WELFARE FUND OF ENGINEERS
LOCAL 513

SUMMARY PLAN DESCRIPTION

EFFECTIVE MAY 1, 2022

Dear Participant:

The Board of Trustees of the Welfare Fund of Engineers Local 513 has adopted a formal Plan document that contains the detailed terms and provisions of the Plan. You are entitled to examine the Plan on request.

This booklet furnishes a brief description of the benefits to which you and your family are entitled, the rules governing these benefits, and the procedures that should be followed when making a claim. The booklet includes certain information concerning the administration of the Plan as required by the Employee Retirement Income Security Act of 1974. Any words used herein which are capitalized but not defined herein shall have the meaning given to such words in the Plan. In case of any inconsistency or error in this booklet, the Plan will take precedence over the booklet.

We urge you and your spouse to read this booklet thoroughly so that you will be familiar with the financial protection the Plan provides you and your family in the event of Illness, Injury or death.

From time to time the Board of Trustees may find it advisable to change the benefit provisions of the Plan. In the event this occurs, you will be advised of material changes. **Be sure to inform the Fund Office in writing of your new address if you move, so that information about the Plan will reach you without delay.**

Only the full Board of Trustees is authorized to interpret the Plan, and no individual Trustee, Union representative, Contributing Employer representative or Fund Office staff member is authorized to interpret the Plan independently on behalf of the Board.

Sincerely,

BOARD OF TRUSTEES

WELFARE FUND OF ENGINEERS LOCAL 513
3449 Hollenberg Drive, Suite 150
Bridgeton, MO 63044
(314) 739-2973
www.iuoe513fringe.org

NAMES AND ADDRESSES OF BOARD OF TRUSTEES

EMPLOYEE TRUSTEES	EMPLOYER TRUSTEES
Tim Sappington Operating Engineers Local Union 513 3449 Hollenberg Drive Bridgeton, MO 63044	Jeremy Bennett Site Improvement Association 2071 Exchange Drive St. Charles, MO 63303
Steve Straatmann Operating Engineers Local Union 513 3449 Hollenberg Drive Bridgeton, MO 63044	Charlie Goodwin Goodwin Brothers 4885 Baumgartner Rd. Saint Louis, MO 63129
Aaron Gray Operating Engineers Local Union 513 3449 Hollenberg Drive Bridgeton, MO 63044	John Grib Alberici 8800 Page Avenue St. Louis, MO 63114

FUND OFFICE
BeneSys, Inc.
3449 Hollenberg Drive, Suite 150
Bridgeton, MO 63044
(314) 739-2973

LEGAL COUNSEL
Bryan Cave Leighton Paisner, LLP
211 North Broadway, Suite 3600
St. Louis, MO 63102

Hartnett Reyes-Jones, LLC
4399 Laclede Avenue
St. Louis, MO 63108

PLAN CONSULTANT
Milliman
650 California Street, 21st Floor
San Francisco, CA 94108

TABLE OF CONTENTS

AUTHORITY OF THE BOARD OF TRUSTEES

The Board of Trustees has the exclusive right, power and authority, in their sole and absolute discretion, to administer, apply, and interpret the Plan and any other related documents and to decide all matters arising in connection with the operation or administration of the Plan. The Board of Trustees in its sole discretion may amend the Plan by a majority vote of the Trustees. Without limiting the generality of the foregoing, the Board of Trustees has the sole and absolute discretionary authority:

1. To take all actions and make all decisions with respect to the eligibility for, and the amount of, benefits provided under the Plan;

2. To formulate, interpret and apply rules, regulations and policies necessary to administer the Plan in accordance with its terms;

3. To decide questions, including legal or factual questions, relating to the calculation and payment of benefits under the Plan;

4. To resolve and/or clarify any ambiguities, inconsistencies and omissions arising under the Plan or other documents; and

5. To process, and approve or deny, benefit claims and rule on any benefit exclusions.

All determinations made by the Board of Trustees with respect to any matter arising under the Plan and any other documents shall be final and binding on all parties.

ELIGIBILITY

EMPLOYEES

If you have any questions regarding eligibility, contact the Fund Office.

An Employee will become eligible for benefit coverage after the Employee works sufficient hours for which contributions are required to be made on the Employee's behalf, and are actually made, by Contributing Employers. All presently eligible Employees will continue to remain eligible until they fail to meet the requirements set forth in the Plan.

A new Employee or an Employee who has not been eligible for at least six months will become eligible on any one of the four eligibility dates each year as follows:

1. **August 1**
   If the Employee has 300 hours of contribution for any three consecutive months from January through June. Owner-Operators contributing on their own behalf must have 520 hours of contributions for any three consecutive months in this same period.

2. **November 1**
   If the Employee has 300 hours of contribution for any three consecutive months from April through September. Owner-Operators contributing on their own behalf must have 520 hours of contributions for any three consecutive months in this same period.

3. **February 1**
   If the Employee has 300 hours of contribution for any three consecutive months from July through December. Owner-Operators contributing on their own behalf must have 520 hours of contributions for any three consecutive months in this same period.

4. **May 1**
   If the Employee has 300 hours of contribution for any three consecutive months from October through March. Owner-Operators contributing on their own behalf must have at least 520 hours of contribution for any three consecutive months in this same period.

Your coverage becomes effective on the date you become eligible.

An Employee who was previously eligible for coverage under the Plan but has experienced a termination of eligibility under the Plan, will be treated as a new Employee required to meet these initial eligibility requirements, if more than six months has elapsed since the Employee's last day of eligibility.

Once eligible, an Employee will remain eligible for at least three months. An Employee will also remain eligible for succeeding three-month intervals so long as the required hours of contribution are made on the Employee's behalf, as explained below.

Changes between Benefit Classes

The Benefit Class to which an Employee is entitled is determined by the contribution rate paid on the Employee's behalf. An Employee may work under two or more collective bargaining agreements that require various contribution rates. Therefore, an Employee may earn initial or continued eligibility based on his or her combined hours of work with more than one Contributing Employer and at different contribution rates. When this happens, the Benefit Class for which such Employee will qualify will be determined according to the following rules:

1. If an Employee works the minimum hours required for eligibility (see Eligibility rules on page 2) through a combination of work at two or more different contribution rates, the Employee will be eligible for the Benefit Class supported by the hourly contribution rate for which most of his or her hours were worked.

2. If an Employee works the minimum hours required for eligibility (see Eligibility rules on page 2) through a combination of work which is evenly divided between two or more contribution rates, the Employee will be eligible for the Benefit Class supported by the highest contribution rate at which he or she worked.

RETIREES

An individual who retires from Covered Employment will be eligible to apply for Retiree benefits from this Fund if the individual meets the eligibility requirements set forth below and makes written application at the Fund Office within the time specified herein. Application for Retiree benefits must be made within 30 days after the retirement date, regardless of whether such individual has active coverage at the time of retirement.

A retired individual who does not make application for Retiree benefits within the time specified in this section shall have no further right to acquire eligibility for Retiree benefits in this Fund, except that individuals who cancelled their Retiree benefits in this Plan after retirement or were eligible to elect Retiree benefits from this Plan but declined the benefits at retirement will have a one-time option to enroll or re-enroll for Retiree benefits in their Plan when they become eligible for Medicare as long as they had continuous health coverage from the time their active or Retiree coverage in the Plan ended. These individuals must apply to enroll for Retiree benefits no later than 30 days after becoming eligible for Medicare, or they will forever waive their right to Retiree benefits from this Plan.

To qualify for Retiree benefits, an Employee must meet one of the requirements set forth below:

1) He or she is approved to receive a regular, early retirement, or disability pension from the Local Union 513 Pension Fund or the Central Pension Fund of the International Union of Operating Engineers and Participating Employers and must have been an Employee with active coverage under the Plan for at least one month in the twelve months immediately preceding the date of retirement or, in the case of a disability pension, immediately preceding the date of disability onset as determined by the Social Security Administration.

2) He or she: (1) is a participant in the Central Pension Fund, (2) has received an award of Social Security disability benefits, (3) would be eligible to receive an early pension from the Central Pension Fund if not for the minimum age requirement, and (4) was an Employee with active coverage in this Plan for at least one month in the twelve months immediately preceding the date of disability onset as determined by the Social Security Administration. In this instance, application for Retiree benefits must be made within 60 days after the date of notice of Social Security Disability Award.

3) He or she is at least 55 years of age, has earned at least 10 Retiree Credits, and must have been an Employee with active coverage under the Plan for at least one month in the twelve months immediately preceding the date of retirement.

4) He or she has permanently ceased performing work in Covered Employment because of disability and meets all of the following requirements:

    a. Has received an award of disability benefits from the Social Security Administration,
    b. Has worked at least 500 hours in Covered Employment during the 36-months prior to the month in which his or her disability onset occurred, as determined by the Social Security Administration,
    c. Has at least 15 Retiree Credits, and
    d. Was an Employee with active coverage in this Plan for at least one month in the twelve months immediately preceding the date of disability onset as determined by the Social Security Administration. In this instance, application for Retiree benefits must be made within 60 days after the date of notice of Social Security Disability Award.

When an Employee with active coverage in this Plan retires, the Employee will be entitled to maintain active coverage earned by contribution hours worked prior to the retirement date, as if the Employee had not retired but had ceased working on the retirement date; provided, however, that no such extended period of active coverage after the retirement date shall continue longer than the end of the Benefit Quarter following the Benefit Quarter in which the Employee retires (such Benefit Quarters being the three month period ending on July 31, October 31, January 31, and April 30). Retired Employees with an award of Social Security disability benefits will be entitled to maintain active coverage earned by contribution hours worked prior to the retirement date through the end of the month following the month in which the notice of Social Security disability award was issued. Where an individual with active coverage enrolls for Retiree benefits, Retiree coverage shall begin on the day following the last day of active coverage (subject to payment of the required contributions). In all other cases, Retiree coverage shall begin on the first day of the month following the month in which application is made (subject to payment of the required contribution).

At the time of applying for Retiree coverage, the Retiree must elect either Retiree Plan A or Retiree Plan B. An initial election of coverage in Retiree Plan A may be subsequently changed to coverage in Retiree Plan B. Coverage in Retiree Plan B may **not** be changed to coverage in Retiree Plan A at any time.

Retiree Credits

A Participant shall be credited with Retiree Credits in this Plan on the basis of hours worked for which contributions to the Welfare Fund were made in accordance with the following schedule:

Hours of Work in Covered Employment During Plan Year	Retiree Credit
Less than 375 hours	No Retiree Credit
At least 375 hours	¼ Retiree Credit
At least 501 hours	½ Retiree Credit
At least 1,001 hours	¾ Retiree Credit
At least 1,400 hours	1 Retiree Credit

DEPENDENTS

If you are eligible for coverage as an Employee or a Retiree, your spouse, Children, and individuals under the age of 18 for whom you have been appointed legal guardian or have legal custody by court order may qualify as Dependents eligible for coverage. The coverage for your eligible Dependent(s) will be effective on the date you become eligible or on the date the Dependent(s) meets the definition of a Dependent, whichever is later.

Your spouse is eligible so long as you are married and not separated under a judicial decree.

Your Children will be eligible so long as your Child is under 26 years old, with the following exception: your Child can remain eligible to any age if, while eligible before age 26, he or she became incapable of self-sustaining employment because of a mental or physical disability and you submit proof of incapacity within 31 days after the Child's 26th birthday.

The following will be considered to be your Child:

1. Your biological child (proof may be required if born out of wedlock);

2. Your child (including grandchildren) adopted by judicial decree, or to the extent required by law, a child placed with you for adoption; and

3. Your stepchild if your spouse is the biological or adopted parent of the child.

4. An individual under 18 years of age for whom you have been appointed legal guardian or have legal custody by court order, provided that you have primary financial responsibility for the individual and the individual is: (1) unmarried, (2) residing with you full-time, and (3) claimed by you as a dependent on your taxes.

A Dependent may also be any other person required by ERISA or other applicable law to be treated as a Dependent eligible for benefits.

QUALIFIED MEDICAL CHILD SUPPORT ORDER

A Qualified Medical Child Support Order is any court judgment, decree, or order, including a court's approval of a domestic relations settlement or a decision from a state administrative body that:

1. provides a child support payment related to health benefits with respect to a child or requires health benefit coverage of such child by the Plan, and is ordered under state domestic relations law; or

2. enforces a state law relating to medical child support payments with respect to the Plan; and

3. creates or recognizes the right of a child as an alternate recipient who is recognized under the order as having a right to be enrolled under the Plan to receive benefits derived from such child's relationship to a full-time eligible Employee who is a Participant in the Plan; and

4. includes the name and last known address of the Employee from whom such child's status as an alternate recipient under this Plan is derived and of each alternate recipient, a reasonable description of the type of coverage to be provided by the Plan, the period for which coverage must be provided, and each plan, including this Plan, to which the order applies; and

5. does not require or purport to require the 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 law relating to medical child support described in Section 1980 of the Social Security Act; and

6. has been determined to be a Qualified Medical Child Support Order under reasonable procedures adopted and uniformly applied by the Plan. Participants and beneficiaries can obtain a copy of such procedures without charge from the Plan Administrator.

Within a reasonable time after the Plan receives a medical child support order, the Plan will notify the Participant and alternate recipient whether the order has been determined to be qualified.

TERMINATION OF AN ACTIVE EMPLOYEE'S ELIGIBILITY

If an active Employee (other than an Owner-Operator) does not have the required hours of contributions made on the Employee's behalf, eligibility for the Employee and his or her Dependents will end on one of the four Termination Dates shown below:

1. **On July 31**

   Unless the Employee has contributions of:

   300 hours for the 3-month period of April, May and June; or
   600 hours for the 6-month period of January through June; or
   900 hours for the 9-month period October through June; or
   1,200 hours for the 12-month period ending in June.

2. **On October 31**

   Unless the Employee has contributions of:

   300 hours for the 3-month period of July, August and September; or
   600 hours for the 6-month period of April through September; or
   900 hours for the 9-month period of January through September; or
   1,200 hours for the 12-month period ending in September.

3. **On January 31**

   Unless the Employee has contributions of:

   300 hours for the 3-month period of October, November and December; or
   600 hours for the 6-month period of July through December; or
   900 hours for the 9-month period of April through December; or
   1,200 hours for the 12-month period ending in December.

4. **On April 30**

   Unless the Employee has contributions of:

   300 hours for the 3-month period of January, February and March; or
   600 hours for the 6-month period of October through March; or
   900 hours for the 9-month period of July through March; or
   1,200 hours for the 12-month period ending in March.

An Owner-Operator contributing on his or her own behalf will lose eligibility for benefits on July 31, October 31, January 31, or April 30, if he or she had less than 520 hours, 1,040 hours, 1,560 hours or 2,080 hours of contributions in the three-month, six-month, nine-month or twelve-month period ending one month prior to the eligibility termination dates.

In addition, an active Employee's eligibility will end on the date the Employee enters any of the armed forces of the United States.

If, upon retirement, you decline Retiree coverage under the Plan, your coverage ends as of the date of your retirement.

TERMINATION OF A RETIREE'S ELIGIBILITY

A Retiree's coverage will end on the last day of the month for which the Retiree made the required self-contribution if the Retiree does not timely pay the contribution for the following month. Eligibility lost in this manner may not be reinstated.

Coverage will also be lost if an individual who qualifies for Retiree benefits due to one of the disability provisions ceases to be disabled prior to turning age 62. Said individual will only be eligible for Retiree benefits under this Plan thereafter, if he or she meets the eligibility requirements set out above when he or she once again seeks Retiree benefits.

Upon the death of a Retiree, the eligibility of his or her covered Dependents will terminate on the last day of the month in which the Retiree died, unless the Retiree's spouse elects to continue coverage by making payments to the Fund in accordance with the Plan.

All eligible Dependent Children of a Retiree will be eligible for benefits until the benefits for the Retiree and spouse are terminated in accordance with these rules, or if the Child ceases to meet the eligibility requirements for being a Dependent.

TERMINATION OF DEPENDENTS' ELIGIBILITY

The eligibility of an Employee/Retiree's Dependent will end on the earliest of the date the Dependent no longer satisfies the Plan's requirements for coverage as a Dependent, or the date on which the Employee/Retiree ceases to be eligible except as provided above or below in the case of an Employee/Retiree's death.

Termination of coverage will not affect a covered Dependent's right to Hospital and in-Hospital benefits for a confinement starting before the termination date.

If an Employee dies while eligible to receive benefit payments under this Plan, and if the deceased Employee was not vested under the Local Union 513 Pension Plan or the Central Pension Fund of I.U.O.E., then the widow or widower of the deceased Employee will be eligible to self-pay for continued coverage up to eight consecutive Benefit Quarters under the Actives Schedule of Benefits at a periodic self-pay rate established by the Board of Trustees and will thereafter be offered continued coverage under COBRA.

If an Employee under this Plan dies who was vested under the Local 513 Pension Plan or the Central Pension Fund of I.U.O.E., or if the decedent was a Retiree under this Plan and was receiving benefits under the Local 513 Pension Plan or the Central Pension Fund of I.U.O.E., the widow or widower of such decedent may elect COBRA continuation of coverage without change in Benefit Class, or Retiree coverage at the appropriate self-pay rate established by the Board of Trustees. If the decedent was covered at the time of death as an active Employee, or in Retiree Plan A, the surviving spouse may elect Retiree coverage in either Retiree Plan A or Retiree Plan B. If the decedent was covered at the time of death in Retiree Plan B, the surviving spouse may elect Retiree coverage only in Retiree Plan B. A surviving spouse's decision to elect Retiree coverage must be made within 30 days after the date of the decedent's death. An initial election

of coverage in Retiree Plan A may be subsequently changed to coverage in Retiree Plan B. Coverage in Retiree Plan B may **not** be changed to coverage in Retiree Plan A at any time. .

CONTINUATION OF AN EMPLOYEE'S COVERAGE DURING DISABILITY PERIODS

If, after an Employee becomes eligible, the Employee is unable to perform work because of a qualifying disability, the Employee will be credited, for the purpose of maintaining eligibility, with 30 disability hours for each full week of such disability. In no event, however, will more than 300 of such disability hours credit be granted during any continuous twelve-month period. A qualifying disability is one for which the Employee submits evidence that he or she is drawing weekly workers' compensation benefits as the result of a disability incurred while performing work for which employer contributions are made to this Plan.

SPECIAL CONTIUATION OF COVERAGE

If an Employee's eligibility is due to terminate on one of the Termination Dates specified because the Fund has not received the required contributions outlined in the "Termination of an Active Employee's Eligibility" section, the Employee may arrange with the Fund Office to make direct contributions to maintain eligibility, provided:

1. the Employee is registered for referral and available for work at the trade within the territorial jurisdiction of Local 513; or

2. the Employee is currently working at the trade within the territorial jurisdiction of Local 513.

An Employee may maintain eligibility in this manner for up to four consecutive Benefit Quarters of self-payments. If an Employee maintains eligibility by self-payments under this section, he or she will not be entitled to COBRA continuation coverage when self-payment coverage ends. The Employee may choose COBRA continuation instead of coverage outlined in this section.

FAMILY AND MEDICAL LEAVE ACT OF 1993

Under some circumstances, a Contributing Employer may become obligated under the Family Medical Leave Act (FMLA) to pay medical benefits to an Employee. If the Contributing Employer does not dispute the FMLA entitlement and if the Contributing Employer pays the additional contribution required by the Board of Trustees, then the Plan will pay, on behalf of the Contributing Employer, the benefits required by the FMLA for an Employee who has eligibility under this Plan.

If a Contributing Employer disputes an Employee's entitlement to maintenance of health benefits under FMLA, the Employee's benefits will be suspended pending resolution of the dispute.

COBRA CONTINUATION OF COVERAGE SELF-PAYMENT PROVISIONS (Exclusive of Death and AD&D Benefits)

Please contact the Fund Office if you have a COBRA Qualifying Event.

In accordance with the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), the Plan provides certain eligible Participants the federally-mandated option of continuing their health care coverage on a limited basis after regular coverage has terminated. Please contact the Fund Office to see if you qualify under this program.

If you lose coverage under the Plan as a result of a Qualifying Event, coverage may be continued for a limited period under COBRA Continuation Coverage by making monthly payments to the Fund.

Should any temporary or permanent changes in the law conflict with any provisions of this section, the provisions set out in the law will apply. For example, should the government extend the timelines a Qualified Beneficiary has to elect or pay for COBRA coverage due to a natural disaster or otherwise, the extended timelines shall apply while in effect and the timelines set out in this section shall be disregarded.

Qualifying Events are:

Employees

If an Employee loses coverage as a result of:

1. reduction in work hours; or

2. termination of employment through resignation, layoff, discharge (other than for gross misconduct), or retirement **unless** the Employee elects Retiree coverage.

Dependents

If a Dependent loses coverage as a result of:

1. reduction in the Employee's work hours that results in a loss of eligibility;

2. the death of the Employee or Retiree;

3. divorce or legal separation from the Employee or Retiree;

4. a Dependent Child ceasing to meet the definition of a "Dependent" as defined by the Plan;

5. the Employee's Qualifying Event; or

6. the Employee's entitlement to Medicare.

An Employee/Retiree, spouse, or Dependent Child can individually elect to continue coverage under COBRA in accordance with this section. Please read this entire section very carefully so that all requirements and restrictions are completely understood.

If you pay a family rate, your COBRA Continuation Coverage under this Plan includes coverage for any Child born or adopted by you on or after your COBRA effective date. The Child will become covered on the date of or birth or placement for adoption and will be covered as long as you remain eligible for COBRA Continuation Coverage.

DURATION OF COVERAGE

If the Qualifying Event is failure of an active Employee to work enough hours to maintain eligibility or termination of employment, then the maximum period of COBRA Continuation Coverage is 18 months, commencing on the first day of the month following the month in which the Employee's termination of eligibility occurred. However, if a second Qualifying Event occurs within such 18-month period, coverage for the Employee's eligible Dependents may be further extended to a maximum of 36 months.

If you or your eligible Dependent obtains a Social Security disability award within 60 days after the effective date of your (or the Dependent's) COBRA Continuation Coverage, and if the Fund Office receives a copy of the award before the end of the initial 18-month COBRA eligibility period, the disabled person and all eligible family members are entitled to up to 11 additional months of COBRA Continuation Coverage (not to exceed a total of 29 months of COBRA Continuation Coverage). The premium for the additional 11 months of coverage will be higher.

If the Qualifying Event is the failure of an active Employee to work enough hours to maintain eligibility or termination of employment and the Employee became entitled to Medicare less than 18 months before the qualifying event, COBRA Continuation Coverage for the Employee's eligible Dependents can last until 36 months after the date the Employee became entitled to Medicare.

If the Qualifying Event is any event other than that described above, the maximum period of COBRA Continuation Coverage shall be 36 months, commencing from the date coverage would otherwise terminate.

COVERAGE OPTIONS

Qualified Beneficiaries may elect:

COBRA Core-Only: This includes Medical and Prescription Drug benefits; or
COBRA Core-Plus: This includes Medical, Prescription Drug, Dental, and Vision benefits.

COBRA Continuation Coverage does NOT include Death and Accidental Death and Dismemberment benefits.

COBRA Core-Plus will cost more than COBRA Core-Only since more benefits are provided. The health benefits under each option are the same as for all other eligible Participants including Calendar Year Deductibles and Copayments.

The COBRA rates are adjusted once each year and current rates may be obtained from the Fund Office.

"Qualified Beneficiaries" are Participants who are covered under the Plan on the day before a Qualifying Event and who would lose such coverage as a result of such Qualifying Event but for the Plan's COBRA Continuation Coverage rules.

NOTICE AND ELECTION PROCEDURES

In order to elect COBRA Continuation Coverage, a Qualified Beneficiary **must notify** the Fund Office of certain Qualifying Events, which are:

1. An Employee's divorce or legal separation; or
2. When a Dependent Child no longer qualifies as a "Dependent" as defined by the Plan.

In the case of any other Qualifying Event, the Contributing Employer must notify the Fund Office within 30 days of the date coverage would otherwise be lost.

NOTE: Notice of a Qualifying Event must be made in writing on a form that may be obtained by calling the Fund Office. If a Qualified Beneficiary fails to file this form with the Fund Office within 60 days of the Qualifying Event or 60 days from the date coverage ends (whichever is later), the right to continue coverage will be terminated.

Following receipt of this notification, the Fund Office will send within 14 days a letter to the Qualified Beneficiaries explaining their options to continue coverage. This letter will be addressed to the Employee and Dependents at the address of record maintained by the Fund Office. Notice to a Qualified Beneficiary who is the spouse of the Participant shall be deemed notice to all other Qualified Beneficiaries residing with the spouse at the time notifications is made.

It is the responsibility of all Participants to keep the Fund Office informed in writing of any changes in mailing address.

Qualified Beneficiaries have 60 days from the later of: (a) the date they received the notification letter, or (b) the date coverage terminates, to make a written election to continue coverage. Qualified Beneficiaries will have 45 days to make the initial payment for COBRA Continuation Coverage after the date the election form is returned to the Fund Office. The initial payment for COBRA Continuation Coverage must include any retroactive amount that may be due. Participants should contact the Fund Office to verify the amount due. Subsequent payments are due on the first day of each month and will not be accepted more than 30 days late.

If a timely election to continue coverage is made, COBRA Continuation Coverage will commence on the first day of the month following the date of the Qualifying Event. However, Qualified

Beneficiaries will not be required to make payments for months during which coverage is otherwise provided under the Plan.

TERMINATION OF COBRA CONTINUATION COVERAGE

COBRA Continuation Coverage will automatically **terminate** upon the earliest of:

1. The date upon which the Qualified Beneficiary first becomes covered after the date of the election as an employee or as a dependent under any other group health plan, provided such coverage does not contain any exclusions or limitations with respect to any pre-existing condition of the Qualified Beneficiary; or

2. The last day of the month for which a timely payment is received by the Fund Office; or

3. The date on which the Qualified Beneficiary becomes entitled to Medicare benefits under Title XVIII of the Social Security Act after electing COBRA Continuation Coverage; or

4. The date this Plan terminates; or

5. At the end of the last day of the maximum coverage period applicable to the Qualified Beneficiary; or

6. The date the Employee's employer no longer provides any group health coverage to any Employee.

EXCEPTIONS TO TERMINATION OF COBRA COVERAGE

1. Qualified Beneficiaries who lose coverage due to a reduction in hours or termination of employment, and are determined under Title II or XVI of the Social Security Act to be disabled at the time of the Qualifying Event or during the first 60 days of COBRA Continuation Coverage, may extend their COBRA Continuation Coverage from 18 months to the earlier of: (a) 29 months or (b) the first day of the month following 30 days after the date of any final determination under Title II or XVI of the Social Security Act that the individual is no longer disabled.

   There will be an increased rate, which will be 150% of the Plan's cost, for the 19th through 29th month. Further, the Qualified Beneficiary must notify the Fund Office: (a) of such determination, and (b) within 30 days of the date of any final determination under Title II or XVI of the Social Security Act that the individual is no longer disabled.

2. If a covered Employee becomes entitled to Medicare coverage, the maximum period of coverage for Qualified Beneficiaries, other than the covered Employee, for such event to any subsequent Qualifying Event shall be 36 months.

UNIFORM SERVICES EMPLOYMENT AND REEMPLOYMENT ACT OF 1994

If an Employee with active coverage leaves his or her Covered Employment to serve on active duty in the Armed Forces of the United States, the Employee may elect to continue his or her coverage under the Plan as well as coverage for his or her Dependents (if any) for up to 24 months of uniformed service. Except where otherwise provided by law, the Employee is required to notify the Fund prior to leaving for service in the uniformed services.

If the service is for no more than 30 days, continued coverage will be paid for by employer contributions. If the period of service is more than 30 days, the Employee must pay for continuation coverage. The maximum payment is 102% of the premium or the same amount as has been determined under COBRA. The same timelines that apply to electing COBRA Continuation Coverage and making payments for COBRA Continuation Coverage apply to Employees electing coverage while performing service in the uniformed services. Coverage under this section will end on the last day of the last period for which contributions are made, if the Employee fails to make any contribution required by this section by the 15th of the month in which said contribution is due. Coverage will also terminate on the day after the date the Employee fails to apply for or return to work as determined under USERRA.

Any liability for employer contributions and benefits arising under this provision shall be allocated to the last Contributing Employer employing the person before the period served in the uniformed services or if such Contributing Employer is no longer functional, the Plan.

Upon discharge from the Armed Forces, such Employee's eligibility and that of the Employee's Dependents will be reinstated on the day the Employee returns to work with a Contributing Employer, provided the Employee returns to work within 90 days from the date of discharge. The 90-day period for returning to work will be extended for an Employee who was hospitalized for or convalescing from, an illness or injury incurred in, or aggravated during, the performance of service in the uniformed services. In such case, the period for returning to work shall be the end of the period that is necessary for the Employee to recover from such illness or injury and reapply for or return to work as required by USERRA, but in no event shall such period of recovery exceed two years. The returning Employee is not subject to any waiting period or preexisting condition limitation or any other exclusion if that exclusion or limitation would not have been applicable if the Employee had never entered uniformed service. However, the Plan can limit coverage for illness or injury incurred or aggravated in the military service. In certain circumstances, the Employee may have to pay for coverage upon his/her return until the Employee earns the credits necessary to sustain continued coverage under the Plan's continuing eligibility provisions.

If the Employee does not return to work with a Contributing Employer within the time required by USERRA, the Employee will be considered a new Employee and will need to satisfy the eligibility requirements in the section entitled "Initial Eligibility" in this Plan booklet.

HEALTH CLINICS

Effective December 1, 2021, the Fund offers Everside Health as part of your benefits package. It's an easier, more convenient healthcare option for everything from screenings and prevention to chronic disease management and urgent care. At the Everside Health clinics, you can:

- Schedule same-day and next-day appointments. If possible, you are encouraged to call the clinics first prior to going to the emergency department or urgent care.
- Meet with your provider where it's easiest for you: at a clinic near you, or virtually with the mobile app.
- Reach your care team 24/7 for urgent needs.
- Spend as much time as you need with a provider who will get to know you.
- Get care for nearly every health issue. If you need a referral, your care team will handle it for you.
- Receive full-scope family medicine including school/sports physicals and sick visits.

The clinics offer comprehensive primary care with no out-of-pocket costs for most services, including generic drugs and any lab work done at the clinic. Currently, there are 5 clinics available for members, with plans to add 3 additional locations. Currently, the 5 clinics are located at:

Chesterfield 1574 Woodlake Dr. Chesterfield, MO 63017 636-489-1219	Creve Coeur 11770 Olive Blvd. Creve Coeur, MO 63141 314-380-3014	Florissant 245 Dunn Rd. Florissant, MO 63031 314-820-0733
South County 4850 Lemay Ferry Rd., 115 St. Louis, MO 63129 314-279-9222	St. Peters Health Center 5700 Mexico Rd., 16 St. Peters, MO 63376 636-224-8445	

The following list provides an overview of the broad scope of diagnoses, procedures, and services that may be offered in Everside Health Centers (not a complete list). The onsite providers make all treatment decisions with the health, well-being, and best interest of the patient as the foremost goal.

Primary and Preventive Care	**Labs**
• Acute illness visits & treatment* • Basic vision screening (color & near vision) • Biometric screening • Blood pressure and vitals screening • Chronic condition management* • Comprehensive personal evaluation including routine checkups*	• Basic metabolic panel • Blood draws & sample collection • Cholesterol • Hemoglobin A1c • Pregnancy test • Screening for diabetes • Strep throat test • Urinalysis

Primary and Preventive Care	Labs
• Coordination with other providers (e.g., specialists, hospitals)* • Depression & anxiety* • Fitness & nutrition coaching* • Health risk assessment* • Hearing screening (audiometry) • Lifestyle & risk-reduction coaching* • Onsite medications at no cost • Pediatric visits* • Pre-op evaluations & clearance • Routine adult physicals • Sports physicals • Women's health	
Procedures	**Behavioral Health**
• Asthma/Pulmonary treatments • Basic ENT procedures • Basic wound care • Dermatological procedures including mole removal • Ingrown toenail removal • Skin biopsy (lab not included) • Skin cyst removal • Skin tag & wart removal (cryo) • Stitches • Suture/Staple removal	• Anxiety assessment & treatment* • Depression assessment & treatment*
Immunizations	**Diagnostic Testing & Vitals**
• Flu vaccine • Hepatitis A series • Hepatitis B series • HIB (haemophilus) • HPV series (human papilloma virus) • Meningococcal • MMR (measles, mumps, rubella) • Pneumococcal • Polio • Rotavirus • Td (tetanus, diphtheria) • Tdap (tetanus, diphtheria, pertussis) • Varicella (chicken pox)	• Blood pressure & vitals • EKG • Peak flow testing • Spirometry

*Available for virtual appointments. Follow-up in-person care will be coordinated with your provider if needed.

MEMBER ASSISTANCE PROGRAM

The Member Assistance Program (MAP) is designed to help when life gets overwhelming. Whether you're dealing with everyday problems or major life events, you can obtain confidential counseling, referral and support for you and your family. The program offers guidance and encouragement for everyday situations and includes counselors trained to deal with a range of personal issues.

The MAP Program is currently administered by Mercy and offers free and confidential counseling, work-life, legal assistance and financial services to you and your dependents. The program covers up to six (6) counseling sessions per eligible participant per episode, as well as unlimited access to telephonic and online services.

To initiate services, call the 24-hour Mercy MAP helpline at (800) 413-8008 or (314) 729-4600 or visit the Mercy MAP website at www.mbh-eap.com/members.

SCHEDULE OF BENEFITS
ACTIVES

NOTE: If you fail to contact the Utilization Review Service within a timely manner prior to a Hospital admission, other than in cases of Hospital admissions immediately following receipt of Emergency Services from an Emergency Services Provider, benefits otherwise payable will be reduced by $300.

Benefit Class 4 and Benefit Class 6 Employees Only	
BENEFIT	**COVERAGE**
Death Benefit	$10,000
Accidental Death and Dismemberment Benefit	Up to $10,000

Benefit Class 4 and Benefit Class 6 Employees and Dependents		
BENEFIT	**PPO COVERAGE**	**NON-PPO COVERAGE**
Comprehensive Major Medical Plan	Benefits provided through the Anthem BlueCross BlueShield network	Providers not in the Anthem BlueCross BlueShield network
Calendar Year Deductible[1] Individual Family	 $300 $600	 $600 $1,200
Out-of-Pocket Limit[2] Individual Family	$2,000 $5,100	
Coinsurance Plan Pays	85% of Covered Expenses	55% of Covered Expenses[3]
Office Visit Copayment	$20 per primary care visit, $40 per specialist visit	
Hospital Copayment	$0 per admission	

[1] Emergency Services provided by an Emergency Services Provider will all be paid at the PPO Coverage level of benefits and will be subject to the PPO Coverage Calendar Year Deductible and Out-of-Pocket Limit regardless of whether care is provided by a PPO provider or non-PPO provider.

[2] Covered Expenses in excess of the Out-of-Pocket Limit will be covered at 100% for the remainder of that calendar year. These limits do not include Copayments, the Chiropractic Benefit or x-rays under the Physical Therapy Benefit; however, in no event will the Out-of-Pocket Limit for all covered essential health benefits (including Copayments, the Chiropractic Benefit and x-rays under the Physical Therapy Benefit) exceed $6,350 per individual and $12,700 per family.

[3] If a PPO provider is not available within a 30-mile radius of a Participant's residence, the coverage for a non-PPO provider within this area will be 65%.

Benefit Class 4 and Benefit Class 6 Employees and Dependents		
BENEFIT	**PPO COVERAGE**	**NON-PPO COVERAGE**
Lifetime Maximum for Non-Essential Benefits (per person)	$1,000,000	
Alcoholism, Chemical Dependency and Drug Addiction Consultation Benefit – Inpatient and Outpatient	Covered under Comprehensive Major Medical Plan	
Chiropractic Benefit	Covered under Comprehensive Major Medical Plan	
Plan Pays	50% of Covered Expenses	40% of Covered Expenses
Maximums		
X-rays	$100 per treatable condition	$100 per treatable condition
All benefits	26 visits per calendar year	26 visits per calendar year
Emergency Room	Covered under Comprehensive Major Medical Plan	Same as PPO Coverage for Emergency Room
Participant Copayment	$150 (waived if admitted)	$150 (waived if admitted)
Hearing Aid Benefit	Covered under Comprehensive Major Medical Plan	
Maximums (per person)		
Routine Exam (per two-calendar year period)	$50	
Instrument (per five-calendar year period)	$600 per ear	
Home Health Care Benefit	Covered under Comprehensive Major Medical Plan	
Calendar Year Maximum	120 visits	
Hospice Care Benefit	Covered under Comprehensive Major Medical Plan	
Lifetime Maximum	Limited to one period of up to six consecutive months	
Hospital Benefit	Covered under Comprehensive Major Medical Plan	
Mental and Nervous Disorder Benefit	Covered under Comprehensive Major Medical Plan	
Organ Transplant Benefit	Covered under Comprehensive Major Medical Plan	
Donor Lifetime Maximum	$20,000	

Benefit Class 4 and Benefit Class 6 Employees and Dependents		
BENEFIT	**PPO COVERAGE**	**NON-PPO COVERAGE**
Orthopedic Shoes, Orthotic Inserts and Impressions Maximum (per person)	Covered under Comprehensive Major Medical Plan Up to $100 per foot per calendar year[4] The Plan will cover a second orthopedic shoe, orthotic insert or impression, or any combination, for each foot in any calendar year, with a renewed limit of $100 on the Plan's payment after applying the Calendar Year Deductible and Coinsurance provisions of the Plan.	
Physical Therapy Benefit[5] Maximums X-rays All benefits	Covered under Comprehensive Major Medical Plan $100 per Injury $75 per visit[6]	

[4] $100 is the maximum payment for the total combined cost of shoes, orthotic inserts and impressions. This coverage is only available if the shoes, inserts and impressions are ordered or prescribed by a Physician and is subject to the Calendar Year Deductible and Coinsurance provisions of the Plan.

[5] Physical Therapy must be commenced within 180 days following a covered hospitalization, accident, or onset of a covered medical condition. Services must be prescribed by a Physician and must be rendered by a licensed or registered physical therapist.

[6] Benefit is a maximum of $75 per visit before Out-of-Pocket Limit is reached. After Out-of-Pocket Limit is reached, Fund pays 100% of costs.

Benefit Class 4 and Benefit Class 6 Employees and Dependents		
BENEFIT	**PPO COVERAGE**	**NON-PPO COVERAGE**
Preventive Care Benefits	All benefits covered to the extent determined by the U.S. Preventive Care Task Force	
Routine Physical Exams	No cost to you	
Counseling[7]	No cost to you	
Screenings[8]	No cost to you	
Breastfeeding Supplies	No cost to you	
Physical Therapy/Exercise	No cost to you Adults age 65 and older	
Contraceptives	No cost to you	
Skilled Nursing Care Benefit Maximum number of days per confinement	Covered under Comprehensive Major Medical Plan 45 days	
Urgent Care	Covered under Comprehensive Major Medical Plan Subject to $40 specialist visit Copayment	

[7] Counseling services include: diet, obesity, STI, skin cancer, breast cancer chemoprevention, breastfeeding, domestic and interpersonal violence, and tobacco and other counseling services when required by the Affordable Care Act and applicable regulations.

[8] Screening services include: abnormal aortic aneurysm, alcohol misuse, blood pressure, cholesterol, depression, HIV, obesity, syphilis, anemia for pregnant women, bacteriuria, Chlamydia, gonorrhea, gestational diabetes, hepatitis B, osteoporosis, RH incompatibility, tobacco use, STI, autism, cervical dysplasia, congenital hypothyroidism, development for children, dyslipidemia, hearing in newborns, hematocrit or hemoglobin for children, hemoglobinopathies (sickle cell) for newborns, lead, oral health, PKU, and tuberculin and other screenings when required by the Affordable Care Act and applicable regulations.

Benefit Class 4 and Benefit Class 6 Employees and Dependents		
BENEFIT	**PPO COVERAGE**	**NON-PPO COVERAGE**
Prescription Drug Benefit	Benefits provided through MedImpact network	Benefits Provided outside of the MedImpact network
Out-of-Pocket Limit[9] Individual Family	$1,400 $2,800	
Participant Coinsurance/Copayment[10]		
Retail Pharmacy (Generic and Brand Name)	30% of prescription costs	35% of prescription costs[11]
Mail Order Program		
Generic	$7.50 per prescription	Not covered
Brand Name	$40 per prescription	Not covered
Specialty Drugs (90-Day Supply)	$40 per prescription, prior authorization from MedImpact is required for specialty drugs	Not covered
Dental Benefit	Benefits provided by a Dentist through a Delta Dental network	Providers not in a Delta Dental network
Deductible (per person per calendar year)	$50	
Plan Pays		
Preventive and Basic Restorative Services	90% of Covered Expenses	
Major Restorative Services	80% of Covered Expenses	

[9] Covered Expenses in excess of the Out-of-Pocket Limit will be covered at 100% for the remainder of that calendar year.

[10] Certain preventive care drugs are covered at no cost to you. Refer to the Prescription Drug Benefits section on page 68 for more information.

[11] Out-of-network prescription drug benefits will only be paid in cases where the Participant does not have reasonable access to an in-network source, as determined by the Board of Trustees at their discretion. The charges considered for out-of-network benefits are limited to Reasonable and Customary Charges.

Benefit Class 4 and Benefit Class 6 Employees and Dependents		
BENEFIT	**PPO COVERAGE**	**NON-PPO COVERAGE**
Calendar Year Maximum (per person) Orthodontic Care (Dependent Children only) Plan Pays Lifetime Maximum (per person)	$2,500 (does not apply to pediatric dental care under age 18) 70% of Covered Expenses after meeting Deductible $2,000	
Vision Benefit[12]	Benefits provided by a provider through the VSP network	Providers not in the VSP network
Exam	Covered once per calendar year at 100%. No Copayment.	Up to $45 allowance Every calendar year
Frame	$200 allowance for a specific selection of frames $220 allowance for featured frame brands 20% discount on the amount over your allowance $110 Costco® frame allowance Once every even numbered calendar year	Up to $70 allowance Once every even numbered calendar year

[12] Dependent spouses are permitted to apply the $200 Vision Benefit to refractive surgery.[1] Emergency Services provided by an Emergency Services Provider will all be paid at the PPO Coverage level of benefits and will be subject to the PPO Coverage Calendar Year Deductible and Out-of-Pocket Limit regardless of whether care is provided by a PPO provider or non-PPO provider.

Benefit Class 4 and Benefit Class 6 Employees and Dependents		
BENEFIT	**PPO COVERAGE**	**NON-PPO COVERAGE**
Lenses	Single vision, lined bifocal, and lined trifocal lenses Polycarbonate lenses for Dependent Children Progressive lenses at no cost Every calendar year	Single vision lenses up to $30 allowance Progressive lenses up to $50 allowance Lined bifocal lenses up to $50 allowance Lined trifocal lenses up to $65 allowance Anti-reflective coating with $25 copayment Every calendar year
Contacts (Instead of Glasses)	$200 allowance for contacts and contact lens exam (fitting and evaluation) 15% discount on a contact lens exam (fitting and evaluation) Every calendar year	Up to $105 allowance Every calendar year
Diabetic Eyecare Plus Program	Services related to diabetic eye disease, glaucoma and age-related macular degeneration (AMD). Retinal screening for eligible Participants with diabetes. Limitations and coordination with medical coverage may apply. $20 Copayment	Not Covered

Benefit Class 4 and Benefit Class 6 Employees and Dependents		
BENEFIT	**PPO COVERAGE**	**NON-PPO COVERAGE**
Laser VisionCare Preferred Program	$500 allowance per eye for LASIK, Custom LASIK, and PRK $250 allowance per eye for Dependents 18 and older for LASIK, Custom LASIK, and PRK Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities One per lifetime	Not Covered
Additional Glasses and Sunglasses	20% discount on additional glasses and sunglasses, including lens enhancements, from any VSP provider within 12 months following the last WellVision Exam.	Not Applicable
Retinal Screening	No more than a $39 Copayment on routine retinal screening as an enhancement to a WellVision Exam	Not Applicable

SCHEDULE OF BENEFITS
RETIREES NOT ELIGIBLE FOR MEDICARE – PLAN A

NOTE: If you fail to contact the Utilization Review Service within a timely manner prior to a Hospital admission, other than in cases of Hospital admissions immediately following receipt of Emergency Services from an Emergency Services Provider, benefits otherwise payable will be reduced by $300.

Retired Employees Not Eligible for Medicare – Plan A Retired Employees Only	
BENEFIT	**COVERAGE**
Death Benefit	$6,000
Accidental Death and Dismemberment Benefit	Up to $4,000
Refractive Surgery (Refer to Article XIII) Lifetime Maximum	 $500 per eye

Retired Employees Not Eligible for Medicare – Plan A Retired Employees and Dependents		
BENEFIT	**PPO COVERAGE**	**NON-PPO COVERAGE**
Comprehensive Major Medical Plan	Benefits provided through the Anthem BlueCross BlueShield network	Providers not in the Anthem BlueCross BlueShield network
Calendar Year Deductible[1] Individual Family	 $300 $600	
Out-of-Pocket Limit[2] Individual Family	 $3,300 $9,600	
Coinsurance Plan Pays	 85% of Covered Expenses	 55% of Covered Expenses[3]
Office Visit Copayment	$20 per primary care visit, $40 per specialist visit	

[1] Emergency Services provided by an Emergency Services Provider will all be paid at the PPO Coverage level of benefits and will be subject to the PPO Coverage Calendar Year Deductible and Out-of-Pocket Limit regardless of whether care is provided by a PPO provider or non-PPO provider.

[2] Covered Expenses in excess of the Out-of-Pocket Limit will be covered at 100% for the remainder of that calendar year. These limits do not include Copayments, the Chiropractic Benefit or x-rays under the Physical Therapy Benefit; however, in no event will the Out-of-Pocket Limit for all covered essential health benefits (including Copayments, the Chiropractic Benefit and x-rays under the Physical Therapy Benefit) exceed $6,350 per individual and $12,700 per family.

[3] If a PPO provider is not available within a 30-mile radius of a Participant's residence, the coverage for a non-PPO provider within this area will be 70%.

Retired Employees Not Eligible for Medicare – Plan A Retired Employees and Dependents		
BENEFIT	**PPO COVERAGE**	**NON-PPO COVERAGE**
Lifetime Maximum for Non-Essential Benefits (per person)	$600,000	
Alcoholism, Chemical Dependency and Drug Addiction Consultation Benefit – Inpatient and Outpatient	Covered under Comprehensive Major Medical Plan	
Chiropractic Benefit	Covered under Comprehensive Major Medical Plan	
Plan Pays	50% of Covered Expenses	40% of Covered Expenses
Maximums		
X-rays	$100 per treatable condition	$100 per treatable condition
All benefits	26 visits per calendar year	26 visits per calendar year
Emergency Room	Covered under Comprehensive Major Medical Plan	Same as PPO Coverage for Emergency Room
Participant Copayment	$150 (waived if admitted)	$150 (waived if admitted)
Hearing Aid Benefit	Covered under Comprehensive Major Medical Plan	
Maximums (per person)		
Routine Exam (per two-calendar year period)	$50	
Instrument (per five-calendar year period)	$500 per ear	
Home Health Care Benefit	Covered under Comprehensive Major Medical Plan	
Calendar Year Maximum	120 visits	
Hospice Care Benefit	Covered under Comprehensive Major Medical Plan	
Lifetime Maximum	Limited to one period of up to six consecutive months	
Hospital Benefit	Covered under Comprehensive Major Medical Plan	
Mental and Nervous Disorder Benefit	Covered under Comprehensive Major Medical Plan	
Organ Transplant Benefit	Covered under Comprehensive Major Medical Plan	
Donor Lifetime Maximum	$20,000	
Orthopedic Shoes, Orthotic Inserts and Impressions	Covered under Comprehensive Major Medical Plan	
Maximum (per person)	Up to $100 per foot per calendar year[4]	

[4] $100 is the maximum payment for the total combined cost of shoes, orthotic inserts and impressions. This coverage is only available if the shoes, inserts and impressions are ordered or prescribed by a Physician and is subject to the Calendar Year Deductible and Coinsurance provisions of the Plan.

Retired Employees Not Eligible for Medicare – Plan A Retired Employees and Dependents		
BENEFIT	**PPO COVERAGE**	**NON-PPO COVERAGE**
	The Plan will cover a second orthopedic shoe, orthotic insert or impression, or any combination, for each foot in any calendar year, with a renewed limit of $100 on the Plan's payment after applying the Calendar Year Deductible and Coinsurance provisions of the Plan	
Physical Therapy Benefit[5] Maximums X-rays All benefits	Covered under Comprehensive Major Medical Plan $100 per Injury $75 per visit[6]	
Preventive Care Benefits Routine Physical Exams Counseling[7] Screenings[8] Breastfeeding Supplies Physical Therapy/Exercise Contraceptives	All benefits covered to the extent determined by the U.S. Preventive Care Task Force No cost to you No cost to you No cost to you No cost to you No cost to you Adults age 65 and older No cost to you	
Skilled Nursing Care Benefit Maximum number of days per confinement	Covered under Comprehensive Major Medical Plan 45 days	

[5] Physical Therapy must be commenced within 180 days following a covered hospitalization, accident, or onset of a covered medical condition. Services must be prescribed by a Physician and must be rendered by a licensed or registered physical therapist.

[6] Benefit is a maximum of $75 per visit before Out-of-Pocket Limit is reached. After Out-of-Pocket Limit is reached, Fund pays 100% of costs.

[7] Counseling services include: diet, obesity, STI, skin cancer, breast cancer chemoprevention, breastfeeding, domestic and interpersonal violence, and tobacco and other counseling services when required by the Affordable Care Act and applicable regulations.

[8] Screening services include: abnormal aortic aneurysm, alcohol misuse, blood pressure, cholesterol, depression, HIV, obesity, syphilis, anemia for pregnant women, bacteriuria, Chlamydia, gonorrhea, gestational diabetes, hepatitis B, osteoporosis, RH incompatibility, tobacco use, STI, autism, cervical dysplasia, congenital hypothyroidism, development for children, dyslipidemia, hearing in newborns, hematocrit or hemoglobin for children, hemoglobinopathies (sickle cell) for newborns, lead, oral health, PKU, and tuberculin and other screenings when required by the Affordable Care Act and applicable regulations.

Retired Employees Not Eligible for Medicare – Plan A Retired Employees and Dependents		
BENEFIT	**PPO COVERAGE**	**NON-PPO COVERAGE**
Urgent Care	Covered under Comprehensive Major Medical Plan Subject to $40 specialist visit Copayment	
Prescription Drug Benefit	Benefits provided through MedImpact network	Benefits provided outside of the MedImpact network
Out-of-Pocket Limit[9] Individual Family	$1,200 $2,400	
Participant Coinsurance/Copayment[10] Retail Pharmacy (Generic and Brand Name) Mail Order Program Generic Brand Name Specialty Drugs (90-Day Supply)	30% of prescription costs $7.50 per prescription $40 per prescription $40 per prescription, prior authorization from MedImpact is required for specialty drugs	35% of prescription costs[11] Not covered Not covered Not covered
Dental Benefit[12]	Benefits provided by a Dentist through a Delta Dental network	Providers not in a Delta Dental network
Deductible (per person per Calendar Year)	$50	
Plan Pays Preventive and Basic Restorative Services	90% of Covered Expenses	
Major Restorative Services	80% of Covered Expenses	

[9] Covered Expenses in excess of the Out-of-Pocket Limit will be covered at 100% for the remainder of that calendar year.

[10] Certain preventive care drugs are covered at no cost to you. Refer to the Prescription Drug Benefits section on page 68 for more information.

[11] Out-of-network prescription drug benefits will only be paid in cases where the Participant does not have reasonable access to an in-network source, as determined by the Board of Trustees at their discretion. The charges considered for out-of-network benefits are limited to Reasonable and Customary Charges.

[12] Orthodontic care is not available for this Benefit Class of Employees and Dependents.

Retired Employees Not Eligible for Medicare – Plan A Retired Employees and Dependents		
BENEFIT	**PPO COVERAGE**	**NON-PPO COVERAGE**
Calendar Year Maximum (per person)	$1,000 (does not apply to pediatric dental care under age 18)	
Vision Benefit	Benefits provided by a provider through the VSP network	Providers not in the VSP network
Exam	Covered once per calendar year at 100%. No Copayment.	Up to $45 allowance Every calendar year
Frame	$150 allowance for a specific selection of frames $170 allowance for featured frame brands 20% discount on the amount over your allowance $80 Costco® frame allowance Once every even numbered calendar year	Up to $70 allowance Once every even numbered calendar year
Lenses	Single vision, lined bifocal, and lined trifocal lenses Polycarbonate lenses for Dependent Children Progressive lenses at no cost Every calendar year	Single vision lenses up to $30 allowance Progressive lenses up to $50 allowance Lined bifocal lenses up to $50 allowance Lined trifocal lenses up to $65 allowance Anti-reflective coating with a $25 copayment Every calendar year
Contacts (instead of glasses)	$150 allowance for contacts and contact lens exam (fitting and evaluation) 15% discount on a contact lens exam (fitting and evaluation) Every calendar year	Up to $105 allowance Every calendar year

Retired Employees Not Eligible for Medicare – Plan A Retired Employees and Dependents		
BENEFIT	**PPO COVERAGE**	**NON-PPO COVERAGE**
Diabetic Eyecare Plus Program	Services related to diabetic eye disease, glaucoma and age-related macular degeneration (AMD). Retinal screening for eligible Participants with diabetes. Limitations and coordination with medical coverage may apply. $20 Copayment	Not Covered
Laser VisionCare Preferred Program	$500 allowance per eye for LASIK, Custom LASIK, and PRK $250 allowance per eye for Dependents 18 and older for LASIK, Custom LASIK, and PRK Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities One per Lifetime	Not Covered
Additional Glasses and Sunglasses	20% discount on additional glasses and sunglasses, including lens enhancements, from any VSP provider within 12 months following the last WellVision Exam.	Not Applicable
Retinal Screening	No more than a $39 Copayment on routine retinal screening as an enhancement to a WellVision Exam	Not Applicable

SCHEDULE OF BENEFITS
RETIREES NOT ELIGIBLE FOR MEDICARE – PLAN B

NOTE: If you fail to contact the Utilization Review Service within a timely manner prior to a Hospital admission, other than in cases of Hospital admissions immediately following receipt of Emergency Services from an Emergency Services Provider, benefits otherwise payable will be reduced by $300.

Retired Employees Not Eligible for Medicare – Plan B Retired Employees Only	
BENEFIT	**COVERAGE**
Death Benefit	Not covered
Accidental Death and Dismemberment Benefit	Not covered

Retired Employees Not Eligible for Medicare – Plan B Retired Employees and Dependents		
BENEFIT	**PPO COVERAGE**	**NON-PPO COVERAGE**
Comprehensive Major Medical Plan	Benefits provided through the Anthem BlueCross BlueShield network	Providers not in the Anthem BlueCross BlueShield network
Calendar Year Deductible[1] Individual Family	$300 $600	
Out-of-Pocket Limit[2] Individual Family	$5,650 $11,300	
Coinsurance Plan Pays	75% of Covered Expenses	45% of Covered Expenses[3]
Office Visit Copayment	$20 per primary care visit, $40 per specialist visit	
Lifetime Maximum for Non-Essential Benefits (per person)	$400,000	

[1] Emergency Services provided by an Emergency Services Provider will all be paid at the PPO Coverage level of benefits and will be subject to the PPO Coverage Calendar Year Deductible and Out-of-Pocket Limit regardless of whether care is provided by a PPO provider or non-PPO provider.

[2] Covered Expenses in excess of the Out-of-Pocket Limit will be covered at 100% for the remainder of that calendar year. These limits do not include Copayments, the Chiropractic Benefit or x-rays under the Physical Therapy Benefit; however, in no event will the Out-of-Pocket Limit for all covered essential health benefits (including Copayments, the Chiropractic Benefit and x-rays under the Physical Therapy Benefit) exceed $6,350 per individual and $12,700 per family.

[3] If a PPO provider is not available within a 30-mile radius of a Participant's residence, the coverage for a non-PPO provider within this area will be 60%.

Retired Employees Not Eligible for Medicare – Plan B Retired Employees and Dependents		
BENEFIT	**PPO COVERAGE**	**NON-PPO COVERAGE**
Alcoholism, Chemical Dependency and Drug Addiction Consultation Benefit – Inpatient and Outpatient	Covered under Comprehensive Major Medical Plan	
Chiropractic Benefit	Covered under Comprehensive Major Medical Plan	
Plan Pays	50% of Covered Expenses	40% of Covered Expenses
Maximums		
X-rays	$100 per treatable condition	$100 per treatable condition
All benefits	26 visits per calendar year	26 visits per calendar year
Emergency Room	Covered under Comprehensive Major Medical Plan	Same as PPO Coverage for Emergency Room
Participant Copayment	$150 (waived if admitted)	$150 (waived if admitted)
Hearing Aid Benefit	Not covered	
Home Health Care Benefit Calendar Year Maximum	Covered under Comprehensive Major Medical Plan 120 visits	
Hospice Care Benefit Lifetime Maximum	Covered under Comprehensive Major Medical Plan Limited to one period of up to six consecutive months	
Hospital Benefit	Covered under Comprehensive Major Medical Plan	
Mental and Nervous Disorder Benefit	Covered under Comprehensive Major Medical Plan	
Organ Transplant Benefit Donor Lifetime Maximum	Covered under Comprehensive Major Medical Plan $20,000	
Orthopedic Shoes, Orthotic Inserts and Impressions Maximum (per person)	Covered under Comprehensive Major Medical Plan Up to $100 per foot per calendar year[4] The Plan will cover a second orthopedic shoe, orthotic insert or impression, or any combination, for each foot in any calendar year, with a renewed limit of $100 on the Plan's payment after applying the Calendar Year Deductible and Coinsurance provisions of the Plan	
Physical Therapy Benefit[5]	Covered under Comprehensive Major Medical Plan	

[4] $100 is the maximum payment for the total combined cost of shoes, orthotic inserts and impressions. This coverage is only available if the shoes, inserts and impressions are ordered or prescribed by a Physician and is subject to the Calendar Year Deductible and Coinsurance provisions of the Plan.

[5] Physical Therapy must be commenced within 180 days following a covered hospitalization, accident, or onset of a covered medical condition. Services must be prescribed by a Physician and must be rendered by a licensed or registered physical therapist.

Retired Employees Not Eligible for Medicare – Plan B Retired Employees and Dependents		
BENEFIT	**PPO COVERAGE**	**NON-PPO COVERAGE**
Maximums X-rays All benefits	 $100 per Injury $75 per visit[6]	
Preventive Care Benefits	All benefits covered to the extent determined by the U.S. Preventive Care Task Force	
Routine Physical Exams	No cost to you	
Counseling[7]	No cost to you	
Screenings[8]	No cost to you	
Breastfeeding Supplies	No cost to you	
Physical Therapy/Exercise	No cost to you Adults age 65 and older	
Contraceptives	No cost to you	
Skilled Nursing Care Benefit Maximum number of days per confinement	Covered under Comprehensive Major Medical Plan 45 days	
Urgent Care	Covered under Comprehensive Major Medical Plan Subject to $40 specialist visit Copayment	

[6] Benefit is a maximum of $75 per visit before Out-of-Pocket Limit is reached. After Out-of-Pocket Limit is reached, Fund pays 100% of costs.

[7] Counseling services include: diet, obesity, STI, skin cancer, breast cancer chemoprevention, breastfeeding, domestic and interpersonal violence, and tobacco and other counseling services when required by the Affordable Care Act and applicable regulations.

[8] Screening services include: abnormal aortic aneurysm, alcohol misuse, blood pressure, cholesterol, depression, HIV, obesity, syphilis, anemia for pregnant women, bacteriuria, Chlamydia, gonorrhea, gestational diabetes, hepatitis B, osteoporosis, RH incompatibility, tobacco use, STI, autism, cervical dysplasia, congenital hypothyroidism, development for children, dyslipidemia, hearing in newborns, hematocrit or hemoglobin for children, hemoglobinopathies (sickle cell) for newborns, lead, oral health, PKU, and tuberculin and other screenings when required by the Affordable Care Act and applicable regulations.

Retired Employees Not Eligible for Medicare – Plan B Retired Employees and Dependents		
BENEFIT	**PPO COVERAGE**	**NON-PPO COVERAGE**
Prescription Drug Benefit	Benefits provided through MedImpact network	Benefits provided outside of the MedImpact network
Out-of-Pocket Limit[9] Individual Family	$950 $1,900	
Participant Copayment[10]		
Retail Pharmacy (Generic and Brand Name)	30% of prescription costs	35% of prescription costs[11]
Mail Order Program Generic Brand Name	 $7.50 per prescription $40 per prescription	 Not covered Not covered
Specialty Drugs (90-Day Supply)	$40 per prescription, prior authorization from MedImpact is required for specialty drugs	Not covered
Dental Benefit	Not covered	
Vision Benefit	Not covered	

[9] Covered Expenses in excess of the Out-of-Pocket Limit will be covered at 100% for the remainder of that calendar year.

[10] Certain preventive care drugs are covered at no cost to you. Refer to the Prescription Drug Benefits section on page 68 for more information.

[11] Out-of-network prescription drug benefits will only be paid in cases where the Participant does not have reasonable access to an in-network source, as determined by the Board of Trustees at their discretion. The charges considered for out-of-network benefits are limited to Reasonable and Customary Charges.

SCHEDULE OF BENEFITS
RETIREES AND DEPENDENTS ELIGIBLE FOR MEDICARE

NOTE: The following benefits are insured through Anthem BlueCross BlueShield. The benefits shown are as of August 1, 2020 and are subject to annual changes based on changes in Medicare.

Retired Employees-Medicare Preferred PPO Plan Medicare Eligible Retirees and their Medicare Eligible Dependents		
	What you pay for these covered services	
COVERED SERVICE	**IN-NETWORK**	**OUT-OF-NETWORK**
Doctor and hospital choice You may go to doctors, specialists, and hospitals in or out of the network. You do not need a referral.		
Prior Authorization Benefit categories that include services that require prior authorization are marked with an asterisk (*). Additional information can be found on the last page of the medical benefits chart		
Annual Deductible The deductible applies to covered services as noted within each category below, prior to the copay or coinsurance, if any, being applied	$0 Combined in-network and out-of-network	
Inpatient Services		
Inpatient hospital care* Includes inpatient acute, inpatient rehabilitation, long-term care hospitals, and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day. Covered services include but are not limited to: • Semi-private room (or a private room if medically necessary) • Meals, including special diets • Regular nursing services • Costs of special care units (such as intensive or coronary care units) • Drugs and medications • Lab tests	For Medicare–covered hospital stays: $0 copay per Admission No limit to the number of days covered by the plan. $0 copay for Medicare-covered physician services received while an inpatient during a Medicare-covered hospital stay	For Medicare–covered hospital stays: $0 copay per Admission No limit to the number of days covered by the plan. $0 copay for Medicare-covered physician services received while an inpatient during a Medicare-covered hospital stay If you receive authorized inpatient

Retired Employees-Medicare Preferred PPO Plan Medicare Eligible Retirees and their Medicare Eligible Dependents		
	What you pay for these covered services	
COVERED SERVICE	**IN-NETWORK**	**OUT-OF-NETWORK**
• X-rays and other radiology services • Necessary surgical and medical supplies • Use of appliances, such as wheelchairs • Operating and recovery room costs • Physical therapy, occupational therapy, and speech language therapy • Inpatient substance abuse services • Inpatient dialysis treatments (if you are admitted as an inpatient to a hospital for special care) • Physician services In-network providers should notify Anthem within one business day of any planned, and if possible, unplanned admissions or transfers, including to or from a hospital, skilled nursing facility, long term acute care hospital, or acute rehabilitation center. **Note**: To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you are not sure if you are an inpatient, you should ask the hospital staff.		care at an out-of-network hospital after your emergency condition is stabilized, your cost is the cost sharing you would pay at an in-network hospital
Inpatient mental health care* Covered services include mental health care services that require a hospital stay in a psychiatric hospital or the psychiatric unit of a general hospital. In-network providers should notify Anthem within one business day of any planned, and if possible unplanned admissions or transfers, including to or from a hospital, skilled nursing facility, long term acute care hospital, or acute rehabilitation center.	For Medicare–covered hospital stays: $0 copay per Admission No limit to the number of days covered by the plan. $0 copay for Medicare-covered physician services received while	For Medicare–covered hospital stays: $0 copay per Admission No limit to the number of days covered by the plan. $0 copay for Medicare-covered physician services received while

Retired Employees-Medicare Preferred PPO Plan Medicare Eligible Retirees and their Medicare Eligible Dependents		
	What you pay for these covered services	
COVERED SERVICE	**IN-NETWORK**	**OUT-OF-NETWORK**
	an inpatient during a Medicare-covered hospital stay	an inpatient during a Medicare-covered hospital stay
Skilled nursing facility (SNF) care* Inpatient skilled nursing facility (SNF) coverage is limited to 100 days each benefit period. A "benefit period" begins on the first day you go to a Medicare-covered inpatient hospital or a SNF. The benefit period ends when you have not been an inpatient at any hospital or SNF for 60 days in a row.	For Medicare covered SNF stays: $0 copay for days 1-100 per benefit period No prior hospital stay required.	For Medicare covered SNF stays: $0 copay for days 1-100 per benefit period No prior hospital stay required.
Inpatient services covered when the hospital or SNF days are not covered or are no longer covered* If you have exhausted your inpatient benefits or if the inpatient stay is not reasonable and necessary, Anthem will not cover your inpatient stay. However, in some cases, Anthem will cover certain services you receive while you are in the hospital or a skilled nursing facility (SNF).	After your SNF day limits are used up, this plan will still pay for covered physician services and other medical services outlined in this benefits chart at the cost share amounts indicated.	
Home health agency care* Prior to receiving home health services, a doctor must certify that you need home health services and will order home health services to be provided by a home health agency. You must be homebound, which means leaving home is a major effort.	$0 copay for Medicare-covered home health visits Durable Medical Equipment (DME) copay or coinsurance, if any, may apply.	$0 copay for Medicare-covered home health visits Durable Medical Equipment (DME) copay or coinsurance, if any, may apply.
Hospice care You may receive care from any Medicare-certified hospice program. You are eligible for the hospice benefit when your doctor and the hospice medical director have given you a terminal prognosis certifying that you're terminally ill and have six months or less to live if your illness runs its normal course. Your hospice doctor can be an in-network provider or an out-of-network provider.	You must receive care from a Medicare-certified hospice. When you enroll in a Medicare certified hospice program, your hospice services and your Part A and B services are paid for by Original Medicare, not this plan.	You must receive care from a Medicare-certified hospice. When you enroll in a Medicare certified hospice program, your hospice services and your Part A and B services are paid for by Original Medicare, not this plan.

Retired Employees-Medicare Preferred PPO Plan Medicare Eligible Retirees and their Medicare Eligible Dependents		
	What you pay for these covered services	
COVERED SERVICE	**IN-NETWORK**	**OUT-OF-NETWORK**
<u>For hospice services and for services that are covered by Medicare Part A or B and are related to your terminal prognosis:</u> Original Medicare (rather than this plan) will pay for your hospice services and any Part A and Part B services related to your terminal prognosis. While you are in the hospice program, your hospice provider will bill Medicare for the services that Original Medicare pays for.	$0 copay for the one time only hospice consultation	$0 copay for the one time only hospice consultation
Physician services, including doctor's office visits* Covered services include: • Office visits, including medical and surgical services in a physician's office • Consultation, diagnosis, and treatment by a specialist • Retail health clinics • Basic diagnostic hearing and balance exams, if your doctor orders it to see if you need medical treatment, when furnished by a physician, audiologist, or other qualified provider • Telehealth services for some physician or mental health services can be found in the section of this benefit chart titled, Video Doctor Visits. You have the option of receiving these services either through an in-person visit or via telehealth. If you choose to receive one of these services via telehealth, then you must use a network provider that has an agreement with Anthem to provide telehealth services. • Certain telehealth services including consultation, diagnosis, and treatment by a physician or practitioner for patients in certain rural areas or other locations approved by Medicare	$0 copay per visit to an in-network Primary Care Physician (PCP) for Medicare-covered services $0 copay per visit to an in-network specialist for Medicare-covered services $0 copay per visit to an in-network retail health clinic for Medicare covered services $0 copay for Medicare-covered allergy testing $0 copay for Medicare-covered allergy injections See antigen cost share in Part B drug section.	$0 copay per visit to an out-of-network Primary Care Physician (PCP) for Medicare covered services $0 copay per visit to an out-of-network specialist for Medicare covered services $0 copay per visit to an out-of-network retail health clinic for Medicare-covered services $0 copay for Medicare-covered allergy testing $0 copay for Medicare-covered allergy injections See antigen cost share in Part B drug section.
Chiropractic services Anthem only covers manual manipulation of the spine to correct subluxation.	$0 copay for each Medicare-covered visit	$0 copay for each Medicare-covered visit

Retired Employees-Medicare Preferred PPO Plan Medicare Eligible Retirees and their Medicare Eligible Dependents		
	What you pay for these covered services	
COVERED SERVICE	**IN-NETWORK**	**OUT-OF-NETWORK**
Podiatry services* Covered services include: • Diagnosis and the medical or surgical treatment of injuries and disease of the feet (such as hammer toe or heel spurs) in an office setting • Medicare-covered routine foot care for members with certain medical conditions affecting the lower limbs • A foot exam covered every six months for people with diabetic peripheral neuropathy and loss of protective sensations	$0 copay for each Medicare-covered visit	$0 copay for each Medicare-covered visit
Outpatient mental health care, including partial hospitalization services* Covered services include: • Mental health services provided by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other Medicare qualified mental health care professional as allowed under applicable state laws "Partial hospitalization" is a structured program of active psychiatric treatment provided as a hospital outpatient service that is more intense than the care received in your doctor's or therapist's office and is an alternative to inpatient hospitalization.	$0 copay for each Medicare-covered professional individual therapy visit $0 copay for each Medicare-covered professional group therapy visit $0 copay for each Medicare-covered professional partial hospitalization visit $0 copay for each Medicare-covered outpatient hospital facility individual therapy visit $0 copay for each Medicare-covered outpatient hospital facility group therapy visit $0 copay for each Medicare-covered	$0 copay for each Medicare-covered professional individual therapy visit $0 copay for each Medicare-covered professional group therapy visit $0 copay for each Medicare-covered professional partial hospitalization visit $0 copay for each Medicare-covered outpatient hospital facility individual therapy visit $0 copay for each Medicare-covered outpatient hospital facility group therapy visit $0 copay for each Medicare-covered

Retired Employees-Medicare Preferred PPO Plan Medicare Eligible Retirees and their Medicare Eligible Dependents		
	What you pay for these covered services	
COVERED SERVICE	**IN-NETWORK**	**OUT-OF-NETWORK**
	partial hospitalization facility visit	partial hospitalization facility visit
Outpatient substance abuse services, including partial hospitalization services* "Partial hospitalization" is a structured program of active psychiatric treatment provided as a hospital outpatient service that is more intense than the care received in your doctor's or therapist's office and is an alternative to inpatient hospitalization.	$0 copay for each Medicare-covered professional individual therapy visit $0 copay for each Medicare-covered professional group therapy visit $0 copay for each Medicare-covered professional partial hospitalization visit $0 copay for each Medicare-covered outpatient hospital facility individual therapy visit $0 copay for each Medicare-covered outpatient hospital facility group therapy visit $0 copay for each Medicare-covered partial hospitalization facility visit	$0 copay for each Medicare-covered professional individual therapy visit $0 copay for each Medicare-covered professional group therapy visit $0 copay for each Medicare-covered professional partial hospitalization visit $0 copay for each Medicare-covered outpatient hospital facility individual therapy visit $0 copay for each Medicare-covered outpatient hospital facility group therapy visit $0 copay for each Medicare-covered partial hospitalization facility visit
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers* Facilities where surgical procedures are performed and the patient is released the same day.	$0 copay for each Medicare-covered outpatient hospital facility or ambulatory surgical center visit for surgery $0 copay for each Medicare-covered	$0 copay for each Medicare-covered outpatient hospital facility or ambulatory surgical center visit for surgery $0 copay for each Medicare-covered

Retired Employees-Medicare Preferred PPO Plan Medicare Eligible Retirees and their Medicare Eligible Dependents		
	What you pay for these covered services	
COVERED SERVICE	**IN-NETWORK**	**OUT-OF-NETWORK**
Note: If you are having surgery in a hospital, you should check with your provider about whether you will be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient surgery. Even if you stay in the hospital overnight, you might still be considered an "outpatient."	outpatient observation room visit	outpatient observation room visit
Ambulance services • Covered ambulance services include fixed wing, rotary wing, water, and ground ambulance services, to the nearest appropriate facility that can provide care only if the services are furnished to a member whose medical condition is such that other means of transportation could endanger the person's health or if authorized by the plan. • Nonemergency transportation by ambulance is appropriate if it is documented that the member's condition is such that other means of transportation could endanger the person's health and that transportation by ambulance is medically required. • Ambulance service is not covered for physician office visits.	Your provider must get an approval from the plan before you get ground, air, or water transportation that is not an emergency. $0 copay per one-way trip for Medicare-covered ambulance services	
Emergency care Emergency care refers to services that are: • Furnished by a provider qualified to furnish emergency services, and • Needed to evaluate or stabilize an emergency medical condition. Emergency outpatient copay is waived if the member is admitted to the hospital within 72 hours for the same condition.	$0 copay for each Medicare-covered emergency room visit	

Retired Employees-Medicare Preferred PPO Plan Medicare Eligible Retirees and their Medicare Eligible Dependents		
	What you pay for these covered services	
COVERED SERVICE	**IN-NETWORK**	**OUT-OF-NETWORK**
A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life, loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse. This coverage is worldwide and is limited to what is allowed under the Medicare fee schedule for the services performed/received in the United States. Cost-sharing for necessary emergency services furnished out-of-network is the same as for such services furnished in-network. If you receive authorized inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the cost-sharing you would pay at an in-network hospital.		
Urgently needed services • Urgently needed services are available on a worldwide basis. The urgently needed services copay is waived if the member is admitted to the hospital within 72 hours for the same condition. If you are outside of the service area for your plan, your plan covers urgently needed services, including urgently required renal dialysis. Urgently needed services are services provided to treat a nonemergency, unforeseen medical illness, injury, or condition that requires immediate medical care. Urgently needed services may be	$0 copay for each Medicare-covered urgently needed care visit	

Retired Employees-Medicare Preferred PPO Plan Medicare Eligible Retirees and their Medicare Eligible Dependents		
	What you pay for these covered services	
COVERED SERVICE	**IN-NETWORK**	**OUT-OF-NETWORK**
furnished by in-network providers or by out-of-network providers when in-network providers are temporarily unavailable or inaccessible. Cost-sharing for necessary urgently needed services furnished out-of-network is the same as for such services furnished in-network. Generally, however, if you are in the plan's service area and your health is not in serious danger, you should obtain care from an in-network provider.		
Outpatient rehabilitation services* Covered services include: physical therapy, occupational therapy, and speech language therapy. Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs).	$0 copay for Medicare-covered physical therapy, occupational therapy, and speech language therapy visits	$0 copay for Medicare-covered physical therapy, occupational therapy, and speech language therapy visits
Durable medical equipment (DME) and related supplies* Covered items include, but are not limited to: wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital bed ordered by a provider for use at home, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, and walkers. Copay or coinsurance only applies when you are not currently receiving inpatient care. If you are receiving inpatient care your DME will be included in the copay or coinsurance for those services. Anthem covers all medically necessary durable medical equipment covered by Original Medicare. If the Anthem supplier in your area does not carry a particular brand or manufacturer, you may ask them if they can special order it for you.	$0 copay for Medicare-covered DME	$0 copay for Medicare-covered DME

Retired Employees-Medicare Preferred PPO Plan Medicare Eligible Retirees and their Medicare Eligible Dependents		
	What you pay for these covered services	
COVERED SERVICE	**IN-NETWORK**	**OUT-OF-NETWORK**
Outpatient diagnostic tests and therapeutic services and supplies* Covered services include, but are not limited to: • X-rays • Complex diagnostic tests and radiology services • Radiation (radium and isotope) therapy, including technician materials and supplies • Testing to confirm chronic obstructive pulmonary disease (COPD) • Surgical supplies, such as dressings • Splints, casts, and other devices used to reduce fractures and dislocations • Laboratory tests • Blood – including storage and administration. Coverage of whole blood, packed red cells, and all other components of blood begins with the first pint • Other outpatient diagnostic tests Certain diagnostic tests and radiology services are considered complex and include heart catheterizations, sleep studies, computed tomography (CT), magnetic resonance procedures (MRIs and MRAs), and nuclear medicine studies, which includes PET scans.	$0 copay for each Medicare-covered X-ray visit and/or simple diagnostic test $0 copay for Medicare-covered complex diagnostic test and/or radiology visit $0 copay for each Medicare-covered radiation therapy treatment $0 copay for Medicare-covered testing to confirm chronic obstructive pulmonary disease $0 copay for Medicare-covered supplies $0 copay for each Medicare-covered clinical/diagnostic lab test $0 copay per Medicare-covered pint of blood	$0 copay for each Medicare-covered X-ray visit and/or simple diagnostic test $0 copay for Medicare-covered complex diagnostic test and/or radiology visit $0 copay for each Medicare-covered radiation therapy treatment $0 copay for Medicare-covered testing to confirm chronic obstructive pulmonary disease $0 copay for Medicare-covered supplies $0 copay for each Medicare-covered clinical/diagnostic lab test $0 copay per Medicare-covered pint of blood
Vision care (non-routine) Covered services include: • Outpatient physician services for the diagnosis and treatment of diseases and injuries of the eye, including treatment for age-related macular degeneration. • For people who are at high risk of glaucoma, we will cover one glaucoma screening each year. People at high risk of glaucoma include: people with a family history of glaucoma, people	$0 copay for visits to an in-network primary care physician for Medicare-covered exams to diagnose and treat diseases of the eye $0 copay for visits to an in-network specialist for Medicare-covered	$0 copay for visits to an out-of-network primary care physician for Medicare-covered exams to diagnose and treat diseases of the eye $0 copay for visits to an out-of-network specialist for Medicare-covered exams to

Retired Employees-Medicare Preferred PPO Plan Medicare Eligible Retirees and their Medicare Eligible Dependents		
	What you pay for these covered services	
COVERED SERVICE	**IN-NETWORK**	**OUT-OF-NETWORK**
with diabetes, African-Americans who are age 50 and older, and Hispanic-Americans who are age 65 or older. • For people with diabetes, screening for diabetic retinopathy is covered once per year. • One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. (If you have two separate cataract operations, you cannot reserve the benefit after the first surgery and purchase two eyeglasses after the second surgery.)	exams to diagnose and treat diseases of the eye $0 copay for Medicare-covered glaucoma screening $0 copay for Medicare-covered diabetic retinopathy screening $0 copay for glasses/contacts following Medicare covered cataract surgery	diagnose and treat diseases of the eye $0 copay for Medicare-covered glaucoma screening $0 copay for Medicare-covered diabetic retinopathy screening $0 copay for glasses/contacts following Medicare covered cataract surgery
Medicare Part B prescription drugs covered under your medical plan (Part B drugs)* These drugs are covered under Part B of Original Medicare. Members in this Anthem plan receive coverage for these drugs through the Anthem plan. Covered drugs include: • "Drugs" include substances that are naturally present in the body, such as blood clotting factors • Drugs that usually are not self-administered by the patient and are injected or infused while receiving physician, hospital outpatient, or ambulatory surgical center services. This drug category may be subject to step therapy. • Drugs you take using durable medical equipment (such as nebulizers) that was authorized by the plan • Clotting factors you give yourself by injection if you have hemophilia	$0 copay for Medicare-covered Part B drugs $0 copay for Medicare-covered Part B drug Administration $0 copay for Medicare-covered Part B chemotherapy drugs $0 copay for Medicare-covered Part B chemotherapy drug administration	$0 copay for Medicare-covered Part B drugs $0 copay for Medicare-covered Part B drug Administration $0 copay for Medicare-covered Part B chemotherapy drugs $0 copay for Medicare-covered Part B chemotherapy drug administration

Retired Employees-Medicare Preferred PPO Plan Medicare Eligible Retirees and their Medicare Eligible Dependents		
	What you pay for these covered services	
COVERED SERVICE	**IN-NETWORK**	**OUT-OF-NETWORK**
• Immunosuppressive drugs, if you were enrolled in Medicare Part A at the time of the organ transplant • Injectable osteoporosis drugs, if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis and cannot self-administer the drug • Antigens • Certain oral anti-cancer drugs and anti-nausea drugs • Certain drugs for home and outpatient dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics and erythropoiesis-stimulating agents such as Erythropoietin (Epogen), Procrit or Epoetin Alfa and Darboetin Alfa (Aranesp) • Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases. This drug category may be subject to step therapy.		
Routine hearing services • Routine hearing exams Routine hearing exams are limited to 1 every 12 months. Routine hearing exams are limited to a $70 maximum benefit every 12 months combined in-network and out-of-network. • Hearing aid fitting evaluations are limited to 1 per covered hearing aid • Hearing aids Hearing aids are limited to a $500 maximum benefit every 12 months combined in-network and out-of-network. Includes digital hearing aid technology and inner ear, outer ear, and over the ear	$0 copay for routine hearing exams $0 copay for hearing aid fitting evaluations $0 copay for hearing aids Members receive a free battery supply during the first 3 years with a 64-cell limit per year, per hearing aid. After the plan pays benefits for routine hearing exams, hearing aids, and hearing aid	$0 copay for routine hearing exams $0 copay for hearing aid fitting evaluations $0 copay for hearing aids Members receive a free battery supply during the first 3 years with a 64-cell limit per year, per hearing aid. After the plan pays benefits for routine hearing exams, hearing aids, and hearing aid

Retired Employees-Medicare Preferred PPO Plan Medicare Eligible Retirees and their Medicare Eligible Dependents		
	What you pay for these covered services	
COVERED SERVICE	**IN-NETWORK**	**OUT-OF-NETWORK**
models. Fitting adjustment after hearing aid is received, if necessary. Anthem partners with Hearing Care Solutions for these discounts and services.	fitting evaluations, you are responsible for the remaining cost.	fitting evaluations, you are responsible for the remaining cost.
Routine vision services • Routine vision exams Routine vision exams are limited to 1 every calendar year. The routine vision exam is limited to a $70 maximum benefit every calendar year combined in-network and out-of-network. • Eyewear Eyewear is limited to a $100 maximum benefit every 2 calendar years combined in-network and out-of-network. This is a primary vision care benefit intended to cover only routine eye examinations and corrective eyewear. Blue View Vision is for routine eye care only. If you need medical treatment for your eyes, visit a participating eye care doctor from your medical network.	Must use a Blue View Vision provider $0 copay for routine vision exams $0 copay for eyewear After the plan pays benefits for routine vision exams and eyewear, you are responsible for the remaining cost.	$0 copay for routine vision exams $0 copay for eyewear After the plan pays benefits for routine vision exams and eyewear, you are responsible for the remaining cost.
Annual routine physical exam The annual routine physical exam benefit covers a standard physical exam in addition to the Medicare-covered "Welcome to Medicare" or “Annual Wellness Visit.”	$0 copay for an annual physical exam	$0 copay for an annual physical exam
Video Doctor Visits LiveHealth Online lets you see board-certified doctors and licensed therapists/psychologists through live, two-way video on your smartphone, tablet or computer.	$0 copay for video doctor visits using LiveHealth Online	
Foreign travel emergency and urgently needed services	$0 copay for emergency care $0 copay for urgently needed services	

Retired Employees-Medicare Preferred PPO Plan Medicare Eligible Retirees and their Medicare Eligible Dependents		
	What you pay for these covered services	
COVERED SERVICE	**IN-NETWORK**	**OUT-OF-NETWORK**
Emergency or urgently needed care services while traveling outside the United States or its territories during a temporary absence of less than six months. Outpatient copay is waived if member is admitted to hospital within 72 hours for the same condition. • Emergency outpatient care • Urgently needed services • Inpatient care (60 days per lifetime) This coverage is worldwide and is limited to what is allowed under the Medicare fee schedule for the services performed / received in the United States.	$0 copay per admission for emergency inpatient care	
Annual out-of-pocket maximum All copays, coinsurance, and deductibles listed in this benefits chart are accrued toward the medical plan out-of-pocket maximum with the exception of the routine hearing services and routine vision services. Part D Prescription drug deductibles and copays do not apply to the medical plan out-of- pocket maximum.	$0 Combined in-network and out-of-network	

* Some services that fall within this benefit category require prior authorization. Based on the service you are receiving, your provider will know if prior authorization is needed. This means an approval in advance is needed, by your plan, to get covered services. In the network portion of a PPO, some in-network medical services are covered only if your doctor or other in-network provider gets prior authorization from our plan. In a PPO, you do not need prior authorization to obtain out-of-network services. However, we recommend you ask for a pre-visit coverage decision to confirm that the services you are getting are covered and medically necessary. Benefit categories that include services that require prior authorization are marked with an asterisk in the Benefits Chart.

For Medicare-eligible retirees and their Medicare-eligible Dependents, Prescription Drug, Dental, Vision, Death, Accidental Death and Dismemberment, and Hearing Aid Benefits are dependent on the Plan election chosen at retirement. Refer to Retiree Plan A or Retiree Plan B for the applicable Schedule of Benefits.

DEATH AND ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

These benefits are payable on account of the death, accidental death or accidental dismemberment of an individual while eligible for coverage as an active Employee or Retiree (except COBRA or Retiree Plan B coverage).

Payment of Death Benefits

If you die from any cause, a death benefit in the amount shown in the Schedule of Benefits for the applicable Benefit Class of coverage will be paid to your designated beneficiary.

Make sure you update your beneficiary designation if you have a change in family circumstances. Be sure that you file a beneficiary designation form with the Fund Office because the death benefits will be paid to the last beneficiary designated by you before your death, as filed in the Fund Office's records.

Designating Your Beneficiary

The Fund Office provides a form on which you may designate your beneficiary(s) to receive your death benefits. A beneficiary must be an individual(s) or your estate. You may change your beneficiary by filing a new form with the Fund Office. The change will become effective when the Fund Office receives the new form.

If you do not have a designated beneficiary form on file at the Fund Office, or if your designated beneficiary is not living, the death benefit will be paid in the following order:

1. Your spouse. If none, then
2. Your children, shared equally. If none, then
3. Your parents, shared equally. If none, then
4. Your brothers and sisters, shared equally
5. If none of the above, the executor or administrator of your estate.

A divorce or legal separation has the effect of canceling a previous designation of your spouse as your beneficiary. If you intend your former spouse to be your beneficiary, you must file a new form after the date of your divorce or legal separation.

Under no circumstances will payment be made to an individual who intentionally caused your death, if known to the Fund.

Accidental Death

If your death is the direct result of an accident and occurs within 90 days after the accident, the Plan will pay to your beneficiary, in addition to the regular Death Benefit, an Accidental Death benefit in the full amount set forth in the Schedule of Benefits for your Benefit Class of coverage.

Accidental Dismemberment

Dismemberment is defined as the loss of a limb (your hand or foot at or above the wrist or ankle) or the total and irrecoverable loss of your eyesight in either or both eyes which results directly from and occurs within 90 days after an accidental Injury. If you suffer such a Dismemberment, the Plan will pay a benefit of one-half of the Accidental Death benefit for loss of one hand, one foot, or the loss of sight in one eye; or the full amount of the Accidental Death benefit for loss of two limbs, or eyesight in both eyes, or one limb and eyesight in one eye.

Payment for all losses due to any one accident may not exceed the full amount of the Accidental Death and Dismemberment Benefit.

Limitations

No benefits will be paid under Accidental Death and Dismemberment for a death or Dismemberment resulting from:

1. Suicide or intentional self-inflicted Injury, while sane; or

2. The intentional act of another during an altercation in which the Employee participated, other than as a spectator; or

3. Travel or flight in or descent from any species of aircraft, except as a fare-paying passenger on a regularly scheduled commercial route or chartered flight; or

4. War or act of war, declared or undeclared; or

5. Service in the armed forces of any country; or

6. Bodily or mental infirmity or disease; or

7. Bacterial infection, except pyogenic infections that occur with and through an accidental cut or wound) or by any other kind of disease; or

8. Any drug unless administered by a Physician; or

9. Any gas or fumes inhaled voluntarily or any voluntary poisoning.

Payment of Benefits

The benefit for Dismemberment will be paid to you, if living, otherwise in the same manner as a death benefit.

MEDICAL BENEFITS

Most of the Plan's medical coverages are within the Comprehensive Major Medical benefit and are subject to the Calendar Year Deductible, Copayments, Coinsurance, and Out-of-Pocket Limit amounts shown in the Schedule of Benefits for the Comprehensive Major Medical Plan. Some medical services also have additional limitations or plan maximums as shown in the Schedule of Benefits.

A few of the Plan's coverages are independent of the Comprehensive Major Medical benefit, such as the Dental, Prescription Drug, and Vision benefits. Applicable deductibles, copayments, and maximums for these stand-alone benefits are shown in the Schedule of Benefits and described further in the respective sections of this Summary Plan Description.

The Board of Trustees have arranged for medical services of many Physicians and Hospitals to be available to you through a contracted network. At the time of printing this booklet, the Plan utilizes the Anthem BlueCross BlueShield PPO network. You will be notified of any future change in the network. The providers who belong to the network have agreed to accept fixed fees for services, which are usually lower than would be charged outside the network.

The Plan offers a higher level of benefits if you use the Anthem BlueCross BlueShield PPO network. However, you have freedom of choice in selecting your Doctor or Hospital. It will usually be advantageous to you to select a PPO provider, but you are not required to do so. Participants can see any provider they choose and do not need to get a referral or go through a primary care Physician to access specialty care. In the event that a Participant sees a non-PPO (out-of-network) provider at a PPO (in-network) facility, the Plan will pay the PPO level of benefits. The Covered Expense will be based on the Reasonable and Customary Charges

A list of providers in the Anthem BlueCross BlueShield PPO network can be found at https://www.anthem.com/health-insurance/provider-directory/.

Participants living outside of the Anthem BlueCross BlueShield PPO network service area can access any Blue Cross or Blue Shield provider through the Blue Card program. Anthem BlueCross BlueShield has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Programs." Whenever you obtain healthcare services outside of Anthem BlueCross BlueShield's service area, the claims for these services may be processed through one of these Inter-Plan Programs, which include the BlueCard Program and may include negotiated National Account arrangements available between Anthem BlueCross BlueShield and other Blue Cross and Blue Shield Licensees.

Typically, when accessing care outside Anthem BlueCross BlueShield's service area, you will obtain care from healthcare providers that have a contractual agreement (i.e., are "participating providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, you may obtain care from nonparticipating healthcare providers. The payment practices in both instances are described below.

1. BlueCard® Program

   Under the BlueCard® Program, when you access covered healthcare services within the geographic area served by a Host Blue, Anthem BlueCross BlueShield will remain responsible for fulfilling its contractual obligations. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating healthcare providers.

   Whenever you access covered healthcare services outside Anthem BlueCross BlueShield's service area and the claim is processed through the BlueCard® Program, the amount you pay for covered healthcare services is calculated based on the lower of:

   a. the billed Covered Charges for your covered services; or

   b. the negotiated price that the Host Blue makes available to Anthem BlueCross BlueShield.

   Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to your healthcare provider. Sometimes, it is an estimated price that takes into account special arrangements with your healthcare provider or provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of healthcare providers after taking into account the same types of transactions as with an estimated price.

   Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price Anthem BlueCross BlueShield uses for your claim because they will not be applied retroactively to claims already paid.

   Laws in a small number of states may require the Host Blue to add a surcharge to your calculation. If any state laws mandate other liability calculation methods, including a surcharge, we would then calculate your liability for any covered healthcare services according to applicable law.

2. Negotiated (non-BlueCard® Program) National Account Arrangements

   As an alternative to the BlueCard® Program, your claims for covered healthcare services may be processed through a negotiated National Account arrangement with a Host Blue.

   The amount you pay for covered healthcare services under this arrangement will be calculated based on the lower of either billed Covered Charges or negotiated price made available to Anthem BlueCross BlueShield by the Host Blue.

The following conditions, limitations and exclusions apply to ALL medical benefits paid by the Plan (not just the Comprehensive Major Medical Benefit):

Reasonable and Customary Charges

The Plan bases its benefits on the amount billed by a provider. However, if the amount billed for a covered service is determined by the Plan to exceed the usual amount generally charged by providers in the geographical area for similar services or supplies, subject to all limitations and exclusions set forth in this Plan, the Plan will pay benefits based on the Reasonable and Customary Charges instead of the billed amount. For Emergency Services, non-emergency items or services performed by a non-PPO provider at a PPO Health Care Facility without advance notice and your written consent, and Air Ambulance Services, the Reasonable and Customary Charge shall be the qualifying payment amount as defined by law. For all other items and services, the determination of Reasonable and Customary Charges will be made by the Board of Trustees, in their discretion and judgment, and they may rely on advice of professionals of their choice in the medical field. Currently, the Fund uses the Reasonable and Customary database of the Fund Office rather than the Plan's network provider.

Covered Charges

The Plan pays benefits only for the kinds of services and supplies identified in the Plan as being covered, and only when furnished by the kinds of providers identified in the Plan as being covered.

Medical Necessity

Medical Necessity is not required for benefits under the Preventive Care Benefit or benefits expressly provided in the Plan for routine hearing exams, routine eye exams, routine dental exams and prophylaxis, or counseling necessary to satisfy the requirements of a drug testing program. In all other cases, the Plan pays benefits only for services and supplies that are Medically Necessary, according to accepted medical standards, for the treatment of a diagnosed Illness or Injury.

Medically Necessary means that the services or supplies must be required and appropriate to treat a diagnosed Illness or Injury. The fact that a Physician orders a service or supply does not, in itself, determine Medical Necessity.

Mandatory Case Management Program

The Board of Trustees has arranged a Mandatory Case Management Program to help reduce costs from overutilization. At the time of printing this booklet, the Plan utilizes HealthLink for these services. You will be notified of any future change in the case management provider.

If HealthLink determines that a patient requires Mandatory Case Management, he or she will be contacted by a nurse case manager and required to fill out a Case Management Authorization Form.

After enrollment in the program, the case manager will work with the patient and his or her Physician to develop an individualized care plan with specific goals. The Mandatory Case

Management Program will continue until all goals have been achieved or when the patient is no longer in need of case management.

If a patient is contacted by a case manager and fails to enroll in the Mandatory Case Management Program by completing the Case Management Authorization Form, a $500 penalty will be assessed against future benefits for that specific condition.

Common conditions that require case management include:

1. Hospital admissions with a length of stay of ten days or greater;

2. Subsequent admissions by the same Participant within a 30-day period;

3. Three admissions by a Participant within a calendar year;

4. A Hospital admission by a Participant who was previously followed in case management;

5. High risk pregnancies;

6. Catastrophic Illnesses and Injuries;

7. Potential transplant candidates; and

8. Admission to specialty units such as critical care, pediatric intensive care, or neonatal intensive care.

Specific Exclusions

The Plan does not pay any benefit for services or supplies listed in the "General Exclusions" or otherwise expressly excluded by the provisions of the Plan. The General Exclusions are summarized later in this booklet.

COMPREHENSIVE MAJOR MEDICAL PLAN
(All Benefit Classes)

Calendar Year Deductible Amount

The Calendar Year Deductible is the dollar amount, per individual, as shown in the Schedule of Benefits, which you are responsible to pay before Comprehensive Major Medical Benefits are payable by the Plan. Only Covered Charges may be used to satisfy the Calendar Year Deductible. The Calendar Year Deductible applies only once in a calendar year. If two individuals in your family satisfy the Calendar Year Deductible, no further Calendar Year Deductible will be applied to any family members in that year.

Expenses incurred during the three-month period immediately preceding the current calendar year which were applied to the Calendar Year Deductible for the preceding calendar year may be included as expenses incurred for the Calendar Year Deductible for the current calendar year.

Common Disaster Provision

In the event more than one Participant in the same family is injured by reason of any one accident or in the event a Participant contracts a contagious disease which is otherwise covered by the Plan and any other Participant in the same family contracts the same disease within thirty days thereafter, only one Calendar Year Deductible will be applied to all Participants in the family as the result of such accident or such contagious disease.

Coinsurance/Copayments

After you have satisfied the annual Calendar Year Deductible, the additional Covered Charges incurred for that person during the same year are shared between you and the Plan, up to your Out-of-Pocket Limit. The Plan's share of the Covered Charges for Comprehensive Major Medical benefits is the percentage shown in the Schedule of Benefits; your Coinsurance is the remaining percentage of Covered Charges. The Plan's percentage is higher, and your Coinsurance is lower, for PPO providers than for non-PPO providers. In addition to Coinsurance, you may also be required to pay a flat dollar Copayment for certain services. Refer to the Schedule of Benefits for more information on the Copayment and Coinsurance requirements.

Out-of-Pocket Limit

The annual Out-of-Pocket Limit is designed to limit the amount an individual is required to pay in each calendar year for Covered Expenses. The Out-of-Pocket Limits (individual and family) stated in the Schedule of Benefits are the maximum amounts that you will have to pay during any calendar year for Calendar Year Deductibles, Copayments, and Coinsurance for any covered individual or family, respectively. After the Out-of-Pocket Limit is reached, the Plan will pay 100% of additional Covered Expenses for the individual or family during the year, up to any applicable maximum benefit limits. Covered Expenses incurred with a non-contracted pharmacy will be disregarded in determining whether the annual Out-of-Pocket Limit has been reached,

except out-of-network expenses incurred where there is not reasonable access to an in-network source, as determined by the Board of Trustees at their discretion.

Maximum Amount Payable

The aggregate amount payable for all accidents and sicknesses covered by the Comprehensive Major Medical Benefit that are not considered essential health benefits shall in no event exceed the Lifetime Maximum Amount, shown in the Schedule of Benefits. In addition, benefits for certain specific services and coverages are limited to the maximums show in the Schedule of Benefits.

COVERED EXPENSES

As used herein, the term "Covered Expense" shall mean expenses incurred by an individual while eligible under the Plan, for services or supplies that are expressly covered under the applicable provisions of the Plan, and not excluded by any provision of the Plan; and are Medically Necessary (to the extent Medical Necessity is required by the Plan), but only to the extent that such expenses do not exceed the least of the following:

A. The provider's contracted rate with the Plan's network provider, or the rate negotiated by the out-of-network fee negotiation provider if there is no contracted rate, or the Reasonable and Customary Charges if neither a contracted or negotiated fee exists;

B. Allowances or limits expressly provided under the Plan; or

C. The amount actually charged in the case of a provider who does not have a contracted rate with the Plan's network provider.

Subject to all applicable conditions, limitations and exclusions, the Comprehensive Major Medical Benefit will be payable on account of the following kinds of expenses, but no others:

Hospital Expense

1. Hospital expenses covered are Hospital room and board charges and miscellaneous Hospital expenses incurred while you are confined in a Hospital.

2. Hospital room and board charges are limited to the Hospital's average semi-private daily rate. Room and board charges in excess of this amount will not be considered covered expenses and may not be applied toward satisfaction of the Calendar Year Deductible.

3. Miscellaneous Hospital expenses are limited to charges incurred in a Hospital for operating room, medicines, drugs, blood and blood plasma (including administration thereof), anesthetic (including administration thereof in a Hospital by a Doctor or Surgeon), x-ray examinations, radiation treatments, physiotherapy, laboratory tests, surgical dressings, and medical supplies.

4. Professional ambulance service to and from a Hospital for covered treatment.

5. The Plan will not restrict benefits in any manner that would violate the following provisions of federal law:

   Newborns and Mothers Health Protection Act

   Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. *However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable).* In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Surgical Expense

Covered surgical expenses are charges incurred by a Participant for Surgical Procedures recommended by the attending Doctor or Surgeon.

"Surgical Procedures" are defined as cutting, suturing, correction of a fracture, reduction of dislocation, electrocauterization, tapping (paracentesis), administration of artificial pneumothorax, removal of stone or foreign body by endoscopic means, or injection of sclerosing solution.

Body Organ Transplant Expense

If a Participant is the Recipient of a covered organ transplant, the following are Covered Expenses:

1. Expenses incurred by the Recipient for:

   a. the use of temporary mechanical equipment, pending the acquisition of "matched" human organ(s);

   b. multiple transplant(s) during one operative session;

   c. replacement(s) or subsequent transplant(s); and

   d. follow-up expenses for covered services (including immunosuppressant therapy).

2. Expenses incurred by the Donor(s) for:

   a. testing to identify suitable Donor(s);

   b. the expense for the acquisition of organ(s) from a Donor;

c. the expense of life support of a Donor pending the removal of a usable organ(s); and

d. transportation of organ(s) or a Donor on life support.

Expenses incurred by a Donor(s) are Covered Expenses only when the Recipient is a Participant under this Plan.

Other Covered Expenses

Charges incurred by a Participant for the following kinds of services and supplies are Covered Expenses for purposes of the Comprehensive Major Medical Benefit:

1. Treatment by a legally qualified Doctor.

2. Services of a licensed or graduate nurse, other than a person who ordinarily resides in the Participant's home or who is a member of the Participant's immediate family.

3. Anesthetic and its administration.

4. Treatment by a physiotherapist (other than a member of the Participant's immediate family).

5. Dental treatment by a Doctor, Dentist or dental Surgeon for a fractured jaw or for Injury to natural teeth including replacement of such teeth within six months after the date of the accident.

6. X-ray or radium treatments.

7. X-ray and laboratory examinations, excluding dental x-ray unless rendered for dental treatment of a fractured jaw or of Injury to natural teeth within six months after the date of the accident.

8. Skilled Nursing Care Confinement, but not to exceed the daily benefit as established by the Missouri Department of Health and Social Services for each day and the Maximum Number of Days Payable for any one period of confinement as show in the Schedule of Benefits.

9. Home Health Care, not to exceed the limits in the Schedule of Benefits, but only if treatment of the patient's Illness or Injury would have required full-time confinement in a Hospital or convalescent facility in the absence of the home health care plan.

   Covered services and supplies are limited following:

   a. Physical, occupational, respiratory and speech therapy.

b. Medical supplies, durable medical and surgical equipment, diagnostic x-ray and laboratory services if these services and supplies would have been covered if the patient had been confined in a Hospital or convalescent facility.

c. Part-time or periodic care by a Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.).

d. Part-time or periodic patient care by a home health aide which consists of primarily caring for the patient.

10. Inpatient treatment of alcoholism, chemical dependency, or drug addiction in a Hospital or properly licensed residential primary treatment facility, when prescribed by a Physician and Medically Necessary.

11. The following medical supplies:

a. Blood and blood plasma;

b. Artificial limbs and eyes;

c. Surgical dressings;

d. Casts, splints, trusses, braces and crutches;

e. Preapproved durable medical equipment for therapeutic treatment, when supported by attending Physician's statement of need to the satisfaction of the Board of Trustees.

f. Rental of wheelchairs, hospital bed, iron lung, or chair lift (but not to exceed purchase price);

g. Oxygen and rental of equipment for its administration (but not to exceed purchase price);

h. A de-rotational knee brace will be covered as durable medical equipment when prescribed by a Physician and Medically Necessary for post-operative recovery from knee surgery;

i. Prosthesis after a mastectomy; and

j. Replacement, not repair, of a C-PAP appliance when evidence satisfactory to the Board of Trustees is provided to show that the current machine is no longer functional.

12. Hospice expenses for one period of hospice care of up to six consecutive months in a lifetime, which include:

    a. Charges incurred by a hospice care agency for services such as:

        i. part-time or intermittent nursing care by an RN or LPN for up to 8 hours per day;

        ii. medical supplies prescribed by a Doctor; and

        iii. medical social services under the direction of a Doctor.

    b. Charges incurred by a home health care agency for such services as part-time or intermittent home health aide services for up to eight hours per day.

    c. Charges incurred by other providers of care, not part of or employed by a hospice or home health care agency, when that agency keeps responsibility for patient care such as a physical or occupational therapist for therapy or Physicians for consultation or case management services.

    d. Inpatient charges made by a hospice care facility, Hospital, or convalescent facility for room and board up to the facility's most common semi-private charges. Services and supplies for pain control and other acute and chronic symptom management are payable on the same basis as a Hospital confinement for any other disease.

13. Hearing aid expenses (Actives and Plan A Retirees only) for a hearing aid instrument which has been prescribed by an audiologist, otologist, or one certified to dispense hearing aids.

    If the Participant has had an exam and ordered a hearing aid and subsequently loses eligibility, charges for expenses incurred for the hearing aid will be covered if the hearing aid is delivered within 60 days following the date of exam, but no more than 30 days after the date eligibility is lost.

    Discounts on hearing aids are available through Amplifon and HearUSA. To find a participating Amplifon provider, go to www.amplifonusa.com/oe513 and enter in your ZIP code, or call (888) 531-1749. To find a participating HearUSA provider, go to www.unitedhearingservices.com and click on "Office Locator" or call (800) 442-8231. There is no requirement that you use a Amplifon or HearUSA provider.

14. Expenses resulting from a pregnancy on the same basis and subject to the same limitations and conditions as any disability from Illness.

15. Charges for treatment of Mental and Nervous Disorders.

16. Treatment of Attention Deficit Hyperactive Disorder and Oppositional Defiant Disorder. Ritalin will be covered when prescribed for diagnosed Attention Deficit Disorder, regardless of whether hyperactivity was also diagnosed.

17. Treatment of alcoholism, chemical dependency or drug addiction.

18. Sleep studies prescribed by a Physician for diagnosis and evaluation of sleep apnea, provided that the attending Physician has adequately documented the Medical Necessity for the procedures, including an adequately supported medical opinion that the patient is likely to suffer harm other than simple snoring if the patient's apnea condition is left untreated.

Exclusions and Limitations

Benefits are not payable under the Comprehensive Major Medical coverage for any service or supply that is not identified in the Plan as covered, or that is described in the General Exclusions.

Benefits are not payable under the Comprehensive Major Medical coverage for any prescription drug, except when furnished during a Hospital stay and covered as a "Hospital Expense."

PREVENTIVE CARE BENEFIT

The Plan pays for certain preventive care benefits even though not Medically Necessary. These benefits are provided to Participants that are not Medicare eligible at no cost if they are obtained by a PPO provider and are encouraged to be used. If there are no PPO providers within 30 miles from your home, you may use a non-PPO provider with no cost sharing.

Routine Physical Examinations

Routine physical examinations are covered for active eligible Employees and their eligible Dependents. No Calendar Year Deductible or Copayment applies.

Examinations that would be covered by this Preventive Care Benefit and by the Major Comprehensive Medical Benefit (because of Medical Necessity) will be considered first under this benefit, and any unpaid portion of the expense will then be considered for further benefits under the Major Comprehensive Medical coverage.

The Plan provides benefits for the following preventive health services:

1. Evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force with respect to the individual involved;

2. Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (Advisory Committee) with respect to the individual involved;

3. With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA); and

4. With respect to women, evidence-informed preventive care and screening provided for in comprehensive guidelines supported by HRSA (not otherwise addressed by the recommendations of the Task Force).

Screenings

The Plan provides benefits for the following screening services:

1. Abnormal aortic aneurysm;

2. Alcohol misuse;

3. Anemia for pregnant women;

4. Autism;
5. Bacteriuria;
6. Blood pressure;
7. Cervical dysplasia;
8. Chlamydia;
9. Cholesterol;
10. Congenital hypothyroidism;
11. Depression;
12. Development for children;
13. Dyslipidemia;
14. Gonorrhea;
15. Gestational diabetes;
16. Hearing in newborns;
17. Hematocrit or hemoglobin for children;
18. Hemoglobinopathies (sickle cell) for newborns;
19. Hepatitis B;
20. HIV;
21. Lead;
22. Obesity;
23. Oral health;
24. Osteoporosis;
25. PKU;
26. RH incompatibility;

27. STI;

28. Syphilis;

29. Tobacco use; and

30. Tuberculin.

Counseling

The Plan provides benefits for the following counseling services:

1. Breast cancer;

2. Breastfeeding;

3. Chemoprevention;

4. Diet;

5. Domestic and interpersonal violence;

6. Obesity;

7. Skin cancer;

8. STI; and

9. Tobacco.

Breastfeeding

Breastfeeding supplies will be provided to pregnant and nursing mothers at no cost to the Participant.

Physical Therapy/Exercise

Exercise and Physical Therapy for adults age 65 and older to prevent falls in community dwellings at no cost to the Participant.

PRESCRIPTION DRUG BENEFIT

Through a service contract, the Plan provides prescription service for covered prescriptions. The Plan pays benefits for covered prescriptions that are filled through the provider network (at a network pharmacy or via the network mail-order service). The Board of Trustees may select, from time to time, a prescription drug network service provider, and shall inform Participants of the provider selected, the identity of participating pharmacies and mail order service, if any, and the procedure for purchasing prescription drugs through the provider network. At the date of this booklet, the Plan's service provider is MedImpact.

A list of pharmacies in the MedImpact network can be found at https://mp.medimpact.com/.

The Plan ordinarily does not pay any benefit for drugs purchased outside the Plan's provider network. Out-of-network prescription drug benefits will only be paid in cases where the Participant does not have reasonable access to an in-network source, as determined by the Board of Trustees at their discretion. The charges considered for out-of-network benefits are limited to Reasonable and Customary Charges.

Benefit Schedule

Prescriptions Filled Through:	Your Copayment:
Walk-In Program	
In-Network Pharmacy	
Generic & Brand Name	30% of prescription drug charges for up to a 30-day supply
Out-of-Network Pharmacy[1]	
Generic & Brand Name	35% of prescription drug charges for up to a 30-day supply
Mail Order Program (Covered only through MedImpact)	
Generic	$7.50 Copayment for up to a 90-day supply
Brand Name	$40 Copayment for up to a 90-day supply

Out-of-Pocket Limit

The Out-of-Pocket Limits (individual and family) stated in the Schedule of Benefits are the maximum amounts that you will have to pay during any calendar year for Calendar Year Deductibles, Copayments, and Coinsurance for any covered individual or family, respectively. After the Out-of-Pocket Limit is reached, the Plan will pay 100% of additional Covered Expenses for the individual or family during the calendar year, up to the maximum benefit limits.

[1] Out-of-network prescription drug benefits will only be paid in cases where the Participant does not have reasonable access to an in-network source, as determined by the Board of Trustees at their discretion. The charges considered for out-of-network benefits are limited to Reasonable and Customary Charges.

Specialty Drugs

Specialty Drugs are prescription medications that require special handling, administration or monitoring. These drugs are used to treat complex, chronic and often costly conditions, such as multiple sclerosis, rheumatoid arthritis, hepatitis C, and hemophilia.

Specialty Drugs are subject to prior authorization under the Plan. Certain Specialty Drugs may only be available from a certain specialty pharmacies. Drugs subject to prior authorization require prescriber verification of specific clinical criteria to help manage the appropriate use of high-cost and/or highly utilized categories of drugs that are likely to be used for off-label indications or beyond recommended duration.

For more information about MedImpact Specialty Pharmacy, call 1-800-788-2949.

What is Covered?

Covered prescription drugs are those that can only be obtained by prescription (except insulin) under state and federal law; have been approved by the Food and Drug Administration (FDA) for general marketing; and are dispensed by a licensed pharmacist and prescribed for the Participant's use by a Physician.

The following drugs will be covered at no cost to you under the following conditions:

1. Aspirin to prevent cardiovascular disease (generic only)
    a. Coverage for Participants age 45 and older
    b. Quantity limit of 100
    c. Over-the-counter only[2]
2. Iron supplements for children at risk of anemia (brand or generic)
    a. Coverage for Participants under 1-year-old
    b. No quantity limit
    c. Prescription or over-the-counter[2]
3. Chemoprevention of dental cavities for children with fluoride deficiency (generic only)
    a. Coverage for Participants older than six months of age and younger than seven years of age

[2] All over-the-counter medications require an authorized prescription and must be purchased from a participating retail pharmacy to be covered by the Plan.

b. No quantity limit

c. Prescription only

4. Folic acid supplements for pregnant individuals (generic only)

   a. Coverage for pregnant Participants up to age 56

   b. Quantity limit over 100

   c. Over-the-counter[2]

5. Tobacco cessation and counseling (generic Zyban only)

   a. Annual limit of two cycles per treatment (12 weeks per cycle)

   b. Prescription or over-the-counter[2]

6. Prilosec OTC[2]

7. Alavert[2]

8. Claritin[2]

9. Loratadine[2]

10. Tavist ND[2]

11. Contraceptives

    a. Coverage for oral, emergency, injectable, intrauterine devices, subdermal rod vaginal rings and transdermal patch

    b. Only generics and single source brands are covered without cost sharing

    c. Quantity limits apply for sub-dermal, IUD and vaginal ring

How Does the Program Work?

Present your prescription I.D. card to the participating pharmacy. Provided your name is included in the list of eligible Participants for Prescription Drug Program coverage when you obtain a covered prescription from a participating pharmacy, you will pay the applicable Copayment and the participating pharmacy will receive the balance of payment directly from the Plan.

You may either go to a participating pharmacy to fill your prescriptions (Walk-in Program) or fill your prescription through the mail (Mail Order Program). Through the Walk-in Program, you may receive up to a 30-day supply for a Copayment of 30% of prescription drug charges for generic or brand name drugs. You may obtain up to a 90-day supply of prescription drugs through the Mail Order Program for a $7.50 Copayment for generic drugs or a $40 Copayment for brand name drugs.

Participants who lose regular eligibility because of insufficient employer contributions will be entitled to continue to receive the prescription drug benefit for one additional month beyond the month in which eligibility for other benefit ends, irrespective whether regular eligibility is restored by self-payment or additional employer contributions.

For additional details concerning the Prescription Drug Benefit, please refer to the descriptive material furnished to you by the Fund Office.

Mandatory Narcotics Utilization Program

If the Board of Trustees determines that there are reasonable grounds to believe that a Participant may be using narcotic drugs in excess of Medically Necessary types or quantities, the Board of Trustees may require that the Participant participate in and comply with a mandatory case management program as a condition of receiving further benefits for any narcotic drugs.

Prior Authorization

The Trustees are authorized, in their discretion, to determine from time to time that benefits for a particular drug or class of drugs under the Prescription Drug Benefit will be denied or limited unless the Participant has obtained prior authorization (PA) from the Trustees or their designee. A PA is documentation of the appropriateness of the prescribed medication for the diagnosis. This procedure helps manage the use of medications identified as high-dollar, high-risk, or having the potential for inappropriate use. If you are prescribed a Specialty Drug, your prescribing Physician will need to submit a prior authorization request to MedImpact in order to receive the medication. Please note that if you are already being prescribed a Specialty Drug, you will not be required to submit a PA for that prescription or any subsequent refills. Unless otherwise stated, prior authorization is for the purpose of determining Medical Necessity. However, when so stated, prior authorization may be for the purpose of determining whether other criteria of coverage approved by the Trustees have been satisfied.

You can initiate the PA process by contacting MedImpact at 1-800-788-2949 or providing the Medication Request Form to your Physician. If you do not initiate the PA, you will be notified about the PA requirement at the pharmacy, which may be able to initiate the PA for you. Note, however, that the pharmacy will not be able to fill your prescription for a Specialty Drug until the PA process has been completed and your prescription is approved.

The following classes and drugs are examples of Specialty Drugs that would require PA:

1. **Arthritis/Psoriasis Drugs**: Enbrel, Humira, Orencia, Otezla, Simponi, Stelara, Xeljanz

2. **Growth Hormones**: Genotropin, Norditropin, Nutropin, Omnitrope, Tev-tropin
3. **Hepatitis C**: Daklinza, Harvoni, Olysio, Sovaldi, Technivie
4. **Multiple Sclerosis**: Aubagio, Avonex, Betaseron, Copaxone, Gilenya, Rebif, Tecfidera
5. **Oncology**: Afinitor, Farydak, Gleevec, Jakafi, Nexavar, Sprycel, Sutent, Tarceva, Xalkori, Zelboraf
6. **Pulmonary Aterial Hypertension**: Adcirca, Adempas, Letairis, Revatio, Opsumit, Tracleer
7. **Pulmonary Fibrosis**: Esbriet, Ofev

Note that the drugs listed above are not all inclusive.

MEDICARE PART D COVERAGE

Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

The Board of Trustees has determined that the prescription drug coverage offered by the Welfare Fund of Engineers Local 513 is, on average for all Participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

If you decide to join a Medicare drug plan, your current prescription drug coverage will be affected. If you enroll in another Medicare Part D plan, you will lose prescription drug coverage under this Plan for the remainder of the calendar year of each year you enroll in another Medicare Part D plan.

You should also know that if you drop or lose your current coverage and do not join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later. If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

DENTAL EXPENSE BENEFIT

If a person eligible under any Benefit Class except Retiree Plan B or COBRA core-only is treated by a licensed Dentist and incurs Covered Dental Expenses, the Plan will, subject to these provisions, pay the percentage stated in the Schedule of Benefits for all Covered Dental Expenses after satisfaction of the Deductible.

The Board of Trustees have arranged for dental services of many Dentists and orthodontists to be available to you through a contracted network. At the time of printing this booklet, the Plan utilizes the Delta Dental network. You will be notified of any future change in the network. The providers who belong to the network have agreed to accept fixed fees for services, which are usually lower than would be charged outside the network. It will usually be advantageous to you to select a Delta Dental provider, but you are not required to do so.

There are two Delta Dental networks to choose from. The Delta Dental "PPO" network will provide the greatest discounts and highest savings. The Delta Dental "Premier" network will also provide discounts and savings, but to a lesser extent. Choosing a provider from either network will save you money compared to choosing a provider that is not in the dental network. To find a participating Dentist, go to www.deltadentalmo.com/IUOE513, click on "Subscribers" and "Find a Participating Dentist".

Benefits Payable

Benefits are payable for covered dental charges incurred during a calendar year for dental care or treatment in an amount equal to a specified percentage of the billed charge, or if less, of the Reasonable and Customary Charges for the dental services performed. The percentage payable varies according to the types of dental services performed as shown in the Schedule of Benefits. Benefits will not exceed the Calendar Year and Lifetime Maximums shown in the applicable Schedule.

Deductible Amount

The Deductible for dental expenses is stated in the applicable Schedule of Benefits. The Deductible is satisfied when total Covered Dental Expenses paid by you equal the Deductible amount.

Covered Dental Expenses

Covered Dental Expenses are those charges incurred for Medically Necessary dental services of the types specified below, which are performed or prescribed by a legally qualified Dentist while the person is eligible and subject to the Exclusions and Limitations that follow.

1. Preventive Services

    a. Routine periodic oral examinations including bite wing x-rays not more than twice in a calendar year.

b. Periapical x-rays as required.

c. Full mouth x-rays once every three calendar years interval unless special need is known.

d. Dental prophylaxis (cleaning, scaling, and polishing) as prescribed by the Dentist but not more than twice in a calendar year.

e. Topical fluoride applications as prescribed by the Dentist but not more than once in a calendar year.

f. Protective sealant applications as prescribed by the Dentist.

2. Basic Restorative Services

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

b. Restorative services using amalgam, stainless steel crowns, synthetic porcelain, and plastic filling material.

c. Oral surgery – extractions and other oral surgery, including pre-operative and post-operative care.

d. Gold restorations when the teeth cannot be restored with another filling material.

e. Non-surgical periodontics – procedures necessary for the treatment of diseases of the gums.

f. Endodontics: root canal filling and pulpal therapy (therapy for the soft tissue of a tooth).

g. Periodontics – the Surgical Procedures necessary for the treatment of diseases of the gums and bond supporting the teeth.

3. Major Restorative Services

a. Crowns, jackets, liabial veneers, and onlays when required for restorative purposes when teeth cannot be restored with a filling material.

b. Prosthetics, removable and fixed – provides bridges, partial dentures, and complete dentures, including temporary plates and bridges.

c. Dental implants as well as bone grafts.

Limitations

The following dental services have limitations:

1. A panoramic film with or without other films is considered equivalent to a full mouth series for coverage purposes. Coverage for multiple radiographs on the same date of service will not exceed the coverage level for complete mouth series.

2. Endodontic (root canal treatment) on the same tooth is covered only once in a two-year period. Re-treatment of the same tooth is allowed when performed by a different dental office.

3. Charges for replacement of filling restorations are only covered once in a 240 month period, unless the damage to that tooth was caused by accidental Injury not related to the normal function of the tooth or teeth.

4. Dental benefits for an initial or replacement crown, jacket, labial veneer, inlay, or onlay on or for a particular tooth will only be provided once every 5 years, unless the damage to that tooth was caused by accidental Injury not related to the normal function of the tooth or teeth.

5. If coverage is terminated before an orthodontic treatment plan is completed, coverage will be provided only to the end of the month of termination.

6. Benefits will not be paid for repair or replacement of an orthodontic appliance.

7. After completion of your orthodontic treatment plan or reaching your orthodontic lifetime maximum, no further orthodontic benefits will be provided.

Exclusions

No payment shall be made for any:

1. Treatment by other than a licensed Dentist or Physician except charges for cleaning of teeth performed by a licensed dental hygienist under the supervision and direction of a Dentist.

2. Dental services or supplies furnished without charge or paid for by any governmental agency, program, or law, employer, benefit association, union, or similar group. This exclusion extends to any benefits provided under the U.S. Social Security Act, as amended.

3. Dental services and supplies performed for cosmetic purposes or to correct congenital malformations, except newborns with congenital dental defects.

4. Charges for orthodontic treatment except as specifically provided.

5. Replacement of dentures and other dental appliances which are lost or stolen.

6. Charges in connection with any accidental bodily Illness or Injury arising out of, or in the course of employment, or which is compensable under any Workers' Compensation or Occupational Disease Act or law.

7. Charges for prosthetic devices (including bridges and crown) and the fitting thereof which were ordered while the person was not eligible under the Plan, or which were ordered while the person was eligible under the Plan but are finally installed or delivered to such person more than thirty days after termination of eligibility.

8. Expenses in connection with any accidental bodily Illness or Injury caused by war or by any act of war, declared or undeclared, or by participating in a riot, or as the result of the commission of a felony by the Participant.

9. Expenses for services or supplies which are furnished, paid for, or otherwise provided in a U.S. Government Hospital or any other Hospital operated by a government unit (unless a charge is made that the Participant is legally required to pay without regard to the existence of benefits).

10. Expenses which exceed the Reasonable and Customary Charges for, or the fair and reasonable value of, the service, supply, or treatment for which the charge is made. Such Reasonable and Customary Charges and such fair and reasonable value shall be determined by the same sex and of approximately the same age, income, and condition of health for similar service, supplies or treatment, and the result of such determination by the Board of Trustees shall constitute the maximum allowable as a covered dental expense.

11. Expenses for which benefits may be payable under the surgical benefits provision of the Comprehensive Major Medical Plan.

12. Covered Dental Expenses that are not Medically Necessary, except as expressly stated in the "Covered Dental Benefits" section starting on page 72.

13. Services or supplies for which the enrollee, absent this coverage, would normally incur no charge, such as care rendered by a Dentist to a member of his/her immediate family or the immediate family of his/her spouse.

14. Services or supplies related to temporomandibular joint (TMJ) dysfunction (this involves the jaw hinge joint connecting the upper and lower jaws).

15. Services or supplies not specifically stated as covered dental services (including Hospital or prescription drug charges).

16. Denture adjustments for the first six months after the dentures are initially received from a network Dentist. Separate fees may not be charged by a Delta Dental network Dentist.

17. Complete occlusal adjustments, crowns for occlusal correction, athletic mouthguards, nightguards, bruxism appliances, and bite therapy appliances.

18. Tooth preparation, temporary crowns, bases, impressions, and anesthesia or other services which are part of the complete dental procedure. These services are considered components of, and included in the fee for, the complete procedure. Separate fees may not be charged by a Delta Dental network Dentist.

19. Analgesia, including nitrous oxide, duplication of radiographs, and temporary appliances.

20. Services or supplies covered under a terminal liability, extension of benefits, or similar provision.

21. Services rendered beyond the scope of a Dentist's or service provider's license, or Experimental or Investigative services/supplies.

22. Services or supplies that a Dentist determines for any reason, in his or her professional judgment, should not be provided.

23. Instructions in dental hygiene, dietary planning, or plague control.

24. Infection control, including sterilization of supplies and equipment.

Pretreatment Review

The Board of Trustees may require as proof of claim a complete dental chart showing any extractions, fillings or other work performed prior to the date of the loss for which claim is being made; itemized bills of the Dentist or Physician or other sources of services, supplies and treatment; x-rays, laboratory or Hospital reports or costs, molds or study models or other similar evidence of the condition or treatment of the tooth or mouth.

VISION EXPENSE BENEFIT
(Actives and Retiree Plan A only)

Benefits Provided

If you incur Covered Vision Expenses while covered under the Plan, reimbursement of such expenses will be made, up to the specified maximum benefit shown in the Schedule of Benefits.

The Board of Trustees have arranged for vision services of many Optometrists to be available to you through a contracted network. At the time of printing this booklet, the Plan utilizes the VSP network. You will be notified of any future change in the network. The providers who belong to the network have agreed to accept fixed fees for services, which are usually lower than would be charged outside the network. It will usually be advantageous to you to select a VSP provider, but you are not required to do so.

To find a participating Optometrist, go to https://www.vsp.com/eye-doctor and click on "Find a Doctor".

Covered Vision Expenses

1. Copayments are required for certain benefits, these Copayments shall be the personal responsibility of the Participant receiving the care and must be paid to the Doctor on the date the services are rendered.

2. Participants are required to identify themselves to in-network providers as enrollees of the VSP vision plan in order to obtain PPO benefit coverage, otherwise coverage will be considered non-PPO.

3. All claims for services received from non-PPO providers (if non-PPO provider coverage is indicated in Article IV) shall be submitted by Participants to VSP within three hundred sixty-five (365) days of the date of service. Claims which are filed more than three hundred sixty-five (365) days after the date of service may be rejected. Failure to submit a claim within three hundred sixty-five (365) days, however, shall not invalidate or reduce the claim if it was not reasonably possible to submit the claim within such time period, provided the claim was submitted as soon as was reasonably possible and in no event, except in absence of legal capacity, later than one year from the required date.

4. Laser Vision Correction Surgery services are only covered if obtained from a VSP Primary Eye Care Doctor, Participating Surgeon and at a Participating LVC Facility, subject to the Copayment as noted in Article IV.

5. Participants should report any complaints and/or grievances to VSP at the following address:

   VSP
   Atten: Complaint & Grievance Unit

P.O. Box 997100
Sacramento, CA 95899-7100

Complaints and grievances are disagreements regarding access to care, quality of care, treatment or service, other than denial of benefits. Complaints and grievances may be submitted to VSP verbally or in writing. A Participant may submit written comments or supporting documentation concerning his/her complaint or grievance to assist in VSP's review. VSP will resolve the complaint or grievance within thirty (30) days after receipt, unless special circumstances require an extension of time. In that case, resolution shall be achieved as soon as possible, but not later than one hundred twenty (120) days after VSP's receipt of the complaint or grievance. If VSP determines that resolution cannot be achieved within thirty (30) days, VSP will notify the Participant of the expected resolution date. Upon final resolution, VSP will notify the Participant of the outcome in writing.

6. If vision claim is denied under the terms of this Plan, Participants have the right to appeal the denied claim to the Board of Trustees of the Welfare Fund of Operating Engineers Local 513, and the right to further review, in accordance with the procedures outlined in Article V, Section 13.

Exclusions

No payment shall be made for any:

1. Services or materials other than specifically set forth in the Schedule of Benefits.

2. Services or materials provided as a result of a workers' compensation or occupational disease law, or for which no charge is made, or furnished by or payable under any plan or law or any government, federal or state or any political subdivision thereof.

3. Sunglasses, which are not prescription.

4. Premium costs for contact lens insurance.

5. Circumstances described in the section "General Exclusions" beginning on page 80.

GENERAL PROVISIONS

Physical Examination and Autopsy

The Board of Trustees, through a Physician, shall have the right and opportunity to examine the person whose Illness or Injury is the basis of claim when and as often as it may reasonably require during pendency of a claim, and to make an autopsy in the case of death where it is not forbidden by law.

Legal Actions

No action at law or suit in equity shall be brought to recover any benefit from the Plan unless and until the Participant has presented the claim and received a final adverse benefit determination in accordance with the claims and appeal procedures of the Plan. No such action or suit shall be commenced more than three (3) years after such final adverse benefit determination.

Payment of Claims

Except in special circumstances, the Plan is not obligated to pay benefits to anyone except an eligible Participant, and Participants cannot validly assign benefits to another, voluntarily or involuntarily. For convenience, the Plan may pay benefits directly to Doctors, Hospitals or other providers instead of the Participant. Any payment made directly to a provider in the discretion of the Board of Trustees will, to that extent, reduce the benefits otherwise payable to the Participant.

To the extent required by law, benefits will be paid:

1. in accordance with any "Qualified Medical Child Support Order," as defined in Section 609(a) of ERISA;

2. in accordance with any assignment of rights made by a Participant as required by a state plan for medical assistance approved under Title XIX of the Social Security Act pursuant to Section 1912 (a)(1)(A) of such Act; and

3. to the extent that payment has been made under such state plan for medical assistance in any case in which this Plan has a legal liability to make payment for items or services constituting such assistance, in accordance with any state law that provides that the state has acquired the rights to such payment for such items or services.

Death benefits, if any, will be paid in accordance with the provisions which apply to such benefits. Any other benefits accrued and due the deceased but unpaid at death may be paid to the deceased Participant's estate, or, if a beneficiary of death benefits has been designated, to such beneficiary at the Board of Trustees' discretion.

If any benefits become payable to a minor not competent to give a valid receipt or release, the Board of Trustees in their discretion may appoint a custodian for such minor under the Missouri Transfer to Minors Law or similar statute and pay the benefits to such custodian.

Right to Offset

If the Fund makes a benefit payment to you or your Dependents, to which you are not entitled, it is your responsibility to notify the Fund Office. The Fund has the right to reduce future payments and/or benefits for you and your Dependents up to the amount of the erroneous payment until the overpayment is recovered.

Effect of Medicaid

To the extent required by law, the fact that an individual is eligible for or is provided medical assistance under a state plan for medical assistance under Title XIX of the Social Security Act will not be taken into account.

Interpretation, Amendment, and Termination

No Participant has a vested right to any benefit under the Plan until paid. The Board of Trustees has authority at any time to amend or eliminate any benefit under the Plan. The Plan can be terminated by written agreement of the Union and Contributing Employers and would terminate if all contributions ceased. If the Plan were to be terminated, the remaining assets would be applied to the expenses, benefits and other purposes of the Plan until they were exhausted.

GENERAL EXCLUSIONS

The following exclusions apply to all parts of the Plan. No benefits are payable under the Plan for:

1. Any Illness or Injury which arises out of or in the course of any occupation or employment for wage or profit, or for which a Participant is entitled to or receives workers' compensation benefits, whether by award or settlement.

2. Any services provided by a Hospital or medical institution owned or operated by the federal, state or local government, or medical practitioners therein, unless charges for such services are imposed against the Participant.

3. Any loss caused by war or any act of war, declared or undeclared.

4. Sterilization reversals and related charges or charges due to complications of a reversal.

5. Any loss, expense or charge resulting from participation in a riot or in the commission of a felony. If a Participant is charged with commission of a felony, or if the Board of Trustees determines, in its discretion, that there are reasonable grounds to believe that a Participant's covered Injury may have resulted from participation in commission of a felony, the Board of Trustees is authorized to suspend benefits pending resolution of the issue. This exclusion does not apply to an Injury that results from being a victim of domestic violence or a medical condition.

6. Any loss incurred while engaged in military, naval, or air service of any country.

7. Any charges the Participant is not required to pay.

8. Any treatment or service not prescribed by a Physician or, for dental treatment, by a Dentist.

9. Any charges for repair, replacement or adjustment of durable medical equipment, except when specifically provided for as a Covered Expense.

10. Organ transplants, other than those specifically provided for under the Plan unless medical documentation is provided that demonstrates to the satisfaction of the Board of Trustees that conventional treatment would be unsatisfactory, unavailable and/or more hazardous than transplant, that the patient's condition is life threatening, and that the patient is legally required to pay for the transplant procedure.

11. Cosmetic surgery, except for treatment of a covered Injury sustained in an accident or surgical treatment after a mastectomy for reconstruction of the breast on which the mastectomy was performed, surgery on the other breast to produce a symmetrical appearance, and prostheses and physical complications of all stages of mastectomy, including lymphedemas.

12. Dental treatment, except dental treatment made with six months of an accidental Injury to sound natural teeth or as specifically provided in the Dental Benefit.

13. Eye refraction or the fitting of glasses or hearing aids, except as specifically provided in the Vision Benefit and the Schedule of Benefits.

14. Treatment of the temporomandibular joint (TMJ); except the Surgeon’s fee for surgical treatment when Medically Necessary.

15. Any expense or charge for routine examinations including check-ups, premarital exams, school or sports physical examinations, or for immunizations, except as specifically provided in the Preventive Care, Vision and Dental Benefits.

16. Hypnosis or biofeedback.

17. Services or supplies that the Board of Trustees determines to be Experimental or Investigative in nature, except to the extent required to be provided by law. For example, routine patient care costs associated with approved clinical trials, while Experimental or Investigative in nature, will be covered to the extent required by the Affordable Care Act.

18. Charges incurred for custodial care.

19. Any loss, expense, or charge which results from weight control or treatment for obesity, except gastric bypass (bariatric) surgery, if Medically Necessary to treat morbid obesity.

20. Except as provided in the Schedule of Benefits, any expense or charge for orthopedic shoes, orthotics (including impressions), or other supportive devices for the feet.

21. Any expense or charge for failure to appear for an appointment as scheduled or for completion of claim forms or attorney fees.

22. Any loss, expense, or charge for sex transformation or complications related thereto.

23. Supplies or equipment ordinarily used for personal hygiene, comfort or convenience such as air conditioning, humidifiers, physical fitness and exercise equipment, waterbeds, tanning beds, or home traction units, even if they are employed for medical treatment.

24. Special home construction to accommodate a disabled individual.

25. Medical transportation services that are not Medically Necessary.

26. Except as specifically provided under the Preventive Care, Dental, Vision, and Death Benefits, any services or supplies which are not Medically Necessary. The fact that a Physician orders a service or supply does not, in itself, determine Medical Necessity.

27. Services or supplies not specifically mentioned in the Plan as being covered.

28. Nutritional counseling.

29. Any treatment related to sexual dysfunction and penile prosthesis and related devices employed in such treatment.

30. Late discharge fee.

31. In-vitro fertilization, artificial insemination, and all related charges.

32. Radial keratotomy and related charges.

33. Wigs, regardless of medical diagnosis.

34. Educational services and/or materials.

35. Speech and occupational therapy unless it is required because of impairment caused by Illness or Injury.

36. Human growth hormones.

37. Eye exercise or vision training.

38. Elective Hospital admissions on Friday, Saturday, or Sunday if surgery is scheduled Monday; Sunday admissions will be eligible for consideration if Medically Necessary.

39. Acupuncture.

40. Milieu therapy or counseling.

41. Recreational therapy or counseling.

42. Family therapy or counseling.

43. Counseling or therapy performed by any person other than a Physician, licensed psychologist, registered nurse, licensed practical nurse, or a person with other professional qualifications expressly authorized by the provisions of the Plan to perform specific covered services.

44. Any inpatient care in a facility that is not a Hospital, a Skilled Nursing Care Facility, a hospice care facility, or a facility for treatment of alcoholism, chemical dependency, or drug addiction.

45. Viagra, or other drugs prescribed for erectile dysfunction.

46. Rental cost of durable medical equipment in excess of the purchase price.

47. Lactation supplies, except to the extent required by the Affordable Care Act and the Health Resources and Services Administration guidelines for preventive services.

48. Any other exclusion or limitation specified in the Plan.

49. Expenses (medical and/or prescription drug) related to gene therapy. The Plan excludes coverage for all gene therapy procedures, which are health care services that introduce or are related to the introduction of genetic material into a person intended to replace or correct faulty or missing genetic material, whether those therapies have received approval from the U.S.Food and Drug Administration ("FDA"). Some examples of gene therapy include, but are not limited to, Chimeric Antigen Receptor T-Cell ("CAR-T") therapies such as Kymriah and Yescarta, as well as other therapies, such as Luxturna and Zolgensma.

SUBROGATION

The Fund will be entitled to reimbursement of benefit payments from a Participant who obtains compensation from a third party for an Illness or Injury on account of which the Fund paid benefits. If reimbursement is not made voluntarily, the Fund may obtain reimbursement by withholding benefits or initiating litigation to obtain reimbursement.

The Fund shall be subrogated to all rights of the Participant against any person, entity, organization or association for reimbursement on account of Illness or Injury for which the Fund has made payments of benefits to the extent thereof, except for the specific limitations contained herein. The Participant shall cooperate with the Fund and do whatever is necessary, to include, prior to the payment of any claims, executing an approved Assignment and Acknowledgment of Lien, to secure the rights of the Fund to recover payments made by it. The Participant shall do nothing which would prejudice the Fund's right to subrogation and/or recovery.

If the Participant fails to take legal action to recover from a party responsible for the Illness or Injury, the Fund may proceed in the name of the Participant against the party responsible and shall be entitled to recovery of the amount of benefit payments made and the expenses, costs and fees incurred in obtaining the recovery, and any excess thereof shall be payable to the Participant. The Fund reserves the right to compromise the amount of the claim against any third party if, in its opinion, it is appropriate to do so. If the person fails to take legal action and the Fund proceeds in the name of the Participant, and a counter claim and other costs and expenses are successfully pursued against the Participant, then the Fund shall hold the Participant harmless for such counterclaim, costs or fees.

The Participant shall have the duty to inform the Fund promptly, in writing, of any claim which may be asserted against a third party for Illness or Injury for which benefits are paid or payable to the Fund and to furnish the name and address of the third party, the basis of the claim and all other relevant details pertinent thereto.

The Participant, upon retaining an attorney in connection with such claim, shall promptly notify the Fund of the name, address and telephone number of the attorney. The Participant shall inform such attorney that the Fund will only be liable for any expenses or attorney's fees incurred in connection with the processing and/or litigation of such claims which are specifically authorized in writing by the Fund and for which written authorization for such fee and/or expense is authorized in advance by the Fund.

The Fund specifically rejects the common fund and make-whole doctrines. The Fund may, when deemed prudent and reasonable, either waive its right to reimbursement for benefit payments made or reduce or settle for a compromise amount of reimbursement of benefit payments made.

The Fund shall have no subrogation rights to any outside medical insurance, medical payments, underinsured motorist or uninsured motorist payments made as a result of insurance purchased by the Participant or by some other individual on the Participant's behalf which results in benefit payments made to that Participant and/or other eligible person.

COORDINATION OF BENEFITS

If a Participant is entitled to benefits under any other plan (as defined below) which will pay part or all of the expenses covered under this Plan, the amount of benefits payable under this Plan and any other plans will be coordinated so that the aggregate amount paid will not exceed the lesser of (i) the Allowable Expense, or (ii) the benefits payable by this Plan in the absence of coordination of benefits.

"Allowable Expense" means any charge or expense incurred by a Participant during a calendar year and while eligible under the Plan for medical care or treatment, part or all of which would be a Covered Expense under the Plan, or would be covered under an Other Plan, or both.
Any “other plan” includes any plan providing benefits or services for or by reason of Hospital or medical care or treatment, such as:

1. Group, blanket or franchise insurance coverage;

2. Group Blue Cross, Blue Shield and other prepayment coverage provided on a group basis;

3. Any coverage under labor-management trusteed plans, union welfare plans, employer organization plans or any other arrangements or benefits for individuals of a group; and

4. Any coverage under governmental programs and any coverage required or provided by any statute except Medicare. Special rules apply to coordination of benefits with Medicare.

If both father and mother are entitled to benefits under this Plan, as Employees, benefits for their eligible Dependent Children shall be paid according to each parent’s Schedule of Benefits. In no event will total benefits paid exceed 100% of the Covered Expenses.

The detailed rules for coordination of benefits can become complex in individual situations. The main objective of coordination of benefits is to determine which of the two plans providing coverage is “primary” (that is, which plan is treated as the plan that pays its benefits first and in full). This Plan’s coordination of benefit rules are summarized as follows:

1. The other plan will be primary if it does not contain any coordination of benefits provisions.

2. The plan that covers an individual directly as an Employee or Participant, other than as a Dependent, will be primary if the other plan covers the individual only as a Dependent.

3. For claims on behalf of a Dependent Child born out of wedlock or born of married parents where the parents are not divorced or separated and both parents are covered by a plan, the primary plan is the plan covering the parent whose birthday (month and day) comes first in the year, with the following exceptions:

    a. If birthdays are the same, the plan that has covered a parent longer is primary.

    b. If the other plan uses a gender rule instead of a birthday rule, the other plan is primary.

    c. If one parent is required by a court decree to be responsible for medical expenses of the child, that parent’s plan is primary.

4. For claims on behalf of a Dependent Child, where the parents are divorced or separated, and if a court decree makes one parent responsible for the child’s medical expenses, that

parent's plan is primary. If there is no such provision in a court decree, then the plan of the parent with custody is primary. If the parent with custody has remarried, the plan of parent with custody is primary, the custodial stepparent will pay second, and the plan of the noncustodial parent will pay last.

5. If none of the foregoing rules applies, the primary plan is the plan that has covered the claimant longer.

When this Plan is not determined to be primary under its coordination of benefits rules, benefits that would otherwise be paid under this Plan will be reduced so that the sum of benefits paid by this Plan and benefits payable by the primary plan do not exceed the lesser of (i) the Allowable Expense, or (ii) the benefits payable by this Plan in the absence of coordination of benefits.

"Benefits payable" by another plan include any benefits not paid in fact, to the extent that such benefits would have been payable under the provisions of the other plan but for: (i) failure to make and pursue a timely claim in accordance with the provisions of the other plan; (ii) failure to satisfy any referral procedure, pre-admission certification, or any other condition imposed by the other plan upon payment of full benefits; (iii) coordination of benefit rules of the other plan in conflict with those of this Plan; or (iv) wrongful refusal of the other plan to pay benefits.

The Fund shall not be required to coordinate benefits with respect to medical payment coverages that may exist under a Participant's and/or other eligible person's automobile insurance policy.

Coordination of Benefits with Medicare - For Retirees

Medicare (Title XVIII of the Social Security Act, as amended) provides a program of health insurance. This Plan provides coverage for Medicare eligible Retirees and Dependents through a Medicare Advantage Plan which provides all Medicare Part A & B benefits. The Retiree costs are shown in the Schedule of Benefits.

Part of the Medicare Advantage Plan requirements is that all Medicare 86ligible upon reaching age 65 enroll in Medicare. Part A of Medicare covering Hospital expenses does not require a premium payment, but Part B covering other medical expenses does require a monthly premium. If a Retiree is eligible for Medicare, in order to be enrolled in the Medicare Advantage Plan they must enroll in Medicare Parts A & B and pay the Part B premium.

Coordination of Benefits with Medicare – For Active Employees

All active Employees who are covered by the Plan as a result of current or recent work have the same health coverage under the Plan until they retire.

Generally, for active Employees and spouses, this means that if a charge is covered by both the Plan and Medicare, the Plan will pay its benefits first. Medicare is the secondary carrier for these persons covered by both this Plan and Medicare.

Government Regulations require that you be allowed to reject the medical and hospitalization coverage under the Plan and rely only on Medicare or other insurance that you may have. If you desire to reject the benefits provided under this Plan, contact the Fund Office for further instructions.

Coordination of Benefits with Medicare –End Stage Renal Disease and Social Security Disability

The Plan shall have the secondary responsibility for expenses incurred by an eligible Participant who is eligible for Medicare benefits solely because of end-stage renal disease where Medicare has primary responsibility.

The Plan shall have primary responsibility for the claim of an eligible Participant who is eligible for Medicare benefits solely because of end-stage renal disease where Medicare has secondary responsibility.

The Plan shall have primary responsibility for expenses incurred by an active Employee (as defined under the Social Security Act and the regulations thereunder) and for the active Employee's Dependents who are eligible for Medicare benefits because he/she is disabled and has received Social Security disability benefits for twenty-four (24) consecutive months.

RECIPROCITY AGREEMENTS

The Board of Trustees is authorized, in its discretion, to enter into Reciprocity Agreements with other health and welfare funds sponsored by other union locals affiliated with the International Union of Operating Engineers.

Such agreements allow employer contributions made on behalf of an Employee who is working away from his or her home area to be sent to the Employee's home fund, in order to maintain eligibility and benefits under the home fund. The Employee receives credit for eligibility and benefits in the Employee's home fund, but not in the transferring fund, on account of the transferred contributions and related work hours.

The Board of Trustees have discretion to enter into Reciprocity Agreements upon such terms as they deem advisable, including the manner of determining an Employee's home fund, and any additional conditions that must be satisfied for transfer of contributions to the home fund.

Contributions made to this Fund on behalf of an Employee will be transferred to the Employee's home fund only if the following conditions are met:

1. A Reciprocity Agreement must be in effect between this Fund and the other fund, and all terms and conditions of the Reciprocity Agreement must be satisfied.

2. The Employee must individually sign consent for contributions made to this Fund to be transferred to the Employee's home fund.

3. Contributions for an Employee will not be transferred by this Fund to any other fund under a Reciprocity Agreement after the Employee has established eligibility for benefits in this Fund, so long as such eligibility remains in effect.

CLAIMS PROCEDURES

Definitions

Claim: A request for Plan benefits, made in accordance with the Plan's claims procedures. A Claim is ordinarily a request that the Plan pays for medical, dental or vision services, supplies or equipment, or prescription drugs, or pay a death benefit.

Claimant: An individual eligible for benefits under the Plan on whose behalf a Claim is submitted.

Pre-Service Claim: A Claim for benefits for which the Plan requires approval in advance of obtaining medical care ("pre-authorization") in order to avoid a reduction in benefits.

Post-Service Claim: Any Claim that is not a Pre-Service Claim.

Claim Involving Urgent Care ("Urgent Care Claim"): Any Claim for medical care which must be decided more quickly than the determination periods applicable to non-urgent care Claims, in order to avoid (i) seriously jeopardizing the life or health of the Claimant; (ii) seriously jeopardizing the ability of the Claimant to regain maximum function; or (iii) severe pain that cannot be adequately managed without the care that is the subject of the Claim. A Claim will be treated as an Urgent Care Claim if a Physician with knowledge of the Claimant's medical condition determines that the requirements of this definition are satisfied, or if a Plan representative determines that such requirements are satisfied after applying the judgment of a prudent layperson with average knowledge of health and medicine.

Concurrent Care Decision: Any decision by the Plan to change benefits that were previously approved in advance for an ongoing course of treatment to be provided to a Claimant for a stated period of time or number of treatments.

Adverse Benefit Determination: Any denial, in whole or in part, of Plan benefits requested in a Claim, including denials based on an individual's lack of eligibility, the application of the Plan's utilization review procedures, or a determination that an item or service is Experimental or Investigative or not Medically Necessary or appropriate. A Concurrent Care Decision to reduce or terminate Plan benefits before the end of the pre-approved time or number of treatments shall be deemed an Adverse Benefit Determination, except when resulting from a Plan amendment of general application to covered individuals.

ERISA: The Employee Retirement Income Security Act of 1974, as amended.

Filing of Claims

1. **Who May File:** The initial filing of a Claim may be made by the Claimant, or by anyone on behalf of the Claimant. In many cases, a Hospital, Physician, pharmacist or other provider will file a Claim for a Claimant; however, it is the responsibility of the Claimant to ensure that a completed Claim is filed in accordance with the time limits and other terms of the Plan.

2. **Authorized Representatives:** Following initial filing, a Claim may be pursued only by the Claimant or a duly authorized representative of the Claimant. Duly authorized representatives include, for an Urgent Care Claim, a duly licensed or accredited health care professional with knowledge of the Claimant's medical condition; and for all Claims, a person possessing a written power of attorney, consent or authorization signed by the Claimant that is sufficient in the reasonable judgment of the Plan to grant to such person legal authority to act on behalf of the Claimant with respect to the Claim. The Plan reserves the right to decide in its discretion whether to deal with any other person who purports to act on behalf of a Claimant with respect to a Claim.

3. **Where to File:**

    a. Except as provided in subsection 6 below for Pre-Service Claims, all Claims for PPO benefits within the Plan's Comprehensive Major Medical Plan Benefit should be filed with the Plan's medical network provider, Anthem BlueCross BlueShield (or the local Blue plan if outside of Missouri) in accordance with the instructions on the Claimant's Anthem BlueCross BlueShield identification card.

    b. Claims for in-network benefits within the Plan's Prescription Drug Benefit should be filed with the Plan's Pharmacy Benefit Manager, MedImpact. For prescriptions filled at a participating pharmacy, the filing of such Claims is automatic, through the procedures established by MedImpact, without any action required of the Claimant except presentation of the Claimant's care identification card. Claims for prescriptions filled through the MedImpact Mail Order Service are also filed automatically, through the procedures established by MedImpact, without any action required of the Claimant. Claims for the Plan's limited out-of-network Prescription Drug Benefit should be filed at the Fund Office:

        Local 513 Fringe Benefit Funds
        3449 Hollenberg Drive, Suite 150
        Bridgeton, MO 63044
        (314) 739-2973

    c. All Claims for Plan benefits that are not described in paragraphs 1 or 2 above, or in subsection 6, should be filed at the Fund Office.

d. A Claim will be processed if filed at the Fund Office, but in such case the Plan's response time may be extended by the time necessary to transmit the Claim to Anthem BlueCross BlueShield. A Claim for in-network prescription drug benefits may only be presented and processed at the time a prescription is filled.

4. What to File:

a. A Claim must include the name, address and Social Security number of the Claimant, and the following information as applicable: the name, address and telephone number of the provider; an itemized description of services, supplies or equipment provided or to be provided, with dates and itemized charges; and such other information as the Plan may require to determine whether and in what amounts benefits are payable. A Claim for medical benefits must include a diagnosis or description of the Illness or Injury for which care is provided; but such diagnosis or description need not be repeated in each related Claim made for the same Illness or Injury.

b. A Claim will not be deemed complete until the required information has been provided, sufficient to permit a benefit determination to be made according to the terms of the Plan.

5. When to File:

a. Initial notice of a Claim, identifying the Claimant, must be given to the Plan within 20 days, or as soon thereafter as reasonably possible, following the date of loss. For this purpose, a "loss" is the occurrence of an event for which Plan benefits may be payable, such as the furnishing by a provider of covered services, supplies or equipment to the Claimant.

b. All information necessary to complete a Claim must be furnished to the Plan within 90 days, or as soon thereafter as reasonably possible, following the date of loss.

c. A Claim will be disallowed if filed more than one year after date of loss, except for unavoidable delay on account of legal incompetence of the Claimant.

6. Special Provisions for Filing Pre-Service Claims:

a. The Plan provides that if proposed medical care of a covered individual includes admission to a Hospital or other inpatient admission (including inpatient admissions for alcoholism and chemical dependency conditions and Mental and Nervous Disorders), the Plan's designated Utilization Review Service must be

notified prior to the admission, or within 48 hours thereafter in the case of an emergency admission. Failure to make timely notification will result in a reduction of $300 in benefits otherwise payable by the Plan. Utilization Review is not required before or after an emergency room visit that does not result in an inpatient admission.

b. The purpose of the required notifications is to permit a timely determination whether the treatment satisfies the Plan's requirements for Medical Necessity and appropriateness, and the notification must include sufficient information to enable such determination to be made. A notification prior to Hospital or other inpatient admission constitutes a Pre-Service Claim.

c. A covered individual may submit a request to the Plan for determination of Medical Necessity and appropriateness with respect to proposed treatments other than those for which notification is required. The Plan will endeavor to respond to such requests, but will not be bound by the time periods set forth in these claims procedures for a response to a required Pre-Service Claim.

d. The Plan's designated Utilization Review Service is HealthLink, Inc. Pre-Service Claims for Hospital admissions should be submitted to HealthLink at (314) 989-6350 or (877) 284-0102. Non-required pre-authorization requests for other medical treatment, should be submitted to the Fund Office.

If a required Pre-Service Claim notification names the Claimant, and a specific medical condition or symptom, and a specific treatment, service or product for which approval is requested, and is made by the Claimant or the Claimant's authorized representative and received by the Plan's designated Utilization Review Service or the Fund Office, but has in other respects failed to comply with the Plan's procedures for filing a Pre-Service Claim, then as soon as possible, not later than 5 days following the failure or 24 hours following the failure in case of an Urgent Care Claim, the Plan shall notify the Claimant or representative of the failure and the proper procedures to be followed. No Participant, Dependent or beneficiary shall have any right or claim to benefits under the Plan or from the Board of Trustees, except as specified in the Plan. Any dispute as to rescissions of coverage, eligibility, Medical Necessity denials, Experimental or Investigative denials, type, amount or duration of benefits under the Plan, or any amendment or modification thereof shall be resolved under the following Claim Determinations and Appeal Procedures. All benefit claim determinations will be made in accordance with governing Plan documents and, where appropriate, the Plan provisions will be applied consistently with respect to similarly situated claimants. No action may be brought for benefits provided under the Plan or any amendment or modification thereof, or to enforce any right thereunder, until after the claim has been submitted to and determined under the following Claim Determinations and appeal Procedures, unless otherwise permitted by law.

Initial Claims Determinations

1. General Provisions

    a. In the case of a failure by a claimant to follow the Plan's procedures for filing a Pre-Service Claim that: (1) is communicated by the claimant and received by a person or organizational unit customarily responsible for handling benefit matters, and (2) names the specific claimant, a specific medical condition or symptom and a specific treatment, service or product for which approval is requested, the Fund will notify the claimant of the failure and the proper procedures to be followed in filing a claim for benefits as soon as possible, but in no event later than five days (or 24 hours in the case of a failure to file a claim involving urgent care) following the failure. The notification to claimant regarding the failure to follow the Plan's procedures for filing a Pre-Service Claim may be made orally, unless written notification is requested by the claimant.

    b. For all claims, the claimant will be afforded the opportunity to review the claim file and present evidence and testimony, including written comments, documents, records, and other information relating to the claim for benefits.

    c. Claim decisions will be made impartially. The Board of Trustees will not base decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to individuals involved in the claims and appeals process, such as a claims adjudicator or medical expert, based upon the likelihood that the individual will support the denial of benefits.

    d. If the Fund has approved an ongoing course of treatment to be provided over a period of time or number of treatments, any reduction or termination by the Fund of such course of treatment (other than by Plan amendment or termination) before the end of such period of time or number of treatments shall constitute an adverse benefit determination. The Fund Office shall notify the claimant of the adverse benefit determination at a time sufficiently in advance of the reduction or termination to allow the claimant to appeal and obtain a determination on review of the adverse benefit determination before the benefit is reduced or terminated.

        Any request by a claimant to extend the course of treatment beyond the period of time or number of treatments that is a claim involving urgent care shall be decided as soon as possible, taking into account the medical exigencies, and the Fund Office shall notify the claimant of the benefit determination, whether adverse or not, within 24 hours after receipt of the claim by the Fund Office, provided that any such claim is made to the Fund Office at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.

e. The Fund Office will provide diagnosis and treatment codes (and their meanings) upon request and will not consider a request for diagnosis and treatment codes in itself as a request for an internal appeal or external review.

2. Timelines

a. *Urgent Care Claims* will be decided and notification provided to claimant as soon as possible, consistent with the medical exigencies involved but in no event later than 72 hours after the Fund Office receives the claim unless the claimant fails to provide sufficient information to determine whether or to what extent benefits are payable under the Plan. In the case of such a failure, the Fund Office shall notify the claimant as soon as possible, but not later than 24 hours after receipt of the claim by the Fund Office of the specific information necessary to complete the claim. The claimant will have a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to respond. The Board of Trustee's designee will decide the claim and provide the required notification to the claimant as soon as possible after receiving the missing information, but no later than 48 hours after receipt of the missing information. If the designee does not receive the missing information, the designee will decide the claim and provide notice to the claimant as soon as possible, but no later than 48 hours after the time for providing the missing information has elapsed. The designee can notify the claimant orally of the benefit determination so long as a written notification is furnished to the claimant no later than three days after the oral notification.

b. *Pre-Service Claims* must be decided within a reasonable period of time appropriate to the medical circumstances, but no later than 15 days after the Fund Office has received the claim. The Board of Trustees' designee may extend the time period up to an additional 15 days if, for reasons beyond the designee's control, the decision cannot be made within the first 15 days. The designee must notify the claimant prior to the expiration of the first 15-day period, explaining the reason for the delay, requesting any additional information, and advising the claimant of when the designee expects to make the decision. If more information is requested, the claimant shall have at least 45 days to supply it. In the event a period of time is extended for deciding a claim due to the claimant's failure to submit information necessary to decide a claim, the period for making the benefit determination shall be tolled from the date on which the notification of the extension is sent to the claimant until the date on which the claimant responds to the request for additional information or the time for responding to the request for additional information has elapsed. The designee must give the claimant written notice that his/her claim has been granted or denied before the end of the time allotted for the decision.

c. *Post-Service Claims* must be decided within a reasonable period of time, but not later than 30 days after the Fund Office has received the claim. If, because of reasons beyond the Board of Trustees' designee's control, more time is needed to review the claimant's request, the designee may extend the time period up to an additional 15 days. However, the designee has to let the claimant know before the

end of the first 30-day period, explaining the reason for the delay, requesting any additional information needed, and advising the claimant when a final decision is expected. If more information is requested, the claimant shall have at least 45 days to supply it. In the event a period of time is extended for deciding a claim due to the claimant's failure to submit information necessary to decide a claim, the period for making the benefit determination shall be tolled from the date on which the notification of the extension is sent to the claimant until the date on which the claimant responds to the request for additional information or the time for responding to the request for additional information has elapsed. The designee must give the claimant written notice that his/her claim has been denied in whole or in part (paying less than 100 percent of the claim) before the end of the time allotted for the decision.

d. *Disability Claims* must be decided within a reasonable period of time, but not later than 45 days after the Fund Office has received the claim. If, because of reasons beyond the Board of Trustees' designee's control, more time is needed to review the claimant's request, the designee can extend the timeframe up to 30 days by notifying the claimant prior to the end of the first 45-day period that additional time is needed, the circumstances requiring the extension of time and the date by which the designee expects to render a decision. If prior to the end of the first 30-day extension period, the designee determines that, due to matters beyond its control, a decision cannot be rendered within that extension period, the period for making the determination may be extended for up to an additional 30 days, provided that the designee notifies the claimant, prior to the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date by which the designee expects to render a decision. In the case of any extension the notice of extension shall specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues, and the claimant shall be afforded at least 45 days within which to provide the specified information. In the event a period of time is extended for deciding a claim due to the claimant's failure to submit information necessary to decide a claim, the period for making the benefit determination shall be tolled from the date on which the notification of the extension is sent to the claimant until the date on which the claimant responds to the request for additional information or the time for responding has elapsed. The designee must give the claimant notice of whether the claimant's claim has been denied before the end of the time allotted for the decision.

3. Notice of Claim Denial

The Board of Trustees' designee shall provide a claimant with written or electronic notification in a culturally and linguistically appropriate manner of any adverse benefit determination. Any electronic notification shall comply with the standards imposed by 29 CFR 2520.104b-1I(1)(i), (iii), and (iv). The notification shall be set forth, in a manner calculated to be understood by the claimant and shall include the following:

a. The specific reason for an adverse benefit determination;

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

c. A description of any additional material or information necessary to perfect the claim and an explanation of why such material is necessary;

d. An explanation of the Plan's appeal procedures, including applicable time limits, how to initiate an appeal, and a statement of the claimant's right to bring civil action following an adverse benefit determination on review;

e. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse benefit determination, a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse benefit determination and that a copy of the rule, guideline, protocol, or other criterion will be provided free of charge to the claimant upon request to the Fund Office;

f. If the adverse benefit determination was based on a Medical Necessity or Experimental or Investigative treatment or similar exclusion or limit, a statement that an explanation of the scientific or clinical judgment for the determination will be provided free of charge upon request to the Fund Office;

g. In the case of an adverse benefit determination concerning a claim involving urgent care, a description of the expedited review process applicable to such claims;

h. In the case of an adverse benefit determination with respect to disability benefits;

   i. A discussion of the decision, including an explanation of the basis for disagreeing with or not following to the extent applicable: (i) the views presented by the claimant to the Fund of health care professionals treating the claimant and vocational professionals who evaluated the claimant; (ii) the views of medical or vocational experts whose advise was obtained on behalf of the Fund in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the adverse benefit determination, and (iii) a disability determination regarding the claimant presented by the claimant to the Fund made by the Social Security Administration;
   ii. If the adverse benefit determination is based on a Medical Necessity or Experimental or Investigative treatment or similar exclusion or limit, a statement that an explanation of the scientific or clinical judgement for the determination will be provided free of charge upon claimant's request to the Fund Office;
   iii. The specific internal rules, guidelines, protocols, standards or other similar criteria of the Fund relied upon in making the adverse benefit determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Fund do not exist; and

iv. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claimant's claim for benefits. A document, record, or other information shall be considered "relevant" to a claimant's claim if such document, record, or other information: (i) was relied upon in making the benefit determination; (ii) was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination; (iii) demonstrates compliance with the administrative process and safeguards required by 29 C.F.R. 2560.503-1 in making the benefit determination; or (iv) constitutes a statement of policy or guidance with respect to the Fund concerning the denied treatment option or benefit for the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

In the case of an adverse benefit determination with respect to disability benefits, the notification shall be provided in a culturally and linguistically appropriate manner;

i. The date of service;

j. The health care provider;

k. The claim amount (where applicable);

l. A statement describing the availability upon request, or the diagnosis code and its corresponding meaning and the treatment code and its corresponding meaning;

m. Denial code and its corresponding meaning as well as a description of the Fund's standard, if any, that was used in denying the claim; and

n. Information about the availability of and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under PHS Act Section 2793 to assist individuals with the internal claims and appeal and external review process.

Internal Appeals

1. General Provisions

a. If the claimant's claim for benefits under the Plan is denied in whole or in part, the Board of Trustee's designee will notify the claimant of such in writing as set out above. The claimant shall have the right to appeal a denied claim to the Board of Trustees, and to request a personal appearance before the Board of Trustees if he/she so desires.

b. To file an appeal of an adverse benefit determination, the claimant must file a request for review of the adverse benefit determination within 180 days of the claimant's receipt of the adverse benefit determination notice. Failure to file a request within the 180-day period will constitute a waiver of the claimant's right to appeal the adverse benefit determination or to take any other action with respect to it. An appeal shall be in writing, shall state in clear and concise terms the reason(s) for disputing the denial, and shall be accompanied by any pertinent documentary material not already furnished to the Board of Trustees that the claimant wishes to submit.

c. The period of time within which a benefit determination on review is required to be made shall begin at the time an appeal is filed in accordance with these procedures without regard to whether all the information necessary to make a benefit determination on review accompanies the filing. In the event that a period of time is extended as permitted due to the claimant's failure to submit information necessary to decide a claim, the period for making the benefit determination on review shall be tolled from the date on which the notification of extension is sent to the claimant until the date on which the claimant responds to the request for additional information.

d. When deciding appeals, the Board of Trustees will 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. The review on appeal will not afford deference to the initial adverse benefit determination and will be conducted by the Board of Trustees, which does not make initial adverse benefit determinations.

e. The Fund Office will provide diagnosis and treatment codes (and their meanings) upon request and will not consider a request for diagnosis and treatment codes in itself as a request for an internal appeal or external review.

f. For all appeals, the claimant will be afforded the opportunity to review the claim file and present evidence and testimony, including written comments, documents, records, and other information relating to the claim for benefits.

g. The claimant shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits. A document, record or other information shall be considered "relevant" to a claimant's claim if such document, record or other information: (i) was relied upon in making the claim determination; (ii) was submitted, considered, or generated in the course of making the claim determination, without regard to whether such document, record, or other information was relied upon in making the claim determination; (iii) demonstrates compliance with the administrative processes and safeguards required by 29 C.F.R 2560.503-1 in making the benefit determination; or (iv) constitutes a statement of policy or guidance with respect to the Fund concerning the denied treatment option

or benefit for the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the claim determination.

h. The Board of Trustees will provide that, in deciding an appeal of any initial adverse benefit determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug or other item is Experimental or Investigative, or not Medically Necessary or appropriate, the Board of Trustees shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. Such health care professional shall be an individual who is neither an individual who was consulted in connection with the initial adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual.

i. The Board of Trustees will provide for the identification of medical or vocational experts whose advice was obtained on behalf of the Fund in connection with the claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination.

j. If the Board of Trustees considers, relies upon or generates new or additional evidence in connection with an appealed claim other than the evidence furnished by the claimant, the Board of Trustees will afford the claimant a reasonable opportunity to respond to the new or additional evidence. The Board of Trustees will provide the claimant with a copy of the new or additional evidence free of charge, within a sufficient amount of time to respond to the evidence prior to the date on which the Board of Trustees is required to provide a final determination on the claim. If the new or additional evidence is received so late that it would be impossible to provide it to the claimant in time for the claimant to have a reasonable opportunity to respond, the period for providing a notice of final internal adverse benefit determination is tolled until such time as the claimant has a reasonable opportunity to respond. After the claimant responds, or has a reasonable opportunity to respond but fails to do so, the Fund Office shall notify the claimant of the Fund's benefit determination as soon as a fund acting in a reasonable and prompt fashion can provide the notice, taking into account medical exigencies.

k. If the Board of Trustees denies a claim on appeal based on a rationale different from the rationale for the original claim denial, the Board of Trustees will afford the claimant a reasonable opportunity to respond to the new rationale. The Board of Trustees will provide the claimant with the rationale free of charge, within a sufficient amount of time to respond to the new rationale prior to the date on which the Board of Trustees is required to provide a final determination on the claim. If the new or additional evidence is received so late that it would be impossible to provide it to the claimant in time for the claimant to have a reasonable opportunity to respond, the period for providing a notice of final internal adverse benefit determination is tolled until such time as the claimant has a reasonable opportunity to respond. After the claimant responds or has a reasonable opportunity to respond but fails to do so, the Fund Office shall notify the claimant of the Fund's benefit

determination as soon as a fund acting in a reasonable and prompt fashion can provide the notice, taking into account medical exigencies.

l. If 10 percent or more of the population residing in the claimant's county are literate in the same non-English language, as determined based on American Community Survey data published by the United States Census Bureau, then upon request, the Board of Trustees will provide notices to a claimant in that non-English language.

m. Appeal decisions will be made impartially. The Board of Trustees will not base decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to individuals involved in the claims and appeals process, such as a claims adjudicator or medical expert, based upon the likelihood that the individual will support the denial of benefits.

n. The Board of Trustees will provide for a review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate named fiduciary for the Fund who is neither the individual who made the adverse benefit determination that is the subject of appeal, nor the subordinate of such individual.

2. Timelines

a. *Urgent Care Claims*: Appeals related to Urgent Care Claims will be decided and notice provided to the claimant as soon as possible consistent with the medical exigencies involved but in no event later than 72 hours after the Fund Office receives the appeal. In the case of an Urgent Care Claim, the request for an expedited appeal may be submitted orally or in writing by the claimant and all necessary information, including the Board of Trustees' benefit determination on review will be transmitted between the Board of Trustees and the claimant by telephone, facsimile, or other available similarly expeditious method.

b. *Pre-Service Claims*: Appeals related to Pre-Service Claims must be decided and notice provided to the claimant within a reasonable period of time consistent with the medical exigencies involved but in no event later than 30 days after the Fund Office receives the appeal.

c. *Post-Service Claims*: Appeals related to Post-Service Claims must be decided by the Board of Trustees no later than the date of the meeting of the Board of Trustees that immediately follows the Fund Office's receipt of a request for review, unless the request for review is filed within 30 days preceding the date of such meeting. In such case, a benefit determination will be made by no later than the date of the second Board of Trustees' meeting following the Fund Office's receipt of the request for review. If special circumstances require a further extension of time for processing, a benefit determination shall be rendered not later than the third Board of Trustees' meeting following the Fund Office's receipt of the request for review. If such an extension of time for review is required because of special circumstances, the Fund Office shall provide the claimant with written notice of the extension,

describing the special circumstances and the date as of which the benefit determination will be made, prior to the commencement of the extension. The Fund Office shall notify the claimant of the Board of Trustees' benefit determination as soon as possible, but not later than five days after the benefit determination on appeal is made.

d. *Disability Claims*: Appeals related to Disability Claims must be decided by the Board of Trustees no later than the date of the meeting of the Board of Trustees that immediately follows the Fund Office's receipt of a request for review, unless the request for review is filed within 30 days preceding the date of such meeting. In such case, a benefit determination will be made by no later than the date of the second Board of Trustees' meeting following the Fund Office's receipt of the request for review. If special circumstances require a further extension of time for processing, a benefit determination shall be rendered not later than the third Board of Trustees' meeting following the Fund Office's receipt of the request for review. If such an extension of time for review is required because of special circumstances, the Fund Office shall notify the claimant in writing of the extension, describing the special circumstances and the date as of which the benefit determination will be made, prior to the commencement of the extension. The Fund Office shall notify the claimant of the Board of Trustees' benefit determination as soon as possible, but not later than five days after the benefit determination on appeal is made.

3. Notice of Benefit Determination on Appeal

The Fund Office shall provide claimant with written or electronic notification of the Board of Trustees' notice of benefit determination following an internal appeal in a culturally and linguistically appropriate manner. Any electronic notification shall comply with the standards imposed by 29 CFR 2520.104I(c)(1)(i), (iii), and (iv). The notification shall be set forth, in a manner calculated to be understood by the claimant and shall include the following:

a. The specific reason for an adverse benefit determination;

b. Reference to the specific Plan provision(s) on which the benefit determination was based;

c. A statement that the claimant is entitled to receive, upon request and free of charge reasonable access to, and copies of all documents, records and other information relevant to the claimant's claim for benefits. A document, record, or other information shall be considered "relevant" to a claimant's claim if such document, record, or other information: (i) was relied upon in making the benefit determination; (ii) was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination; (iii) demonstrates compliance with the administrative process and safeguards required by 29 C.F.R. 2560.503-1 in making the benefit determination; or (iv) constitutes a statement of policy or guidance with respect to the Fund concerning the denied

treatment option or benefit for the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination;

d. An explanation of the Plan's external review procedures, including applicable time limits, how to initiate an external review and a statement of the claimant's right to bring civil action following the final external review decision. The explanation shall include a description of any applicable contractual limitations period that applies to the claimant's right to bring a civil action under Section 502(a) of the Act, including the calendar date on which the contractual limitations period expires for the claim;

e. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse benefit determination on appeal, a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse benefit determination on appeal and that a copy of the rule, guideline, protocol, or other criterion will be provided free of charge to the claimant upon request to the Fund Office;

f. If the adverse benefit determination on appeal was based on a Medical Necessity or Experimental or Investigative treatment or similar exclusion or limit, a statement that an explanation of the scientific or clinical judgment for the determination will be provided free of charge upon request to the Fund Office;

g. 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."

h. In the case of an adverse benefit determination on appeal with respect to disability benefits,

    i. A discussion of the decision, including an explanation of the basis for disagreeing with or not following to the extent applicable: (i) the views presented by the claimant to the Fund of health care professionals treating the claimant and vocational professionals who evaluated the claimant; (ii) the views of medical or vocational experts whose advise was obtained on behalf of the Fund in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the adverse benefit determination, and (iii) a disability determination regarding the claimant presented by the claimant to the Fund made by the Social Security Administration;

    ii. If the adverse benefit determination on appeal is based on a Medical Necessity or Experimental or Investigative treatment or similar exclusion or limit, a statement that an explanation of the scientific or clinical judgement for the determination, applying the terms of the Plan to the claimant's medical circumstances will be provided free of charge upon claimant's request to the Fund Office;

iii. The specific internal rules, guidelines, protocols, standards or other similar criteria of the Fund relied upon in making the adverse benefit determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Fund do not exist; and

iv. In the case of an adverse benefit determination on appeal with respect to disability benefits, the notification shall be provided in a culturally and linguistically appropriate manner;

i. In the case of an adverse benefit determination on appeal concerning a claim involving urgent care, the notification of adverse benefit determination may be provided to the claimant orally within the time lines set out above for responding to claims involving urgent care, provided that a written or electronic notification of adverse benefit determination is provided to the claimant not later than 3 days after the oral notification;

j. The date of service;

k. The health care provider;

l. The claim amount (where applicable);

m. A statement describing the availability upon request, or the diagnosis code and its corresponding meaning and the treatment code and its corresponding meaning;

n. Denial code and its corresponding meaning as well as a description of the Plan's standard, if any, that was used in denying the claim; and

o. Information about the availability of and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under PHS Act Section 2793 to assist individuals with the internal claims and appeal and external review process.

External Review Procedure

If a claim or internal appeal involving: (1) medical judgment (excluding those that involve only contractual or legal interpretation without any use of medical judgment) as determined by the external reviewer, (2) Emergency Services received from non-PPO providers, (3) non-Emergency Services performed by non-PPO providers at PPO Health Care Facilities, (4) Air Ambulance Services furnished by non-PPO providers, or (5) a rescission of coverage, is denied by the Board of Trustees, the claimant will have the opportunity to request external review of the Board of Trustees' decision according to the following procedure.

1. Standard External Review Process:

This section sets forth procedures for standard external review. Standard external review is external review that is not considered expedited.

a. A claimant may file a request for external review within four months after receipt of a notice that a claim or internal appeal was denied. If there is no corresponding date four months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth month following the receipt of the notice. For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday, or federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or federal holiday.

b. Within five business days after receipt of a request for external review, the Board of Trustees will complete a preliminary review to verify: (1) that the claimant is or was covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the Plan at the time the health care item or service was provided; (2) that the claim or appeal denial was not based on ineligibility for coverage; (3) that the claimant has exhausted the Plan's internal claims and appeals processes (or is deemed under applicable regulations to have done so), and that the claim or appeal denial is otherwise eligible for external review; and (4) that the claimant has furnished all information required to process an external review.

c. The Board of Trustees will notify the claimant in writing of whether the request is complete and the request is eligible for external review within one business day after completion of the preliminary review. If the request is not eligible for external review, the notice will explain why, and provide contact information (including phone number) for the Employee Benefits Security Administration. If the request is not complete, the notice will describe the information needed, and the Board of Trustees will allow the claimant to perfect the request within the four-month filing period or, if longer, within 48 hours after receipt of the notice.

d. The Fund will ensure that the Independent Review Organization ("IRO") process is not biased and ensures independence. Any IRO used by the Fund will be accredited by URAC or by a similar nationally-recognized accrediting organization. The IRO is not eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits and the IRO process may not impose any costs, including filing fees on the claimant requesting the external review.

e. The Fund will ensure that the contract between the IRO and the Fund complies with 45 CFR 147.136(d)(2)(iii)(B).

f. The Fund will contract with at least three accredited IROs, and will assign eligible requests for external review to them in rotating order.

g. Within five business days after assignment of a request to an IRO, the Fund Office will provide to the IRO the documents and information considered by the Board of Trustees or its designee in denying the claim or appeal. Regulations provide that if the Fund fails to timely provide the documents and information, the external review cannot be delayed and the IRO may terminate the external review and make a decision to reverse the adverse benefit determination. Within one business day after making the decision, the IRO must notify the claimant and the Fund.

h. Regulations provide that the IRO will: (1) utilize legal experts where appropriate to make coverage determinations under the Plan; (2) timely notify the claimant of the request's eligibility and acceptance for review and allow the claimant ten days to submit additional information for consideration; (3) forward any additional information submitted by the claimant to the Board of Trustees within one business day so the Fund can reconsider its adverse benefit determination as provided in (i) below; (4) review all of the information and documents timely received and review the claim without consideration for the previous decisions made by the Board of Trustees or its designee; and (5) provide written notice to the Board of Trustees and the claimant of the IRO's final decision within 45 days after receiving the request for external review.

i. Where additional information is submitted by the claimant during the external review and that information is then forwarded to the Fund as provided in (h) above, the Fund may reconsider its adverse benefit determination that is the subject of the external review. Reconsideration by the Fund will not delay the external review and the external review may only be terminated as a result of the reconsideration if the Fund decides, upon completion of its reconsideration to reverse its adverse benefit determination and provide coverage or payment. Within one business day after making such decision, the Fund must provide written notice of its decision to the claimant and the assigned IRO. The assigned IRO must terminate the external review upon receipt of the notice from the Fund.

j. In conducting its review, the IRO will consider the following documents in reaching a decision to the extent they are available and the IRO considers them appropriate:

    i. The claimant's medical records;

    ii. The attending health care professional's recommendation;

iii. Reports from appropriate health care professionals and other documents submitted by the Fund, claimant or the claimant's treating provider;

iv. 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;

v. 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;

vi. Any applicable clinical review criteria developed and used by the Fund unless the criteria are inconsistent with the terms of the Plan or applicable law; and

vii. To the extent the final IRO decision maker is different from the IRO's clinical reviewer, the option of such clinical reviewer, after considering information described in the notice, to the extent the information or documents are available and the clinical reviewer or reviewers consider such information or documents appropriate.

k. The decision notice from the IRO will contain the following:

i. 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), and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the Fund's denial);

ii. The date the IRO received the assignment to conduct the external review and the date of the IRO decision;

iii. References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;

iv. A discussion of the principal reason(s) for the IRO's decision including the rational for its decision and any evidence-based standards that were relied on in making its decision;

v. A statement that the IRO's determination is binding except to the extent that other remedies may be available under State or Federal

law to either the Fund or the claimant, or to the extent the Fund voluntarily makes payment on the claim or otherwise provides benefits at any time, including after a final external revision decision that denies the claim or otherwise fails to require such payment or benefits;

vi. A statement that judicial review may be available to the claimant; and

vii. Current contact information, including phone number for any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793.

l. After a final external review decision, the IRO will maintain records of all claims and notices associated with the external review process for six years. The IRO will 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.

m. Upon receipt of a notice of a final external review decision reversing the adverse benefit determination or adverse benefit determination on appeal, the Fund will immediately provide coverage or payment (including immediately authorizing care or immediately paying benefits) for the claim.

2. Expedited External Review

A claimant may make a request for an expedited external review with the Fund Office at the time the claimant receives: (1) an adverse benefit determination if the adverse benefit determination involves a medical condition of the claimant for which the timeframe for completion of an expedited internal appeal would seriously 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 (2) an adverse benefit determination on appeal, if the claimant has 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 adverse benefit determination on appeal 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 the facility. Where a claimant has requested an expedited external review, the expedited external review will be processed as follows:

a. The Board of Trustees or its designee will conduct the preliminary review immediately upon receipt of the request for expedited external review, to determine whether the request meets the reviewability requirements for standard external review, and then immediately send notification in writing

to the claimant of its determination. If the request is complete but not eligible for external review, such notification will include the reasons for its ineligibility and current contact information, including the phone number, for the EBSA. If the request is not complete, such notification must describe the information or materials needed to make the request complete and the Fund must allow the claimant to perfect the request for external review within the four-month period or within the 48 hour period following receipt of the notification, whichever is later.

b. Upon determining that the request is eligible for external review, the Board of Trustees or its designee will assign the request to an IRO pursuant to the requirements set out above in Standard External Review Process. The Fund will provide or transmit all necessary documents and information considered in making the adverse benefit determination or final internal adverse benefit determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method.

c. The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the information or documents described above under the Standard External Review Process. 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 Fund's internal claims and appeals process.

   The Board of Trustees contract will require the IRO to provide notice of its decision to the Board of Trustees and the claimant as expeditiously as possible given the claimant's medical condition and circumstances, but no later than 72 hours after receiving the request for expedited external review. The notice will be consistent with the notice provided under the Standard External Review Process set out in Section C(1)(k) above. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO must provide written confirmation of the decision to the claimant and the Fund.

Authorized Representatives

A claimant has the right to designate an authorized representative to represent him/her under these Claim Determinations and Appeal Procedures, including the external review process set out above. Claimant must designate his/her authorized representative to the Board of Trustees in writing, except in the case of an Urgent Care Claim, in which case, a health care professional with knowledge of the claimant's medical condition shall be permitted to act as the authorized representative of the claimant.

Culturally and Linguistically Appropriate Notices

To ensure the Fund is providing notifications in a culturally and linguistically appropriate manner, the Fund will, when required to do so by law:

1. Provide oral language services (such as a telephone customer assistance hotline) that includes answering questions in any applicable non-English language and providing assistance with filing claims and appeals (including external review) in any applicable non-English Language;

2. Provide, upon request, a notice in any applicable non-English language; and

3. Include, in the English versions of all notices, a statement prominently displayed in any applicable non-English language clearly indicating how to access the language services provided by the Fund.

With respect to an address in any Untied States county to which a notice is sent, a non-English language is an "applicable non-English language" if ten percent or more of the population residing in the county is literate only in the same non-English language, as determined in guidance published by the Secretary of the Department of Labor.

Providing continued coverage pending the outcome of an appeal

The Fund will provide continued coverage pending the outcome of an appeal where the Fund has approved an ongoing course of treatment. The Fund will provide an opportunity for appeal or review before reducing/terminating coverage (except where reduction or termination is due to a Plan amendment or termination).

Timelines extended when required by law

Should any temporary or permanent changes in the law conflict with any provisions of this section, the provisions set out in the law will apply. For example, should the government require the Plan to provide additional time for Participants and Beneficiaries to file claims and/or appeals due to a natural disaster or otherwise, the extended timelines shall apply while in effect and the timelines set out in this section shall be disregarded.

DEFINITIONS

Air Ambulance Services: means medical transport by a rotary wing air ambulance, as defined in 42 CFR 414.605, or fixed wing air ambulance, as defined in 42 CFR 414.605, for patients.

Benefit Class: means the classification of Participant benefit level determined by his/her hourly contribution rate or the Retiree self-pay rate.

Contributing Employer: means any employer signatory to a collective bargaining agreement with the Union requiring contributions to this Fund, or any employer or Union signatory to any other agreement requiring contributions to this Fund, provided the employer has been accepted as a Contributing Employer by the Board of Trustees.

Covered Employment: means employment for which a Contributing Employer acceptable to the Board of Trustees is required, by written agreement, to contribute to the Fund on behalf of Employees.

Dentist: means a licensed dentist practicing within the scope of his/her license. The term "Dentist" also includes a Physician authorized by his/her license to perform the particular dental services he/she has rendered.

Doctor, Physician, or Surgeon: means licensed Physicians, osteopaths, Dentists, podiatrists, chiropractors and speech pathologists, when practicing within the scope of their licenses.

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

Emergency Department: means a Hospital emergency room or a Hospital outpatient department that provides Emergency Services.

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) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (i) 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, (ii) serious impairment to bodily functions; or (iii) serious dysfunction of any bodily organ or part.

Emergency Services: means with respect to an Emergency Medical Condition: (i) a medical screening examination by an Emergency Services Provider (as required under section 1867 of the Social Security Act (42 U.S.C. 1395dd) or as would be required under such section if such section applied to an Independent Freestanding Emergency Department) that is within the capability of the Emergency Services Provider, including Ancillary Services routinely available to the Emergency Services Provider to evaluate such emergency medical condition, and (ii) such further medical examination and treatment (as are required under section 1867 of the Social Security Act

(42 U.S.C. 1395dd), or as would be required under such section if such section applied to an Independent Freestanding Emergency Department) to Stabilize the patient, to the extent they are within the capabilities of the staff and facilities available at the Hospital or the Independent Freestanding Emergency Department, as applicable, and (iii) post-stabilization care to the extent required under 26 U.S.C. Section 9816(a)(3)(C)(ii).

Emergency Services Provider: means an Emergency Department or an Independent Freestanding Emergency Department.

Employee: means any employee of a Contributing Employer who is eligible for benefits according to the provisions set forth in Article III, "Eligibility" of these Rules and Regulations.

Experimental or Investigative: means a treatment, procedure, device, drug or medicine that:

(1) cannot be lawfully marketed without U.S. Food and Drug Administration approval, which approval has not been granted; or
(2) is educational or provided primarily for research; or
(3) relates to or is provided for the transplant of non-human organs; or
(4) according to the consensus of medical opinion, requires further clinical trials or studies to determine efficacy, safety, toxicity or maximum tolerated dose; or
(5) is undergoing phase I, II, or III clinical trials, or is under study.

Fund: means the Welfare Fund of Engineers Local 513, a Trust.

Fund Office: means the business location of the Fund, which is located at 3449 Hollenberg Drive, Suite 150, Bridgeton, Missouri 63044.

Health Care Facility: means, in relations to non-Emergency Services: (i) a hospital (as defined in section 1861(e) of the Social Security Act); (ii) a hospital outpatient department; (iii) critical access hospital (as defined in section 1861(mm)(1) of the Social Security Act); and (iv) an ambulatory surgical center described in section 1833(i)(1)(A) of the Social Security Act.

Hospital: As used herein, the term "Hospital" shall mean an institution that meets all these requirements:

(1) is a place which is licensed or recognized as a general hospital by the proper authority of the state in which it is located;
(2) is mainly engaged in providing in-patient medical care for diagnosis and treatment of Injuries or Illnesses, and routinely makes a charge for the care;
(3) is supervised by a staff of Physicians on the premises;
(4) continually provides twenty-four (24)-hour-a-day nursing service by registered nurses;
(5) has a laboratory and x-ray facility; and
(6) is operated with organized facilities for operative surgery on the premises.

When treatment is needed for a Mental or Nervous Disorder, “Hospital” can also mean a place that meets these requirements:

(1) is licensed as a mental hospital by the proper authority of the state in which it is located;
(2) has rooms for resident inpatients;
(3) is equipped to treat Mental and Nervous Disorders;
(4) has a resident psychiatrist on duty or on call at all times; and
(5) as a regular practice, charges the patient for the Expense of confinement.

The term "Hospital" does not include a hospital or institution or part of a hospital or institution which is licensed or used principally as a clinic, convalescent home, rest home, nursing home or home for the aged.

Illness: means a disorder of the body or mind, a disease, or a pregnancy. Multiple Illnesses due to the same cause or related causes are considered one Illness.

Independent Freestanding Emergency Department: means a health care facility (not limited to those described in the definition of Health Care Facility) that: (i) is geographically separate and distinct and licensed separately from a Hospital under applicable State law; and (ii) provides any Emergency Services.

Injury: means bodily injury caused by an accident and that results directly from the accident, independent of all other causes.

Mental and Nervous Disorder: means any severe medical disturbance as manifested by impaired functioning, caused by genetic, physical, chemical, biological, or psychological factors. Mental and Nervous Disorders shall not include behavioral dysfunction, mental retardation, learning disabilities or senescent changes such as confusion, memory loss, senile dementia and Alzheimer's Disease.

Owner-Operator: means an individual employed in Covered Employment, whose Contributing Employer is himself or an entity in which he has ownership interest.

Participant: means a person eligible for benefits under the Plan, as an Employee, Retiree, or Dependent.

Plan: means the "Plan Document of Welfare Fund of Engineers Local 513 Rules and Regulations Amended and Restated as of May 1, 2014", and any amendments thereto.

Recipient: means an eligible Participant who undergoes a surgical operation to receive a body organ transplant.

Retiree: means a retired person who was an Employee at or before the time of retirement and is eligible to receive Retiree benefits under the Plan.

Stabilize: means with respect to an Emergency Medical Condition, that: (i) no material deterioration of the condition is likely, within reasonable medical probability, to result from or

occur during the transfer of the individual from a facility, or, (ii) with respect to a pregnant woman who is having contractions where there is inadequate time to make a safe transfer to another hospital before delivery or the transfer may pose a threat to the health or safety of the woman or the unborn child, that the woman has delivered (including the placenta).

Surgical Procedures: means the cutting, suturing, correction of a fracture, reduction of dislocation, electro cauterization, tapping (paracentesis), administration of artificial pneumothorax, removal of stone or foreign body by endoscopic means or injection of sclerosing solution.

ADDITIONAL INFORMATION REQUIRED BY ERISA

a. PLAN NAME

Welfare Fund of Engineers Local 513

b. BOARD OF TRUSTEES

The Board of Trustees is responsible for the operation of the Fund. The Board of Trustees consists of an equal number of Employer and Union representatives. To contact the Board of Trustees use the address and phone number below:

Welfare Fund of Engineers Local 513
c/o BeneSys, Inc.
3449 Hollenberg Drive, Suite 150
Bridgeton, MO 63044
(314) 739-2973

The Board of Trustees is the Plan Administrator. As of May 1, 2022, the Trustees of the Fund are:

UNION TRUSTEES

Tim Sappington Operating Engineers Local Union 513
3449 Hollenberg Drive
Bridgeton, MO 63044

Steve Straatmann Operating Engineers Local Union 513
3449 Hollenberg Drive
Bridgeton, MO 63044

Aaron Gray Operating Engineers Local Union 513
3449 Hollenberg Drive
Bridgeton, MO 63044

EMPLOYER TRUSTEES

Jeremy Bennett
Site Improvement Association
2071 Exchange Drive
St. Charles, MO 63303

Charlie Goodwin
Goodwin Brothers
4885 Baumgartner Rd.
Saint Louis, MO 63129

John Grib
Alberici
8800 Page Avenue
St. Louis, MO 63114

A complete list of the Contributing Employers and employee organizations sponsoring the Plan may be obtained by Participants and beneficiaries upon written request to the Plan Administrator and is available for examination by Participants and beneficiaries as required by law. Information as to whether a particular employer or employee organization is a sponsor of the Plan, including the sponsor's address is also available upon written request.

c. PLAN'S EMPLOYER IDENTIFICATION NUMBER

The Employer Identification Number (EIN) assigned to the Board of Trustees by the Internal Revenue Service is 43-6071748

PLAN NUMBER

The plan identification number assigned to this Fund is 501

d. TYPE OF PLAN

The Plan is a group health plan as defined by ERISA Section 733. The Plan provides self-funded Hospital, medical, surgical, prescription drug, dental, vision, and death and accidental death and dismemberment benefits. The Plan also provides a fully insured Medicare Advantage Plan to Medicare-eligible Participants.

e. ADMINISTRATION OF THE TRUST FUND

The day to day administration of the Plan is performed by the Fund Manager retained by the Board of Trustees and compensated by the Fund at the direction of the Board of Trustees.

In accordance with prudent management standards, the following professional advisors are retained by the Fund to assist the Board of Trustees in the operation of the Fund:

1. Consultant who assists the Board of Trustees in technical matters relating to the operations of the Fund, such as the design of benefit programs and eligibility provisions, analysis of emerging loss experience and projections of anticipated benefit costs, preparation of specifications for competitive bids, etc.;

2. Certified Public Accountant, responsible to the Board of Trustees for auditing the financial statements of the Fund; and

3. Legal Counsel.

f. FUND MANAGER ADDRESS

BeneSys, Inc.
3449 Hollenberg Drive, Suite 150
Bridgeton, MO 63044
(314) 739-2973

g. NAME AND ADDRESS OF AGENT FOR SERVICE OF PROCESS

Welfare Fund of Engineers Local 513
c/o BeneSys, Inc.
3449 Hollenberg Drive, Suite 150
Bridgeton, MO 63044
(314) 739-2973

Service of legal process may be made upon any trustee or the Plan Administrator.

h. COLLECTIVE BARGAINING AGREEMENT

The Plan is maintained pursuant to Collective Bargaining Agreements between the Union and Contributing Employers. A copy of the applicable Collective Bargaining Agreement(s) will be provided to you upon written request to the Fund Office or the Local Union and is available at the Fund Office for examination by Participants and beneficiaries.

i. ELIGIBILITY FOR PARTICIPATION AND BENEFITS

Eligibility: See pages 2 to 14 of this booklet for the summary of these rules.

Summary of Benefits/Cost-Sharing Provisions: See pages 17 to 49 of this booklet for the Summary of Benefits.

Premiums: Generally, your Covered Employer will pay the required premium for coverage. See page 9 ("Special Continuation of Coverage") and pages 10 to 13 of this booklet for the rules about when you are required to pay a premium for coverage.

Deductibles: See pages 17 to 49 of this booklet for the Summary of Benefits and pages 57 and 72 of this booklet for additional information about the deductibles required under this Plan.

Coinsurance: See pages 17 to 49 of this booklet for the Summary of Benefits.

Copayments: See pages 17 to 49 of this booklet for the Summary of Benefits and page 57 for additional information about the Copayments required under this Plan.

Out-of-Pocket Limits and Annual and Lifetime Caps: See pages 17 to 49 of this booklet for the Summary of Benefits and pages 57 to 58, 67, and 77 for additional information about the maximums and annual Out-of-Pocket Limits required under this Plan.

Other Limitations: See pages 51, 63, 74 to 76, 78, and 80 to 83 of this booklet for a list of limitations and exclusions under this Plan.

Preventive Services: See pages 17 to 49 of this booklet for the Summary of Benefits and pages 64 to 66 of this booklet for preventive services covered under this Plan.

Prescription Drugs: See page 67 to 71 of this booklet.

Medical Tests, Devices, and Procedures: See pages 17 to 49 of this booklet for the Summary of Benefits and pages 58 to 63 of this booklet for additional information about the medical expenses covered under this Plan.

Network Providers: See pages 53 to 54, 62, 67, and 72 of this booklet for information about network providers.

Composition of Provider Network and Coverage Out-of-Network: See pages 17 to 49 of this booklet for the Summary of Benefits.

Selection of Primary Care Providers or Specialty Providers: The Plan does not require selection of a primary care provider. Participants may choose to see any provider they choose.

Emergency Medical Care: See pages 17 to 49 of this booklet for the Summary of Benefits.

Utilization Review: See pages 17 to 49 of this booklet for Summary of Benefits and pages 55 to 56, 70, and 76 for additional information about pretreatment review and mandatory case management.

j. CIRCUMSTANCES WHICH MAY RESULT IN DISQUALIFICATION, INELIGIBILITY, DENIAL, LOSS, FORFEITURE, SUSPENSION, OFFSET, REDUCTION, OR RECOVERY OF BENEFITS

A Participant who is eligible for benefits may become ineligible as a result of the following circumstances:

1. The Employee's failure to work the required hours to maintain eligibility (or failure to make a Retiree payment or COBRA or USERRA payment, where authorized). See pages 2 to 14 of this booklet for a summary of the eligibility rules.

2. The failure of your Contributing Employer to report the hours and remit correct contributions on your behalf to the Fund.

3. The failure of your Contributing Employer to enter into a signed written collective bargaining agreement, or renewal thereof, with the International Union of Operating Engineers Local 513.

4. In the case of Dependents of an eligible Employee, they may become ineligible if they are no longer Dependents or they have attained the disqualifying age. See pages 5 to 6 of this booklet for a summary of the Dependent eligibility rules.

5. You or your eligible Dependents do not elect COBRA Continuation Coverage upon a qualifying event, or if you or your Dependents elect COBRA continuation coverage, and the required payments are not made timely or the COBRA extension period expires. See pages 10 to 13 of this booklet for a summary of the COBRA rules.

A Participant or beneficiary who is eligible may be denied benefits as a result of any of the following circumstances:

1. The failure of the Participant or beneficiary to file a claim for benefits within 90 days following the date of loss, or within one year of the date he or she incurred the expense for which benefits are payable, if it was not reasonably possible to file within the 90-day filing period.

2. The failure of the Participant or beneficiary to file a complete and truthful benefit application.

3. If the Participant has other group insurance coverage, benefits payable under this Plan may be reduced or denied due to "coordination of benefits" between the two plans.

4. If the loss for which the claim is being made is subject to an exclusion or limitation of the Plan.

5. If a Participant is paid benefits in error and the Plan is not reimbursed, the Plan may offset future claims payments by the amount that was not repaid.

6. If a Participant is injured by a third party and a claim or lawsuit is being pursued against a third party.

The information provided is intended as a summary of the circumstances that would result in a denial of eligibility or benefits. It is not intended to be an exhaustive list of all such circumstances. Please refer to the remainder of this booklet for additional circumstances.

The Board of Trustees has the authority to terminate the Plan or amend or eliminate benefits under the Plan at any time.

Amendments to the Plan shall be adopted by action of the Board of Trustees at a regular or special meeting of the Board of Trustees and shall be recorded in the minutes of such meeting, or in a formal document executed by the Board of Trustees as an amendment to the Plan.

Any such amendment to the Plan shall become effective upon adoption or, if a different effective date is specified by the Board of Trustees, on such specified date.

If an amendment to the Plan is recorded in minutes of the meeting at which it is adopted, the amendment shall be given effect as recorded in the minutes. If such amendment to the Plan is thereafter incorporated in a formal document executed by the Board of Trustees as an amendment to the Plan, the provisions of the formal document shall, upon execution, supersede the provisions of the meeting minutes with respect to such amendment to the Plan.

Upon termination of the Plan, the Board of Trustees shall continue to apply the funds available to them to the obligations and purposes of the Trust until all such funds are exhausted, whereupon the entire Trust estate shall be wound up and terminated and the Board of Trustees shall be discharged from their obligations and duties. Under no circumstances shall any portion of the funds directly or indirectly revert or accrue to the benefit of any Contributing Employer or the Union.

k. CONTINUATION COVERAGE

See pages 10 to 13 of this booklet for a summary of the COBRA Continuation Coverage rules.

l. SOURCES OF CONTRIBUTIONS TO THE PLAN

The Plan is financed by employer contributions pursuant to the Collective Bargaining Agreements. A supplemental source of financing is income earned on the investment of reserve funds and through voluntary contributions of Participants to retain eligibility.

m. FUNDING MEDIUM

All contributions are received, collected, and deposited by a designated bank or trust company. The funds are then used to pay providers of services, pay benefits directly when applicable, pay the expenses of administration, and to provide reserves.

Benefits provided for in the Plan can be paid only to the extent that the Fund has available adequate resources for such payments. No Contributing Employer has liability, directly or indirectly, to provide benefits beyond the obligation of the Contributing Employer to make contributions as stipulated in the Contributing Employer's Collective Bargaining Agreement. In the event that at any time the Fund does not have sufficient assets to permit continued payments of benefits, nothing contained in the Plan obligates any Contributing Employer to make payments or contributions (other than the contributions for which the

Contributing Employer may be obligated by the Contributing Employer's Collective Bargaining Agreement) in order to provide such benefits. Likewise, there shall be no liability upon the Board of Trustees, individually or collectively, or upon any Employer, any signatory Association, the Union, or any other person or entity of any kind to provide such benefits if the Fund does not have sufficient assets to make such payments.

n. PLAN YEAR

The accounting records of the Fund are kept on a fiscal year basis beginning on May 1 and ending the following April 30.

o. CLAIMS PROCEDURES

See pages 88 to 108 of this booklet for a summary of the claims procedures.

p. YOUR RIGHTS - EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)

As a Participant in the Welfare Fund of Engineers Local 513, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan Participants shall be entitled to:

Receive Information about Your Plan and Benefits

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

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

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

Continue Group Health Plan Coverage

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

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to preexisting condition exclusions under other group health plans.

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 which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a 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 your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of

Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

q. MATERNITY OR NEWBORN INFANT COVERAGE

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

NAMES AND ADDRESSES

FUND OFFICE
Benesys, Inc.
3449 Hollenberg Drive, Suite 150
Bridgeton, MO 63044

CERTIFIED PUBLIC ACCOUNTANT
Anders CPAs + Advisors
800 Market Street, Suite 500
St. Louis, MO 63101

PLAN CONSULTANT
Milliman
650 California Street, 21st Floor
San Francisco, CA 94108

NAMES AND ADDRESSES OF HEALTH PROVIDERS FOR THE FUND

Anthem BlueCross BlueShield
1831 Chestnut Street
St. Louis, MO 63103

Administers a network of medical providers for the Plan.
Also provides coverage for Medicare eligible retirees and their dependents through a Medicare Advantage Plan.

HealthLink
1831 Chestnut Street
St. Louis, MO 63103

Administers a utilization review programs for the Plan.

MedImpact
P.O. Box 51580
Phoenix, AZ 85076-1580

Administers a network of pharmacy and mail order prescription drug providers for the Plan.

Delta Dental
12399 Gravois Road
St. Louis, MO 63127

Administers a network of dental providers for the Plan.

Vision Service Plan Insurance Company (VSP)
3333 Quality Drive
Rancho Cordova, CA 95670

Administers a network of vision providers for the Plan.

Everside Health, LLC
1400 Wewatta Street, Suite 350
Denver, CO 80202

Administers several health clinics for the Plan.

PRIVACY RULES

This Notice Describes How Medical Information About You May Be Used and Disclosed and How You Can Get Access To This Information. Please Review It Carefully And Contact the Plan Office If You Have Any Questions.

We are required by law, namely the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA), to make sure that medical information that identifies you, sometimes referred to as "protected health information" or "PHI," is kept private to the extent required by law. We are required to give you this notice regarding: (1) the uses and disclosures of medical information that may be made by the Plan, and (2) your rights and the Plan's legal duties with respect to such information. We are also required to notify you following a breach of your unsecured protected health information. This notice and its contents are intended to conform to the requirements of HIPAA.

How We May Use and Disclose Medical Information about You

The following categories describe different ways that we use and disclose medical information. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Treatment. We may use and disclose medical information about you to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with your Physician or other third party involved in your care. For example, we may disclose to a specialist involved in your care the name of your primary care Physician so that the specialist may obtain records from your primary care Physician.

For Payment. We may use and disclose medical information about you to determine eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. For example, we may tell your health care provider about your eligibility for benefits to confirm whether payment will be made for a particular service. We may also share medical information with a utilization review or precertification service provider. Likewise, we may share medical information with another entity to assist with the coordination of benefit payments.

For Health Care Operations. We may use and disclose medical information about you for Plan operations. These uses and disclosures are necessary to run the Plan. For example, we may use medical information in connection with conducting quality assessment and improvement activities; underwriting, premium rating, and other activities relating to Plan coverage; reviewing and responding to appeals; conducting or arranging for medical review, legal services, audit services, and fraud and abuse detection programs; and general Plan administrative activities.

As Required By Law. We will disclose medical information about you when required to do so by federal, state or local law. For example, we may disclose medical information when required by a court order in a litigation proceeding such as a malpractice action.

To Avert a Serious Threat to Health or Safety. We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

To Inform You About Treatment Alternatives or Other Health Related Benefits. We may use PHI to identify whether you may benefit from communications from the Plan regarding: (1) available provider networks or available products or services under the Plan, (2) your treatment, (3) case management or care coordination for you, or (4) recommended alternative treatments, therapies, health care providers, or settings of care for you. For instance, we may forward a communication to a Participant who is a smoker regarding an effective smoking-cessation program.

Disclosure to Health Plan Sponsor. Medical information may be disclosed to the Plan Sponsors, i.e. the Union and the Associations, or the Board of Trustees, solely for purposes of administering benefits under the Plan.

Organ and Tissue Donation. If you are an organ Donor, we may release medical information to organizations that handle organ procurement or transplantation.

Military and Veterans. If you are a member of the armed forces, we may release medical information about you as required by military command authorities.

Workers' Compensation. We may release medical information about you for workers' compensation or similar programs.

Public Health Risks. We may disclose medical information about you for public health activities to a public authority. These disclosures will be made for the purpose of controlling disease, injury or disability.

Health Oversight Activities. We may disclose medical information to a health oversight agency for activities authorized by law, such as audits, investigations, inspections, and licensure.

Lawsuits and Disputes. We may disclose medical information in response to a court order or administrative tribunal. We may also disclose medical information in response to a subpoena, discovery request, or other lawful process, that is not accompanied by an order of a court or administrative tribunal, if we receive satisfactory assurance from the party seeking the information that reasonable efforts have been made to notify you of the request or, if such assurance is not forthcoming, if we have made a reasonable effort to notify you about the request.

Law Enforcement. We may release medical information if asked to do so for law enforcement purposes so long as applicable legal requirements have been met.

Coroners, Medical Examiners, and Funeral Directors. We may release medical information to a coroner or medical examiner.

National Security and Intelligence Activities. We may release medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official.

Individuals Involved in Your Care or Payment for Your Care. Unless you object or request additional privacy restrictions or alternative communications that are accepted by the Plan, the Plan may, in the exercise of professional judgment, disclose to your family member, other relative, or close personal friend, PHI directly relevant to such person's involvement in your care or payment for your care.

Fundraising Activities. We do not anticipate using or disclosing your PHI for fundraising activities; however, we may use and disclose your PHI, as necessary in order to contact you for fundraising activities. You have the right to opt out of receiving fundraising communications. If you do not want to receive these materials, please submit a written request to the Privacy Officer for the Plan.

Your Rights Regarding Medical Information about You

You have the following rights regarding medical information we maintain about you:

Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your Plan benefits. To inspect and copy such medical information, you must submit your request in writing to the Plan Office. We will respond to your request, usually within 30 days. If you request a copy of this information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request. We may deny your request to inspect and copy your medical information in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed.

Right to Amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan. To request an amendment, your request must be made in writing and submitted to the Plan Office. In addition, you must provide a reason that supports your request.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that: (1) is not part of the medical information kept by or for the Plan, (2) was not created by us, unless the person or entity that created the information is no longer available to make the amendment, (3) is not part of the information which you would be permitted to inspect and copy, or (4) or is accurate and complete. If your request is denied, we will tell you why in writing, usually within 60 days of your request.

Right to an Accounting of Disclosures. You have a right to obtain an accounting of certain disclosures of your medical information. This right to an accounting extends to disclosures, other than disclosures made: (1) to carry out treatment, payment or health care operations, (2) to individuals about their own medical information, (3) incident to an otherwise permitted use or disclosure, (4) pursuant to an authorization, (5) for purposes of creation of a facility directory or to persons involved in the patient's care or other notification purposes, (6) as part of a limited data set, (7) for other national security or to correctional institutions or law enforcement officials, or (8) before April 14, 2003.

To request an accounting of disclosures, you must submit your request in writing to the Plan Office. Your request must specify a time period, which may not be longer than six years. Your request should indicate in what form you want the accounting (for example, paper or electronic). The first accounting you request within a 12-month period will be free. For additional accountings, we may charge you for the costs of providing the accounting. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. We are not, however, required to agree to your request. To request restrictions, you must make your request in writing to the Plan Office. In your request, you must tell us: (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. Such requests shall be honored if, in the sole discretion of the Plan, the requests are reasonable and can be accommodated with minimal disruption to Plan administration. However, the Plan shall accommodate such a request if the Participant clearly provides information that the disclosure of all or part of that information could endanger the Participant. To request confidential communications, you must make your request in writing to the Plan Office. Your request must specify how or where you wish to be contacted.

Right to an Electronic Copy of Electronic PHI. If your PHI is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. The Fund will provide access to your electronic PHI as required by law and will make every effort to provide access to your PHI in the form or format you request, if it is readily producible in such form or format. If the PHI is not readily producible in the form or format you request, your record will be provided in either the Fund's standard electronic format or if you do not want this form or format, a readable hard copy form. The Fund may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

Changes to This Notice

The effective date of this Notice is September 23, 2013. We reserve the right to: (1) change the terms of this notice, and (2) to make the revised or changed notice terms effective for medical information we already have about you as well as any information we receive in the future. If there are any material changes to this Notice, we will mail a revised Notice to all Participants in the Plan within the time required by law. The Plan will comply with the terms of any such Notice currently in effect.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with the Plan or with the Secretary of the Department of Health and Human Services. To file a complaint with the Plan, contact Amy Davis at the Plan Office, 3449 Hollenberg Drive, Suite 150, Bridgeton, MO 63044. All complaints must be submitted in writing. To file a complaint with the Secretary of the Department of Health and Human Services, contact them by mail at 200 Independence Avenue, S.W., Washington, D.C. 20201, by telephone at (877) 696-6775 or by visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. You will not be penalized or retaliated against for filing a complaint.

Other Uses of Medical Information

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. Without your authorization, we are expressly prohibited from using or disclosing your PHI for marketing purposes. We may not sell your PHI without your authorization. We may not use or disclose most psychotherapy notes contained in your PHI. We will not use or disclose any of your PHI that contains genetic information for underwriting purposes. Finally, the Plan may disclose your PHI to disaster relief organizations that seek your PHI to coordinate your care, or notify family and friends of your location or condition in a disaster. The Plan will provide you with an opportunity to agree or object to such disclosure whenever it is practical to do so.

If you provide us permission to use or disclose medical information about you, you may revoke that permission at any time by submitting written notice of your intent to revoke to the Plan. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission.

Personal Representatives

You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of his/her authority to act on your behalf before that person will be given access to your PHI or allowed to take any action for you.

We retain the discretion to deny a personal representative access to PHI in order to provide protection to those vulnerable individuals who depend on others to exercise their rights under this

Notice and who may be subject to abuse or neglect. This also applies to personal representatives of minors.

Privacy Regulations

The Plan's use and disclosure of your PHI is regulated by federal and state law, including the Health Insurance Portability and Accountability Act ("HIPAA"). This Notice attempts to summarize the regulations. The regulations will supersede any discrepancy between the information contained in this Notice and the regulations.

For Further Information

If you need additional information regarding the matters discussed in this Notice, please contact Amy Davis, Plan Manager for the Plan at (314) 739-2973.

FREQUENTLY ASKED QUESTIONS ABOUT THE PLAN (FAQS)

The following are questions and answers relating to the benefit program. If you familiarize yourself with these answers, they may clarify the purpose and benefit coverage of the benefit program.

Are all Employees covered?

No. Only those Employees who satisfy eligibility requirements of the Plan are automatically covered.

Is the cost of the benefits equivalent to the amount paid by the Contributing Employer?

No. The employer contributions cover the cost of the benefits, the administration expenses, and the establishment of a reserve fund which will be used to give security to the Employees through the continuation of benefits during slack construction periods and depressions.

I have just become an Employee in the Jurisdiction of Local 513 and have gone to work for a Contributing Employer. When am I eligible?

You will become eligible for benefits on the first of the month following a period of three consecutive months during which at least 300 hours of contributions were made in your name. Refer to the "Eligibility" section on page 2 for more information.

Is a medical examination required to get the benefits provided by the Fund?

No medical examination is required.

Do I have any evidence that I am eligible?

The Fund Office will issue to each eligible Employee a booklet describing the benefits of the Fund. The continuation of your benefits however, depends upon you continuing to be eligible according to the Eligibility Rules and is subject to the provision regarding termination.

Do I have the right to change the beneficiary of my death benefit?

Yes. You may change the beneficiary of your death benefit by signing a form provided by the Fund Office.

I support my mother. Can she become eligible as my Dependent?

No. Only an Employee's spouse and Children can qualify as eligible Dependents.

Does the benefit program cover me on the job?

Workers' compensation insurance carried by your employer covers you on the job. The Welfare Plan covers you for non-occupational Illness or Injuries. However, the Death Benefit and Accidental Death and Dismemberment Insurance are on a 24-hour basis and cover you on or off the job.

I carry several hospitalization policies. Can I collect under those policies and under the Plan, too?

If you or your Dependents are also covered under other plans of insurance, benefits payable from this Plan for Covered Expenses incurred by you or your Dependents may be reduced as described in the "Coordination of Benefits" section beginning on page 84.

My spouse and I are over 65 and are covered under Parts A and B of the Medicare Program. Will this affect the benefits payable under this Plan?

If you are covered under Parts A and B of Medicare, you will be eligible for a Medicare Advantage Plan insured through Anthem.

Am I covered for routine physical examinations?

Active Employees and their Dependent spouses and Dependent Children are eligible for routine exams. See the section entitled "Preventive Care Benefits" beginning on page 64 for more information.

DISCLAIMER

The medical benefits provided by the Plan to non-Medicare eligible Participants are not insured by any contract of insurance. No health insurance issuer is responsible for financing or administering the Plan. There is no liability on the Board of Trustees or any individual or entity to provide payment over and above the amounts in the Fund collected and available for such payment.

DEFINED TERMS

Words that are capitalized in this booklet but not defined herein are defined in the Plan. An effort has been made to use such terms in this booklet in an easily understood manner. If you have any doubt about the meaning of a defined term, please consult the Plan or the Fund Office.

IMPORTANT THINGS TO REMEMBER

It is important that you notify the Fund Office whenever:

1. you change your home address;
2. you wish to change your beneficiary;
3. you are receiving Workers' Compensation Benefits;
4. you return to work after disability ceases;
5. you enter the Armed Forces of the United States;
6. you get married or divorced; or
7. your Dependent child reaches age 26.

Also, the Fund Office should be notified of the death of a covered Employee or covered Retiree.

NOTES

NOTES

Contact Information:

WELFARE FUND OF ENGINEERS LOCAL 513
Fringe Benefit Funds
3449 Hollenberg Drive, Suite 150
Bridgeton, MO 63044
(314) 739-2973
www.iuoe513fringe.org