INDIANA/KENTUCKY/OHIO REGIONAL COUNCIL OF CARPENTERS WELFARE FUND

SUMMARY PLAN DESCRIPTION

2024

PREFACE

The Board of Trustees of the Indiana/Kentucky/Ohio Regional Council of Carpenters' Welfare Fund (Trustees) have adopted this document setting forth the benefits provided by the Plan. It is intended that the Plan be maintained for the exclusive benefit of participants and dependents, on an ongoing basis. It is also intended that this Plan conforms to the requirements of the Employee Retirement Income Security Act of 1974 (ERISA), as amended from time to time. If any portion of this Plan now, or in the future, conflicts with ERISA or other applicable federal law or regulations, ERISA or such other federal law or regulations will govern.

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

This document is a Summary Plan Description (SPD). The SPD is intended to summarize the terms of the Plan, and as such does not contain all the terms, conditions, and limitations of coverage, or all the exclusions from coverage. Every effort has been made to accurately set forth the coverage provided by the Plan, but in the event of any inconsistency between the terms of the Plan and this SPD, the terms of the Plan control.

F

In the event of any inconsistency between the terms of the Plan and this SPD, the terms of the Plan control.

TABLE OF CONTENTS

In the event of any inconsistency between the terms of the Plan and this SPD, the terms of the Plan control.

In the event of any inconsistency between the terms of the Plan and this SPD, the terms of the Plan control.

In the event of any inconsistency between the terms of the Plan and this SPD, the terms of the Plan control.

ARTICLE 1 – DEFINITIONS

As used in this document, the following words have the following meanings (other terms may also be defined elsewhere in this document):

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

Ancillary Services means emergency medicine, anesthesiology, pathology, radiology, and neonatology whether provided by a participating or nonparticipating provider; items and services provided by assistant surgeons, hospitalists, and intensivists; and diagnostic services, including radiology and lab services (excluding certain advanced diagnostic laboratory tests per federal guidance or rulemaking).

Calendar Year means a 12-month period commencing January 1st and ending December 31st, during which benefits are determined.

Child–

(a) Any person up until the end of the month in which he/she turns age 26, is not a Participant or a Participant's Spouse, and either:
  (1) is a Participant's natural child or adopted child; or
  (2) has been placed with a Participant for adoption; or
  (3) is a Participant's step-child, which means he/she is the child of his/her Spouse; or

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

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

Collective Bargaining Agreement means an agreement or agreements between the United Brotherhood of Carpenters and Joiners of America, or a subordinate body thereof, and an employer or association of employers which requires contributions to the Indiana/Kentucky/Ohio Regional Council of Carpenters Welfare Fund.

Consent to Out of Network Services means:

(a) a covered person provided informed consent under applicable law to receive either:
  (1) post-stabilization services following Emergency Services from an out-of-network provider or out-of-network emergency facility; or
  (2) nonemergency services from an out-of-network provider at an in-network facility; and

(b) the Plan receives notice of such consent.

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

Continuing Care Patient means a Covered Person who, with respect to a provider or facility—

(a) is undergoing a course of treatment for a serious and complex condition;
(b) is undergoing a course of institutional or inpatient care;
(c) is scheduled to undergo nonelective surgery, including receipt of postoperative care with respect to such a surgery;

(d) is pregnant and undergoing a course of treatment for the pregnancy; or
(e) is or was determined to be terminally ill (i.e., a medical prognosis that the individual's life expectancy is 6 months or less).

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

Covered Charges means only those charges made for services and supplies which the Trustees would consider to be reasonably priced and Medically Necessary in light of the injury or sickness being treated.

Covered Employment is employment by an Employee that is (a) bargaining unit work, i.e. any classification or work under the Collective Bargaining Agreement pursuant to which Contributions are required to be made to this Fund; or (b) any other work or employment for which Contributions have or are required to be made to this Fund except for non-bargaining unit employees participating in the Fund via a participant agreement.

Covered Person means an eligible Participant or his Dependent while such Participant or Dependent is covered under the Plan.

Custodial Care means care (including room and board needed to provide that care) that is given principally for personal hygiene or for assistance in daily activities and can, according to generally accepted medical standards, be performed by persons who have no medical training. Examples of Custodial Care are help in walking and getting out of bed; assistance in bathing, dressing, feeding; or supervision over medication, which could normally be self-administered.

Dependents mean a Participant's legal Spouse and Children.

Developmental Care means services, supplies or prescription drugs, regardless of where or by whom provided, which meet one of the following criteria:

(1) Are provided to a Covered Person who has not previously reached the level of development expected for his age in areas of major life activity such as intellectual; receptive and expressive language, learning, mobility, self-direction, capacity for independent living;
(2) Are not rehabilitative in nature (restoring fully developed skills that were lost or impaired due to Injury or Sickness); or
(3) Are educational in nature.

Developmental Care does not include treatment related to attention-deficit/hyperactivity disorder (ADHD) or autism spectrum disorder.

Dollar Bank Account means the individual account that Employers contribute on Employee's behalf for hours worked. The Dollar Bank Account is used to purchase eligibility under this Plan and to reimburse eligible medical expenses.

Drug Abuse--A condition classified as a mental disorder and described in the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) or the most recent version, as drug dependence, abuse, or drug psychosis.

Durable Medical Equipment means equipment which:

- Can withstand repeated use;
- is mainly and customarily used for a medical purpose;
- is not generally useful to a person in the absence of an injury or sickness; and
- is suited for use in the home.

Durable Medical Equipment includes, but is not limited to, crutches rental, up to the purchase price of a wheelchair, hospital-type bed, iron lungs, or equipment for the administration of oxygen and other gases.

Effective Date means April 28, 1981. The Plan has been restated and amended numerous times. This Restatement is effective June 9, 2021.

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

Emergency Services with respect to an Emergency Medical Condition means:

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

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

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

Employee means a member whose Employer is required by terms of a Collective Bargaining Agreement, Participation Agreement or other written agreement to make contributions on his behalf to this Plan.

Employer means any employer who has signed a Collective Bargaining Agreement, Participation Agreement or other written agreement that has been approved by the Trustees requiring contributions to be paid to the Fund.

Expenses Incurred means a covered expense incurred on the day the purchase is made or the service rendered for which a charge is made.

Experimental or Investigational Drug, Device, Medical Treatment, or Procedure— A drug, device, medical treatment, supply, or procedure is Experimental or Investigational:

- If the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished;

- If reliable evidence shows that the drug, device, medical treatment, or procedure is the subject of ongoing phase I, II, or III clinical trials or is under study to determine maximum tolerated dose, toxicity, safety, or efficacy as compared with the standard means of treatment or diagnosis; or
- If reliable evidence shows that the consensus of opinion among experts regarding the drug, device, medical treatment, or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, toxicity, safety, or efficacy as compared with the standard means of treatment or diagnosis.

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

Drugs are considered also Experimental if they are not commercially available for purchase or they are not approved by the Food and Drug Administration for general use.

Extended Care Facility means an institution which is licensed as an extended care facility or long-term nursing facility and which is qualified to participate in and is eligible to receive payments under the Medicare Program, but which is not, other than incidentally, a home for the aged or a domiciliary care home.

Fund means the Indiana/Kentucky/Ohio Regional Council of Carpenters Welfare Fund established by the Agreement and Declaration of Trust of Indiana/Kentucky/Ohio Regional Council of Carpenters Welfare Fund, as amended from time to time.

Fund Office – means BeneSys, Inc, 700 Tower Drive, Suite 300, Troy, Michigan 48099.

Health Care Reform— Those requirements applicable to this Plan under the federal Patient Protection and Affordable Care Act.

Hospice Care -- a coordinated program intended to meet the special physical, psychological, spiritual and social needs of a Terminally Ill person and the immediate family. A Terminally Ill person is defined as one who (1) has no reasonable prospect of cure; and (2) as certified in writing by an attending Physician, has a life expectancy six months or less.

Hospital--An Institution which is engaged primarily in providing medical care and treatment to sick and injured persons on an inpatient basis at the patient's expense and which fully meets the requirements set forth in (1), (2), (3), or (4) below:

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

(2) It is a Hospital accredited by the Joint Commission on the Accreditation of Health Care Organizations (JCAHO) or accredited by the American Osteopathic Association (AOA) or be qualified to participate in and is eligible to receive payments under and in accordance with the provisions of Medicare.

(3) It is a psychiatric Hospital as defined by Medicare which is qualified to participate in and is eligible to receive payments under and in accordance with the provisions of Medicare.
(4) It is a licensed facility specializing in the treatment of substance abuse, or mental and nervous disorders.

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

Injury means an accidental bodily injury. All injuries sustained by a Covered Person in connection with any one accident shall be considered one Injury.

Incurred—Services rendered by a Provider. All services rendered by the Institutional Provider during an Inpatient admission prior to termination of coverage are considered to be Incurred on the date of admission.

Inpatient--A Covered Person who receives care as a registered bed patient in a Hospital or Other Facility Provider where a room and board charge is made.

Institution (Institutional)--A Hospital or Other Facility Provider.

Medical Condition means any condition resulting from illness, injury (whether or not the injury is accidental), pregnancy, or congenital malformation.

Medically Necessary (or Medical Necessity) means a service or supply which meets all of the following tests:

- Is consistent with the patient's symptom or diagnosis; and
- Is rendered for the treatment or diagnosis of an injury or disease, including premature birth, congenital defects or birth defects; and
- Is appropriate treatment according to generally accepted standards of medical practice; and
- Is not provided only as a convenience to the patient; and
- Is not experimental or investigative; and
- Is the most appropriate supply or level of service needed to provide safe, adequate and appropriate treatment. When applied to confinement in a Hospital or other facility, this test means that the eligible person needs to be confined as an in-patient due to the nature of the service rendered or due to the eligible person's condition and that the person cannot receive safe and adequate care through out-patient treatment.

Medicare--The program of health care for the aged and disabled established by Title XVIII of the Social Security Act of 1965, as amended.

Mental Illness--A condition classified as a mental disorder in the International Classification of Diseases, ninth Revision, Clinical Modification (ICD-10-CM) or the most recent version, excluding Drug Abuse and Alcoholism. Mental Illness does not include conditions related to Developmental Care, learning disabilities, hyperkinetic syndromes, behavioral problems, or intellectual disability (intellectual developmental disorder).

Named Fiduciary means the entity or persons who have the authority to control and manage the operation and administration of this Plan. The Named Fiduciary for this Plan will be the Trustees of the Indiana/Kentucky/Ohio Regional Council of Carpenters Welfare Fund.

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

Non-occupational Sickness or Injury means a Sickness or Injury which does not arise out of or in the course of and which is not caused or contributed to by, or as a consequence of any employment or occupation for remuneration or profit.

Occupational Injury--An accidental injury arising out of or in the course of any work for pay or profit, or in any way resulting from such an injury.

Office Visit-- medical visits or consultations in a Physician's office or patient's residence. A Physician's office can be in a medical/office building, Outpatient department of a Hospital, freestanding clinic facility, or a Hospital based Outpatient clinic facility.

Organ Transplant Benefits – means the following transplant services provided during the benefit period and related to the organ transplant:

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

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

- Outpatient surgical facility
- Outpatient treatment of Mental Illness.
- Dialysis facility
- Residential Treatment Facility
- Home Health Care Agency

In the event of any inconsistency between the terms of the Plan and this SPD, the terms of the Plan control.

- Hospice Facility

Other Professional Provider--Only the following persons or entities which are licensed as required:
- Advanced nurse practitioner (A.N.P.);
- Ambulance services;
- Dentist;
- Doctor of chiropractic medicine;
- Durable medical equipment or prosthetic appliance vendor;
- Laboratory (must be Medicare Approved) ;
- Licensed independent social workers (L.I.S.W.);
- Licensed practical nurse (L.P.N.);
- Licensed professional clinical counselor;
- Licensed vocational nurse (L.V.N.);
- Mechanotherapist (licensed or certified prior to November 3, 1975);
- Nurse-midwife;
- Occupational therapist;
- Physical therapist;
- Physician assistant;
- Podiatrist;
- Psychologist;
- Registered nurse (R.N.);
- Registered nurse anesthetist; and
- Urgent Care Provider.

Out-of-Network Rate means: (1) for an item or service furnished in a State that has an All-Payer Model Agreement under 1115A of the Social Security Act, the amount the State approves under such system; (2) if there is no applicable All-Payer Model Agreement, an amount determined by a specified by State law where the item or service is furnished; (3) if neither (1) or (2) apply, the amount agreed upon; (4) if there is no agreement, then the amount determined by IDR.

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

Participant – An Active Employee or Retiree who is eligible for benefits under the Plan.

Physician means any of the following licensed practitioners who are acting within the scope of his license and who performs a service payable under the Plan:
- A doctor of medicine (MD), osteopathy (DO), podiatrist (DPM) or chiropractor (DC).
- A psychologist (PhD or PsyD) or psychiatrist (MD) providing services in connection with mental therapy or behavioral counseling.
- A licensed doctoral clinical psychologist, and a licensed or certified social worker (LCSW or CCSW), a licensed Physician's assistant (PA) or any other licensed practitioner who
    - Is acting under the supervision of a doctor of medicine (MD); and
    - Performs a service which is payable under the plan when performed by a doctor of medicine (MD).
- Physician does not include a person who:
    - Lives in the eligible Employee's home; or
    - Is a member of the eligible Employee's family.

Plan means the Indiana/Kentucky/Ohio Regional Council of Carpenters Welfare Fund's Plan document, as it may be amended from time to time.

Plan Administrator means the persons or entity responsible for the day-to-day functions and management of the Plan. The Plan Administrator is the Board of Trustees of the Indiana/Kentucky/Ohio Regional Council of Carpenters Welfare Fund.

Plan Year means a 12-month period beginning January 1st and ending December 31st.

Preferred Provider Organization (PPO)-- A program in which contracts are established with providers of medical care.

Pregnancy means any child-bearing condition and includes therapeutic abortion (for a Participant or eligible Spouse or Dependent), miscarriage, or childbirth, or any complications thereof. Pregnancy coverage is limited to a Participant or the spouse of a Participant, except in the case of therapeutic abortion, which is covered for a Participant, eligible Spouse or Dependent.

Prescription Drug (Federal Legend Drug) --Any medication that by federal or state law may not be dispensed without a legally valid prescription and is FDA approved.-

Provider means a facility, person or organization, including a Hospital or Physician which is licensed as required to render covered services to Employees and eligible dependents.

Psychologist—an individual licensed as a psychologist having either a doctorate in psychology or a minimum of five years of clinical experience. In states where there is no licensure law, the Psychologist must be certified by the appropriate professional body.

Qualifying Payment Amount (QPA) for an item or service means, as of 1/1/22, the median in-network rate for (a) the same or similar services; (b) furnished in the same or a similar facility; (c) by a provider of the same or similar specialty; and (d) in the same or similar geographic area, adjusted as required by applicable regulations for inflation and base billing units, if applicable.

Recognized Amount with respect to an item or service furnished by a nonparticipating provider is: (1) for an item or service furnished in a State that has an All-Payer Model Agreement under 1115A of the Social Security Act, the amount the State approves under such system; (2) if there is no applicable All-Payer Model Agreement, an amount determined by a specified by State law where the item or service is furnished; or (3) if neither of the above apply, the lesser of (a) the amount billed by the provider or facility or (b) the Qualifying Payment Amount (QPA).

Residential Treatment Facility -- A facility providing Inpatient care for the evaluation and treatment of residents with psychiatric or chemical dependency disorders, with residential treatment plans supervised by a professional staff of qualified Physician(s), licensed nurses, counselors, and social workers for the chemical, psychological, and social needs.

Retiree – an individual who applies to the Plan for retiree coverage within 30 days of the last month in which he/she is eligible in the Plan as an Active Employee and meets the conditions of (a) or (b) below:

(a) Has retired from Covered Employment and:

(1) is receiving a defined benefit pension from a plan affiliated with the International Brotherhood of Carpenters and Joiners of America or Social Security; and

(2) Was covered under the Plan just prior to retirement:
  (a) the current month and the previous 23 months; or
  (b) three consecutive months in each of the last three 24-month periods; and
(3) is a member of the Union in good standing (if your coverage under the Plan prior to retirement was based on Covered Employment as a bargaining unit member, which includes Employees of the Union who are alumni of the bargaining unit).

(b) Was covered under the Plan as an Active Employee under Section 2.2 as a Non-bargaining Unit Employee and:
(1) was covered under the Fund as a Non-bargaining Unit Employee immediately prior to retirement;
(2) was covered under the Fund for at least 60 months of the 72-month period immediately preceding retirement;
(3) is at least age 60; and
(4) notifies the Fund Office immediately of their retirement and provides proof of same.

Semiprivate means a hospital accommodation under which two persons share a room.

Serious and Complex Condition means

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

Sickness means a disease or a mental, emotional, or nervous disorder. For purposes of this Plan, Sickness also includes a covered Pregnancy.

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

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

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

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

Surgery -- generally accepted operative and other invasive procedures.

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

Totally Disabled -- For purposes of the Accident and Sickness Weekly Income Benefit, Totally Disabled means wholly and continuously disabled by a Sickness or accidental bodily Injury, which prevents the Participant from being gainfully employed.

Trust Agreement means the Indiana/Kentucky/Ohio Regional Council of Carpenters Welfare Fund Agreement and Declaration of Trust, as amended. The Trust Agreement and any amendments thereto, will form a part of this Plan Document as if all terms and provisions thereof were incorporated in the Plan Document.

Trust Fund or Fund means the Indiana/Kentucky/Ohio Regional Council of Carpenters Welfare Fund and the entire assets thereof, including all funds received by the Trustees in the form of Employer contributions, together with all contracts (including dividends, interest, refunds, and other sums payable to the Trust Fund on account of such contracts), all investments made and held by the Trustees, all income, increments, earnings and profits therefrom, and any and all other property or funds received and held by the Trustees under the Amended Agreement and Declaration of Trust.

Trustee or Board of Trustees—Trustee means any person so named in the Trust Agreement and any successor Trustee. The group of Trustees is known as the Board of Trustees.

Union means the Indiana/Kentucky/Ohio Regional Council of Carpenters of the United Brotherhood of Carpenters and Joiners of America.

Urgent Care Provider—A provider that performs medical services that require immediate medical attention but are not Emergencies.

Usual, Customary and Reasonable Charges or UCR means the usual, customary and reasonable charge for the services or procedures rendered and the supplies furnished, based upon data collected from the health insurance industry for the geographic area where such services are rendered or supplies are furnished.

ARTICLE 2 – ELIGIBILITY RULES

2.1 Eligibility for Employees (Excluding Union Office Employees and Non-Bargaining Unit Employees)

(a) Dollar Bank System

1) The Fund shall maintain a bookkeeping account for each Employee. The account shall be credited with Contributions received on behalf of each Employee, and the cumulative amount credited to the account shall be referred to as the Employee's "Dollar Bank" or "Bank."

(2) The Trustees shall establish a monthly cost of coverage (Cost of Coverage) and a monthly subsidy (Subsidy), to be deducted from an Employee's Dollar Bank as set forth below. As of January 1, 2022, the Cost of Coverage is $1,050.00. The Cost of Coverage is determined and can be changed from time to time in the sole and exclusive discretion of the Trustees.

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

(b) Initial Eligibility. Provided a completed application has been provided to the Fund Office, initial eligibility will begin the first day of the third month following the date an Employee's Dollar Bank equals one month's Cost of Coverage in the amounts established under section 2.1(a)(2), above, provided such amount was accumulated in a 12 month period. If a Participant is not initially credited in any one month with the amount required to be eligible, contributions credited for more than one month will be combined to establish initial eligibility. Any credit in a Dollar Bank Account will be reduced by an administration fee for each month in which the Participant remains ineligible. The current administration fee is $18.00.

In the event of any inconsistency between the terms of the Plan and this SPD, the terms of the Plan control.

(c) **Accelerated Initial Eligibility.** Notwithstanding 2.1(b), an Employee may accelerate initial eligibility if he/she:

(1) was never previously covered by the Plan;
(2) immediately prior to entering Covered Employment was working for a non-contributing employer;
(3) within the immediate 30 days prior to entering Covered Employment, had comprehensive medical coverage meeting the minimum value standard of the Affordable Care Act (Other Coverage) as an employee (not as a dependent), and provides written proof Other Coverage satisfactory to the Trustees; and
(4) is engaged in Covered Employment as of the date he/she provides a completed application for coverage to the Fund Office.

If the above requirements are met, an Employee will be eligible for benefits the first of the month following 30 days after the Employee entered Covered Employment, provided a completed application for coverage is received within 59 days of the termination of his/her Other Coverage. Non-bargaining unit, full-time employees are also eligible for accelerated initial eligibility.

(d) **Delayed Eligibility**

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

(1) Such Participant has not previously been eligible for benefits from this Plan;
(2) His participation in the Plan arose as the result of a transfer or change of his union membership to a participating Union;
(3) He is currently eligible in a jointly-trusteed welfare plan sponsored by an affiliate of the United Brotherhood of Carpenters;
(4) If he becomes immediately eligible for this Plan, he will have double-coverage; and
(5) His eligibility in this Plan will automatically commence once eligibility for coverage from the other plan is exhausted.

A Participant is required to provide any and all information and documentation necessary to establish the foregoing criteria.

(e) **Continuing Eligibility**

(1) **Crediting Contributions.** Contributions are credited towards eligibility as follows:

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

In the event of any inconsistency between the terms of the Plan and this SPD, the terms of the Plan control.

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

***Eligibility Months**

Special Rule for Apprentices: Effective September 1, 2021, for any work months during which an indentured Apprentice attends school required by a training program in affiliated with the United Brotherhood of Carpenters and Joiners of America, the Apprentice shall be credited with an amount equal to the actual number of hours the Apprentice attends school per week.

(2) Maintaining Coverage and the Dollar Bank

(a) When monthly Contributions equal or exceed the sum of the Cost of Coverage and the Subsidy, this sum will be deducted for monthly eligibility. For example, if the Cost of Coverage is $1,050.00 and the Subsidy is $150, and monthly Contributions are $1,300.00, $1,200.00 will be used for eligibility and $100.00 will be placed in the Employee's Dollar Bank.

(b) When monthly Contributions are less than the sum of Cost of Coverage and the Subsidy, but greater than the Cost of Coverage, an amount equal to the monthly Contributions will be deducted for monthly eligibility. For Example, if the Cost of Coverage is $1,050.00, the Subsidy is $150.00, and monthly contributions are $1,150.00, $1,150.00 will be used for eligibility.

(c) When monthly Contributions are equal to or less than the Cost of Coverage, the Cost of Coverage will be deducted for monthly eligibility. For example, if the Cost of Coverage is $1,050.00, the Subsidy is $150.00, and monthly Contributions are $1,000.00, the $1,000.00 in contributions plus $50.00 from the Employee's Dollar Bank will be used for eligibility.

(d) When no monthly contributions are received, the Cost of Coverage will be deducted from the Employee's Bank for monthly eligibility until the balance in the Employee's Dollar is less than the Cost of Coverage.

(3) Eligibility Lapses Due to Employer Delinquency. If Eligibility lapses because the Employer contributions are delinquent and the Employee's Dollar Bank Account is depleted, the Participant may provide check stubs showing the hours worked for the delinquent Employer. Credit may be given for hours worked, up to three months, as determined by the Trustees.

(4) Self-Payments

- When the balance in the Dollar Bank is less than the Cost of Coverage, an Employee may self-pay to maintain coverage.
- The monthly self-pay equals the Cost of Coverage less any amount remaining in the Dollar Bank. Where the self-pay equals the Cost of Coverage, it is a "full self-payment."
- Full self-payments can be made for a maximum of 18 months consecutive months.
- Full self-payments run concurrently with Article 16 -- COBRA Continuation Coverage.

In the event of any inconsistency between the terms of the Plan and this SPD, the terms of the Plan control.

- Where the self-payment is less than the Cost of Coverage, it is a "partial self-payment." Participants can make unlimited partial self-payments.
- Participants who are Totally Disabled and are eligible for benefits under this Plan at the time they become disabled, are allowed unlimited self-payments until they are able to return to work or decide to retire.
- Payments must be received by the Fund Office by the 25th of the month, or postmarked by the 23rd of the month, for the month the self-payment is due (e.g. for April eligibility, the self-payment must be received by April 25th or postmarked by April 23rd). Failure to timely remit self-payments will result in termination of coverage retroactive to the first of the month for which self-payment is due and COBRA will be offered. Late self-payments to reinstate eligibility are not allowed.
- If a Participant fails to make a self-payment, any credit remaining in his Dollar Bank Account will be reduced by an administration fee for each month for which he remains ineligible. This fee will be deducted until the Participant's eligibility account is depleted or until he has reestablished eligibility.

(5) Dollar Bank in Excess of Three Months' Eligibility. When the balance in an Active Employee's Bank exceeds three times the Cost of Coverage such excess may be used for unreimbursed medical expenses as set forth in Article 5.

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

(1) is Totally Disabled
(2) is not Retired and is represented by the Union at the time the Disability was incurred, the date of application for benefits under (5), below, and remains represented by the Union,
(3) is not eligible for FMLA;
(4) is receiving Accident and Sickness Weekly Disability benefits from this Fund, or is entitled to benefits under Workers' Compensation or occupational disease law; and
(5) submits a written application to the Fund Office for such credits within 6 months after the Disability starts.

Notwithstanding, the Trustees may require that an Active Employee submit to an examination by a physician designated by the Fund prior to or during the receipt of such credit. At the end of 26 weeks, the Participant may elect COBRA Continuation Coverage under Article 16.

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

2.2 Eligibility for Non-Bargaining Unit Employees

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

(A) The Trustees enter into a participation agreement with the Employer for NBU coverage (Participation Agreement);

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

(C) The Employer covers all NBU who are working at least 32 hours a week for at least single coverage (no later than the first of the month following one month of employment), and is not allowed to cover those working less than 32 hours a week; and

(D) The Employer timely pays the monthly premium for coverage at the time and in the amount established in the sole and exclusive discretion of the Trustees. Premiums are due prior to the month of coverage. Coverage terminates in the event premiums are not timely remitted.

(ii) NBU are eligible for all benefits provided by the Fund with the exception of weekly disability benefits and the MRA (as they do not have Banks).

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

(vi) Contributions must be received by the 20th of the month following the work month.

(b) Retired Non-Bargaining Unit Employees.

(i) Must comply with the requirements of 2.3(a), below.

(ii) Must notify the Fund Office if he/she returns to work in any capacity.

(iii) Dependents of Retired Non-Bargaining Unit Employees are eligible provided they meet the requirements of Section 2.4.

2.3 Eligibility for Retirees. Retirees will be offered a choice between COBRA coverage, which is of limited duration, or Retiree coverage, as set forth below. Participants have the responsibility to notify the Fund Office when they retire and to furnish proof of such Retirement.

(a) Conditions of Coverage. To be eligible, an individual must meet the definition of Retiree and remit self-payments to maintain coverage at the time and in the amount established in the sole discretion of the Trustees from time to time. If a Retiree has contributions in his Dollar Bank Account when he retires, he may use his Dollar Bank Account to purchase benefits under Section 2.3. When a Retiree's Dollar Bank Account is depleted, the Retiree is required to make self-payment to maintain coverage. Once a Participant retires and enters the Retiree Program, he will not be allowed to reenter the active Participant program unless he becomes eligible by meeting the rules of Section 2.1(b)-Initial Eligibility. Self-payments must be:

- received by the Fund Office by the 25th of the month, or postmarked by the 23rd of the month, preceding the benefit month (e.g., for April eligibility, the self-payment must be received by March 25th or postmarked by March 23rd);
- made by check, money order, cashier's check, or remitted directly from a pension fund by a legally permissible assignment of benefits;
- made from the date Employee coverage terminated; and
- continue on an uninterrupted basis.

Failure to make self-payments in the amount and within the time frame specified will result in a permanent loss of coverage. If a Retiree declines to elect Retiree coverage when first offered, he/she

cannot elect such coverage at a later date. If Retiree coverage lapses or is terminated, it cannot be reinstated.

(b) Return to Work. If a Retiree returns to work he must notify the Fund Office. Contributions received on behalf of a Retiree will be credited to his/her MRA, less the Cost of Coverage and the Subsidy. Notwithstanding, if a Retiree ceases drawing a pension benefit and informs the Fund Office that he/she desires to re-establish eligibility as an Active Employee, such Contributions will be credited per Section 2.1.

2.4 Dependent Eligibility

(a) Effective Date of Eligibility and Enrollment

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

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

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

Any changes in dependent status must be reported to the Plan Administrator (i.e., marriage, divorce, etc.). Failure to provide timely notification will result in termination of eligibility under the Plan. A divorced spouse or overage Dependent will be terminated on the last day of the month in which the Dependent no longer meets the definition of Dependent.

If a Retiree elects to not initially cover a Dependent or if a Retiree elects to remove Dependent from coverage, the Retiree must make that election in writing to the Fund Office. Once a Retiree elects not to cover a Spouse or Dependent Child, the Retiree will not be able to add such Dependent back to coverage at any time in the future unless the reason for such election was the that the Dependent had other coverage, in which case reenrollment must be within 30 days of the loss of other insurance.

(b) Coverage Following the Death of a Participant

(1) Surviving Spouse

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

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

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

(2) Dependent Children

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

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

2.5 Termination of Coverage

(a) Participant. Notwithstanding any term of the Plan to the contrary, all coverage terminates on the earliest of the following:

- The last day of the month the Participant maintains eligibility via the Dollar Bank or self-payments;
- The last day of the month a Participant begins active duty in the armed forces;
- The date a Participant accepts employment in the same industry with a noncontributing employer.
- The date an Active Employee ceases Covered Employment and is not on the Union's out-of-work list; or
- The date the Plan terminates.

Notwithstanding, if a Participant stops working for a contributing Employer but continues to work under the terms of a Collective Bargaining Agreement of another affiliated Union of the United Brotherhood of Carpenters and Joiners of America, or continues to work for a contributing employer

in a non-bargaining unit position, he will be covered so long as his Dollar Bank Account is sufficient to continue eligibility, and upon exhaustion of the Bank will be offered COBRA coverage.

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

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

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

2.7 Initial Eligibility for New Employer Groups. At the Trustees' discretion, an Employee may become eligible as of the first day on which Employer contributions are required to be paid on behalf of such Employee. The circumstances under which this initial eligibility rule will be applied will be the acceptance by the Trustees of newly organized bargaining units.

2.8 Special Opt Out Provision. A spouse or child of an Active Employee may opt out of the Plan's coverage due to eligibility under a high deductible health plan (such as a Health Savings Account) through their employer, by completing the Plan's appropriate form with proof that the spouse or child has a high deductible healthcare plan. A spouse or child of an Active Employee may rejoin this Plan by completing the Plan's appropriate form with proof that the spouse or child is no longer being covered under the high deductible healthcare plan and that the Employee is still eligible under this Plan. Eligibility will commence on the first day of termination under the high deductible plan if proof of termination is provided within 30 days of the termination of other insurance. If proof of termination is not provided within 30 days of the termination of the other coverage, eligibility will commence the first day of the month following notification to the Plan.

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

3.1 Medical Network. The Fund has contracted with Independence Blue Cross (Independence), a preferred provider network. A list of participating physicians and facilities, known as in-network providers, is available at the Plan Office free of charge. Information may also be accessed at www.myibxtpabenefits.com. Covered Persons are encouraged to use in-network providers to save money for themselves and the Plan, but can choose treatment from an out-of-network provider and pay greater out of pocket expenses. For contact information for Independence, see Article 26.

Services Provided by Nonparticipating Provider at Participating Facility: Notwithstanding any term of the Plan to the contrary, where covered nonemergency items or services are provided by nonparticipating providers at participating facilities, in the absence of Consent to Out of Network Services, the Plan will:

(a) not impose a cost sharing requirement greater than the requirement that would apply if the items or services were provided by a participating provider;

(b) calculate cost-sharing as if the total amount that would have been charged for the items or services by a participating provider were equal to the Recognized Amount for such services; and

(c) apply any cost-sharing payments with respect to such items and services toward any in-network deductible or in-network out-of-pocket maximums the same as if the services were received in-network.

Continuing Care Patient: If a covered person is a Continuing Care Patient of a provider or facility that terminates its participating provider status with the Plan as a result of: (a) termination of its contractual relationship as a participating provider (not including termination of the contract for failure to meet quality standards or fraud), or (b) termination of benefits under the Plan due to a change in the terms of the participation of the provider or facility in the network, the Plan will:

(a) notify each Continuing Care Patient on a timely basis of such termination and such individual's right to elect continued transitional care from such provider or facility as set forth in c), below;

(b) provide such individual with an opportunity to notify the Plan of the individual's need for transitional care; and

(c) allow such individual to elect to continue to benefits provided under the Plan under the same terms and conditions as would have applied to the individual as a Continuing Care Patient had such termination not occurred, during the period beginning on the date on which the notice under a), above, is provided and ending on the earlier 90 days or the date on which such individual is no longer a Continuing Care Patient with respect to such provider or facility.

3.2 Medical Benefits, Exclusions, and Other Limitations

(a) Chart of Benefits. Subject to the exclusions and limitations set forth in Section 3.2(b)-(d), the following benefits are provided by the Plan.

Out of Network benefits will be paid based on the Applicable Medicare Rate, defined below, instead of Reasonable and Customary rates. Therefore, any reference to "UCR" in the chart of benefits is deleted and replaced with "Applicable Medicare Rate."

Applicable Medicare Rate:

Professional Procedures: 100% of the applicable Medicare Rate
Institutional Procedures: 150% of the applicable Medicare Rate
Where There Is No Medicare Rate Available: 50% of actual charges

	Active Employees and Non-Medicare Retirees	
Medical Benefits	**In-Network**	**Out-Of Network**
Annual Deductibles -In/Out DO NOT Satisfy each other -Common accident deductible applies	$500/individual $1,250/family	$500/individual $1,250/family
Annual Out of Pocket Maximums (includes Co-Insurance, Deductible, and Co-Payments)	$5,000/person $10,000/family	$5,000/person $10,000/family
Inpatient Hospital		

	Active Employees and Non-Medicare Retirees	
Medical Benefits	**In-Network**	**Out-Of Network**
Precertification required. **See Section 3.2(c), below.**		
Facility - Inpatient Hospital (Semi-private room; private room only when Medically Necessary)	75% after deductible	60% of Applicable Medicare Rate after deductible.
Birthing Center/Ambulatory Surgery Center	75% after deductible	60% of Applicable Medicare Rate after deductible.
Surgery -Surgical procedure(s) performed during the same operative session as a primary procedure will be paid at 50% of the amount allowed, subject to the Deductible Amount, for each secondary procedure if performed alone, under the following criteria: -The secondary procedure is to correct a separate pathological condition. -The pathological condition would have required surgical intervention had an incision not already been present; and -The degree of difficulty, operative time and risk are significantly increased by the secondary procedure. -If any of the above criteria are not met, the secondary procedure will be considered an integral part of the primary procedure and will not be reimbursed separately. -Physician assistance will be 20% of the amount allowed. -Includes reconstructive breast surgery and breast prosthesis following a mastectomy, including: (a) reconstruction of the breast on which mastectomy was performed; (b) surgery and reconstruction of the other breast to produce a symmetrical appearance; and (c) prostheses and treatment of physical complications are all stages of the mastectomy, including lymphedemas. -Includes surgery for morbid obesity limited to one surgery per lifetime where the eligible Participant must have a BMI of at least 35, must have Physician documented unsuccessful, non-surgical weight loss attempts within the previous six months and at least one of the following associated medical conditions: Severe Sleep Apnea,	75% after deductible	60% of Applicable Medicare Rate after deductible.

	Active Employees and Non-Medicare Retirees	
Medical Benefits	**In-Network**	**Out-Of Network**
Pickwickian Syndrome, Congestive Heart Failure, Cardiomyopathy, Insulin Dependent Diabetes or Severe Musculoskeletal Dysfunction		
Ancillary Hospital Benefits (services and supplies other than room and board, provided and billed for by a Hospital. Excludes take-home items)	75% after deductible	60% of Applicable Medicare Rate after deductible.
Anesthesia	75% after deductible	60% of Applicable Medicare Rate after deductible.
Certified registered nurse anesthetist	75% after deductible	60% of Applicable Medicare Rate after deductible.
Assistant Surgeon	75% after deductible	60% of Applicable Medicare Rate after deductible.
Inpatient Medical Visits. -Professional services rendered by the attending Physician and calls made by the operating Physician in rendering necessary preoperative care before surgical procedures and post-operative care after surgery. -Limited to one visit per day unless the visit is due to unrelated diagnosis.	75% after deductible	60% of Applicable Medicare Rate after deductible.
Diagnostic Labs and Services (radiology, ultrasound, nuclear medicine, lab, pathology, EKG, EEG, MRI, and other electronic diagnostic medical procedures; psychological testing, and neuropsychological testing) ordered by a Physician due to specific symptoms	75% after deductible	60% of Applicable Medicare Rate after deductible.
Labs	75% after deductible	60% of Applicable Medicare Rate after deductible.
Necessary Preadmission Tests and Studies performed in an outpatient setting before an inpatient Hospital admission	75% after deductible	60% of Applicable Medicare Rate after deductible.
Respiratory Therapy Outpatient when related to surgery or emergency care	75% after deductible	60% of Applicable Medicare Rate after deductible.
Kidney Dialysis	75% after deductible	60% of Applicable Medicare Rate after deductible.
Pre-Natal/ Post-Natal/ Labor and Delivery (including midwife) **Special Notice Regarding Maternity Benefits:** Group health plans and health insurance issuers generally may not, under	75% after deductible	60% of Applicable Medicare Rate after deductible.

	Active Employees and Non-Medicare Retirees	
Medical Benefits	**In-Network**	**Out-Of Network**
federal law, restrict benefits or require authorization for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable). Where an earlier discharge is not against medical advice, a home or office visit for education, physical and home assessment, feeding, and routine tests not completed due to early discharge is covered if conducted by a Physician or nurse within 72 hours of discharge. -Includes only pre-natal care for Dependent Children. Labor and Delivery not covered for Dependent Children.		
Physical Therapy -to restore or improve movement or function impaired due to an acute episode of disease, injury or trauma, or a congenital anomaly that is expected to achieve measurable improvement within a reasonable timeframe (usually four - six months) -Inpatient services must be provided in an acute hospital, rehabilitation unit or skilled nursing facility for short-term, active progressive services that cannot be provided in an outpatient or home setting	75% after deductible	60% of Applicable Medicare Rate after deductible.
Organ Transplant Benefits **Precertification Required section 3.2(c).** See also conditions of coverage and exclusions at section 3.2(f).	75% after deductible	No coverage
Outpatient Care		
Surgery -Will cover second opinion for necessity of surgery, and third opinion only if first and second disagree. The consulting Physicians must not be in practice together nor in practice with the Physician who first recommended surgery.	75% after deductible	60% of Applicable Medicare Rate after deductible.

	Active Employees and Non-Medicare Retirees	
Medical Benefits	**In-Network**	**Out-Of Network**
Diagnostic Labs and Services (radiology, x-ray, ultrasound, nuclear medicine, lab, pathology, EKG, EEG, MRI, and other electronic diagnostic medical procedures, psychological testing, and Neuropsychological testing.)	75% after deductible	60% of Applicable Medicare Rate after deductible.
Emergency Services for an Emergency Medical Condition	75% after $250 copayment $250 waived if the patient is admitted to the hospital or if the reason for the emergency room visit is due to an accidental injury or life threatening condition.	75% Applicable Medicare Rate after $250 copayment $250 waived if the patient is admitted to the hospital or if the reason for the emergency room visit is due to an accidental injury or life threatening condition.
Occupational/Physical/Speech Restorative Therapy -to restore or improve movement/function, skills, or speech impaired due to an acute episode of disease, injury or trauma, or a congenital anomaly that is expected to achieve measurable improvement within a reasonable timeframe (usually four - six months).	75% after deductible	60% of Applicable Medicare Rate after deductible.
Respiratory Therapy -must be related to surgery or Emergency care. -must be outpatient	75% after deductible	60% of Applicable Medicare Rate after deductible.
Cardiac Rehabilitation	75% after deductible	60% of Applicable Medicare Rate after deductible.
Radiation and Chemotherapy	75% after deductible	60% of Applicable Medicare Rate after deductible.
Hemodialysis and peritoneal dialysis	75% after deductible	60% of Applicable Medicare Rate after deductible.
Acute Kidney Dialysis	75% after deductible	60% of Applicable Medicare Rate after deductible.
Second surgical opinion	75% after deductible	60% of Applicable Medicare Rate after deductible.
Mental Health and Nervous Disorder Benefit		
Inpatient Hospital Care -**Precertification Required, see section 3.2(c).** - Inpatient treatment must be a licensed facility specializing in the treatment of mental or nervous disorders.	75% after deductible	60% of Applicable Medicare Rate after deductible.

In the event of any inconsistency between the terms of the Plan and this SPD, the terms of the Plan control.

	Active Employees and Non-Medicare Retirees	
Medical Benefits	**In-Network**	**Out-Of Network**
- Care or treatment must be administered by a medical doctor, psychiatrist, clinical psychologist or licensed practitioner including a licensed social worker.		
Inpatient Residential Treatment Facility -**Precertification Required, see section 3.2(c).** **-60 day visit limitation per Plan year**	75% after deductible	No coverage
Outpatient - Care or treatment must be administered by a medical doctor, psychiatrist, clinical psychologist or licensed practitioner including a licensed social worker.	75% after deductible	60% of Applicable Medicare Rate after deductible.
Substance Abuse Benefit		
Inpatient Hospital Care -**Precertification Required, see section 3.2(c).** - Inpatient treatment must be a licensed facility specializing in the treatment of mental or nervous disorders. - Care or treatment must be administered by a medical doctor, psychiatrist, clinical psychologist or licensed practitioner including a licensed social worker.	75% after deductible	50% of Applicable Medicare Rate after deductible.
Inpatient Residential Treatment Facility **-Precertification Required, see section 3.2(c).** **-60 day visit limitation per Plan Year**	75% after deductible	No coverage.
Outpatient - Care or treatment must be administered by a medical doctor, psychiatrist, clinical psychologist or licensed practitioner including a licensed social worker.	75% after deductible	50% of Applicable Medicare Rate after deductible.
Physician's Office/Urgent Care/On-Line All services received during one visit billed separately, and accordingly have separate cost sharing requirements.		
Telehealth: Teladoc – see Section 3.2(e) below	100%	No coverage
Physician Office Visit or In-home treatment by Physician	75% after deductible	60% of Applicable Medicare Rate after deductible.
Specialists & Consultations	75% after deductible	60% of Applicable Medicare Rate after deductible.
Pre and Post Natal Care that is not preventive care	75% after deductible	60% of Applicable Medicare Rate after deductible.
Allergy Testing/Injections	75% after deductible	60% of Applicable Medicare Rate after deductible.

	Active Employees and Non-Medicare Retirees	
Medical Benefits	**In-Network**	**Out-Of Network**
Diagnostic Lab/X-Ray	75% after deductible	60% of Applicable Medicare Rate after deductible.
Surgery	75% after deductible	60% of Applicable Medicare Rate after deductible.
Urgent Care	75% after $75 copayment	60% of Applicable Medicare Rate after $75 copayment
Preventive Care The following, and other required preventive services, are covered only to the extent required under federal law.		
Adult Physical/GYN/Routine PAP/Mammograms (limited to 1 per calendar year)	100%	60% of Applicable Medicare Rate after deductible.
Standard Pre- and Post-natal visits	100%	60% of Applicable Medicare Rate after deductible.
Gestational Diabetes Screening (24-48 weeks pregnant)	100%	60% of Applicable Medicare Rate after deductible.
Prostate/Immunizations (limited to 1 per calendar year)	100%	60% of Applicable Medicare Rate after deductible.
Routine Colonoscopy (over age 50) -Maximum 1 Exam every 5 Years	100%	60% of Applicable Medicare Rate after deductible.
HPV DNA Testing (once every 3 years/women 30 & older)	100%	60% of Applicable Medicare Rate after deductible.
Annual STI Counseling; HIV Screening & Counseling	100%	60% of Applicable Medicare Rate after deductible.
Domestic Violence Screening & Counseling	100%	60% of Applicable Medicare Rate after deductible.
Contraceptive Counseling Breastfeeding Support & Counseling (with birth of child)	100%	60% of Applicable Medicare Rate after deductible.
Children's Physicals (to age 21)	100%	60% of Applicable Medicare Rate after deductible.
Obesity Screening and Counseling, if required to be covered as preventive services under federal law	100%	60% of Applicable Medicare Rate after deductible.
Well Child Care (up to age 24 months, including immunizations recommended by the CDC)	100%	60% of Applicable Medicare Rate after deductible.
Immunizations for children and adults as required by Health Care Reform and recommended by the Advisory Committee on Immunization Practices, as appropriate based on age and population.[1]	100%	60% of Applicable Medicare Rate after deductible.

[1] The Plan also covers the following immunizations to the extent not required by federal law: shingles per CDC recommendations (or for those over 50 if established medical necessity for deviating from guidelines), rabies, and pneumonia.

	Active Employees and Non-Medicare Retirees	
Medical Benefits	**In-Network**	**Out-Of Network**
Smoking Cessation	100%	100%
Any other required preventive care coverage under the Affordable Care Act	100%	60% of Applicable Medicare Rate after deductible.
Coronavirus/COVID-19		
COVID-19 testing	75% after deductible	60% of Applicable Medicare Rate after deductible.
Treatment for COVID-19	75% after deductible	60% of Applicable Medicare Rate after deductible.
OTC COVID-19 Testing – FDA approved tests purchased on or after January 15, 2022 through December 31, 2023, for personal use (e.g., not for employment purposes or resale) Maximum 8 tests per 30 day period covered person Note: OTC COVID-19 tests covered via Pharmacy Benefit Manager	100% coverage at retail and via direct to consumer shipping options provided by Pharmacy Benefits Manager	60% of Applicable Medicare Rate after deductible.
Other Providers		
Chiropractors – Limit 25 visits per calendar year (office visits, manipulations, modalities, x-rays).	100% up to $30 per visit	100% of Applicable Medicare Rate after deductible up to $30 per visit
Other Services		
Skilled Nursing Facility **Precertification required, see Section 3.2(c).**	75% after deductible	Not covered.
Private Duty Nursing – Covered under Transplant Services 90 day visit limitation per Plan Year.	75% after deductible	60% of Applicable Medicare Rate after deductible.
Home Health Care -must be homebound	75% after deductible	60% of Applicable Medicare Rate after deductible.
Home Infusion Therapy – excludes rest homes, custodial care	75% after deductible	60% of Applicable Medicare Rate after deductible.
Hospice Care - **Pre-certification required, see Section 3.2(c)** -Hospice benefits payable whether the services were performed in a Hospice or at the patient's home and include palliative and supportive medical nursing or health services. - Allowed Charges include: (1) Room and board for confinement in a Hospice; (2) Physician services available	75% after deductible	75% of Applicable Medicare Rate after deductible.

	Active Employees and Non-Medicare Retirees	
Medical Benefits	**In-Network**	**Out-Of Network**
by consultation; (3) Services and supplies furnished by the Hospice while the patient is confined therein; (4) Intermittent nursing care by a registered professional nurse or licensed practical nurse under the supervision of a Registered Nurse (RN); (5) Home Health Aide services and supplies; (6) Nutritional guidance given by a registered nutritionist; and (7) Counseling services by a licensed social worker or a licensed pastoral counselor.		
Durable Medical Equipment (including rental fees not to exceed purchase price) -Covered Charges for deluxe items are limited to cost of standard items -Expenses for special fittings, adaptions, maintenance agreements or repairs for such equipment are not considered Covered Charges.	75% after deductible	75 % of Applicable Medicare Rate after deductible.
Prosthetics -purchase, fitting, adjustments, repairs and replacements of prosthetic devices, including necessary supplies, that replace all or part of a missing body organ or limb or replace a permanently inoperative or malfunctioning body organ; this includes a cranial prosthesis medically necessary due to hair loss resulting from medical conditions such as alopecia areata or chemotherapy.	75% after deductible	60% of Applicable Medicare Rate after deductible.
Orthotic Appliances -purchase, fitting, repair, replacement, and adjustments of orthotic appliances.	75% after deductible	Medicare Rate after deductible
Medical Supplies -Must serve a specific therapeutic purpose such as needles, oxygen, syringes, and surgical dressings and other similar items and be provided per physician orders.	75% after deductible	Medicare Rate after deductible
Ambulance -To and from the Hospital for a covered inpatient admission or initial treatment of an Emergency Medical Condition provided by a Hospital or a government-certified ambulance service.	75% after deductible	Ground ambulance: 60% of Applicable Medicare Rate after deductible.

	Active Employees and Non-Medicare Retirees	
Medical Benefits	**In-Network**	**Out-Of Network**
		Air ambulance: 75% of Applicable Medicare Rate after deductible
Abortion (therapeutic and elective – elective subject to exception in 3.2(b))	75% after deductible	60% of Applicable Medicare Rate after deductible.
Vasectomies, tubal ligation, and birth control services	75% after deductible	60% of Applicable Medicare Rate after deductible.
Diagnostic Services for Infertility -Treatment of Infertility excluded. See section 3.2(b) below.	75% after deductible	60% of Applicable Medicare Rate after deductible.
Temporomandibular Joint Disorder -Maximum lifetime benefit per person $2,000	100% after deductible	100% Medicare Rate after deductible

(b) Exclusions and Limitations. In addition other restrictions to coverage set forth in this Plan, the Fund will not provide coverage, under this Article 3 or any other provision of this Plan, for any service, items, condition, or expenditure:

(1) That are not Medically Necessary;
(2) For any condition, disease, ailment, or accidental Injury arising out of and in the course of employment, including self-employment for profit.
(3) Received in any sanitarium or any state or federal Hospital, including any Veterans Administration Hospital (except as provided by law), or treatment for which indemnification or Hospital care is available under the laws of the United States or any state or political subdivision thereof.
(4) Received in rest homes, health resorts, homes for the aged, college infirmaries, or places primarily for home or Custodial Care.
(5) Sustained as a result of war, declared or undeclared, or any act of war.
(6) Related to sex transformation, sexual therapy or counseling, or sexual dysfunction or inadequacy. This exclusion includes penile prosthesis and all other procedures and equipment developed for male impotency, except as specifically covered in the Plan.
(7) Rendered prior to the individual's effective date of coverage or after the date of termination.
(8) To the extent that benefits are available from or provided by any other group healthcare coverage, including any governmental health plan (except Medicaid). The payment of benefits from the Fund will be coordinated with the other coverage to the extent permissible under existing laws and regulations.
(9) For which the Covered Person has no legal obligation to pay, or for which no charge has been made.
(10) Arising from elective abortions, except in the case of rape, incest, ectopic pregnancy, missed miscarriage, missed abortion, silent miscarriage or to save the life of the Participant or eligible Spouse or Dependent.
(11) For cosmetic purposes, including cosmetic surgery designed primarily to improve or enhance the appearance of normal or of abnormal structures without having a significant impact on the

In the event of any inconsistency between the terms of the Plan and this SPD, the terms of the Plan control.

function of that structure. Covered reconstructive surgery is Medically Necessary surgery designed to improve the function of abnormal structures, including those caused by Illness, accident, covered surgery or congenital malformation where there are objective functional defects. The presence of a psychological or emotional condition by itself does not make a surgical procedure reconstructive.

- Examples of excluded cosmetic surgery include, but are not limited to, removal of excess skin or tissues, augmentation procedures, liposuction, scar removal and cosmetic use of Botox.
- Examples of covered reconstructive surgery include treatment of severe burns, repairs of the face or extremities following an accident or correction of birth defects in a child that cause a functional defect.

(12) That are Experimental or Investigational.

(13) For hearing aids, supplies and testing, except as provided under the Hearing Benefit.

(14) For eyeglasses (including contact lenses) and examinations and fittings for them, whether or not prescribed (except for prosthetic lenses or sclera shells following intra-ocular surgery or for soft contacts where dictated by a medical condition), except as provided under Vision Benefits.

(15) For travel, whether or not recommended by a Physician, except as provided for under the Organ Transplant Benefit.

(16) For genetic testing, including chromosome studies, except when pre-certified as Medically Necessary to determine an appropriate course of treatment;

(17) For treatment of corns, bunions (except capsular or bone surgery), calluses, nails of the feet (except surgery for ingrown nails), flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet (except when surgery is performed).

(18) For weight reduction programs or treatment for obesity, except as provided under Section 3.2(a) and certain weight loss drugs covered under Section 3.3(b)(5) and 4.2, or any surgery for the removal of excess fat or skin following weight loss, services at a health spa, similar facility or psychiatric care services for weight loss, regardless of Medical Necessity.

(19) Charges for In-Patient admission for environmental change, convalescent rest, or Custodial Care.

(20) Acupuncture, anesthesia by hypnosis, or charges for anesthesia for non-covered services.

(21) Any confinement in a skilled nursing facility, except for physical therapy rehabilitation or as allowed under the Medicare Advantage Plan;

(22) Services, supplies or treatments not specified as a Covered Charge. This includes, but is not limited to:

- self-help training and other forms of non-medical self-care, except for educational training for a diabetic including the family when the diabetic is a child;
- immunizations not specified in the Chart of Medical Benefits in Section 3.2(a);
- premarital examinations; and
- participation in a research study;

(23) Charges in excess of the Usual, Customary and Reasonable Charge.

(24) Charges for injuries sustained while participating in felonious criminal activity (not as an innocent victim).

(25) For dental services and procedures involving tooth structures, extractions, gingival tissues, alveolar processes, except when certified by an acceptable medical review that hospitalization and/or general anesthesia was necessary to safeguard the life or health of the patient from the effects of a dental procedure because of the existence of a specific non-dental organic

impairment or when such expense is incurred as the result of an accidental bodily Injury or as provided under the Dental Benefit.

(26) For dental x-rays or examinations or dental services and procedures, except for removal of cysts of the mouth or except as provided for in the Dental Benefit.

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

(28) For inpatient admission for audiometric testing, eye refractions, examinations for the fitting of eyeglasses or hearing aids, dental examinations, diagnostic study relating to physical examinations or checkups.

(29) For personal hygiene and convenience items, such as, but not limited to, air conditioners, humidifiers or physical fitness equipment, non-legend drugs and personal items, such as TV, telephone, cots and visitors' meals.

(30) Inpatient admissions and related services and supplies for the purpose of diagnostic studies or tests.

(31) Diagnostic procedures, except as specifically provided for by this Plan.

(32) Related to treatment for speech therapy, except as specifically provided for by this Plan.

(33) Invitro fertilization.

(34) For fertility drugs or devices, or services to remedy/treat infertility except as specifically provided for by this Plan.

(35) For Non-medical supplies and equipment such as, but not limited to, treadmills and exercise bicycles.

(36) For routine or periodic physical examinations or for screening purposes, except as specifically provided for by this Plan.

(37) All expenses, accommodations, materials, services, and care related to non-covered services are not covered, including complications resulting directly from a non-covered service.

(38) Charges for telephone consultations, except as provided for by this Plan, failure to keep a scheduled appointment, completion of a claim form or to obtain medical records or other information

(39) Routine hearing tests and audiograms that are not performed in connection with an Illness, injury or medical condition.

(40) Services and supplies rendered by a Provider who is a member of the patient's immediate family or who resides in the patient's household.

(41) Services by or supplies from a person or entity that does not meet the definition of Provider.

(42) Any Durable Medical Equipment having certain convenience or luxury features which are not Medically Necessary, except that benefits for the cost of standard equipment used in the treatment of disease, Illness or injury will be provided towards the cost of any deluxe equipment selected. Expenses for special fittings, adaptions, maintenance agreements or repairs for such equipment are not considered Covered Charges.

(43) With respect to Home Health Care:

- Visiting teachers, friendly visitors, vocational guidance and other counselors and services related to diversional occupational and social activities.
- Services rendered by registered or licensed practical nurses or other health professionals and other allied health workers who are not employed by or functioning pursuant to a contractual arrangement with a Community or Hospital Home Health Care Agency.
- Services provided to persons who are not essentially homebound for medical reasons.

(44) Expenses for treatment incurred as a result of an Intentionally Self-Inflicted Injury, Sickness or other condition or attempt at self-destruction unless the injury is in connection with a Medical Condition (except for Life Insurance Benefit).

(45) Food, housing, homemaker services (such as light housekeeping, laundry, shopping, simple errands, teaching of household routine to well members of the family, supervision of the patient's children and other similar functions) and home delivered meals.

(46) Services or supplies not specifically provided for in the Plan.

(47) Handrails, ramps, telephones, air conditioners, appliances and similar services and devices.

(48) Services or supplies for vision correction surgery or vision therapy, except vision therapy for treatment of strabismus (lazy eye)

(49) Reversal of voluntary sterilization.

(50) Growth hormone medications and similar biopharmaceuticals unless pre-certified as Medically Necessary.

(51) Developmental Care, as defined in this Plan, regardless of where or by whom provided.

(52) Organ Transplant Benefits will not be provided for expenses (i) when government funding of any kind is provided; (ii) where recipient, donor and procurement services and costs incurred outside the United States; or (iii) when Any animal organ or tissue or mechanical device or equipment that is not considered Medically Necessary as determined by the Plan.

(53) Necessary Preadmission tests and studies performed in an outpatient setting before an inpatient Hospital admission will not be covered if they are:

- Performed to establish a diagnosis,
- Repeated after the Covered Person is admitted,
- Performed more than seven days before the Covered Person is admitted, or
- The Covered Person cancels or postpones the admission.

(54) Hospice Care does not include: services or treatment provided more than six months from the date service commenced; care for patients with a greater than six month life expectancy; care beyond palliative care management; services or supplies for any medical condition other than the life threatening illness; and Custodial Care or services, i.e., room and board or other institutional or nursing services which are provided to or for an Eligible Person due to his/her age, mental or physical condition, mainly to aid the person in daily living; or medical services to maintain the person's present state of health and which cannot reasonably be expected to improve the Eligible Person's medical condition.

(55) All FDA-approved Cellular and Gene Therapy products.

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

(c) Precertification

Inpatient: Precertification means that admissions and certain procedures are reviewed prior to delivery to ensure medical necessity and other requirements for coverage are met. It is required prior to all in-patient hospital admissions, organ transplants, residential treatment facility admissions, and skilled nursing facility admissions. Pre-certification of benefits is provided by American Health Independence Administrators. For contact information for Independence Administrators see Article 26. Precertification is required within the following timeframes:

- Emergency care: within two working days after admission.
- Maternity care: within one working day after admission.

- All other medical, surgical, or psychiatric care: by mail at least 14 working days before admission, by phone at least two working days before admission.
- If an emergency admission is required, the Covered Person must have the admission precertified within 48 hours following admission.

If the pre-certification organization finds that the Covered Person can be treated as an outpatient, the inpatient admission will not be certified for inpatient admission. If precertification is denied, this is considered a claim denial that may be appealed under Article 14.

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

(d) **Large Case Management.** Large case management services are provided by American Health Holdings to assist with management of medically necessary and cost effective care.

(e) **Teladoc.** Teladoc is a program that allows Covered Persons to contact a Physician online (with a webcam) or through a smartphone 24 hours a day, 7 days a week, for non-emergency issues. Teladoc is accessible at www.TeladocHealth.com or via telephone at 1-800-835-2362. Telehealth visits through Teladoc are covered 100% (in-network only).

(f) **Organ Transplant Benefit**

(1) Benefits will only be paid for transplant services during the Benefit Period (see (2), below), as follows:
  (a) With respect to procedures directly related to a transplant procedure being performed, beginning on the date the person is designated as a transplant candidate through the predetermination process, and ending on the earlier of the date 18 months after the covered transplant procedure is performed or the date this Plan is terminated.
  (b) If a covered transplant procedure is not performed as scheduled due to the intended recipient's medical condition or death, otherwise covered benefits will be paid for transplant services up to the recipient's death or up to and including the date the decision is made by the recipient's Physician not to perform the transplant.

(2) If a recipient requires more than one covered transplant procedure, the Fund will consider reimbursement for transplant services during each Benefit Period as follows:
  (a) If each transplant is due to unrelated causes, each is considered as a separate Benefit Period.
  (b) If each transplant is due to related causes, each is considered as a separate Benefit Period, if
    (a) In the case of an Employee, the transplants are separated by the Employee's return to work for a period of 90 days; or
    (b) In the case of a Dependent, the transplants are separated by at least 90 days; or
    (c) If the transplants are due to related causes, they are considered as one Benefit Period when not separated as in (b), above.

(3) Organ Transplant Benefits will not be provided for expenses (i) when government funding of any kind is provided; (ii) where recipient, donor and procurement services and costs incurred outside the United States; or (iii) when any animal organ or tissue or mechanical device or equipment that is not considered Medically Necessary is involved.

In the event of any inconsistency between the terms of the Plan and this SPD, the terms of the Plan control.

(g) Diabetic Testing Supplies: OneHealth is a comprehensive program that provides certain diabetic testing supplies without cost sharing to the Covered Person. A list of covered diabetic test supplies is available at the Plan Office, and includes blood glucose monitors, test strips, lancets, alcohol prep pads, blood ketone test strips, and insulin pumps. If a Covered Person does not receive their diabetic testing supplies through OneHealth or through the Prescription Drug program provided by the Fund, see Section 3.3 and 4.2 as applicable, then applicable deductibles and copayments may apply as set forth in Section 3.2(a). See Article 26 for contract information for OneHealth.

3.3 Prescription Drugs

(a) Administration. Self-funded prescription drug coverage is administered by Express Scripts, a Pharmacy Benefits Manager (PBM). See Article 24 for contact information. Participants are issued a prescription drug card and must present this card at participating pharmacies for benefits. Participants that utilize a non-participating pharmacy must pay the entire cost of the drug at the time of purchase and submit original receipts for reimbursement, not to exceed the amount the Fund would have paid a participating pharmacy, to the Fund Office. A Participant that wants a Multiple Source Brand name drug instead of its generic equivalent will be required to pay the Multiple Source Brand drug copayment plus the difference between the cost of the Multiple Source Brand drug and the cost of its generic equivalent. However, if the prescription specifically notes "dispense as written," the Participant will only be responsible for foe Multiple Source Brand copayment (not cost difference amount).

(b) Covered Drugs

(1) All Federal Legend drugs; including oral contraceptives and other birth control devices;
(2) Self-administered injectables and certain specialty drugs;
(3) Syringes for self-administered injectables;
(4) Pre-natal vitamins prescribed during pregnancy.
(5) Notwithstanding any other term of this Plan to the contrary, the Plan will cover certain weight loss drugs, subject to the specific eligibility criteria applicable to each drug, which generally will require the individual:
    (a) Be at least 18 years of age;
    (b) Engage in behavioral modification and a reduced-calorie diet (which may be required prior to the commencement of drug coverage); and
    (c) Have a Body Mass Index (BMI):
        (i) Equal or greater than 30; or
        (ii) Equal or greater than 27 and at least one of the following risk factors:
            (A) Type 2 diabetes;
            (B) Hypertension;
            (C) Dyslipidemia;
            (D) Obstructive sleep apnea; or
            (E) Cardiovascular disease.

A list of covered weight loss drugs, and the applicable drug eligibility criteria, both of which may change from time to time, is available at the Fund Office or by contacting ExpressScripts, the Pharmacy Benefits Manager (PBM) at 855-837-3582.

(c) Exclusions

(1) Any drug or medicine charges for which benefits are provided under any other provision of the Plan;
(2) Medicine which can be purchased without a written prescription except for those specifically allowed under the Plan;
(3) Therapeutic devices or appliances;
(4) All injectable products except self-administered injectables;
(5) Blood or blood plasma;
(6) Investigational or experimental drugs;
(7) Vitamins (prescription and over the counter, except for pre-natal vitamins prescribed during pregnancy), cosmetics, dietary supplements, health and beauty aids;
(8) Prescriptions to treat sexual dysfunction and/or sexual inadequacy, except for prescribed impotency medications up to six pills per 30 days;
(9) Agents or treatment related to baldness or thinning hair (prescription or over the counter);
(10) Fertility drugs;
(11) Proton Pump Inhibitor (PPI) drugs.
(12) Any exclusion listed under Section 3.2(b).

(d) Co-payments and Maximum Out of Pocket Costs. Most prescription drugs will be subject to the copayments set forth in the table below, Specialty Drugs are covered through the Saveon SP Program and are subject to the cost sharing requirements as set forth by Saveon SP. Specialty drugs are limited to a 30-day supply per fill.

The following copayments apply:

Retail (up to 30 day supply)* (first three refills of same drug)	
Tier 1	Generic: $20
Tier 2	Formulary Brand: $40
Tier 3	Non-formulary Brand: $80
Tier 4	Specialty: 25% up to $200
Retail (up to 30 day supply)* (fourth or more refills of same drug)	
Tier 1	Generic: 100% up to $100
Tier 2	Formulary Brand: 100% up to $100
Tier 3	Non-formulary Brand: 100% up to $100
Mail Order (up to 90 day supply)*	
Tier 1	Generic: $50
Tier 2	Single Source Brand: $100
Tier 3	Formulary Brand: $200
Tier 4	Non-formulary: 25% up to 200

*This chart sets forth amounts paid by the Covered Person at participating pharmacies. As noted above, Covered Persons that utilize a non-participating pharmacy must pay the entire

In the event of any inconsistency between the terms of the Plan and this SPD, the terms of the Plan control.

cost of the drug at the time of purchase and submit original receipts for reimbursement, not to exceed the amount the Fund would have paid a participating pharmacy, to the Fund Office.

Maintenance Drugs: Maintenance drugs, which are drugs taken longer than 90 days, may use Mail Order Pharmacies. There is no limitation on the number of times a prescription may be refilled by mail order. The Plan pays 100% of the cost of the drug **after** payment of the applicable Co-Payment.

Maximum Out-of-Pocket Costs: There is an annual in-network maximum out-of-pocket costs for prescription drugs purchased with participating pharmacies, which will be adjusted annually. This maximum is the difference between the maximum in-network out-of-pocket for medical and prescription drugs established by Health Care Reform, as adjusted annually, and the maximum out-of-pocket for in-network medical set forth in the chart in section 3.2(b). For example, for 2023, the maximum in-network out of pocket costs for medical and prescription drugs established by Health Care Reform is $9,100 for single coverage and $18,200 for family coverage. The maximum out-of-pocket for medical expenses under this Plan, as set forth in the chart at section 3.2(b), is $5,000 for single in-network coverage and $10,000 for in-network family coverage. Thus, the 2023 maximum out-of- pocket costs for in-network prescription drugs is $4,100 single and $8,200 family. There is no out-of-pocket maximum for drugs obtained from non-participating (i.e. out of network) pharmacies.

Diabetic Test Supplies: These are provided without cost sharing for the Covered Person. A list of covered diabetic test supplies is available at the Plan Office, and include blood glucose monitors, test strips, lancets, alcohol prep pads, blood ketone test strips, and insulin pumps. Covered Persons may also receive certain diabetic testing supplies at no cost through OneHealth, see Section 3.2(f). If a Covered Person does not receive their diabetic testing supplies through OneHealth or through the Prescription Drug program provided by the Fund, see Section 3.3 and 4.2 as applicable, then applicable deductibles and copayments may apply as set forth in Section 3.2(a).

Specialty Drugs subject to the SaveonSP. The SaveonSP Program covers specialty drugs for which manufacturer assistance programs are available. This saves costs for both the Covered Person and the Fund. A list of these drugs, which changes from time to time, is available at the Fund Office and by calling SaveonSP at 1-800-683-1074. The specialty drugs covered by this program are not defined as essential health benefits under applicable state benchmark plans, see section 3.4, below).

Specialty drugs covered by the SaveonSP Program are subject to the following copayments:

- 0% copayment if the Covered Person timely enrolls in the SaveonSP Program; or
- the copayment assigned by the SaveonSP Program. These copayments may be thousands of dollars per month, and <u>do not</u> count towards the maximum out of pocket amounts set forth in section 3.3(d), above.

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

ARTICLE 4 –BENEFITS FOR MEDICARE ELIGIBLE PARTICIPANTS AND DEPENDENTS

4.1 Medical Benefits

(a) General. The coverages set forth in this Article 4 applies to all Medicare-eligible Participants and Dependents, whether eligibility for Medicare is based on age, disability, or end stage renal disease

(Non-Medicare eligible dependents of Medicare eligible Participants are covered under the Fund's self-insured medical and drug plan set forth in Article 3.). This Plan provides benefits as if Medicare eligible Participant or Dependent obtained Medicare coverage when first eligible to do so, even if this is not the case. It is the Participant's or Dependent's responsibility to timely obtain Medicare coverage. If he/she does not do so, he/she is responsible for the costs of medical expenses that otherwise would have been covered by Medicare, the Medicare Policy (section 4.1(a)), or otherwise under the terms of this Plan as if Medicare had been timely obtained. This Plan will not pay benefits that would have been paid by Medicare. It is recommended that a Retiree, Spouse, or an Employee contemplating retirement, contact the Social Security Administration at least 4 months before they will reach age 65.

All Medicare eligible Participants and Dependents must have Medicare Parts A and B in order to receive benefits under Article 4.

(b) Medical Benefits. Medicare eligible Participants and Dependents are provided medical coverage via a fully insured Medicare coordinated policy (Medicare Policy) through Humana. The terms and conditions of such coverage are set forth in the Medicare Policy. This Fund does not cover any medical expenses for Medicare eligible Participants or Dependents. All such expenses are covered by Medicare or the Medicare Policy. See Article 24 for contact information.

4.2 Prescription Drug Card Benefit.

Medicare eligible Participants and Dependents who are covered by the Medicare Policy under Section 4.1(b), also have prescription drug benefits under an Employer Group Waiver Plan (EGWP). No coverage is provided if the Covered Person is enrolled in Medicare Part D. The following is a summary of the EGWP. Benefits, formulary, pharmacy network, premiums and/or co-payments/coinsurance may change on January 1 of each year.

(a) Employer Group Waiver Plan

The Plan has contracted with a Pharmacy Benefit Manager, Express Scripts to administer a prescription drug program known as an Employer Group Waiver Plan (EGWP). The amount of coverage depends upon the annual out of pocket costs incurred by a Covered Person, as follows:

Deductible Stage: $200 deductible must be paid by each Covered Person before coverage provided by Plan.

Initial Coverage Stage: After deductible satisfied, Covered Person pays the following copayments until a Covered Person's total annual drug cost (what the Covered Person and Plan pay, combined) equals the CMS Standard to enter the Coverage Gap (in 2022, this is $4,430; in 2023, this is $4,660):

Retail (up to 31-day supply)	
Tier 1	Generic: $10
Tier 2	Preferred Brand: $38
Tier 3	Non-Preferred Brand: $63
Retail (32-to-60-day supply)*	

Tier 1	Generic: $20
Tier 2	Preferred Brand: $76
Tier 3	Non-Preferred Brand: $126
Retail (up to 90-day supply) **	
Tier 1	Generic: $30
Tier 2	Preferred Brand: $114
Tier 3	Non-Preferred Brand: $189
Smart 90 Pharmacies	
Tier 1	Generic: $17.50
Tier 2	Preferred Brand: $95.00
Tier 3	Non-Preferred Brand: $159
Mail Order (up to 90-day supply)	
Tier 1	Generic: $17.50
Tier 2	Preferred Brand: $95.00
Tier 3	Non-Preferred Brand: $159

*Does not apply to Smart 90 pharmacies.

**Not all drugs are available at a 90-day supply, and not all retail pharmacies offer a 90-day supply.

Coverage Gap Stage: After annual total costs (Covered Person and Plan) equal the CMS Standard to enter the Coverage Gap (in 2022, this is $4,430; in 2023, this is $4,660), a Covered Person will pay the following copayments until his/her own out-of-pocket drug costs reach the CMS TrOOP Limit to enter Catastrophic Coverage (in 2022 this is $7,050; in 2023 this is $7,400):

Retail (up to 31-day supply)	
Tier 1	Generic: $10
Tier 2	Preferred Brand: $38
Tier 3	Non-Preferred Brand: $63
Retail (32-to-60-day supply)	
Tier 1	Generic: $20
Tier 2	Preferred Brand: $76
Tier 3	Non-Preferred Brand: $126
Retail (up to 90-day supply) **	
Tier 1	Generic: $30
Tier 2	Preferred Brand: $114
Tier 3	Non-Preferred Brand: $189
Smart 90 Pharmacies	
Tier 1	Generic: $17.50
Tier 2	Preferred Brand: $95.00
Tier 3	Non-Preferred Brand: $159
Mail Order (up to 90-day supply)	
Tier 1	Generic: $17.50
Tier 2	Preferred Brand: $95.00
Tier 3	Non-Preferred Brand: $159

In the event of any inconsistency between the terms of the Plan and this SPD, the terms of the Plan control.

*Does not apply to Smart 90 pharmacies.
**Not all drugs are available at a 90-day supply, and not all retail pharmacies offer a 90-day supply.

Catastrophic Coverage Stage: After a Covered Person's yearly out-of-pocket drug costs reach the CMS TrOOP Limit to enter Catastrophic Coverage (in 2022 this is $7,050; in 2023 this is $7,400), a Covered Person will pay the greater of 5% coinsurance or:

- a $3.95 for 2022 ($4.15 for 2023, subject to further annual adjustment) copayment for covered generic drugs, not to exceed the copayment that would be charged if the Covered Person was in the Initial Coverage stage, or
- a $9.85 for 2022 ($10.35 for 2023, subject to further annual adjustment) copayment for all other covered drugs, not to exceed the copayment that would be charged if the Covered Person was in the Initial Coverage stage.

Provisions applicable to all Coverage Stages:

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

4.3 Dental Benefit. Dental Benefits are available to Medicare Eligible Participants and Dependents for an additional premium per individual. If Dental Benefits are not elected at the time of retirement, this Benefit will not be available in the future. Once elected, Dental Benefits must be continued for a minimum of 24 months. Additionally, once a Retiree discontinues coverage (after 24 months of continuous coverage), this Benefit will not be available in the future. The coverage provided to Medicare Eligible Participants and their Dependents is the same as provided to Active Employees under Article 7.

4.4 Vision Benefit. Vision Benefits are available to Medicare Eligible and Dependents for an additional premium per individual. If Vision Benefits are not elected at the time of retirement, this Benefit will not be available in the future. Once elected, Vision Benefits must be continued for a minimum of 24 months. Additionally, once a Retiree discontinues coverage (after 24 months of continuous coverage), this Benefit will not be available in the future. The coverage provided to Medicare Eligible Participants and their Dependents is the same as provided to Active Employees under Article 8.

ARTICLE 5 - MEDICAL REIMBURSEMENT ACCOUNT

5.1 Funding of Medical Reimbursement Account, When the balance in an Active Employee's Bank exceeds three times the Cost of Coverage, such excess may be used for unreimbursed medical expenses in the form of a Medical Reimbursement Account (MRA). Like all other benefits provided by the Plan, regardless of the balance in the MRA, the MRA is not a vested benefit. Under the Medical Reimbursement Plan a Participant may request that his deductible, Co-Payment, and certain other eligible expenses not covered by the Plan be reimbursed to him using the money he has accumulated in his individual Dollar Bank Account.

5.2 Eligible Expenses in General. Medical expenses are eligible for reimbursement from a Participant's Medical Reimbursement Account if they:

(a) Were incurred on or after the date on which the Participant became eligible for benefits under the Plan (expenses are incurred when a Participant is provided with medical care that gives rise to the expenses, not when he is billed for or pays for the medical care);
(b) Qualify as a medical expense under §213 of the Internal Revenue Code (with the exception of over-the-counter drugs, which are not eligible for reimbursement); and
(c) Have not been or will not otherwise be paid by the Plan, or have not been reimbursed by or are not reimbursable under any other health plan coverage.

5.3 Reimbursement. To utilize the Medical Reimbursement Plan, a Participant can:

1. Provide the Benny Card to their provider (or pharmacy) and it works like a credit card when making a purchase (see below for more detail); or
2. Complete and file a claim form with the Fund Office submitting a copy of the paid receipt. If a paper claim is filed, the Dollar Bank Account will be charged a $5 administration fee for issuing the medical reimbursement check

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

Medical reimbursement claims must be filed with proof of payment using the appropriate claim form no later than 24 months from the date the expense was incurred. In the event a Participant enters into a payment plan for a qualified medical expense(s), the Medical Reimbursement Account may be used to reimburse all payments under the payment plan, provided the Participant submits their initial request for reimbursement, and acceptable proof of the payment plan, within two years from the date the expense(s) subject to the payment plan was incurred.

In no event will reimbursement be allowed to reduce the balance in his Dollar Bank Account to an amount equal to less than three months of eligibility.

Benny Card - Electronic Reimbursement

Each Participant is issued a pre-paid credit card called a “Benny Card” from the Administrator. The Benny Card will be updated daily to properly reflect the value of your Dollar Bank Account available for medical expenses.

The Benny Card will only work for medical reimbursements allowed by federal regulations for health care reimbursements. It will reject any type of usage for noneligible charges.

5.4 Use of Dollar Bank by Retiree/Surviving Spouse/Children. An MRA with a balance equal to the balance in an Active Employee’s MRA plus the balance in the Active Employee’s Dollar Bank as of the date of retirement may be used after retirement for all eligible expenses, including Retiree self-payments. After the death of a Retiree, any balance in his/her MRA may be used by his/her Surviving Spouse, or in the absence of a Surviving Spouse by his/her Children, so long as such individuals are otherwise covered by this Plan.

5.5 Cancellation of Medical Reimbursement Account. The balance in the MRA will be cancelled and forfeited the earlier of: (a) the date the Participant is no longer eligible for coverage under the Plan; (b) if there is no activity (employer contributions or claims) for three years; (c) if deemed necessary in the sole and exclusive

discretion of the Trustees to meet requirements of Health Care Reform; or (d) if the Trustees in their sole discretion terminate the MRA. In the event reimbursement at any time was provided as a result of fraud, suspected fraud (as determined in the sole and exclusive discretion of the Board of Trustees), or intentional misrepresentation of a material fact, by a Participant. Dependent, or an individual seeking reimbursement on behalf of such Participant or Dependent, a Participant's MRA will be terminated. In the event the MRA is terminated, the Benny Card will be permanently suspended, and the use of paper claim forms will be eliminated. The balance of the Participant's Dollar Bank will be available for self-payments only.

ARTICLE 6 – ACCIDENT AND SICKNESS WEEKLY DISABILITY BENEFITS

6.1 Eligibility. Weekly Disability Benefits are weekly payments paid by the Fund to an Active Employee who is Totally Disabled and is unable to work due to a Non-Occupational Accidental Accident or Sickness, provided benefits for a Non-Occupational Accident or Sickness will only be paid if the injury was incurred on a date the Active Employee was eligible for coverage under the Plan. To be eligible, an Active Employee must either: (1) be under the continuous care of a Physician who has provided a certification of Disability specifying the diagnosis, dates of Disability, and the date the Physician was first consulted for the Disability; or (2) submit a copy of a Social Security Disability award. In the Fund Office's sole discretion, additional certifications may be requested during the period of Disability and must be completed and returned to continue benefits. Weekly Disability Benefits are payable the first day of a Disability due to an Accident, or the eighth day of a Disability due to Sickness. For purposes of this benefit, if treatment for an injury is not sought within 72 hours of sustaining the injury, the disability will be treated as a Sickness and benefits will not commence until the eighth day. No right or interest of any Participant any Participant in the Accident and Sickness Weekly Income Benefit portion of the Plan shall be assignable or transferable.

6.2 Schedule of Benefits

Benefit Amount	$250/week
	Benefits begin on 1st day after Accident
	Benefits begin on 8th day after Sickness
Maximum Period of Payment per Disability	26 weeks

Successive periods of disability due to the same or related causes shall be considered as the same period of disability, unless the disabilities were attributable to unrelated causes. All related Sicknesses are considered as one Sickness. Benefits will not be paid for longer than the maximum benefit period of 26 weeks for any one continuous period of disability unless:

- They are due to entirely different and unrelated causes and are separated by return to active work for a minimum of 40 hours; or
- They are separated by a continuous period of at least two weeks during which the covered individual is not absent from full-time, active work.

6.3 Exclusions. Weekly Disability benefits are not payable for:

(a) Any period of Disability during which the Active Employee is not under the regular care of a Physician;
(b) Accidental bodily injuries arising out of or in the course of the employment of the Covered Person or Sickness covered by a Workers' Compensation Act or similar legislation;
(c) Participation in the commission of an illegal act; or
(d) War or act of war, declared or undeclared, or service in any military, naval or air force of any country while such country is engaged in war, or police duty as a member of any military, naval or air organization.

In the event of any inconsistency between the terms of the Plan and this SPD, the terms of the Plan control.

ARTICLE 7 – DENTAL BENEFITS (Actives, Non Medicare Participants and Dependents, and Medicare Participants and Dependents that elect these benefits)

7.1 Dental Network. The Plan provides self-insured dental benefits and has contracted with Delta Dental, a preferred provider network. Se Article 24 for contact information. A list of the dentists participating in this network, known as in-network providers, is available at the Plan Office free of charge. Participants and their Dependents are encouraged to use in-network providers to save money for themselves and the Plan, but may choose to receive treatment from an out-of-network provider and incur greater out-of-pocket expenses. Regardless of the provider chosen, benefits paid by the Plan will not exceed those amounts set forth in 7.2, below.

7.2 Covered Benefits. Dental benefits are provided as outlined below, subject to an annual maximum of $1,000 per Covered Person (annual maximum not applicable to Covered Persons under age 19) unless otherwise stated below:

Dental Benefits	In-Network (PPO or Premier)	Out-Of-Network
Preventative Services	100%	100%
All other Covered Services	75% after $100 deductible	75% UCR after $100 deductible

(a) Preventative Services:
- (1) Routine periodic examinations, twice in any Calendar Year;
- (2) Bitewing x-rays, twice in any Calendar Year;
- (3) Full-mouth x-rays, once in any three-year period;
- (4) Dental prophylaxis (cleaning, scaling and polishing including periodontal maintenance visits), twice in any Calendar Year;
- (5) Topical fluoride application for patients under age 19 once in any Calendar Year;
- (6) Sealants.

(b) Other Dental Services
- (1) Emergency palliative treatment as needed (minor procedures to temporarily reduce or eliminate pain);
- (2) Restorative services using amalgam, synthetic porcelain, plastic filling material and composite resin (white). Composite resin is payable only on posterior teeth;
- (3) Endodontics: root canal filling and pulpal therapy (therapy for the soft tissue of a tooth);
- (4) Prosthetics: bridges and dentures (once in five years);
- (5) Labial veneers on incisors and cuspids (once per tooth in five years);
- (6) Implants and implant related services (once per tooth in five years);
- (7) Periodontics: treatment for diseases of the gums and bone supporting the teeth;
- (8) Crowns, jackets, inlays and onlays: required due to gross decay or fracture and when teeth cannot be restored with a filling material.
- (9) Oral surgery (including extractions);
- (10) Space maintainers that replace prematurely lost teeth of eligible dependent children under age 16 (once in five years).
- (11) Orthodontic Treatment up to age 19 subject to $1,500.00, lifetime maximum benefit (orthodontic treatment not included in individual annual maximum.

7.3 Limitations

(a) The Plan is liable for not more than the amount it would have been liable for if only one dentist had supplied the service if a Covered Person transfers from the care of one dentist to that of another dentist during the course of treatment, or if more than one dentist supplies services for one dental procedure.

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

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

(d) Benefits for full mouth x-rays will not be provided more frequently than once in a three-year period, unless special need shown.

(e) Benefits for supplementary bitewings will be provided upon request, but not more frequently than twice each Calendar Year.

(f) Benefits for prophylaxis (cleaning) will not be provided more frequently than twice per Calendar Year.

7.4 Exclusions. The Plan does not cover, in whole or in part, any dental service or benefit that is not considered Medically Necessary. The fact that a dentist may prescribe, order, recommend or approve a service does not, of itself make the charge an allowable expense, even though the service is not specifically listed as an exclusion. The final authority for determining whether services are covered is the Trustees of the Plan. In addition to limitations imposed by Delta Dental, the exclusions applicable to medical benefits set forth in Section 3.2(b) and the following exclusions apply to dental benefits:

(a) Replacement of lost or stolen appliances;

(b) Appliances, restorations, or procedures for the purpose of altering vertical dimension, restoring or maintaining occlusion, splinting, or replacing tooth structure lost as a result of abrasion, or treatment of disturbances of the temporomandibular joint;

(c) A service not reasonably necessary or not customarily performed for the dental care of the eligible person;

(d) A service not furnished by a dentist, unless the service is performed by a licensed dental hygienist under the supervision of a dentist or is an x-ray ordered by a dentist;

(e) For initial installation of, or addition to, full or partial dentures or fixed bridgework, unless each installation or addition is required due to the extraction of one or more natural teeth, injured or diseased and if such denture or bridgework includes the replacement of the extracted tooth, while the person is eligible under the Plan;

(f) For replacement or alteration of full or partial dentures or fixed bridgework, unless such charge is required due to one of the following events, and if such event occurred while the person is eligible under the Plan and if the replacement or alteration is completed within 12 months after the event:

  (1) An accidental injury requiring oral surgery;

  (2) Oral surgery treatment involving the repositioning of muscle attachments, or the removal of a tumor, cyst, torus or redundant tissue; or

  (3) Replacement of a full denture, when required as the result of structural change within the mouth and when made more than five years after the installation of the denture, but not a replacement made less than two years after the person is eligible under the Plan.

(g) Nutritional guidance, hygiene instructions and periodontal splinting;

(h) Temporary appliances; or

ARTICLE 8 – VISION BENEFITS (Actives, Non Medicare Participants and Dependents, and Medicare Participants and Dependents that elect these benefits)

8.1 **Vision Network.** The Fund has entered into an agreement with VSP to provide vision services to Covered Persons at reduced fees. See Article 24 for contract information. A list of such providers is available upon request at the Plan Office. A Covered Person does not have to use one of these providers, as it is always the Covered Person's choice as to which vision service provider to use. Regardless of the provider chosen, benefits paid by the Fund will not exceed those amounts set forth in §8.2, subject to the exclusions in §8.3, below.

8.2 **Covered Benefits.** Vision benefits are provided as outlined below:

Vision Benefits	In-Network	Out-Of-Network
Eye Exam (once every 12 months)	100% after $10 Co-Payment	100% up to $45
Contacts (once every 12 months) Elective Medically Necessary	 100% after up to $60 copay up to $100; effective 7/1/2021: up to $125 100%	 100% up to $105 100% up to $210
Frames (once every 24 months)	100% up to $15 Co-payment up to $120 (retail) and $47 (wholesale); effective 7/1/2021 up to $150 (retail) and $57 (wholesale) (20% discount on any amount over the $120 allowance) Featured Frames up to $140; effective 7/1/2021 up to $170. Costco Frames up to $65; effective 7/1/201 up to $80.	100% up to $70
Lenses	100% (included in Frames Co-payment)	Single-Vision 100% up to $30 Bifocal Vision 100% up to $50 Trifocal Vision 100% up to $65 Lenticular Vision 100% up to $100
Safety Glasses (Employee Only) (once every 24 months)	100% up to $60	Not covered.

(a) Covered In-Network Benefits:
- (1) Vision Examination
- (2) Materials
  - (i) Lenses, except as described in Section 4.16 C.
  - (ii) Frames, except as described in Section 4.16 C.

(iii) Contact lenses. Covered in full when prescribed by an In-Network Provider who has received prior approval for one of the following conditions:
  (A) Following cataract surgery,
  (B) To correct extreme visual acuity problems not correctable with spectacle lenses,
  (C) To correct for significant anisometropia, or
  (D) Keratoconus.

(iv) Cosmetic (elective) contact lenses. When contact lenses are chosen for reasons other than the above, they are considered cosmetic in nature and an allowance will be made toward their cost in lieu of all other benefits for that year.

(b) Out-of-Network Benefits

When an ophthalmologist, optometrist or dispensing optician who is not an In-Network Provider is used, the Covered Person should pay the doctor his full fee and obtain an itemized receipt which must contain the following information: the Participant's name, the patient's name, the date services began, services and materials the Participant or Dependent received, and the type of lenses received (single vision, bifocal, trifocal, etc.). The Participant will be reimbursed according to the Schedule of Benefits.

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

(a) Vision examination more often than once every 12 months.
(b) Lenses more often than once every 12 months.
(c) Frames more often than once every 24 months.
(d) Extra cost items, such as:
  (1) Blended lenses, photo gray lenses, or faceted lenses, or
  (2) A frame that costs more than the vision allowance.
(e) Orthoptics or vision training and any associated supplemental testing.
(f) Plano lenses (non-prescription).
(g) Two pairs of glasses in lieu of bifocals.
(h) Replacement of lenses and frames furnished under this Section 4.16 which are lost or broken, except at the normal intervals when services are otherwise available.
(i) Medical or surgical treatment of the eyes.
(j) Any eye examination, or any corrective eyewear, required by an employer as a condition of employment.
(k) Corrective vision services, treatments, and materials of an experimental nature

ARTICLE 9 – HEARING BENEFIT
(Actives, Non Medicare Participants and Dependents)

9.1 Hearing Aid Providers. The Plan provides self-insured hearing benefits. There is no discounted in-network provider.All claims should be submitted to the Fund Office.Benefits paid by the Plan will not exceed the limits set forth in 9.2, below.

9.2 Covered Benefits. Hearing benefits are provided as outlined below:

Hearing Benefit	In-Network	Out-Of-Network
Exam (once every three years per Covered Person; maximum exam benefit $100)	75% UCR	75% UCR
Hearing Aid (once every three years per Covered Person; maximum hearing aid benefit $1,500)	75% UCR	75% UCR

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

(a) Charges for services or supplies which are covered in whole or in part under any other portion of the Plan or hearing benefits provided by an Employer;
(b) Expenses for which benefits are payable under Workers' Compensation law;
(c) Amplifiers;
(d) Hygienic cleaning of the hearing aid;
(e) Lip reading or speech reading;
(f) Replacement batteries; or
(g) Maintenance or repair of the hearing aid.

ARTICLE 10 – LIFE INSURANCE/ ACCIDENTAL DEATH AND DISMEMBERMENT - ACTIVES AND NON-MEDICARE RETIREES

10.1 Benefits. Active Employees and Retirees are eligible for coverage under a fully insured life insurance policy purchased by the Plan through Anthem Life Insurance Company (Carrier). See Article 24 for contact information. The amount of coverage is:

Active Employee

Basic Life--Principal Sum	$10,000
Accidental Death & Dismemberment Benefit	up to $10,000

Retiree

Basic Life--Principal Sum	$4,000
Accidental Death & Dismemberment Benefit	None

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

10.2 Claim Form. Upon the death of an eligible Employee, the Carrier will pay a Life Insurance Benefit in the amount set forth in Section 10.1 to the designated Beneficiary of the deceased Employee. The payment of any such Life Insurance Benefit is contingent upon the receipt by the Fund Office of a completed claim form and proper proof of the eligible Employee's death. Proper proof of the eligible Employee's death includes certified proof of death certificate and the obituary notice (where appropriate).

10.3 Beneficiary Designation. An eligible Employee may designate any natural person or persons or legal entity as the Beneficiary of any Life Insurance Benefit payable from the Carrier by filing the designation, in writing,

with the Fund Office (Beneficiary). An eligible Employee may designate a new Beneficiary at any time by filing a new Beneficiary Designation Form with the Fund Office and such designation will be effective only when received by the Fund Office during the Participant's lifetime. Each beneficiary designation timely received by the Fund Office will cancel all beneficiary designations previously made. The revocation of a beneficiary designation will not require the consent of any designated beneficiary. Neither the Fund nor the Trustees shall be liable for any payment made before the change was received in the Fund Office. If an eligible Employee designates more than one Beneficiary without specifying their respective interests, the Life Insurance Benefit will be paid in equal shares. In the event that the deceased Employee dies without designating a Beneficiary or in the event that the designated Beneficiary(ies) has predeceased the Employee, the amount of the Life Insurance Benefit shall be paid as specified in the Life Insurance Policy issued by the Carrier. Benefits payable to minor children may be paid to the minor's legal guardian.

Notwithstanding any term of this Plan to the contrary, in the event of any conflict between the provisions of this Plan and the insurance policy, including the proper determination of the Beneficiary, the terms of the insurance policy and the determination by the Carrier controls.

10.4 Claims and Appeals. All claims and appeals regarding insured life insurance benefits shall be determined by the procedures set forth in the applicable life insurance policies and not pursuant to Article 14, below.

ARTICLE 11 – COORDINATION OF BENEFITS

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

11.2 Coordination. Plan rules regarding coordination:

(a) Another plan without a coordinating provision shall always be deemed to be the primary plan.
(b) Provisions in other plans which provide such other plan is always secondary or which places a limit on benefits where coordination of benefits is applicable shall be disregarded and such plans shall pay primary to this Plan.
(c) If another plan has a coordinating provision and provides coverage to a Covered Person, then in the following order:
    (1) The other plan is primary and this Plan is secondary.
    (2) The plan that covers a person directly as a participant or nondependent rather than as a dependent is primary and the other is secondary.
    (3) The plan that covers a person directly as an active employee rather than as a retired or laid off employee is primary and the other is secondary.
    (4) The plan that covers a person as a dependent spouse is primary to the plan that covers the person as a dependent child.
    (5) If a child is covered under both parents' plans, the plan that covers the parent whose birthday occurs earlier in the calendar year shall be considered the primary plan, except

(a) If both parents' birthdays are on the same day, the plan that covers the covers that covers the parent as an active employee is primary over the plan covering the parent as a retired or laid-off employee. If the other plan does not follow this rule, the plan that has covered the person the longest will would be the primary plan

(b) If another plan does not include this COB rule based on the parents' birthdays, but instead has a result based on the gender of the parent, then that plan's COB rule will determine the order of benefits.

(6) The plan covering the Covered Person longest is primary.

(7) If none of the foregoing applies, the expenses shall be shared equally.

(8) Notwithstanding the above, in all cases a policy of insurance providing benefits to a Covered Person for injuries arising out of a motor vehicle accident shall be primary.

(d) With respect to dependents of divorced or separated parents, the following rule applies after rule (1) and (2), if applicable:

(1) if there is a court decree, the plan that covers the dependent of the parent with responsibility to do so pursuant to such decree shall be primary;

(2) if (1) does not apply:

(A) the plan covering the parent with custody of the dependent shall be considered the primary plan;

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

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

(e) The plan that covers a covers a patient as an active employee (or that person's dependent) is primary over the plan covering the same patient as a retired or laid-off employee (or their dependent). If the other plan does not follow this rule, the plan that has covered the person the longest would be the primary plan.

(f) Medicare Coordination

(1) With respect to individuals entitled to Medicare as a result of being age 65 or older, this Plan is primary for someone who is actively working unless the Plan is granted an exception under the Small Employer Exception (for those Employers employing 20 or fewer employees.)

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

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

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

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

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

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

In the event of any inconsistency between the terms of the Plan and this SPD, the terms of the Plan control.

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

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

Where coordination of benefits is applicable and this Plan is not the primary payor, the benefits payable under this Plan shall not exceed the difference between the benefits payable by the other plan(s) and the amount that would have been payable under this Plan in the absence of coordination of benefits. Benefits payable under another plan include the benefits that would have been payable had the claim been timely and properly filed under that plan. Notwithstanding anything to the contrary, a Participant or Dependent will never receive less if covered by two or more plans than he would receive if covered by this Plan alone; provided, however, that this Plan will pay no more than an amount which would bring total coverage up to the amount which would have been provided under this Plan alone.

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

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

ARTICLE 12 – THIRD PARTY LIABILITY

12.1. Subrogation

(a) Application

Subrogation means the Plan has the right to recover from a Participant or Dependent those amounts paid by the Plan for medical care or other expenses due to an injury caused by a third party (for example, another person or company), except insurers on policies of health insurance issued to and in the name of the Covered Person. To the extent benefits are paid by the Plan to a Participant or Dependent for medical, prescription drug, dental, wage loss, or other expenses arising out of such an injury, the Plan is subrogated to any claims the Participant or Dependent may have against the third party who caused the injury. In other words, the Participant or Dependent must repay to the Plan the benefits paid on his or her behalf out of any recovery received from a third party and/or any applicable insurer.

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

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

has first priority to any funds recovered by the injured Participant or Dependent from the third party or insurer.

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

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

(b) Conditions to Payment of Benefits

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

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

(2) A Participant must take such action, furnish such information and assistance, and execute such papers as the Plan may require to facilitate the enforcement of its rights, and the Covered Person will take no action prejudicing the rights and interests of this Plan.

(3) Claims for injuries arising from the actions of third parties will not be considered for payment until the Participant has completed and returned a subrogation agreement acknowledging the provisions of this Section, assigning his or her rights to the Plan to any recovery arising out of or relating to the injury, and providing certain important information. If another source has already paid the Participant for the injury, the Plan will not begin paying benefits until the total expenses for the injury exceed the total amount recovered from the other source. If such assignment is not made before the receipt of benefits, then the receipt of benefits automatically assigns to the Plan any rights the Participant or Dependent may have to recover payments from any third party or insurer. (If the recovery so assigned exceeds the benefits paid by the Plan, such excess shall be delivered to the Participant or Dependent or other person as required by law.)

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

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

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

In the event of any inconsistency between the terms of the Plan and this SPD, the terms of the Plan control.

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

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

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

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

ARTICLE 13 – RECIPROCITY

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

ARTICLE 14 – INTERNAL CLAIMS AND APPEALS PROCESS

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

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

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

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

14.2 Initial Submission of Claims

Most claims will be submitted directly from the provider to the appropriate party. However, if they are not, claims for benefits should be submitted to the Fund Office.

Claims must be submitted to the Fund Office by the end of the Calendar Year following the year in which the expense was incurred. However, when a Participant's coverage terminates for any reason, written proof of the claim must be given to the Fund Office within 90 days of the date of termination of coverage, provided the Plan remains in force. However, upon termination of the Plan, final claims must be received within 30 days of termination.

The Plan shall have the right (at its own expense) to require a claimant to undergo a physical examination, when and as often as may be reasonable.

Payment of any claim will be made to the Participant only when using a non-Preferred Provider Organization. If the Participant dies before all benefits have been paid, the remaining benefits may be paid to any relative of the Participant or to any person or corporation appearing to the Plan to be entitled to payment. The Plan will fully discharge its liability by such payment.

No legal action against the Plan for the recovery of any claim may begin within 60 days or after two years from the expiration of the time in which proof of claim is required, or as limited by Section 14.10.

14.3 Notice That Additional Information is Needed to Process Claim

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

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

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

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

14.4 Avoiding Conflicts of Interest. The Fund must ensure that all claims and appeals are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion, or other similar matters with

respect to any individual (such as a claims adjudicator or medical expert) must not be made based upon the likelihood that the individual will support the denial of benefits.

14.5 Initial Decision On A Claim

(a) Additional Evidence

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

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

- For Urgent Health Claims – As soon as possible, taking into account medical exigencies, but not later than 72 hours after receiving initial claim, if it was complete; or 48 hours after receiving completed claim or after the 48-hour claimant deadline for submitting information needed to complete claim, whichever is earlier. For Pre-Service Health Claims – 15 days after receiving the initial claim. A 15-day extension permitted is Plan needs more information and it has provided notice of same to Claimant during initial 15 day period. Fund deadline for responding is tolled while awaiting requested information from Claimant.
- For Post-Service Health Claims – 30 days after receiving initial claim. A 15-day extension permitted if Plan needs more information and has provided notice of same to claimant during initial 30 day period. Fund deadline for responding is tolled while awaiting requested information from Claimant.
- For Disability Claims – 45 days after receiving the initial claim. A 30-day extension permitted if Plan needs more information and has provided proper notice of same to Claimant. An additional 30-day extension is permitted if the Plan needs more information and has provided notice of same to claimant during first 30-day extension. Fund deadline for responding is tolled while awaiting additional information from Claimant.

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

- the specific reasons for the denial;
- the specific Plan provision or provisions on which the decision was based;
- if applicable, what additional material or information is necessary to complete the claim and the reason why such material or information is necessary;
- the internal rule or similar guideline relied upon in denying the claim or, if applicable, a statement that such rule or similar guideline does not exist;
- if the denial was based on medical necessity, experimental nature of treatment or similar matter, an explanation of same;
- information sufficient to identify the claim involved (including the date of service, the health care provider, the claim amount (if applicable);
- a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;

- a description of available internal appeal process and how to initiate the external review process for an adverse benefit determination which involves a medical condition of the claimant for which the timeframe for completion of the internal appeal would jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function; and
- if applicable, a statement of the Claimant's right to bring a civil action after further denial on appeal or external appeal.

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

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

14.7 Internal Appeals

(a) Adverse Benefit Determinations

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

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

(b) Submission of Internal Appeals

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

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

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

The review on appeal shall take into account all comments, documents, records, and other information submitted by the Claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination. The review will not defer to the decision on the initial claim. Appeals should be submitted as to the Fund Office.

(c) Time for Submitting Internal Appeals

A Claimant must appeal a benefit denial within the following time limits:

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

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

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

- the specific reasons for the denial;
- the specific Plan provision or provisions on which the decision was based;
- a statement that the Claimant is entitled to receive, free of charge, copies of all documents and other information relevant to the claim for benefits;
- the internal rule or similar guideline relied upon in denying the claim or, if applicable, a statement that such rule or similar guideline does not exist;
- if the denial was based on medical necessity, experimental nature of treatment or similar matter, an explanation of same;
- information sufficient to identify the claim involved (including the date of service, the health care provider, the claim amount, if applicable),
- a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;
- a description of the external review process, including information regarding how to initiate the external review process;
- a statement of the Claimant's right to bring a civil action under ERISA §502(a);
- a statement describing any contractual limitation period that applies to the Claimant's right to bring an action under ERISA §502(a) and the calendar date on which such contractual limitation expires; and
- the following statement "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

Before the Fund can issue a notice of decision on appeal with respect to disability benefits based on new or additional evidence or rationale, the Fund must provide the Claimant, free of charge, with any

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

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

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

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

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

* Reference to decisions made at a Trustee Board Meeting means the appeal will be decided at the first meeting following receipt of an appeal, unless the appeal is filed within 30 days preceding the date of such meeting. In such case, the decision may be made no later than the date of the second Board Meeting following the Trustees receipt of the appeal. If special circumstances require a further extension, upon due notice to the Claimant, the decision shall be made no later than the third board meeting following receipt of appeal. The Plan shall notify the Claimant of the Trustees decision on appeal no later than five days after the decision is made.

14.8 Deemed Exhaustion of Internal Claims and Appeals Processes

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

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

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

and that the violation occurred in the context of an ongoing, good faith exchange of information between the Plan and the Claimant.

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

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

14.9 Discretion of Trustees. The Trustees have full discretionary authority to determine eligibility for benefits, interpret plan documents, and determine the amount of benefits due. Their decision, if not in conflict with any applicable law or government regulation, shall be final and conclusive. If a decision of the Trustees or those acting for the Trustees is challenged in court, it is the intention of the parties to the Trust that such decision is to be upheld unless it is determined to be arbitrary or capricious.

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

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

14A.1 Definitions

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

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

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

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

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

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

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

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

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

		Grievances (Medical Necessity Appeals)	Complaints (Administrative Appeals)
		Applicable to Pre-Service Health Claims, only.	Applicable to Pre-Service Health Claims, only.
Second Level Appeals	***Deadline to file?***	**Standard External Review:** 180 days from the date of the First Level Appeal denial. **Expedited External Review:** 72 hours from receipt of the First Level Appeal decision.	60 days from the date of the First Level Appeal denial.
	Where to file?	Independence Administrators Appeals Department P.O. Box 21974 Eagan, MN 55121 Phone: 1-8880234-2393 / Fax: (215) 761-0956	The Board of Trustees of the Indiana/Kentucky/Ohio Regional Council of Carpenters' Welfare Fund c/o BeneSys Inc. 700 Tower Drive., Suite 300 Troy, MI 48098
	Who makes the decision?	For Grievances, the Second Level Appeal is decided by an Independent Review Organization (IRO) (another term may be External Review Organization (ERO)). The IRO has no direct or indirect professional, familial, or financial conflicts of interest with the entity involved with the original benefit determination or the First Level Appeal decision.	For Complaints, the Second Level Appeal is decided by the Fund's Board of Trustees.
	Decision Timeline?	**Standard External Review:** 45 calendar days from the receipt of the request for External Review. **Expediated External Review:** 72 hours from the receipt of the request for External Review.	**Pre-Service Heath Claims:** 30 calendar days from receipt of the Second Level Appeal requests. **Post-Service Health Claims:** The Trustees will decide the Second Level Appeal at the next regularly scheduled Board Meeting, unless the appeal is filed within 30 days preceding the date of such meeting. In such case, the Trustees will decide the appeal no later than the date of the second regularly scheduled Board Meeting following the receipt of the Second Level Appeal request. **Urgent or Expedited Appeals:** 72 hours from receipt of the Second Level Appeal request.

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

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

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

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

ARTICLE 15 – EXTERNAL REVIEW PROCESS

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

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

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

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

(iv) The Claimant has provided all the information and forms required to process an external review.

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

15.4 Referral to Independent Review Organization

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

(b) The IRO will timely notify the Claimant in writing of the request's eligibility and acceptance for external review. This notice will include a statement that the Claimant may submit in writing to the IRO within ten business days additional information that the IRO must consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted after ten business days. Upon receipt of any information submitted by the Claimant, the assigned IRO must within one business day forward the information to the Fund. Upon receipt of such information, the Fund may reconsider its final internal decision on appeal, but such reconsideration will not delay the external review. If the Fund decides to provide coverage, within one business day after such decision the Fund must provide written notice of same to the Claimant and the IRO and the IRO must then terminate the external review.

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

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

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

7) The opinion of the IRO's clinical reviewer or reviewers after considering information described in this notice to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.

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

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

1) A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount, if applicable, the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous denial);
2) the date the IRO received the assignment and the date of the IRO decision;
3) references to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;
4) a discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;
5) A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the group health plan or to the claimant;
6) A statement that judicial review may be available to the Claimant; and
7) Current contact information, including phone number, for any applicable state office of health insurance consumer assistance or ombudsman established under PHS Act §2793.

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

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

15.5 Expedited External Review. A Claimant can make a request for an expedited external review at the time the Claimant receives:

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

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

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

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

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

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

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

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

ARTICLE 16 – COBRA CONTINUATION COVERAGE

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

16.2 Qualifying Events

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

(b) A Participant will become a qualified beneficiary if coverage is lost under the Fund because either one of the following qualifying events happens:
   (1) Hours of employment are reduced such that hours are insufficient to maintain eligibility, or
   (2) Employment ends for any reason other than gross misconduct.

(c) The Spouse of a participant will become a qualified beneficiary if coverage is lost under the Fund because any of the following qualifying events happens:
   (1) Death of spouse;
   (2) Spouse's hours of employment are reduced such that hours are insufficient to maintain eligibility;
   (3) Spouse's employment ends for any reason other than his or her gross misconduct;

(4) Spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
(5) Divorce or legal separation from the Participant.

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

16.3 When COBRA Coverage Is Available. The Fund will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the death of the participant, the employer must notify the Plan Administrator of this qualifying event within 30 days of the death. The Plan Administrator will monitor whether a qualifying event has occurred due to reduction in hours, termination of employment, or Medicare eligibility.

16.4 Participant/Spouse Obligation to Give Notice to the Fund of Some Qualifying Events. In the event of divorce or legal separation or a dependent child loses eligibility for coverage as a dependent child (for example, exceeds age limitations), or if after COBRA coverage is elected a qualified beneficiary becomes covered under another group health plan, the participant and his spouse both have an obligation to notify the Plan Administrator of such event within 60 after this qualifying event occurs. This notice must include: the name of the participant, the social security number of the participant, the name of the qualified beneficiaries (for example, a former spouse after divorce or a child no longer eligible for coverage as a dependent), the qualifying event (for example, the date of a divorce), and the date on which the qualifying event occurred. In the event of divorce, the divorce decree or equivalent state court documents must be provided. In the event of the death of the Participant, the death certificate must be provided. If timely notice is not provided, the right to COBRA coverage is forfeited. Further, failure to timely notify the Fund of a divorce or legal separation or a child losing eligibility gives the Fund the right to hold the Participant and his/her Spouse separately and fully liable for any benefits paid by the Fund which would not have been paid had the Fund received timely notification of such event. At its sole election, the Fund may suspend the payment of future benefits until such amount has been recovered. See Article 20.

16.5 How COBRA Coverage Is Provided. Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries within 14 days. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered participants may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children. The COBRA notice will contain information regarding the premium that must be paid for COBRA coverage, which is 102% of the cost to the Fund for such coverage. If the period of COBRA coverage is extended due to disability, discussed below, the premium is 150% of the cost to the Fund. Coverage under the Fund will be terminated upon the occurrence of a qualifying event and will be retroactively reinstated to the date of

the qualifying event once a qualified beneficiary elects COBRA continuation coverage and pays the applicable premium.

16.6 Duration of COBRA Coverage. COBRA continuation coverage is a temporary continuation of coverage, as follows:

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

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

For example, if a participant becomes entitled to Medicare 8 months before the date on which his eligibility terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months).

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

(1) Disability Extension

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

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

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

(2) Second Qualifying Event Extension

If another qualifying event occurs while receiving 18 months of COBRA continuation coverage, the covered spouse and dependent children are eligible for up to an additional 18 additional months of COBRA coverage, for a maximum of 36 months. This extension may be available to the spouse and any dependent children on COBRA if the participant or former

participant dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Fund as a dependent child, but only if such event would have caused the spouse or dependent child to lose coverage under the Fund had the first qualifying event not occurred.

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

(3) Application for Social Security Disability Award Pending.

A Participant will be eligible for up to a six-month extension of COBRA continuation coverage, provided:

(A) The Participant has exhausted their Dollar Bank, their ability to make self-payments, and their COBRA continuation coverage;
(B) At the time the Participant qualified for COBRA continuation coverage, the Participant had thirty years of credited service in the Indiana/Kentucky/Ohio Regional Council of Carpenters Pension Fund; and
(C) The Participant has an application for Social Security disability benefits pending with the Social Security Administration.

Any period of time a Participant or his/her Dependents are maintaining coverage via full self-payments under Section 2.1(e)(4), above, counts towards the maximum COBRA periods set forth above.

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

16.8 Premium Payment for COBRA Coverage. Following an election, a qualified beneficiary has 45 days to pay the initial COBRA premium. If this is not timely paid, coverage will not be reinstated and the qualified beneficiary will not be given a second chance to reinstate coverage. Payments are thereafter due on the first day of the month of coverage. The postmark will serve as proof of the date paid. There is a 30-day grace period to make such payment. Coverage will be terminated the first day of the month of coverage for which payment has not yet been received, and rectroactively reinstated if such payment is received within the grace period. If payments are not made by the end of the grace period, coverage will terminate and the qualified beneficiary will not be given an opportunity to reinstate coverage. If, for whatever reason, the Fund pays medical benefits for a month in which the premium was not timely paid, the qualified beneficiary will be required to reimburse the Fund for such benefits. The premium equals the cost to the Fund of providing coverage plus a 2% administration fee. In the event of extended coverage as a result of a disability for the 19th – 29th months of coverage, the Fund will charge 150% of the cost of providing coverage.

16.9 Scope of Coverage. COBRA coverage only pertains to health benefits available under the Fund. If a Qualifying Event occurs, the Plan Office will offer each Qualified Beneficiary an opportunity to elect to continue the health care coverage for full medical and prescription drug coverage subject to COBRA or medical and prescription drugs only. Note also that coverage may change while on COBRA coverage due to Plan

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

16.10 Enrollment of Dependents During COBRA Coverage/Coverage Options. A child born to, adopted by, or placed for adoption with a Participant during a period of COBRA coverage is considered to be a qualified beneficiary, provided that the Participant has elected continuation coverage for himself/herself. If a Participant desires to add such a child to COBRA coverage, he must notify the Plan Office within 30 days of the adoption, placement for adoption, or birth. During the COBRA coverage period, a Participant may add an eligible dependent who initially declined COBRA coverage because of alternative coverage and later lost such coverage due to certain qualifying reasons. If a Participant desires to add such a child to COBRA coverage, he must notify the Plan Office within 30 days of the loss of coverage.

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

16.12 Termination of COBRA Coverage. COBRA continuation coverage terminates the earliest of the last day of the maximum coverage period, the first day timely payment (including payment for the full amount due) is not made, the date upon which the Plan terminates, the date after election of COBRA that a qualified beneficiary becomes covered under any other group health plan, or the date after election if a qualified beneficiary becomes entitled to Medicare benefits and such entitlement would have caused the qualified beneficiary to lose coverage under the Fund had the first qualifying event not occurred. In the case of a qualified beneficiary entitled to a disability extension, COBRA continuation coverage terminates the later of: (a) 29 months after the date of the Qualifying Event, or the first day of the month that is more than 30 days after the date of a final determination from Social Security that the qualified beneficiary is no longer disabled, whichever is earlier; or (b) the end of the maximum coverage period that applies to the qualified beneficiary without regard to the disability extension.

16.13 Keep the Plan Office Informed of Address Changes. A participant or his spouse must keep the Plan Administrator informed of any changes in the addresses of family members and is advised to keep a copy of any notices sent to the Plan Administrator.

ARTICLE 17 – ABSENCE DUE TO MILITARY SERVICE

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

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

Upon termination for military duty, a Participant will be reinstated under that same status upon his/her discharge from the military. Exclusions and waiting periods will not be imposed upon re-employment provided coverage would have

been afforded had the person not been absent for military service, unless there are disabilities that the Veterans Administration determines to be service related. For these benefits to apply the following conditions must be met:

(a) The Participant has given advance written or verbal notice of the military leave to the Fund Office (advance notice to the Fund Office is not required in situations of military necessity or if giving notice is otherwise impossible or unreasonable under the circumstances);
(b) The cumulative length of the leave and all previous absences from employment do not exceed five years, however, eligibility may be extended beyond five years if certain exceptions apply;
(c) Reemployment follows a release from military service under honorable conditions; and
(d) You report to, or submit an application to, Fund Office as follows:
    (1) On the first business day following completion of military service for a leave of 30 days or less; or
    (2) Within 14 days of completion of military service for a leave of 31 days to 180 days; or
    (3) Within 90 days of completion of military service for a leave of more than 180 days.

Failure to provide notification in a timely manner will result in reduction of Participant's Dollar Bank Account to zero.

If you are hospitalized for, or recovering from, an illness or injury when your military leave expires, you have 2 years to apply for reemployment. If you provide written notice of your intent not to return to work after military leave, you are not entitled to reemployment benefits.

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

ARTICLE 18 – QUALIFIED MEDICAL SUPPORT ORDER

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

ARTICLE 19 – HIPAA PLAN SPONSOR PROVISIONS

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

ARTICLE 20 – RESCISSION OF COVERAGE

Rescission means the retroactive cancellation of coverage. Where coverage was provided as a result of fraud or an intentional misrepresentation of a material fact by a Participant or Dependent, or an individual seeking coverage on behalf of such Participant or Dependent, the Plan will rescind coverage. Providing false information to maintain or obtain coverage, or knowingly cooperating in any actions designed to provide false information to maintain or obtain

coverage, is an example of a fraud or intentional misrepresentation of material fact. Examples of fraud or intentional misrepresentation of material fact also include, but are not limited to, failing to inform the Fund Office of: (1) a divorce or legal separation, (2) lapsed Union membership, which is required to maintain Retiree coverage, (3) that a Participant or Dependent is covered under another health plan, (4) employment with a noncontributing employer, (5) continuing to use the benefit cards after eligibility is terminated, or (6) any other event which makes a Participant a Dependent ineligible for coverage.

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

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

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

ARTICLE 21 – CHANGES TO OR TERMINATION OF COVERAGE

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

ARTICLE 22 – OVERPAYMENTS

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

ARTICLE 23 – FAMILY MEDICAL LEAVE ACT

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

In the event of any inconsistency between the terms of the Plan and this SPD, the terms of the Plan control.

ARTICLE 24 – CHILDREN'S HEALTH INSURANCE PROGRAM REAUTHORIZATION ACT

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

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

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

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

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

ARTICLE 25 – INTERPRETATION OF PLAN DOCUMENTS

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

ARTICLE 26 – SERVICE PROVIDERS

Third Party Administrator/ Fund Office BeneSys, Inc. 700 Tower Drive, Suite 300 Troy, MI 48098 (248) 813-9800	**Legal Counsel** AsherKelly 25800 Northwestern Highway, Suite 1100 Southfield, MI 48075 (248) 746-2710
Benefit Consultant/Actuary United Actuarial Services, Inc. 11590 N. Meridian Street, Suite 610 Carmel, IN 46032	**Medical Claims Administrator / Precertification** Independence Administrators (833) 242-3330
Medical PPO Network Independence Blue Cross (833) 242-3330	**Prescription Network** Express Scripts PO Box 747000 Cincinnati, OH 45274-7000 (800) 867-4518 www.express-scripts.com

In the event of any inconsistency between the terms of the Plan and this SPD, the terms of the Plan control.

Dental PPO Network Delta Dental PO Box 9085 Farmington Hills, MI 48333-9085 (800) 524-0149 www.deltadentalin.com	**Vision Network** Vision Service Plan (VSP) (800) 877-7195 www.vsp.com
Medicare Advantage Plan Humana (800) 733-9064 www.humana.com	**Specialty Pharmacy Savings Plan** Saveon SO (800) 683-1074
Diabetic Testing Supplies OneHealth (877) 316-2460 www.D360.care	**Life Insurance** Anthem Life Insurance Company Participants directed to BeneSys for Information 800-447-0460
Telehealth Teladoc www.TeladocHealth.com 1-800-835-2362	

ARTICLE 27 - OTHER PROVISIONS

A. Type of Administration/Plan Administrator/Plan Sponsor

The Board of Trustees of the Indiana/Kentucky/Ohio Regional Council of Carpenters Welfare Fund is the Plan Administrator and Plan Sponsor. As such, the Trustees are responsible for overall Plan administration. The current Trustees are:

LABOR TRUSTEES	MANAGEMENT TRUSTEES
Matt McGriff (Co-Chairman) IKORCC 771 Greenwood Springs Drive Greenwood, IN 46143	William Nix (Co-Chairman) 401 NW First Street Evansville, IN 47708
Mike Dugan IKORCC 5370 Covert Court Newburgh, IN 47630	John Hasse 10 Lincoln Ave., P.O. Box 300 Calumet City, IL 60409
Andy Tropp IKORCC 1091 Mariners Drive Warsaw, IN 46582	Carey Weddle 8802 North Meridian Street Indianapolis, IN 46260
Waylon Isaacs IKORCC 771 Greenwood Springs Drive Greenwood, IN 46143	James Hacker 872 Floyd Dr. Lexington, KY 40505
Charles Davis IKORCC 1245 Durrett Lane Louisville, KY 40213	Andy Binkley 7808 Honeywell Dr. Fort Wayne, IN 46825

In the event of any inconsistency between the terms of the Plan and this SPD, the terms of the Plan control.

Adam Fedak IKORCC 771 Greenwood Springs Drive Greenwood, IN 46143	Derrick Anderson 2401 Stanley Gault Parkway Louisville, KY 40223

LEGAL COUNSEL FOR THE PLAN

Jacqueline Asher Kelly, Esq.
Lyndsey K. Bates, Esq.
AsherKelly
25800 Northwestern Hwy, Suite 1100
Southfield, MI 48075
(248) 746-2748

The Trustees have delegated the day-to-day responsibilities for Plan administration to BeneSys, Inc., 700 Tower Drive, Suite 300, Troy, Michigan 48098, telephone number (248) 813-9800 or (248) 641-4967.

B. Effective Date of Plan: April 28, 1981.

C. Agent for Service of Legal Process: Service of process should be made upon BeneSys, Inc., 700 Tower Drive, Suite 300, Troy, Michigan 48098, telephone number (248) 813-9800. Service of legal process may also be made upon any Fund Trustee.

D. Type of Plan/Employer Identification Number/Plan Number: The Plan is a welfare benefit plan hospitalization, medical, prescription drugs, dental, vision, disability and death benefits. The employer identification number assigned by the IRS is 35-6042362. The Plan Number is 501.

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

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

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

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

In the event of any inconsistency between the terms of the Plan and this SPD, the terms of the Plan control.

Receive Information About Your Plan and Benefits:

- Examine, without charge, at the Plan Administration Office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Administrator may make a reasonable charge for the copies.
- Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

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

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

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

Enforce Your Rights: If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you

In the event of any inconsistency between the terms of the Plan and this SPD, the terms of the Plan control.

have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions: If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration, United States Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, United States Department of Labor, 200 Constitution Avenue, NW, Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

I. Termination of the Plan: **The Trustees reserve the right to amend, alter, or terminate any or all coverages provided in this Plan, for any or all classes of Participants (Actives or Retirees) or Dependents, at any time.** The Trustees also have the right to change required self-payment amounts for any benefit or class of Participants (Actives or Retirees) or Dependents, including the right to impose self-payment for coverage that previously had been provided without requiring such self-payments. If the Plan is terminated, plan assets shall be used to pay eligible claims and expenses incurred prior to termination and expenses incident to the termination. The Trustees will, in their discretion, allocate any remaining assets in a manner which best effectuates the purposes of the Trust. In no event will plan assets revert to or inure to the benefit of contributing employers or the Association.

This Summary Plan Description is not intended to cover every detail of the Plan or every situation that might occur. It is simply a summary. The complete Plan is available for inspection at any time at the Plan Office. If there is any conflict between this summary and the Plan, the Plan controls. For a more detailed statement of your rights and obligations consult the Plan document.

W2479527

In the event of any inconsistency between the terms of the Plan and this SPD, the terms of the Plan control.