

**BRICKLAYERS AND ALLIED CRAFT
WORKERS WELFARE FUND OF
WESTERN PENNSYLVANIA**

**SUMMARY PLAN DESCRIPTION
AND
PLAN OF BENEFITS**

Effective January 1, 2026

LETTER FROM THE BOARD OF TRUSTEES

December 2026

Dear Plan Participant:

The Board of Trustees of the Welfare Fund is pleased to present your Summary Plan Description. This Summary Plan Description is furnished to each eligible participant to describe the benefits available to you through your Plan. It also contains the Eligibility Requirements for Employees and Retirees. From time to time you will receive new Summaries of Material Modification notices from the Plan informing you of changes to your benefits or other Plan provisions. These notices will act as updates to this booklet for your reference. Once you have had an opportunity to review this booklet, should you have any questions or require any additional assistance, please contact the Fund Office at:

Bricklayers and Allied Craft Workers Welfare Fund of Western Pennsylvania
c/o BeneSys, Inc.
100 Kingston Drive
Pittsburgh, PA 15235
Local: (412) 317-6538
Toll Free: 1-877-270-1199
Fax: (412) 307-3691
www.baclocal9benefits.org

Sincerely,

Your Board of Trustees

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IMPORTANT PHONE NUMBERS AND WEBSITES

If you need information about your Plan, please use the following guide to help you determine who to contact:

HIGHMARK

Contact Highmark at (800) 241-5704 if:

- you have a question about a medical or prescription drug claim;
- you need to locate an in-network provider; or
- you need a replacement Highmark ID card.

You can also access claims information, print a temporary ID card, search for network providers, research health issues, and much more at www.highmark.com.

MEDICARE PLANS

Contact Retiree First at (856) 780-6218:

- you are a Medicare Retiree and wish to enroll;
- you wish to switch your current option; or
- you have a question regarding your premium payment.

MEMBER ASSISTANCE PROGRAM

Contact LifeSolutions at (855) 209-8762, or visit www.lifesolutionsforyou.com, Organization Code: BRICK to get information regarding counseling services.

FUND OFFICE

Contact the Fund Office at (877) 270-1199 if:

- you have a question about eligibility for you or a dependent;
- you have a question about Death, AD&D claims or Weekly Accident and Sickness benefits;
- you are receiving Workers' Compensation benefits;
- you have a question about your Medical Reimbursement Account;
- you have a question about payment of Retiree, Self-Payment, or COBRA contributions; or
- you have an unresolved issue with Highmark.

I. GENERAL COVERAGE INFORMATION

A. MEDICAL PLAN CHOICES:

Eligible Participants may select from among the following five medical and prescription drug insurance plan options offered through Highmark. The specific benefits provided are described in Section IV.A.

- **Plan A – Base Plan** – This is the base plan.
- **Plan B – Buy-Up Plan** – This plan also has lower deductibles, copayments, and out-of-pocket maximums. This plan and Plan E are the only plans that include dental and vision benefits. There is no coinsurance under the Enhanced Value Network for this plan option.
- **Plan C – Buy-Down Plan** – This plan has increased deductibles, copayments, coinsurance and out-of-pocket maximums; however, the hours requirement for this plan is lower than for Plans A, B, D or E.
- **Plan D – Base Plan (Expanded Network)** – This plan is comparable to Plan A in terms of eligibility and monthly cost, however, the expanded PPO Blue network includes UPMC Medical Group facilities as in-network providers. In order to offset the cost of the broader network, the plan deductible is increased while other benefits remain the same.
- **Plan E – Buy Up Plan (Expanded Network)** – This plan is comparable to Plan B in terms of eligibility and monthly cost, however, the expanded PPO Blue network includes UPMC Medical Group facilities as in-network providers. In order to offset the cost of the broader network, the plan deductible is increased while other benefits remain the same. This plan includes dental and vision benefits. There is no coinsurance under the in in-network benefits for this plan option.
- **Plan F - High Deductible \$9,450 Plan** – This is a new plan option first offered for 2024. It has a catastrophic level deductible and higher copayments, but a lower hours eligibility threshold than the other plans.
- **Opt-Out Option** – You may also choose to waive medical and prescription drug coverage under the Plan if you certify that you have other group medical coverage, such as through your spouse’s employer. If you so waive coverage and were eligible for one of Plans A through E, you may participate in the Medical Reimbursement Account described in Section IV.E. Plans A through E include participation in the Medical Reimbursement Account while Plan F does not. A description of the Medical Reimbursement Account is found in Section IV.E.

B. PROVIDER NETWORKS:

Please call Member Services at (800) 241-5704 to verify if a provider participates in your health plan. You can also go to www.highmarkbcbs.com and select “Find a Doctor or Rx”. Failure to confirm a provider’s participation in your health plan may result in lower levels of reimbursement and/or denial of payment by Highmark.

C. ENROLLMENT FORMS:

New employees are automatically enrolled in the default medical plan option - Plan C - Buy-Down Plan. You will need to complete and return the Enrollment Form, which is sent by the Fund Office, in order to change plan options and to add any dependents to the

coverage. To avoid any unnecessary delay in the processing and payment of your medical claims, the enrollment form must be completed in its entirety, specifically the social security number and dates of birth for the employee, spouse and any dependents.

D. IDENTIFICATION CARDS:

Highmark Identification Cards will be issued separately and should be presented at the time of service.

E. EFFECTIVE DATE OF COVERAGE:

Employee's coverage becomes effective as of the date the Employee becomes eligible. Benefit coverage with respect to eligible Dependents becomes effective on the later of the date the Employee becomes eligible or the date the dependent qualifies as an eligible Dependent.

F. OBLIGATION TO NOTIFY THE FUND OFFICE:

If a change occurs in your family status by reason of marriage, birth or adoption of a child, death, divorce or legal separation, or if a child ceases to be an eligible Dependent, you should immediately notify the Fund Office and secure any proper form to execute the change. In addition, if your mailing address has changed, you must notify the Fund Office and submit the change. You must also notify the Fund Office when you initially become eligible for Medicare. Finally, you must notify the Fund Office if you enter or are discharged from military service. Failure to notify the Fund Office immediately upon one of the foregoing events may result in loss of benefits, or in your obligation to repay the Fund for benefits received by, or on behalf of, an ineligible dependent.

II. ELIGIBILITY RULES

A. PARTICIPANTS. Any Employee working under the jurisdiction of a Participating Union, any Employee of a Participating Union, full-time Office, Official or Supervisory Employees of a Participating Employer (providing such Participating Employer has executed an Agreement assenting to participate), and any member of a Participating Union may become eligible by virtue of meeting the eligibility requirements set forth below. Once an Employee or union member is eligible to participate, he may enroll his spouse and eligible Dependents.

1. Employees Working At the Trade

a. Initial Eligibility Requirements. A new employee will become eligible on the first day of the Benefit Period corresponding to the Work Period in which he has worked for a Contributing Employer either:

- Plans A and D - Base Plans 380 Hours
- Plans B and E - Buy-Up 430 Hours
- Plan C - Buy Down 295 Hours
- Plan F - High Deductible 200 Hours

If you do not work the required hours but you work a minimum of 50 hours in the Work Period, then you may make the required self-payment for the hours differential based upon the plan option in which you have elected to enroll. Plan F works differently. As soon as you join Local 9, you are eligible to join Plan F and pay \$100 per month (subject to change) for Plan F coverage for either six months or until you work the minimum of at least 200 hours during the corresponding Work Period, whichever occurs first.

The Work Periods and corresponding Benefit Periods are as follows:

WORK PERIODS	LAG PERIODS	BENEFIT PERIODS
Jan-Feb-Mar	Apr-May-Jun	Jul-Aug-Sep
Apr- May-Jun	Jul-Aug-Sep	Oct-Nov-Dec
Jul-Aug-Sep	Oct-Nov-Dec	Jan-Feb-Mar
Oct-Nov-Dec	Jan-Feb-Mar	Apr-May-Jun

New employees who do NOT make a Plan election by the start of their first eligible Benefit Period will be automatically enrolled in Plan C - Buy-Down Plan.

- b. Maintenance of Eligibility.** To maintain eligibility in succeeding Benefit Periods, you must meet either the Work Period Hours Requirement for the specified Work Period, or the 4-Quarter Look-Back Hours Requirement as set forth in the chart below:

Plan	Work Quarter	Hours Required	4 Quarter Look Back	Hours Required	Benefit Quarter
Plans A&D - Base	Jan Feb Mar	330	Apr-Mar	1040	Jul Aug Sep
	Apr May June	380	Jul-June	1040	Oct Nov Dec
	Jul Aug Sep	380	Oct-Sep	1040	Jan Feb Mar
	Oct Nov Dec	330	Jan-Dec	1040	Apr May June
Plans B&E - Buy Up	Jan Feb Mar	380	Apr-Mar	1500	Jul Aug Sep
	April May June	430	Jul-June	1500	Oct Nov Dec
	July Aug Sep	430	Oct-Sep	1500	Jan Feb Mar
	Oct Nov Dec	380	Jan-Dec	1500	Apr May June
Plan C - Buy Down	Jan Feb Mar	245	Apr-Mar	940	Jul Aug Sep
	April May June	295	Jul-June	940	Oct Nov Dec
	July Aug Sep	295	Oct-Sep	940	Jan Feb Mar
	Oct Nov Dec	245	Jan-Dec	940	Apr May June
Plan F - High Deductible	Jan Feb Mar	200	Apr-Mar	700	Jul Aug Sep
	April May June	200	Jul-June	700	Oct Nov Dec
	July Aug Sep	200	Oct-Sep	700	Jan Feb Mar
	Oct Nov Dec	200	Jan-Dec	700	Apr May June

If you do not work at least the required hours in the Work Period according to the chart above, then the next test would be the 4-Quarter Look-Back provision of 1040, 1500, 940 or 700 hours. If there is still an hours shortage, then the hours shortage may be taken from the Hour Bank, if any. If you do not have enough hours in the Hour Bank, then you may make the required Self-Payment for the hours differential as described in section II.D.2 based upon which of the three plan options in which you have elected to enroll.

IMPORTANT: *If you do not remit the required self-payment to maintain coverage, any Bank Hours used for the hours shortage will be forfeited.*

- c. Disability Credits.** Any Participant under age 65, who becomes temporarily disabled and unable to work due to an accident or illness while Plan eligible shall (for purposes of maintaining Plan eligibility) be granted four (4) hours of Credited Employment for each day of disability for which Weekly Disability Benefits are payable. Disability Credits will be limited to a maximum of one hundred (105) days or four hundred (420) hours for any one period of continuous disability. For the purposes of these Credits, a period of disability shall be considered continuous (i) until the Participant returns to work for a Contributing Employer and earns 200 hours of Credited Employment or (ii) unless the succeeding period of disability arose from entirely different and unrelated causes. These Disability Credits are only available for days on or after January 1, 2020.

- d. Hours Bank.** Prior to October 1, 2015, Participants were eligible to accrue hours in an Hour Bank. Effective October 1, 2015, Bank Hours are no longer added to a Participant's Hour Bank and new Participants are no longer able to establish an Hour Bank. Any Bank Hours accumulated as of October 1, 2015 may be used in accordance with the provisions of the Plan until the Participant's Bank Hours have been exhausted.
- e. Reciprocal Agreements.** In order to extend protection to those employees who are required from time to time to work outside the jurisdiction of this Plan, the Trustees have entered into Reciprocal Agreements with many of the Welfare Funds in adjacent areas. These Reciprocal Agreements provide for the transfer to this Plan of contributions for those employees who are temporarily working outside this Plan's jurisdictional area.

Employees working at the trade under the jurisdiction of another welfare fund, which had executed a "Reciprocal Agreement" with this Plan, and where such agreement provides for the transfer of contributions, shall be credited with the number of "hours" determined by dividing the contribution received by the Employer Contribution Rate currently in effect. Such hours shall be applied to the Work Period in which such transferred contributions were earned.

CHECK WITH THE PLAN ADMINISTRATOR BEFORE LEAVING the area to make certain that you will remain eligible and that this Plan has a Reciprocal Agreement in effect with the Welfare Fund in the area where you will be working. If there is no Reciprocal Agreement in effect, you may be able to continue your coverage by making a Self-Payment, as described in Section II.D.2.

- f. Unreported Hours.** Upon receiving your Quarterly Work History Report, you should review carefully the hours that were reported to and received by the Fund Office. If the report does not reflect the hours that you worked for a Contributing Employer within the particular Work Period, then you should do the following:
- i. Hours Worked Within the Jurisdictional Area of the Plan**
- You should send a copy of your pay stubs to the Fund Administrator's Eligibility Department.
 - Based on the pay stubs, the Administrator will add the Hours Worked to the respective Work Period. Should the additional hours eliminate the Self-Payment requirement for the plan option you have chosen, then you will be eligible for the respective Work Period.
 - If, after applying the pay stub hours, you are still required to make a Self-Payment, then the Administrator will apply the additional hours to the Four Work Quarter Look-Back requirement for the plan option you have chosen. Should the additional hours eliminate the Self-Payment requirement, then you will be eligible for the respective Work Period.
 - If, after applying the pay stub hours to the Four Work Quarter Look-Back

requirement, you are still required to make a Self-Payment, then the Self-Payment amount will be based on the lesser of the Work Period requirement for the plan option you have chosen less total hours worked plus your Hour Bank, if any, or the Four Work Quarter Look-Back requirement for the plan option you have chosen less total hours worked plus your Hour Bank, if any.

- The Administrator will write a letter to the Employer and request that the Employer remit the Contributions for all hours worked, as per the pay stubs.

ii. **Hours Worked Outside the Jurisdictional Area of the Plan**

- You should send a copy of your pay stubs to the Fund Administrator's Eligibility Department along with the Local Area in which the work was performed.
- You will not receive credit for these hours until they are actually reported and paid to the Fund Office. However, the Administrator will contact the other Local's Health & Welfare Fund and request that the hours and contributions be reciprocated.

iii. **Administrative Restriction.** The Plan Administrator is not permitted to make any changes to a Participant's records without proper documentation. Therefore, you must provide copies of your pay stubs to receive credit for any unreported hours. The Administrator is also not permitted to make any changes to your address, dependents, etc. via a telephone conversation. You will be required to submit your changes in writing.

- g. **Reinstatement of Eligibility.** If you lose coverage due to failure to make any required Self-Payments, you will be eligible to reinstate coverage beginning on the first of the month of the respective Benefit Period after you work the required number of hours in the Work Period for your elected option. If you do not work the required hours for your elected option and are still eligible for Self-Payment, you may make a Self-Payment based on the number of hours that you are short of your required hours times the current contribution rate.

2. **Disabled Participants**

- a. **Eligibility.** Participants under Age 65 who become totally and permanently disabled while eligible hereunder may continue to maintain their eligibility and that of their dependents for all benefits except Weekly Disability providing:
- i. they make application for Total Disability Benefits with the Plan, and
 - ii. they make the required Self-Payment in accordance with the Rules and Regulations pertaining to such contributions.
- b. **Duration of Benefits.** If you meet the foregoing requirements, you will remain eligible for all benefits (except Weekly Disability) until the earliest of the following events:

- i. you qualify for Medicare Benefits under Social Security. When you qualify for Medicare, all benefits except the Death Benefit will be terminated. However, the coverage for your eligible Dependents may be continued, providing the required Self-Payment is made on their behalf.

IMPORTANT: *You MUST notify the Fund Office when they become eligible for Medicare.*

- ii. you recover from your disability. If you are under age 65 and you recover in the course of a Benefit Period, you shall continue to remain eligible until the end of the Benefit Period. Thereafter, you may continue to maintain your eligibility by making the required Self-Payment as an Active Employee in accordance with the eligibility rules then in effect.
- iii. you attain age 65. If you attain age 65 while eligible under this disability section, your coverage will continue as a retiree (for Retiree Death Benefits only), providing you had been eligible for at least five years prior to attaining age 65.
- iv. 24 months after you became totally disabled.

3. Office, Clerical and Supervisory Eligibility Class

- a. **Initial Eligibility.** An office, clerical or supervisory employee will become eligible on the first day of a benefit period in which the required contributions are made on his behalf for the plan option elected or he may make the required Self-Payment. A newly-eligible office, clerical or supervisory employee may become eligible as of a mid-benefit period date as long as the required payment is received under the Plan on a timely basis.
- b. **Maintenance of Eligibility.** You will continue to be eligible in succeeding Benefit Periods, providing your employer contributes the required amount as determined by the Board of Trustees for the plan option elected.

4. Surviving Spouses Eligibility Class

- a. **Death of an Eligible Participant.** For eligible Active Participants, in the event of your death in a Benefit Period in which you are eligible, your eligible Dependents will remain covered under the same terms as if you were still alive up until the eligible Dependent becomes eligible for Medicare or ceases to qualify as a Dependent, except that (i) the eligible Dependent may continue coverage until the earlier of becoming Medicare eligible or ceasing to qualify as a Dependent by making the necessary Self-Payments fully and timely and (ii) the Bank of Hours may not be used to reduce any necessary Self-Payments. This special right to continue coverage through Self-Payment shall cease permanently if any Self-Payment is not made fully or timely.

IMPORTANT: *The primary difference in medical benefits is that the Surviving Spouse Schedule of Benefits will not include the Medical Reimbursement Account. Under no circumstances would the Surviving Spouse and/or eligible Dependents*

be eligible for Life, Accidental Death & Dismemberment, and Weekly Accident & Sickness Benefits.

5. Retired Eligibility Class Age 65 and Over

- a. Eligibility.** For eligible Active Participants, if you retired after November 1, 1967, you are eligible for Retiree Death Benefits providing:
 - i. you have been covered under this Plan for at least five consecutive years immediately prior to retirement; and
 - ii. you make the required Self-Payment, if any, in accordance with the Rules and Regulations adopted by the Trustees.
- b. Medicare Benefits.** Please contact the nearest Social Security office for complete information and instructions about Medicare Part A & Part B enrollment. It is important to enroll for all Medicare benefits. While the Fund Office does not administer Medicare benefits, there are several Medicare Supplemental coverage options available to you. For additional information please refer to the **Important Phone Numbers and Websites section**.
- c. Retire.** “Retire” means receiving payment under a Bricklayer or Building Trades qualified retirement plan and no longer working.

6. Early Retired Eligibility Class

- a. Early Retirement.**
 - i. Eligibility to Continue Active Schedule of Benefits.** If you are an eligible Active Participant who elects to retire prior to attaining age 65, you may maintain the Active Schedule of Benefits, providing that your hours worked meet the Maintenance of Eligibility Requirements as set forth in Section II.A.1.b. If you do not have the required hours, then your Hour Bank, if any, will be applied towards the quarterly eligibility requirement. If the Hour Bank does not meet the quarterly eligibility requirement, then you may make a Self-Payment required to maintain the Active Schedule of Benefits or the Self-Payment required to maintain the Retired Schedule of Benefits. If you have attained age 65 but your spouse has not, your spouse may have the same right to make Self-Payment that you would have had if you had not attained age 65.
 - ii. Eligibility for Retired Schedule of Benefits.** If you are an eligible Active Participant who elects to retire prior to attaining age 65, and your coverage under the Plan is terminated prior to age 65 due to your failure to make the required Self-Payment or your voluntary election to terminate benefits, you may re-enroll in the Retired Schedule of Benefits at any time within one year after the termination of benefits, provided you make the required self-payments. In no event shall coverage under this provision continue past your attainment of age 65.
 - iii. Municipal Members.** Any member of a Participating Union who was

working for a municipality may, upon retirement prior to attaining age 65, elect to participate in the Retired Schedule of Benefits of the Plan. Election to participate must be made in writing within 30 days of your retirement. If no election is made within the 30-day time period, you will not be able to participate in the Plan. If you elect to participate in the Plan, you must make Self-Payments in the amount, and at the frequency, determined by the Fund Office to maintain coverage for yourself and your eligible Dependents.

iv. **Board of Trustees.** The Board of Trustees may approve a formal resolution to provide continued Plan coverage for certain eligible Active Participants who either retire prior to their or their covered spouse's attainment of age 65 or were previously covered by the Plan.

b. **Effect of Medicare or Other Group Insurance Plans.** Any benefit payments made to you or your Dependents (or on your or their behalf) under this Section will be offset by any benefits made by Medicare (assuming you are no longer working) or other group insurance plan, and only the charges which are not covered will be paid. (See the Nonduplication of Benefit Provisions in the documentation provided by the insurance company). Upon attaining age 65 while hereunder, you will continue to be eligible for Retiree Death Benefits only, providing you had been covered under this plan for at least five (5) consecutive years immediately prior to retirement.

B. TERMINATION & SUSPENSION OF BENEFITS

Except as described below, your coverage and that of your eligible Dependents will terminate on the last day of a Benefit Period upon your failure to meet the eligibility requirements for the next succeeding Benefit Period. Further, a Dependent's coverage will automatically terminate when he or she ceases to be a Dependent as herein defined, except that in the event of your death, the provisions of Section II.A.4.a will apply.

All benefits available under the Plan are only available to Participants meeting the Eligibility Requirements and that are currently available for work. Your benefits will be suspended, regardless of whether or not you had previous Hours Worked, Bank Hours or self-payments if:

- You cease to work for a Contributing Employer;
- You work in any manner in the construction industry for a non-signatory employer;
- You withdraw from the Union; or
- You are an owner of a Contributing Employer that is delinquent in submitting contributions to the Plan on behalf of the employees of the Contributing Employer. An "owner" is a sole proprietor, partner, or a majority shareholder of the Contributing Employer. Ownership interest of your spouse, parents and children, if any, will be attributed to you. A Contributing Employer is considered "delinquent" under this provision if it is considered delinquent under the terms of the applicable collective bargaining agreement, participation or other agreement, unless the Contributing Employer has entered into, and is compliant with the terms of, a payment agreement with the Delinquency Committee of the Bricklayers Combined Funds, Inc.

Retired and disabled Participants are not necessarily required to be currently available for work or to work for a Contributing Employer to maintain eligibility otherwise provided under the Plan for such Participants, but will have their eligibility terminated if they work in any manner in the construction industry for a non-signatory employer.

You are required to notify in writing the Board of Trustees, through its administrator, BeneSys, Inc., of any employment or work activity, especially if you work in any manner in the construction industry for a non-signatory employer.

The Board of Trustees of the Fund has the right to require you to supply tax records or other form(s) of verification in order to determine your eligibility. Members that are not eligible to use the Hour Bank shall maintain their Hour Bank in accordance with the rules established for the Hour Bank. **Any Participant who has ceased to meet the eligibility requirements by reasons of this section; i.e., by working in any manner in the construction industry for a non-signatory employer, not paying their Union dues, or being an owner of a delinquent Contributing Employer, will be notified that their benefits are suspended as of the end of the current month.**

An administrative charge of 115 hours will be deducted each work quarter from any and all suspended Hour Banks. These deductions will continue until the Hour Bank account balance is zero, or you are again eligible to participate in the Plan. Application for reinstatement of benefits after eligibility is suspended by this section must be made to the Board of Trustees with confirmation of renewed eligibility meeting the requirements of the Plan.

Active Employees who waive enrollment in a medical plan option and who certify that they have group health plan coverage available elsewhere shall not lose eligibility for Death Benefits, Accidental Death and Dismemberment Benefits or Weekly Disability Benefits merely because of their waiver of enrollment in a medical plan option.

C. **QUALIFIED MEDICAL CHILD SUPPORT ORDERS (QMCSOs)**

1. **Orders.** The law provides that an “alternate recipient”, as defined below, under a “qualified medical child support order”, also defined below, must continue to receive medical coverage in compliance with a court order. A “qualified medical child support order” is a judgment or court decree that requires a group health plan to provide coverage to the children of a plan Participant under a state domestic relations law. The term “alternate recipient” means any child of an employee who is recognized under a medical child support order as having a right to enrollment under a group health plan.

Medical child support orders must be “qualified” before a plan is required to honor them. A Qualified Medical Support Order must clearly specify the following:

- a. the name and last known mailing address of the plan Participant;
- b. the name and last known mailing address of each alternate recipient covered by the Order;
- c. a reasonable description of the coverage to be provided by the plan or the manner

- in which the type of coverage is to be determined;
- d. the period to which the order applies; and
- e. each plan the Order covers.

A Qualified Medical Support Order cannot require a plan to provide any type or form of benefit or option not otherwise provided under the plan, except to the extent necessary to meet the requirements of laws relating to medical support orders as described in Section 908 of the Social Security Act. A child cannot be denied coverage on the grounds that he or she was born out of wedlock or is not the tax dependent of the plan Participant or does not reside with the plan Participant or in the insurer's service area.

A child who is an alternate recipient under a Qualified Medical Child Support Order is considered a participant under the plan for purposes of ERISA. Thus, the child is entitled to summary plan descriptions and other disclosures to which a plan participant is entitled and has standing to bring actions under ERISA.

2. **Procedures.** The plan Participant and the alternate recipient must be promptly notified by the Plan Administrator of the receipt of a medical child support order and the plan's procedures for determining whether the medical child support order is a Qualified Medical Support Order. Within a reasonable period after receipt of the order, the plan administrator must determine whether the medical child support order constitutes a Qualified Medical Support Order and notify the plan Participant and the alternate recipient of the determination. The child must be allowed to designate a representative for the receipt of copies of notices with respect to such order. If you currently have dependent health insurance, you must complete an Address and Dependent Change Form and send the form and a copy of the medical support order to the Fund Office. The Fund Office will forward a copy of the form and the Order to any appropriate carriers. Effective date of coverage will be the date of the Court Order.

If you do not have dependent health insurance, you must complete an Application for Basic Coverage adding dependent coverage for the child(ren). Coverage must be under the same plan in which you are enrolled. The effective date will be the first day of a pay period following the date of the Court Order.

You MAY NOT change plans at this time. Children who reside with your ex-spouse will receive "in network" benefits no matter where they live.

The Fund Office will enroll the child(ren) as required by the Court Order, inform the insurance carrier(s) of the enrollment and begin payroll deductions, if applicable. The computer system will be marked to indicate that there is a Court Order in effect and coverage may not be cancelled before the date specified in the Court Order. You will not be allowed to drop dependent coverage prior to the date specified in the Court Order, unless it is subsequently revised.

If you are the subject of a medical child support order and you terminate employment, are laid off, retire or go on leave of absence etc., the Fund Office must give information to the alternate recipient or his/her representative about continuing insurance. The information must be given in the same timeframe as required by COBRA law.

D. SELF-PAYMENTS

1. **General.** In order to allow as many Participants as possible to continue to maintain their eligibility in the Plan, the Plan has extended to such individuals the ability of making Self-Payments.

All Self-Payments must be made before the first of the month of the eligibility quarter or by the first of the month if you qualify to make monthly payments.

Checks and money orders should be made payable to the BRICKLAYERS AND ALLIED CRAFT WORKERS WELFARE FUND OF WESTERN PENNSYLVANIA.

2. Basis of Payment

- a. **Active Eligibility Class.** The right to make a Self-Payment under the following rules is restricted to Active Employees. Only those employees who are working at the trade who have one or more Hours of Credited Employment in any of the immediately preceding five consecutive Work Periods will be considered Active Employees.

As an Active Employee, if you fail to accumulate enough Hours of Credited Employment in a Work Period for the plan option you elected, do not have enough hours in your Hour Bank to make up the shortage, have not worked enough Hours of Credited Employment in the corresponding Four-Quarter Look Back Period, and are not otherwise eligible for your elected plan option, you may maintain your eligibility by making Self-Payments for the difference between (i) Hours of Credited Employment (automatically increased by any hours in your Hour Bank) and (ii) the Work Period hours requirement or the Four-Quarter Look-Back hours requirement, whichever is less.

You will receive a “Work History Eligibility Determination” for each quarterly benefit period, which will provide the hours reported for the respective qualifying quarter and the last twelve-month period. The Self-Payment amount will be calculated based on the number of hours that you are short for eligibility for the elected plan option less the number of hours actually worked times the contribution rate in effect at the time.

NOTE: Should you become eligible through the look-back provision or self payment, any insufficient hours in your hour bank that can be used towards meeting the quarterly or four-quarter look-back provision are forfeited to the Plan. For a complete description of this process, please see Section II.A.1.b. - Maintenance of Eligibility.

If you are a new employee (or an employee being reinstated after not having been in good standing) and you do not work the required hours, but you have worked a minimum of 50 hours in the Work Period, then you may make the required Self-Payment for the hours differential based upon the plan option in which you have

enrolled.

Limitations:

- i. Self-Payments can only be made for the Benefit Period immediately following the Work Period in which you failed to meet the hourly work requirements. No advance payments will be accepted.
- ii. Unless you continue to work at least one or more Hours of Credited Employment in any of the immediately preceding five consecutive Work Periods, you are limited to making Self-Payments for three consecutive full quarter contributions. However, if you are temporarily disabled or on workers' compensation, you may maintain benefits under the "Disabled Eligibility Class" as described below.

- b. Disabled Eligibility Class.** Active Participants that are temporarily disabled or on workers' compensation may make Self-Payments. Benefits are the same as the Early Retired and Surviving Spouse participants and the Self-Payment is based on your family status.

Limitation: As long as you can provide proof of your disability or workers' compensation, you will be permitted to make quarterly Self-Payments to maintain your eligibility.

- c. Office Eligibility Class.** You will receive a quarterly Eligibility Payment Coupon(s) which will indicate the amount due based on your particular classification, family status, contribution rate and maximum premium cost for your actual coverage. It is very important that you inform the Plan Administrator as to any changes in your classification and/or family status.
- d. Retired, Permanently Disabled, and Surviving Spouse Eligibility Classes.** You will receive a quarterly Eligibility Payment Coupon(s) which will indicate the amount due based on your particular classification, family status, contribution rate and maximum premium cost for your actual coverage. It is very important that you inform the Plan Administrator as to any changes in your classification and/or family status.

- 3. Self-Payment Rate.** The Trustees reserve the right to change the Self-Payment Rate and/or amount at any time, without prior notice.

III. CONTINUATION OF COVERAGE (COBRA)

You can continue your health care coverage temporarily in certain circumstances where coverage would otherwise end. This extended health care coverage is called “COBRA continuation coverage,” named for the federal law that sets forth the rules for it. Upon the occurrence of a qualifying event as defined in COBRA, qualified Participants and their dependents shall have the right to continue health care coverage provided under this Plan. You must pay the premium for this coverage, but the cost of the coverage is based on group rates rather than individual rates and may include an additional 2% administrative charge. This notice is intended to inform you, in a very general way, of your rights and obligations under the COBRA coverage provisions. **Both you and your spouse should take the time to read this notice carefully.**

A. QUALIFYING EVENT

A “qualifying event” is a situation that involves a covered Participant and/or their eligible dependents that results in the loss (or termination) of group health coverage (for reasons other than gross misconduct).

The following is a list of Qualifying Events and the period of time COBRA coverage can be continued:

<u>Qualifying Event</u>	<u>Qualifying Beneficiaries</u>	<u>Continuation Coverage</u>
Employee's termination of employment or reduction in hours of employment	Employee, spouse and dependent child	18 months (29 months if qualified beneficiary is disabled)
Death of employee	Spouse and dependent child	36 months
Employee's divorce or legal separation from spouse	Spouse and dependent child	36 months
Employee's entitlement to Medicare	Spouse and dependent child	36 months
Dependent child is no longer an eligible dependent	Dependent child	36 months

B. NOTIFICATION OF QUALIFYING EVENT

Under the law, you or a family member has the responsibility to notify the Plan of a divorce, legal separation or a child's loss of dependency status within 60 days of the event. Dependent children who attain age 26 will lose their dependent status. If notice is not received within the 60 day time period, you, your spouse and/or Dependents will not be entitled to choose COBRA Continuation Coverage. Note that if you do not notify the Fund Office of a divorce or a child's loss of dependent status, you will be required to repay any amounts expended by the Fund to provide benefits to your former spouse or ineligible dependent.

C. COBRA ELECTION FORM

Within 14 days of receipt of notice that one of the qualifying events has occurred, the Fund

Office will notify you and any eligible dependents, including those not living with you (whose address is known to the Fund Office), of the right to elect COBRA continuation coverage. The Fund Office also will provide instructions about how to elect and pay for COBRA continuation coverage.

To elect COBRA continuation coverage, you must complete an election form (provided by the Fund Office) and submit it to the Fund Office within 60 days of the later of the date coverage would be lost as a result of the event or the date of the notice sent to you by the Fund Office of your right to elect COBRA continuation coverage.

If you do not choose COBRA coverage, your Plan health coverage will end.

D. COBRA BENEFITS

If you choose COBRA coverage, the Plan is required to make available medical coverage which, as of the time of the Qualifying Event, is identical to coverage being provided to similarly situated Participants or family members.

E. DISABILITY

The 18 months of COBRA continuation coverage may be extended to 29 months if an individual is determined to be disabled (for Social Security disability purposes) at any time before or during the first 60 days of COBRA coverage, provided that notice of the disability is given to the Fund Office within 60 days of the later of (i) the determination of disability, or (ii) the date of the qualifying event, but before the 18-month maximum coverage period expires. This special 11-month extension also applies to non-disabled family members who were eligible for COBRA due to the same qualifying event. The affected individual must also notify the Plan Administrator within 30 days of any final determination that the individual is no longer disabled.

F. COBRA PREMIUM PAYMENT

You do not have to show that you are insurable to choose continuation coverage. However, continuation coverage under COBRA is provided subject to your eligibility for coverage; the Plan Administrator reserves the right to terminate your COBRA coverage retroactively if you are determined to be ineligible.

If you elect the continuation coverage, you have to pay all or part of the premium for your continuation coverage. There is a grace period of 45 days for payment of the initial premium from the date you elect to continue COBRA coverage. COBRA continuation coverage will not be in effect until premiums are paid. There is a grace period of at least 30 days for payment of the regularly scheduled premium.

G. TERMINATION OF COBRA CONTINUATION COVERAGE

The law provides that COBRA coverage may be discontinued for any of the following reasons:

1. The Plan no longer provides group health coverage to any employees;
2. The premium for your COBRA coverage is not paid on time;

3. The qualified beneficiary becomes covered under another group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition he or she may have;
 4. You become eligible for Medicare;
 5. Your coverage extended for up to 29 months due to your disability and there has been a final determination that you are no longer disabled;
 6. The date the 18 month or 36 month coverage period ends.
- If you have any questions about the law, please contact the Fund Office.

H. EXTENSION OF COBRA MAXIMUM COVERAGE PERIOD

In accordance with Treas. Reg. §54.4980B-7, Q&A-4(b)(1)(i)-(ii), the maximum coverage period is measured from the date when coverage is lost rather than from the date of the qualifying event. The 30-day notice period (during which the Plan is required to notify the plan administrator of the occurrence of certain qualifying events such as the death of the covered employee or the termination of employment or reduction of hours of employment of the covered employee) begins on the date of the loss of coverage rather than on the date of the qualifying event. A loss of coverage includes any increase in the premium or contribution that must be paid for the coverage.

I. AMERICAN RESCUE PLAN ACT OF 2021

The Plan shall operate in conformity with § 9501 of the American Rescue Plan Act of 2021 in all respects, which include providing COBRA continuation coverage, premium assistance and notifications to the appropriate eligible assistance individuals for the period beginning on April 1, 2021 and ending on September 30, 2021.

IV. DESCRIPTION OF BENEFITS

A. MEDICAL AND PRESCRIPTION DRUG INSURANCE

1. **Benefits Provided.** The Welfare Plan provides for the payment of premiums on a medical and prescription drug insurance contract. The Welfare Plan itself does not provide any medical or prescription drug benefits. Refer to the materials provided by the insurance company for details on the benefits provided and any exclusions that may apply. If you need a copy of the insurance company documents, please call the Fund Office.

2. **Plan Options.** You may select from among the following five medical and prescription drug insurance plan options offered through Highmark: The specific benefits provided under these plans are described in Section IV.A.

- **Plan A – Base Plan** – This is the base plan.
- **Plan B – Buy-Up Plan** – This plan also has lower deductibles, copayments, and out-of-pocket maximums. This plan and Plan E are the only plans that include dental and vision benefits. There is no coinsurance under the Enhanced Value Network for this plan option.
- **Plan C – Buy-Down Plan** – This plan has increased deductibles, copayments, coinsurance and out-of-pocket maximums; however, the hours requirement for this plan is lower than for Plans A, B, D, and E.
- **Plan D – Base Plan (Expanded Network)** – This plan is comparable to Plan A in terms of eligibility and monthly cost, however, the expanded PPO Blue network includes UPMC Medical Group facilities as in-network providers. In order to offset the cost of the broader network, the plan deductible is increased while other benefits remain the same.
- **Plan E – Buy Up Plan (Expanded Network)** – This plan is comparable to Plan B in terms of eligibility and monthly cost, however, the expanded PPO Blue network includes UPMC Medical Group facilities as in-network providers. In order to offset the cost of the broader network, the plan deductible is increased while other benefits remain the same. This plan includes dental and vision benefits. There is no coinsurance under the in-network benefits for this plan option.
- **Plan F - High Deductible \$9,450 Plan** – This is a new plan option first offered for 2024. It has a catastrophic level deductible and higher copayments, but a lower hours eligibility threshold than the other plans.
- **Opt-Out Option** – You may also choose to waive medical and prescription drug coverage under the Plan if you certify that you have other group medical coverage, such as through your spouse's employer. If you so waive coverage and were eligible for one of Plans A through E, you may participate in the Medical Reimbursement Account described in Section IV.E. Plans A through E include participation in the Medical Reimbursement Account while Plan F does not. A description of the Medical Reimbursement Account is found in Section IV.E.

3. **Choosing Benefits.** Prior to each Plan Year, there will be an Open Enrollment period during which you will elect which plan option you want to participate in for the upcoming Plan Year. Current Participants who do not make an election during open

enrollment for the new year will continue to have their prior year's election remain in effect.

If you become newly eligible for benefits in the middle of a Plan Year, you will be provided an opportunity to enroll in one of the plan options or to waive medical and prescription drug coverage. New employees who do not make an election during their initial enrollment period will be automatically enrolled in Plan C - Buy-Down Plan.

- 4. Changing Benefit Choices Mid-Year.** Once you enroll (or are automatically enrolled) in a plan option for the Plan Year (or for the remainder of the Plan Year in the case of newly eligible employees), the choice of plan option cannot be changed until the next Open Enrollment period, unless one of the following qualifying events occurs:
- Your legal marital status changes
 - Marriage
 - Divorce, legal separation or annulment
 - Death of spouse
 - Your number of eligible dependent children changes
 - Birth or adoption of a child
 - Child gains or loses eligibility for coverage under the Plan
 - Death of a child
 - Your Dependent's eligibility for benefits or coverage under another employer's group health plan changes
 - A change in work scheduled or status causes him or her to gain or lose eligibility
 - He or she gains a benefit option or loses coverage
 - He or she makes new coverage choices during his or her employer's annual enrollment period
 - Your or a dependent's COBRA coverage from another employer expires
 - You or a dependent becomes eligible for or loses Medicare or Medicaid
 - You or a dependent lose coverage under a government's or educational institution's plan

Bricklayers and Allied Craft Workers Welfare Fund of Western PA

▲ Performance Flex Blue PPO – Base Plan A – Group numbers 107141-00,01,70

On the chart below, you'll see what your plan pays for specific services. There are two levels of network benefits coverage for certain services: Enhanced Value and Standard Value*. When you receive services from providers at the Enhanced Value level of benefits, you will pay less out-of-pocket. You may be responsible for a facility fee, clinic charge or similar fee or charge (in addition to any professional fees) if your office visit or service is provided at a location that qualifies as a hospital department or a satellite building of a hospital.

Benefit	Network		Out-of-Network
	Enhanced Value	Standard Value	
General Provisions			
Benefit Period(1)	Calendar year		
Deductible (per benefit period) (All in-network services are credited to both the standard and the enhanced deductibles.)			
Individual	\$500	\$1,500	\$6,750
Family	\$1,000	\$3,000	\$11,250
Plan Pays – payment based on the plan allowance	90% after deductible	70% after deductible	50% after deductible
Out-of-Pocket Limit (Includes deductible and coinsurance. Once met, plan pays 100% coinsurance for the rest of the benefit period.)			
Individual	\$1,250	\$3,750	\$10,000
Family	\$2,250	\$6,750	\$20,000
Total Maximum Out-of-Pocket (Includes deductible, coinsurance, copays, prescription drug and other qualified medical expenses, Network only) Once met, the plan pays 100% of covered services for the rest of the benefit period.			
Individual	\$10,150		Not applicable
Family	\$20,300		Not applicable
Office/Clinic/Urgent Care Visits			
Retail Clinic Visits	100% after \$20 copayment	100% after \$40 copayment	50% after deductible
Primary Care Provider Office Visits	100% after \$20 copayment	100% after \$40 copayment	50% after deductible
Specialist Office & Virtual Visits	100% after \$40 copayment	100% after \$80 copayment	50% after deductible
Urgent Care Center Visits	100% after \$40 copayment	100% after \$80 copayment	50% after deductible
Telemedicine (5)	100% after \$15 copayment		Not covered
Preventive Care(2)			
Routine Adult			
Adult immunizations	100% (deductible does not apply)		50% after deductible
Colorectal cancer screening	100% (deductible does not apply)		50% after deductible
Diagnostic services and procedures	100% (deductible does not apply)		50% after deductible
Mammograms, annual routine and medically necessary	Routine: 100% (deductible does not apply) Medically Necessary: 100% (deductible does not apply)		50% after deductible
Physical exams	100% (deductible does not apply)		50% after deductible
Routine gynecological exams, including a Pap Test	100% (deductible does not apply)		50% (deductible does not apply)
Routine Pediatric			
Diagnostic services and procedures	100% (deductible does not apply)		50% after deductible
Pediatric immunizations	100% (deductible does not apply)		50% (deductible does not apply)
Physical exams	100% (deductible does not apply)		50% after deductible
Hospital and Medical/Surgical Expenses (including maternity)			
Hospital Inpatient	90% after deductible	70% after deductible	50% after deductible
Hospital Outpatient	90% after deductible	70% after deductible	50% after deductible
Maternity (non-preventive facility & professional services. Includes dependent daughter.)	90% after deductible	70% after deductible	50% after deductible
Medical Care (including inpatient visits and consultations)/ Surgical Expenses	90% after deductible	70% after deductible	50% after deductible

Benefit	Network		Out-of-Network
	Enhanced Value	Standard Value	
Emergency Services			
Emergency Room Services	100% after \$125 copayment (waived if admitted)		
Ambulance (7)	90% after enhanced deductible		
Ambulance – <u>Non-Emergency</u>	90% after enhanced deductible		
Therapy, Rehabilitative and Habilitative Services			
Physical Medicine (Rehabilitative and Habilitative)	100% after \$15 copayment	100% after \$30 copayment	50% after deductible
Respiratory Therapy	90% after deductible	70% after deductible	50% after deductible
Speech & Occupational Therapy (Rehabilitative and Habilitative)	100% after \$15 copayment	100% after \$30 copayment	50% after deductible
Spinal Manipulations	100% after \$15 copayment	100% after \$30 copayment	50% after deductible
Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	90% after deductible	70% after deductible	50% after deductible
Mental Health/Substance Abuse			
Inpatient	90% after enhanced deductible		50% after deductible
Inpatient Detoxification/Rehabilitation	90% after enhanced deductible		50% after deductible
Outpatient	100% after \$15 copayment		50% after deductible
Other Services			
Allergy Extracts and Injections	90% after deductible	70% after deductible	50% after deductible
Assisted Fertilization Procedures	Not Covered		
Dental Services Related to Accidental Injury	90% after deductible	70% after deductible	50% after deductible
Diagnostic Services			
Advanced Imaging (MRI, CAT, PET scan, etc.)	90% after deductible	70% after deductible	50% after deductible
Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)	90% after deductible	70% after deductible	50% after deductible
Durable Medical Equipment, Orthotics and Prosthetics	90% after deductible	70% after deductible	50% after deductible
Home Health Care	90% after deductible	70% after deductible	50% after deductible
Hospice	90% after deductible	70% after deductible	50% after deductible
Infertility Counseling, Testing and <u>Treatment</u> (3)	90% after deductible	70% after deductible	50% after deductible
Private Duty Nursing	90% after deductible	70% after deductible	50% after deductible
Skilled Nursing Facility Care	90% after deductible	70% after deductible	50% after deductible
Transplant Services	90% after deductible	70% after deductible	50% after deductible
Precertification <u>Requirements</u> (4)	YES		
Prescription Drugs			
Prescription Drug Deductible Individual Family	None None		
Prescription Drug <u>Program</u> (6) <i>Defined by the National Pharmacy Network - Not Physician Network. Prescriptions filled at a non-network pharmacy are not covered.</i> <i>Your plan uses <u>the Comprehensive Formulary</u> with an Incentive Benefit Design.</i>	Retail <u>Drugs</u> 31-day Supply (Mandatory Generic) \$10 generic copayment \$55 brand copayment - formulary \$80 brand copayment – non-formulary Specialty Drugs – Limited to a <u>30-day</u> supply Maintenance Drugs through Mail Order 90-day Supply (Mandatory Generic) \$20 generic copayment \$110 brand copayment - formulary \$160 brand copayment – non-formulary Specialty Drugs – Limited to a <u>30-day</u> supply		
Incentive Choice Home Program	After the 2 nd fill of a maintenance medication at a retail pharmacy, a \$5 penalty applies if not filled <u>through the home delivery</u> .		

(1) Your group's benefit period is based on a Calendar Year. The Calendar Year is from January 1-December 31.
 (2) Services are limited to those listed on the Preventive Schedule (Women's Health Preventive Schedule may apply). Gender, age and frequency limits may apply.
 (3) Treatment includes coverage for the correction of a physical or medical problem associated with infertility. Infertility drug therapy may or may not be covered depending on your group's prescription drug program.
 (4) Medical Management & Policy (MM&P) must be contacted prior to a planned inpatient admission or within 48 hours of an emergency or maternity-related inpatient admission. Be sure to verify that your provider is contacting MM&P for precertification. If this does not occur and it is later determined that all or part of the inpatient stay was not medically necessary or appropriate, you will be responsible for payment of any costs not covered.
 (5) Services are provided for acute care for minor illnesses. Services must be performed by a Highmark approved telemedicine provider. Virtual Behavioral Health visits provided by a Highmark approved telemedicine provider are eligible under the Outpatient Mental Health/Substance abuse benefit
 (6) The formulary is an extensive list of Food and Drug Administration (FDA) approved prescription drugs selected for their quality, safety and effectiveness. It includes products in every major therapeutic category. The formulary was developed by the Highmark Pharmacy and Therapeutics Committee made up of

"The terms "enhanced value" and "standard value" are not descriptors of the provider's ability. This is not intended as a contract of benefits. It is designed purely as a reference of the many benefits available under your program.

clinical pharmacists and physicians. Your program includes coverage for both formulary and non-formulary drugs at the specific copayment or coinsurance amounts listed above. Under the soft mandatory generic provision, you are responsible for the payment differential when a generic drug is authorized by your [provider](#) and you purchase a brand name drug. Your payment is the price difference between the brand name drug and generic drug in addition to the brand name drug copayment or coinsurance amounts, which may apply.

(7) [Medically](#) necessary Air Ambulance services rendered by out-of-network providers will be covered at the highest network tier level of benefits

**Bricklayers and Allied Craft Workers Welfare Fund of Western PA
Performance Flex Blue PPO – Buy Up Plan B – Group numbers 107141-10,11,80**

On the chart below, you'll see what your plan pays for specific services. There are two levels of network benefits coverage for certain services: Enhanced Value and Standard Value*. When you receive services from providers at the Enhanced Value level of benefits, you will pay less out-of-pocket. You may be responsible for a facility fee, clinic charge or similar fee or charge (in addition to any professional fees) if your office visit or service is provided at a location that qualifies as a hospital department or a satellite building of a hospital.

Benefit	Network		Out-of-Network
	Enhanced Value	Standard Value	
General Provisions			
Benefit Period (1)	Calendar year		
Deductible (per benefit period) (All in-network services are credited to both the standard and the enhanced deductibles.)			
Individual	\$250	\$1,500	\$8,750
Family	\$500	\$3,000	\$11,250
Plan Pays – payment based on the plan allowance	100% after deductible	70% after deductible	50% after deductible
Out-of-Pocket Limit (Includes deductible and coinsurance. Once met, plan pays 100% coinsurance for the rest of the benefit period.)			
Individual	N/A	\$3,750	\$10,000
Family		\$8,750	\$20,000
Total Maximum Out-of-Pocket (Includes deductible, coinsurance, copays, prescription drug and other qualified medical expenses, Network only) Once met, the plan pays 100% of covered services for the rest of the benefit period.			
Individual	\$10,150		Not applicable
Family	\$20,300		Not applicable
Office/Clinic/Urgent Care Visits			
Retail Clinic Visits	100% after \$10 copayment	100% after \$40 copayment	50% after deductible
Primary Care Provider Office Visits	100% after \$10 copayment	100% after \$40 copayment	50% after deductible
Specialist Office & Virtual Visits	100% after \$20 copayment	100% after \$80 copayment	50% after deductible
Urgent Care Center Visits	100% after \$20 copayment	100% after \$80 copayment	50% after deductible
Telemedicine (5)	100% after \$5 copayment		Not covered
Preventive Care(2)			
Routine Adult			
Adult immunizations	100% (deductible does not apply)		50% after deductible
Colorectal cancer screening	100% (deductible does not apply)		50% after deductible
Diagnostic services and procedures	100% (deductible does not apply)		50% after deductible
Mammograms, annual routine and medically necessary	Routine: 100% (deductible does not apply) Medically Necessary: 100% (deductible does not apply)		50% after deductible
Physical exams	100% (deductible does not apply)		50% after deductible
Routine gynecological exams, including a Pap Test	100% (deductible does not apply)		50% (deductible does not apply)
Routine Pediatric			
Diagnostic services and procedures	100% (deductible does not apply)		50% after deductible
Pediatric immunizations	100% (deductible does not apply)		50% (deductible does not apply)
Physical exams	100% (deductible does not apply)		50% after deductible
Hospital and Medical/Surgical Expenses (including maternity)			
Hospital Inpatient	100% after deductible	70% after deductible	50% after deductible
Hospital Outpatient	100% after deductible	70% after deductible	50% after deductible
Maternity (non-preventive facility & professional services. Includes dependent daughter.)	100% after deductible	70% after deductible	50% after deductible
Medical Care (including inpatient visits and consultations)/ Surgical Expenses	100% after deductible	70% after deductible	50% after deductible

Benefit	Network		Out-of-Network
	Enhanced Value	Standard Value	
Emergency Services			
Emergency Room Services	100% after \$125 copayment (waived if admitted)		
Ambulance (7)	100% after enhanced deductible		
Ambulance – Non-Emergency	100% after enhanced deductible		
Therapy, Rehabilitative and Habilitative Services			
Physical Medicine (Rehabilitative and Habilitative)	100% after \$15 copayment	100% after \$30 copayment	50% after deductible
	Limit: 30 visits per benefit period		
Respiratory Therapy	100% after deductible	70% after deductible	50% after deductible
Speech & Occupational Therapy (Rehabilitative and Habilitative)	100% after \$15 copayment	100% after \$30 copayment	50% after deductible
	Limit: 30 visits per benefit period		
Spinal Manipulations	100% after \$10 copayment	100% after \$30 copayment	50% after deductible
	Limit: 30 visits per benefit period		
Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	100% after deductible	70% after deductible	50% after deductible
Mental Health/Substance Abuse			
Inpatient	100% after enhanced deductible		50% after deductible
Inpatient Detoxification/Rehabilitation	100% after enhanced deductible		50% after deductible
Outpatient	100% after \$10 copayment		50% after deductible
Other Services			
Allergy Extracts and Injections	100% after deductible	70% after deductible	50% after deductible
Assisted Fertilization Procedures	Not Covered		
Dental Services Related to Accidental Injury	100% after deductible	70% after deductible	50% after deductible
Diagnostic Services			
Advanced Imaging (MRI, CAT, PET scan, etc.)	100% after deductible	70% after deductible	50% after deductible
Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)	100% after deductible	70% after deductible	50% after deductible
Durable Medical Equipment, Orthotics and Prosthetics	100% after deductible	70% after deductible	50% after deductible
Home Health Care	100% after deductible	70% after deductible	50% after deductible
Hospice	100% after deductible	70% after deductible	50% after deductible
Infertility Counseling, Testing and Treatment(3)	100% after deductible	70% after deductible	50% after deductible
Private Duty Nursing	100% after deductible	70% after deductible	50% after deductible
Limit: 240 hours/benefit period			
Skilled Nursing Facility Care	100% after deductible	70% after deductible	50% after deductible
	Limit: 100 days per benefit period		
Transplant Services	100% after deductible	70% after deductible	50% after deductible
Precertification Requirements(4)	YES		
Prescription Drugs			
Prescription Drug Deductible	None		
Individual	None		
Family	None		
Prescription Drug Program(8) Defined by the National Pharmacy Network - Not Physician Network. Prescriptions filled at a non-network pharmacy are not covered. Your plan uses the Comprehensive Formulary with an Incentive Benefit Design.	Retail Drugs 31 day Supply (Mandatory Generic)		
	\$10 generic copayment \$55 brand copayment - formulary \$80 brand copayment – non-formulary Specialty Drugs – Limited to a 30 day supply		
Incentive Choice Home Program	Maintenance Drugs through Mail Order 90-day Supply (Mandatory Generic)		
	\$20 generic copayment \$110 brand copayment - formulary \$180 brand copayment – non-formulary Specialty Drugs – Limited to a 30 day supply		
	After the 2 nd fill of a maintenance medication at a retail pharmacy, a \$5 penalty applies if not filled through the home delivery.		

- (1) Your group's benefit period is based on a Calendar Year. The Calendar Year is from January 1-December 31.
- (2) Services are limited to those listed on the Preventive Schedule (Women's Health Preventive Schedule may apply). Gender, age and frequency limits may apply.
- (3) Treatment includes coverage for the correction of a physical or medical problem associated with infertility. Infertility drug therapy may or may not be covered depending on your group's prescription drug program.
- (4) Medical Management & Policy (MM&P) must be contacted prior to a planned inpatient admission or within 48 hours of an emergency or maternity-related inpatient admission. Be sure to verify that your provider is contacting MM&P for precertification. If this does not occur and it is later determined that all or part of the inpatient stay was not medically necessary or appropriate, you will be responsible for payment of any costs not covered.
- (5) Services are provided for acute care for minor illnesses. Services must be performed by a Highmark approved telemedicine provider. Virtual Behavioral Health visits provided by a Highmark approved telemedicine provider are eligible under the Outpatient Mental Health/Substance abuse benefit
- (6) The formulary is an extensive list of Food and Drug Administration (FDA) approved prescription drugs selected for their quality, safety and effectiveness. It includes products in every major therapeutic category. The formulary was developed by the Highmark Pharmacy and Therapeutics Committee made up of

**The terms "enhanced value" and "standard value" are not descriptors of the provider's ability. This is not intended as a contract of benefits. It is designed purely as a reference of the many benefits available under your program.*

clinical pharmacists and physicians. Your program includes coverage for both formulary and non-formulary drugs at the specific copayment or coinsurance amounts listed above. Under the soft mandatory generic provision, you are responsible for the payment differential when a generic drug is authorized by your [provider](#) and you purchase a brand name drug. Your payment is the price difference between the brand name drug and generic drug in addition to the brand name drug copayment or coinsurance amounts, which may apply.

- (7) Medically necessary Air Ambulance services rendered by out-of-network providers will be covered at the highest network tier level of benefits



Performance Flex Blue PPO

**Bricklayers and Allied Craft Workers Welfare Fund of Western PA
Performance Flex Blue PPO – Buy Down Plan C – Group numbers 107141-20,21,90**

On the chart below, you'll see what your plan pays for specific services. There are two levels of network benefits coverage for certain services: Enhanced Value and Standard Value*. When you receive services from providers at the Enhanced Value level of benefits, you will pay less out-of-pocket. You may be responsible for a facility fee, clinic charge or similar fee or charge (in addition to any professional fees) if your office visit or service is provided at a location that qualifies as a hospital department or a satellite building of a hospital.

Benefit	Network		Out-of-Network
	Enhanced Value	Standard Value	
General Provisions			
Benefit Period (1)	Calendar year		
Deductible (per benefit period) (All in-network services are credited to both the standard and the enhanced deductibles.)			
Individual	\$4,000	\$6,000	\$8,750
Family	\$8,000	\$12,000	\$11,250
Plan Pays – payment based on the plan allowance	80% after deductible	70% after deductible	50% after deductible
Out-of-Pocket Limit (Includes deductible and coinsurance. Once met, plan pays 100% coinsurance for the rest of the benefit period.)			
Individual	\$6,650	\$6,880	\$10,000
Family	\$13,300	\$13,760	\$20,000
Total Maximum Out-of-Pocket (Includes deductible, coinsurance, copays, prescription drug and other qualified medical expenses, Network only) Once met, the plan pays 100% of covered services for the rest of the benefit period.			
Individual	\$10,150		Not applicable
Family	\$20,300		Not applicable
Office/Clinic/Urgent Care Visits			
Retail Clinic Visits	100% after \$30 copayment	100% after \$40 copayment	50% after deductible
Primary Care Provider Office Visits	100% after \$30 copayment	100% after \$40 copayment	50% after deductible
Specialist Office & Virtual Visits	100% after \$80 copayment	100% after \$80 copayment	50% after deductible
Urgent Care Center Visits	100% after \$80 copayment	100% after \$80 copayment	50% after deductible
Telemedicine (5)	100% after a \$25 copayment		Not covered
Preventive Care (2)			
Routine Adult			
Adult immunizations	100% (deductible does not apply)		50% after deductible
Colorectal cancer screening	100% (deductible does not apply)		50% after deductible
Diagnostic services and procedures	100% (deductible does not apply)		50% after deductible
Mammograms, annual routine and medically necessary	Routine: 100% (deductible does not apply) Medically Necessary: 100% (deductible does not apply)		50% after deductible
Physical exams	100% (deductible does not apply)		50% after deductible
Routine gynecological exams, including a Pap Test	100% (deductible does not apply)		50% (deductible does not apply)
Routine Pediatric			
Diagnostic services and procedures	100% (deductible does not apply)		50% after deductible
Pediatric immunizations	100% (deductible does not apply)		50% (deductible does not apply)
Physical exams	100% (deductible does not apply)		50% after deductible
Hospital and Medical/Surgical Expenses (including maternity)			
Hospital Inpatient	80% after deductible	70% after deductible	50% after deductible
Hospital Outpatient	80% after deductible	70% after deductible	50% after deductible
Maternity (non-preventive facility & professional services. Includes dependent daughter.)	80% after deductible	70% after deductible	50% after deductible
Medical Care (including inpatient visits and consultations)/ Surgical Expenses	80% after deductible	70% after deductible	50% after deductible

Benefit	Network		Out-of-Network
	Enhanced Value	Standard Value	
Emergency Services			
Emergency Room Services	100% after \$125 copayment (waived if admitted)		
Ambulance (7)	80% after enhanced deductible		
Ambulance – Non-Emergency	80% after enhanced deductible		
Therapy, Rehabilitative and Habilitative Services			
Physical Medicine (Rehabilitative and Habilitative)	100% after \$15 copayment	100% after \$30 copayment	50% after deductible
	Limit: 30 visits per benefit period		
Respiratory Therapy	80% after deductible	70% after deductible	50% after deductible
Speech & Occupational Therapy (Rehabilitative and Habilitative)	100% after \$15 copayment	100% after \$30 copayment	50% after deductible
	Limit: 30 visits per benefit period		
Spinal Manipulations	100% after \$15 copayment	100% after \$30 copayment	50% after deductible
	Limit: 30 visits per benefit period		
Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	80% after deductible	70% after deductible	50% after deductible
Mental Health/Substance Abuse			
Inpatient	80% after enhanced deductible		50% after deductible
Inpatient Detoxification/Rehabilitation	80% after enhanced deductible		50% after deductible
Outpatient	100% after \$15 copayment		50% after deductible
Other Services			
Allergy Extracts and Injections	80% after deductible	70% after deductible	50% after deductible
Assisted Fertilization Procedures	Not Covered		
Dental Services Related to Accidental Injury	80% after deductible	70% after deductible	50% after deductible
Diagnostic Services			
Advanced Imaging (MRI, CAT, PET scan, etc.)	80% after deductible	70% after deductible	50% after deductible
Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)	80% after deductible	70% after deductible	50% after deductible
Durable Medical Equipment, Orthotics and Prosthetics	80% after deductible	70% after deductible	50% after deductible
Home Health Care	80% after deductible	70% after deductible	50% after deductible
Hospice	80% after deductible	70% after deductible	50% after deductible
Infertility Counseling, Testing and Treatment(3)	80% after deductible	70% after deductible	50% after deductible
Private Duty Nursing	80% after deductible	70% after deductible	50% after deductible
	Limit: 240 hours/benefit period		
Skilled Nursing Facility Care	80% after deductible	70% after deductible	50% after deductible
	Limit: 100 days per benefit period		
Transplant Services	80% after deductible	70% after deductible	50% after deductible
Precertification Requirements(4)	YES		
Prescription Drugs			
Prescription Drug Deductible	None None		
Individual Family			
Prescription Drug Program(6) Defined by the National Pharmacy Network - Not Physician Network. Prescriptions filled at a non-network pharmacy are not covered. Your plan uses the Comprehensive Formulary with an Incentive Benefit Design.	Retail Drugs 31-day Supply (Mandatory Generic) \$15 generic copayment \$80 brand copayment - formulary \$80 brand copayment – non-formulary Specialty Drugs – Limited to a 30 day supply Maintenance Drugs through Mail Order 90-day Supply (Mandatory Generic) \$30 generic copayment \$120 brand copayment - formulary \$180 brand copayment – non-formulary Specialty Drugs – Limited to a 30 day supply		
Incentive Choice Home Program	After the 2 nd fill of a maintenance medication at a retail pharmacy, a \$5 penalty applies if not filled through the home delivery.		

- (1) Your group's benefit period is based on a Calendar Year. The Calendar Year is from January 1-December 31.
- (2) Services are limited to those listed on the Preventive Schedule (Women's Health Preventive Schedule may apply). Gender, age and frequency limits may apply.
- (3) Treatment includes coverage for the correction of a physical or medical problem associated with infertility. Infertility drug therapy may or may not be covered depending on your group's prescription drug program.
- (4) Medical Management & Policy (MM&P) must be contacted prior to a planned inpatient admission or within 48 hours of an emergency or maternity-related inpatient admission. Be sure to verify that your provider is contacting MM&P for precertification. If this does not occur and it is later determined that all or part of the inpatient stay was not medically necessary or appropriate, you will be responsible for payment of any costs not covered.
- (5) Services are provided for acute care for minor illnesses. Services must be performed by a Highmark approved telemedicine provider. Virtual Behavioral Health visits provided by a Highmark approved telemedicine provider are eligible under the Outpatient Mental Health/Substance abuse benefit
- (6) The formulary is an extensive list of Food and Drug Administration (FDA) approved prescription drugs selected for their quality, safety and effectiveness. It includes products in every major therapeutic category. The formulary was developed by the Highmark Pharmacy and Therapeutics Committee made up of

*The terms "enhanced value" and "standard value" are not descriptors of the provider's ability. This is not intended as a contract of benefits. It is designed purely as a reference of the many benefits available under your program.

clinical pharmacists and physicians. Your program includes coverage for both formulary and non-formulary drugs at the specific copayment or coinsurance amounts listed above. Under the soft mandatory generic provision, you are responsible for the payment differential when a generic drug is authorized by your [provider](#) and you purchase a brand name drug. Your payment is the price difference between the brand name drug and generic drug in addition to the brand name drug copayment or coinsurance amounts, which may apply.

(7) [Medically](#) necessary Air Ambulance services rendered by out-of-network providers will be covered at the highest network tier level of benefits

Summary of PPO Blue Benefits

On the chart below, you'll see what your plan pays for specific services. You may be responsible for a facility fee, clinic charge or similar fee or charge (in addition to any professional fees) if your office visit or service is provided at a location that qualifies as a hospital department or a satellite building of a hospital.

Bricklayers and Allied Craft Workers Welfare Fund of Western PA

Base Plan D

Group numbers 104916-00,01,70

Benefit	Network	Out-of-Network
General Provisions		
Benefit Period: ⁽¹⁾	Calendar Year	
Deductible (per benefit period)		
Individual	\$2,000	\$6,750
Family	\$4,000	\$11,250
Plan Pays – payment based on the plan allowance	90% after deductible	50% after deductible
Out-of-Pocket Maximums (Includes deductible and coinsurance. Once met, plan pays 100% coinsurance for the rest of the benefit period.)		
Individual	\$2,250	\$10,000
Family	\$4,500	\$20,000
Total Maximum Out of Pocket (includes deductible, coinsurance, copays and other qualified medical expenses, Network <u>only</u> .) Once met, plan pays 100% of covered services for the rest of the benefit period.		
Individual	\$10,150	Not applicable
Family	\$20,300	
Autism Spectrum Disorders (ASD) Maximum (per person) ⁽²⁾	90% after deductible	50% after deductible
Office/Clinic/Urgent Care Visits		
Retail Clinic Visits	100% after \$20 copayment	50% after deductible
Primary Care Provider Office Visits	100% after \$20 copayment	50% after deductible
Specialist Office Visits	100% after \$40 copayment	50% after deductible
Urgent Care Center Visits	100% after \$40 copayment	50% after deductible
Telemedicine ⁽⁷⁾	100% after \$15 copayment	Not covered
Preventive Care ⁽³⁾		
Routine Adult		
Physical exams	100% (deductible does not apply)	50% after deductible
Adult immunizations	100% (deductible does not apply)	50% after deductible
Colorectal cancer screening	100% (deductible does not apply)	50% after deductible
Routine gynecological exams, including a Pap Test	100% (deductible does not apply)	50% (deductible does not apply)
Mammograms, annual routine and medically necessary	Routine: 100% (deductible does not apply) Medically Necessary: 100% after deductible	50% after deductible
Diagnostic services and procedures	100% (deductible does not apply)	50% after deductible
Routine Pediatric		
Physical exams	100% (deductible does not apply)	50% after deductible
Pediatric immunizations	100% (deductible does not apply)	50% (deductible does not apply)
Diagnostic services and procedures	100% (deductible does not apply)	50% after deductible
Hospital and Medical/Surgical Expenses (including maternity)		
Hospital Inpatient		
Hospital Outpatient		
Maternity (non-preventive facility & professional services)	90% after deductible	50% after deductible
Medical/Surgical (except office visits)		
Emergency Services		
Emergency Room Services	100% after \$125 copayment (waived if admitted)	
Ambulance ⁽⁹⁾	90% after deductible	
Therapy and Rehabilitation Services		
Physical Medicine	100% after \$15 copayment	50% after deductible
	Limit: 30 visits per calendar year	
Respiratory Therapy	90% after deductible	50% after deductible
Speech & Occupational Therapy	100% after \$15 copayment	50% after deductible
	Limit: 30 visits per calendar year	

Benefit	Network	Out-of-Network
Spinal Manipulations	100% after \$15 copayment Limit: 30 visits per calendar year	50% after deductible
Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	90% after deductible	50% after deductible
Mental Health/Substance Abuse		
Inpatient Inpatient Detoxification/Rehabilitation	90% after deductible	50% after deductible
Outpatient	100% after \$15 copayment	50% after deductible
Other Services		
Allergy Extracts and Injections	90% after deductible	50% after deductible
Assisted Fertilization Procedures	90% after deductible	50% after deductible
Applied Behavior Analysis for Autism Spectrum Disorders ⁽²⁾	90% after deductible	50% after deductible
Dental Services Related to Accidental Injury	90% after deductible	50% after deductible
Diabetic Treatment	90% after deductible	50% after deductible
Diagnostic Services Advanced imaging (MRI, CAT, PET scan, etc.)	90% after deductible	50% after deductible
Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)	90% after deductible	50% after deductible
Durable Medical Equipment, Orthotic and Prosthetic		50% after deductible
Home Health Care Hospice Infertility Counseling, Testing and Treatment ⁽⁴⁾	90% after deductible	
Home Infusion Therapy	90% after deductible	
Private Duty Nursing	90% after deductible	50% after deductible
	Limit: 240 hours per calendar year	
Enteral Formulas	90% (deductible does not apply)	50% (deductible does not apply)
Skilled Nursing Facility Care	90% after deductible	50% after deductible
	Limit: 100 days per calendar year	
Transplant Services	90% after deductible	50% after deductible
Precertification Requirements ⁽⁵⁾	Yes	
Prescription Drugs		
Prescription Drug Deductible Individual Family	None None	
Prescription Drug Program ⁽⁶⁾ Mandatory Generic Defined by the Advantage Pharmacy Network - Not Physician Network. Prescriptions filled at a non-network pharmacy are not covered. Your plan uses the Comprehensive Formulary.	Retail Drugs (31-day Supply) \$10 generic copayment \$55 formulary brand copayment \$80 non-formulary brand copayment Specialty Drugs – Limited to a 30-day supply Maintenance Drugs through Mail Order (90-day Supply) \$20 generic copayment \$110 formulary brand copayment \$160 non-formulary brand copayment Specialty Drugs – Limited to a 30-day supply	
Incentive Choice Home Delivery Program	After the 2 nd fill of a maintenance medication at a retail pharmacy, a \$5 penalty applies if not filled through the home delivery.	

- (1) Your group's benefit period is based on a Calendar Year.
- (2) Coverage for eligible members to age 21. Services will be paid according to the benefit category (e.g. speech therapy). Treatment for autism spectrum disorders does not reduce visit/day limits.
- (3) Services are limited to those listed on the Highmark Preventive Schedule. Gender, age and frequency limits may apply.
- (4) Treatment includes coverage for the correction of a physical or medical problem associated with infertility. Infertility drug therapy may or may not be covered depending on your group's prescription drug program. Excludes coverage for services related to in-vitro fertilization and artificial insemination.
- (5) Highmark Medical Management & Policy (MM&P) must be contacted prior to a planned inpatient admission or within 48 hours of an emergency or maternity-related inpatient admission. Be sure to verify that your provider is contacting MM&P for precertification. If not, you are responsible for contacting MM&P. If this does not occur and it is later determined that all or part of the inpatient stay was not medically necessary or appropriate, you will be responsible for payment of any costs not covered.
- (6) The formulary is an extensive list of Food and Drug Administration (FDA) approved prescription drugs selected for their quality, safety and effectiveness. It includes products in every major therapeutic category. The formulary was developed by the Highmark Pharmacy and Therapeutics Committee made up of clinical pharmacists and physicians. Your program includes coverage for both formulary and non-formulary drugs at the specific copayment or coinsurance amounts listed above. You are responsible for the payment differential when a generic drug is authorized by your prescriber and you purchase a brand name

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Effective 07/01/14, Allegheny College 01 1804-00, 01, 60, 70

drug. Your payment is the price difference between the brand name drug and generic drug in addition to the brand name drug copayment or coinsurance amounts, which may apply.

- (7) Services are provided for acute care for minor illnesses. Services must be performed by a Highmark approved telemedicine provider. Virtual Behavioral Health visits provided by a Highmark approved telemedicine provider are eligible under Outpatient Mental Health benefit.
- (8) ~~Effective~~ with plan years beginning on or after January 1, 2014, the Network Total Maximum Out-of-Pocket as mandated by the federal government ~~applies~~ applies Deductible, coinsurance, copays, and any qualified medical expenses.
- (9) ~~Medical~~ necessary Air Ambulance services rendered by out-of-network providers will be covered at the highest network tier level of benefits.

Summary of PPO Blue Benefits

On the chart below, you'll see what your plan pays for specific services. You may be responsible for a facility fee, clinic charge or similar fee or charge (in addition to any professional fees) if your office visit or service is provided at a location that qualifies as a hospital department or a satellite building of a hospital.

Bricklayers and Allied Craft Workers Welfare Fund of Western PA

Buy Up Plan E

Group numbers 104916-10,11,80

Benefit	Network	Out-of-Network
General Provisions		
Benefit Period ⁽¹⁾	Calendar Year	
Deductible (per benefit period)		
Individual	\$1,500	\$6,750
Family	\$3,000	\$11,250
Plan Pays – payment based on the plan allowance	100% after deductible	50% after deductible
Out-of-Pocket Maximums (Includes deductible and coinsurance. Once met, plan pays 100% coinsurance for the rest of the benefit period.)		
Individual	N/A	\$10,000
Family		\$20,000
Total Maximum Out of Pocket (Includes deductible, coinsurance, copays and other qualified medical expenses, Network <u>only</u> ⁽⁸⁾) Once met, plan pays 100% of covered services for the rest of the benefit period.		
Individual	\$10,150	Not applicable
Family	\$20,300	
Autism Spectrum Disorders (ASD) Maximum (per person) ⁽²⁾	100% after deductible	50% after deductible
Office/Clinic/Urgent Care Visits		
Retail Clinic Visits	100% after \$10 copayment	50% after deductible
Primary Care Provider Office Visits	100% after \$10 copayment	50% after deductible
Specialist Office Visits	100% after \$20 copayment	50% after deductible
Urgent Care Center Visits	100% after \$20 copayment	50% after deductible
Telemedicine ⁽⁷⁾	100% after \$5 copayment	Not covered
Preventive Care ⁽³⁾		
Routine Adult		
Physical exams	100% (deductible does not apply)	50% after deductible
Adult immunizations	100% (deductible does not apply)	50% after deductible
Colorectal cancer screening	100% (deductible does not apply)	50% after deductible
Routine gynecological exams, including a Pap Test	100% (deductible does not apply)	50% (deductible does not apply)
Mammograms, annual routine and medically necessary	Routine: 100% (deductible does not apply) Medically Necessary: 100% after deductible	50% after deductible
Diagnostic services and procedures	100% (deductible does not apply)	50% after deductible
Routine Pediatric		
Physical exams	100% (deductible does not apply)	50% after deductible
Pediatric immunizations	100% (deductible does not apply)	50% (deductible does not apply)
Diagnostic services and procedures	100% (deductible does not apply)	50% after deductible
Hospital and Medical/Surgical Expenses (including maternity)		
Hospital Inpatient		
Hospital Outpatient		
Maternity (non-preventive facility & professional services)	100% after deductible	50% after deductible
Medical/Surgical (except office visits)		
Emergency Services		
Emergency Room Services	100% after \$125 copayment (waived if admitted)	
Ambulance ⁽⁹⁾	100% after deductible	
Therapy and Rehabilitation Services		
Physical Medicine	100% after \$15 copayment	50% after deductible
	Limit: 30 visits per calendar year	
Respiratory Therapy	100% after deductible	
Speech & Occupational Therapy	100% after \$15 copayment	50% after deductible
	Limit: 30 visits per calendar year	

Benefit	Network	Out-of-Network
Spinal Manipulations	100% after \$10 copayment Limit: 30 visits per calendar year	50% after deductible
Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	100% after deductible	50% after deductible
Mental Health/Substance Abuse		
Inpatient	100% after deductible	50% after deductible
Inpatient Detoxification/Rehabilitation	100% after deductible	50% after deductible
Outpatient	100% after \$10 copayment	50% after deductible
Other Services		
Allergy Extracts and Injections	100% after deductible	50% after deductible
Assisted Fertilization Procedures	100% after deductible	50% after deductible
Applied Behavior Analysis for Autism Spectrum Disorders ⁽²⁾	100% after deductible	50% after deductible
Dental Services Related to Accidental Injury	100% after deductible	50% after deductible
Diabetes Treatment	100% after deductible	50% after deductible
Diagnostic Services	100% after deductible	50% after deductible
Advanced Imaging (MRI, CAT, PET scan, etc.)	100% after deductible	50% after deductible
Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)	100% after deductible	50% after deductible
Durable Medical Equipment, Orthotics and Prosthetics	100% after deductible	50% after deductible
Home Health Care	100% after deductible	50% after deductible
Hospice	100% after deductible	50% after deductible
Infertility Counseling, Testing and Treatment ⁽⁴⁾	100% after deductible	50% after deductible
Home Infusion Therapy	100% after deductible	50% after deductible
Private Duty Nursing	100% after deductible	50% after deductible
	Limit: 240 hours per calendar year	
Enteral Formulae	100% (deductible does not apply)	50% (deductible does not apply)
Skilled Nursing Facility Care	100% after deductible	50% after deductible
	Limit: 100 days per calendar year	
Transplant Services	100% after deductible	50% after deductible
Precertification Requirements ⁽⁵⁾	Yes	Yes
Prescription Drugs		
Prescription Drug Deductible	Individual Family	None None
Prescription Drug Program ⁽⁶⁾	Mandatory Generic Defined by the Advantage Pharmacy Network - Not Physician Network. Prescriptions filled at a non-network pharmacy are not covered. Your plan uses the Comprehensive Formulary.	Retail Drugs (31-day Supply) \$10 generic copayment \$55 formulary brand copayment \$80 non-formulary brand copayment Specialty Drugs – Limited to a 30-day supply Maintenance Drugs through Mail Order (90-day Supply) \$20 generic copayment \$110 formulary brand copayment \$160 non-formulary brand copayment Specialty Drugs – Limited to a 30-day supply
Incentive Choice Home Delivery Program	After the 2 nd fill of a maintenance medication at a retail pharmacy, a \$5 penalty applies if not filled through the home delivery.	

- (1) Your group's benefit period is based on a Calendar Year.
- (2) Coverage for eligible members to age 21. Services will be paid according to the benefit category (e.g. speech therapy). Treatment for autism spectrum disorders does not reduce visit/day limits.
- (3) Services are limited to those listed on the Highmark Preventive Schedule. Gender, age and frequency limits may apply.
- (4) Treatment includes coverage for the correction of a physical or medical problem associated with infertility. Infertility drug therapy may or may not be covered depending on your group's prescription drug program. Excludes coverage for services related to in-vitro fertilization and artificial insemination.
- (5) Highmark Medical Management & Policy (MM&P) must be contacted prior to a planned inpatient admission or within 48 hours of an emergency or maternity-related inpatient admission. Be sure to verify that your provider is contacting MM&P for precertification. If not, you are responsible for contacting MM&P. If this does not occur and it is later determined that all or part of the inpatient stay was not medically necessary or appropriate, you will be responsible for payment of any costs not covered.
- (6) The formulary is an extensive list of Food and Drug Administration (FDA) approved prescription drugs selected for their quality, safety and effectiveness. It includes products in every major therapeutic category. The formulary was developed by the Highmark Pharmacy and Therapeutics Committee made up of clinical pharmacists and physicians. Your program includes coverage for both formulary and non-formulary drugs at the specific copayment or coinsurance amounts listed above. You are responsible for the payment differential when a generic drug is authorized by your provider and you purchase a brand name

This is not intended as a contract of benefits. It is designed purely as a reference of the many benefits available under your program.
Effective 07/01/14, Allegheny College 011804-00, 01, 60, 70

drug. Your payment is the price difference between the brand name drug and generic drug in addition to the brand name drug copayment or coinsurance amounts, which may apply.

- (7) Services are provided for acute care for minor illnesses. Services must be performed by a Highmark approved telemedicine provider. Virtual Behavioral Health visits provided by a Highmark approved telemedicine provider are eligible under Outpatient Mental Health benefit.
- (8) Effective with plan years beginning on or after January 1, 2014, the Network Total Maximum Out-of-Pocket as mandated by the federal government must include deductible, coinsurance, copays, and any qualified medical expenses.
- (9) Medically necessary Air Ambulance services rendered by out-of-network providers will be covered at the highest network tier level of benefits

Bricklayers Performance Blue \$9450 Plan

On the chart below, you'll see what your plan pays for specific services. You may be responsible for a facility fee, clinic charge or similar fee or charge (in addition to any professional fees) if your office visit or service is provided at a location that qualifies as a hospital department or a satellite building of a hospital.

Group#s 107141-30,31,32

Benefit	In Network	Out of Network
General Provisions		
Benefit Period (1)	Calendar Year	
Deductible (per benefit period)		
Individual	\$9,450	\$18,900
Family	\$18,900	\$37,800
Plan Pays – payment based on the plan allowance	100% after deductible	80% after deductible
Out-of-Pocket Limit (Includes coinsurance. Once met, plan pays 100% coinsurance for the rest of the benefit period)		
Individual	None	None
Family	None	None
Total Maximum Out-of-Pocket (Includes deductible, coinsurance, copays, prescription drug cost sharing and other qualified medical expenses, Network only) (2) Once met, the plan pays 100% of covered services for the rest of the benefit period.		
Individual	\$10,150	Not Applicable
Family	\$20,300	Not Applicable
Office/Clinic/Urgent Care Visits		
Retail Clinic Visits & Virtual Visits	100% after deductible	80% after deductible
Primary Care Provider (PCP) Office Visits & Virtual Visits	100% after deductible	80% after deductible
Specialist Office Visits & Virtual Visits	100% after deductible	80% after deductible
Virtual Visit Provider Originating Site Fee	100% after deductible	80% after deductible
Urgent Care Center Visits	100% after deductible	80% after deductible
Telemedicine Services (3)	100% after deductible	not covered
Preventive Care (4)		
Routine Adult		
Physical Exams	100% (deductible does not apply)	80% after deductible
Adult Immunizations	100% (deductible does not apply)	80% after deductible
Routine Gynecological Exams, including a Pap Test	100% (deductible does not apply)	80% (deductible does not apply)
Mammograms, Annual Routine	100% (deductible does not apply)	80% after deductible
Mammograms, Medically Necessary	100% (deductible does not apply)	80% after deductible
Diagnostic Services and Procedures	100% (deductible does not apply)	80% after deductible
Routine Pediatric		
Physical Exams	100% (deductible does not apply)	80% after deductible
Pediatric Immunizations	100% (deductible does not apply)	80% (deductible does not apply)
Diagnostic Services and Procedures	100% (deductible does not apply)	80% after deductible
Emergency Services		
Emergency Room Services (5)	100% after deductible	
Ambulance - Emergency (6)	100% after deductible	100% after in-network deductible
Ambulance - Non-Emergency (6)	100% after deductible	80% after in-network deductible
Hospital and Medical / Surgical Expenses (Including maternity) (5)		
Hospital Inpatient	100% after deductible	80% after deductible
Hospital Outpatient	100% after deductible	80% after deductible
Maternity (non-preventive facility & professional services) including dependent daughter	100% after deductible	80% after deductible
Medical Care (including inpatient visits and consultations)/Surgical Expenses	100% after deductible	80% after deductible
Therapy and Rehabilitation Services		
Physical Medicine	100% after deductible	80% after deductible
	Limit: 20 visits/benefit period	
Respiratory Therapy	100% after deductible	100% after in-network deductible
Speech Therapy	100% after deductible	80% after deductible

Benefit	In Network	Out of Network
	Limit: 20 visits/benefit period	
Occupational Therapy	100% after deductible	80% after deductible
	Limit: 20 visits/benefit period	
Spinal Manipulations	100% after deductible	80% after deductible
	Limit: 20 visits/benefit period	
Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	100% after deductible	80% after deductible
Mental Health / Substance Abuse		
Inpatient Mental Health Services	100% after deductible	80% after deductible
Inpatient Detoxification / Rehabilitation	100% after deductible	80% after deductible
Outpatient Mental Health Services (includes virtual behavioral health visits)	100% after deductible	80% after deductible
Outpatient Substance Abuse Services	100% after deductible	80% after deductible
Other Services		
Allergy Extracts and Injections	100% after deductible	80% after deductible
Applied Behavior Analysis for Autism Spectrum Disorder (7)	100% after deductible	80% after deductible
Assisted Fertilization Procedures	not covered	not covered
Dental Services Related to Accidental Injury	100% after deductible	80% after deductible
Diagnostic Services		
Advanced Imaging (MRI, CAT, PET scan, etc.)	100% after deductible	80% after deductible
Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)	100% after deductible	80% after deductible
Durable Medical Equipment, Orthotics and Prosthetics	100% after deductible	80% after deductible
Home Health Care	100% after deductible	80% after deductible
	limit: 90 visits/benefit period	
Hospice	100% after deductible	80% after deductible
Infertility Counseling, Testing and Treatment (8)	100% after deductible	80% after deductible
Private Duty Nursing	100% after deductible	80% after deductible
	240 hours per benefit period	
Skilled Nursing Facility Care	100% after deductible	80% after deductible
	100 days per benefit period	
Transplant Services	100% after deductible	80% after deductible
Recertification/Authorization Requirements (9)	Yes	Yes
Prescription Drugs		
Prescription Drug Deductible		
Individual	none	
Family	none	
Prescription Drug Program (10)	Retail Drugs <u>31/60/90-day Supply</u>	
Hard Mandatory Generic	Tier One: 100% after deductible	
National Plus	Tier Two: 100% after deductible	
Prescriptions filled at a non-network pharmacy are not covered.	Tier Three: 100% after deductible	
Your plan uses the Comprehensive Formulary with an Incentive Benefit Design	Specialty Drugs (<u>31 day supply only</u>) 100% after deductible	
	Maintenance Drugs through Mail Order (90-day Supply) 100% after deductible	

This is not a contract. This benefits summary presents plan highlights only. Please refer to the policy/ plan documents, as limitations and exclusions apply. The policy/ plan documents control in the event of a conflict with this benefits summary.

(1) Your group's benefit period is based on a Calendar Year which runs from January 1 to December 31.

(2) The Network Total Maximum Out-of-Pocket (TMOOP) is mandated by the federal government. TMOOP must include deductible, coinsurance, copays, prescription drug cost share and any qualified medical expense.

(3) Telemedicine Services (acute care for minor illnesses available on-demand 24/7), must be performed by a Highmark Designated Telemedicine Provider. Additional services provided by a Designated Telemedicine Provider are paid according to the benefit category that they fall under (e.g. Behavioral Health is eligible under the Outpatient Mental Health Services benefit).

(4) Services are limited to those listed on the Highmark Preventive Schedule (Women's Health Preventive Schedule may apply).

(5) Benefits for Emergency Care Services rendered by an Out-of-Network Provider will be paid at the Network services level. Benefits for Hospital Services or Medical Care Services rendered by an Out-of-Network Provider to a member requiring an inpatient admission or observation immediately following receipt of Emergency Care Services will be paid at the Network services level. The member will not be responsible for any amounts billed by the Out-of-Network Provider that are in excess of the plan allowance for such services.

(6) Air Ambulance services rendered by out-of-network providers will be covered at the highest network level of benefits.

(7) Services for the treatment of Autism Spectrum Disorders are covered for eligible members to age 21. After initial evaluation, Applied Behavioral Analysis will be covered as specified above. All other Covered Services for the treatment of Autism Spectrum Disorders will be covered according to the benefit category (e.g. speech therapy, diagnostic services). Treatment for Autism Spectrum Disorders does not reduce visit/day limits. If ASD benefit period dollar maximum applies, only non-essential health benefits will accumulate.

(8) Treatment includes coverage for the correction of a physical or medical problem associated with infertility. Infertility drug therapy may or may not be covered depending on your group's prescription drug program.

(9) If you receive services from an out-of-area provider or an out-of-network provider, you must contact Highmark Utilization Management prior to a planned inpatient admission, prior to receiving certain outpatient services or within 48 hours of an emergency or unplanned inpatient admission to obtain any required precertification. If precertification is not obtained and it is later determined that all or part of the services received were not medically necessary or appropriate, you will be responsible for the payment of any costs not covered by your health plan.

(10) The Highmark formulary is an extensive list of Food and Drug Administration (FDA) approved prescription drugs selected for their quality, safety and effectiveness. The formulary was developed by Highmark Pharmacy Services and approved by the Highmark Pharmacy and Therapeutics Committee made up of clinical pharmacists and physicians. All plan formularies include products in every major therapeutic category. Plan formularies vary by the number of different drugs they cover and in the cost-sharing requirements. Your program includes coverage for both formulary and non-formulary drugs at the copayment or coinsurance amounts listed above. Under the hard mandatory generic provision, when you purchase a brand drug that has a generic equivalent, you will be responsible for the brand drug copayment plus the difference in cost between the brand and generic drugs. With the Smart90 CVS Network, after two fills at a retail pharmacy that is not CVS you must choose between a 90-day supply through CVS retail pharmacy stores or through Express Scripts Mail Order Pharmacy. Your plan requires that you use Accredo specialty pharmacy for select specialty medications. The Copay Armor program helps members to afford high-cost medications (mostly specialty) by leveraging manufacturer coupon dollars. Members will not need to change where prescriptions are filled and will be contacted by Pillar Rx for cost savings enrollment.

Health benefits or health benefit administration may be provided by or through Highmark Blue Cross Blue Shield or Highmark Choice Company, which are independent licensees of the Blue Cross Blue Shield Association.

Summary of Benefits: Blue Edge Dental Flex

Blue Edge Dental Flex plan options provide you maximum flexibility. Benefits are paid at the same level for care received from any provider. The listed percentages represent the portion of the maximum allowable charge (MAC) for which the plan is responsible. Network providers agree to accept the MAC as payment in full and agree to file your claims. If you receive covered services from an out-of-network provider, the plan will apply the percentages shown to the MAC for covered services and you will be responsible for the difference, up to the provider's charge. Standard deductibles, exclusions and limitations apply. Network dentists may elect to discount non-covered services and services above the annual maximum. Discounts vary by service and region and when agreed to by the provider; not permitted in all jurisdictions.

Bricklayers and Allied Craft Workers Welfare Fund of Western Pennsylvania Blue Edge Dental Flex Value 4 - NS		
Network	Advantage	
Deductible – Individual/Family (waived for In and Out-of-network Class I services)	\$0	
Benefit Period Maximum per member	\$1,000	
Class I Services		
Exams	100%	
X-rays	100%	
Cleanings	100%	
Fluoride Treatment	100%	
Sealants	100%	
Space Maintainers	100%	
Palliative Treatment (Emergency)	100%	
Class II Services		
Simple Extractions	50%	
Basic Restorative (Fillings), Posterior Resins	50%	
Repairs of Crowns, Inlays, Onlays, Bridges & Dentures	50%	
General Anesthesia	50%	
Class III Services		
Oral Surgery (including Surgical Extractions)	20%	
Endodontics	20%	
Periodontics (Surgical and Nonsurgical)	20%	
Inlays, Onlays, Crowns	20%	
Prosthetics (Bridges, Dentures)	20%	
Orthodontics (dependents to age 19)		
Diagnostic, Active, Retention Treatment	Not Covered	
Orthodontic Lifetime Maximum per covered dependent	Not Applicable	
Implants		
Implant Surgery, Supported Restoration	Not Covered	
Additional Features		
<input type="checkbox"/> TMD/TMJ*	<input checked="" type="checkbox"/> Smile for Health®–Wellness	<input checked="" type="checkbox"/> Pregnancy
<input type="checkbox"/> Annual Maximum Rollover*	<input checked="" type="checkbox"/> College Tuition Benefit	<input type="checkbox"/> Preventive Incentive*
<input type="checkbox"/> Occlusal Guard*		

Insurance may be provided by Highmark Blue Cross Blue Shield, Highmark Choice Company, Highmark Health Insurance Company, Highmark Coverage Advantage, First Priority Life Insurance Company or First Priority Health, all of which are independent licensees of the Blue Cross and Blue Shield Association. United Concordia is a separate company that administers Highmark dental benefits.

Smile for Health–Wellness is a registered service mark of United Concordia Companies, Inc.

*These features are for Large Group only. Additional fees may apply.

Vision Benefits



In-Network Benefits – Non-Voluntary		Fashion Advantage V	
Frequency – Once Every:			
Eye Examination (including dilation when professionally indicated)		12 months	
Spectacle Lenses		12 months	
Frame		12 months	
Contact Lenses (in lieu of eyeglass lenses)		12 months	
Copayments			
Eye Examination		\$0	
Spectacle Lenses		\$0	
Contact Lens Evaluation, Fitting & Follow-Up Care		n/a	
Eyeglass Benefit - Frame		Average Retail Value	
Non-Collection Frame Allowance (Retail):		Up to \$130	
Davis Vision Frame Collection¹ (in lieu of Allowance):		Up to \$60	
- Fashion level		Up to \$125	
- Designer level		Up to \$175	
- Premier level		Up to \$225	
Eyeglass Benefit - Spectacle Lenses		Average Retail Value	
Member Charges			
Lenses: Single Lined Bifocal Trifocal Lenticular		\$60-\$120	
Oversize Lenses		\$20	
Tinting of Plastic Lenses		\$20	
Scratch-Resistant Coating		\$25-\$40	
Scratch Protection Plan: Single Vision Multifocal Lenses		\$60 - \$120	
Polycarbonate Lenses ²		\$60-\$75	
Ultraviolet Coating		\$25-\$30	
Anti-Reflective Coating: Standard Premium Ultra Ultimate		\$100-\$175	
Progressive Lenses: Standard Premium Ultra Ultimate		\$230-\$440	
High-Index Lenses: 1.67 1.74		\$120-\$160	
Polarized Lenses		\$95-\$110	
Plastic Photosensitive Lenses		\$95-\$150	
Blue Light Filtering		\$25	
Contact Lens Benefit (in lieu of eyeglasses)			
Non-Collection Contact Lenses: Materials Allowance		Up to \$85	
- Evaluation, Fitting & Follow-Up Care – Standard Lens Types		Not Covered	
- Evaluation, Fitting & Follow-Up Care – Specialty Lens Types		Not Covered	
Collection Contact Lenses¹ (in lieu of Allowance): Materials		Up to \$85	
- Disposable		Covered In Full	
- Planned Replacement		Covered In Full	
- Evaluation, Fitting & Follow-up Care		Included	
Medically Necessary Contact Lenses (with prior approval)		Up to \$85	
- Materials, Evaluation, Fitting & Follow-Up Care		Included	
Out-of-Network Reimbursement Schedule: up to			
Eye Examination: \$32	Single Vision Lenses: \$25	Trifocal Lenses: \$46	Elective Contact Lenses: \$85
Frame: \$30	Bifocal/Progressive Lenses: \$36	Lenticular Lenses: \$72	Medically Necessary CL: \$225

¹Collection is available at most participating independent provider offices. Collection is subject to change. Collection is inclusive of select torics and multifocals.

²Polycarbonate lenses are covered in full for dependent children, monocular patients and patients with prescriptions +/- 6.00 diopters or greater.

One-year eyeglass breakage warranty included

Network providers—The Davis Vision provider network is being used through a contractual arrangement between Davis Vision and Highmark. Davis Vision is an independent company that manages a network of licensed vision providers in both private practice and retail locations. Network providers are reviewed and credentialed to ensure that standards for quality and service are maintained.

Network retail locations—In order to provide you with the greatest amount of flexibility and convenience, the network includes a number of retail establishments. Benefits at the retail locations may vary slightly from other locations, as noted in this benefit description. However, your value is comparable.

Locating a network provider—To find a network provider, go to www.highmarkbcbs.com and click on "Find a Doctor or Rx." Click on "Find an Eyecare Provider". Enter your zip code and mile radius then click on "Search" to see the most current listing of providers that will accept your vision plan.

Receiving services from a network provider:

- Call the network provider of your choice and schedule an appointment.
- Identify yourself as a Highmark member, or eligible dependent, in a vision plan administered by Davis Vision.
- Provide the office with your identification (ID) number (located on your Highmark ID card), and the name and birth date of the covered dependent receiving services.

It's that easy! The provider's office will verify your eligibility for services. No claim forms are required!

Frame benefit—You may choose from 'The Collection' in most independent network provider offices or a program allowance will be applied toward a network provider's own frames. Many Collection frames are covered in full or have a nominal copayment which helps you select high-quality frames, while minimizing out-of-pocket expenses. Network retail providers typically do not display the Collection. You will instead be given a program allowance toward your frame purchase. If the chosen frame exceeds the allowance, you will be responsible for any remaining balance.

Contact lenses benefit—Contact lenses may be selected in lieu of eyeglass lenses. No copayment applies towards the initial supply of formulary contact lenses (many of the most popular standard, soft daily wear; disposable or planned replacement) including fitting/follow-up charges. A program allowance will be applied toward contact lenses from the provider's own supply (which may or may not include fitting/follow-up charges). At a network retail location, you will receive an allowance toward the cost of lenses from the retailer's supply. With prior approval, medically necessary contact lenses will be covered in full at all network provider locations.

Low vision services—You and your covered dependents are entitled to a comprehensive low vision evaluation once every five years and low vision aids up to the plan maximum. Up to four follow-up visits will be covered during the five-year period.

Exclusions—This vision program excludes coverage for certain items and services, including: medical treatment of eye disease or injury; vision therapy; special lens designs or coatings other than those previously described; replacement of lost or stolen eyewear; non-prescription (Plano) lenses; and services not performed by licensed personnel.

VALUE-ADDED FEATURES

Replacement contact lens program—Highmark offers a contact lens replacement program to members. This mail order program exclusively allows you to enjoy the guaranteed lowest prices on contact lens replacement materials. Visit www.davisvisioncontacts.com or call 1-855-589-7911 with a current prescription. Every order comes with a complimentary starter kit.

Laser Vision Correction

Highmark members enjoy lower prices on LASIK procedures than other carriers, along with flexible financing options - up to 12 months interest free. These savings are up to 40% - 50% off the national average price of traditional LASIK and are available at over 1,000 locations across our nationwide network of laser vision correction providers. Laser vision correction services are administered by QualSight, LLC. Terms and conditions are subject to change. Locate a participating provider by calling 1-855-502-2020.

Hearing Aid Discounts-Our members have access to exclusive discounts from Your Hearing Network to get started on the way to better hearing. Members receive a free hearing exam, and discounts of up to 40% off premium hearing aids. Each order includes:

- A Trial period - 60 day money back guarantee
- 1 year of follow-up care
- A 4-year service warranty, including 1 year of loss and damage
- A 4-year supply of batteries (included with each hearing aid purchase)

Call 1 (888) 809-0044 for more information, or to schedule your consultation with a local hearing aid professional.

Call Member Service at 1-800-223-4795 (TTY users call 1-800-523-2847).

Monday through Friday, 8:00 am to 5:00 pm, Eastern Standard Time (EST) to find a network provider, ask benefit questions, verify eligibility or request an out-of-network provider reimbursement form.

Discrimination is Against the Law

The Claims Administrator/Insurer complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity. The Claims Administrator/Insurer does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex assigned at birth, gender identity or recorded gender. Furthermore, the Claims Administrator/Insurer will not deny or limit coverage to any health service based on the fact that an individual's sex assigned at birth, gender identity, or recorded gender is different from the one to which such health service is ordinarily available. The Claims Administrator/Insurer will not deny or limit coverage for a specific health service related to gender transition if such denial or limitation results in discriminating against a transgender individual. The Claims Administrator/Insurer:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, contact the Civil Rights Coordinator.

If you believe that the Claims Administrator/Insurer has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity, you can file a grievance with: Civil Rights Coordinator, P.O. Box 22492, Pittsburgh, PA 15222, Phone: 1-866-286-8295, TTY: 711, Fax: 412-544-2475, email: CivilRightsCoordinator@highmarkhealth.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)
Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

Insurance or benefit/claims administration may be provided by Highmark, Highmark Choice Company, Highmark Coverage Advantage, Highmark Health Insurance Company, First Priority Life Insurance Company, First Priority Health, Highmark Benefits Group, Highmark Select Resources, Highmark Senior Solutions Company or Highmark Senior Health Company, all of which are independent licensees of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield plans.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call the number on the back of your ID card (TTY: 711).

ATENCIÓN: Si usted habla español, servicios de asistencia lingüística, de forma gratuita, están disponibles para usted. Llame al número en la parte posterior de su tarjeta de identificación (TTY: 711).

请注意：如果您说中文，可向您提供免费语言协助服务。
请拨打您的身份证背面的号码（TTY：711）。

CHÚ Ý: Nếu quý vị nói tiếng Việt, chúng tôi cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Xin gọi số điện thoại ở mặt sau thẻ ID của quý vị (TTY: 711).

알림: 한국어를 사용하시는 분들을 위해 무료 통역이 제공됩니다. ID 카드 뒷면에 있는 번호로 전화하십시오 (TTY: 711).

ATENSYON: Kung nagsasalita ka ng Tagalog, may makukuha kang mga libreng serbisyong tulong sa wika. Tawagan ang numero sa likod ng iyong ID card (TTY: 711).

ВНИМАНИЕ: Если вы говорите по-русски, вы можете воспользоваться бесплатными услугами языковой поддержки. Позвоните по номеру, указанному на обороте вашей идентификационной карты (номер для текст-телефонных устройств (TTY): 711).

تنبيه: إذا كنت تتحدث اللغة العربية، فهناك خدمات المعاونة في اللغة المجانية متاحة لك. اتصل بالرقم الموجود خلف بطاقة هويتك (جهاز الاتصال لذوي صعوبات السمع والنطق: 711).

Kominike : Si se Kreyòl Ayisyen ou pale, gen sèvis entèprèt, gratis-ticheri, ki la pou ede w. Rele nan nimewo ki nan do kat idantite w la (TTY: 711).

ATTENTION: Si vous parlez français, les services d'assistance linguistique, gratuitement, sont à votre disposition. Appelez le numéro au dos de votre carte d'identité (TTY: 711).

UWAGA: Dla osób mówiących po polsku dostępna jest bezpłatna pomoc językowa. Zadzwoń pod numer podany na odwrocie karty ubezpieczenia zdrowotnego (TTY: 711).

ATENÇÃO: Se a sua língua é o português, temos atendimento gratuito para você no seu idioma. Ligue para o número no verso da sua identidade (TTY: 711).

ATTENZIONE: se parla italiano, per lei sono disponibili servizi di assistenza linguistica a titolo gratuito. Contatti il numero riportato sul retro della sua carta d'identità (TTY: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, steht Ihnen unsere fremdsprachliche Unterstützung kostenlos zur Verfügung. Rufen Sie dazu die auf der Rückseite Ihres Versicherungsausweises (TTY: 711) aufgeführte Nummer an.

注：日本語が母国語の方は言語アシスタンス・サービスを無料でご利用いただけます。ID カードの裏に明記されている番号に電話をおかけください (TTY: 711)。

توجه: اگر شما به زبان فارسی صحبت می کنید، خدمات کمک زبان، به صورت رایگان، در دسترس شماست. با شماره واقع در پشت کارت شناسایی خود (TTY: 711) تماس بگیرید.

B. DEATH BENEFITS

1. Eligibility. Active Employees, Disabled Employees, Office, and Early Retiree Eligibility Classes are eligible for death benefits after one Year of Participation. Retirees age 65 and older are eligible for death benefits while retired if they have completed five Years of Participation immediately preceding retirement. One Year of Participation is defined as twelve (12) consecutive months of Plan participation immediately preceding your death. Five Years of Participation is defined as sixty (60) consecutive months of Plan participation immediately preceding your retirement.

2. Benefits.

a. For Active Employees, Disabled Employees, Office and Early Retiree Eligibility Classes

One Year of Participation	\$2,500.00
Two Years of Participation	\$5,000.00
Three Years of Participation	\$7,500.00

The Death Benefits shown above for eligible Early Retirees and Disabled Employees will continue until attainment of age 65, providing the required Self-Payment is made. Upon attainment of age 65, the Death Benefit will be reduced to \$5,000.00 (See Death Benefits For Retirees Age 65 and Over), providing you had five Years of Participation immediately preceding your time of retirement. In the event an Early Retiree or Disabled Employee had less than five Years of Participation at the time of retirement, all death benefits will terminate upon attainment of age 65.

b. For Retirees Age 65 and Over

Less than Five Years of Participation	None
Five Years of Participation immediately preceding retirement....	\$5,000.00

3. Payment of Benefits

a. Beneficiary. In the event of death from ANY CAUSE, the amount shown in the Schedule of Benefits will be paid to the named Beneficiary. It is MOST IMPORTANT that you designate the person to whom the proceeds are to be paid. You do this by filling in his or her name on the Plan Enrollment Card which may be obtained by contacting the Fund Office. Upon WRITTEN REQUEST the Beneficiary may be changed at any time and as often as desired.

The designation of a Beneficiary shall take effect upon receipt of such notice in the Fund Office. If a Beneficiary dies before you, the interest of such Beneficiary shall thereupon terminate unless otherwise provided by such written notice.

If no designated Beneficiary has survived you or no Beneficiary has been

designated as of the time of your death, payment will be made in equal parts to the person or persons designated as your Beneficiary in the following order: (a) your surviving spouse, (b) your surviving children if you are not survived by a spouse, (c) the person or persons designated on the Union beneficiary designation card who survive you if you are not survived by a spouse or any children, or (d) your estate otherwise.

- b. Filing for Death Benefits.** Written proof of your death must be filed at the Fund Office by the claimant within 180 days from the date of such event. Failure to furnish such proof within 180 days shall not invalidate the claim if it shall be shown not to have been reasonably possible to furnish such proof within the time required. However, effective as of July 1, 2020, all liability on the part of the Plan and the Trustees shall cease and any person’s claim to benefits shall be forfeited unless notice and the required proofs are submitted within 12 months from the date of death.
- c. Payment of Death Benefits.** The Trustees reserve the right to pay all Death Benefits in a single sum, or such other manner as they may deem advisable to the surviving Beneficiary within twelve months from the date of receipt of the required proof. No interest will accrue to the principal benefit amount during the period between the date of death and the date of the benefit payment.
- d. Assignment of Death Benefits.** You cannot assign the Death Benefits under this Plan.

C. ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

- 1. Eligibility.** Active Employees, Disabled Employees, Office, and Early Retiree Eligibility Classes are eligible for Accidental Death and Dismemberment benefits after one Year of Participation. A Year of Participation is defined as twelve (12) consecutive months of eligibility immediately preceding your death or dismemberment.
- 2. Benefits.** If you sustain any of the following losses solely through external and accidental means, you (or your Beneficiary) will be paid the indicated benefit shown below:

One Year of Participation	\$2,500.00
Two Years of Participation	\$5,000.00
Three Years of Participation	\$7,500.00

Loss of life.....	Full Amount
Loss of two limbs, sight of both eyes, or loss of one limb and sight of one eye.....	Full Amount
Loss of one limb or sight of one eye	½ Amount

Loss must occur within 90 days from the day of the accident. Loss of limb means dismemberment by severance at or above the wrist or ankle joint. Loss of sight means the total and irrevocable loss of sight. If more than one of the losses set forth above is

suffered as the result of any one accident, not more than the full amount of Accidental Death and Dismemberment Benefit will be payable.

No payment will be made for death or any loss resulting from or caused directly, wholly or partly, by bodily or mental infirmity, hernia, ptomaine, bacterial infections (except infections caused by pyogenic organisms which shall occur with and through an accidental cut or wound), or disease or illness of any kind, or intentional self-destruction, or intentional self-inflicted injury, while sane or insane, or participation in the committing of a felony, or war or an act of war, or service in any military, naval or air force of any country while such country is engaged in war or police duty as a member of any military, naval or air organization.

3. **Assignment of Benefit.** You cannot assign the Accidental Death and Dismemberment Benefits under this Plan.
4. **Filing for Death Benefits.** In case of your death, written proof of your death must be filed at the Fund Office by the claimant within 180 days from the date of your death. Failure to furnish such proof within 180 days shall not invalidate the claim if it shall be shown not to have been reasonably possible to furnish such proof within the time required. However, all liability on the part of the Plan and the Trustees shall cease and any person's claim to benefits shall be forfeited unless notice and the required proofs are submitted within 12 months from the date of death.

D. WEEKLY DISABILITY BENEFITS FOR ACTIVE EMPLOYEES ONLY

1. **Eligibility.** Active Employees who are covered under the Plan are eligible for Weekly Disability benefits.
2. **Benefits.** Weekly Disability Benefits equal to \$600 will be payable to you if you become disabled and unable to work because of a non-occupational accident or sickness. Injuries or sickness sustained on the job, or which are compensable under Workmen's compensation, are not covered. In addition, Weekly Disability Benefits will not be paid during any period for which you are receiving retirement income under a construction industry pension or retirement plan. Further, no benefits will be payable during any period for which you are receiving unemployment benefits.

Benefits will begin as of the eighth day of disability, or the first day confinement as a resident bed patient in the hospital, whichever is earlier. Benefits will be payable as long as you remain disabled and under the care of a doctor, up to a maximum of (20) weeks during any period of disability.

Successive periods of disability separated by less than 200 hours (bank hours do not apply) of employment shall be considered as one continuous period of disability unless they arise from entirely different and unrelated causes.

You do not have to be confined to your home to collect benefits, but you must be under the care of a physician. No disability will be considered as beginning prior to the first visit or treatment by a physician.

3. **Claiming Benefits.** To qualify for Weekly Disability Benefits, you must submit a completed claim form. Your attending physician must certify on this form that you were disabled or confined to a hospital and show the date of all examinations and treatments.

The Trustees reserve the right to have any claimant for Weekly Disability Benefits referred to a physician of their choice for examination or reexamination. Failure without good excuse to report to the Plan's physician within 48 hours after notice to do so may result in suspension of disability payments.

Disability payments will normally be paid for the period certified on the claim form up until the time of the last examination by the doctor. In order to receive additional payments for continuing periods of disability, you must submit a Subsequent Statement of Claim.

In order to qualify for Weekly Disability Benefits, you must be covered by the Plan.

If you have been covered by the Plan and your hours worked have dropped, then to re-qualify for Weekly Disability Benefits for a disability, you must again be covered by the Plan no later than the quarter following the quarter of the injury, provided the qualifying disability continues through the eligibility effective date.

Example: Let's assume your hours have dropped so you're no longer covered by the Plan. Let's further assume that you complete the minimum hours during the first quarter of 2020 (January, February, March) to re-qualify for the Plan as of July 1, 2020. You then suffer a disability after the first quarter but before July 1, 2020. What happens? You will be eligible for the Weekly Disability Benefit as of July 1, 2020 for the disability that occurred before July 1, 2020 provided your qualifying disability continues at least until that date.

E. MEDICAL REIMBURSEMENT ACCOUNT (MRA)

1. **Eligibility for Contributions.** Active Participants who are enrolled in Plan A, B, C, D, or E will be eligible to receive credits to their MRA balance based on their hours paid during the applicable Work Period equal to \$0.50 per hour for members enrolled in Plan A, B, D, or E and equal to \$0.75 per hour for members enrolled in Plan C. A special case may arise when an Active Participant enrolled in Plan A, B, C, D, or E is required mid-year to make Self-Payment in order to continue their same enrollment. If this Active Participant chooses to not make Self-Payment but certifies that they have group health coverage through another group health plan that provides minimum value coverage, the Active Participant may continue to receive the same MRA credits being received while enrolled in Plan A, B, C, D or E.

Active Participants who during open enrollment or when eligible to change their enrollment waive enrollment in all medical options (after being eligible for Plan A, B, C, D, or E) and certify that they have group health coverage through

another group health plan that provides minimum value coverage and that is not Medicare or individual coverage purchased through an Insurance Exchange or the Individual Marketplace will have up to 50% of the hourly contribution rate of their hours paid credited to their MRA, up to a maximum annual amount of \$10,000. Active Participants must certify that any spouse or dependent covered by the MRA for reimbursement is covered by another group health plan that provides minimum value coverage and that is not individual coverage described above. The other group health plan provides minimum value coverage if it covers at least 60% of the total allowed costs for benefits provided under that plan in accordance with Internal Revenue Code § 36B(c)(2)(C)(ii).

Contributions shall be credited to the MRA balances of office employees of a participating employer as the participating employer may so agree for employees who either are enrolled in Plan A, B, C, D or E or have properly waived Plan coverage in favor of group health through a spouse or parent.

Your ability to receive additional credits in your MRA will terminate once you are no longer covered by Plan A, B, C, D or E and are no longer covered by another eligible group health plan coverage, as certified by you. You also must continue to be a member of Local 9 in good standing, which includes not working in any manner in the construction industry for a non-signatory employer, or you will permanently forfeit your right to receive any further reimbursements based on any MRA credits accrued before your return to good standing.

2. **Eligibility for Reimbursement.** Active Participants who either are enrolled in Plan A, B, C, D, or E or have waived medical coverage according to the above terms are eligible to receive reimbursement of qualified medical expenses through their MRA. Active Participants who are not eligible for additional contributions may only receive reimbursement to the extent the MRA is still credited with unused contributions. Any Participant whether active, inactive or retired may permanently opt out of and waive future reimbursement from the MRA at least annually during open enrollment and as of when the Participant ceases to work additional hours.
3. **Year-to-Year Accumulation.** Contributions will no longer be forfeited if not used within 12 months. Claims still need to be submitted within 12 months of when the expense is incurred. Unused credits will rollover year-to-year up to a maximum of \$30,000. Office employees will not be subject to any annual or lifetime maximum.
4. **Inactive and Retired Participants.** A retired Participant is considered an active Participant under this Subsection E unless the Participant works in any manner in the construction industry for a non-signatory employer. Any member who works in the construction industry for a non-signatory employer or is not

a member in good standing for any other reason is not eligible for contributions or reimbursement under this Subsection E, and will forfeit any and all right to any further MRA reimbursements.

- 5. Timing and Eligibility for MRA Contributions.** Contributions to the MRA shall be deposited and made available each month based on the hours worked and the Plan option elected for the immediately preceding month.

Claims must be submitted within one year from the date of service to be eligible for reimbursement.

- 6. Qualified Medical Expenses.** Qualified medical expenses generally, but not always, are those that would qualify as tax-deductible medical, dental or vision expenses. These are explained in IRS Publication 502.

Also, a medicine or drug will be a qualified medical expense for MRA purposes only if the medicine or drug:

- requires a prescription;
- is available without prescription (an over-the-counter medicine or drug) and you get a prescription for it; or
- is insulin.

Qualified medical expenses reimbursable from your MRA include the following:

- amounts paid for health insurance premiums*;
- amounts paid for long-term coverage;
- amounts that are not covered under another health plan; and
- deductibles, copayments or coinsurance.

***IMPORTANT:** *An MRA may reimburse health insurance premiums paid by you or your spouse for coverage for you, your spouse and your dependents, as long as the premiums were not paid on a pre-tax basis (i.e., through salary reduction in a cafeteria plan).*

All claims are subject to the review and approval of the Trustees who have the authority to make all final decisions. All claims for reimbursement must be sent to the Fund Office and must be substantiated. The Fund Office may establish procedures for reimbursement and may require use of a specific form. You may contact the Fund Office to inquire about the eligibility of certain expenses and to request any additional information. If any request for reimbursement is denied, you always have the right to appeal the denial.

- 7. Local 11 Participants.** Those individuals who were participants in the Bricklayers Local No. 11 – PA Health & Welfare Fund (“Local 11 Fund”) at the time of its merger with the Fund shall be entitled to reimbursement from the MRA established on their behalf at the time of the merger for any qualified medical expenses that they incur until the earlier of their exhaustion of the amount credited to the MRA as of the time of the merger or their date of death.

8. Debit Card. Participants (and spouses) will be able to use an MRA debit card to pay for qualified medical expenses. You may use the card one of two ways:

- You may wait until you receive your Explanation of Benefits (EOB) from the Plan to understand your share of any amount due to a provider. When you receive an invoice statement from the provider, you may write your MRA debit card number on the statement (similar to how you would use a credit card) and return the statement to the provider.
- Alternatively, you may swipe your debit card at the point of purchase without waiting to receive an EOB or invoice.
 - At a pharmacy, you may pay for your co-pay share of the prescription drug. Don't pay for the entire cost, just your co-pay.
 - You may use the card at another provider to pay for your qualified medical expenses

IMPORTANT! Save your bills, EOBs and itemized receipts. The IRS requires that all debit card purchases be substantiated with written records that support the purchases as qualified medical expenses. The Trustees may need to implement additional rules and procedures designed to meet the IRS substantiation requirements. You will be responsible to reimburse the Plan for any ineligible use of the debit card. ***If you do not submit the required documentation on a timely basis, your MRA debit card may be suspended until the matter is resolved.*** Your debit card may not be used to pay for expenses incurred more than 12 months ago.

F. MEMBER ASSISTANCE PROGRAM

The Plan provides you, your spouse and your Dependents with access to professional counselors to assist you with a wide range of everyday life issues including family/relationship concerns, work/career challenges, stress, making health changes, managing anxiety and depression, and alcohol/drug abuse. You can contract a counselor 24 hours a day, 7 days a week, 365 days per year at (855) 209-8762. You also have access to a secure WorkLife portal at www.lifesolutionsforyou.com (use Organization Code BRICK) which provides a web-based library of articles and tips, surveys, ready documents, self-search locators and resource links in five core areas of interest – family and care giving, emotional wellbeing, health and wellness, working smarter and daily living – in one easy to navigate site. These benefits are provided through UPMC *LifeSolutions*.

V. ADMINISTRATION AND CLAIMS

A. ADMINISTRATION

The Trustees have all rights, duties and powers necessary or appropriate for the administration of the plan, except to the extent that they are vested in a separate claims authority (as described in this section) or in the appeals authority (as described in the following section).

All of the deadlines for decisions by the Trustees or other decision maker are deadlines which you have a right to insist upon. But nothing in these rules prevents you from giving up that right and voluntarily agreeing to an extension of any deadline for the Trustees or other decision maker.

Notification in writing includes any form of writing. For example, this may include a printed form, a letter, a fax or an e-mail.

B. FILING CLAIMS UNDER INSURANCE CONTRACTS

If the benefit provided is the payment of premiums on an insurance contract, then that benefit under the plan does *not* pay your bills or pay you any cash benefits. Instead, that benefit under the plan provides you with *insurance coverage*. If you incur covered expenses or become entitled to cash benefits, it is up to the *insurance company* to pay those expenses (or pay the cash benefits) to the extent provided in the insurance contract.

IMPORTANT: *You should read the booklet and any other literature prepared by the insurance company in which the insurance company describes the procedure for collecting benefits under the insurance contract, and follow the procedures set forth in that booklet for making claims to the insurance company under the insurance contract. The booklets prepared by the insurance company are distributed regularly and are available upon request from the plan administrator. If you're not sure whether an expense is covered by the insurance contract, you should ask the insurance company.*

Any disputes over whether an expense is eligible for reimbursement under the insurance contract, how much the insurance company is contractually obligated to pay, or any other aspect of your contractual rights under the insurance contract, is a matter solely between you and the insurance company under the insurance contract. However, if you experience difficulty in resolving any disputes with the insurance company, feel free to let the plan administrator know, in case the plan administrator can be helpful.

C. FILING CLAIMS FOR BENEFITS PAID BY THE PLAN

- 1. Claim Forms.** Death Benefits, Accidental Death and Dismemberment Benefits, Weekly Accident and Sickness Benefits, and MRA Benefits require you to file a claim form to receive the benefit. Please contact the Fund Office for the appropriate form.
- 2. Submitting a Claim.** You must submit your written Proof of Claim to the Fund office within 90 days from the date your claim was incurred. As an exception, a written Proof

of Claim for MRA benefits may be submitted up to 365 days after the date the claim was incurred. A Proof of Claim consists of the completed claim form, together with all itemized bills or other documents called for under the Plan, signed and certified to by you, your doctor, and in the case of death, your Beneficiary with the Plan.

3. **Payment Of Self-Insured Claims.** All self-insured benefits will be paid directly to you.
4. **Beneficiaries.** In the event of your death, benefits will be paid to your named Beneficiary if the Beneficiary has survived you. If no designated Beneficiary has survived you or no Beneficiary has been designated as of the time of your death, payment will be made in equal parts to the person or persons designated as your Beneficiary in the following order: (a) your surviving spouse, (b) your surviving children if you are not survived by a spouse, (c) the person or persons designated on the Union beneficiary designation card who survive you if you are not survived by a spouse or any children, or (d) your estate otherwise.

In no event will any benefits be payable under the Plan after your death if no eligible Beneficiary had made a claim for benefits within 12 months of your date of death.

D. PROCESSING CLAIMS

1. **General rules for processing claims.** The claims administrator (which will be the insurance company for insured benefits, and the Fund Office for self-funded benefits) will respond to you in writing, point out the specific reasons and plan provisions on which any denial is based, describe any additional information needed to complete the claim, and describe the appeal procedure, including time limits and your right to file a lawsuit under ERISA if your appeal is unsuccessful. Unless a shorter period is provided in the sections below regarding additional rules for Medical and Disability claims and appeals, the time limit for deciding on your claim is 90 days after you filed your claim, except that the claims administrator may take an additional 90 days as long as the claims administrator notifies you within the original 90 days why more time is needed and when a decision can be expected.
2. **Additional rules for processing medical claims.** There are special rules for processing claims for "medical care" within the meaning of section 733(a) of ERISA. The special rules depend on whether the claim is an "urgent care" claim, a "pre-service" claim, a "concurrent care" claim, or a "post-service" claim.
 - a. **"Urgent care" claims.** An "urgent care" claim is a claim for medical care or treatment where the normal time limits could seriously jeopardize your life or health or your ability to regain maximum function, as determined by an individual acting on behalf of the plan and applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. An "urgent care" claim is also a claim for medical care or treatment where, in the opinion of any physician with knowledge of your medical condition, the normal time limits would subject you to severe pain that cannot be adequately managed without the care or treatment that you are claiming. In making that

determination, the plan will defer to the judgment of the attending provider (such as the doctor). A claim for benefits under the MRA will never be considered an “urgent care” claim.

If you don't follow the right procedure for filing an urgent care claim, but at least you have communicated with the claims administrator and provided your name, your specific medical condition or symptom, and the specific treatment, service, or product for which you seek approval, then you will be notified within 24 hours and you will be told about the proper procedure for filing an urgent care claim. This notification may be oral, unless you or your representative requests notice in writing, in which case it will be in writing.

Once you have filed an "urgent care" claim, you will receive a decision on your claim as soon as possible, taking into account the medical exigencies, but always within 72 hours. As an exception, if you don't include enough information to determine whether (or how much) benefits are payable under the plan, you will be notified about the missing information as soon as possible, but always within 72 hours. You will then have 48 hours to provide the necessary information. You will then receive a decision on your claim within 72 hours after you provide the information (or, if you don't provide the information, within 72 hours after you were supposed to have provided the information). You will be notified in writing. Alternatively, you may be notified orally (and oral notification will satisfy the deadline), but, if so, the plan will follow up with written notification within 72 hours after the oral notification.

- b. **“Pre-service” claims.** The plan (or insurance contract) may provide that, in some circumstances, a claim will not be honored, or will not be paid in full or at a favorable rate, unless you get approval before the medical care is provided. When you apply for approval before the medical care is provided, that is a "pre-service" claim.

If you don't follow the right procedure for filing a pre-service claim, but at least you have communicated with the claims administrator and provided your name, your specific medical condition or symptom, and the specific treatment, service, or product for which you seek approval, then you will be notified within 5 days and you will be told about the proper procedure for filing a pre-service claim. This notification may be oral, unless you or your representative requests notice in writing, in which case it will be in writing.

Once you have filed a "pre-service" claim, you will be notified of the decision on your claim within a reasonable period of time appropriate to the medical circumstances, but always within 15 days. As an exception, the decision maker may take an additional 15 days (for a total of 30) as long as the decision maker concludes that an extension is necessary for reasons outside the control of the decision maker and notifies you, before the original 15 days expire, about why an extension is necessary and when a decision is expected. If the reason for the extension is that you have not provided all of the information necessary to decide on your claim, then the original 15-day clock will stop, beginning on the date when you are sent notification of the extension, until you provide the

information. You will be notified in writing.

- c. **“Concurrent care” claims.** Sometimes, the plan (or insurance company) may approve payment for an ongoing course of treatment, specifying a period of time, for example, or a number of treatments. Any reduction in (or termination of) that approval is a "concurrent care" decision. You will be notified of a concurrent care decision before the decision takes effect and sufficiently in advance to permit you to appeal the decision and get a decision on your appeal before the decision takes effect.
- d. **“Post-service” claims.** A "post-service" claim is any claim for benefits that is made after the medical care has been received. It is also any other type of claim that does not fall under the heading of "urgent care" claim, "concurrent care" decision, or "pre-service" claim.

Once you have filed a "post-service" claim, you will be notified of the decision on your claim only if the decision is adverse, meaning that you have been granted less than everything you asked for. You will be notified within a reasonable period of time, but always within 30 days. As an exception, the plan may take an additional 15 days (for a total of 45) as long as the decision maker concludes that an extension is necessary for reasons outside the control of the decision maker and notifies you, before the original 30 days expire, about why an extension is necessary and when a decision is expected. If the reason for the extension is that you have not provided all of the information necessary to decide on your claim, then the original 30-day clock will stop, beginning on the date when you are sent notification of the extension, until you provide the information. You will be notified in writing.

- e. **Information provided with denials of medical claims.** In addition to the information that is provided upon denial of any other type of claim, if a claim for "medical care" is denied, then:
 - i. If the plan provisions involve the application of terms such as "medical necessity" or "experimental," you will be offered, upon request and free of charge, an explanation of the scientific or clinical judgment underlying the decision, applying the terms of the plan to your medical circumstances. Alternatively, the decision maker may simply include the explanation with your notification.
 - ii. If the decision maker relied on an internal rule, guideline, protocol, or other similar criterion, you will be offered a copy, upon request and free of charge. Alternatively, the decision maker may simply include a copy with your notification.
 - iii. If the claim was for urgent care, the description of the appeal procedure will include the expedited appeal procedure.
 - iv. The availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under section 2793

of the Public Health Service Act to assist you.

The decision on the claim will also be sure to include information sufficient to identify the claim, including the date of service, the health care provider, the claim amount (if applicable), a statement describing the availability (upon request) of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning, and (if the decision is adverse) the denial code and its corresponding meaning.

- 3. Additional rules for processing disability claims.** On a claim for disability benefits, you will ordinarily be notified of the initial decision within 45 days after receipt of the claim. Two extensions of 30 days each are available if the claims administrator decides that additional time is necessary due to circumstances outside the control of the claims administrator, as long as the claims administrator notifies you by the current deadline and tells you why the extension is necessary and when a decision can be expected. In explaining why the extension is necessary, the claims administrator will explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and any additional information needed to resolve those issues. If additional information is required, you will have at least 45 days to provide it.

In addition to the information provided with the denial of other types of claims:

- a. If the provisions of the plan (or insurance contract) involve the application of terms such as "medical necessity" or "experimental," you will be provided an explanation of the scientific or clinical judgment underlying the decision, applying the terms of the plan (or insurance contract) to your medical circumstances.
- b. If the claims administrator relied on an internal rule, guideline, protocol, or other similar criterion, you will be provided a copy, or the notice will state that none were relied upon.
- c. The denial will include a discussion of the decision, including an explanation of the basis for disagreeing with or not following:
 - i. the views you presented to the Plan of health care professionals treating you and vocational professionals who evaluated you;
 - ii. the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and
 - iii. a disability determination regarding you from the Social Security Administration provided to the Plan.

E. APPEALS

If your claim is denied and you disagree and want to pursue the matter, you *must* file an appeal in accordance with the following procedures. You *cannot* take any other steps unless and until you have exhausted the appeal procedure. For example, if your claim is

denied and you do not use the appeal procedure, the denial of your claim is conclusive and *cannot be challenged, even in court*. (A different rule *may* apply to certain claims and appeals for medical or disability benefits, as explained below.)

1. **Appeals of claims under insurance contracts.** As noted above, where the benefit provided by the plan is payment of premiums on an insurance contract, if you incur covered expenses or become entitled to cash benefits, it is up to the *insurance company* to pay those expenses (or pay the cash benefits) to the extent provided in the insurance contract. If the insurance company denies your claim, you must pursue whatever appeal rights are available under the insurance contract.

IMPORTANT: *You should read the booklet and any other literature prepared by the insurance company in which the insurance company describes the procedure for collecting benefits under the insurance contract, and follow the procedures set forth in that booklet for making appeals to the insurance company under the insurance contract. The booklets prepared by the insurance company are distributed regularly and are available upon request from the plan administrator. If you're not sure whether an expense is covered by the insurance contract, you should ask the insurance company.*

2. **General rules for processing appeals on claims for benefits paid by the plan.** To file an appeal, write to the Trustees stating the reasons why you disagree with the denial of your claim. You must do this within *60 days after the claim was denied*. You have the right to be represented by anyone else, including a lawyer if you wish.

Upon request, you will be provided reasonable access to, and free copies of, all documents, records and other information relevant to your claim. Information is considered relevant for this purpose if any of the following apply:

- a. The claims administrator relied upon it in making the decision on your claim.
- b. It was submitted, considered or generated in the course of deciding on your claim, even if the claims administrator did not rely on it in deciding your claim.
- c. It was generated or obtained by the claims administrator in the process of deciding your claim in order to assure or verify that the decision was made in accordance with the governing plan documents and, where appropriate, that the plan provisions have been applied consistently to similarly situated claimants.

If you file an appeal, you have the right to submit written comments, documents, records and other information relating to your claim. This may include new information that was not submitted as part of your claim. All such information will be considered in your appeal.

The Trustees may, in their sole discretion, hold a hearing. Unless a shorter period is provided in the rules for medical or disability appeals, the Trustees will make a decision on the claim no later than the date of the Trustee meeting that immediately follows the plan's receipt of the appeal, unless the appeal is received within 30 days preceding the date of such meeting. In such case, a decision will be made no later than

the date of the second meeting of the Trustees following receipt of the appeal by the plan. If special circumstances (such as the need to hold a hearing) require a further extension of time, a decision shall be made by the Trustees no later than the date of the third meeting following receipt of the appeal by the plan. The Trustees, or someone on behalf of the Trustees, will notify you in writing of the decision within 5 days after a decision is made. The decision will explain the reasoning of the Trustees, will refer to the specific provisions of this plan on which the decision is based, and will remind you once again of your right of reasonable access to, and copies of, all relevant documents.

The claims administrator and Trustees shall have and shall exercise complete discretionary authority to construe, interpret and apply all of the terms of the plan, including all matters relating to eligibility for benefits, amount, time or form of payment, and any disputed or allegedly doubtful terms. In exercising such discretion, the claims administrator and Trustees shall give controlling weight to the intent of the sponsor of the plan. All decisions of the Trustees in the exercise of its authority under the plan (or of the claims administrator if the decision is not appealed) shall be final and binding on the plan, the plan sponsor and all Participants and Beneficiaries.

3. **Special rules for processing appeals on claims for medical benefits.** The processing of appeals on medical benefits depends on what type of appeal you have.
 - a. **“Rescission” appeals.** If your medical coverage under the plan is “rescinded,” meaning that it is cancelled or discontinued with retroactive effect, for any reason other than your failure to pay employee contributions or premiums, that is considered a denial of benefits that triggers a right to appeal.
 - b. **“Urgent care” appeals.** For “urgent care” appeals, you have 180 days in which to file an appeal. Once you have filed an "urgent care" appeal, you will receive a decision on your appeal as soon as possible, taking into account the medical exigencies, but always within 72 hours. You will be notified in writing.
 - c. **“Pre-service” and “concurrent care” appeals.** You have 180 days in which to file an appeal. Once you have filed a "pre-service" appeal, you will receive a decision on your appeal within a reasonable period of time appropriate to the medical circumstances, but always within 30 days. As an exception, if there are two levels of appeal, the decision on each appeal will be decided within 15 days. You will be notified in writing.
 - d. **“Post-service” appeals.** You have 180 days in which to file an appeal. Once you have filed a "post-service" appeal, your appeal will be decided within a reasonable period of time, but always within 60 days. As an exception, if there are two levels of appeal, the decision on each appeal will be made within 30 days. You will be notified in writing.
 - e. **All medical appeals.** The appeals authority on the appeal of a medical claim will never be the same person who denied the claim and will never be subordinate to the person who denied the claim. To assure independence and impartiality, decisions regarding hiring, compensation, termination, promotion,

or other similar matters with respect to any individual (such as a member of the appeals committee) will never be based on the likelihood that the individual will support a denial of benefits. The appeals authority on the appeal of a medical claim will review each appeal without giving any deference to the initial decision that was made on the claim.

In addition to the information that is provided upon denial of any other type of claim, if a claim for "medical care" is denied, then, upon request, you will be provided reasonable access to the claim file. You will be provided reasonable access to, and free copies of, all documents, records, and other information that constitute a statement of policy or guidance with respect to the plan (or insurance contract) concerning the denied treatment option or benefit for your diagnosis (without regard to whether the decision maker relied on it in making the decision on your claim). And if the decision maker obtained the advice of medical or vocational experts in connection with your claim, you are entitled to know who they are, regardless of whether the decision maker relied on their advice.

If the denial of your claim was based, in any part, on a medical judgment, such as a judgment whether a particular treatment or drug is experimental or medically necessary, the appeals authority will consult with a health care professional who has appropriate training and experience in that field of medicine. This will not be (or be a subordinate of) any health care professional who consulted on the initial denial of your claim.

If during the appeal process any new or additional evidence is considered, relied upon, or generated in connection with your claim, it will be provided to you as soon as possible and sufficiently in advance of the time when the appeal decision is due to give you a reasonable opportunity to respond before the appeal decision is made. Before the appeals authority can issue an adverse decision based on any new or additional rationale, you will be advised of the rationale as soon as possible and sufficiently in advance of the time when the appeal decision is due to give you a reasonable opportunity to respond before the appeal decision is made. While the appeals authority is not required to hold a hearing, you will be entitled to present testimony. (This paragraph does not apply to appeals of claims for MRA benefits.)

- f. **Denial on appeal.** If you are not granted all that you seek in filing the appeal for medical benefits, you will be given:
 - i. The specific reasons why.
 - ii. Specific references to the provisions of the plan (or insurance contract) on which the decision was based. If those provisions involve the application of terms such as "medical necessity" or "experimental," you will be offered, upon request and free of charge, an explanation of the scientific or clinical judgment underlying the decision, applying the terms of the plan to your medical circumstances. Alternatively, the decision maker may simply include the explanation with your notification.

- iii. If the decision maker relied on an internal rule, guideline, protocol, or other similar criterion, you will be provided a copy, upon request and free of charge. Alternatively, the decision maker may simply include a copy with your notification.
- iv. A statement that you are entitled to receive relevant information.
- v. A description of available internal appeals and any external review process, including information about how to initiate them and the following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U. S. Department of Labor office and your state insurance regulatory agency."
- vi. The availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under section 2793 of the Public Health Service Act to assist you.

The decision on the appeal will also be sure to include information sufficient to identify the claim, including the date of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and (if the decision is adverse) the denial code and its corresponding meaning. (This paragraph does not apply to claims and appeals for MRA benefits.)

When a document is presented to the claims administrator and claimed to be a qualified domestic relations order or a qualified medical child support order, the claims administrator will decide the question in the manner specified in the law, rather than as a claim for benefits under these rules. But anyone who is adversely affected by the claims administrator's decision and who wishes to pursue it must use the procedure set forth here for appeals of "post-service" medical claims.

- 4. Special rules for processing appeals on claims for disability benefits.** You will have 180 days to file an appeal after receiving the denial of your claim. If coverage for disability benefits is retroactively rescinded for any reason other than your failure to pay any required self-payments for coverage, this is considered a denial of benefits that triggers the right to appeal. The appeals authority will issue a written decision within 45 days, unless special circumstances require more time, in which case you will be advised before the original 45 days have elapsed and the decision will be issued within 90 days.

The appeals authority will never be the same person who denied the claim and will never be subordinate to the person who denied the claim. To assure independence and impartiality, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a member of the appeals committee) will never be based on the likelihood that the individual will support a denial of benefits. The appeals authority under this claim and appeal procedure will review each appeal without giving any deference to the initial decision that was made on the claim.

In addition to the information that is provided upon denial of any other type of claim, if a claim for disability benefits is denied, then, upon request, you will be provided reasonable access to the claim file. You will be provided reasonable access to, and free copies of, all documents, records, and other information that constitute a statement of policy or guidance with respect to the plan (or insurance contract) concerning the denied treatment option or benefit for your diagnosis (without regard to whether the decision maker relied on it in making the decision on your claim). And if the decision maker obtained the advice of medical or vocational experts in connection with your claim, you are entitled to know who they are, regardless of whether the decision maker relied on their advice.

If the denial of your claim was based, in any part, on a medical judgment, such as a judgment whether a particular treatment or drug is experimental or medically necessary, the appeals authority will consult with a health care professional who has appropriate training and experience in that field of medicine. This will not be (or be a subordinate of) any health care professional who consulted on the initial denial of your claim.

If during the appeal process any new or additional evidence is considered, relied upon, or generated in connection with your claim, it will be provided to you as soon as possible and sufficiently in advance of the time when the appeal decision is due to give you a reasonable opportunity to respond before the appeal decision is made. Before the appeals authority can issue an adverse decision based on any new or additional rationale, you will be advised of the rationale as soon as possible and sufficiently in advance of the time when the appeal decision is due to give you a reasonable opportunity to respond before the appeal decision is made. While the appeals authority is not required to hold a hearing, you will be entitled to present testimony.

- a. Denial of appeal.** If you are not granted all that you seek in filing an appeal on a claim for disability benefits, you will be given:
- i. The specific reasons why.
 - ii. Specific references to the provisions of the plan (or insurance contract) on which the decision was based. If those provisions involve the application of terms such as "medical necessity" or "experimental," you will be provided an explanation of the scientific or clinical judgment underlying the decision, applying the terms of the plan to your medical circumstances.
 - iii. If the decision maker relied on an internal rule, guideline, protocol, or other similar criterion, you will be provided a copy, or the notice will state that none was relied upon.
 - iv. A statement that you are entitled to receive relevant information.
 - v. The denial will include a discussion of the decision, including an explanation of the basis for disagreeing with or not following:

- (1) the views you presented to the Plan of health care professionals treating you and vocational professionals who evaluated you;
 - (2) the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and
 - (3) a disability determination regarding you from Social Security Administration provided to the Plan
- vi. The following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U. S. Department of Labor office and your state insurance regulatory agency."

b. Multiple levels of appeal. You may not be required to go through more than two levels of appeal on a claim for disability benefits before filing a lawsuit under ERISA. If more than two levels of appeal are offered, then anything above the first two levels is strictly voluntary, which means:

- i. The plan (or insurance company) will not claim that you have failed to exhaust your administrative remedies under the plan (or insurance contract) as long as you have completed 1st two levels of appeal
- ii. If you do pursue an appeal beyond the first two levels of appeal, the time that you spend doing so will not count against any statute of limitations.

Upon request, you are entitled to information sufficient to enable you to make an informed judgment about whether to make an appeal beyond the first two levels, including a statement that your decision will have no effect on your rights to any other benefits under the plan and information about the applicable rules, your right to representation, the process for selecting the decision maker, and the circumstances, if any, that may affect the impartiality of the decision maker, such as any financial or personal interests in the result or any past or present relationship with any party to the review process.

You will not be required to pay any fees or costs to the plan (or insurance company) or any decision maker to take an appeal beyond the first two levels. And you will not be required to submit your appeal to binding arbitration.

F. DESIGNATED REPRESENTATIVE

You (including your beneficiary) have the right to appoint authorized representatives to act on your behalf in connection with an initial claim for benefits as well as an appeal of an adverse benefit determination. Such right is for benefits paid by the Plan. A similar right should exist for benefits paid under an insurance contract. To appoint an authorized representative, please contact the Fund Office and request for submission the appropriate forms. Once you appoint a representative, all information and notifications regarding a claim and/or appeal will be sent to you and your appointed representative unless you provide contrary direction.

G. TIME LIMIT FOR FUTURE LEGAL ACTION

No legal action can be taken for a claim made under the Plan after the earlier of:

- 1) one year after any final decision on appeal (or one year after the denial of a claim if no appeal is filed within one year of a denial of a claim) or
- 2) three years after a right to the claim first occurred under the Plan.

VI. MISCELLANEOUS PROVISIONS

A. ERRORS IN BENEFIT PAYMENTS

The Trustees specifically retain the right to recover all monies paid in error to, or in behalf of any person, from such person. Upon discovery of a payment "made in error," the Trustee shall notify the recipient or Beneficiary of such payment, indicating the circumstances and amount of such payment, together with a request for repayment. Upon failure to repay the amount due within a reasonable time after such notification, the Trustees may take such legal action as they deem necessary, or in the case of a Participant of the fund, the amount of the payment made in error may be deducted from any future benefit payments that such Participant or his Dependents or Beneficiary may become entitled to under this plan.

B. PHYSICAL EXAMINATION

The Trustees, at their expense, shall have the right and opportunity to have any Participant or dependent examined when and as often as they may reasonably require while a claim is pending and thereafter. Failure without reasonable cause, to report to the Physician designated by the Trustees after notice to do so, may, at the Trustees' discretion, disqualify a claimant for further benefit payments.

C. FRAUD

Any person attempting to submit false, misleading or incomplete information, or who in any way attempts to defraud the Fund, may be prosecuted in such manner as the Trustees deem advisable.

D. LIABILITY FOR THE PAYMENT OF BENEFITS

The total liability for the payment of all self-insured benefits herein shall be limited to the assets of the Fund.

E. COORDINATION OF BENEFITS

See the documents provided by the insurance company for rules on coordination of medical benefits. For benefits paid by the Plan, you are not entitled to reimbursement by the Fund for expenses incurred as a result of an illness or injury which is work-related or for which benefits may be paid through Workers' Compensation Laws of the State of Pennsylvania or any other state.

F. SUBROGATION OF THIRD PARTY LIABILITY

The Fund will take advantage of its right to subrogation if you or your dependents are paid benefits for expenses due to accidental injuries for which someone else may be liable.

Subrogation means that the Fund can recover from the person who caused the injury, or that person's insurance company, the benefits paid on your behalf for that injury, including, but not limited to, claims compensable under state workers' compensation laws, medical

malpractice or tortious conduct by a third (3rd) party. The right to Subrogation is not subject to reduction for your attorneys' fees or legal expenses. The right to subrogation includes the right of the Fund to seek reimbursement from any insurance policy that you may purchase individually.

Your claims and benefit payments will normally continue to be paid in the same way as they always have been. However, you or your dependent will have certain responsibilities to the Plan. When you or your dependent submit a claim for injuries, the Fund Office will have you complete a form requesting information as to how the injuries occurred and the identity of any potentially responsible third (3rd) parties. At the request of the Fund Office, you must also sign any other documents and do whatever else is reasonably necessary to secure the Fund's Right of Subrogation. You shall notify the Plan whenever you have commenced litigation, or any administrative proceeding in connection with any illness or injury for which the Fund has paid benefits. You must notify the Plan of any attorney that is engaged to represent you in any such proceeding. Further, you shall notify the Plan of the discharge of such attorney and the further employment of any successor attorney. When an attorney is retained, your attorney shall acknowledge the existence of the Fund's right of Subrogation. You must not do anything to impair or negate this Right of Subrogation, and if any of your acts or omissions to act compromise this Right of Subrogation, the Fund will seek reimbursement of all appropriate benefits paid directly to you and/or your eligible dependents, or to your providers on your behalf.

All terms and conditions of the Agreement and Declaration of Trust for the Fund are hereby incorporated, including but not limited to those provisions setting forth the Fund's priority in subrogation.

The Fund also retains a subrogation right to seek reimbursement of amounts paid for the benefit of a Participant's Spouse and/or Dependent(s) which are subsequently recovered by said Spouse and/or Dependent(s) or by someone acting on his or her behalf from an insurer or other source. In order to receive benefit payments, a Participant's Spouse and/or Dependent(s) shall be required to execute the Plan's subrogation form. In addition, if the Participant's Dependent(s) is a minor, the Participant shall be required to sign the Plan's subrogation form on behalf of the Participant's minor Dependent.

Reimbursement to the Fund shall not exceed the gross amount that the Participant and providers on behalf of the Participant have received. The Fund shall be reimbursed to the extent of any payments made by the Fund to or on behalf of a Participant. If any balance remains from such recovery, it shall be applied to reimburse the Participant.

The Fund shall be entitled to first dollar recovery even though the Participant may not have been fully compensated for all losses incurred by the Participant.

The Participant must agree to reimburse the Fund for such benefits paid by the Fund regardless of whether or not the recovery made by the Participant is for the purpose of compensating for pain and suffering, medical expenses, dental expenses, attorneys fees, loss of income, loss of consortium or other losses and without regard to whether the recovery is specifically designated as a recovery for certain damages or expenses. There

shall be no reduction in the amount of reimbursement paid by the Participant to the Fund for attorney's fees incurred or paid by the Participant in connection with said claim.

G. FELONY EXCLUSION

The Plan will not pay any benefits for claims for any period caused by or contributed to by a Participant committing or attempting to commit a felony, or participating in an illegal occupation, or actively participating in a violent disorder or riot. Actively participating does not include being at the scene of a violent disorder or riot while performing his or her official duties. This exclusion applies to any and all benefits offered by the Plan.

H. NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT (NMHPA)

Group Health Plans and Health Insurance issuers generally may not, under Federal Law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours, following a vaginal delivery, or less than 96 hours following a Cesarean section. However, Federal Law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable). In any case, plans and issuers may not, under Federal Law, require that a provider obtain authorization from the Plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours, as applicable).

I. MILITARY SERVICE

Under the Uniformed Services Employment and Reemployment Act (USERRA), if you enter military service or are called for active military service from reserve status you can continue health coverage for yourself or your family, similar to COBRA coverage, while you are on active service or away from work as a reservist. To receive the continued coverage, you must follow the following procedures:

1. The Participant must notify the Employer, the Union and/or Plan Administrator of the effective date that he will begin Active Duty by providing a copy of his Orders calling him to Active Duty.
2. The Participant must be an active eligible Participant in the Plan on the date that he enters the Armed Forces.
3. The Participant's eligibility will be terminated after the first of the month following his entering Active Duty. The Administrator will send a notice to the Participant informing him that he may continue his coverage in the Plan via meeting the hourly eligibility requirements and/or making self-payments. However, should the Participant elect to discontinue his coverage in the Plan, since his medical benefits for himself would be provided by the military, then the following would apply.
4. The Participant's Bank of Hours, if any, will be frozen at the time he enters Active Duty.

5. The Participant's eligibility will be reinstated the month that he returns to work and for the remainder of the Benefit Quarter, as per the following:

<u>Length of Military Service</u>	<u>Reemployment Deadline</u>
Less than 31 days	1 workday after discharge (allowing 8 hours for travel)*
31 through 180 days	14 days after discharge**
More than 180 days	90 days after discharge

* Or as soon as possible after the expiration of the eight hours travel time if such is impossible or unreasonable;

** Or if such is impossible, then the next day when it becomes possible after the 14 days

6. The right to reinstate eligibility may terminate if the separation from active service is due to a dishonorable discharge, bad conduct discharge, or for separation under other than honorable conditions.
7. If an eligible active Participant has Dependents, then the same will apply for the Participant, however, the Dependents will remain eligible while the Participant is serving in the Armed Forces, without having to make a self-payment.

Should the Participant become disabled during this period, then the eligibility rules for disabled Participants will apply upon the Participant's discharge from the service.

Should the Participant die during this period, then the eligibility rules for surviving spouse and their dependents will apply upon the death of the Participant.

If the Participant had Bank Hours, then those hours would be used to maintain the Participant's Active Benefits upon becoming disabled or those hours would be used to continue eligibility for the surviving spouse and dependents.

Once the Bank Hours are not enough to continue eligibility, then the appropriate self-payment rates would apply.

J. HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires the Plan to maintain the confidentiality of protected health information. As such, the Board of Trustees, as sponsor of the Plan, agrees to:

1. Not use or further disclose Protected Health Information ("PHI"), as that terms is defined under HIPAA, other than as permitted or required by the Plan documents or as required by law;
2. Ensure that any agents, including subcontractors, to whom it provides PHI received from the Plan agrees to the same restrictions and conditions that apply to the Plan

- Sponsor for such PHI;
3. Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor;
 4. Report to the Plan any use or disclosure of PHI that is inconsistent with the uses or disclosures provided for in the Plan documents or which the Plan Sponsor becomes aware;
 5. Provide individuals with access to their PHI;
 6. Provide a means for individuals to amend their PHI;
 7. Make available PHI necessary to provide individuals with accountings for disclosures;
 8. Establish procedures for return, destruction, and restrictions of further use of PHI by Employers or the Plan Sponsor;
 9. Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of Health and Human Services for compliance review purposes;
 10. Provide for adequate separation between the Plan and the Plan Sponsor, including identification of the Plan Sponsor or employer staff who have access to PHI;
 11. Restrict access to and use by such employees to plan administrative functions;
 12. Establish procedures to resolve/remedy inappropriate use or disclosure of PHI by the Plan Sponsor or employer staff;
 13. Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of electronic PHI that it creates, receives, maintains or transmits; and
 14. Report any security incident of which it becomes aware.

K. FAMILY AND MEDICAL LEAVE ACT

If you become eligible for a family or medical leave of absence in accordance with the Family and Medical Leave Act of 1993 (FMLA), your eligibility under this Plan may be continued during your FMLA leave provided your employer makes the required contribution on your behalf.

Talk to your employer to see if you are eligible for FMLA leave. FMLA generally requires covered employers to permit eligible employees to take the following amounts of unpaid, job-protected leave under the following circumstances:

1. up to 12 workweeks in any 12-month period because of the birth of a child or the placement of a child for adoption or foster care, to care for an immediate family member who has a serious health condition, or because of your own serious health condition;
2. up to 12 workweeks in any 12-month period for a “qualifying exigency” arising because your spouse, son, daughter or parent is on active duty or is called to active duty status in a foreign country (or has been notified of an impending call or order to covered active duty in a foreign country) in the Armed Forces; and
3. up to 26 workweeks for “military caregiver leave” during a single 12-month period for you to care for a covered servicemember with a serious illness or injury if you are the spouse, son, daughter, parent or next of kin of the “covered servicemember.”

CONDITIONS

1. You are eligible to continue your coverage under FMLA if:
 - (a) you have worked for your employer for at least one (1) year;
 - (b) you have worked at least 1,250 hours over the previous 12 months for such employer;
 - (c) your employer employs at least 50 employees within 75 miles from your work site; and
 - (d) your employer continues to pay your required contributions.
2. If, on the day your eligibility is to begin, you are already on an FMLA leave, you will be considered actively at work. Benefits for you and any eligible Dependents (if applicable) will be in accordance with the terms of the Plan as herein set forth.
3. You and your eligible Dependents (if applicable) are subject to conditions and limitations of the Plan during your leave, except that anything in conflict with the provisions of the FMLA will be construed in accordance with the FMLA.
4. FMLA continuation ends on the earliest of :
 - (a) the day your return to work;
 - (b) the day you notify your employer that you are not returning to work;
 - (c) the day your coverage would otherwise end under the Plan; or
 - (d) the day coverage has been continued for 12 (or 26) weeks, as indicated above.

L. WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

Under federal law, group health plans that provide medical and surgical benefits in connection with a mastectomy must provide benefits for certain reconstructive surgery. This covers reconstruction of the breast on which the mastectomy was performed, surgery on the other breast to produce symmetrical appearance, and prostheses and physical complications of all stages of mastectomy, including lymphedema.

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- all stages of reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance;
- prostheses; and
- treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, call your Plan Administrator.

VII. GENERAL PLAN/ERISA INFORMATION

A. Plan Name Bricklayers and Allied Craft Workers Welfare Fund of Western Pennsylvania

B. Plan Fiduciaries The Board of Trustees is comprised of the following members:

For the Union:

Thomas Auman
William Greer
Norman Ringer, Jr.
Timothy Wachter

For the Employer:

William Clair
James Massaro
Thomas Swidzinski
Ed Stevens

C. Administration of the Plan The Board of Trustees (Plan Administrators under ERISA) may be contacted by writing or calling below:

Bricklayers and Allied Craft Workers Welfare Fund of Western Pennsylvania
c/o BeneSys, Inc.
100 Kingston Drive
Pittsburgh, PA 15235
412-317-6538
Toll Free 1-877-270-1199
Fax 412-307-3691
www.baclocal9benefits.org

D. Agent for Service of Legal Process Should a legal dispute involving the Plan arise, any legal documents should be served upon Fund Counsel at:

Tucker Arensberg, P.C.
1500 One PPG Place
Pittsburgh, PA 15222.

Service may also be made upon the Plan Administrator at:

Bricklayers and Allied Craft Workers Welfare Fund of Western Pennsylvania
c/o BeneSys, Inc.
3660 Stutz Drive, Suite 101
Canfield, OH 44406
412-317-6538
Toll Free 1-877-270-1199
Fax 412-307-3691

E. Employer Identification Number 25-6103466

F. Plan Document This Booklet, the Trust Agreement, and all amendments, resolutions and contracts adopted and entered into by the Board of Trustees constitute the Plan Documents.

G. Collective Bargaining Agreements Each of the Plan's Participating Unions has executed a Collective Bargaining Agreement requiring Employers to make contributions into the Fund. Copies of the Collective Bargaining Agreements may be secured from the Participating Unions

at the addresses listed below (please give at least 24 hours notice for staffing purposes):

Bricklayers & Allied Crafts Local 9
 100 Kingston Drive
 Pittsburgh, PA 15235

H. Plan Year The financial records of the Plan are maintained on a fiscal year commencing January 1, and ending on December 31.

I. Source of Benefits and Funding Medium

Employer Contributions are held in the Bricklayers and Allied Craft Workers Welfare Fund of Western Pennsylvania (the “Fund”). Some benefits under this Plan are self-insured, which means that the benefits themselves are paid from the Fund. As of the date of this Summary Plan Description, the following applies:

Benefit Type	Type of Administration/ Claims Administrator	Source of Benefits and Type of Funding
Comprehensive Medical and Prescription Drug Benefits	Self-Insured with Third Party Claims Administrator (Highmark)	Benefits paid from the Fund
Medical Reimbursement Account	Self-Insured with Third Party Claims Administrator (BeneSys, Inc.)	Benefits paid from the Fund
Employee Life and Accidental Death and Dismemberment	Self-Insured with Third Party Claims Administrator (BeneSys, Inc.)	Benefits paid from the Fund
Weekly Disability Benefits	Self-Insured with Third Party Claims Administrator (BeneSys, Inc.)	Benefits paid from the Fund
Member Assistance Program	Self-Insured with Third Party Claims Administrator (UPMC)	Benefits paid from the Fund

J. Amendment or Termination of Plan

Neither this Plan nor any of its benefits is guaranteed. Although the Plan is intended to be permanent, the Board of Trustees has the authority to terminate the Plan or eliminate Plan benefits, in whole or part, as it finds necessary. The Plan shall terminate upon the occurrence of any one or more of the following events: if the Plan assets are, in the opinion of the Board, inadequate to carry out the intent and purpose of the Plan or are inadequate to meet the payments due or which may become due to Participants and Beneficiaries; if there are no individuals living who can qualify as Employees, if the Union and Employers agree to terminate the Plan; if the Plan is merged into another employee benefit plan; any other event which may, by law, require termination.

In the event of termination of the Plan, the Board of Trustees shall make provision out of the Plan assets for the payment of expenses incurred up to the date of termination and the expenses

incidental to termination; arrange for a final audit and report of the Board's transactions and accounts for the purposes of ending the trusteeship; and apply any surplus in a manner that will inure to the exclusive benefit of the Participants and Beneficiaries in accordance with the purposes of the Plan and the requirement law.

VIII. ERISA RIGHTS

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

Receive Information About Your Plan and Benefits

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

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

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

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

If you have creditable coverage under another Plan, then the exclusionary periods of coverage for pre-existing conditions may be reduced or eliminated. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan Participants, ERISA imposes obligations upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan Participants and Beneficiaries. No one, including your Employer, your Union, or any other person, may discharge you or otherwise discriminate against you in any way to prevent you

from obtaining a benefit under this Plan or exercising your rights under ERISA.

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees; for example, if it finds your claim is frivolous.

Assistance with Your Questions

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

IX. DEFINITIONS

1. **BENEFICIARY** shall mean a person designated by a Participant or by the terms of the Plan as one who is or may become eligible to receive benefits under the Plan.
2. **COLLECTIVE BARGAINING AGREEMENT** shall mean a contract or agreement, entered into between the Union and an Employer, which covers wages, hours and conditions of employment.
3. **DEPENDENTS** shall include the Participant's spouse and children under age 26 years of age, regardless of marital status, residency, employment, eligibility/enrollment under an employer's group plan, or student status. Such children include: (1) a blood descendent of the first degree; (2) a legally adopted child (including a child living with the adopting parents during the period of probation); (3) a stepchild, or (4) a child of which the employee is the legal guardian. If an Participant's dependent child is incapable of self-sustaining employment because of mental retardation or a physical handicap his benefits will be continued provided his incapability commenced prior to attaining age 26 and providing written proof of the dependent child's incapability is submitted to the Fund Office within 31 days after the date such dependent child attains 26 years of age. Proof of the continued existence of such incapability must be furnished to the Fund Office from time to time as they may request. Coverage for such disabled dependent child over 26 will terminate on the date the employee ceases to be eligible or on the date of recovery, whichever comes first. To be eligible for dependent coverage, proof may be required that the dependent comes within the foregoing definition.
4. **EMPLOYERS** shall mean an Employer who is a party to a Collective Bargaining Agreement with a participating Union, which requires the Employer to make welfare payments to the Bricklayers and Allied Craft Workers Welfare Fund of Western Pennsylvania.
5. **ERISA** shall mean the Employee Retirement Income Security Act of 1974, as presently enacted and as it may be amended from time to time, together with its rules and regulations.
6. **FUND** shall mean all assets, property or money received by the Trustees for the uses and purposes as defined by the Trust Agreement.
7. **FUND OFFICE** refers to the office maintained by the third party administrator on behalf of the Plan, i.e., The Bricklayers and Allied Craft Workers Welfare Fund, c/o BeneSys, Inc., 100 Kingston Drive, Pittsburgh, PA 15235.
8. **HOURS OF CREDITED EMPLOYMENT** shall mean hours of work for a participating Employer for which such Employer is required to make a contribution to the Fund.
9. **MEDICARE** shall mean the benefits provided under Title XVIII of the Social Security Act of 1965, as amended.
10. **PARTICIPANT** shall mean any Employee or former Employee of an Employer who is or may become eligible to receive a benefit under this Plan. The term "Participant" shall not include any Employee or former Employee who has not been credited with the required number of hours of Covered Employment in a specified period, under the eligibility rules established by the Trustees.
11. **RETIREE** shall mean a former Employee who has retired from employment with his or her employer and has been awarded retirement from a pension plan affiliated with a Union participating in this Plan and whose employers are contracted to pay at a contribution rate level established by the Board of Trustees to allow participation in the retiree benefit plan.
12. **SELF-PAYMENT** shall mean payments to the Fund for the purpose of maintaining eligibility in the Plan by employees of a Participating Union who, because of lack of employment with a Contributing Employer, disability, or retirement, might otherwise be terminated. Self-payments shall be billed directly to the Participant and are payable prior to the coverage period.
13. **PLAN** shall mean this booklet, together with the Trust Agreement, the contracts issued by

insurance companies and/or any other providers, and all amendments, resolutions and agreements duly adopted and entered into by the Board of Trustees of the Bricklayers and Allied Craft Workers Welfare Fund of Western Pennsylvania.

14. **TRUST AGREEMENT** shall mean the Agreement and Declaration of Trust and any amendments thereto that governs the Fund.

15. **UNION** shall mean only those Unions who have in effect a Collective Bargaining Agreement with Employers in the Industry requiring such employers to make the required welfare payments to the Bricklayers and Allied Craft Workers Welfare Fund of Western Pennsylvania.

NOTICE OF PRIVACY PRACTICES

PART I – NOTICE OF PRIVACY PRACTICES (HIPAA)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

THIS NOTICE ALSO DESCRIBES HOW WE COLLECT, USE AND DISCLOSE NON-PUBLIC PERSONAL FINANCIAL INFORMATION.

Our Legal Duties

The Plan is committed to protecting the privacy of your protected health information. “Protected health information” is your individually identifiable health information, including demographic information, collected from you or created or received by a health care provider, a health plan, your employer, or a health care clearinghouse that relates to: (i) your past, present, or future physical or mental health or condition; (ii) the provision of health care to you; or (iii) the past, present, or future payment for the provision of health care to you.

This Notice describes our privacy practices, which include how we may use, disclose, collect, handle, and protect our members’ protected health information. We are required by applicable federal and state laws to maintain the privacy of your protected health information. We also are required by the HIPAA Privacy Rule (45 C.F.R. parts 160 and 164, as amended) to give you this Notice about our privacy practices, our legal duties, and your rights concerning your protected health information.

We will inform you of these practices the first time you become eligible for the Plan. We must follow the privacy practices that are described in this Notice as long as it is in effect. This Notice became effective April 1, 2003, and will remain in effect unless we replace it.

On an ongoing basis, we will review and monitor our privacy practices to ensure the privacy of our members’ protected health information. Due to changing circumstances, it may become necessary to revise our privacy practices and the terms of this Notice. We reserve the right to make the changes in our privacy practices and the new terms of our Notice will become effective for all protected health information that we maintain, including protected health information we created or received before we made the changes. Before we make a material change in our privacy practices, we will change this Notice and notify all affected members in writing in advance of the change.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

I. Uses and Disclosures of Protected Health Information

In order to administer our health benefit programs effectively, we will collect, use and disclose protected health information for certain of our activities, including payment and health care operations.

A. Uses and Disclosures of Protected Health Information for Payment and Health Care Operations

The following is a description of how we may use and/or disclose protected health information about you for payment and health care operations:

- 1. Payment.** We may use and disclose your protected health information for all activities that are included within the definition of “payment” as set out in 45 C.F.R. § 164.501. We have not listed in this Notice all of the activities included within the definition of “payment,” so please refer to 45 C.F.R. § 164.501 for a complete list.

For example:

We may use and disclose your protected health information to pay claims from doctors, hospitals, pharmacies and others for services delivered to you that are covered by your health plan, to determine your eligibility for benefits, to coordinate benefits, to examine medical necessity, to obtain premiums, and/or to issue explanations of benefits to the person who subscribes to the health plan in which you participate.

- 2. Health Care Operations.** We may use and disclose your protected health information for all activities that are included within the definition of “health care operations” as set out in 45 C.F.R. § 164.501. We have not listed in this Notice all of the activities included within the definition of “health care operations,” so please refer to 45 C.F.R. § 164.501 for a complete list.

For example:

We may use and disclose your protected health information to rate our risk and determine the premium for your health plan, to conduct quality assessment and improvement activities, to credential health care providers, to engage in care coordination or case management, and/or to manage our business and the like.

B. Uses and Disclosures of Protected Health Information to Other Entities

We also may use and disclose protected health information to other covered entities, business associates, or other individuals (as permitted by the HIPAA Privacy Rule) who assist us in administering our programs and delivering health services to our members.

- 1. Business Associates.** In connection with our payment and health care operations activities, we contract with individuals and entities (called “business associates”) to perform various functions on our behalf or to provide certain types of services (such as member service support, utilization management, subrogation, or pharmacy benefit management). To perform these functions or to provide the services, business associates will receive, create, maintain, use, or disclose protected health information, but only after we require the

business associates to agree in writing to contract terms designed to appropriately safeguard your information.

2. **Other Covered Entities.** In addition, we may use or disclose your protected health information to assist health care providers in connection with *their* treatment or payment activities, or to assist other covered entities in connection with certain of *their* health care operations. For example, we may disclose your protected health information to a health care provider when needed by the provider to render treatment to you, and we may disclose protected health information to another covered entity to conduct health care operations in the areas of quality assurance and improvement activities, or accreditation, certification, licensing or credentialing.

II. Other Possible Uses and Disclosures of Protected Health Information

In addition to uses and disclosures for payment, and health care operations, we may use and/or disclose your protected health information for the following purposes:

A. To Plan Sponsors

We may disclose your protected health information to the plan sponsor of your group health plan to permit the plan sponsor to perform plan administration functions. For example, a plan sponsor may contact us regarding a member's question, concern, issue regarding claim, benefits, service, coverage, etc. We may also disclose summary health information (this type of information is defined in the HIPAA Privacy Rule) about the enrollees in your group health plan to the plan sponsor to obtain premium bids for the health insurance coverage offered through your group health plan or to decide whether to modify, amend or terminate your group health plan.

B. Required by Law

We may use or disclose your protected health information to the extent that federal or state law requires the use or disclosure. For example, we must disclose your protected health information to the U.S. Department of Health and Human Services upon request for purposes of determining whether we are in compliance with federal privacy laws.

C. Public Health Activities

We may use or disclose your protected health information for public health activities that are permitted or required by law. For example, we may use or disclose information for the purpose of preventing or controlling disease, injury, or disability.

D. Health Oversight Activities

We may disclose your protected health information to a health oversight agency for activities authorized by law, such as: audits; investigations; inspections; licensure or disciplinary actions; or civil, administrative, or criminal proceedings or actions. Oversight agencies seeking this information include government agencies that oversee: (i) the health care system; (ii) government benefit programs; (iii) other government regulatory programs; and (iv) compliance with civil rights laws.

E. Abuse or Neglect

We may disclose your protected health information to a government authority that is authorized by law to receive reports of abuse, neglect, or domestic violence.

F. Legal Proceedings

We may disclose your protected health information: (1) in the course of any judicial or administrative proceeding; (2) in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized); and (3) in response to a subpoena, a discovery request, or other lawful process, once we have met all administrative requirements of the HIPAA Privacy Rule. For example, we may disclose your protected health information in response to a subpoena for such information.

G. Law Enforcement

Under certain conditions, we also may disclose your protected health information to law enforcement officials. For example, some of the reasons for such a disclosure may include, but not be limited to: (1) it is required by law or some other legal process; or (2) it is necessary to locate or identify a suspect, fugitive, material witness, or missing person.

H. Coroners, Medical Examiners, Funeral Directors, and Organ Donation

We may disclose protected health information to a coroner or medical examiner for purposes of identifying a deceased person, determining a cause of death, or for the coroner or medical examiner to perform other duties authorized by law. We also may disclose, as authorized by law, information to funeral directors so that they may carry out their duties. Further, we may disclose protected health information to organizations that handle organ, eye, or tissue donation and transplantation.

I. Research

We may disclose your protected health information to researchers when an institutional review board or privacy board has: (1) reviewed the research proposal and established protocols to ensure the privacy of the information; and (2) approved the research.

J. To Prevent a Serious Threat to Health or Safety

Consistent with applicable federal and state laws, we may disclose your protected health information if we believe that the disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.

K. Military Activity and National Security, Protective Services

Under certain conditions, we may disclose your protected health information if you are, or were, Armed Forces personnel for activities deemed necessary by appropriate military command authorities. If you are a member of foreign military service, we may disclose, in certain circumstances, your information to the foreign military authority. We also may disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, and for the protection of the President, other authorized persons, or heads of state.

L. Inmates

If you are an inmate of a correctional institution, we may disclose your protected health information to the correctional institution or to a law enforcement official for: (1) the institution to provide health care to you; (2) your health and safety and the health and safety of others; or (3) the safety and security of the correctional institution.

M. Workers' Compensation

We may disclose your protected health information to comply with workers' compensation laws and other similar programs that provide benefits for work-related injuries or illnesses.

N. Others Involved in Your Health Care

Unless you object, we may disclose your protected health information to a friend or family member that you have identified as being involved in your health care. We also may disclose your information to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status, and location. If you are not present or able to agree to these disclosures of your protected health information, then we may, using our professional judgment, determine whether the disclosure is in your best interest.

III. Required Disclosures of Your Protected Health Information

The following is a description of disclosures that we are required by law to make:

A. Disclosures to the Secretary of the U.S. Department of Health and Human Services

We are required to disclose your protected health information to the Secretary of the U.S. Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA Privacy Rule.

B. Disclosures to You

We are required to disclose to you most of your protected health information that is in a “designated record set” (defined below) when you request access to this information. We also are required to provide, upon your request, an accounting of many disclosures of your protected health information that are for reasons other than payment and health care operations.

IV. Other Uses and Disclosures of Your Protected Health Information

Other uses and disclosures of your protected health information that are not described above will be made only with your written authorization. If you provide us with such an authorization, you may revoke the authorization in writing, and this revocation will be effective for future uses and disclosures of protected health information. However, the revocation will not be effective for information that we already have used or disclosed, relying on the authorization.

V. Your Individual Rights

The following is a description of your rights with respect to your protected health information:

A. Right to Access

You have the right to look at or get copies of your protected health information in a designated record set. Generally, a “designated record set” contains medical and billing records, as well as other records that are used to make decisions about your health care benefits. However, you may not inspect or copy psychotherapy notes or certain other information that may be contained in a designated record set.

You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your protected health information.

To inspect and/or copy your protected health information, you may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. The first request within a 12-month period will be free. If you request access to your designated record set more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. If you request an alternative format, we will charge a cost-based fee

for providing your protected health information in that format. If you prefer, we will prepare a summary or an explanation of your protected health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.

We may deny your request to inspect and copy your protected health information in certain limited circumstances. If you are denied access to your information, you may request that the denial be reviewed. A licensed health care professional chosen by us will review your request and the denial. The person performing this review will not be the same one who denied your initial request. Under certain conditions, our denial will not be reviewable. If this event occurs, we will inform you in our denial that the decision is not reviewable.

B. Right to an Accounting

You have a right to an accounting of certain disclosures of your protected health information that are for reasons other than treatment, payment or health care operations. You should know that most disclosures of protected health information will be for purposes of payment or health care operations. An accounting will include the date(s) of the disclosure, to whom we made the disclosure, a brief description of the information disclosed, and the purpose for the disclosure.

You may request an accounting by contacting the Fund Office. Your request may be for disclosures made up to 6 years before the date of your request, but in no event, for disclosures made before April 14, 2003.

The first list you request within a 12-month period will be free. If you request this list more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.

C. Right to Request a Restriction

You have the right to request a restriction on the protected health information we use or disclose about you for treatment, payment or health care operations. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement unless the information is needed to provide emergency treatment to you. Any agreement we may make to a request for additional restrictions must be in writing signed by a person authorized to make such an agreement on our behalf. We will not be bound unless our agreement is so memorialized in writing.

You may request a restriction by contacting Fund Office. In your request tell us: (1) the information whose disclosure you want to limit; and (2) how you want to limit our use and/or disclosure of the information.

D. Right to Request Confidential Communications

If you believe that a disclosure of all or part of your protected health information may endanger you, you have the right to request that we communicate with you in confidence about your protected health information by alternative means or to an alternative location. For example, you may ask that we contact you only at your work address or via your work e-mail.

You must make your request in writing, and you must state that the information could endanger you if it is not communicated in confidence by the alternative means or to the alternative

location you want. We must accommodate your request if it is reasonable, specifies the alternative means or location, and continues to permit us to collect premiums and pay claims under your health plan, including issuance of explanations of benefits to the subscriber of the health plan in which you participate.

E. Right to Request Amendment

If you believe that your protected health information is incorrect or incomplete, you have the right to request that we amend your protected health information. Your request must be in writing, and it must explain why the information should be amended.

We may deny your request if we did not create the information you want amended or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement to be appended to the information you wanted amended. If we accept your request to amend the information, we will make reasonable efforts to inform others, including people you name, of the amendment and to include the changes in any future disclosures of that information.

F. Right to a Paper Copy of this Notice

If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form. Please contact us using the information listed at the end of this Notice to obtain this Notice in written form.

VI. Questions and Complaints

If you want more information about our privacy policies or practices or have questions or concerns, please contact us using the information listed below.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your protected health information or in response to a request you made to amend or restrict the use or disclosure of your protected health information or to have us communicate with you in confidence by alternative means or at an alternative location, you may complain to us using the contact information listed below.

You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to protect the privacy of your protected health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Fund Office Contact Information:	Bricklayers and Allied Craft Workers Welfare Fund of Western Pennsylvania c/o BeneSys, Inc. 100 Kingston Drive Pittsburgh, PA 15235 (412) 317-6538 Toll Free: 1-877-270-1199 www.baclocal9benefits.org
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