance with the items listed in (a) through (d) above.

(c) If the Plan denies coverage on the basis that a drug's use is considered Experimental or Investigational, you may appeal this decision under the Plan's Claims and Appeals Procedures.

PART 5 – HEALTH REIMBURSEMENT ARRANGEMENT

17. HEALTH REIMBURSEMENT ARRANGMENT BENEFIT

17.01 This Health Reimbursement Arrangement (HRA) is intended to be a health reimbursement arrangement as defined in IRS Notice 2002-45. Its purpose is to reimburse active employees, retirees, former employees, and their eligible dependents for Eligible Health Care Expenses that are not otherwise covered by the Plan up to the amount of their individual HRA Account.

17.02 **Contributions to HRA Account**. Contributions shall be made to your HRA Account for each month that you (1) work over 250 hours for which your employer is required under a collective bargaining agreement to make contributions to the Plan for your covered hours and the employer makes the required contributions, and (2) you have the maximum allowable hours in your reserve account, 480 hours. The amount of HRA contributions will depend on whether one or both of the following requirements are met: (1) contributions shall be made for each month in a calendar year that you work over 250 hours for which your employer is required under a collective bargaining agreement to make contributions to the Plan, the employer makes the required contributions, and you have the maximum allowable hours in your reserve account, 480 hours, or (2) after the end of each calendar year if it is determined you worked over 2,300 hours between January 1 and December 31 of that calendar year, and your employer was required to make, and made, contributions for those hours, then the amount of your HRA contribution will be based on the higher number of hours resulting from that calculation.

17.03 **Amount of Contribution**. The monthly amount contributed to your HRA Account shall be equal to the then-current hourly contribution rate under the applicable collective bargaining agreement multiplied by the number of hours for which you are eligible for an HRA contribution under Part 5, Section 17.02.

17.04 **Eligible Health Care Expenses**. An Eligible Health Care Expense is an expense incurred by you or your dependent for medical care as that term is defined in Internal Revenue Code Section 213(d).

Examples of Eligible Health Care Expenses:

- Premiums for medical insurance under the Plan (including retiree premiums and COBRA premiums)
- Over the Counter Medications or insulin
- Uninsured medical expenses (i.e., copayments, coinsurance, deductibles)
- Acupuncture
- Chiropractor expenses
- Eye exams
- Contact lenses or glasses used to correct a vision impairment
- Dental expenses

- Dermatology
- Hearing aids
- Laboratory fees
- Nursing services
- Physical therapy
- Smoking cessation programs
- Wheelchairs
- Menstrual care products
- Personal Protective Equipment purchased for the primary purpose of preventing the spread of coronavirus disease 2019 (COVID-19), including but not limited to: face masks, hand sanitizer, and sanitizing wipes.

Examples of common items that are **not** Eligible Health Care Expenses:

- Cosmetic surgery (unless necessary to improve a dfeformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or a disfiguring disease)
- Funeral or burial expenses
- Household and domestic help
- Massage therapy
- Custodial care
- Health club or fitness program dues
- Weight loss programs
- Vitamins or nutritional supplements

17.05 **Procedure for Reimbursement**. You may obtain reimbursement from your HRA Account for Eligible Health Care Expenses by submitting a reimbursement form with supporting documentation to the Plan Administrator. Payment of claims will be subject to the regular claims payment procedures of the Plan. Reimbursement will only be made after an Eligible Health Care Expense is incurred by you or your eligible dependent, and a reimbursement request is submitted with supporting documentation.

17.06 **HRA Account Rollover**. Your HRA Account balance equals all contributions made to your HRA Account minus reimbursements for Eligible Health Care Expenses. Any unused amounts in your HRA Account at the end of the Plan Year will be rolled over to the next Plan Year and will be available for reimbursement. In the event of your death, if you have a remaining HRA Account, the Account can be used to pay for the Eligible Health Care Expenses of your dependents covered under the Plan. If there are no remaining eligible dependents under the Plan, the amount remaining in your HRA Account will be forfeited to the general assets of the Plan. The Internal Revenue Code prohibits the Plan from distributing the remaining HRA Account as a death benefit.

17.07 **Forfeiture of HRA Account for Cause**. If your eligibility is lost for cause under Section 2.06 of this Plan, your HRA Account will be terminated, and the Account will be forfeited to the general assets of the Plan.

17.08 **Waiver of HRA Account**. You are permitted to permanently opt out of or waive future reimbursement from the HRA. If you elect to waive future reimbursement, your HRA Account shall be forfeited to the general assets of the Plan, and will not be reinstated at a later time for any reason.

17.09 **Administrative Fee**. The Board of Trustees reserves the power to assess an administrative charge against each HRA Account. There is no requirement that investment earnings or interest be allocated to a HRA Account inasmuch as the Plan incurs expenses relating to the operation of this benefit. The Trustees may, however, at their discretion, establish an annual earnings allocation to the individual HRA Accounts.

17.10 **Not a Vested Benefit**. The HRA is funded only by employer contributions, and is not a vested benefit. The HRA may be terminated by the Board of Trustees at any time, in which event the HRA Accounts shall revert to the general assets of the Plan.

PART 6 – HEARING AID BENEFIT

18. HEARING AID BENEFIT

18.01 The Plan will pay up to $1,000 towards one hearing aid device for each ear once every thirty-six (36) months as medically necessary. You will be responsible for any balance beyond this specified allowance. Deductibles, coinsurance or copays do not apply. Eligibility for a replacement aid or aids becomes effective thirty-six (36) months from the order date of the previous aid obtained and reimbursed under the Plan.

18.02 Reimbursement of the $1,000 per hearing aid allowance may be obtained by submitting a reimbursement form with supporting documentation to the Trust Fund Office. Payment of claims will be subject to the regular claim time limits under the Plan.

PART 7 – LASER EYE SURGERY BENEFIT

19. LASER EYE SURGERY BENEFIT

19.01 The Plan will pay a lifetime maximum of up to $500 towards laser eye surgery (e.g., LASIK or PRK) for each eye as medically necessary. You will be responsible for any balance beyond this specified allowance. Deductibles, coinsurance or copays do not apply.

19.02 Reimbursement of the $500 allowance for each eye may be obtained by submitting a reimbursement form with supporting documentation to the Trust Fund Office. Payment of claims will be subject to the regular claim time limits under the Plan.

IN WITNESS of the adoption of these Formal Plan Rules as revised July 1, 2025, the Chairman and Secretary hereby subscribe their names, on the dates indicated.

Date: 8/12/2025 | 2:57 PM EDT

Chairman

Robert Filippi

Date: 8/19/2025 | 3:02 PM PDT

Secretary