CENTRAL MIDWEST
REGIONAL COUNCIL OF CARPENTERS
WELFARE FUND

SUMMARY PLAN DESCRIPTION

2026

INTRODUCTION

We are pleased to distribute this Summary Plan Description (SPD) for the Central Midwest Council of Carpenters Welfare Fund (Fund). This document summarizes the terms of the Central Midwest Council of Carpenters Welfare Fund Plan document (the Plan).

This SPD is not intended to cover every detail of the Plan or every situation that may occur. It is simply a *summary*. The complete Plan is available for inspection at any time at the Fund Office. If there is any conflict between the provisions in this SPD and the Plan, the Plan controls. For a more detailed statement of your rights, benefits, and obligations, please consult the complete Plan.

Although the Trustees expect to continue the Plan indefinitely, they reserve the right to change or terminate the Plan at any time and for any reason, for any group or class of Participants, Active or Retiree, or Dependents, or for all such groups. Correspondingly, the Trustees may change the level of benefits provided, or eliminate an entire category of benefits, at any time and/or for any reason. There are no benefits provided other than those set forth in the Plan. THERE ARE NO VESTED BENEFITS UNDER THE PLAN FOR ACTIVES, RETIREES, OR DEPENDENTS.

Please read this SPD carefully and keep it for future reference. This SPD replaces all prior Summary Plan Descriptions (and corresponding amendments and summaries of material changes) previously provided. If you have any questions, please contact the Fund Office.

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ARTICLE 1 – DEFINITIONS

Except as otherwise set forth in the Plan or this document, the following terms have the following meanings:

Accidental Injury means a trauma to the body resulting from an accident, such as a strain, sprain, fracture, abrasion, or contusion.

Active Employee or **Active** is an Employee eligible for coverage under the Plan.

Ancillary Services means:

(a) emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether provided by a participating or nonparticipating provider;
(b) items and services provided by assistant surgeons, hospitalists, and intensivists; and
(c) diagnostic services, including radiology and lab services (excluding certain advanced diagnostic laboratory tests provided for in applicable federal regulation(s) or sub-regulatory guidance).

Applicable Medicare Rate means the following, as applicable:

(a) Professional Procedures: 100% of the Medicare Rate; or
(b) Institutional Procedures: 150% of the Medicare Rate; or
(c) Where neither (a) or (b) is available: 50% of the actual charges.

Child or **Children** means:

(a) Any person up until the end of the month in which he/she turns age 26, is not a Participant or a Participant's Spouse, and either:

  (1) is a Participant's natural child or adopted child; or
  (2) has been placed with a Participant for adoption; or
  (3) is a Participant's stepchild, which means he/she is the child of his/her Spouse; or
  (4) is the Participant's eligible foster child; or

(b) A person who would qualify as a "child" under paragraph (a) but for the age limitations, who, by reason of mental or physical handicap, is incapable of sustaining employment and for whom the Participant has submitted proof of such to the Fund Office prior to the end of the month in which he/she turns 26 years of age and at such other times as further requested by the Fund Office; or

(c) An alternate recipient under a Participant's Qualified Medical Child Support Order.

Cleveland Fund means Cleveland and Vicinity Carpenters Health Fund, which merged into the Ohio Fund.

COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended, and the regulations promulgated thereunder.

Code means the Internal Revenue Code of 1986, as amended, and the regulations promulgated thereunder.

Collective Bargaining Agreement or **CBA** means a collective bargaining agreement with the Union.

Common Accident Deductible means that if two or more Covered Persons who are Immediate Family incur charges as a result of the same accident, then only one deductible will be applied to all of the charges relating to the accident for such Covered Persons during the Plan Year.

Consent to Out of Network Services means:

(a) a Covered Person provided informed consent under applicable law to receive either:

(1) post-stabilization services following Emergency Services from an out-of-network provider or out-of-network emergency facility; or
(2) nonemergency services from an out-of-network provider at an in-network facility; and

(b) the Plan receives notice of such consent.

Notwithstanding, Consent to Out of Network Services does not include Ancillary Services or items or services provided as a result of unforeseen, urgent medical needs that arise at the time an item or service is furnished.

Continuing Care Patient means a Covered Person who, with respect to a provider or facility, satisfies one of the following conditions:

(a) is undergoing a course of treatment for a serious and complex condition;
(b) is undergoing a course of institutional or inpatient care;
(c) is scheduled to undergo nonelective surgery, including receipt of postoperative care with respect to such surgery;
(d) is pregnant and undergoing a course of treatment for the pregnancy; or
(e) is or was determined to be a Terminally Ill Person.

Contributions or **Employer Contributions** mean payments to the Fund by an Employer as required under a Collective Bargaining Agreement or other written agreement satisfying the requirements of the National Labor Relations Act. Contributions become vested plan assets when they are due and owing.

Covered Employment means employment by an Employee that is either:

(a) bargaining unit work (i.e., any classification or work under a Collective Bargaining Agreement) for which Contributions are required to be made to the Fund; or
(b) any other work or employment for which Contributions are required to be made to the Fund.

Covered Person means a Participant or Dependent eligible for coverage under the Plan.

Covered Services mean those services and items for which coverage is provided by the Plan.

Custodial Care means care (including necessary room and board) that is given principally for personal hygiene or for assistance in daily activities and can, according to generally accepted medical standards, be performed by persons who have no medical training. Examples of Custodial Care include, but are not limited to, the following: help in walking and getting out of bed; assistance in bathing, dressing, feeding; or supervision over medication, which could normally be self-administered.

Dependent or **Dependents** mean(s) a Participant's Spouse or Child(ren).

Disabled means any medical condition (including a Mental Health Condition or Substance Use Disorder), which in the opinion of a Physician satisfactory to the Trustees, prevents a person from engaging in any regular occupation or employment for remuneration or profit for which Contributions were received by the Plan prior to his/her disability. Notwithstanding, no person shall be deemed to have a Disability if such incapacity was contracted, suffered, or incurred while he was engaged in an illegal activity or from service in the Armed Forces of any country.

Dollar Bank or **Bank** means the individual bookkeeping account maintained by the Fund for eligibility purposes.

DSM means the most current version of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, which is currently the Fifth Edition, Text Revision published in March 2022. Any subsequent version of the DSM will be considered the most current version beginning on the 1st day of the Plan Year that begins on or after that date that is 1 year after the date the subsequent version is published.

Durable Medical Equipment or **DME** means equipment which:

(a) can withstand repeated use;
(b) is mainly and customarily used for medical purposes;
(c) is not generally useful to a person in the absence of injury or sickness; and
(d) is suitable for use in the home.

Emergency Medical Condition means a medical condition (including a Mental Health Condition or Substance Use Disorder) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect that the absence of immediate medical attention would result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

Emergency Services with respect to an Emergency Medical Condition means:

(a) a medical screening examination that is within the capability of the emergency department of a hospital or of an independent freestanding emergency department, including Ancillary Services routinely available to the emergency department to evaluate such emergency medical condition, and

(b) medical examination and treatment that are within the capabilities of the staff and facilities available at such hospital or independent freestanding emergency department as required to Stabilize the patient (regardless of the department of the hospital in which such items or services are furnished), and

(c) unless Consent to Out-of-Network Services is provided to the Plan by the provider or facility, items and services for which benefits are provided by the Plan that are furnished by a nonparticipating provider or nonparticipating emergency facility after the Covered Person is Stabilized and as part of outpatient observation or an inpatient or outpatient stay with respect to the Emergency Medical Condition which gave rise to the initial Emergency Services.

Employee means an individual on whose behalf Contributions are currently required to be made by an Employer to the Fund and who is also either: (a) represented by the Union; (b) a full-time employee of the Union or related organization; or (c) an eligible salaried employee of an Employer. Notwithstanding, a self-employed individual is not an Employee.

Employer means those who:

- Have assigned their bargaining rights to an employer association which is a party to a Collective Bargaining Agreement requiring Contributions to the Fund;
- Are a party to a Collective Bargaining Agreement requiring Contributions to the Fund that is acceptable to the Trustees; or
- Have executed an Employer Participation Agreement with the Fund that is acceptable to the Trustees requiring Contributions to the Fund.

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

Experimental or Investigational Drug, Device, Medical Treatment, Supply, or Procedure means a drug, device, medical treatment, supply, or procedure that meets any of the following criteria:

(a) If the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA) and approval for marketing has not been given at the time the drug or device is furnished;
(b) If Reliable Evidence shows that the drug, device, medical treatment, or procedure is the subject of ongoing phase I, II, or III clinical trials or is under study to determine maximum tolerated dose, toxicity, safety, or efficacy as compared with the standard means of treatment or diagnosis;
(c) If Reliable Evidence shows that the consensus of opinion among experts regarding the drug, device, medical treatment, or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, toxicity, safety, or efficacy as compared with the standard means of treatment or diagnosis; or
(d) If the drug is not commercially available for purchase or is not approved by the FDA for general use.

Former Niles Fund Active Employee means an Active Employee eligible for a self-insured death benefit under section 10.4(b).

Former Niles Fund Inactive Employee means an individual only eligible under this Plan for a self-insured death benefit under section 10.4(c).

Former Niles Fund Retiree means a Retiree who was a retiree in the Cleveland Fund on or before January 1, 2013, who is eligible for Medicare Supplemental coverage under section 4.1(b).

Fund is the Central Midwest Regional Council of Carpenters' Welfare Fund.

Fund Office means BeneSys, Inc, 700 Tower Drive, Suite 300, Troy, Michigan 48099, (248)-813-9800, or dedicated CMRCC Fund Office number 800-700-6756, www.cmrccbenefits.org.

Health Care Reform means those requirements applicable to this Plan under the federal Patient Protection and Affordable Care Act, as amended.

Hospice Care means a coordinated program intended to meet the special physical, psychological, spiritual, and social needs of a Terminally Ill Person and his/her Immediate Family.

Hospice Facility means a facility which provides Hospice Care.

Hospital means an establishment which is engaged primarily in providing medical care and treatment to sick and injured persons on an inpatient basis at the patient's expense and which fully meets the following requirements:

(a) It is an institution:
    (1) Which is operating in accordance with the law of jurisdiction in which it is located pertaining to institutions identified as a Hospital;
    (2) Is primarily engaged in providing, for compensation from its patients and on an inpatient basis, diagnosis, treatment, and care of injured or sick persons by or under the supervision of a staff of Physicians or surgeons;
    (3) Continuously provides 24-hour nursing service by registered graduate nurses; and
    (4) Maintains facilities on the premises for major operative surgery; and is not, other than incidentally, a place for rest, a place for the aged, or a nursing home;

    and

(b) Either:
  (1) It is a Hospital accredited by the Joint Commission on the Accreditation of Health Organizations (JCAHO) or accredited by the American Osteopathic Association (AOA) or be qualified to participate in and is eligible to receive payments under an in accordance with the provisions of Medicare; or
  (2) It is a licensed facility specializing in the treatment of Substance Use Disorders or Mental Health Conditions.

ICD means the most current version of the World Health Organization's International Classification of Diseases adopted by the Department of Health and Human Services through 45 CFR § 162.1002, which is the 10th Revision, Clinical Modification adopted for the period beginning on October 1, 2015. Any subsequent version of the ICD adopted through 45 CFR § 162.1002 will be considered the most current version beginning on the 1st day of the Plan Year that begins on or after the date that is one year after the date the subsequent version is adopted.

IKORCC Participant means a Participant or Dependent who was eligible for coverage under the IKORCC Plan on December 31, 2024.

IKORCC Plan means the Indiana/Kentucky/Ohio Regional Council of Carpenters Welfare Fund Plan document in effect on December 31, 2024.

Immediate Family means the Participant and the Participant's Spouse, Children, parents, stepparents, grandparents, nieces, nephews, aunts, uncles, cousins, brothers, and sisters, whether by blood, marriage, or adoption.

Incurred means the date on which a service(s) or supply (supplies) are rendered by a Provider. All services rendered by a Provider during an Inpatient admission prior to termination of coverage are Incurred on the date of admission.

Inpatient Services mean the services and supplies that are received by a Covered Person while a registered bed patient in a Hospital or Other Facility where a room and board charge is made.

Institutional – A Hospital or Other Facility.

Medically Necessary or **Medical Necessity** means a service, supply, and/or Prescription Drug that is required to diagnose or treat a medical condition and which is:

(a) Appropriate with regard to the standards of good medical practice and not Experimental or Investigational;
(b) Not primarily for convenience of the patient or Provider;
(c) Medically proven to be effective treatment of the condition; and
(d) The most appropriate supply or level of service, which is determined pursuant to the applicable standard of care. When applied to Inpatient Services or care, this includes a determination that the medical symptoms or condition requires that the services cannot be safely or adequately provided on an outpatient basis. When applied to Prescription Drugs, this includes a determination that the Prescription Drug is cost effective compared to alternative Prescription Drugs that produce comparable effective clinical results.

Medicare means the health care program for the aged and disabled established by Title XVIII of the Social Security Act of 1965, as amended, and the regulations promulgated thereunder.

Mental Health Benefit means a benefit with respect to items or services for a Mental Health Condition.

Mental Health Condition means those conditions, except a Substance Use Disorder, that either: (1) fall under any of the diagnostic categories listed in the mental, behavioral, and neurodevelopmental disorders chapter (or equivalent chapter) of the most current version of the ICD; or (2) that are listed in the most current version of the DSM.

MHPAEA means the Mental Health Parity and Addiction Equity Act, as amended, and the regulations promulgated thereunder.

Non-Bargaining Unit Participation Agreement is an agreement made between an Employer and the Fund to allow for contributions on behalf of the Employer's non-bargaining unit employees.

Non-Occupational Accidental Injury, Sickness, Illness, or Disease means an Accidental Injury, Sickness, Illness, or Disease that does not arise out of or in the course of, and which is not caused, contributed to, or a consequence of, any employment, occupation, or work for pay or profit.

Office Employee means an Employee of the Union or an apprenticeship fund sponsored by the Union who is not a member of the bargaining unit or an alumnus of the bargaining unit.

Office Visit means a medical visit or consultation in a Physician's office or, if covered, a patient's residence. A Physician's office can be in a medical / office building, Outpatient Department of a Hospital, a freestanding clinic facility, or a Hospital-based Outpatient clinic facility.

Occupational Accidental Injury, Sickness, Illness, or Disease means an Accidental Injury, Sickness, Illness, or Disease that arises out of or in the course of, and which are caused, contributed to, or a consequence of, any employment, occupation, or work for pay or profit.

Ohio Participant means a Participant or Dependent who was eligible for coverage under the Ohio Plan on December 31, 2024.

Ohio Plan means the Ohio Carpenters Health Fund's Plan document in effect on December 31, 2024.

Other Facility means the following establishments which are licensed as required by applicable law, are not used more than incidentally as offices or clinics for the private practice of a Physician or Other Professional Provider:

(a) Outpatient surgical facility;
(b) Outpatient treatment facilities for Mental Health Conditions or Substance Use Disorders;
(c) Dialysis facility;
(d) Residential Treatment Facility;
(e) Home Health Care Agency;
(f) Hospice Facility.

Other Professional Provider means only the following persons or entities which are licensed as required:

(a) Advanced nurse practitioner (A.N.P.);
(b) Ambulance services;
(c) Dentist;
(d) Doctor of chiropractic medicine;
(e) Durable medical equipment or prosthetic appliance vendor;
(f) Laboratory (must be Medicare Approved);
(g) Licensed independent social workers (L.I.S.W.);
(h) Licensed practical nurse (L.P.N.);
(i) Licensed professional clinical counselor;
(j) Licensed vocational nurse (L.V.N.);
(k) Mechanotherapist (licensed or certified prior to November 3, 1975);
(l) Nurse-midwife;
(m) Occupational therapist;

(n) Physical therapist;
(o) Physician assistant;
(p) Podiatrist;
(q) Psychologist;
(r) Registered nurse (R.N.);
(s) Registered nurse anesthetist; and
(t) Urgent Care Provider.

Outpatient means services or supplies through a Hospital, Other Facility, Physician, or Other Professional Provider while not confined as an Inpatient.

Participant means an Active Employee or Retiree who is eligible for benefits under the Plan.

Physician means any of the following licensed practitioners who are acting within the scope of his or her license and who perform a service payable under the Plan:

(a) A Doctor of Medicine (MD), Osteopathy (DO), Podiatrist (DPM), or Chiropractor (DC).
(b) A psychologist (PhD or PsyD) or psychiatrist (MD) providing services in connection with mental therapy or behavioral counseling.
(c) A licensed doctoral clinical psychologist, and a licensed or certified social worker (LCSW or CCSW), a licensed Physician's assistant (PA) or any other licensed practitioner who
    (1) Is acting under the supervision of a Doctor of Medicine (MD); and
    (2) Performs a service which is payable under the plan when performed by a Doctor of Medicine (MD).

Notwithstanding the above, a Physician does not include any person who:

- Resides in the Covered Person's home; or
- Is a member of the Covered Person's Immediate Family.

Plan means the program of benefits and coverage set forth in the Central Midwest Regional Council of Carpenters Welfare Fund's Plan document.

Plan Administrator means the Board of Trustees of the Central/Midwest/Regional Council of Carpenters Welfare Fund. The Board of Trustees has delegated to BeneSys, Inc., the authority and responsibility for general administration and day-to-day operation of the Fund.

Plan Year means 12-consecutive months beginning May 1 and ending the following April 30, which is the Plan's fiscal year.

Prescription Drug or **Federal Legend Drug** means any medication that, under federal or state law, may not be dispensed without a legally valid prescription and is FDA approved.

Provider means a Hospital, Other Facility, Physician, or Other Professional Provider.

Qualifying Payment Amount or **QPA** means, for an item or service, the median in-network rate for:

(a) the same or similar services;
(b) furnished in the same or a similar facility;
(c) by a provider of the same or similar specialty; and
(d) in the same or similar geographic area, adjusted as required by applicable regulations for inflation and base billing units, if applicable.

Recognized Amount with respect to an item or service furnished by a nonparticipating provider means:

(a) for an item or service furnished in a State that has an All-Payer Model Agreement under 1115A of the Social Security Act, the amount the State approves under such system;
(b) if there is no applicable All-Payer Model Agreement, then an amount determined by State law where the item or service is furnished; or
(c) if neither of the above apply, then the lesser of:
    (1) the amount billed by the provider or facility; or
    (2) the Qualifying Payment Amount.

Reliable Evidence means only the following:

(a) published reports and articles in authoritative medical and scientific literature;
(b) the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, medical treatment, or procedure; or
(c) the written informed consent used by the treating facility, or by another facility studying substantially the same drug, device, medical treatment, or procedure.

Residential Treatment Facility means a facility providing Inpatient care for the evaluation and treatment of residents with Mental Health Conditions or Substance Use Disorders, with residential treatment plans supervised by a professional staff of qualified Physician(s), licensed nurses, counselors, and social workers for the chemical, psychological, and social needs.

Retiree means an individual who satisfies the requirements of (1), (2), or (3) below:

(1) An individual who:

    (a) applies to the Plan for retiree coverage within 30 days of the last month in which he/she is eligible in the Plan as an Active Employee;
    (b) is receiving a defined benefit pension benefit from a plan affiliated with the UBC;
    (c) is a member of the Union in good standing (if coverage under the Plan prior to retirement was based on Covered Employment as a bargaining unit member, which includes Employees of the Union who are alumni of the bargaining unit); and
    (d) Meet the requirements of (1) or (2), below, as applicable:

        (1) all Participants, other than former IKORCC Participants covered by paragraph (2), below:
            (i) must have been eligible in the Plan as an Active Employee immediately preceding retirement and in the following time frames immediately preceding retirement:
                - for a total of 60 months in the last 10 years; and
                - 9 of the 12 months immediately preceding retirement; and
            (ii) have not made more than 12 full or partial consecutive self-payments to continue Plan coverage in the year immediately preceding retirement (or 24 months if timely and actively pursuing a Social Security Disability Award); or

        (2) a former IKORCC Participant retiring before January 1, 2027: must have been eligible in the Plan (or prior to 1/1/25, in the IKORCC Plan) as an Active Employee immediately preceding retirement and in the following time frames immediately preceding retirement:
            - in the current month and the previous 23 months, or
            - three consecutive months in each of the last three 24-month periods.

(2) Effective for retirements on or after July 1, 2026, a Shop Employee who:

(a) applies to the Plan for retiree coverage within 30 days of the last month in which he/she is eligible in the Plan as an Active Employee,
(b) is a member of the Union in good standing, and
(c) was eligible in the Plan as an Active Employee immediately preceding retirement and in each of the 60 months immediately preceding retirement.

(3) Effective for retirements on or after July 1, 2026, an Office Employee who:

(a) applies to the Plan for retiree coverage within 30 days of the last month in which he/she is eligible in the Plan as an Active Employee, and
(b) was eligible in the Plan as an Active Employee immediately preceding retirement and in each of the 60 months immediately preceding retirement.

Semi-private means an Inpatient accommodation where two individuals share a room.

Serious and Complex Condition means:

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

Shop Employee means those individuals on whose behalf Contributions are required to be made by an Employer to the Fund under a CBA covering such employees.

Sickness, Illness, or **Disease** means an illness, disease, a Mental Health Condition, or Substance Use Disorder. For purposes of this Plan, Sickness or Illness also includes a covered pregnancy.

Skilled Care means care that requires the skill, knowledge, or training of a Physician, Registered Nurse, Licensed Practical Nurse, Physical therapist performing under the supervision of a Physician.

Skilled Nursing Facility means a facility which primarily provides 24-hour Inpatient Skilled Care and related services to patients requiring convalescent and rehabilitative care. Such care must be provided by either a registered nurse, licensed practical nurse, or physical therapist performing under the supervision of a Physician.

Spouse means a Participant's legal spouse, who is not divorced or legally separated from the Participant.

Stabilized means, with respect to an Emergency Medical Condition, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility.

Substance Use Disorder means those disorders that either: (1) fall under any of the diagnostic categories listed as a mental or behavioral disorder due to psychoactive substance use (or equivalent category) in the mental, behavioral, and neurodevelopmental disorders chapter (or equivalent chapter) of the most current version of the ICD; or (2) are listed as a Substance-Related and Addictive Disorder (or equivalent category) in the most current version of the DSM.

Substance Use Disorder Benefit means any benefit with respect to items or services for Substance Use Disorders.

Surgery means generally accepted operative and other invasive procedures.

Surviving Spouse means the Spouse of a Participant as of the date of the Participant's death.

Terminally Ill Person means an individual who satisfies the following conditions, as certified in writing by an attending Physician:

(a) has no reasonable prospect of cure; and
(b) has a life expectancy of six months or less.

Trust Agreement means the Central Midwest Regional Council of Carpenters Welfare Fund Agreement and Declaration of Trust, as amended.

Trust Fund or **Fund** means the Central Midwest Regional Council of Carpenters Welfare Fund.

Trustee or **Board of Trustees** means any person, or group of persons, serving as a Trustee(s) under the terms of the Trust Agreement.

UBC means the United Brotherhood of Carpenters and Joiners of America.

Union means the Central Midwest Regional Council of Carpenters, or its constituent Local Unions.

ARTICLE 2 – ELIGIBILITY RULES

2.1 Eligibility for Employees (Excluding Shop Employees, Office Employees, and Non-bargaining Unit Employees)

(a) Dollar Bank System

(1) The Fund shall maintain a bookkeeping account for each Employee, known as the Employee's "Dollar Bank" or "Bank." An Employee's Dollar Bank shall be credited with Contributions received on his/her behalf (less the MRA credit under section 5.2) up to a maximum of twelve months Premium, defined below.

The Premium is the monthly cost of coverage determined from time to time in the sole discretion of the Trustees. The Premium will be deducted monthly from each Employee's Dollar Bank to maintain eligibility, see section 2.1(e), below. The monthly Premium is $1,250.00, and therefore the Dollar Bank can be credited to a maximum of $15,000.00.

(2) An Employee has no right or title to any amounts credited to his/her Bank. At all times all amounts in the Dollar Bank are Plan assets. The Trustees may at any time and for any reason terminate the Bank and any credit in any Employee's Bank at such time will remain a Plan asset.

(b) Initial Eligibility: Provided a completed application has been provided to the Fund Office, coverage will begin the first day of the second month following the date an Employee's Dollar Bank equals one month's Premium, in the amounts established under section 2.1(a)(2), above, provided such amount was accumulated in a consecutive 12-month period. For example, an Employee works sufficient hours in January to establish initial eligibility. If Contributions for this work are received by the Fund Office in February, eligibility will start April 1.

(c) Accelerated Initial Eligibility

Notwithstanding 2.1(b), an Employee may accelerate initial eligibility if he/she:

(1) was never previously covered by the Plan;
(2) immediately prior to entering Covered Employment was working for a non-contributing employer;

(3) within the immediate 30 days prior to entering Covered Employment, had comprehensive medical coverage meeting the minimum value standard of the Affordable Care Act (Other Coverage) as an employee (not as a dependent), and provides written proof Other Coverage satisfactory to the Trustees;
(4) is engaged in Covered Employment as of the date he/she provides a completed application for coverage to the Fund Office, and this completed application is received within 59 days of the termination of his/her Other Coverage.

If the above requirements are met, an Employee will be eligible for benefits the first of the month following the month in which Contributions on his/her behalf are received by the Fund Office, and provided Contributions are received for the two subsequent months will remain eligible for the two following months. For example, the Employee commences Covered Employment in June for which Contributions are received in July and then eligibility will begin in August. Provided Contributions continue monthly, coverage will continue for September and October and thereafter eligibility will continue as set forth in Section 2.1(e), below. To the extent Contributions for these initial three months of eligibility do not equal the monthly Premium (see 2.1(a)), this amount will be recovered by deductions from future Contributions before crediting the Participant's Bank.

(d) Delayed Eligibility

Notwithstanding the foregoing provisions, a Participant, immediately upon qualifying for Initial Eligibility in accordance with Section 2.1(b), may request that eligibility for coverage be delayed until a future date if:

(1) He/she was not previously eligible for benefits from this Plan;
(2) Participation in this Plan arose as the result of a transfer or change of union membership to a participating Union;
(3) The Participant is currently eligible in jointly-trusteed welfare plan sponsored by an affiliate of the UBC (other coverage) and eligibility in this Plan will result in double-coverage; and
(4) Eligibility in this Plan will automatically commence once the other coverage is exhausted.

A Participant is required to provide all information and documentation necessary, in the discretion of the Trustees, to establish the foregoing criteria.

(e) Continued Eligibility

(1) Crediting Contributions

Eligibility will continue so long as an Employee's Dollar Bank is sufficient to pay the Premium, with Contributions credited as follows:

Work in the month of:	**For which Contributions are received in:**	**Are credited towards eligibility for:***
January	February	April
February	March	May
March	April	June
April	May	July
May	June	August
June	July	September
July	August	October
August	September	November
September	October	December
October	November	January

November	December	February
December	January	March

***Eligibility Months**

Special Rule for Apprentices: Each work month an Apprentice attends school required by a training program affiliated with the UBC in which he/she is indentured, the Apprentice's Bank will be credited with an amount equal to the Premium minus total Contributions actually received for such month, not to exceed the number of hours in school attendance times the current contribution rate for such apprentice.

(2) Self-Payments

(a) If monthly Contributions combined with the balance in an Employee's Dollar Bank are not enough to cover the Premium, a self-payment must be made to maintain coverage.

(b) Where the self-pay equals the Premium, it is a "full self-payment." Full self-payments can be made for a maximum of 12 months. However, full self-payments are permitted for up to 24 months where the Employee is actively pursuing a Social Security Disability Award (SSD), provided the Employee made an application for SSD within 12 months of the onset of the Disability. After the 12- or 24- month period for self-payments is exhausted, the Employee will be offered COBRA if eligibility has not been re-established under the Initial Eligibility rules.

(c) If there is enough in the Employee's MRA to cover the required self-payment, then an automatic deduction will be made from the Employee's MRA.

For example: Monthly Contributions equal $800, the Employee has a Dollar Bank balance of $100 and a MRA balance of $700, and the Premium is $1,250. The Premium will be satisfied by the $800 in Contributions, $100 Bank balance, and a $350 self-payment that will be automatically withdrawn from the Employee's MRA.

(d) If there is not enough in an Employee's MRA to cover the required self-payment, a self-pay notice will be sent to the Employee. Self-payments must be received by the Fund Office by the 25th of the month prior to the month for which the self-payment must be made to maintain eligibility. If there is any amount in an Employee's MRA, the Employee can elect to use the MRA balance towards the required self-payment.

For example: Monthly Contributions equal $800, the Employee has a Dollar Bank balance of $100 and a MRA balance of $100, and the Premium is $1,250. The Employee will receive a self-payment notice for $350. The Employee can pay the entire $350 or can pay $250 and request that the remainder be paid with the $100 MRA balance.

(e) Failure to timely remit self-payments will result in termination of coverage retroactive to the first of the month for which self-payment is due and COBRA will be offered. Late self-payments to reinstate eligibility are not allowed.

(3) Eligibility Lapses Due to Employer Delinquency

If eligibility lapses because Employer Contributions to be remitted via reciprocity have not been received and the Employee's Dollar Bank Account and Medical Reimbursement Account are depleted, if the Participant provides check stubs showing the hours worked for which such reciprocity is owing, then credit may be given for such hours not to exceed three months.

If eligibility lapses because Employer Contributions are delinquent and the Employee's Dollar Bank Account and Medical Reimbursement Account are depleted, the Participant may provide check stubs showing the hours worked for the delinquent Employer. Credit may be given for hours worked, up to three months, upon notice to and approval by the Trustees.

(4) Cancellation of Dollar Bank: All amounts in a Dollar Bank will be cancelled and forfeited upon termination of eligibility under section 2.7(a)(iii) or 2.7(a)(iv) or if there are 12 consecutive months of no Contributions.

(f) Temporarily Disabled Employees

Effective the first day of an injury or the eighth of an Illness, an Active Employee's Dollar Bank will be credited on each business day per week (Monday – Friday), an amount established in the sole discretion of the Trustees from time to time, up to a maximum of 26 weeks where the Employee:

(1) is temporarily Disabled, as supported by the statement of a Physician regularly treating the Active Employee confirming the Disability;
(2) is not Retired and is represented by the Union at the time the Disability was incurred, the date of application for benefits under (5), below, and remains represented by the Union,
(3) is receiving Weekly Disability benefits from this Fund, or is entitled to benefits under Workers' Compensation or occupational disease law;
(4) if requested, submits to an examination by a Physician designated and paid for by the Fund (prior to or during the receipt of such credits); and
(5) submits a written application to the Fund Office for such credits within 6 months after the Disability starts.

Notwithstanding, this 6-month limitation may be extended if:
(i) the Disability is due to an on the job injury, and
(ii) the Participant returned to work following the injury, but due to a deterioration in his/her condition was unable to continue and has not returned to work again prior to the date of application, and
(iii) the Participant presents proof, acceptable in the sole discretion of the Trustees, that his initial injury was misdiagnosed, leading to prolonged treatment, and
(iv) the Participant did not at any time prior to the application receive credits under this section for such injury.

If the above conditions are met, the application will be timely if submitted within 12 months of the last hour of work for which Contributions were received on behalf of such Participant.

(g) Reinstatement of Eligibility: In the event that eligibility is terminated, an Employee may reinstate eligibility by satisfying the Initial Eligibility provisions in Section 2.1(b).

2.2 Eligibility for Non-Bargaining Unit Employees

(a) Active Non-Bargaining Unit Employees

(i) Subject to approval of the Trustees, an Employer may provide coverage under this Plan to its Non-Bargaining Unit Employees (NBU) provided:

(A) The Trustees enter into a Non-Bargaining Unit Participation Agreement with the Employer for NBU coverage (Participation Agreement);
(B) Employer has been a contributing Employer for at least 12 months prior to making application to cover its NBU;

(C) On average for each 12-month period a Participation Agreement is in effect, at least 50% of the Employer's employees are individuals for whom Contributions are required under the CBA;

(D) The Employer covers all NBU who are working at least 32 hours a week for at least single coverage as of the first of the month following one month of employment, and is not allowed to cover those working less than 32 hours a week. Notwithstanding:

(1) as applied to Employers who were contributing to the Ohio Plan on behalf of NBU employees as of December 31, 2024, 24 hours will be substituted for 32 hours through December 31, 2026, and

(2) if the Employer employs two married NBU for whom contributions are otherwise payable, contributions only have to be paid on one spouse.

(ii) In no event will NBU participation exceed 10% of the total participation.

(iii) Union Employees who are alumni of the bargaining unit are covered under Section 2.1, not this Section 2.2, and entitled to all benefits provided by the Fund.

(b) Eligibility and Premium

NBU do not have Banks. A monthly premium of $1,250.00 is required to establish and maintain eligibility for NBU. Premiums are credited and due as follows:

Work Month of:	For which Premiums are received in:	Provide Eligibility for:
August	September	October
September	October	November
October	November	December
November	December	January
December	January	February
January	February	March
February	March	April
March	April	May
April	May	June
May	June	July
June	July	August
July	August	September

The Premium must be received by the 25th of the month prior to the eligibility month for which it is due. For example, the premium for the work month of August is due no later than September 25th to provide October eligibility. The Trustees may change the amount of the premium and timing of payment at any time in their sole discretion.

Eligibility shall terminate the first of the month for which such payment is due and not received.

(c) Retired Non-Bargaining Unit Employees

This Plan will not provide NBU Retiree coverage except for the following:

(1) Individuals who were participating as NBU retirees under the IKORCC Plan as of December 31, 2024; and

(2) For retirements before December 31, 2026, NBU employees working for employers who provided NBU employee coverage under the IKORCC plan as of December 31, 2024, will be eligible for NBU retiree coverage, provided they comply with Sections 2.5(a) and (c), below.

(d) Benefits: Notwithstanding any term of this Plan to the contrary, NBU are eligible for all benefits provided by the Fund except for weekly disability benefits, the MRA, and retiree coverage other than set forth in (c), above.

2.3 Eligibility for Office Employees

Office Employees will be eligible for coverage the first of the month following the month in which the Fund receives a monthly payment for coverage, in an amount determined by the Trustees, which may be changed by the Trustees from time to time in their sole discretion. Currently, a monthly premium of $1,250.00 is required to establish and maintain eligibility for Office Employees. Premiums are credited on the same schedule set forth for NBU in section 2.2(b), above. Office Employees do not have Banks.

Eligibility shall terminate the first of the month for which such payment is not received.

Notwithstanding any term of this Plan to the contrary, Office Employees are eligible for all benefits provided by the Fund except for the MRA (Office Employees became eligible for Retiree benefits effective for retirements on or after July 1, 2026).

2.4 Eligibility for Shop Employees

(a) Initial Eligibility: Shop Employees will be eligible for coverage the first of the month following the month in which the Fund receives Contributions equal to one month's Premium. The Premium is the monthly cost of coverage determined from time to time in the sole discretion of the Trustees. The amount of the Premium dependent on the Shop Employee's election, see section 2.4(f), below.

(b) Accelerated Initial Eligibility

Notwithstanding section 2.4(a), above, a Shop Employer may accelerate initial eligibility for his/her Shop Employees if:

(1) the Shop Employees were never previously covered by the Plan (i.e., must be new Shop Employees); and
(2) the Shop Employer remits two months of Contributions.

If the above requirements are met, eligibility will begin the first of the month following receipt payment. For example, if two months of Contributions are received in May, then eligibility will be effective June 1 and will continue through July. The Shop Employer must then follow the schedule set forth in 2.4(c)(1), below, i.e., remit Contributions in June for August eligibility.

(c) Continuing Eligibility

(1) Contributions

Eligibility continues so long as monthly Contributions are sufficient to pay the Premium. For such purposes, Contributions will be credited as follows:

Work in the month of:	For which Contributions are received in:	Provide credit for the following Eligibility Month:
January	February	March
February	March	April
March	April	May
April	May	June
May	June	July
June	July	August

July	August	September
August	September	October
September	October	November
October	November	December
November	December	January
December	January	February

(2) Self-Payments

Except as provided in paragraph 2.4(c)(3), below, if monthly Contributions are not enough to cover the Premium, a self-payment must be made to maintain coverage.

Self-payments must be received by the Fund Office by the 25th of the month prior to the month for which the self-payment must be made to maintain eligibility. Failure to timely remit self-payments will result in termination of coverage retroactive to the first of the month for which self-payment is due and COBRA will be offered. Late self-payments to reinstate eligibility are not allowed.

Where the self-pay equals the Premium, it is a "full self-payment." Full self-payments can be made for a maximum of 12 months. However, full self-payments are permitted for up to 24 months when the Employee is actively pursuing a Social Security Disability Award (SSD), provided the participant made an application for SSD within 12 months of the onset of the Disability. After the 12- or 24- month period for self-payments is exhausted, the Employee will be offered COBRA if eligibility has not been re-established under the Initial Eligibility rules.

(3) Dollar Banks and Medical Reimbursement Accounts

Due to work under certain Collective Bargaining Agreements, some Shop Employees may also have Dollar Banks and/or Medical Reimbursement Accounts (MRA). Under these Collective Bargaining Agreements, Contributions are based on hours worked. Contributions to the Bank are credited under the same schedule as set forth in paragraph 2.4(c)(1), above.

Where Employer Contributions under section 2.4(c)(1), above, are not sufficient to cover the Premium, the Dollar Bank can be used in lieu of self-payments to maintain coverage. The use of the Dollar Bank is subject to the following:

(a) The Dollar Bank is a bookkeeping account for each Employee that is credited with Contributions received on his/her behalf up to a maximum of twelve months Premium.

(b) All amounts in a Dollar Bank will be cancelled and forfeited if there are 12 consecutive months of no Contributions to the Bank.

(c) An Employee has no right or title to any amounts credited to his/her Bank. At all times all amounts in the Dollar Bank are Plan assets. The Trustees may at any time and for any reason terminate the Bank and any credit in any Employee's Bank at such time will remain a Plan asset.

(d) Contributions to the Bank are credited under the same schedule as set forth in paragraph 2.4(c)(1), above.

(e) Where Contributions for work months on or after July 2025 are credited to a Shop Employees Bank, he/she is also entitled to a contribution to, and may use, an MRA under Article 5.

(f) In the event a Shop Employers monthly Contribution is not sufficient to provide eligibility, prior to the issuance of a self-pay notice, an amount equal to the Premium for the month at issue will be deducted from the Shop Employee's Bank.

In the event there are insufficient amounts in a Shop Employee's Bank to cover the self-payment, if there is enough in the Employee's MRA to cover the required self-payment, then an automatic deduction will be made from the Employee's MRA.

For example: The Premium is $1,250. Monthly Contributions equal $800, the Employee has a Dollar Bank balance of $100 and an MRA balance of $700. The $1,250 Premium will be satisfied by the $800 in Contributions, $100 Bank balance, and a $350 self-payment automatically withdrawn from the Employee's MRA.

If there is not enough in an Employee's MRA to cover the required self-payment, a self-pay notice will be sent to the Employee. Self-payments must be received by the Fund Office by the 25th of the month prior to the month for which the self-payment must be made to maintain eligibility. If there is any amount in an Employee's MRA, the Employee can elect to use the MRA balance towards the required self-payment.

For example: The Premium is $1,250. Monthly Contributions equal $800, the Employee has a Dollar Bank balance of $100 and an MRA balance of $100. The Employee will receive a self-payment notice for $350. The Employee can pay the entire $350 or can pay $250 and request that the remainder be paid with the $100 MRA balance.

The provisions of section 2.1(e)(3) apply for delinquent or reciprocated contributions.

(d) Temporarily Disabled Employees

Effective the first day of an injury or the eighth of an illness, a Shop Employee will be credited on each business day per week (Monday – Friday), an amount towards eligibility, established in the sole discretion of the Trustees from time to time, up to a maximum of 26 weeks where the Employee:

(1) is temporarily Disabled, as supported by the statement of a Physician regularly treating the Active Employee confirming the Disability;
(2) is not Retired and is represented by the Union at the time the Disability was incurred, the date of application for benefits under (4), below, and remains represented by the Union,
(3) is receiving Weekly Disability benefits from this Fund, or is entitled to benefits under Workers' Compensation or occupational disease law; and
(4) submits a written application to the Fund Office for such credits within 6 months after the Disability starts.

Notwithstanding, the Trustees may require that the Employee submit to an examination by a physician designated by the Fund prior to or during the receipt of such credit.

(e) Reinstatement of Eligibility: In the event eligibility is terminated, an Employee may reinstate eligibility by satisfying the Initial Eligibility provisions in Section 2.4(a).

(f) Benefit Elections and Benefits

(1) Election

One-time per year during the open enrollment month of December, to be effective the following calendar year, Shop Employees may elect single or family coverage under the Shop Plan or the Active Employees and Non-Medicare Retirees Plan (Full Plan).

A Shop Employee may only switch coverage options during a calendar year if the Shop Employee acquires a new Dependent as a result of marriage, birth, adoption, or placement for adoption and the request to change an election is made within 60 days of such event. If the request to change an election is timely received, coverage will be retroactive to the date of such event. If the request to change an election is not timely received, coverage will be effective the first day of the first month following the requested change.

In addition, once per calendar year other than during open enrollment, a Shop Employee who elected the Full Plan during open enrollment, may elect to move to the Shop Plan.

(2) Full Plan and Shop Plan Benefits

Notwithstanding any term of this Plan to the contrary, under the Full and Shop Plan options, a Shop Employee is only entitled to the following benefits:

(a) Full Plan: A Shop Employee who has elected the Full Plan has the following benefits:

- Full Plan medical benefits as set forth in section 3.2;
- Prescription drug, weekly disability, dental, vision, hearing, and life insurance benefits as set forth in section 3.3, and Articles 6, 7, 8, 9, and 10.

(b) Shop Plan: A Shop Employee who has elected the Shop Plan has the following benefits:

- Shop Plan medical benefits as set forth in section 3.2; and
- Weekly Disability and Life Insurance as set forth in Articles 6 and 10.

A Shop Employee in the Shop Plan DOES NOT have prescription drug, dental, vision, or hearing benefits.

(c) Dollar Bank and Medical Reimbursement Account (MRA): Shop Employees only have Dollar Banks and MRAs as set forth in Section 2.4(c)(3).

(d) Shop Employees are eligible for Retiree coverage if they meet the definition of Retiree in Article 1.

(3) Premiums: The monthly Premiums effective July 1, 2025, applicable to the September 2025 Eligibility Month, are:

- Shop Plan: $550 Single/ $900 Family.
- Full Plan: $1,250 (applies to single or family coverage).

2.5 Eligibility for Retirees

Retirees will be offered a choice between COBRA coverage, which is of limited duration, and Retiree coverage, as set forth below.

(a) Conditions of Coverage

To be eligible, an individual must meet the definition of Retiree and remit self-payments to maintain coverage at the time and in the amount established in the sole discretion of the Trustees from time to time. Self-payments must be:

- received by the Fund Office by the 5th of the month, or postmarked by the 2nd of the month, for which the self-payment is due (e.g., for April eligibility, the self-payment must be received by April 5th or postmarked by April 2nd);
- made by check, money order, or cashier's check, or remitted directly from a pension fund by a legally permissible assignment of benefits;
- made from the date Employee coverage terminated; and
- continue on an uninterrupted basis.

Alternatively, a Retiree may have the option to have his/her self-payment automatically deducted from a defined benefit pension benefit from a plan affiliated with the UBC.

Failure to make self-payments in the amount and within the time frame specified, or failure to continue to meet the definition of Retiree, will result in a permanent loss of coverage. If a Retiree declines to elect Retiree coverage when first offered, he/she cannot elect such coverage at a later date. If Retiree coverage lapses or is terminated, it cannot be reinstated.

No Retiree coverage is available to NBU (unless covered under 2.2(c)).

(b) Dollar Bank Upon Retirement: If, on the date a Participant becomes eligible for Retiree coverage, Contributions are not owed for work in Covered Employment based on the schedule in section 2.1(e)(1), his/her Dollar Bank will terminate and an amount equal to the amount that was in his/her Dollar Bank immediately prior to retirement will be credited to his/her MRA.

If, on the date a Participant becomes eligible for Retiree coverage, Contributions are still owed for work in Covered Employment based on the schedule in section 2.1(e)(1), eligibility will continue based on the Dollar Bank under the same terms as an Active Participant (including, if applicable, Active self-payments). This will continue until the first day of the fourth month following the month the Retiree last worked in Covered Employment. During this time, the Retiree will be eligible for Active Employee benefits, except Weekly Disability benefits under Article 6 and Active life insurance benefits under Article 10. Thereafter, any amount remaining in the Dollar Bank will be credited to the Retiree's MRA and Retiree self-payments will begin to maintain eligibility for Retiree only benefits.

> For example: Participant A last worked in Covered Employment in September and is approved for Retiree coverage effective October 1. For the months of October, November, and December, coverage will be based on his Dollar Bank at the Active Premium. As of January 1, the balance in the Retiree's Dollar Bank will be credited to his MRA and he will commence Retiree benefits for the applicable Retiree self-payment.

Upon election, amounts in the Retiree's MRA may be used to make self-payments to maintain coverage.

(c) Return to Work: If a Retiree returns to work, he must notify the Fund Office. The Retiree will continue to make Retiree self-payments and will be reimbursed out of Contributions received on his/her behalf (less the MRA credit under section 5.2, which the Retiree will receive) up to the amount of the self-payment. No other amounts will be credited to the Retiree. Notwithstanding, if a Retiree ceases drawing a pension benefit and informs the Fund Office that he/she desires to re-establish eligibility as an Active Employee, such Contributions will be credited in the same manner as for Actives per Section 2.1.

2.6 Dependent Eligibility

(a) Effective Date of Eligibility and Enrollment

Subject to the terms of this Plan, Dependents are eligible for benefits when the Participant of whom they are dependent is eligible.

A completed enrollment form for Dependents must be received by the Fund Office within 30 days of an Employee's initial eligibility, in which case the Dependents are eligible as of the effective date of the Employee's eligibility. If not received within these 30 days, Dependents will be eligible the first of the month after a completed enrollment form is received (i.e. coverage will not be retroactively reinstated).

An Active Employee must provide a completed enrollment form to the Fund Office for a new Dependent within 60 days of marriage, birth, adoption, etc., in which case coverage will be retroactive to date of such event. If not received within these 60 days, new Dependents will be eligible the first of the month after a completed enrollment form is received (i.e. coverage will not be retroactively reinstated).

Retirees may add Dependents to coverage after the date of their retirement on the same terms and conditions as Active Employees.

(b) Coverage Following the Death of a Participant

(1) Surviving Spouse

The Surviving Spouse shall continue eligibility through the end of the month in which the Participant died and thereafter may continue coverage via monthly self-payments in an amount established in the sole discretion of the Trustees from time to time.

The Surviving Spouse may continue coverage via self-payments for 36 months following the Participant's death, to run concurrently with COBRA continuation coverage if applicable. The Surviving Spouse may use any amounts remaining in the Participant's Dollar Bank Account for such self-payments, or the MRA if the Bank is exhausted. Notwithstanding, a Surviving Spouse of a Retiree receiving a monthly benefit from a defined benefit pension plan affiliated with the UBC may continue self-payments to maintain coverage for so long as he/she is receiving such benefit.

Notwithstanding the above, coverage for a Surviving Spouse will terminate the first of the month following the date he/she remarries. It is the Surviving Spouse's responsibility to inform the Fund Office of remarriage and failure to do so is a fraud upon the Fund.

(2) Dependent Children

Children of a deceased Participant and a Surviving Spouse who were covered by the Fund at the time of the Participant's death will continue until the earlier of the date they no longer meet the definition of a Child or the date the Surviving Spouse's coverage terminates.

Children of a deceased Participant who were covered by the Fund at the time of the Participant's death who are not Children of the Surviving Spouse may continue coverage via self-payment if an election is made for the continuation of coverage: (1) by any individual with a familial or established caretaking relationship with the deceased Participant's Children who assumes responsibility to make the required self-payments for continued coverage, or (2) by an adult Child of the deceased Participant who assumes responsibility on his or her own behalf to make the required self-payments for continued coverage.

(3) Surviving Spouses and Children of Shop Employees: Sections (1) and (2), above, do not apply to Surviving Spouses and Children of Shop Employees, who will be offered COBRA coverage as required by law upon the death of the participant.

2.7 Termination of Coverage

(a) Participant

Notwithstanding any term of the Plan to the contrary, all coverage terminates on the earliest of the following:

(i) The last day of the month the Participant maintains eligibility via the Dollar Bank or self-payments;
(ii) The last day of the month a Participant begins active duty in the armed forces;
(iii) The date a Participant becomes employed by an employer who does not contribute to any fund sponsored by a Regional Council or Local Union of the UBC and who employs individuals in a trade or craft covered by a CBA;
(iv) The date a Participant remains employed by an employer who no longer contributes to any fund sponsored by a Regional Council or Local Union of the UBC and who employs individuals in a trade or craft covered by a CBA;
(v) The date an Active Employee ceases Covered Employment and is not on the Union's out-of-work list; or
(vi) The date the Plan terminates.

Notwithstanding, if a Participant stops working for a contributing Employer but continues to work under the terms of a Collective Bargaining Agreement for another affiliated Union of the UBC, or continues to work for a contributing employer in a non-bargaining unit position, he will be covered so long as his Dollar Bank Account is sufficient to continue eligibility, and upon exhaustion of same, he will be offered COBRA coverage.

(b) Dependent: Unless otherwise set forth in this Plan, Dependent coverage will terminate on the earliest of the following:

- The Participant's coverage terminates;
- The end of the month in which a Dependent Child no longer meets the definition of Child;
- The date a Dependent becomes a Participant under this Plan (in which case coverage will continue as a Participant and not as a Dependent);
- The date a Dependent begins full-time active duty in the armed forces; or
- The date that class of coverage is terminated.

2.8 Dollar Bank Freeze: If a Participant becomes employed by a city, county, state government or International Union in a job classification normally covered by a Collective Bargaining Agreement covering Participants in this Plan, and is employed within the jurisdiction of the Fund, or if the Eligible Participant is employed by the International Union, the Dollar Bank Account will be "frozen" upon written application to the Fund Office. If the participant returns to active work for at least one hour, the freeze will end.

2.9 Special Opt Out Provision: A spouse or child of an Active Employee may opt out of the Plan's coverage due to eligibility under a high-deductible health plan (such as a Health Savings Account) through their employer, by completing the Plan's appropriate form with proof that the spouse or child has a high-deductible healthcare plan. A spouse or child of an Active Employee may rejoin this Plan by completing the Plan's appropriate form with proof that the spouse or child is no longer being covered under the high-deductible healthcare plan and that the Employee is still eligible under this Plan. If proof of termination is provided within 30

days of termination of insurance, then coverage will commence on the first day of termination under the high-deductible plan. If proof of termination is not provided within 30 days of the termination of the other coverage, then coverage will commence the first day of the month following notification to the Plan.

ARTICLE 3 – MEDICAL AND PRESCRIPTION DRUG BENEFITS FOR ACTIVE EMPLOYEES AND NON-MEDICARE RETIREES AND DEPENDENTS

3.1 Medical Network

(a) In-Network Providers and Facilities

The Fund has contracted with Independence Blue Cross (Independence), a preferred provider network. A list of participating Providers and Facilities, known as in-network Providers or Facilities, is available at the Fund Office free of charge. Covered Persons are encouraged to use in-network Providers and Facilities to save money for themselves and the Plan but can choose treatment from an out-of-network provider and pay greater out-of-pocket expenses. (Out-of-Network benefits are paid based on the Applicable Medicare Rate.) Independence may be contacted at: (833) 242-3330, www.myibxtpabenefits.com.

(b) Services Provided by Nonparticipating Provider at Participating Facility

Notwithstanding any term of the Plan to the contrary, where covered nonemergency items or services are provided by nonparticipating (*i.e.*, out-of-network) Providers at participating Facilities, in the absence of Consent to Out-of-Network Services, the Plan will:

(1) not impose a cost sharing requirement greater than the requirement that would apply if the items or services were provided by a participating provider;
(2) calculate cost-sharing as if the total amount that would have been charged for the items or services by a participating provider were equal to the Recognized Amount for such services; and
(3) apply any cost-sharing payments with respect to such items and services toward any in-network deductible or in-network out-of-pocket maximums the same as if the services were received in-network.

(c) Continuing Care Patients

If a Covered Person is a Continuing Care Patient of a Provider or Facility that terminates its participating Provider or Facility status with the Plan as a result of the termination of:

(1) its contractual relationship as a participating provider (not including termination of the contract for failure to meet quality standards or fraud), or
(2) benefits under the Plan due to a change in the terms of the participation of the provider or facility in the network,

then the Plan will:

(1) notify each Continuing Care Patient on a timely basis of such termination and such individual's right to elect continued transitional care from such provider or facility as set forth in c), below;
(2) provide such individual with an opportunity to notify the Plan of the individual's need for transitional care; and
(3) allow such individual to elect to continue to benefits provided under the Plan under the same terms and conditions as would have applied to the individual as a Continuing Care Patient had

such termination not occurred, during the period beginning on the date on which the notice under (3), above, is provided and ending on the earlier 90 days or the date on which such individual is no longer a Continuing Care Patient with respect to such provider or facility.

3.2 Medical Benefits, Exclusions, and Other Limitations

(a) Chart of Covered Benefits

Subject to the exclusions and limitations set forth in Sections 3.2(b)-(d), and other applicable limitations in the Plan, the following benefits are provided:

Medical Benefits	Full Plan – Active Employees and Non-Medicare Retirees		Shop Plan – Shop Employees, unless elected Full Plan	
	In-Network	**Out-Of-Network**	**In-Network**	**Out-Of-Network**
Annual Deductibles In- and Out-of-Network deductibles DO NOT Satisfy each other. Common accident deductible applies.	$500/person $1,000/family	$500/person $1,250/family	$1,750/person $3,500/family	$3,500/person $7,000/family
Annual Out-of-Pocket (OOP) Maximums Co-Insurance, Deductible, and Co-Payment Maximums-In/Out DO NOT Satisfy each other	$3,500/person $7,000/family	$5,000/person $10,000/family	$7,350/person $14,700/family	$10,000/person $20,000/family

ACTIVE EMPLOYEES AND NON-MEDICARE RETIREES NOTE DIFFERENT CO-INSURANCE AMOUNTS FOR FULL AND SHOP PLANS		
Medical Benefit	**In-Network**	**Out-of-Network**
Office Visits/Urgent Care/On-Line All services received during one visit are billed separately and accordingly have separate cost-sharing requirements.		
Primary Care Physician	100% after $20 copay.	Full: 60% of Applicable Medicare Rate after deductible. Shop: 55% of Applicable Medicare Rate after deductible.
Specialist and Consultations	100% after $40 copay.	Full: 60% of Applicable Medicare Rate after deductible. Shop: 55% of Applicable Medicare Rate after deductible.
Pre- and Post-Natal Care that is not Preventive Care	Full: 80% after deductible. Shop: 75% after deductible	Full: 60% of Applicable Medicare Rate after deductible. Shop: 55% of Applicable Medicare Rate after deductible.
Allergy Testing/Injections - Prescription drugs and biologicals that cannot be self-administered and are furnished as part of Physician's professional service, such an antibiotics and joint injections.	Full: 80% after deductible. Shop: 75% after deductible	Full: 60% of Applicable Medicare Rate after deductible. Shop: 55% of Applicable Medicare Rate after deductible.
Diagnostic Lab/X-Ray	Full: 80% after deductible. Shop: 75% after deductible	Full: 60% of Applicable Medicare Rate after deductible. Shop: 55% of Applicable Medicare Rate after deductible.
Surgery	Full: 80% after deductible. Shop: 75% after deductible	Full: 60% of Applicable Medicare Rate after deductible. Shop: 55% of Applicable Medicare Rate after deductible.
Urgent Care	Full: 80% after deductible. Shop: 75% after deductible	Full: 60% of Applicable Medicare Rate after deductible. Shop: 55% of Applicable Medicare Rate after deductible.

ACTIVE EMPLOYEES AND NON-MEDICARE RETIREES NOTE DIFFERENT CO-INSURANCE AMOUNTS FOR FULL AND SHOP PLANS		
Medical Benefit	**In-Network**	**Out-of-Network**
Telehealth: Teladoc	100%.	No coverage.
Preventive Service Required to be Covered by Law Preventive service benefits are covered without cost-sharing in-network to the extent required under federal law. This means deductibles, co-insurance, and copayments do not apply to these benefits if provided in-network. The following chart provides a representative list of items covered by law as preventive services as of July 1, 2025, but is not a complete list of all such items, and this list changes from time to time. Preventive services and items covered by the Plan for will be updated automatically as required by law, and any such coverage will be limited as provided by federal law based on age, sex, health history or status, or other limitation imposed or allowed by law. Also, preventive services are subject to frequency limitations. It is beyond the scope of the Plan to list all such limitations. Contact the Fund Office with any questions. For a list of items and services covered as preventive services under federal law at any given time, please visit the following websites: ● U.S. Preventive Services Task Force, A & B Recommendations: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations ● Health Resources & Services Administration Adopted-Guidelines for Women: https://www.womenspreventivehealth.org/recommendations/well-woman-preventive-visits/ ● Health Resources & Services Administration Adopted-Guidelines for Infants, Children, and Adolescents (the Bright Futures Periodicity Schedule): https://www.aap.org/en/practice-management/care-delivery-approaches/periodicity-schedule/ ● Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention: https://www.cdc.gov/vaccines/hcp/acip-recs/index.html As with any benefit, contact the Fund Office if you have any questions regarding the scope of coverage for any preventive service or item.		
For Adults: ● Screenings, including for: ○ Abdominal Aortic Aneurysm ○ Anxiety ○ Cholesterol ○ Colorectal Cancer (and follow-up, if required by law) ○ Depression ○ Hepatitis C ○ STIs (including Hepatitis B, HIV, Syphilis) ○ Hypertension ○ Latent Tuberculosis ○ Lung Cancer ○ Prediabetes and Type 2 Diabetes ○ Unhealthy Alcohol and Drug Use ● Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. ● Tobacco Smoking Cessation Interventions ● Behavioral Counseling, including for: ○ Skin Cancer Prevention; ○ Sexually Transmitted Infections ○ Healthy Diet and Physical Activity for Cardiovascular Disease Prevention; ○ Unhealthy Alcohol Use ● Weight Loss Behavioral Interventions to Prevent Obesity-Related Morbidity and Mortality ● Exercise Interventions to Prevent Falls and Fall-Related Morbidity in Community-Dwelling Adults	100%.	Full: 60% of Applicable Medicare Rate after deductible. Shop: 55% of Applicable Medicare Rate after deductible.

ACTIVE EMPLOYEES AND NON-MEDICARE RETIREES NOTE DIFFERENT CO-INSURANCE AMOUNTS FOR FULL AND SHOP PLANS		
Medical Benefit	**In-Network**	**Out-of-Network**
For Women (in addition to the preventive services listed in the "For Adults" section): ● Screenings, including the following: ○ Breast Cancer (Mammography), including, beginning 1/1/2026, additional imaging / pathology required to complete screening, if required by law ○ Cervical Cancer ○ Intimate Partner Violence, Elder Abuse, and Abuse of Vulnerable Adults ○ Osteoporosis ○ Urinary Incontinence ○ STIs (including Chlamydia, Gonorrhea) ● Beginning, 1/1/2026, Patient Navigation Services for Breast and Cervical Cancer Screenings ● BRCA-Related Cancer Risk Assessment, Genetic Counseling and Genetic Testing ● Contraception Education, Counseling, the Provision of Contraception, and Follow-Up Care [including sterilization surgery] ● Obesity Prevention Counseling ● Well-Women Visits [which include pre-pregnancy, prenatal, postpartum, and interpregnancy visits]	100%.	Full: 60% of Applicable Medicare Rate after deductible. Shop: 55% of Applicable Medicare Rate after deductible.
For Pregnant Women or Women Who Were Pregnant (in addition to the preventive services listed in the "For Adults" and "For Women" sections): ● Screenings, including for the following: ○ Bacteriuria ○ Gestational Diabetes ○ Diabetes After Gestational Diabetes ○ Rh(D) Incompatibility ○ STIs (including Chlamydia, Gonorrhea, Hepatitis B, HIV, and Syphilis) ○ Preeclampsia ○ Urinary Tract or other Infection ● Breastfeeding Services and Supplies (including, but not limited to double electric breast pumps [including pump parts and maintenance] and breast milk storage supplies ● Behavioral Counseling, including for the following: Breastfeeding Healthy Weight and Weight Gain ● Perinatal Depression Preventive Interventions ● Preeclampsia Prevention ● Substance Use Assessment	100%	Full: 60% of Applicable Medicare Rate after deductible. Shop: 55% of Applicable Medicare Rate after deductible.

ACTIVE EMPLOYEES AND NON-MEDICARE RETIREES NOTE DIFFERENT CO-INSURANCE AMOUNTS FOR FULL AND SHOP PLANS		
Medical Benefit	**In-Network**	**Out-of-Network**
For Children/ Adolescents/ Young Adults (Newborn—21 years old): ● Screenings, including for the following: ○ Anemia ○ Autism Spectrum Disorder ○ Behavioral/Social/Emotional ○ Blood Pressure ○ Cervical Dysplasia ○ Depression and Suicide Risk ○ Developmental Disorders ○ Dyslipidemia ○ Hearing ○ Hepatitis C ○ Lead Level ○ Newborn Blood, Bilirubin, and Critical Congenital Heart Defect ○ STIs (including but not limited to Chlamydia, Gonorrhea, Hepatitis B, HIV, Syphilis) ○ Tobacco, Alcohol, and Drug Use ○ Tuberculosis ○ Vision ● Fluoride Varnish and Oral Fluoride Supplementation ● Ocular Prophylaxis for Gonococcal Ophthalmia Neonatorum ● Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. ● Behavioral Counseling, including for the following: ○ Skin Cancer Prevention ○ Sexually Transmitted Infections ● Behavioral Interventions for High BMI Children and Adolescents ● Oral Health Risk Assessment and Referral ● Sudden Cardiac Arrest/Death Risk Assessment ● Tobacco, Alcohol, and Drug Use Interventions ● Well Baby/Child Examinations	100%	Full: 60% of Applicable Medicare Rate after deductible. Shop: 55% of Applicable Medicare Rate after deductible.
Preventive Services Not Required To Be Covered By Law		
Prostate tests and immunizations, including doctor visit (one per year)	100%	Full: 60% of Applicable Medicare Rate after deductible. Shop: 55% of Applicable Medicare Rate after deductible.
Annual Physicals (one per year)	100%	Full: 60% of Applicable Medicare Rate after deductible. Shop: 55% of Applicable Medicare Rate after deductible.
Inpatient Hospital — Precertification Required for All Inpatient Benefits		
Facility – Inpatient Hospital (Semi-private room; private room only when Medically Necessary)	Full: 80% after deductible. Shop: 75% after deductible	Full: 60% of Applicable Medicare Rate after deductible. Shop: 55% of Applicable Medicare Rate after deductible.

ACTIVE EMPLOYEES AND NON-MEDICARE RETIREES NOTE DIFFERENT CO-INSURANCE AMOUNTS FOR FULL AND SHOP PLANS		
Medical Benefit	**In-Network**	**Out-of-Network**
Physician/Surgeon	Full: 80% after deductible. Shop: 75% after deductible	Full: 60% of Applicable Medicare Rate after deductible. Shop: 55% of Applicable Medicare Rate after deductible.
Surgery - Two or more surgeries through same opening during one operation: coverage only for most complex procedure (but if such surgeries are mutually exclusive, then coverage will be provided for each). - Two or more surgical procedures performed through different openings during one operation: coverage provided for the most complex procedure for the amount payable by the Plan as if it was the sole procedure, and coverage provided for the secondary procedures for half the amount payable by the Plan as if each was the sole procedure. - Multiple foot surgeries on same foot during one operation: coverage provided for the most complex procedure up to the amount payable by the Plan as if it were the sole procedure, coverage provided for the two next most complex procedures for half the amount payable by the Plan as if each was the sole procedure, and for additional procedures coverage one-fourth the amount payable by the Plan if each were the sole procedure. - Includes surgery for morbid obesity limited to one surgery per lifetime where the eligible Participant must have a BMI of at least 35, must have Physician documented unsuccessful, non-surgical weight loss attempts within the previous 6 months and at least 1 of the following associated medical conditions: Severe Sleep Apnea, Pickwickian Syndrome, Congestive Heart Failure, Cardiomyopathy, Insulin Dependent Diabetes, or Severe Musculoskeletal Dysfunction	Full: 80% after deductible. Shop: 75% after deductible	Full: 60% of Applicable Medicare Rate after deductible. Shop: 55% of Applicable Medicare Rate after deductible.
Anesthesia	Full: 80% after deductible. Shop: 75% after deductible	Full: 60% of Applicable Medicare Rate after deductible. Shop: 55% of Applicable Medicare Rate after deductible.
Certified Registered Nurse Anesthetist	Full: 80% after deductible. Shop: 75% after deductible	Full: 60% of Applicable Medicare Rate after deductible. Shop: 55% of Applicable Medicare Rate after deductible.
Assistant Surgeon	Full: 80% after deductible. Shop: 75% after deductible	Full: 60% of Applicable Medicare Rate after deductible. Shop: 55% of Applicable Medicare Rate after deductible.
In-Hospital Consultations	Full: 80% after deductible. Shop: 75% after deductible	Full: 60% of Applicable Medicare Rate after deductible. Shop: 55% of Applicable Medicare Rate after deductible.
Diagnostic Labs and Services (radiology, ultrasound, nuclear medicine, lab, pathology, EKG, EEG, MRI, and other electronic diagnostic medical procedures	Full: 80% after deductible. Shop: 75% after deductible	Full: 60% of Applicable Medicare Rate after deductible. Shop: 55% of Applicable Medicare Rate after deductible.

ACTIVE EMPLOYEES AND NON-MEDICARE RETIREES NOTE DIFFERENT CO-INSURANCE AMOUNTS FOR FULL AND SHOP PLANS		
Medical Benefit	**In-Network**	**Out-of-Network**
Labs	Full: 80% after deductible. Shop: 75% after deductible	Full: 60% of Applicable Medicare Rate after deductible. Shop: 55% of Applicable Medicare Rate after deductible.
Respiratory Therapy	Full: 80% after deductible. Shop: 75% after deductible	Full: 60% of Applicable Medicare Rate after deductible. Shop: 55% of Applicable Medicare Rate after deductible.
Maternity Care/Birthing Center (including midwife) **Special Notice Regarding Maternity Benefits:** Group health plans and health insurance issuers generally may not, under federal law, restrict benefits or require authorization 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). Where an earlier discharge is not against medical advice, a home or office visit for education, physical and home assessment, feeding, and routine tests not completed due to early discharge is covered if conducted by a Physician or nurse within 72 hours of discharge.	Full: 80% after deductible. Shop: 75% after deductible	Full: 60% of Applicable Medicare Rate after deductible. Shop: 55% of Applicable Medicare Rate after deductible.
Organ Transplant Benefits – See section 3.2(g). Precertification Required.	Full: 80% after deductible. Shop: 75% after deductible	Full: 60% of Applicable Medicare Rate after deductible. Shop: 55% of Applicable Medicare Rate after deductible.
Other Outpatient Care		
Surgery/Ambulatory Surgical Center -Will cover second opinion for necessity of surgery and third opinion only if first and second disagree.	Full: 80% after deductible. Shop: 75% after deductible	Full: 60% of Applicable Medicare Rate after deductible. Shop: 55% of Applicable Medicare Rate after deductible.
Diagnostic Labs and Services (includes radiology, x-ray, ultrasound, nuclear medicine, lab, pathology, EKG, EEG, MRI, and other electronic diagnostic medical procedures)	Full: 80% after deductible. Shop: 75% after deductible	Full: 60% of Applicable Medicare Rate after deductible. Shop: 55% of Applicable Medicare Rate after deductible.
Emergency Services for an Emergency Medical Condition	Full: 80% after deductible and $250 copay. Shop: 75% after deductible and $250 copay. $250 copay waived (not deductible) if the patient is admitted to the hospital or if the reason for the emergency room visit is due to an Accidental Injury or life threatening condition.	Full: 80% after deductible and $250 copay. Shop: 75% after deductible and $250 copay. $250 copay waived (not deductible) if the patient is admitted to the hospital or if the reason for the emergency room visit is due to an Accidental Injury or life threatening condition.

ACTIVE EMPLOYEES AND NON-MEDICARE RETIREES NOTE DIFFERENT CO-INSURANCE AMOUNTS FOR FULL AND SHOP PLANS		
Medical Benefit	**In-Network**	**Out-of-Network**
Occupational, Physical, and Speech Therapies - for therapies to treat medical conditions that are not Mental Health Conditions or Substance Use Disorders, treatment must be restorative: (i.e., to restore or improve movement/function, skills, or speech impaired due to an acute episode of disease, injury or trauma, or a congenital anomaly that is expected to achieve measurable improvement within a reasonable time frame (usually four – six months) - for therapies to treat Mental Health Conditions or Substance Use Disorders, treatment is not required to be restorative.	Full: 80% after deductible. Shop: 75% after deductible	Full: 60% of Applicable Medicare Rate after deductible. Shop: 55% of Applicable Medicare Rate after deductible.
Applied Behavioral Analysis (ABA) Therapy to treat Autism Spectrum Disorder	Full: 80% after deductible. Shop: 75% after deductible	Full: 60% of Applicable Medicare Rate after deductible. Shop: 55% of Applicable Medicare Rate after deductible.
Respiratory Therapy	Full: 80% after deductible. Shop: 75% after deductible	Full: 60% of Applicable Medicare Rate after deductible. Shop: 55% of Applicable Medicare Rate after deductible.
Cardiac Rehabilitation	Full: 80% after deductible. Shop: 75% after deductible	Full: 60% of Applicable Medicare Rate after deductible. Shop: 55% of Applicable Medicare Rate after deductible.
Hemodialysis	Full: 80% after deductible. Shop: 75% after deductible	Full: 60% of Applicable Medicare Rate after deductible. Shop: 55% of Applicable Medicare Rate after deductible.
Acute Kidney Dialysis	Full: 80% after deductible. Shop: 75% after deductible	Full: 60% of Applicable Medicare Rate after deductible. Shop: 55% of Applicable Medicare Rate after deductible.
Second Surgical Opinion	Full: 80% after deductible. Shop: 75% after deductible	Full: 60% of Applicable Medicare Rate after deductible. Shop: 55% of Applicable Medicare Rate after deductible.
Hyperbaric Therapy – Must be provided by a Hospital.	Full: 80% after deductible. Shop: 75% after deductible	Full: 60% of Applicable Medicare Rate after deductible. Shop: 55% of Applicable Medicare Rate after deductible.
Cochlear Implants	80% after deductible	Full: 60% of Applicable Medicare Rate after deductible. Shop: 55% of Applicable Medicare Rate after deductible.
Mental Health & Substance Use Disorder Benefits		
Inpatient Hospital Care -Precertification Required. -Includes counseling for Covered Persons who are Immediate Family.	Full: 80% after deductible. Shop: 75% after deductible	Full: 60% of Applicable Medicare Rate after deductible. Shop: 55% of Applicable Medicare Rate after deductible.
Inpatient Residential Treatment Facility -Maximum of 60 days per Plan Year -Precertification required.	Full: 80% after deductible. Shop: 75% after deductible	Not covered.

ACTIVE EMPLOYEES AND NON-MEDICARE RETIREES NOTE DIFFERENT CO-INSURANCE AMOUNTS FOR FULL AND SHOP PLANS		
Medical Benefit	**In-Network**	**Out-of-Network**
Outpatient	Full: 80% after deductible. Shop: 75% after deductible	Full: 60% of Applicable Medicare Rate after deductible. Shop: 55% of Applicable Medicare Rate after deductible.
Other Providers		
Chiropractors - Maximum of 25 visits per Plan Year (includes office visits, manipulations, modalities, x-rays). Braces or molds in conjunction with chiropractic care are not covered.	Full: 80% after deductible. Shop: 75% after deductible	Full: 60% of Applicable Medicare Rate after deductible. Shop: 55% of Applicable Medicare Rate after deductible.
Other Services		
Skilled Nursing Facility - Precertification Required - Maximum of 60 days per Plan Year	Full: 80% after deductible. Shop: 75% after deductible	Not covered.
Home Health Care - Maximum of 40 visits per Plan Year.	Full: 80% after deductible. Shop: 75% after deductible	Full: 60% of Applicable Medicare Rate after deductible. Shop: 55% of Applicable Medicare Rate after deductible.
Private Duty Nursing - Maximum of 90 visits per Plan Year	Full: 80% after deductible. Shop: 75% after deductible	Full: 60% of Applicable Medicare Rate after deductible. Shop: 55% of Applicable Medicare Rate after deductible.
Home Infusion Therapy	Full: 80% after deductible. Shop: 75% after deductible	Full: 60% of Applicable Medicare Rate after deductible. Shop: 55% of Applicable Medicare Rate after deductible.
Hospice Care - must be provided at freestanding Hospice Facility or, if received at a private residence, provided through a hospice program sponsored by a Hospital, Hospice Facility, or other entity licensed to provide Hospice Care	Full: 80% after deductible. Shop: 75% after deductible	Full: 60% of Applicable Medicare Rate after deductible. Shop: 55% of Applicable Medicare Rate after deductible.
Durable Medical Equipment - Includes rental fees not to exceed the DME purchase price. For crutches, benefit includes rental fees up to the purchase price of a (non-motorized) wheelchair. - Expenses for special fittings, adaptions, maintenance, or repairs of DME are not considered covered charges. - Deluxe DME (*i.e.*, those with certain convenience or luxury features which are not medically necessary) are not covered (*e.g.*, handrails, ramps, telephones, air conditioners, appliances, and similar services and devices), except that benefits for the cost of standard DME will be provided toward the cost of such deluxe DME.	Full: 80% after deductible. Shop: 75% after deductible	Full: 60% of Applicable Medicare Rate after deductible. Shop: 55% of Applicable Medicare Rate after deductible.
Prosthetics - purchase, fitting, adjustments, repairs and replacements of prosthetic devices, including necessary supplies, that replace all or part of a missing body organ or limb and its adjoining tissues; or replace all or part of the function of a permanently useless or malfunctioning body organ or limb; this includes a cranial prosthesis medically necessary due to hair loss resulting from medical conditions such as alopecia areata or chemotherapy.	Full: 80% after deductible. Shop: 75% after deductible	Full: 60% of Applicable Medicare Rate after deductible. Shop: 55% of Applicable Medicare Rate after deductible.

ACTIVE EMPLOYEES AND NON-MEDICARE RETIREES NOTE DIFFERENT CO-INSURANCE AMOUNTS FOR FULL AND SHOP PLANS		
Medical Benefit	**In-Network**	**Out-of-Network**
Medical Supplies - Must serve a specific therapeutic purpose such as needles, oxygen, syringes, and surgical dressings and other similar items and be provided per physician orders.	Full: 80% after deductible. Shop: 75% after deductible	Full: 60% of Applicable Medicare Rate after deductible. Shop: 55% of Applicable Medicare Rate after deductible.
Ambulance - to and from the Hospital for a covered inpatient admission or initial treatment of an Emergency Medical Condition provided by a Hospital or a government-certified ambulance service	Full: 80% after deductible. Shop: 75% after deductible	Full: Ground Ambulance: 60% of Applicable Medicare Rate after deductible. Air Ambulance: 80% of the lesser of the billed charges or the Qualified Payment Amount, after deductible (in-network deductible and in-network out-of-pocket maximums apply and out-of-network coinsurance and deductible for air ambulance counts towards in-network out of pocket maximums). Shop: For Ground Ambulance substitute 55% for 60%, and for Air Ambulance substitute 75% for 80%.
Abortion (therapeutic and elective abortions are covered – elective abortions are not subject to the medical necessity requirement)	Full: 80% after deductible. Shop: 75% after deductible	Full: 60% of Applicable Medicare Rate after deductible. Shop: 55% of Applicable Medicare Rate after deductible.
Male Sterilization - Medical Necessity not required. - Female Sterilization covered as a preventive service	Full: 80% after deductible. Shop: 75% after deductible	Full: 60% of Applicable Medicare Rate after deductible. Shop: 55% of Applicable Medicare Rate after deductible.
Male Sterilization reversal, if medically necessary to treat a condition other than infertility	Full: 80% after deductible. Shop: 75% after deductible	Full: 60% of Applicable Medicare Rate after deductible. Shop: 55% of Applicable Medicare Rate after deductible.
Temporomandibular Joint Disorder (TMJ) - Maximum lifetime benefit per person $2,000	Full: 80% after deductible. Shop: 75% after deductible	Full: 60% of Applicable Medicare Rate after deductible. Shop: 55% of Applicable Medicare Rate after deductible.
Nutritional Counseling, as required to comply with the MHPAEA	Full: 80% after deductible. Shop: 75% after deductible	Full: 60% of Applicable Medicare Rate after deductible. Shop: 55% of Applicable Medicare Rate after deductible.

Out of network benefits processed at in-network co-insurance rate: If the Fund Office confirms that there is no suitable in-network provider within a 50-mile radius of the covered person's residence, then the out of network claim will be processed applying the in-network co-insurance rate.

(b) Exclusions and Limitations

Unless otherwise required by law, in addition to other restrictions on coverage set forth in this Plan, the Fund will not provide coverage under this Article 3 or any other provision of this Plan for any service, item, condition, or expenditure set forth below for the following:

(1) Not Medically Necessary.

(2) Not prescribed by or performed under the direction of a Physician or Other Professional Provider;

(3) Not performed or provided within the scope of the Provider's license;

(4) That is Experimental or Investigational;

(5) Provided by a governmental unit or agency;

(6) Arising from war, whether or not a declared war;

(7) For which the Covered Person has no legal obligation to pay in the absence of this or similar coverage;

(8) Received from a facility maintained by or on behalf of an employer, mutual benefit association, labor union, trust, or similar person or group;

(9) Received from a member of the Covered Person's Immediate Family or a person who usually lives in the Covered Person's home;

(10) Incurred after eligibility terminates or before eligibility begins;

(11) Sustained while participating in a felonious criminal activity (not as an innocent victim);

(12) Services, supplies, or treatments not otherwise covered, including:

- (i) Examinations required by an insurance company to obtain insurance, a governmental agency, or an employer or prospective employer;
- (ii) Self-help training and other forms of non-medical self-care and supplies (such as treadmills and exercise bicycles), except for educational training for a diabetic including the Immediate Family when the diabetic is a Child;
- (iii) Participation in a research study;
- (iv) Premarital examinations;
- (v) Screening examinations (such as employment related exams); or
- (vi) X-ray examinations made without film.

(13) Arising out of or in the course of employment, if whole or partial benefits or compensation could be available under the laws of any governmental unit, regardless of whether a claim is filed.

(14) Covered by Medicare for the Covered Person, or would have been covered by Medicare if the Covered Person had timely applied for and obtained Medicare coverage when eligible to do so;

(15) Received in a military facility, including a Veterans Administration facility, for a condition related to military service;

(16) Cosmetic surgery, including surgery to correct a deformity or birth defect for psychological reasons where there is no functional impairment, and cosmetic surgery following weight loss. Any repairs, revisions, or modifications of excluded cosmetic surgery are also excluded. This exclusion will not preclude coverage for:

- (i) reconstructive surgery following a mastectomy, including coverage for reconstructive surgery performed on a non-diseased breast to establish symmetry as well as coverage

for prostheses and physical complications in all stages of mastectomy, including lymphedemas; and

(ii) surgery to correct functional or physiological impairment which was caused by disease, trauma, birth defects, growth defects, or prior therapeutic processes);

(17) Any care, services, or items, related to a cosmetic surgery which was or would be excluded under (16), above, or any other cosmetic item or procedure;

(18) For a stand-by anesthesiologist, unless associated with coronary angioplasty surgery.

(19) For the removal of tattoos;

(20) For dietary and/or nutritional guidance or training, except as otherwise specifically provided for by this Plan or required under federal law as a preventive service benefit;

(21) For educational, vocational, or training purposes, except as otherwise specifically provided for by this Plan. For the sake of clarity, this exception will not bar coverage for Applied Behavioral Therapy to treat Autism Spectrum Disorder;

(22) For topical anesthetics;

(23) Arch supports and other routine foot care; corrective shoes, except with accompanying orthopedic braces; foot support devices or services only to improve comfort or appearance, including but not limited to, care for flat feet, subluxations, corns, bunions (except capsular and bone surgery), calluses, and toenails; notwithstanding orthotics will be covered with an accompanying prescription once every 12 months;

(24) Weight loss drugs, programs, or services, except as otherwise specifically provided for by this Plan or required under federal law as a preventive service benefit or to comply with the requirements under the MHPAEA;

(25) Dietary supplements, food, vitamins, and any care which is primarily dieting or exercise unless required under federal law as a preventive service benefit or to comply with the requirements under the MHPAEA;

(26) Weight loss surgery and any repairs, revisions, or modifications of such surgery, including weight loss device removal except as specifically provided for by this Plan;

(27) Marital counseling;

(28) Treatment of erectile dysfunction or other sexual problems not caused by a specific Illness or Injury except as covered under Section 3.3 (Prescription Drugs);

(29) Treatment of Gender Dysphoria (*e.g.*, transsexual or transgender surgery, sex transformation, gender reassignment, and any treatment leading to or in connection with transsexual or transgender surgery). This exclusion includes all medications, implants, surgery, medical, or psychiatric treatment, both pre- and post-operative care, and related hormone treatments;

(30) Contraceptives, except as specified;

(31) Reversal of male sterilization, unless medically necessary to treat condition other than infertility;

(32) Artificial insemination, in vitro fertilization, embryo transfer procedures, or other procedures related to the treatment of infertility. This exclusion will not preclude coverage for procedures

related to diagnosis of infertility, including genetic testing used to diagnose infertility (see exclusion 49(ii));

(33) Related to any surrogate parent services (unless required to cover by law);

(34) Expenses in connection with dental work, dentures, or dental appliances, except:

(i) for treatment made necessary by an accident and rendered by a physician or a legally licensed dentist within 90 days of such accident; or

(ii) if the dental procedure(s) is required to prevent complications arising from the treatment of a life-threatening medical condition, as supported by documentation acceptable to the Trustees, and such dental procedures will be covered to the extent not covered by any dental benefits (insured or self-insured) for which the Covered Person is eligible.

(35) Personal hygiene and convenience items;

(36) Eyeglasses, contact lenses, or examinations for prescribing or fitting them, except those for aphakic patients, keratoconus, and soft lenses or sclera shells for use as corneal bandages when needed as a result of surgery, except as otherwise specifically provided for by this Plan;

(37) Any surgical procedure for the correction of a visual refractive problem including, but not limited to, radial keratotomy and Lasik;

(38) All services related to hearing loss, including hearing aids or examinations for prescribing or fitting them, except coverage will be provided for cochlear implants as specified above in Section 3.2(a) or as otherwise specifically provided for by this Plan;

(39) Immunizations, except as otherwise specifically provided for by this Plan;

(40) For massotherapy or massage therapy;

(41) For hypnosis and acupuncture;

(42) For telephone and online consultations (other than services specifically covered by the Plan), missed appointments, completion of claim forms, or copies of medical records;

(43) For fraudulent or misrepresented claims;

(44) For blood which is available without charge; outpatient blood storage services; autotransfusions or cell saver transfusions occurring during or after surgery.

(45) For over-the-counter drugs, vitamins, or herbal remedies;

(46) Camps.

(47) Items usually stocked in the home for general use, including but not limited to corn and bunion pads, elastic bandages, support/compression stockings, thermometers; etc.

(48) Items for comfort and convenience, disposable supplies, hygienic equipment, and self-help devices, unless otherwise specifically covered by the Plan.

(49) Genetic testing, with the exception of the following covered genetic testing:

(i) genetic counseling and routine breast cancer susceptibility testing (BRCA testing), if deemed appropriate for a woman by her health care provider and if required by federal

law to be covered as a preventive service (and therefore covered in-network without cost-sharing and not covered out-of-network); and

(ii) testing used to determine appropriate medical treatment for currently active, ongoing medical conditions;

(50) Wigs and hair pieces, except cranial prosthesis medical necessary due to hair loss resulting from medical conditions such as alopecia areata or chemotherapy;

(51) Prosthetics that are specially designed for uses such as sporting events;

(52) Clinical trials, except for Routine Patient Costs incurred in an Approved Clinical Trial as set forth below. For purposes of this provision:

(i) An Approved Clinical Trial is a clinical trial for which coverage is required under federal law, the Public Health Services Act §2709, which is a phase I, phase II, phase III, or phase IV clinical trial conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition (*i.e.*, any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted) and is a federally funded trial or is conducted under an investigational new drug application reviewed by the Food and Drug Administration (or is exempt from investigational new drug application requirements); and

(ii) Routine Patient Costs are items and services typically covered by the Plan for Covered Persons not enrolled in Clinical Trials. Further, Routine Patient Costs do not include:

(A) the investigational item, device, or service, itself;
(B) items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or
(C) a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

Where an in-network provider is participating in an Approved Clinical Trial in the Covered Person's state of residence and this participating provider will accept the Covered Person as a participant in that trial, coverage for Routine Patient Costs will only be provided for participation in such trial.

In-network and out-of-network Routine Patient Costs will be subject to the Plan's standard cost-sharing provisions for in- and out-of-network services and expenditures, which means a Covered Person may be balance billed for participating with an out-of-network provider.

(53) Custodial Care, rest care, rest homes, health resorts, residential care, college infirmaries. Care which is only for someone's convenience, or care to support a Covered Person after optimal level of recovery has been reached and further care is no longer in pursuit of recovery and medical/mental health improvement;

(54) Non-covered Hospital services include but are not limited to the following: gowns and slippers; shampoo, toothpaste, body lotions, and hygiene packets; take-home drugs; telephone and television; and guest meals or gourmet menus;

(55) Electroshock therapy and related anesthesia unless provided in a Hospital;

(56) Newborn care is not covered for the newborns of Dependent Children (Maternity care is provided for Dependent Children);

(57) Taxes included in the purchase of covered over the counter supplies or devices;

(58) Biofeedback;

(59) All FDA-approved Cellular and Gene therapy products;

(60) Organ Transplant Benefit unless covered by section 3.2(g).

(61) For claims filed more than 365 days after the date of service or date the expenditure was incurred;

(62) Hot tubs;

(63) Received outside of the United States of America for a non-Emergency Medical Condition (charges will only be covered for medical services necessary to treat an Emergency Medical Condition in a foreign country and will not include charges for travel or repatriation).

(64) In-Patient admission for environment change;

(65) For hospitalization primarily for hydrotherapy or physical therapy except as specifically provided for by this Plan;

(66) Not specifically provided for in this Plan;

(67) Except as required by law, charges for care, items, services, or treatment for caffeine-related substance use disorders (*e.g.*, caffeine intoxication, caffeine withdrawal, caffeine-induced mental disorders, and unspecified caffeine-related disorder) and tobacco-related substance use disorders (*e.g.*, tobacco use disorder, tobacco withdrawal, tobacco-induced mental disorders, and unspecified tobacco-related disorder).

(c) Precertification

Inpatient: Precertification means that admissions and certain procedures are reviewed prior to delivery to ensure medical necessity and other requirements for coverage are met. It is required prior to in-patient hospital admissions, organ transplants (subject to section 3.2(g)), residential treatment facility admissions, and skilled nursing facility admissions. If an emergency admission is required, the Covered Person must have the admission precertified within 48 hours following admission. Pre-certification of benefits is provided by Independence Administrators www.myibxtpabenefits.com.

Denial of precertification is considered a claim denial that may be appealed under Article 14.

Outpatient: Upon request, outpatient procedures and ongoing services such as physical therapy, home health care, durable medical equipment, etc, can be reviewed by Independence Administrators to ensure medical necessity and other requirements for coverage are met.

Independence Administrator contact for precertification: Medical/Surgical: 888-234-2393, Mental Health/Substance Abuse: 888-778-2119.

(d) Large Case Management: Large case management services are provided by Independence Administrators to assist with management of medically necessary and cost-effective care.

(e) Live Health On-Line – Teladoc: Teladoc is a program that allows Covered Persons to contact a Physician online (with a webcam) or through a smartphone 24 hours a day, 7 days a week, for non-

emergency issues. Teladoc is accessible at www.TeladocHealth.com or via telephone at: 1-800-835-2362. Telehealth visits through Teladoc are covered 100% (in-network only).

(f) **Diabetic Testing Supplies:** One Source, (877) 316-2460, www.D360.care, is a comprehensive program that provides certain diabetic testing supplies without cost sharing to the Covered Person. A list of covered diabetic test supplies is available at the Fund Office, and includes blood glucose monitors, test strips, lancets, alcohol prep pads, blood ketone test strips, and insulin pumps. If a Covered Person does not receive their diabetic testing supplies through One Source or through the Prescription Drug program provided by the Fund, see Section 3.3, then applicable deductibles and copayments may apply as set forth in Section 3.2(a).

(g) **Organ Transplant Benefit**

(1) **Definitions:**

Organ Transplant Benefit means the following transplant services or supplies provided for the organ transplant recipient related to the organ transplant, which have been precertified under section 3.2(c):

(a) Inpatient and Outpatient Hospital services.
(b) Services of a Physician for the diagnosis, treatment, and surgery for a covered transplant procedure.
(c) Services provided to a living donor of an organ or tissue.
(d) Procurement of an organ or tissue.
(e) Reasonable and necessary transportation costs incurred for travel to and from the site of surgery for a covered transplant procedure for the transplant recipient and one companion. If the recipient is a minor, transportation costs for two companions. Reasonable and necessary lodging and meal expenses incurred by the recipient's companion.
(f) Private duty nursing by a Registered Nurse (R.N.) or a License Practical Nurse (L.P.N.) when recommended by a Physician. The Nurse cannot be the recipient's Immediate Family or normally live in the recipient's house. Inpatient private duty nursing is a Covered Service only if the Hospital's regular staff cannot provide the care needed due to the recipient's condition.
(g) Rental of durable medical equipment for use outside the Hospital. Covered Charges are limited to the purchase price of the same equipment.
(h) Prescription drugs, including immunosuppressive drugs; oxygen and diagnostic services.
(i) Speech therapy, audio therapy, visual therapy, occupational therapy, physical therapy and chemotherapy. Speech therapy for voice training or to correct a lisp is not a Covered Service.
(j) Service and supplies for High Dose Chemotherapy when provided as part of a treatment plan which includes bone marrow transplantation. Benefits will be paid only if the person is a participant in an FDA approved phase III or IV clinical trial and no alternative conventional treatment and be expected to result in an equal or better benefit or outcome.
(k) Surgical dressing and supplies.
(l) Home health care.

Organ Transplant Benefit Period means the period that begins on the date the Covered Person is designated as a transplant candidate through the predetermination process and ends on the earlier of:

(a) 18 months after the transplant is performed;
(b) the date the decision is made by the recipient's Physician not to perform the transplant;
(c) the death of the recipient; or
(d) the date the Organ Transplant Benefit is terminated (which includes termination of the Plan).

If a recipient requires more than one covered transplant procedure, the Organ Transplant Benefit Period is further defined as follows:

(a) If each transplant is due to unrelated causes, each is considered a separate Organ Transplant Benefit Period;
(b) If each transplant is due to related causes, each is considered a separate Organ Transplant Benefit Period if:

(i) In the case of an Employee, the transplants are separated by the Employee's return to work for a period of 90 days;
(ii) in the case of a Dependent, the transplants are separated by at least 90 days; or

(c) If the transplants are due to related causes, they are considered as one Transplant Benefit Period if (b), above, does not apply.

(2) Covered Benefit: An Organ Transplant Benefit will be paid during the Organ Transplant Benefit Period.

(3) Exclusions

Organ Transplant Benefits will not be provided for expenses that meet any of the following:

(a) when government funding of any kind is provided;
(b) where recipient, donor, or procurement services or costs are incurred outside of the United States; or
(c) when any exclusion set forth in section 3.2(b) is applicable, including lack of Medical Necessity for any service or cost.

(h) Cleveland Clinic Virtual Second Opinion Program: To help participants who are diagnosed with a serious condition, about to make a major decision about a medical next step, considering a treatment that involves risk or has significant consequences, or dealing with a condition or chronic illness that isn't improving or is getting worse, the Fund provides access to the Clinic by Cleveland Clinic Virtual Second Opinion Program. Participants can access this service at www.clinicbyclevelandclinic.com/central-midwest-carpenters. There is no out of pocket cost to the participant for using this service.

(i) Cancer Navigator: For support with a cancer diagnosis, treatment, or screening, the Fund provides access to Cancer Navigator. Participants can access this service at (317) 942-9953 or www.cancernavigator.com. There is no out of pocket cost to the participant for using this service.

3.3 Prescription Drugs

(a) Administration: Self-funded prescription drug coverage is administered by ExpressScripts, a Pharmacy Benefits Manager (PBM), (800) 867-4518, www.express-scripts.com. Participants are issued a prescription drug card and must present this card at participating pharmacies for benefits. Participants that utilize a non-participating pharmacy must pay the entire cost of the drug at the time of purchase and submit original receipts for reimbursement, not to exceed the amount the Fund would

have paid a participating pharmacy, to the Fund Office. A list of participating pharmacies is available without charge from the PBM.

(b) Covered Drugs

(1) General Information. Except as otherwise provided in this Plan, the Plan will cover all lawful state and federal legend drugs on the PBM formulary. The Formulary is available at the Fund Office by contacting the PBM at (800) 867-4518. The list of covered drugs and eligibility criteria may change from time to time.

(2) Preventive Service Medications. The Fund also covers preventive health drugs without cost-sharing, as required by federal law. Preventive health drugs must be: (1) prescribed by a healthcare provider (even for over-the-counter products); and (2) obtained from an in-network pharmacy. Preventive health drugs include but may not be limited to the following:

(i) Antiretrovirals (PrEP);
(ii) Aspirin;
(iii) Bowel Preparation Products;
(iv) Breast Cancer Prevention Drugs;
(v) Female Contraceptives, including but not limited to the full range of FDA-approved contraceptives and emergency contraceptives;
(vi) Fluoride;
(vii) Ocular Prophylaxis for Gonococcal Ophthalmia Neonatorum;
(viii) Folic Acid;
(ix) Low to Moderate Dose Statins; and
(x) Tobacco Cessation Drugs.

Please be aware that federal law may limit these benefits to certain individuals by age, sex, health history or status.

You may also find a list of such drugs at: U.S. Preventive Services Task Force, A & B Recommendations: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations

(c) Exclusions and Limitations

All of the exclusions listed above in Section 3.2(b) also apply to Drug Coverage, as well as the following exclusions:

(1) Any drug or medicine charges for which benefits are provided under any other provision of the Plan;
(2) Medicine which can be purchased without a written prescription except for those specifically allowed under the Plan;
(3) Therapeutic devices or appliances;
(4) All injectable products except self-administered injectables;
(5) Blood or blood plasma;
(6) Investigational or experimental drugs;
(7) Cosmetics, dietary supplements, health and beauty aids;
(8) Prescriptions to treat sexual dysfunction and/or sexual inadequacy, except for prescribed impotency medications up to 8 pills per 30 days; and
(9) Agents for treatment related to baldness or thinning hair (prescription or over the counter).

(10) Opioids: Initial fills are limited to a 7-day supply, based on FDA guidelines, and opioids are otherwise subject to additional pre-authorization requirements. These requirements are available by contacting the PBM.

(11) Fertility drugs.

(12) Weight loss drugs will be excluded unless a covered person meets specific eligibility criteria applicable to each drug, which generally will require the individual:

- (a) Be at least 18 years of age;
- (b) Engage in behavioral modification and a reduced-calorie diet (which may be required prior to the commencement of drug coverage); and
- (c) Have a Body Mass Index (BMI):
  - (i) Equal or greater than 30; or
  - (ii) Equal or greater than 27 and at least one of the following risk factors:
    - (A) Type 2 diabetes;
    - (B) Hypertension;
    - (C) Dyslipidemia;
    - (D) Obstructive sleep apnea; or
    - (E) Cardiovascular disease.

A list of covered weight loss drugs, and the applicable drug eligibility criteria, both of which may change from time to time, is available at the Fund Office or by contacting ExpressScripts, the Pharmacy Benefits Manager (PBM) at (800) 867-4518.

(d) Co-payments and Maximum Out of-Pocket Costs

Most prescription drugs will be subject to the co-payments set forth in this Section 3.3(d). Specialty Drugs are covered through the Saveon SP Program and are subject to the cost sharing requirements set forth by Saveon SP. Specialty Drugs are limited to a 30-day supply per (re)fill.

The following copayments apply:

Retail (up to 30 day supply)	
Tier 1	Generic: $20
Tier 2	Preferred Brand: $40
Tier 3	Non-Preferred Brand: $80
Tier 4	Specialty: 25%, not to exceed $200
Notwithstanding above, if 4th or more fills of same Tier 1-3 drug at Retail, copayment increases to $100	
Mail Order (up to 90 day supply)	
Tier 1	Generic: $50
Tier 2	Preferred Brand: $100
Tier 3	Non-Preferred Brand: $200
Tier 4	Specialty: 25%, not to exceed $200

*Not all drugs are available in the supplies indicated on the above chart.

Brand Name Drug Obtained Where Generic Available: DAW-1 occurs when a prescriber writes a prescription directing the pharmacist to dispense the brand-name drug – in other words, no generic substitution. DAW-2 occurs when the covered person specifically requests the brand-name drug instead of the generic version. If a drug is dispensed DAW-2, meaning the covered person and not the prescriber requested the brand name drug, in addition to the above copayments, the covered person will also pay the price between the brand name drug and the generic substitute.

Maintenance Drugs: Maintenance drugs, which are drugs taken for longer than 90 days, are covered at retail for the first 3 30-day (re)fills, and thereafter no coverage will be provided at retail (*i.e.*, all additional (re)fills must be via mail order to be covered).

Annual Out-of-Pocket Maximum: There is an annual in-network maximum for out-of-pocket costs for prescription drugs purchased with participating pharmacies, which will be adjusted annually. This maximum is the difference between the maximum in-network out-of-pocket for medical and prescription drugs established by the Affordable Care Act and the maximum out-of-pocket for in-network medical set forth in Section 3.2(b).

For example, for 2026 the maximum in-network out-of-pocket costs for medical and prescription drugs established by the Affordable Care Act is $10,600 for single coverage and $21,200 for family coverage. The maximum out of pocket for medical expenses under this Plan, as set forth in Section 3.2(b), is $3,500 for single in-network coverage and $7,000 for in-network family coverage. **Thus, the 2026 maximum out-of-pocket costs for in-network prescription drugs is $7,100 single and $14,200 family.**

There is no out of pocket maximum for drugs obtained from non-participating (*i.e.*, out-of-network) pharmacies.

Diabetic Test Supplies: These are provided without cost sharing for the Covered Person. A list of covered diabetic test supplies is available at the Fund Office, and include blood glucose monitors, test strips, lancets, alcohol prep pads, blood ketone test strips, and insulin pumps. Covered Persons may also receive certain diabetic testing supplies at no cost through One Source, see Section 3.2(f). If a covered Person does not receive their diabetic testing supplies through One Source or through the Prescription Drug program provided by the Fund, then applicable deductibles and copayments may apply as set forth in Section 3.2(a).

3.4 **Benchmark:** The Plan adopts the Utah state benchmark plan for purposes of defining essential health benefits for purposes of compliance with federal Health Care Reform laws.

ARTICLE 4 – MEDICAL AND PRESCRIPTION DRUG BENEFITS FOR MEDICARE-ELIGIBLE PARTICIPANTS AND DEPENDENTS

The coverages set forth in this Article 4 applies to all Medicare-eligible Participants and Dependents, whether eligibility for Medicare is based on age, disability, or end stage renal disease. (Non-Medicare eligible dependents of Medicare eligible Participants are covered under the Fund's self-insured medical and drug plan set forth in Article 3).

This Plan provides benefits as if the Medicare-eligible Participant or Dependent obtained Medicare coverage when first eligible to do so, even if this is not the case. It is the Participant's or Dependent's responsibility to timely obtain Medicare coverage, which means when the person would first become eligible. If he/she does not do so, then he/she is responsible for the costs of medical expenses that otherwise would have been covered by Medicare, the Medicare Policy (Section 4.1), or otherwise under the terms of this Plan as if Medicare had been timely obtained.

This Plan will not pay benefits that would have been paid by Medicare. It is recommended that a Retiree, Spouse, or an Employee contemplating retirement, contact the Social Security Administration at least 4 months before they reach age 65.

4.1 Medical Benefits

(a) Medicare Eligibles Other than Former Niles Fund Retirees with Supplemental Only Coverage Under 4.1(b)

Medicare-eligible Participants and Dependents are provided medical coverage via a fully insured Medicare coordinated policy issued by Humana (Medicare Policy) (800) 733-9064, www.humana.com. The terms and conditions of such coverage are set forth in the Medicare Policy. This Fund does not cover any medical expenses for Medicare eligible Participants or Dependents. All such expenses are covered by Medicare or the Medicare Policy.

Customer service for Medicare Advantage participants is provided by Retiree First, (800) 716-0774, www.laborfirst.com.

Special Note Regarding Diabetic Testing Supplies: Diabetic Testing Supplies may be obtained through the Medicare Policy or through the Prescription Drug program provided by the Fund in Section 4.2.

(b) Medicare Supplemental Coverage for Former Niles Fund Retirees

This self-insured Medicare supplemental only coverage provides coverage for deductibles and co-insurance on Medicare approved items and services which Medicare does not pay. It does not provide coverage for any item or service not covered on a primary basis by Medicare (with the exception of care received for emergencies outside of the United States, as set forth below in 4.2(c)).

These supplemental benefits are administered by BeneSys, (248)-813-9800, or dedicated CMRCC Fund Office number 800-700-6756. The following is the Schedule of Medicare Supplemental Benefits:

(1) Part A Supplemental Benefits – Inpatient Benefits

The Plan will provide the following supplemental inpatient benefits for benefits for Medicare covered services received in a Medicare approved facility:

- Part A deductible for the first 60 days of Hospital care per Medicare Benefit Period.
- The Part A coinsurance for the 61st through the 90th day of Hospital care per Medicare Benefit Period.
- The Part A coinsurance for lifetime reserve days.
- The first three pints of blood that you receive each calendar year.
- Part A coinsurance for hospice care services and home health care services.
- Part A coinsurance for the 21st through the 100th day of care in a Skilled Nursing Facility.

(2) Part B Supplemental Benefits – Outpatient Benefits

- Part B deductible (except deductible on pints of blood, see below).
- Part B blood deductible for the first 3 pints of blood each calendar year.
- Part B coinsurance.

(3) Providers Not Approved by Medicare:

If services are received by a facility or provider, whether inpatient or outpatient, which is not Medicare-approved, then benefits will be paid in an amount not to exceed the amount that would have been paid had the services been provided by a Medicare-approved facility or provider.

(c) Travel Outside U.S. : Medicare does not provide coverage for services or items obtained outside of the United States. The Plan will provide coverage for Emergency Medical Conditions while a Participant or Dependent is outside the United States for a period of no longer than 30 consecutive days (*i.e.*, a vacation), and payment will be limited to no more than the Plan would have paid for a non-Medicare eligible person for similar in-network treatment in that country (Independence has an out-of-country network).

4.2 Prescription Drug Coverage for Medicare-Eligible Participants and Dependents

(a) Employer Group Waiver Plan

Medicare-Eligible Participants and Dependents who are covered by the Medicare Policy under Section 4.1(a), also have prescription drug benefits under an Employer Group Waiver Plan (EGWP). The formulary, pharmacy network, premiums and cost-sharing requirements may change on January 1 of each year. For information on covered drugs and pharmacy network, contact ExpressScripts, the Pharmacy Benefits Manager (PBM) at (800) 867-4518, www.express-scripts.com.

Subject to the above, the following is a summary of the EGWP Benefits:

Deductible Stage: This Plan does not have a deductible that must be paid by each Covered Person before coverage is provided by the Plan.

Initial Coverage Stage: After deductible satisfied, Covered Person pays the following copayments until a Covered Person's total annual drug cost (what the Covered Person and Plan pay, combined) equals the CMS Standard to enter the Coverage Gap (in 2025, this is $2,000):

Retail (up to 31-day supply)	
Tier 1	Generic: $10
Tier 2	Preferred Brand: $30
Tier 3	Non-Preferred Brand: $75
Tier 4	Specialty: $100
Retail (32-to-60-day supply)	
Tier 1	Generic: $20
Tier 2	Preferred Brand: $60
Tier 3	Non-Preferred Brand: $150
Tier 4	Specialty: $200
Retail (up to 90-day supply)	
Tier 1	Generic: $30
Tier 2	Preferred Brand: $90
Tier 3	Non-Preferred Brand: $225
Tier 4	Specialty: $300
Mail Order (up to 90-day supply)	
Tier 1	Generic: $20
Tier 2	Preferred Brand: $60
Tier 3	Non-Preferred Brand: $150
Tier 4	Specialty: $200

*Not all drugs are available at a 90-day supply, and not all retail pharmacies offer a 90-day supply. Not all drugs are available in the supplies indicated on the above chart.

Catastrophic Coverage Stage: After a Covered Person's yearly out-of-pocket drug costs reach the CMS TrOOP Limit to enter Catastrophic Coverage (in 2025 this is $2,000), a Covered Person will not pay anything for Covered Drugs.

Provisions applicable to all Coverage Stages:

- The Plan may require Covered Persons to try one drug to treat a condition before it will cover another drug for that same condition (*e.g.*, step therapy), or require prior authorization prior to filling a prescription. Contact the PBM for this information.
- If the actual cost of a drug is less than the co-payment for that drug, the Covered Person will pay the actual cost.

ARTICLE 5 – MEDICAL REIMBURSEMENT ACCOUNT

5.1 Medical Reimbursement Account

A Medical Reimbursement Account (MRA) is established for each Participant, excluding NBU Employees, Office Employees, and Shop Employees (unless the Shop Employee has Contributions made to a Dollar Bank under section 2.4(c)(3), above). A MRA is an account to be used by the Participant for reimbursement for eligible medical expenses incurred by the Participant or his/her Dependents.

Like all other benefits provided by the Plan, regardless of the amount in the MRA, the MRA is not a vested benefit. The Trustees may at any time and for any reason terminate the MRA and any credit in any Employee's MRA at such time will remain a Plan asset.

5.2 **Funding:** Currently, $1.00 of the hourly Employer Contributions received will be credited to an eligible Participant's MRA. This amount may be changed, or eliminated, as determined by the Trustees in their sole discretion from time to time. Amounts in the MRA accumulate over time (i.e., unused amounts may accumulate and be carried over year to year).

5.3 Eligible Expenses in General

Medical expenses are eligible for reimbursement from the MRA if they:

(a) Were incurred on or after the date on which the Participant became eligible for benefits under the Plan (expenses are incurred when a covered person is provided with medical care that gives rise to the expenses, not when he is billed for or pays for the medical care) (a claim for a Dependent who is not enrolled in the Plan may be reimbursed if at the time the claim is incurred: (i) this person is in fact a Dependent of the Participant and (ii) the Dependent has coverage under a group health plan providing coverage for at least 60% of allowed costs and substantial coverage of inpatient hospital and physician services, i.e. minimum value);

(b) Qualify as a medical expense under Code § 213 (with the exception of over-the-counter drugs, which are not eligible for reimbursement); and

(c) Have not been or will not otherwise be paid by the Plan, or have not been reimbursed by or are not reimbursable under any other health plan coverage.

(d) Examples of Eligible Expenses: Subject to IRC 213, eligible reimbursable medical expenses under the MRA include, but are not limited to:

(1) Deductibles and co-payments for covered medical expenses under this Plan or a qualified plan of your Spouse;
(2) Unreimbursed hospital service fees;
(3) Unreimbursed medical service fees;
(4) Unreimbursed medical items such as artificial limbs, eyeglasses, contact lenses, hearing aids, crutches, wheelchair, etc.;
(5) Unreimbursed transportation for needed medical care;
(6) Unreimbursed dental expenses;
(7) Capital expenses for equipment or improvements to your home needed for medical care;
(8) Cost and care of guide dogs or other animals aiding the blind, deaf, and disabled;
(9) Cost of lead-based paint removal;
(10) Expenses of an organ donor;
(11) Oxygen equipment and oxygen;
(12) Part of life-care fee paid to retirement home for medical care;
(13) Unreimbursed prescription medicines;
(14) Psychiatric care at a specially equipped medical center (includes meals and lodging);
(15) Legal abortion;
(16) Legal operation to prevent having children;
(17) Unreimbursed meals and lodging provided by a hospital during medical treatment;
(18) Special school or home for mentally or physically disabled persons;
(19) Unreimbursed treatment at a drug or alcohol center (includes meals and lodging provided by the center);
(20) Wages for nursing services;
(21) Hot Tub used for the cure, mitigation, treatment, or prevention of disease, up to $5,100.00, provided the Fund Office has received:
    (i) a statement from the participant as to who the hot tub is for – self, spouse, or dependent child;
    (ii) a written statement from the treating physician dated within six months of the participant's request setting forth the medical condition for which the hot tub is needed and why the hot tub is medically necessary for treatment of such conditions; and
    (iii) An invoice and receipt for the hot tub.

5.4 Submission of Claims

(a) For reimbursement from his/her MRA, the Participant must submit:

(1) A completed reimbursement form (available from the Fund Office), and
(2) If applicable, the explanation of benefits received from the claims processor, or original receipt and proof of payment to the Central Midwest Regional Council of Carpenters Welfare Fund, P.O. Box 1257, Troy, Michigan 48099-1257. Unreimbursed amounts must total at least $20 for reimbursement. Separate bills may be itemized on the same reimbursement form.

(b) The Fund Office processes reimbursement claims weekly. Reimbursement checks will be mailed to the Participant or, if preferred, benefits may be assigned directly to Providers.

(c) Reimbursement will be permitted up to the balance of the MRA.

(d) The deadline for submitting reimbursement for unreimbursed medical expenses is 24 months from the date the expense was incurred. The Participant must have been eligible at the time the claim was incurred.

(e) In lieu of the above manual reimbursement procedures, a Participant may be issued a special debit card, known as a "Benny Card," to pay for eligible expenses out of his/her MRA. This will allow for payment of some, but not all, expenses without the necessity of submitting paper receipts to the Fund Office. Some expenses will still require submission of paper receipts or additional documentation, so all such documentation must be retained. If such documentation is requested and cannot be provided, then a Participant will have to repay the Plan or incur tax consequences and the Benny Card may be permanently cancelled.

5.5 Use of MRA by Retiree and Surviving Spouse/Child(ren): Retirees are permitted to use their MRA. Upon election, amounts in a Retiree's MRA may be used for self-payments. After the death of a Participant, any balance in his/her MRA may be used by his/her Surviving Spouse, or in the absence of a Surviving Spouse by his/her Children, so long as such individuals are otherwise covered by this Plan.

5.6 Termination of Medical Reimbursement Account

(a) Upon termination of eligibility, a Participant's access to his/her MRA will be terminated, which means the Benny card can no longer be used. Any balance in the MRA can be used for claims incurred prior to the termination of eligibility, provided a paper claim for reimbursement is submitted within 24 months of the date the expense was incurred. See section 5.4(d), above.

(b) Notwithstanding 5.6(a), above, the balance in the MRA will be cancelled and permanently forfeited in its entirety upon the occurrence of the earlier of the following events:

(1) the date the Participant's eligibility is terminated under section 2.7 because:

- The Participant becomes employed by an employer who does not contribute to any fund sponsored by a Regional Council or Local Union of the UBC and who employs individuals in a trade or craft covered by a CBA;
- The Participant remains employed by an employer who no longer contributes to any fund sponsored by a Regional Council or Local Union of the UBC and who employs individuals in a trade or craft covered by a CBA; or

(2) there has been no activity in the Participant's MRA, i.e., no MRA contributions or claims, for three years; or

(3) when deemed necessary in the sole and exclusive discretion of the Trustees to meet requirements of Health Care Reform; or

(4) when the Trustees in their sole discretion terminate the MRA either in its entirety or for any particular classification (for example, Retiree, Surviving Spouse, etc.).

5.7 Election: On an annual basis a Participant can elect to limit expenses paid from his/her MRA to reimbursement of dental, vision, and preventive care expenses only. In addition, a Participant may make such an election during the calendar year if the Participant's spouse becomes eligible for an Health Savings Account; such election will be valid for the remainder of the calendar year. Annually, a Participant is permitted to permanently opt-out of and waive MRA benefits.

ARTICLE 6 – WEEKLY DISABILITY BENEFITS

6.1 Eligibility

Weekly Disability Benefits are weekly payments paid by the Fund to an eligible Active Employee who is unable to work due to a Disability arising from a Non-Occupational Accidental Injury or Illness, provided, however, that benefits for a Non-Occupational Accidental Injury will only be paid if the injury was incurred on a date the Active Employee was eligible for coverage under the Plan. For purposes of Weekly Disability benefits, pregnancy is considered an "Illness."

NBU are not eligible for Weekly Disability benefits.

Employees must either:

(a) be under the continuous care of a Physician who has provided a certification of Disability specifying the diagnosis, dates of Disability, and the date the Physician was first consulted for the Disability; or
(b) submit a copy of a Social Security Disability award.

In the Fund Office's sole discretion, additional certifications may be requested during the period of Disability and must be completed and returned to continue benefits.

Weekly Disability Benefits are payable the 1st day of a Disability due to an Accidental Injury, or the 8th day of a Disability due to Illness. No Disabilities, including those resulting from accidents, will be considered as beginning more than 2 days before treatment is first received by a Physician.

No right or interest of any Participant in the Weekly Disability Benefit portion of the Plan shall assignable or transferable.

6.2 Schedule of Benefits

Benefit Amount	$250/week
Maximum Period of Payment per Disability	26 weeks

Benefits cannot be paid for the same Disability unless the Active Employee has returned to work for at least 80 hours of continuous Covered Employment within a 30-day period. Benefits cannot be paid for an unrelated Disability (*i.e.*, it is not related to the prior accident, Injury, or Illness) unless the Active Employee has returned to work for at least 40 hours of continuous Covered Employment within a 30-day period.

6.3 Exclusions

Weekly Disability benefits are payable only if a completed claim for benefits is received within 90 calendar days of the date the Physician certifies the Disability and within 180 calendar days of the first day of Disability. A completed claim includes the execution of an assignment or other documents requested to be provided or executed by the Fund pursuant to Article 12.

In addition, Weekly Disability benefits are not payable for:

(a) Any period of Disability during which the Active Employee is not under the regular care of a Physician;
(b) Any Disability due to sickness which is covered by a Workers' Compensation Act or similar legislation, or due to injury arising out of or in the course of any employment for wage or profit;
(c) Any Disability which began during a month the Active Employee was eligible based on full self-payments;
(d) Any day the Active Employee works for compensation or profit or receives compensation through an Employer, including unemployment benefits;

(e) Any Retiree, including a Retiree who has returned to work;
(f) Any intentionally self-inflicted injury of any kind, while sane or insane; or
(g) Any reason for which coverage of medical benefits would be denied under Section 3.2(b).

ARTICLE 7 – DENTAL BENEFITS - Active Employees (except Shop Employees Covered by the Shop Plan), Pre-Medicare Retirees and Dependents, and Medicare Retirees and Dependents (except Former Niles Fund Retirees)

7.1 Eligibility

Dental benefits are provided to:

(a) Active Employees (excluding Shop Employees covered under the Shop Plan), Pre-Medicare Retirees, and their Dependents; and

(b) Medicare-eligible Retirees (excluding Former Niles Fund Retirees) and their Dependents, unless they opt out when first eligible (i.e. the later of retirement or Medicare eligibility) or at a later date. An additional monthly self-payment, as established by the Trustees from time to time in their sole discretion, is included in the Retiree self-payment for this coverage. If the Retiree opts out at any time, this Benefit will not be available in the future unless such coverage is requested within 30 days of one of the following events:

(1) dental coverage through a Spouse was terminated;
(2) the Retiree acquires a new eligible Dependent because of marriage, birth, adoption, or placement for adoption; or
(3) upon the death of a Retiree, the Surviving Spouse requests coverage.

If elected following one of the events above, Dental Benefits must be continued for a minimum of 24 months.

7.2 Dental Network: The Plan provides self-insured dental benefits and has contracted with Delta Dental, a preferred provider network, (800) 524-0149, www.deltadentaloh.com. A list of the dentists participating in this network, known as in-network providers, is available at the Fund Office free of charge. Participants and their Dependents are encouraged to use in-network providers to save money for themselves and the Plan, but may choose to receive treatment from an out-of-network provider and incur greater out of pocket expenses. Regardless of the provider chosen, benefits paid by the Plan will not exceed those amounts set forth in Section 7.3, below.

7.3 Covered Benefits

Annual maximum of $1,000 per Covered Person (not applicable to those under age 19) and a lifetime limit of $1,500 for orthodontics. There is no deductible for in-network services, but a $50 per Covered Person/$100 per Covered Family deductible for out-of-network services.

(a) Diagnostic and Preventive Services – Covered 100%:
(1) Examinations/evaluations (twice per calendar year).
(2) Teeth cleaning (twice per calendar year).
(3) Space maintainers (up to age 14).
(4) Sealants (first permanent molars to age 9; second permanent molars to age 14).
(5) Fluoride treatments (twice per calendar year up to age 19).

(6) Brush biopsy to detect oral cancer.
(7) Emergency palliative treatment to temporarily relieve pain.
(8) Radiographs: (Bitewing X-rays are payable once per calendar year. Full mouth x-rays (including bitewings) are payable once in any five-year period. A panographic x-ray (including bitewings) is considered a full mouth x-ray.

(b) Basic Services – Covered 80%:
(1) Oral surgery – extractions and dental surgery, including preoperative and postoperative care.
(2) Endodontic services – treatment of teeth with diseases or damaged nerves (for example, root canals).
(3) Periodontic services – treatment of diseases of the gums and supporting structures of the teeth.
(4) Relines and repairs – to bridges, partial dentures, and complete dentures.
(5) Minor Restorative Services – to rebuild and repair natural tooth structure damaged by disease or injury, including fillings and crown repair.

(c) Major Services – Covered 50%:
(1) Major Restorative Services – including crowns and onlays – limited to once per tooth in any 5-year period.
(2) Prosthodontic Services – to replace missing natural teeth (such as bridges, endoseal implants, and partial and complete dentures) – limited to once per tooth in any 5-year period.

(d) Orthodontic services to correct malposed teeth through age 18 – Covered 50%.

7.4 Exclusions

In addition to limitations imposed by Delta Dental, the exclusions applicable to medical benefits set forth in Section 3.2(b) and the following exclusions apply to dental benefits:

(a) Replacement of lost or stolen appliances;
(b) Appliances, restorations, or procedures for the purpose of altering vertical dimension, restoring or maintaining occlusion, splinting, or replacing tooth structure lost as a result of abrasion, or treatment of disturbances of the temporomandibular joint;
(c) A service not reasonably necessary or not customarily performed for the dental care of the eligible person;
(d) A service not furnished by a dentist, unless the service is performed by a licensed dental hygienist under the supervision of a dentist or is an x-ray ordered by a dentist;
(e) For initial installation of, or addition to, full or partial dentures or fixed bridgework, unless each installation or addition is required due to the extraction of one or more natural teeth, injured or diseased and if such denture or bridgework includes the replacement of the extracted tooth, which the person is eligible under the Plan;
(f) For replacement or alteration of full or partial dentures or fixed bridgework, unless such charge is required due to one of the following events, and if such event occurred while the person is eligible under the Plan and if the replacement or alteration is completed within 12 months after the event:
(1) An Accidental Injury requiring oral surgery;
(2) Oral Surgery treatment involving the repositioning of muscle attachments, or the removal of a tumor, cyst, torus or redundant tissue; or
(3) Replacement of a full denture, when required as the result of structural change within the mouth and when made more than five years after the person is eligible under the Plan
(g) Nutritional guidance, hygiene instructions, and periodontal splinting;
(h) Temporary appliances;
(i) Orthodontic treatment except as otherwise covered by the Plan;

(j) Charges for failure to keep a scheduled visit with the Dentist; or

(k) Services or supplies for which no charge is made, for which the patient is not legally obligated to pay; or for which no charge would be made in the absence of coverage.

ARTICLE 8 – VISION BENEFITS - Active Employees (except Shop Employees Covered by the Shop Plan), Pre-Medicare Retirees and Dependents, and Medicare Retirees and Dependents (except Former Niles Fund Retirees)

8.1 Eligibility

Vision benefits are provided to:

(a) Active Employees (excluding Shop Employees covered under the Shop Plan), Pre-Medicare Retirees, and their Dependents; and

(b) Medicare-eligible Retirees (excluding Former Niles Fund Retirees) and their Dependents, unless they opt out when first eligible (i.e. the later of retirement or Medicare eligibility) or at a later date. An additional monthly self-payment, as established by the Trustees from time to time in their sole discretion, is included in the Retiree self-payment for this coverage. If the Retiree opts out at any time, this Benefit will not be available in the future unless such coverage is requested within 30 days of one of the following events:

(1) vision coverage through a Spouse was terminated;

(2) the Retiree acquires a new eligible Dependent because of marriage, birth, adoption, or placement for adoption; or

(3) upon the death of a Retiree, the Surviving Spouse requests coverage.

If elected following one of the events above, Vision Benefits must be continued for a minimum of 24 months.

8.2 Vision Network: The Fund has entered into an agreement with VSP, (800) 877-7915, www.vsp.com, to provide vision services to Covered Persons at reduced fees. A list of such providers is available upon request at the Fund Office. A Covered Person does not have to use one of these providers, as it is always the Covered Person's choice as to which vision service provider to use. Regardless of the provider chosen, benefits paid by the Fund will not exceed those amounts set forth in Section 8.3, subject to the exclusions in Section 8.4, below.

8.3 Covered Benefits

Vision Benefits	In-Network	Out-Of-Network
Exam (1x every 12 months)	100% after $10 Co-Payment	100% up to $45
Contacts (1x every 12 months) Elective Medically Necessary	 100% after $60 copay up to $125 100%	 100% up to $105 100% up to $210
Frames (1x every 24 months)	100% after $15 Co-payment up to $150 retail and $57 wholesale Featured Frames up to $170 Costco Frames up to $80	100% up to $70

Vision Benefits	In-Network	Out-Of-Network
Lenses	100%, included in Frames Co-payment	Single-Vision 100% up to $30 Bifocal Vision 100% up to $50 Trifocal Vision 100% up to $65 Lenticular Vision 100% up to $100
Safety Glasses - Active Employees only once every 24 months	100% up to $60	Not covered

8.4 Exclusions

The exclusions applicable to medical benefits set forth in Section 3.2(b) and the following exclusions apply to vision benefits:

(a) Diagnostic services, drugs, or medications not part of a vision examination.
(b) An Exam or Materials ordered as a result of an Exam prior to the Effective Date of coverage.
(c) Materials which are not prescribed.
(d) Medical or surgical treatment.
(e) Replacement of Materials.
(f) Safety glass and safety goggles.
(g) Services categorized, in the sole discretion of the Trustees, as special or unusual, such as orthoptics, vision training, and low vision aids.
(h) Tints other than Number One or Two.
(i) Tints with photosensitive or antireflective properties.
(j) Exam required by an employer as a condition of employment or by virtue of a labor agreement or a government body or agency.

ARTICLE 9 – HEARING AID BENEFIT

9.1 Hearing Aid Provider

The Plan provides self-insured hearing aid benefits through TruHearing, (877)-653-8876, www.TruHearing.com/CMRCC. A list of TruHearing Providers (*i.e.* in-network providers) is available at www.TruHearing.com/CMRCC. Coverage will only be provided through a TruHearing Provider. Hearing aids and other hearing products and services will not be covered by the Plan if obtained from an out-of-network provider.

This benefit is available to Actives (excluding Shop Employees covered by the Shop Plan) and Retirees (including Former Niles Fund Retirees).

9.2 Covered Benefits

If a Covered Person's Physician upon examination determines that a hearing aid would compensate for the loss of hearing acuity, upon request for reimbursement the Plan will provide coverage for:

(a) as defined below, Audiometric Examinations, Hearing Aid Evaluation Tests, Hearing Aids, and Hearing Aid Conformity Evaluations, once every three years for each ear and not to exceed a total of $3,000.00 every three years per Covered Person; and
(b) up to $250.00 annually to repair a Hearing Aid that is out of warranty.

Audiometric Examination: An examination performed by a physician specializing in hearing issues or an audiologist after or in conjunction with an examination by a physician wherein a Covered Person has been

diagnosed with a potential hearing issue. Subject to above dollar limitations, the Audiometric Examination is paid at 100% in-network.

Hearing Aid Evaluation Tests: A test performed by a physician specializing in hearing issues or an audiologist, must be supported by the most recent Audiometric Examination, and may include the trial and testing of various makes and models of hearing aids. Paid at 100%, subject to above dollar limitations.

Hearing Aids: Covered hearing aids are those in-the-ear, behind-the-ear (including air conduction and bone conduction types), eyeglass-type, and on-the-body.

Conformity Evaluation: An examination performed by a physician specializing in hearing issues or an audiologist to evaluate the performance of a prescribed hearing aid to determine the conformance of the hearing aid to the prescription. Paid at 100%, subject to above dollar limitations.

9.3 Exclusions

The exclusions applicable to medical benefits set forth in Section 3.2(b) and the following exclusions apply to Hearing Aid Benefits:

(a) Hearing examinations or materials ordered prior to the Covered Persons effective date of coverage.
(b) Hearing Aids ordered while the Covered Person is an Eligible Participant but delivered more than 60 days after coverage ends.
(c) For medical or surgical treatment related to Hearing Aids.

ARTICLE 10 – LIFE INSURANCE AND DEATH BENEFITS – ACTIVE EMPLOYEES AND CERTAIN RETIREES

10.1 Insured Basic Life and Accidental Death and Dismemberment Benefits

Active Employees and Retirees (including Former Niles Fund Retirees) are eligible for coverage under a fully insured life insurance policy purchased by the Plan from ULLICO, (202) 682-0900, www.ullico.com. The amount of coverage is:

Active Employee	
Basic Life – Principal Sum	$15,000
Accidental Death & Dismemberment Benefit	up to $15,000
Retiree (Non-Medicare and Medicare-Retiree)	
Basic Life – Principal Sum	$5,000
Accidental Death & Dismemberment Benefit	None

Further information, including limitations and exclusions to coverage, are set forth in the life insurance policy, available at the Fund Office.

10.2 Beneficiary Designation

The benefits designated above are payable to the beneficiary(ies) designated by the Participant on the Beneficiary Designation card. Each Participant has the right to change their beneficiary at any time by written notice, submitted directly to the Fund Office, and the change will be effective on the date of receipt by the Fund Office. However, no designation or change will be effective if received by the Fund Office after date of death.

Spousal Beneficiary Designation: If a participant designates a spouse as their beneficiary, this will become null and void in the event of a divorce, unless the participant re-designates the ex-spouse as the participant's beneficiary subsequent to divorce by completing and returning to the Fund Office a new beneficiary designation card.

In the event of any conflict between the provisions of this Plan and the insurance policy (if applicable), including the proper determination of the beneficiary, the terms of the insurance policy and the determination by the insurance company controls.

10.3 Claims and Appeals: All claims and appeals regarding insured life insurance benefits (10.1) shall be determined by the procedures set forth in the applicable life insurance policies and not pursuant to Article 14, below. Claims and appeals regarding the self-insured life insurance benefits (Section 10.4), are determined by the claims and appeals procedures in Article 14, below

10.4 Self-Insured Death Benefits for Former Niles Fund Retirees and Former Niles Fund Active Employees

(a) In 2013, Former Niles Fund Retirees and Former Niles Fund Active Employees who became active employees and retirees in the Ohio Plan could elect to have an amount credited to their dollar banks equal to the value of a death benefit provided by the Cleveland Fund. By making this election, they forfeited any claim to this self-insured death benefit.

(b) If the individuals referenced in (a), above, did not make the above election, they became eligible for a self-insured death benefit under the Ohio Plan equal to the value of the death benefit they had in the Cleveland Fund as of April 30, 2013, minus the value of any fully insured death benefit provided by the Ohio Plan for which they were eligible at the time of their death. The CMRCC Plan will continue this death benefit as follows: the self-insured death benefit equals the value of the death benefit the individual had in the Cleveland Fund as of April 30, 2013, minus the value of any fully insured death benefit provided by this CMRCC Plan for which the individual is eligible at the time of their death. This death benefit will be paid to the beneficiary(ies) designated in Section 10.2, provided a written claim for this benefit is received by the Fund Office within one year of the date of death.

(c) Individuals who were inactive in the Cleveland Fund as of April 30, 2013, Former Niles Fund Retirees and Former Niles Fund Active Employees who were not allowed to make the election referenced in paragraph (a), above, remain eligible for a payout of the death benefit they had in the Cleveland Fund, in an amount equal to the present value of this death benefit as calculated by the actuary in 2013. To be entitled to this benefit, they must provide the Fund Office a certificate of coverage issued by the Cleveland Fund.

ARTICLE 11 – COORDINATION OF BENEFITS

11.1 Application

Coordination of benefits determines the priority of payment amongst two or more plans, including this Plan, which may provide coverage for Covered Person. In no event shall the coverage provided by this Plan when combined with the coverage provided by any other plan exceed the benefits that would be payable under this Plan in the absence of coordination of benefits (the "allowable expense"). For example, if a charge is $120 and the allowable expense under this Plan is $100, where coverage is provided on a primary basis by another plan in the amount of $80 (or would have been provided by the other plan if timely and properly submitted), this Plan will pay no more than $20.

As noted in the above example, for purposes of coordination, benefits payable under another plan include the benefits that would have been payable had the claim been timely and properly filed under that plan.

For the purpose of coordination of benefits with other plans, as allowed by applicable law, the Plan Administrator shall retain the right, without the consent of or notice to any person, to release or to obtain from any insurance company or other organization or person, any information, with respect to any Participant or Dependent, which the Plan Administrator deems to be necessary for the purpose of implementing this provision. Any person claiming benefits under the Plan shall furnish to the Plan Administrator such information as may be necessary to administer this provision and as allowed by applicable law.

Whenever payments have been made by the Plan in an amount which is at any time in excess of the amount payable under this provision, the Fund has the right to recover such excess payments from any persons or entities to which such payments were made or who benefitted from such payments.

For purposes of coordination of benefits, another plan is a plan of any type that pays benefits for medical, dental, or vision care, or prescription drugs.

11.2 Coordination

Plan rules regarding coordination:

(a) Another plan without a coordinating provision shall always be deemed to be the primary plan.

(b) Provisions in other plans which provide such other plan is always secondary or which places a limit on benefits where coordination of benefits is applicable shall be disregarded and such plans shall pay primary to this Plan.

(c) If another plan has a coordinating provision and provides coverage to a Covered Person, then in the following order:

(1) The other plan is primary and this Plan is secondary.
(2) The plan that covers a person directly as a participant rather than as a dependent is primary and the other is secondary.
(3) The plan that covers a person directly as an active employee rather than as a retired or laid off employee is primary and the other is secondary.
(4) The plan that covers a person as a dependent spouse is primary to the plan that covers the person as a dependent child.
(5) If a child is covered under both parents' plans, the plan that covers the parent whose birthday occurs earlier in the calendar year shall be considered the primary plan.
(6) The plan covering the Covered Person longest is primary.
(7) If none of the foregoing applies, the expenses shall be shared equally.
(8) Notwithstanding the above, in all cases a policy of insurance providing benefits to a Covered Person for injuries arising out of a motor vehicle accident shall be primary.

(d) With respect to dependents of divorced parents, the following rule applies:

(1) if there is a court decree, the plan that covers the dependent of the parent with responsibility to do so pursuant to such decree shall be primary;
(2) if (1) does not apply:
(A) the plan covering the parent with custody of the dependent shall be considered the primary plan;

(B) the plan covering the spouse, if any, of the parent with custody of the dependent will be secondarily liable; then

(C) the plan covering the parent without custody shall be considered last.

(3) if neither (1) nor (2) apply, coordination of benefits shall be determined in accordance with Ohio Coordination of Benefits Act (ORC Ann. 3902.11 et. seq.,), or any successor law.

(e) Medicare Coordination

(1) Benefits will be coordinated with Medicare according to the Medicare Secondary Payer (MSP) rules as of the date the Covered Person becomes eligible for Medicare benefits, even is he/she has not timely applied for and obtained such benefits. Thus, if Medicare would have been primary had the Covered Person obtained available Medicare benefits, this Plan will pay only those benefits it would have paid if Medicare coverage was in place.

(2) In the event a Medicare-eligible Covered Person is eligible under one plan as a dependent (for example, a dependent of an actively employed spouse) and another plan other than as a dependent (for example, a Retiree under this Plan), and as a result of the Medicare Secondary Payer Rules, Medicare is

(A) Secondary to the plan covering the Covered Person as a dependent, and

(B) Primary to the plan covering the Covered Person other than as a dependent,

then benefits of the plan covering the Covered Person as a dependent are primary to those of the plan covering the Covered Person other than as a dependent. For example, if a Retiree is covered as a dependent under a plan covering his/her Spouse as an active employee, then the benefits of the Spouse's plan are primary to the benefits provided by this Plan (and in no event will this Plan pay more than the complementary Medicare coverage set forth in Article 4).

(3) The Plan will pay primary, and only as required by MSP, for the first 30 months of treatment of End Stage Renal Disease.

(f) Notwithstanding any of the provisions above, with respect to a Covered Person on COBRA Continuation Coverage under any other plan, this Plan will be secondary.

(g) To the extent required by law, this Plan is primary when Medicaid is involved as the other plan.

(h) If two Participants are married, this Plan is primary when applied to each person as a Participant and secondary when applied to each person as a Spouse.

ARTICLE 12 – THIRD PARTY LIABILITY

12.1. Subrogation

(a) Application

Subrogation means the Plan has the right to recover from a Participant or Dependent those amounts paid by the Plan for medical care or other expenses due to an injury caused by a third party (for example, another person or company). To the extent benefits are paid by the Plan to a Participant or Dependent for medical, prescription drug, dental, wage loss, or other expenses arising out of such an injury, the Plan is subrogated to any claims the Participant or Dependent may have against the third party who caused the injury. In other words, the Participant or Dependent must repay to the Plan the

benefits paid on his or her behalf out of any recovery received from a third party and/or any applicable insurer. Notwithstanding, no amounts will be recovered from any underinsured or uninsured motorist insurance purchased by the Participant or Dependent.

The Plan's right of subrogation applies to any amounts recovered, whether or not designated as reimbursement for medical expenses or any other benefit provided by the Plan. The right of subrogation applies regardless of the method of recovery, *i.e.* whether by legal action, settlement or otherwise.

The Plan's right to subrogation applies regardless of whether the injured Participant or Dependent has been fully compensated, or made whole, for his or her losses and/or expenses by the third party or insurer, as the Plan's right to subrogation applies to any full or partial recovery. This provision is intended to make it clear that this provision shall apply in lieu of the "make whole" doctrine. The Plan has first priority to any funds recovered by the injured Participant or Dependent from the third party or insurer.

Further, the Plan does not have any responsibility for the injured Participant or Dependent's attorneys' fees, *i.e.*, the common fund doctrine will not be applied.

The Plan also has a lien on any amounts recovered by a Participant or Dependent due to an injury caused by a third party, and such lien will remain in effect until the Plan is repaid in full for benefits paid because of the injury.

(b) Conditions to Payment of Benefits

If a Participant or Dependent sustains an injury caused by a third party, then the Plan will pay benefits related to such injury (provided such benefits are otherwise properly payable under the terms and conditions of the Plan), provided all the following conditions are met:

(1) As soon as reasonably possible, the Participant or Dependent must notify the Claims Administrator that he or she has an injury caused by a third party.

(2) Prior to the receipt of benefits for such injury, the injured Participant or Dependent must assign to the Plan his or her rights to any recovery arising out of or related to any act or omission that caused or contributed to the injury. If such assignment is not made before the receipt of benefits, then the receipt of benefits automatically assigns to the Plan any rights the Participant or Dependent may have to recover payments from any third party or insurer. (If the recovery so assigned exceeds the benefits paid by the Plan, such excess shall be delivered to the Participant or Dependent or other person as required by law.)

(3) The Participant or Dependent does not take any action that would prejudice the Plan's subrogation rights.

(4) The Participant or Dependent cooperates in doing what is necessary to assist the Plan in any recovery, which includes but is not limited to executing and delivering all necessary instruments and papers.

(c) Right to Pursue Claim: The Plan's subrogation right allows the Plan to directly pursue any claims the Participant or Dependent has against any third party, or insurer, whether or not the Participant or Dependent chooses to pursue that claim.

(d) Enforcement: If it becomes necessary for the Plan to enforce this provision by initiating any action against the Participant or Dependent, the Participant or Dependent agrees to pay the Plan's attorney's fees and costs associated with the action regardless of the action's outcome. The Plan shall be entitled to enforce this provision by way of an equitable restitution, constructive trust, or any other

equitable remedy. At the Plan's option, it may enforce this provision by deducting amounts owed from future benefits.

12.2 Workers' Compensation

The Plan does not pay any claims covered by Workers' Compensation or similar legislation. The Plan will only cover those claims which:

(a) Workers' Compensation denies because they are not work-related; and
(b) Are covered under the terms of the Plan.

If a Participant or Dependent receives any benefits under this Plan that are properly payable by workers' compensation, then this Plan must be indemnified by the Participant or Dependent for the amount paid by the Plan for such benefits. The Plan shall be indemnified out of the proceeds received from the Participant or Dependent in settlement of any workers' compensation claim. The Participant must complete any forms required by the Fund to preserve its rights under this section.

ARTICLE 13 – RECIPROCITY

Upon receipt of a Reciprocity Authorization and subject to the rules and regulations adopted by the Trustees, the Plan may enter into reciprocity agreements pursuant to which (1) Contributions received on behalf of individuals who are working on a temporary basis in the jurisdiction of the Union will be forwarded to such individuals' home locals, and (2) contributions received from other health and welfare funds on behalf of Participants will be credited by the Plan.

ARTICLE 14 – INTERNAL CLAIMS AND APPEALS PROCESS

All benefits provided by the Plan are governed by the terms of this Article 14 and 15, where applicable, except as follows:

- **For benefits provided under the fully insured policies, including life insurance, claims and appeals will be governed solely by the procedures set forth in the documents governing such benefits.**
- **Medical benefits administered by Independence, which are governed by Article 14A.**

14.1 Types of Claims Covered: For purposes of the procedures set forth below, the following terms are used to define health claims:

- Urgent Health Claims: claims that require expedited consideration in order to avoid jeopardizing the life or health of the Claimant or subjecting the Claimant to severe pain;
- Pre-service Health Claims: for example, pre-certification of a hospital stay or predetermination of dental coverage;
- Post-service Health Claims: for example, Claimant or his Physician submits a claim after claimant receives treatment from Physician; and
- Concurrent Claims: claims for a previously approved ongoing course of treatment subsequently reduced or terminated, other than by plan amendment or plan termination.
- Rescission of Coverage: retroactive cancellation of coverage.
- Disability Claims: initial claims for disability benefits or any rescission of coverage of a disability benefit.
- Self-insured death benefits.

14.2 Initial Submission of Claims: Most claims will be submitted directly from the provider to the appropriate party. However, if they are not, claims for benefits should be submitted to the Fund Office. No claim will be covered unless submitted to the Fund Office within 365 days of the date incurred.

14.3 Notice That Additional Information is Needed to Process Claim

After the claim is submitted, the Fund deadline to provide notice to Claimant that the claim is incomplete (with explanation of additional information is necessary to process claim) is:

- For Urgent Health Claims – 24 hours after receiving improper claim.
- For Pre-Service Health claims – 5 days after receiving improper claim.

After receipt of notice from the Fund that the claim is incomplete, the Claimant's deadline to supply the Fund the information requested to complete claim is:

- For Urgent Health Claims – 48 hours after receiving notice.
- For Pre-Service Health Claims – 45 days after receiving notice.
- For Post-Service Health Claims – 45 days after receiving notice.
- For Disability Claims – 45 days after receiving notice.

14.4 Avoiding Conflicts of Interest: The Fund must ensure that all claims and appeals are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) must not be made based upon the likelihood that the individual will support the denial of benefits.

14.5 Initial Decision on a Claim

(a) Additional Evidence

(1) The Fund must provide the Claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by the Fund (or at the direction of the Fund) in connection with the claim; such evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of the adverse benefit determination is required to be provided under (b), below, to give the Claimant a reasonable opportunity to respond prior to that date; and

(2) Before the Fund can issue an initial benefit determination based on a new or additional rationale, the Claimant must be provided, free of charge, with the rationale. The rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of the adverse benefit determination is required to be provided under (b), to give the claimant a reasonable opportunity to respond prior to that date.

(b) The Fund deadline for making an initial decision on a claim is:

- For Urgent Health Claims – As soon as possible, taking into account medical exigencies, but not later than 72 hours after receiving initial claim, if it was complete; or 48 hours after receiving completed claim or after the 48-hour claimant deadline for submitting information needed to complete claim, whichever is earlier.
- For Pre-Service Health Claims – 15 days after receiving the initial claim. A 15-day extension permitted if the Plan needs more information and it has provided notice of same to Claimant during initial 15-day period. Fund deadline for responding is tolled while awaiting requested information from Claimant.

- For Post-Service Health Claims – 30 days after receiving initial claim. A 15-day extension permitted if Plan needs more information and has provided notice of same to claimant during initial 30-day period. Fund deadline for responding is tolled while awaiting requested information from Claimant.
- For Disability Claims – 45 days after receiving the initial claim. A 30-day extension permitted if Plan needs more information and has provided proper notice of same to Claimant. An additional 30-day extension is permitted if the Plan needs more information and has provided notice of same to claimant during first 30-day extension. Fund deadline for responding is tolled while awaiting additional information from Claimant.

14.6 Adverse Benefit Determination: Notice of an adverse benefit determination will include:

- the specific reasons for the denial;
- the specific Plan provision or provisions on which the decision was based;
- if applicable, what additional material or information is necessary to complete the claim and the reason why such material or information is necessary;
- the internal rule or similar guideline relied upon in denying the claim or, if applicable, a statement that such rule or similar guideline does not exist;
- if the denial was based on medical necessity, experimental nature of treatment or similar matter, an explanation of same;
- information sufficient to identify the claim involved (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;
- a description of available internal appeal process and how to initiate the external review process for an adverse benefit determination which involves a medical condition of the claimant for which the timeframe for completion of the internal appeal would jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function; and
- if applicable, a statement of the Claimant's right to bring a civil action after further denial on appeal or external appeal.

With respect to an adverse benefit determination involving a disability claim, the adverse benefit determination must also contain the following:

- An explanation of the basis for disagreeing with any of the following:
  - The health care professional that treated the Claimant;
  - The advice of the health professional obtained by the Plan; or
  - A disability determination from the Social Security Administration.
- A statement that the Claimant is entitled to receive, free of charge and upon request, reasonable access to copies of all documents, records, and other information relevant to the Claimant's claim for benefits.
- The adverse benefit determination must be in a culturally and linguistically appropriate manner.

14.7 Internal Appeals

(a) Adverse Benefit Determinations:

A Claimant may appeal any Adverse Benefit Determination received Section 14.6. An Adverse Benefit Determination means any of the following:

- a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make

payment that is based on a determination of a participant's or beneficiary's eligibility to participate in a plan;

- a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review;
- failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate;
- rescission of coverage; or
- A denial, reduction, termination of, or failure to provide or make payment (in whole or in part) for a disability benefit or any rescission of coverage of a disability benefit.

(b) Submission of Internal Appeals

An appeal is a written request to the Trustees setting forth issues to consider related to the benefit denial, along with any additional comments the claimant may have. A Claimant, free of charge and upon request, shall be provided reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits.

The Plan will not consider a request for diagnosis and treatment information, in itself, to be a request for an internal appeal.

The Plan will continue to provide coverage for an ongoing course of treatment pending the outcome of an internal appeal.

The review on appeal shall take into account all comments, documents, records, and other information submitted by the Claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination. Appeals should be submitted as to the Fund Office.

(c) Time for Submitting Internal Appeals: A Claimant must appeal a benefit denial within the following time limits:

- For Urgent Health Claims – 180 days after receiving denial.
- For Pre-Service Health Claims – 180 days after receiving denial.
- For Post-Service Health Claims – 180 days after receiving denial.
- For Concurrent Claims – Claimant must be given enough time to appeal decision before termination effective.
- For Disability Claims – 180 days after receiving denial.

ALL APPEALS MUST BE TIMELY SUBMITTED. A CLAIMANT WHO DOES NOT TIMELY SUBMIT AN APPEAL WAIVES HIS/HER RIGHT TO HAVE THE BENEFIT CLAIM SUBSEQUENTLY REVIEWED ON INTERNAL APPEAL, ON EXTERNAL REVIEW, OR IN A COURT OF LAW.

(d) Notice of Decision on Internal Appeal: The notice of a decision on appeal will include:

- the specific reasons for the denial;
- the specific Plan provision or provisions on which the decision was based;
- a statement that the Claimant is entitled to receive, free of charge, copies of all documents and other information relevant to the claim for benefits;
- the internal rule or similar guideline relied upon in denying the claim or, if applicable, a statement that such rule or similar guideline does not exist;

- if the denial was based on medical necessity, experimental nature of treatment or similar matter, an explanation of same;
- information sufficient to identify the claim involved (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;
- a description of the external review process, including information regarding how to initiate the external review process;
- a statement of the Claimant's right to bring a civil action under ERISA § 502(a);
- a statement describing any contractual limitation period that applies to the Claimant's right to bring an action under ERISA § 502(a) and the calendar date on which such contractual limitation expires; 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."

Before the Fund can issue a notice of decision on appeal with respect to disability benefits based on new or additional evidence, the Fund must provide the Claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by the Fund (or at the direction of the Fund) in connection with the claim; such evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of decision on appeal is required to be provided to give the Claimant a reasonable opportunity to respond prior to that date.

Before the Fund can issue a notice of decision on appeal with respect to disability benefits based on a new or additional rationale, the Claimant must be provided, free of charge, with the rationale. The rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of decision on appeal is required to be provided to give the claimant a reasonable opportunity to respond prior to that date.

With respect to an adverse benefit determination involving a disability claim, the adverse benefit determination must also contain the following:

- An explanation of the basis for disagreeing with any of the following:
  - The health care professional that treated the Claimant;
  - The advice of the health professional obtained by the Plan; or
  - A disability determination from the Social Security Administration.
- A statement that the Claimant is entitled to receive, free of charge and upon request, reasonable access to copies of all documents, records, and other information relevant to the Claimant's claim for benefits.
- The adverse benefit determination must be in a culturally and linguistically appropriate manner.

The Plan deadline for deciding an appeal of a benefit denial and notifying the Claimant of its decision is:

- For Urgent Health Claims – 72 hours after receiving appeal.
- For Pre-Service Health Claims – 30 days after receiving the appeal if one level appeal is applicable.
- For Post-Service Health Claims: The Trustees shall decide the appeal at a Board Meeting.*
- For Concurrent Claims – Prior to termination of previously approved course of treatment.
- For Disability Claims – The Trustees shall decide the appeal at a Board Meeting.*

* Reference to decisions made at a Trustee Board Meeting means the appeal will be decided at the first meeting following receipt of an appeal, unless the appeal is filed within 30 days preceding the date of such meeting. In such case, the decision may be made no later than the date of the second Board Meeting following

the Trustees' receipt of the appeal. If special circumstances require a further extension, upon due notice to the Claimant, the decision shall be made no later than the third board meeting following receipt of appeal. The Plan shall notify the Claimant of the Trustees' decision on appeal no later than five days after the decision is made.

14.8 Deemed Exhaustion of Internal Claims and Appeals Processes

If the Plan fails to adhere to all of the requirements in this Article 14 with respect to any claim for benefits, the Claimant is deemed to have exhausted the internal claims and appeals process. Accordingly, the Claimant may initiate an external review under Article 15. The Claimant is also entitled to pursue any available remedies under ERISA § 502(a), or under State law, as applicable, on the basis that the Plan has failed to provide a reasonable internal claims and appeals process that would yield a decision on the merits of the claim.

In addition to the above, if the Plan fails to strictly adhere to all procedures with respect to a claim for disability benefits and the Claimant chooses to pursue available remedies under ERISA § 502(a), the claim is deemed denied on review without the exercise of discretion by the Trustees.

Notwithstanding the above, the internal claims and appeals process will not be deemed exhausted based on de minimis violations that do not cause, and are not likely to cause, prejudice or harm to the Claimant so long as the Plan demonstrates that the violation was for good cause or due to matters beyond the control of the Plan and that the violation occurred in the context of an ongoing, good faith exchange of information between the Plan and the Claimant.

The Claimant may request a written explanation of the violation from the Plan, and the Plan must provide such explanation within ten days, including a specific description of its bases, if any, for asserting that the violation should not cause the internal claims and appeals process to be deemed exhausted.

If an external reviewer or a court rejects the Claimant's request for immediate review on the basis that the Plan met the standards for the exception to the deemed exhaustion rule, the Claimant has the right to resubmit and pursue the internal appeal of the claim. In such a case, within a reasonable time after the external reviewer or court rejects the claim for immediate review (not to exceed ten days), the Plan shall provide the Claimant with the notice of the opportunity to resubmit and pursue the internal appeal of the claim. Time periods for re-filing the claim shall begin to run upon Claimant's receipt of such notice.

14.9 Discretion of Trustees: The Trustees have full discretionary authority to determine eligibility for benefits, interpret plan documents, and determine the amount of benefits due. Their decision, if not in conflict with any applicable law or government regulation, shall be final and conclusive.

14.10 Limitations of Actions: For adverse benefit denials not subject to external review, no action may be brought to recover any benefits allegedly due under the terms of the Plan more than 180 days following the Notice of Decision on Appeal. For adverse benefit denials subject to external review, a request for external review must be made within the time limitations provided in Section 15.2. In the event a Claimant does not abide by these time limitations, he/she waives his/her right to any further review of an adverse determination, including waiving his/her right to have the determination reviewed in a court of law.

ARTICLE 14A – CLAIMS AND APPEALS PROCESS FOR MEDICAL BENEFITS ADMINISTERED BY INDEPENDENCE BLUE CROSS

14A.1 Definitions: For purposes of the procedures set forth below, the following terms are used to define health claims and appeals:

(a) **Grievances.** Grievances are appeals arising from the denial of claims for lack of Medical Necessity. In other words, if a claim is denied because it does not meet the standard of Medically Necessary (or Medical Necessity), a Grievance may be filed, subject to the requirements of this section. The Medically Necessary standard is defined in Article 1. Grievances are also referred to as Medical Necessity Appeals

(b) **Complaints.** Complaints are appeals arising from the denial of claims for any reason other than a lack of Medical Necessity. These include, but are not limited to, a denial due to lack of eligibility, the application of plan exclusions, etc. Complaints are also referred to as Administrative Appeals.

(c) **Pre-Service Health Claims.** A request for benefits that, under the terms of the Plan, must be pre-certified or pre-approved (sometimes referred to a requiring prior authorization) before the medical care is obtained for coverage to be available.

(d) **Post-Service Health Claims.** Any request for benefits that is not a Pre-Service Health Claims.

(e) **Urgent or Expedited Appeals.** Any Appeal for medical care or treatment with respect to which the application of the time periods for making non-urgent determinations could seriously jeopardize the life or health of the Claimant or the ability of the Claimant to regain maximum function, or in the opinion of a physician with knowledge of the Claimant's medical condition would subject the Claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the Appeal. Post-Service Health Claims concerning medical care or treatment that the Claimant has already obtained do not qualify for an Urgent or Expedited Appeal.

14A.2 **Initial Submission of Claims:** Most claims will be submitted directly from the provider to the appropriate party. However, if they are not, claims for benefits covered under this Article 14A must be submitted to Independence within 365 days of the date incurred.

14A.3 **Levels of Appeals for Grievances and Complaints:** For both Grievances and Complaints, there are two levels of appeals: First Level Appeals and Second Level Appeals. In other words, upon receipt of a claim denial, a First Level Appeal may be filed. If the First Level Appeal is denied, then a Second Level Appeal may be filed. The procedures for First and Second Level Appeals are as follows:

		Grievances (Medical Necessity Appeals)	Complaints (Administrative Appeals)
First Level Appeals	***Deadline to file?***	180 days from the date of receipt of the original claim denial.	180 days from the date of receipt of the original claim denial.
	Where to file?	Independence Administrators Appeals Department P.O. Box 21545 Eagan, MN 55121 Phone: 1-800-952-3404 / Fax: (215) 761-0956	Independence Administrators Appeals Department P.O. Box 21545 Eagan, MN 55121 Phone: 1-800-952-3404 / Fax: (215) 761-0956
	Who Makes the Decision?	For Grievances, the First Level Appeal is decided by a Peer Consultant in the same or similar specialty as the attending Physician.	For Complaints, the First Level Appeal is decided by Administrative Appeal Committee.
	Decision Timeline?	**Pre-Service Health Claims:** 30 calendar days from the receipt of the appeal request. **Post-Service Health Claims:** 60 calendar days from the receipt of the appeal request **Urgent or Expedited Appeals:** 72 hours from the receipt of the appeal request. Applicable to Pre-Service Health Claims, only.	**Pre-Service Health Claims:** 15 calendar days from the receipt of the appeal request. **Post-Service Health Claims:** 30 calendar days from the receipt of the appeal request. **Urgent or Expedited Appeals:** 72 hours from the receipt of the appeal request. Applicable to Pre-Service Health Claims, only.

		Grievances (Medical Necessity Appeals)	Complaints (Administrative Appeals)
Second Level Appeals	***Deadline to file?***	**Standard External Review:** 180 days from the date of the First Level Appeal denial. **Expedited External Review:** 72 hours from receipt of the First Level Appeal decision.	60 days from the date of the First Level Appeal denial.
	Where to file?	Independence Administrators Appeals Department P.O. Box 21974 Eagan, MN 55121 Phone: 1-888-234-2393 / Fax: (215) 761-0956	The Board of Trustees of the Central Midwest Regional Council of Carpenters' Welfare Fund c/o BeneSys Inc. 700 Tower Drive., Suite 300 Troy, MI 48098
	Who makes the decision?	For Grievances, the Second Level Appeal is decided by an Independent Review Organization (IRO) (another terms may be External Review Organization (ERO)). The IRO has no direct or indirect professional, familial, or financial conflicts of interest with the entity involved with the original benefit determination or the First Level Appeal decision.	For Complaints, the Second Level Appeal is decided by the Fund's Board of Trustees.
	Decision Timeline?	**Standard External Review:** 45 calendar days from the receipt of the request for External Review. **Expedited External Review:** 72 hours from the receipt of the request for External Review.	**Pre-Service Health Claims:** 30 calendar days from receipt of the Second Level Appeal requests. **Post-Service Health Claims:** The Trustees will decide the Second Level Appeal at the next regularly scheduled Board Meeting, unless the appeal is filed within 30 days preceding the date of such meeting. In such case, the Trustees will decide the appeal no later than the date of the second regularly scheduled Board Meeting following the receipt of the Second Level Appeal request. **Urgent or Expedited Appeals:** 72 hours from receipt of the Second Level Appeal request.

14A.4 Timely Submission of Appeals: All appeals must be timely submitted in accordance with the deadlines detailed in Section 14A.3. Failure to timely submit an appeal results in a waiver of any right to have the benefit claim subsequently reviewed on First or Second Level Appeals, External Review, or in a Court of Law.

14A.5 Discretion of Trustees: The Trustees or Independence, as applicable, in making Second Level Appeal decisions, have full discretionary authority to determine eligibility for benefits, interpret plan documents, and determine the amount of benefits due. Their decision, if not in conflict with any applicable law or governmental regulation, is finding and conclusive on all interested parties.

14A.6 Incorporation of Certain Provisions from Article 14: The following provisions apply and are explicitly incorporated into this Article 14A (in such incorporated provisions, any reference to the "Fund" or the "Plan" will be also mean any entity involved in the original benefit determination or First and Second Level Appeals determinations, as relevant):

(a) Section 14.6 (Adverse Benefit Determination);
(b) Section 14.7(d) (Internal Appeals/Notice of Decision on Appeal);
(c) Section 14.8 (Deemed Exhaustion of Internal Claims and Appeals Processes); and
(d) Section 14.10 (Limitations of Actions).

ARTICLE 15 – EXTERNAL REVIEW PROCESS

15.1 Eligibility for External Review

The external review process applies to any final internal adverse benefit determination that involves (1) medical judgment, including, but not limited to, medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit, or experimental or investigational treatment (excluding, however, determinations that involve only contractual or legal interpretation without any use of medical judgment); (2) whether the Plan is complying with the nonquantitative treatment limitation provisions which, in general require parity in the application of medical management techniques; (3) consideration of whether the Plan is complying with the surprise billing and cost-sharing protections set forth in ERISA sections 716 and 717; or (4) a rescission of coverage (whether or not the rescission has any effect on any particular benefits at that time). Weekly disability benefits are not subject to external review.

A denial, reduction, or termination, or a failure to provide payment for a benefit based on a determination that a Claimant fails to meet the requirements for eligibility under the terms of the Plan is not eligible for the external review process.

15.2 Request for External Review: A Claimant must file a request for an external review with the Fund within four months after receipt of a notice of the final internal appeal. If he/she fails to do so, he/she waives the right to an external review or review in a court of law. The Fund will not consider a request for diagnosis and treatment information, in itself, to be a request for an external review.

15.3 Preliminary Review

Within five business days following the receipt of the external review request, the Fund must complete a preliminary review of the request to determine whether:

(i) The Claimant is or was covered under the Plan at the time the health care item or service was requested or provided;
(ii) The final adverse benefit determination does not relate to the Claimant's failure to meet the requirements for eligibility under the terms of the Plan;
(iii) The Claimant has exhausted the Plan's internal appeal process; and
(iv) The Claimant has provided all the information and forms required to process an external review.

Within one business day after completion of the preliminary review, the Fund must issue a notification in writing to the Claimant. If the request is complete but not eligible for external review, such notification must include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444-ESBS (3272)). If the request is not complete, the notification must describe the information or materials needed to make the request complete and the Fund must allow a Claimant to perfect the request for external review within the four-month filing period or within the 48-hour period following the receipt of the notification, whichever is later.

15.4 Referral to Independent Review Organization

(a) The Fund must assign an independent review organization (IRO) to conduct the external review.

(b) The IRO will timely notify the Claimant in writing of the request's eligibility and acceptance for external review. This notice will include a statement that the Claimant may submit in writing to the IRO within ten business days additional information that the IRO must consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted after ten business days.

Upon receipt of any information submitted by the Claimant, the assigned IRO must within one business day forward the information to the Fund. Upon receipt of such information, the Fund may reconsider its final internal decision on appeal, but such reconsideration will not delay the external review. If the Fund decides to provide coverage, within one business day after such decision the Fund must provide written notice of same to the Claimant and the IRO and the IRO must then terminate the external review.

(c) Within five business days after the date of assignment, the Fund will provide to the IRO documents and any information considered in making the final decision on internal appeal, but failure to do so will not delay the conduct of the external review. If the Fund fails to timely provide this information, the IRO may terminate the external review and make a decision to reverse the adverse benefit determination and notice of such decision will be provided by the IRO to the Claimant and Fund within one business day.

(d) The IRO will review all of the information and documents timely received. In reaching a decision, the assigned IRO will review the claim de novo and not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. The IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:

(1) The Claimant's medical records;
(2) The attending health care professional's recommendation;
(3) Reports from appropriate health care professionals and other documents submitted by the plan or issuer, Claimant, or the Claimant's treating provider;
(4) The terms of the Claimant's Plan to ensure that the IRO's decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law;
(5) Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations;
(6) Any applicable clinical review criteria developed and used by the Plan, unless the criteria are inconsistent with the terms of the Plan or with applicable law; and
(7) The opinion of the IRO's clinical reviewer or reviewers after considering information described in this notice to the extent the information or documents are available, and the clinical reviewer or reviewers consider appropriate.

(e) The IRO must provide written notice of the final external review decision within 45 days after the IRO receives the request for the external review and deliver its decision to the Claimant and the Fund.

(f) The IRO's decision notice will contain:

(1) A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates 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 the reason for the previous denial);
(2) the date the IRO received the assignment and the date of the IRO decision;
(3) references to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;
(4) a discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;
(5) A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the group health plan or to the claimant;
(6) A statement that judicial review may be available to the Claimant; and

(7) Current contact information, including phone number, for any applicable state office of health insurance consumer assistance or ombudsman established under the Public Health Services Act § 2793.

(g) The external reviewer's decision is binding on the Plan and the Claimant, except to the extent other remedies are available under State or Federal law. The Plan must provide any benefits (including by making payment on the claim) pursuant to the final external review decision without delay, regardless of whether the Plan intends to seek judicial review of the external review decision and unless or until there is a judicial decision otherwise.

(h) The IRO must maintain records of all claims and notices associated with the external review process for six years. An IRO must make such records available for examination by the Claimant, Fund, or State or Federal oversight agency upon request, except where such disclosure would violate State or Federal privacy laws.

15.5 Expedited External Review

A Claimant can make a request for an expedited external review at the time the Claimant receives:

(a) An adverse benefit determination which involves a medical condition of the Claimant for which the timeframe for completion of an expedited internal appeal would jeopardize the life or health of the Claimant or would jeopardize the Claimant's ability to regain maximum function and the Claimant has filed a request for an expedited internal appeal; or

(b) A final internal appeal denial which involves a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the Claimant, or would jeopardize the Claimant's ability to regain maximum function, or if the final internal adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or service for which the Claimant received emergency services, but has not been discharged from a facility.

Immediately upon receipt of the request for expedited external review, the Fund must take the steps for Preliminary Review outlined above under the standard external review procedures and immediately send the notification of such review to the claimant.

Upon a determination that a request is eligible for external review following the preliminary review, the plan will assign an IRO as outlined in Section 12.3, above. The Plan must provide or transmit all necessary documents and information considered in making the final internal adverse benefit determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method.

The IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information or documents described above under the procedures for standard review. In reaching a decision, the assigned IRO must review the claim de novo and is not bound by any decisions or conclusions reached during the plan's internal claims and appeals process.

The contract with the assigned IRO must require the IRO to provide notice of the final external review decision as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO must provide written confirmation to the Claimant and the Fund.

15.6 Discretion of Trustees: The Trustees have full discretionary authority to determine eligibility for benefits, interpret plan documents, and determine the amount of benefits due. Their decision, if not in conflict with any applicable law or government regulation, shall be final and conclusive.

15.7 Limitations of Actions: No action may be brought to recover any benefits allegedly due under the terms of the Plan more than 180 days following the Notice of Decision on External Review. In the event a Claimant does not bring an action within such 180 days, he/she waives his/her right to any further review of an adverse determination in a court of law.

ARTICLE 16 – COBRA CONTINUATION COVERAGE

16.1 Introduction: A federal law known as the "Consolidated and Omnibus Budget Reconciliation Act" ("COBRA") requires most employers sponsoring group health plans to offer Participants and their families the opportunity to elect a temporary extension of health coverage (called "continuation coverage" or "COBRA coverage") in certain instances in which coverage under the group health plan would otherwise end. Qualified Beneficiaries who elect COBRA continuation coverage must pay for such coverage.

16.2 Qualifying Events

(a) COBRA continuation coverage is a continuation of coverage when coverage would otherwise end because of a life event known as a "qualifying event." After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary."

(b) A Participant will become a qualified beneficiary if coverage is lost under the Fund because either one of the following qualifying events happens:

(1) Hours of employment are reduced such that hours are insufficient to maintain eligibility, or
(2) Employment ends for any reason other than gross misconduct.

(c) The Spouse of a participant will become a qualified beneficiary if coverage is lost under the Fund because any of the following qualifying events happens:

(1) Death of spouse;
(2) Spouse's hours of employment are reduced such that hours are insufficient to maintain eligibility;
(3) Spouse's employment ends for any reason other than his or her gross misconduct;
(4) Spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
(5) Divorce or legal separation from the Participant.

(d) Dependent Children become qualified beneficiaries if coverage is lost under the Fund because any of the following qualifying events happens:

(1) The parent-participant dies;
(2) The parent-participant's hours of employment are reduced such that hours in the hour bank are insufficient to maintain eligibility;
(3) The parent-participant's employment ends for any reason other than his or her gross misconduct;
(4) The parent-participant becomes entitled to Medicare benefits (under Part A, Part B, or both);
(5) The parents become divorced or legally separated; or
(6) The child stops being eligible for coverage under the Fund as a "Dependent Child."

16.3 When COBRA Coverage Is Available: The Fund will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When

the qualifying event is the death of the participant, the employer must notify the Plan Administrator of this qualifying event within 30 days of the death. The Plan Administrator will monitor whether a qualifying event has occurred due to reduction in hours, termination of employment, or Medicare eligibility.

16.4 Participant/Spouse Obligation to Give Notice to the Fund of Some Qualifying Events

In the event of divorce or legal separation or a dependent child loses eligibility for coverage as a dependent child (for example, exceeds age limitations), or if after COBRA coverage is elected a qualified beneficiary becomes covered under another group health plan, the participant and his spouse both have an obligation to notify the Plan Administrator of such event within 60 after this qualifying event occurs. This notice must include: the name of the participant, the social security number of the participant, the name of the qualified beneficiaries (for example, a former spouse after divorce or a child no longer eligible for coverage as a dependent), the qualifying event (for example, the date of a divorce), and the date on which the qualifying event occurred. If timely notice is not provided, the right to COBRA coverage is forfeited.

Further, failure to timely notify the Fund of a divorce or legal separation or a child losing eligibility gives the Fund the right to hold the Participant and his/her Spouse separately and fully liable for any benefits paid by the Fund which would not have been paid had the Fund received timely notification of such event. At its sole election, the Fund may suspend the payment of future benefits until such amount has been recovered. See Article 20.

16.5 How COBRA Coverage Is Provided

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries within 14 days. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered participants may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

The COBRA notice will contain information regarding the premium that must be paid for COBRA coverage, which is 102% of the cost to the Fund for such coverage. If the period of COBRA coverage is extended due to disability, discussed below, the premium is 150% of the cost to the Fund.

Coverage under the Fund will be terminated upon the occurrence of a qualifying event and will be retroactively reinstated to the date of the qualifying event once a qualified beneficiary elects COBRA continuation coverage and pays the applicable premium.

16.6 Duration of COBRA Coverage

COBRA continuation coverage is a temporary continuation of coverage, as follows:

(a) When the qualifying event is the death of the participant, the participant's becoming entitled to Medicare benefits (under Part A, Part B, or both), divorce, legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months.

(b) When the qualifying event is the end of employment or reduction of the participant's hours of employment, and the participant became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the participant lasts until 36 months after the date of Medicare entitlement.

For example, if a participant becomes entitled to Medicare 8 months before the date on which his eligibility terminates, COBRA continuation coverage for his spouse and children can last up to 36

months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months).

(c) In all other events, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

(1) Disability Extension

If the qualified beneficiary or anyone in his family covered under the Fund is determined by the Social Security Administration to be disabled, all covered family members may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. To obtain this extension, the disability would have to have started before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage.

The Plan Administrator must be notified of the Social Security Administration's determination within 60 days of the date of the determination and before the end of the 18-month period of COBRA continuation coverage for this extension to apply.

The Plan Administrator must also be notified of any subsequent determination by the Social Security Administration that the qualified beneficiary is no longer disabled. This notice must be provided within 30 days of such determination.

(2) Second Qualifying Event Extension

If another qualifying event occurs while receiving 18 months of COBRA continuation coverage, the covered spouse and dependent children are eligible for up to an additional 18 additional months of COBRA coverage, for a maximum of 36 months. This extension may be available to the spouse and any dependent children on COBRA if the participant or former participant dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Fund as a dependent child, but only if such event would have caused the spouse or dependent child to lose coverage under the Fund had the first qualifying event not occurred.

The Plan Administrator must be notified of this second qualifying event within 60 days of such event for the extension to apply.

16.7 The Election Period for COBRA Continuation: Qualified beneficiaries have 60 days after receipt of the Election Notice, which will be sent to each qualified beneficiaries' last known address, to elect COBRA continuation coverage. Each qualified beneficiary has an independent right to elect COBRA continuation coverage.

16.8 Premium Payment for COBRA Coverage

Following an election, a qualified beneficiary has 45 days to pay the initial COBRA premium. If this is not timely paid, coverage will not be reinstated, and the qualified beneficiary will not be given a second chance to reinstate coverage.

Payments are thereafter due on the first day of the month of coverage. The postmark will serve as proof of the date paid. There is a 30-day grace period to make such payment. Coverage will be terminated the first day of the month of coverage for which payment has not yet been received, and retroactively reinstated if such

payment is received within the grace period. If payments are not made by the end of the grace period, coverage will terminate, and the qualified beneficiary will not be given an opportunity to reinstate coverage.

If, for whatever reason, the Fund pays medical benefits for a month in which the premium was not timely paid, the qualified beneficiary will be required to reimburse the Fund for such benefits.

The premium equals the cost to the Fund of providing coverage plus a 2% administration fee. In the event of extended coverage as a result of a disability for the 19th – 29th months of coverage, the Fund will charge 150% of the cost of providing coverage.

16.9 Scope of Coverage

COBRA coverage only pertains to health benefits available under the Fund (including the MRA). If a Qualifying Event occurs, the Fund Office will offer each Qualified Beneficiary an opportunity to elect to continue the health care coverage for full medical and prescription drug coverage subject to COBRA or medical and prescription drugs only.

Note also that coverage may change while on COBRA coverage due to Plan amendments that affect all participants in the Fund. A qualified beneficiary may also be able to elect different coverage options during the period of time he is on COBRA coverage, provided such a right is available to similarly situated active employees.

16.10 Enrollment of Dependents During COBRA Coverage/Coverage Options

A child born to, adopted by, or placed for adoption with a Participant during a period of COBRA coverage is considered to be a qualified beneficiary, provided that the Participant has elected continuation coverage for himself/herself. If a Participant desires to add such a child to COBRA coverage, then he/she must notify the Fund Office within 30 days of the adoption, placement for adoption, or birth.

During the COBRA coverage period, a Participant may add an eligible dependent who initially declined COBRA coverage because of alternative coverage and later lost such coverage due to certain qualifying reasons. If a Participant desires to add such a child to COBRA coverage, then he/she must notify the Fund Office within 30 days of the loss of coverage.

16.11 Qualified Medical Child Support Orders: If a Child is enrolled in the Fund pursuant to a qualified medical child support order while the Participant was an active employee under the Fund, he is entitled to the same rights under COBRA as any dependent Child.

16.12 Termination of COBRA Coverage

COBRA continuation coverage terminates the earliest of the last day of the maximum coverage period, the first day timely payment (including payment for the full amount due) is not made, the date upon which the Plan terminates, the date after election of COBRA that a qualified beneficiary becomes covered under any other group health plan, or the date after election if a qualified beneficiary becomes entitled to Medicare benefits and such entitlement would have caused the qualified beneficiary to lose coverage under the Fund had the first qualifying event not occurred.

In the case of a qualified beneficiary entitled to a disability extension, COBRA continuation coverage terminates the later of: (a) 29 months after the date of the Qualifying Event, or the first day of the month that is more than 30 days after the date of a final determination from Social Security that the qualified beneficiary is no longer disabled, whichever is earlier; or (b) the end of the maximum coverage period that applies to the qualified beneficiary without regard to the disability extension.

16.13. Keep the Fund Office Informed of Address Changes: A participant, spouse, or adult child must keep the Plan Administrator informed of any changes in the addresses of themselves and dependents and is advised to keep a copy of any notices sent to the Plan Administrator.

ARTICLE 17 – ABSENCE DUE TO MILITARY SERVICE

If a Participant's military service is for 30 or fewer days, coverage under the Plan may be continued for the Participant and their dependents, at the same cost as before short service. You must notify the Fund office before you leave for military service.

If coverage under the Plan is terminating due to active duty for more than 30 days, a Participant may elect to continue the health coverage under the Plan for up to 24 months after the absence begins, or for the period of military service, if shorter. The Participant must notify the Plan Administration Office as soon as he volunteers for or is called to active duty. If the Participant elects military coverage, or any other coverage, while on active duty for more than 30 days, their status in the Plan, including their dollar bank, will be frozen.

Upon termination for military duty, a Participant will be reinstated under that same status upon his/her discharge from the military. Exclusions and waiting periods will not be imposed upon re-employment provided coverage would have been afforded had the person not been absent for military service, unless there are disabilities that the Veterans Administration determines to be service related. For these benefits to apply the following conditions must be met:

(a) The Participant has given advance written or verbal notice of the military leave to the Fund Office (advance notice to the Fund Office is not required in situations of military necessity or if giving notice is otherwise impossible or unreasonable under the circumstances);
(b) The cumulative length of the leave and all previous absences from employment do not exceed five years, however, eligibility may be extended beyond five years if certain exceptions apply;
(c) Reemployment follows a release from military service under honorable conditions; and
(d) The Participant reports to, or submits an application to, Fund Office as follows:

    (1) On the first business day following completion of military service for a leave of 30 days or less; or
    (2) Within 14 days of completion of military service for a leave of 31 days to 180 days; or
    (3) Within 90 days of completion of military service for a leave of more than 180 days.

A Participant who is hospitalized for, or recovering from, an illness or injury when military leave expires has 2 years to apply for reemployment. If a Participant provides written notice of intent not to return to work after military leave, he/she is not entitled to reemployment benefits.

For purposes of federal law, the above applies to military service with the Armed Forces of the United States, the Army National Guard or the Air National Guard when engaged in active duty for training, inactive duty training or full-time National Guard duty, the Commissioned Corps of the Public Health Service and any other category designated by the President in time of war or emergency. "Service" means the performance of duty on a voluntary or involuntary basis, including active duty, active duty for training, initial active duty for training, inactive duty training, full-time National Guard Duty, and a period for which a Participant is absent from employment for a physical examination to determine your ability to perform service in the uniformed services.

ARTICLE 18 – QUALIFIED MEDICAL SUPPORT ORDER

In accordance with §609 of ERISA, the Plan shall provide benefits as required by a Qualified Medical Support Order ("QMSCO"). In general, a QMSCO is a medical child support order which creates or recognizes the right of an alternate recipient (*i.e.* a child of the Participant) to receive benefits under a group health plan. A QMSCO must meet certain requirements and cannot require a Plan to provide any type or form of benefit, or any option, not otherwise provided under the Plan, except to the extent necessary to meet the requirements of 42 U.S.C. §1396g-1. Procedures for determining the qualified status of medical support orders are available, without charge, from the Fund Office.

ARTICLE 19 – HIPAA PLAN SPONSOR PROVISIONS

The Plan complies with all HIPAA required privacy and security laws and regulations to maintain and safeguard the confidentiality and integrity of Protected Health Information.

ARTICLE 20 – CHILDREN'S HEALTH INSURANCE PROGRAM REAUTHORIZATION ACT

Under the Children's Health Insurance Program Reauthorization Act of 2009 (CHIP), Participants and Dependents who are eligible for coverage but who are not enrolled for coverage may exercise special enrollment rights and enroll in the Plan if the Covered Person:

(a) loses coverage under a Medicaid Plan under Title XIX of the Social Security Act; or
(b) loses coverage under State Children's Health Insurance Program (SCHIP) under Title XXI of the Social Security Act; or
(c) becomes eligible for group health plan premium assistance under Medicaid or SCHIP.

If any of these circumstances arises and the Covered Person wishes to take advantage of these special enrollment rights, the Covered Person must request to enroll for coverage within 60 days from the date:

(a) the coverage terminates under the Medicaid Plan or SCHIP; or
(b) the Participant or Dependent child is determined eligible for state premium assistance.

If you believe you are eligible for special enrollment under CHIP, you must contact the Fund Office to request an election form as soon as possible. A request for enrollment must be made in writing on the form provided by the Fund Office. Requests for special enrollment must be made within 60 days after an event described above.

ARTICLE 21 – RESCISSION OF COVERAGE

Rescission means the retroactive cancellation of coverage. Where coverage was provided as a result of fraud or an intentional misrepresentation of a material fact by a Participant or Dependent, or an individual seeking coverage on behalf of such Participant or Dependent, the Plan will rescind coverage.

Providing false information to maintain or obtain coverage, or knowingly cooperating in any actions designed to provide false information to maintain or obtain coverage, is an example of a fraud or intentional misrepresentation of material fact. Examples of fraud or intentional misrepresentation of material fact also include, but are not limited to, failing to inform the Fund Office of:

(a) a divorce or legal separation;
(b) lapsed Union membership, which is required to maintain eligibility for certain individuals;

(c) that a Participant or Dependent is covered under another health plan;
(d) employment with a noncontributing employer;
(e) continuing to use the benefit cards after eligibility is terminated; or
(f) any other event which makes a Participant a Dependent ineligible for coverage.

A 30-day notice of rescission will be provided, but termination of coverage will be retroactive to the date coverage should have been terminated if the fraud or intentional misrepresentation had not occurred (Date of Rescission). The intent of this provision is to rescind coverage to the full extent allowed by federal law.

In the event coverage is rescinded as a result of fraud or intentional misrepresentation, in addition to any legal and equitable means of recovery available, the Plan has the right to demand and receive repayment from the Participant or Dependent, jointly and severally, for all costs incurred by the Fund after the Date of Rescission, and the Fund is also entitled to demand and receive repayment from the Participant or Dependent, on a joint and several basis, all costs and attorneys' fees expended in collecting such amounts owed. At the Plan's sole option, it may enforce this provision by offsetting future benefits until the amount owed has been recovered.

Nothing in this section limits the rights of the Plan to prospectively terminate coverage where such coverage was previously provided because of a mistake, intentional misrepresentation, or fraud. Further, nothing in this section limits the right of the Plan to cancel coverage retroactively for failure of a Participant or Dependent to make a self-payment, where there has been a reasonable delay in terminating coverage due to administrative recordkeeping.

ARTICLE 22 – CHANGES TO OR TERMINATION OF COVERAGE

The Trustees reserve the right to amend, alter, or terminate any or all coverages under this Plan, for any or all classes of Participants or Dependents, at any time.

ARTICLE 23 – INTERPRETATION OF PLAN DOCUMENTS

The Trustees have full discretionary authority to determine eligibility for benefits, interpret plan documents, and determine the amount of benefits due. Their decision, if not in conflict with any applicable law or government regulation, shall be final and conclusive, and binding on all interested parties.

ARTICLE 24 – OVERPAYMENTS

Whenever payments have been made with respect to allowable expenses in an amount in excess of the amount otherwise payable under the Plan, to the extent allowed by law, the Board of Trustees of the Plan shall have the right, exercisable alone and in its sole discretion, to recover such payments to the extent of such excess from among one or more of the following: any persons to, or for, or with respect to, whom such payments were made, or any other organizations, the Dollar Bank, the MRA, or future benefits of the Participant.

ARTICLE 25 – FAMILY MEDICAL LEAVE ACT

Certain Employers are required to continue to make contributions to the Fund on behalf of an employee while such employee is on a medical leave of absence pursuant to the federal Family and Medical Leave Act (FMLA). Details concerning FMLA leave are available from the Participant's Employer and requests for FMLA leave must be directed to such Employer. The Plan cannot determine whether a person qualifies for FMLA leave. If a dispute arises between a Participant and his Employer concerning eligibility for FMLA leave, the Participant may continue health coverage by making COBRA payments. If the dispute is resolved in the Participant's favor, then the Plan will refund COBRA payments made by the Participant upon receipt of the FMLA required contributions from the Employer.

ARTICLE 26 – ADDITIONAL INFORMATION

A. **Type of Administration/Plan Administrator/Plan Sponsor.** The Board of Trustees of the Central Midwest Regional Council of Carpenters Welfare Fund is the Plan Administrator and Plan Sponsor. As such, the Trustees are responsible for overall Plan administration. The current Trustees are:

LABOR TRUSTEES	MANAGEMENT TRUSTEES
Matt McGriff 771 Greenwood Springs Dr. Greenwood, IN 46143	Kevin Reilly 1327 Youngstown-Kingsville Road Vienna, OH 44473
Trampas Pucket 575 Carpenters Way Grayson, KY 41143	Art Lindrose 271 Alpha Park Highland Heights, OH 44143
Charles Davis 1245 Durrett Lane Louisville, KY 40213	Chris Shafer 2000 W. Dorothy Lane Moraine, OH 45439
Alan Hibbard 204 Garver Road Monroe, OH 45050	Justin Taulbee 2203 Fowler Street Cincinnati, OH 45206
Mike Dugan 5370 Covert Court Newburgh, IN 47630	Clark Townsend 370 N. Eureka Road Columbus, OH 43204
Troy Woodyard 1950 Arlingate Lane Columbus, OH 43228	Daniel Edwards 1755 Northwest Blvd Columbus, OH 43212
Mark Lichty 2554 East 22nd Street Cleveland, OH 44115	Bill Hasse 10 Lincoln Ave Calumet City, IL 60409
Andy Tropp 1091 Mariners Drive Warsaw, IN 46582	Jim Hacker 872 Floyd Dr. Lexington, KY 40505
Waylon Issacs 771 Greenwood Springs Drive Greenwood, IN 46143	William Nix 4040 Fall Creek Drive Evansville, IN 47711

LABOR TRUSTEES	MANAGEMENT TRUSTEES
Lee Daher 9278 Bass Pro Blvd Rossford, OH 43460	Carey Weddle 8802 North Meridian Street Indianapolis, IN 46260
Joseph Pittman 204 Garver Road Monroe, OH 45050	Andy Binkley 7808 Honeywell Dr. Fort Wayne, IN 46825
Adam Fedak 711 Greenwood Springs Dr. Greenwood, IN 46143	Derrick Anderson 2401 Stanley Gault Parkway Louisville, KY 40223

The Trustees have delegated the day-to-day responsibilities for Plan administration to BeneSys, Inc., 700 Tower Drive, Suite 300, Troy, Michigan 48098, telephone number (248) 813-9800.

B. **Effective Date of Plan:** 05/01/2008.

C. **Agent for Service of Legal Process:** Service of process should be made upon BeneSys, Inc., 700 Tower Drive, Suite 300, Troy, Michigan 48098, telephone number (248) 813-9800. Service of legal process may also be made upon Legal Counsel or any Fund Trustee. Legal Counsel for the Fund is Jacqueline Asher Kelly, Esq., AsherKelly PLC, 25800 Northwestern Hwy, Suite 1100, Southfield, MI 48075, (248) 746-2748.

D. **Type of Plan/Employer Identification Number/Plan Number:** The Plan is a welfare benefit group plan providing medical, prescription drugs, dental, vision, disability, and death benefits. The employer identification number assigned by the IRS is 45-0593187. The Plan Number is 501.

E. **Collective Bargaining Agreements:** The Plan is maintained pursuant to collective bargaining agreements. Copies of such agreements may be obtained upon written request to the Fund Office or are available for examination by participants and beneficiaries at the Fund Office. Alternatively, within 10 days of a written request, such agreements will be made available at the Union Hall or at any employer establishment where at least 50 or more participants are customarily working. The Plan may impose a reasonable charge for such copies.

F. **Source of Plan Contributions:** The primary source of financing for the benefits provided under this Plan and for the expenses of the Plan operations are employer contributions. The rate of contribution is set forth in applicable Collective Bargaining Agreements. Additionally, under certain circumstances pursuant to the terms of the Plan, a Participant may make self-payments to retain eligibility. A portion of Plan assets are invested and this also produces additional Plan income. A complete list of the employers contributing to the Plan may be obtained upon written request to the Fund Office and may be examined at the Fund Office.

G. **Welfare Trust Assets and Reserves:** The Board of Trustees holds all assets in trust for the purpose of providing benefits to eligible participants and defraying reasonable administrative expenses.

H. **Statement of ERISA Rights:** As a participant in the Central Midwest Regional Council of Carpenters Welfare Fund you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits:

- Examine, without charge, at the Plan Administration Office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with

the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Administrator may make a reasonable charge for the copies.
- Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of 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 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.

Prudent Actions by Plan Fiduciaries: In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights: If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or 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 this statement or about your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration, United States Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, United States Department of Labor, 200 Constitution Avenue, NW, 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.

I. Termination of the Plan: The Trustees reserve the right to amend, alter, or terminate any or all coverages provided in this Plan, for any or all classes of Participants (Actives or Retirees) or Dependents, at any time. The Trustees also have the right to change required self-payment amounts for any benefit or class of Participants (Actives or Retirees) or Dependents, including the right to impose self-payment for coverage that previously had been provided without requiring such self-payments. If the Plan is terminated, plan assets

shall be used to pay eligible claims and expenses incurred prior to termination and expenses incident to the termination. The Trustees will, in their discretion, allocate any remaining assets in a manner which best effectuates the purposes of the Trust. In no event will plan assets revert to or inure to the benefit of contributing employers or the Association.

PRIMARY SERVICE PROVIDERS CONTACT INFORMATION

Fund Office BeneSys, Inc. General: (248) 813-9800 CMRCC Fund Office/Eligibility: (800) 700-6756 Participant Website: www.cmrccbenefits.org	**Medical Claims Administrator / PPO Network/ Precertification** Independence Administrators Member Claim Questions: 833-242-3330 Precertification Medical/Surgical: (888) 234-2393 Precertification Mental Health/Substance Abuse: (888) 778-2119 www.myibxtpabenefits.com	**Virtual Second Opinion Services** The Clinic by Cleveland Clinic Phone: (844) 777-0788 www.clinicbyclevelandclinic.com/central-midwest-carpenters
Prescription Network/EGWP Express Scripts (ESI) Phone: (800) 867-4518 www.express-scripts.com	**Medicare Advantage Plan** Humana Phone: (800) 733-9064 www.humana.com	**Telehealth** Teladoc Phone: (800) 835-2362 www.TeladocHealth.com
Medicare Advantage Plan Customer Service Retiree First Phone: (800) 716-0774 Website: www.laborfirst.com	**Vision Network** Vision Services Plan (VSP) Phone: (800) 877-7915 www.vsp.com	**Hearing Benefit** TruHearing Phone: (877)-653-8876 www.TruHearing.com/CMRCC
Dental Network Delta Dental Phone: (800) 524-0149 www.deltadentaloh.com	**Life Insurance** ULLICO Phone: (202) 682-0900 www.ullico.com	**Cancer Support Services** CancerNavigator Phone: (317) 942-9953 www.cancernavigator.com

Updated 6.24.26[1]

4928-9480-4663, v. 1

1 This SPD is updated through the fourth amendment to the September 1, 2025, plan document.