MAHONING & TRUMBULL

COUNTY BUILDING TRADES

INSURANCE FUND

PLAN DOCUMENT &
SUMMARY PLAN DESCRIPTION

January 1, 2024

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1. Introduction

The Board of Trustees is pleased to provide this updated Plan document and Summary Plan Description of the benefits available through Mahoning and Trumbull County Building Trades Insurance Fund, (hereinafter referred to as the "Insurance Fund"). This booklet replaces any and all booklets that were previously issued. Please read this booklet and keep it in a safe place for future reference. It explains when you and your dependents are eligible for benefits, what your benefits are and how claims are processed for your benefits. This program was adopted by the Board of Trustees and involves some important cost management measures for you and your dependents.

This booklet has been prepared to provide you with the information required for you to become familiar with the benefits provided by the Insurance Fund, and to familiarize you with the manner in which the benefit claims are administered.

The Insurance Fund is a fund created under the Taft-Hartley Act and is governed by the Employee Retirement Income Security Act, frequently referred to as ERISA. It is funded through employer contributions made on behalf of employee participants of the Fund, and from income earned through investment of Fund assets. The amount of contributions your employer makes to the Fund on your behalf is the amount specified in the collective bargaining agreement under which you work. The Insurance Plan adopted by the Trustees, which is fully described in this booklet, is designed to provide benefits for employees employed under the terms of the collective bargaining agreements negotiated by your local union and your employer. A copy of your collective bargaining agreement may be obtained upon written request to the Plan Administrator.

The Fund is administered by a joint Board of Trustees, half of whom are union appointed trustees, and the other half employer appointed trustees.

2. Plan Administration

2.1 Identification of the Plan

Name of Plan: Mahoning and Trumbull County Building Trades Insurance Plan

Type of Plan: The Plan is a welfare benefit plan that provides medical benefits, prescription drug benefits, and death benefits.

Plan Number: YV00

Date Plan Year Ends: September 30th

Type of Administration: BeneSys, Inc. (a Contract Administrator) carries out the administration of the Plan

Plan Sponsor: Board of Trustees

Plan Administrator: BeneSys, Inc.
3660 Stutz Drive, Suite 101
Canfield, OH 44406
Toll Free (800) 435-2388

Employer Identification Number: 34-0746419

Agent of Service of Legal Process: Board of Trustees
Mahoning and Trumbull County Building Trades Insurance Fund
3660 Stutz Drive, Suite 101
Canfield, OH 44406

2.2 Collective Bargaining Agreements

The Plan is maintained pursuant to several collective bargaining agreements between the Unions and Contributing Employers. To determine whether an employer is a Contributing Employer, you may write to the Plan Administrator. Each collective bargaining agreement is available for examination at the Fund office. You may receive a copy of any such agreement from the Plan Administrator upon written request.

2.3 Source of Funding

The Plan is funded through employer contributions made on behalf of the Plan's employee participants and income earned through the investment of Fund assets. The amount of contributions each employer makes to the fund is the amount specified in its respective collective bargaining agreement. Further, there are provisions for the self-payment of premiums made to the Plan, for example, by qualified beneficiaries who elect COBRA Continuation Coverage.

2.4 Procedure on Termination

The Board of Trustees intends to continue the Plan indefinitely, although it reserves the right to change, discontinue, or end the Plan at any time. In the event of the termination of the Amended and Restated Agreement and Declaration of Trust ("Trust Agreement"), the Trustees shall apply the Fund's assets to pay or to provide for the payment of any and all of the Fund's obligations and shall distribute and apply any remaining surplus in accordance with ERISA's provisions and the Plan's provisions.

2.5 Procedure for Amending the Plan

The Board of Trustees may modify or amend the Plan from time to time at its sole discretion, and such modification or amendment shall be final and binding on all individuals claiming benefits under this Plan.

2.6 Board of Trustees

LABOR TRUSTEES

Brian Collier, Co-Chairman
Bricklayers Local #23
OH-WV-KY-MD Northeast Ohio Chapter
5211 Mahoning Ave., Ste. 270
Austintown, OH 44515

Anthony Deley
Iron Workers Local 207
694 Bev Road
Youngstown, OH 44512

Todd Ambrose
IBEW Local Union #573
4550 Research Parkway
Warren, OH 44483

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Painters District Council #6
8257 Dow Circle West
Strongsville, OH 44136

Kevin Streby
Insulators Local 84
277 Martinel Drive
Kent, OH 44240

MANAGEMENT TRUSTEES

Kevin Reilly, Co-Chairman
Builders Association of Eastern Ohio and Western Pennsylvania
P.O. Box 488
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Warren, OH 44484

Joseph Joseph
Joseph Painting Contractors, Inc.
696 McClurg Road
Youngstown, OH 44512

Larry Knittle
MICON, Inc.
P.O. Box 67
Canfield, OH 44406

2.7 Plan Professionals

PLAN ADMINISTRATOR
BeneSys, Inc.
3660 Stutz Drive, Suite 101
Canfield, OH 44406
Phone: (330) 779-8861
www.mahoningtrumbullbenefits.org

LEGAL COUNSEL
Faulkner, Hoffman & Phillips., LLC
20445 Emerald Parkway Dr., Suite 210
Cleveland, OH 44135

BENEFIT CONSULTANT
Segal Consulting
1111 Superior Avenue, Suite 2340
Cleveland, OH 44114

INVESTMENT CONSULTANT
AndCo Consulting
875 Green Tree Road
Seven Parkway Center, Suite 840
Pittsburgh, PA 15220

PREFERRED PROVIDER ORGANIZATION (PPO)
Anthem Blue Cross and Blue Shield
Phone: 1-800-796-3102
Website: www.anthem.com

AUDITOR
Yurchyk & Davis, CPAs
3701 Boardman-Canfield Rd., Suite 2
Canfield, OH 44406

PHARMACY BENEFIT MANAGER
Express Scripts
Phone: (800) 282-2881
Website: www.express-scripts.com

3. General Information

Day to day operation of the Fund is conducted by BeneSys, Inc., a third- party administrator, to act as the responsible party for maintaining the necessary records and processing claims for benefits filed by participants in the Fund. You may contact them at 1-800-435-2388.

The Plan year of the Fund is the period between October 1 and September 30. The records of the Fund are kept on the basis of a fiscal year ending September 30.

Plan documents and other plan information including a complete list of the employers sponsoring the plan, will be provided by the Trustees if this information is requested in writing. A reasonable charge will be made for providing copies of the document requested. All plan documents are available for examination at the office address of the Fund at no charge.

The employer identification number of the Fund is 34-0746419. Information that you may require or desire may be secured from the Insurance Fund Office.

The Board of Trustees is the Plan's agent for service of legal process. Accordingly, if legal disputes involving the Plan arise, any legal documents should be served upon the Board of Trustees c/o the Plan Administrator.

3.1 Benefit to You of Choosing a Network Provider

The Plan has entered into an arrangement with a preferred provider organization (PPO). When you choose providers that are members of the PPO panel, costs are reduced for you and the Plan.

You may contact the PPO directly to learn if your providers are in the panel. Copies of participating provider lists are also available from the Fund Office. A copy of the provider list will be provided to you for free, as a separate document.

The PPO is:

Anthem Blue Cross and Blue Shield

Phone: 1-800-796-3102

Website: www.anthem.com

3.2 Deductible

You must pay all the costs up to the deductible amount before this Plan begins to pay for covered services you use.

3.3 Co-Payments

Co-payments are fixed dollar amounts you pay for covered health care, usually when you receive the service.

3.4 Co-Insurance

Co-insurance is your share of the costs of a covered service, calculated as a percent of the allowed amount for the service. For example, if the Plan's allowed amount for an overnight hospital stay is $1,000, your co-insurance payment of 20% would be $200. This may change if you haven't met your deductible.

3.5 Allowed Amount/Balanced Billing

The amount the plan pays for covered services is based on the allowed amount. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the allowed amount is $1,000, you may have to pay the $500 difference. (This is called Balanced Billing).

3.6 Reasonable and Customary Charges

The Plan will only consider Reasonable and Customary charges unless using a network provider for which there is a negotiated rate. This generally means the rate for a covered procedure or service charged by the majority of providers within the area where a claim is incurred. Accordingly, you may desire to discuss fees with your providers before services are rendered.

3.7 Spouse

For purposes of the Plan, the term "spouse" will be read to refer to any individuals who are lawfully married under any state law, including individuals married to a person of the same sex who were legally married in a state that recognizes such marriages, but who are domiciled in a state that does not recognize such marriages.

For purposes of the Plan, the term "marriage" will be read to include a same-sex marriage that is legally recognized as a marriage under any state law.

3.8 Trustee Decisions

The Board of Trustees maintains the sole and exclusive right to determine the eligibility requirements for participation in the Fund. The Trustees maintain the sole and exclusive right to alter, amend or terminate any or all portions of the benefit program provided through the Fund and to determine the cost to be charged for the benefits and coverage provided. No Eligible Person - active, disabled or retired - has any vested rights to benefits, to retiree benefits, or coverages. The Board of Trustees' decisions on eligibility requirements and Plan provisions shall be final and binding upon all affected parties.

3.9 Plan Representations

Only the Board of Trustees has the authority to interpret and answer questions regarding eligibility for participation in the Fund. However, the Plan Administrator has been given discretion by the Board of Trustees to interpret the Plan document and answer questions regarding Plan benefits. No Union or Employer representative, Trustee, business agent or other individual has the authority

to answer questions and/or interpret the provisions or the types of benefits, amount, duration or nature provided by the Plan unless such individual has been given written authority by the Board of Trustees and is acting on its behalf.

3.10 Change of Address and Status

It is extremely important that you keep the Fund office informed of any change to address or desired change in beneficiary. This is your obligation and failure to fulfill this obligation could jeopardize your eligibility or benefits.

The importance of a current, correct address on file in the Fund Office cannot be overstated. It is the **ONLY** way the Trustees can keep in touch with you regarding plan changes and other developments affecting your interests under the Plan.

Also, you have the responsibility to inform the Fund Office within sixty (60) days of a marriage, divorce, legal separation, birth of a child, or a child losing dependent status under the Plan.

Respectfully,

BOARD OF TRUSTEES

4. Medical Benefits

4.1 Essential Benefits

Essential Benefits include ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health, and substance abuse disorder services (including behavioral health treatment), prescription drugs, rehabilitative and habilitative services, laboratory services, preventative and wellness services and chronic disease management and pediatric services, including oral and vision care. Effective January 1, 2024, preventative care, if in network, is covered at 100% and not subject to deductibles and coinsurance; however, if out of network, such services are subject to the applicable deductibles and coinsurance.

There are no annual limits for Essential Benefits.

The following chart will answer some important questions you may have about your cost for essential benefits and common medical events:

Important Questions	Answers	Why This Matters
What is the Benefit Period?	The Benefit Period is the Calendar Year (January to December)	Calculation of your deductible and other amounts you are responsible for paying will start over in January of each calendar year.
What is the overall **Deductible**?	In Network: $300 per person/ $600 per family. Out of Network: $600 per person/ $1,200 per family. Balance Billing, excluded services do not count toward the Deductible.	You must pay all the costs up to the Deductible amount before this plan begins to pay for covered services. If you have other family members on this Plan, each family member must meet their own individual Deductible until the total amount of Deductible expenses paid by all family members meets the overall family Deductible.
Are there other **Deductibles** for specific services?	No.	You do not have to meet Deductibles for specific services.

Is there an **out-of-pocket limit** on my expenses?	Yes. There is a **Medical** out of pocket maximum, a **Prescription Drug** out of pocket maximum, and a **Combined** out of pocket maximum. **Medical OOP Maximum**: <u>In Network</u> $1,400 Per Individual $4,200 Family Maximum i.e., Member only: $1,400 max; Member +1: $2,800 max; Member + 2 or more: $4,200 max <u>Out of Network</u> $2,800 Per Individual $8,400 Family Maximum i.e., Member only: $2,800 max; Member +1: $5,600 max; Member + 2 or more: $8,400 max **Prescription OOP Maximum**: Per Individual: $8,050 In Network; $16,100 Out of Network Per Family: $14,700 In Network; $29,400 Out of Network	The out-of-pocket limit is the most you could pay during a Benefit Period for your share of the cost of covered services; the Medical OOP includes your deductible.

Important Questions	Answers	Why This Matters
	Combined OOP Maximum: Per Individual: $9,450 In Network; $18,900 Out of Network Per Family: $18,900 In Network; $37,800 Out of Network	
What is not included in out-of-pocket expenses?	Premiums, balance billing, health care the Plan does not cover.	Even though you may pay these expenses, they don't count toward the out-of-pocket limit.
Is there an overall **annual or lifetime limit** on what the Plan pays?	No.	Any limits on what the Plan will pay for *specific* covered services is described elsewhere in this booklet.
Does the Plan use a network of providers?	Yes. For a list of in-network providers call- 1-800-796-3102 or visit www.anthem.com.	If you use an In-Network doctor or other health care provider, the Plan will pay some or all of the costs of covered services. Be aware that an In-Network doctor or hospital may use an Out of Network provider for some services.
Do I need a referral to see a **Specialist?**	No.	You can see the specialist you choose without permission from the Plan.
Are there services this plan doesn't cover?	Yes.	Services this plan doesn't cover are listed in this booklet.

4.2 Schedule of Benefits

All medical expenses are subject to the Usual, Customary and Reasonable charges. The Fund will provide you a detailed copy of the Schedule of Benefits for free, upon request.

Common Medical Event	Service You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations, Exceptions and other Information
Visit to a Health Care Provider's Office or Clinic	Primary care visit to treat an injury or illness; Special visit; Other practitioner office visit; Preventive Care/ screening/ immunization	20% co-insurance	30% co-insurance	You may also use Live Health Online, a telemedicine program for minor illness
Testing	Diagnostic test (x-ray, blood work); Imaging (CT/PET scans, MRIs	20% co-insurance	30% co-insurance	None
Outpatient Surgery	Facility fee (e.g., ambulatory surgery center); Physician/ surgeon fees	20% co-insurance	30% co-insurance	None
Immediate medical attention	Emergency room care; Emergency medical transportation; Urgent Care	20% co-insurance	20% co-insurance (30% co-insurance for transport except 20% for air ambulance).	None
Hospital stay	Facility fee (e.g., hospital room); Physician/Surgeon Fee	20% co-insurance	30% co-insurance	Only semi-private room rate covered
Mental health, behavioral health or substance abuse services	Outpatient services Inpatient services	20% co-insurance	30% co-insurance	 Only semi-private room rate covered
Pregnancy	Childbirth/ delivery professional and facility services	20% co-insurance	30% co-insurance	Coverage only for employee and spouse
Recovery and special health needs	Home health care (only for skilled nursing visits); Rehabilitation services; Habilitation services; Skilled nursing care; Durable medical equipment	20% co-insurance	30% co-insurance	Hospice service not covered
Live Health Online*	Telehealth services using Live Health online	20% co-insurance	Not covered	
Telehealth / Virtual Visits	Telehealth services other than Live Health Online	20% co-insurance	30% co-insurance	Includes mental health services

*Note: Effective September 1, 2023, the Plan shall continue to waive the Participant co-insurance for the LiveHealth Online through August 31, 2024 only, unless further extended by the Trustees.

4.2.1 COVID-19 Relief for Participants

Testing

Effective March 18, 2020, through the end of the National Emergency Concerning the Novel Coronavirus Disease (COVID-19) Outbreak on May 11, 2023, cost-sharing shall be waived for the following services:

- Diagnostic tests to detect the virus that causes COVID-19 that are approved or authorized by the FDA, including the administration of such tests; and

- Items and services furnished to individuals during provider office visits (whether in-person or via telehealth), urgent care visits, and emergency room visits that result in an order for, or the administration of, the test described above, but only to the extent such items or services relate to the furnishing or administration of the test or the evaluation of whether the person needs the test.

4.3 Basic Medical Expenses

All medical expenses are subject to the Usual, Customary, and Reasonable charges.

These benefits are payable after satisfying your deductible with the Plan reimbursing 80% of the Usual, Customary, and Reasonable charges up to the first $4,000; thereafter 100% subject to limitations set forth herein, unless otherwise noted:

- Hospital Expense Benefit, Room and Board, and other Hospital Services

- Outpatient Hospital Services

- Surgical fees

- X-ray and Lab

- Inpatient Doctor visits and Consultations

- Emergency Room Physicians charges

- Provider office visits

- Durable medical equipment

- Ambulance fees

- FDA-Approved Gene Therapies*
- Telehealth and virtual office visits

*FDA-approved gene therapies are excluded from coverage under the Plan's prescription drug benefits. However, FDA-approved gene therapies are covered under the Plan's schedule of benefits. Please contact the Fund office in the event that you have any questions about the Plan's provisions related to FDA-approved gene therapies.

4.4 In-Network Cost Sharing for Out-of-Network Services

Effective October 1, 2022, you may only be responsible for Network Cost Sharing for certain services, even if a Non-Network Provider provided those services.

"**Network Cost Sharing**" means:

The amount you pay out-of-pocket (including amounts paid toward the Deductible, Coinsurance payments, and Copayments) will not be more than it would be if a Network Provider provided the services. In addition, the Plan will apply the amount you pay for the services to your Network Deductible and Network Out-of-Pocket Maximum in the same manner it would apply the amount you would have paid if a Network Provider provided those services.

"Qualifying Payment Amount ("QPA") means:

QPA is used to calculate your Network Cost Sharing for items and services covered by the balance-billing protections of the No Surprises Act. In general, your Network Cost Sharing for emergency items and services, air ambulance services, and non-emergency items and services furnished by Non-Network providers in a Network facility, will be the lesser of the billed charges or the QPA.

Surprise Billing Situations

You will only be responsible for Network Cost Sharing for Surprise Billing Situations.

"**Surprise Billing Situation**" refers to:

- Non-Network Emergency Care;
- Non-Network air ambulance services; and
- Non-Network Non-Emergency Care at a Network Facility where there is no Notice and Consent. However, Ancillary Services are not subject to balance billing even in the absence of Notice and Consent.

"Ancillary Services" mean the following:

- Items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether provided by a physician or non-physician practitioner;

- Items and services provided by assistant surgeons, hospitalists, and intensivists;
- Diagnostic services, including radiology and laboratory services; and
- Items and services provided by a Non-Network Provider if there is no Network Provider who can furnish such item or service at such facility.

"**Emergency Care**" means:

- Services in an emergency department of a hospital or an independent freestanding emergency department as well as post-stabilization services in certain instances. The Plan will not require prior authorization for Emergency Care in an emergency department of a hospital or an independent freestanding emergency department. The Plan will not impose any administrative requirement or limitation on Non-Network Emergency Care that is more restrictive than for Network Emergency Care.

"**Notice and Consent**" means that:

- 72 hours before providing the services, the Provider sent you (through postal mail or email) notice of its network status and an estimate of charges; and
- You consented in writing to receiving Non-Network services.

Continuing Care Patients

If, while you are a Network Provider's Continuing Care Patient, the Provider's Network status changes (for example, the Provider no longer participates in the Plan's Network), you will only be responsible for Network Cost Sharing for that Provider's services (if those services are related to the reason you are classified as a Continuing Care Patient) for the period ending on the earlier of:

- The 90-day period beginning on the date the Provider's network status changed; or
- The date on which you are no longer a Continuing Care Patient.

A "**Continuing Care Patient**" is, with respect to a Provider:

- Undergoing treatment for a Serious and Complex Condition;
- Undergoing institutional or inpatient care;
- Scheduled to undergo nonelective surgery, including postoperative care;
- Pregnant and undergoing pregnancy treatment; or
- Terminally ill (as defined by the Social Security Act) and receiving treatment for such illness.

A "**Serious and Complex Condition**" is:

- 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

- 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.

Plan Payment of No Surprises Act Claims

When the Plan receives a "clean claim" which generally means receipt of the information needed to decide a claim for payment for services by a Non-Network provider or facility, the Plan will send an initial payment or a notice of denial of payment not later than thirty (30) calendar days after the Non-Network provider or facility submits a bill related to items and services that fall within the scope of the No Surprises Act balance billing protections.

Provider Directory Information

The Plan will verify and update the provider directory information included on the public website database that contains a list of each health care provider and health care facility with which the Plan has a direct or indirect contractual relationship for furnishing items and services under the Plan. The Plan will provide for the removal of such a provider or facility when it has been unable to verify information during a period specified by the Plan. Notification will be provided that the information contained in the directory was accurate as of the date of publication of such directory and that an individual enrolled under the Plan should consult the database or contact the Plan to obtain the most current provider directory information.

In the case of an individual enrolled under the Plan who requests information through a telephone call or electronic, web-based, or Internet-based means on whether a health care provider or health care facility has a contractual relationship to furnish items and services under the Plan, the Plan will follow a protocol under which, in the case such request is made through a telephone call—(A) responds to such individual as soon as practicable after such call is received, through a written electronic or print (as requested by such individual) communication; and (B) retains such communication in such individual's file for at least 2 years following such response.

External Claims Review

An adverse determination that involves consideration of whether the Plan complied with the surprise billing and cost-sharing protections of the No Surprises Act is eligible for external review.

5. Prescription Drug Benefits – For All Eligible Members, Early Retirees and their Enrolled Dependents

The Prescription Drug Benefit covers charges for drugs prescribed by a physician, dispensed by a pharmacist and not available over the counter without a prescription.

Covered Expenses include:

- **Federal Legend Drugs -** Any medicinal substance which bears the legend: "Caution: Federal Law prohibits dispensing without a prescription."

- **State Restricted Drugs -** Any medicinal substance which may be dispensed by prescription only according to state law, excluding medical marijuana as defined in Ohio Revised Code 3796.01(A)(1) or any other medicinal substance that is illegal under federal law.

- **Compounded Medication** - Any medicinal substance which has at least one ingredient that is a Federal Legend or State Restricted Drug in a therapeutic amount.

- **Insulin** - Available by prescription only (includes insulin syringes).

The Fund has contracted with Express Scripts to provide an efficient and cost-effective program that will be easy for you and your dependents to use when you purchase your prescriptions at a Network Pharmacy.

The Prescription plan offers two ways to get your medication:

- **Retail network (short-term medications)**
  Use an Express Scripts-participating retail pharmacy when filling short-term prescriptions for medications such as antibiotics.

- **Mail service pharmacy (long-term medications)**
  Use the Express Scripts Mail Service Pharmacy to fill your long-term prescriptions. Mail service is a cost-effective choice for long-term medication because you can get up to a 90-day supply for less than what you would pay for the same supply at retail.

Information about the Retail Network, Mail Service and other Express Scripts services can be obtained by calling Express Scripts at 1-800-282-2881, or by visiting www.express-scripts.com.

Your cost for prescription drugs is explained in the following chart:

Prescription Drug Coverage (more information can be found at www.express-scripts.com)	**Your Cost If You Use an In-Network Provider**	**Your Cost If You Use an Out-of-Network Provider**	**Limitations & Exceptions**
Generic drugs	$10 co-pay retail $20 co-pay mail	$10 co-pay retail $20 co-pay mail	30-day supply retail; 90-day supply mail *see below
Preferred brand drugs	25% co-ins. retail 20% co-ins. mail	25% co-ins. retail 20% co-ins. mail	Covered if there is no generic equivalent. *see below
Non-preferred brand drugs	50% co-ins. retail 35% co-ins. mail	50% co-ins. retail 35% co-ins. mail	*see below
Specialty drugs	10% co-ins. Up to a $150 maximum per fill (retail and mail)	10% co-ins. Up to a $150 maximum per fill (retail and mail)	*see below

* 30-day supply retail; 90-day supply mail order. If you do not show your prescription drug card when filling your prescription, you will be charged the full price of the prescription. You can submit a claim for reimbursement, but you will only be reimbursed for part of the cost (i.e., the contracted rate minus the copay or coinsurance, as applicable). No charge for ACA-required generic preventive drugs such as FDA-approved contraceptives (or brand name drugs if a generic is medically inappropriate).

Effective January 1, 2024, the Plan will participate in SaveOnSP, a specialty pharmacy copay assistance program. The specialty drugs that are included in this program are considered non-essential health benefits under the Plan, and the cost of such drugs will not be applied toward satisfying the Participant's out-of-pocket maximum. Although the cost of the program drugs will not be applied towards satisfying a Participant's out-of-pocket maximum, the manufacturer will reimburse the cost of the program drugs at no cost to the Participant.

If a Participant's specialty medication is part of the SaveOnSP program, the Participant must participate in the SaveOnSP program to receive the medication without cost-sharing. Specialty medications on the drug list will be subject to 30% drug cost coinsurance; A Participant who does not participate in the SaveOnSP program will be responsible for the full cost of the drug for specialty medications that are part of the SaveOnSP program.

If you are taking a medication that is part of the SaveOnSP program, SaveOnSP will contact you. If you have any questions or need more information, please contact SaveOnSP at 1-800-683-1074, Monday - Thursday 8:00 a.m. - 11:00 p.m. Eastern, and Friday 8:00 a.m. - 9:00 p.m. Eastern.

The following services, supplies and charges are not covered under this benefit:

1. Contraceptive devices, except as otherwise specified;
2. Therapeutic devices;
3. Artificial appliances;
4. Disposable insulin syringes which are not prescribed;
5. Fees for administering or injecting Prescription Drugs;
6. Charges for more than a 90-day supply of Prescription Drugs;
7. Any refill or Prescription Drug, dispensed after one year from the date of the original Prescription Order;
8. Drugs you can purchase without a Prescription;
9. Prescription Drugs consumed or administered at a location where Prescription Order is issued;
10. Fertility drugs;
11. Nicorette gum and/or other tobacco cessation related medication;
12. Genetically engineered drugs (may be paid upon prior authorization);
13. Male sexual dysfunctional drugs (except a 6-pill monthly limit for Viagra);
14. Anorexiants (diet pills);
15. Diabetic supplies (e.g., glucometers, lancets, test strips which are covered under the Plan's Basic Medical Expenses);
16. Ostomy products;
17. Medical marijuana or any other medicinal substance that is illegal under federal law; and
18. Weight loss drugs and weight management programs.

5.1 Oral Contraceptives

Effective January 1, 2021, the Plan will provide benefits for generic and brand oral contraceptives (birth control pills) subject to the prescription drug coverage co-payment and co-insurance chart above.

5.2 COVID-19 Vaccine

Effective December 26, 2020 through the end of the COVID-19 Public Health Emergency on May 11, 2023, the Plan will cover 80% of the usual, customary, and reasonable charges for any FDA-authorized or approved COVID-19 vaccine by an In-Network Provider, or 70% of the usual, customary, and reasonable charges for any FDA-authorized or approved COVID-19 vaccine by an Out-of-Network Provider.

5.3 COVID-19 Antiviral Therapy Program

Effective with the roll-out of the Express Scripts COVID-19 Oral Antiviral Therapeutics Program on or about January 15, 2022 through the end of the COVID-19 Public Health Emergency on May 11, 2023, the Plan, through its prescription benefit manager Express Scripts, will process and reimburse COVID-19 oral antiviral drug claims. The ingredient cost is paid for by the federal government; the dispensing fee is paid for by the Plan. Only oral antiviral therapies for COVID-19 that received Emergency Use Authorization from the FDA are covered. Member copay will follow the Plan's existing benefit setup. The Plan's formulary will provide for the addition of FDA-approved COVID-19 antiviral therapeutic medications. There is a quantity limit for one (1) course of treatment every 180 days for plans with standard limited Drug Quantity Management (DQM), Anti-Infectives DQM, or Medicare DQM rules in place.

6. Eligibility

6.1 Rules of Eligibility for Employees' Coverage

The eligibility rules now in effect are shown below. They may be changed from time to time as the Trustees, in their discretion, may deem necessary.

You are eligible for coverage if you are employed under the jurisdiction of one of the union locals participating in the Fund and if sufficient contributions have been made on your behalf by participating employers or a participating employer.

6.1.1 Initial Eligibility – Active Employees

An employee working under a bargaining agreement shall qualify for initial eligibility following the receipt of four hundred and five (405) hours of contributions within a six (6) month period. The employee will be eligible for benefits on first day of the third month, plus the following two (2) months, following the period in which the employee received 405 hours of contributions and became qualified for initial eligibility. Once qualified, the employee will be credited with the required hours as outlined under the Continuation of Eligibility Provisions.

As an example, when contributions are received for an employee as follows:

September	105 hrs.
October	90 hrs.
November	95 hrs.
December	115 hrs.

This employee will qualify for benefits effective March 1 and will be eligible for benefits during for the months of March, April and May.

6.1.2 Effective Eligibility Date

An employee will be covered on the date he or she became eligible if he or she is available for work on that date; otherwise, the employee shall not become covered until he or she becomes available for work.

Coverage for a newborn dependent Child begins from birth.

6.1.3 Continuation of Eligibility – Active Employees

Once qualified for benefits under the Initial Eligibility rules, you must receive 135 hours of contributions per month to remain qualified beginning with the first month for which your initial eligibility entitles you to coverage. If you receive contributions for the required number of hours for continuation eligibility, you will be eligible for coverage on the first day of the third month following the month in which you received the required amount of contributions.

Using the example above, the employee must receive at least 135 hours of contributions for each

month beginning with January. For example, if this employee receives 140 hours of contributions for work performed in January, he or she will be eligible for benefits in June; if the employee receives 135 hours of contributions for work performed in February, he or she will be eligible for benefits in July.

6.1.4 Non-Covered Employment

Any employment or self-employment by a Participant in any capacity for or as a non-signatory building or construction contractor anywhere will be deemed to be disqualifying employment that will result in the termination of coverage under the Plan. For this purpose, a non-signatory building or construction contractor is any such contractor who is not signatory to a collective bargaining agreement with a participating union or an affiliated AFL-CIO Building Trades Union. It shall also include any employment for or as a construction or project manager who subcontracts or permits to be subcontracted, directly or indirectly, building trades work to a non-signatory building or construction contractor.

The National Labor Relations Board has determined that union organizers, whether paid or unpaid, are employees protected under the National Labor Relations Act. Accordingly, the employment of such an organizer known as "salt" by a non-signatory contractor will not disqualify such organizer as an employee from participation in the Fund; the Fund shall accept contributions made to the Fund by the Union for such an employee.

When the Plan administrator has determined that a participant has engaged in such disqualifying employment, it will promptly so notify the participant. If the participant thereafter engages in *any* disqualifying employment at any time after the 15th day following the date of such notice, the Participant and his or her Dependents' coverage under the Plan will be terminated – including forfeiture of all accumulated hour bank credits and any self-payment rights other than COBRA continuation coverage rights. The Participant and Dependents shall be offered the COBRA continuation coverage rights otherwise available under the Plan for loss of coverage due to a reduction in hours in covered employment.

6.1.5 Self-Contributions

If you have accumulated less than the minimum required number of hours for continuation of eligibility, were unemployed, or working under a state residential agreement for an employer not signatory to the Eastern Ohio, Western Pennsylvania Builders Association collective bargaining agreement, and are not eligible for retirement benefits, you may make a self-contribution at the then current contribution rate for the number of hours needed to meet the minimum eligibility requirements for the next succeeding benefit period. Self-contributions shall be limited to six (6) consecutive benefit periods for which no hours are reported. After exhausting your self-pay rights, you may be eligible for COBRA benefits as set forth in this booklet.

6.1.6 Newly Organized or Apprentices

Plan coverage will be provided to any newly organized employee or apprentice under the following conditions:

A. The employee must notify the Fund office in writing that he or she is a newly organized

employee or apprentice. The employee must include written notification from the Local Union.

B. If notice is provided to the Benefit office on or before the 15th day of a month, the Fund office will send the employee a notice that Plan coverage will start on the first day of the following month if the employee elects to make a one-time special self-payment.

C. If notice is provided to the Fund Office after the 15th day of a month, the Fund Office will send the employee a notice that Plan coverage will start on the first day of the second following month if the employee elects to make a one-time special self-payment.

D. This offer will be available to an employee only once during his or her lifetime. The employee can make the special self-payments for up to nine (9) consecutive months.

E. The Trustees, upon consultation with the Plan Administrator, shall establish the amount of the special self-payment, and shall notify the employee.

F. The Fund office must receive the employee's first self-payment no later than the first day of the month for which coverage is to start. The employee can mail the payment deliver it personally, but the Fund Office must receive it no later than the due date.

6.1.7 Self Employed

In no event may a self-employed individual make self-contributions to maintain eligibility.

6.1.8 Hour Bank

Reserve hours will be calculated monthly basis. All hours worked in excess of 135 hours in a month will be credited to a reserve hour bank up to a maximum of 1,620 hours. These 1,620 hours will allow a Participant to build up to twelve months of coverage. When contributions are increased under the Collective Bargaining Agreements, an adjustment will be made in the Participant's reserve hours to reflect the increased cost of the Plan.

The use of these hours is expressly conditioned upon the Participant's Local Union, where at least a majority of these hours have been accumulated, sponsoring a Collective Bargaining Agreement requiring contributions to this Fund.

The Trustees shall also have the discretion to freeze or terminate a Participant's reserve hour bank if it is determined that he or she are performing work in Covered Employment in the craft jurisdiction for an Employer not subject to a collective bargaining agreement. The reserve hour bank is not a vested benefit and is subject to amendment, reduction or termination

The Plan shall accept contributions for work performed in covered employment on behalf of a retiree who has maintained continuous eligibility in the Plan. Such contributions received will be subject to the same hour bank limitations imposed in the Plan on active Participants.

Employer contributions that qualify for eligibility periods when a participant is on active military duty shall be credited to the participant's hour bank. These hour bank credits are subject to the

same overall maximums set forth in the first paragraph above.

6.1.9 Sick Credit

An eligible employee will be credited with four hours per day for a period not to exceed 26 weeks for the purpose of maintaining eligibility. You are eligible for this credit if you:

- are receiving Sickness & Accident benefits from this Fund or receiving Workers Compensation benefits; and
- are seen on a regular basis by a physician who so states you are Disabled; and
- make written application to the Fund Office for such credits within six months after the Disability starts.

Credit is given the first day for an injury and beginning the eighth day for an illness. You will receive credit until you are no longer receiving Disability or Sickness and Accident Benefits or Workers' Compensation, or until you have received the maximum of 26 weeks, whichever comes first.

There is no limit to the number of separate periods of disability for which benefits are payable. However, successive terms of disability for the same or a related cause and separated by less than two weeks of full-time work will be considered one period of disability.

The Plan may require that the Plan's Physicians examine you from time to time.

6.1.10 Family and Medical Leave Act Credits

Contribution Credits of up to 12 weeks in a 12-month period may be available from your Employer for Family and Medical Leave (FMLA). You must have worked 1,250 hours in a 12- month period for an Employer covered by FMLA. Certain other requirements must be met.

Forms for seeking these Credits are available from the Fund Office. The Form must be completed by you and your Employer. FMLA Contribution Credits may be available for:

- The birth of your child and to care for such child.
- Placement of a child with you for adoption or foster care;
- To care for your Spouse, Child or parent with a serious health condition; or
- For your own serious health condition that makes you unable to perform your job.

Please contact the Fund Office for Rules and Regulations governing FMLA Contribution Credits.

6.1.11 Military Service Provision

If you are called up for active duty in the armed services, you are entitled to the protection of the

Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). The Fund will allow you the choice of using your Hour Bank to continue coverage for you and/or your dependents or freezing your Hour Bank until your reinstatement in the Plan. The provisions for reinstatement are based on your application for re-employment and will vary depending on your length of stay in the uniformed services. You need to contact the Fund Office to discuss your options to continue coverage for you and your dependents. In most instances, when you are called to active duty, coverage is provided to you through Tri Care which offers several plans to persons on active duty and, under certain conditions, his/her dependents.

It is extremely important, if you wish to have a continuation of benefits under USERRA, that immediately upon learning of your armed service-related absence for any period, you discuss your options with the Fund Office.

The maximum period of coverage available under this election shall be the lesser of:

(a) 24 months from the date on which the eligible employee's absence begins; or

(b) The day after the date on which the eligible employee fails to apply for or return for a position of employment, as set forth below.

6.2 Rules of Eligibility for Dependents' Coverage

A Participant is eligible for Dependents' coverage on the day he or she becomes eligible for employee coverage or on the day he or she acquires his first Dependent, whichever is later.

Eligible Dependents include the following:

(a) The Participant's legal spouse;

(b) The Participant's children up to the age of 26 years regardless of student status, marital status, support tests or the availability of employer-based coverage to such children. Such children include (1) step-children residing in the Participant's household; and (2) legally adopted children.

(c) Children after attainment of age 26 while incapable of self-support because of a disabling sickness or injury that commenced prior to age 19 provided such child was eligible for coverage as a dependent prior to attainment of age 19. Such children must otherwise meet the definition of Dependent as contained in (b), must legally reside with the Participant and must be principally supported by the Participant.

(d) A child (19 years or younger) of whom the participant has had legal custody for two (2) consecutive years or more prior to applying to the Fund for coverage. Additionally, the child must meet the definition of dependency as accepted by the Internal Revenue Service.

To be eligible for dependent coverage, proof may be required that the purported Dependent meets the requirements stated above.

"Eligible Dependents" do not include a person who is covered under any other group insurance

plan or program toward the cost of which an employer contributes or who is covered as a member under this Plan, except that the Participant's children up to the age of 26 are Eligible Dependents regardless of student status, marital status, support tests, or the availability of other employer-based coverage.

6.2.1 Special Enrollment Rights

The Plan does require that you specifically enroll in coverage once you become eligible. However, your dependents must be enrolled with the Plan in order to have coverage. If you do not enroll any of the Eligible Dependents upon becoming initially eligible for coverage under this Plan, your Dependents may qualify for the Special Enrollment described in this Section. If you and your Dependents do not meet the Special Enrollment rules, then the Dependent will not become eligible for coverage under this Plan until the date that all of the enrollment forms are completed and claims will not be paid retroactively to the date of their initial eligibility. You may obtain enrollment forms from the Fund Office.

If you decline enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this Plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within sixty (60) days after your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within sixty (60) days after the marriage, birth, adoption, or placement for adoption.

If the completed written enrollment form is submitted on a timely basis, coverage will be effective as follows:

- Your coverage, your Spouse's coverage, and/or the coverage of any of your other Dependent Child(ren), except with respect to coverage of a newborn or newly adopted Dependent Child, will become effective on the date of the event that created the special enrollment opportunity.

- Coverage of a newborn who is enrolled within sixty (60) days after birth will become effective as of the date of the child's birth.

- Coverage of a newly adopted Dependent Child who is enrolled within sixty (60) days after birth will become effective as of the date of the child's adoption or placement for adoption, whichever occurs first.

If you do not enroll your Spouse for coverage within sixty (60) days of the date on which he or she became eligible for coverage, and if you subsequently acquire a Dependent Child by birth, adoption or placement for adoption, you may enroll your Spouse together with your newly acquired Dependent Child no later than sixty (60) days after the date of your newly acquired Dependent Child's birth, or placement for adoption. If you decide to enroll other Dependent

Children other than the newly born or adopted child under this provision, your coverage for the other Dependent Children will not commence until all of the proper enrollment forms are completed and claims will not be paid retroactively to the date of their initial eligibility.

If you, your Spouse or other Dependent had medical coverage under Medicaid or a State child health insurance plan (a "CHIP" plan) but lose eligibility for that Medicaid or CHIP coverage and request coverage under the Plan within 60 days after such coverage terminates; or if you, your spouse or other Dependent becomes eligible for state CHIP assistance or coverage under Medicaid and request coverage within 60 days after you or your Dependent are determined to be eligible for such assistance.

If your Spouse and Dependent Child(ren) did not enroll for coverage within the sixty (60) days after the date of their initial eligibility because they had other health care coverage under any other health insurance policy or program or employer plan, including COBRA Continuation coverage, individual insurance, Medicare, Medicaid or other public program, and your Spouse and/or Dependent Child(ren) cease to be covered under that other health insurance policy or plan, you may enroll your Spouse and/or Dependent Child(ren) within the sixty (60) days after the termination of their coverage under the other health care policy or plan. This applies only if the other coverage terminated because:

- Of loss of eligibility for that other coverage as a result of termination of employment or reduction in the number of hours of employment, or death, divorce or legal separation; or

- Of the termination of employer contributions toward that other coverage; or

- If the other coverage was COBRA Continuation Coverage, the coverage was exhausted.

COBRA Continuation Coverage is exhausted if it ceases for any reason other than either the failure of the individual to pay the applicable COBRA premium on a timely basis, or for cause (such as making a fraudulent claim or an intentional misrepresentation of material fact in connection with that COBRA Continuation Coverage). Exhaustion of COBRA Continuation Coverage can also occur if the coverage ceases:

- Due to the failure of the employer or other responsible entity to remit premiums in a timely basis;

- When the employer or other responsible entity terminates the health care plan and there is no other COBRA Continuation Coverage available to the individual;

- When the individual no longer resides, lives or works in a service area of an HMO or similar program (whether or not by the choice of the individual) and there is no other COBRA Continuation Coverage available to the individual; or

- Because the 18-month or 36-month period of COBRA Continuation Coverage has expired.

- However, you may not avail yourself of this opportunity for Special Enrollment for yourself or any Dependent unless, at the time of Initial or Special Enrollment, you indicated

in writing that the reason your Spouse and/or Dependent Child(ren) were not enrolled was because they had coverage under another health insurance policy or plan

6.2.2 Qualified Medical Child Support Orders (QMCSOs)

Upon receipt of a QMCSO, the Plan Administrator will promptly notify the eligible Participant and each Alternate Recipient, as defined in ERISA Section 609(a), of the receipt of such order and, within a reasonable amount of time, notify you as to whether or not the order is qualified. Participants and Beneficiaries can obtain, without charge, a copy of the Plan's written procedures governing QMCSO determinations.

In general, a QMCSO is a judgment, decree or order issued by a court of competent jurisdiction or through an administrative process established under state law that requires a person to provide medical coverage for his or her children (called Alternate Recipients). Such orders are often issued in situations involving divorce, legal separation, or a paternity dispute. A QMCSO may not require the Plan to provide any type or form of benefit, or any option not otherwise provided under the Plan. Once the Eligible Dependent child is enrolled as an Alternate Recipient under a QMCSO, the child's custodial parent will receive a copy of this Benefit Booklet, as well as all other information needed to receive benefits under the Plan. If the QMCSO requires payments for services rendered to an Alternate Recipient to be paid to other than the Participant, payment will be issued to the Provider of service.

6.3 Eligibility for Early Retirees and Dependents (Under Age 65)

You are able to continue your coverage as an Early Retiree and coverage for your Dependents through timely self-payments if you:

- have had at least 20 quarters of eligible participation in this Plan out of the 40 quarters immediately before retirement date; and
- have had at least 12 consecutive months' eligible participation in this Plan immediately before retirement date; and
- are receiving a pension from a plan which is sponsored by a local union affiliated with the Fund or early retirement benefits under the Federal Social Security Act; and:
- are retired from Covered Employment in the trade.

You must notify the Fund Office in writing that you want to maintain eligibility through the retiree program within 31 calendar days of the last month in which you are covered as an active Employee. The Fund Office will notify you of the amount due. Self-payments must be made from the date coverage was lost. These self-payments count toward the duration of COBRA continuation coverage. If you fail to make a self-payment, you will lose your coverage and it cannot be reinstated.

Eligible participation during the twelve (12) consecutive months immediately before the retirement of a participant recognized for coverage shall include months of coverage under subsidized COBRA while the participant was available for employment.

Coverage for the Early Retiree's Dependents as of the Retiree's effective retirement date may be continued for the same periods, as set forth above, upon timely self-payment. Dependents acquired after the Retiree's effective retirement date will not be eligible for benefits under this Plan.

Retiree benefits have been made available by the Trustees as a privilege, not a right. No person acquires a vested right to such benefits, either before or after their retirement. The Trustees may expand, reduce or cancel coverage for Retirees, change eligibility requirements or the amount of self-payments and otherwise exercise their prudent discretion at any time without legal right or recourse by a Retiree or any other person.

6.3.1 Eligibility for Disabled Retirees and Dependents

If you are Totally and Permanently Disabled, you are able to continue eligibility under the Disability Retiree program for you and your Dependents through timely self-payments if:

- you have been determined to be totally and permanently disabled by the Social Security Administration and have received a Social Security disability award;
- you were an active, Eligible Employee in the Plan for a total of 20 quarters out of the 40 quarters immediately before the date you were determined to be totally and permanently disabled by the Social Security Administration; and
- you are retired from Covered Employment in the trade.

A Disabled Employee must notify the Fund Office in writing that he or she wants to maintain eligibility through self-payments within 31 days of the last month in which he or she was covered as an active employee or retires. He will be notified by the Fund Office of the amount due. If he fails to make a timely self-payment, he loses his or her eligibility and it cannot be reinstated. Self-payments must be made from the date coverage was lost, and will be counted toward any required COBRA continuation coverage.

Coverage will terminate if your self-payments are late, your Disability ends and you are able to return to active employment, or you become eligible for the Normal Retiree Program.

Coverage for the Disabled Employee's Dependents as of the effective date of disability may be continued for the same periods, as set forth above, upon timely self-payment. Dependents acquired after the Disabled Employee's effective disability date will not be eligible for benefits under this Plan.

Disabled Employee benefits have been made available by the Trustees as a privilege, not a right. No person acquires a vested right to such benefits, either before or after the Employee becomes disabled. The Trustees may expand, reduce or cancel coverage for Disabled Employees, change eligibility requirements or the amount of self-payments and otherwise exercise their prudent discretion at any time without legal right or recourse by a Disabled Employee or any other person.

6.3.2 Eligibility for Normal Retired Employees (at or After Age 65)

This coverage is limited to employees of the construction industry employed under the jurisdiction

of one of the union locals participating in the Fund who:

A. Have retired from active employment of any kind or are receiving Social Security retirement benefits; and

B. Are not eligible for benefits as an active employee; and

C. Have accumulated 6,000 hours of credit as an active employee, on the basis of credited hours paid by contributing employers and self-payments; and

D. Have otherwise maintained eligibility in accordance with the Rules of Eligibility.

You must notify the Fund Office in writing that you want to maintain your eligibility through the Normal Retiree Program within 31 days of the last month in which you were covered as an active employee or Early or Disabled Retiree. You will be notified by the Fund Office of the amount due. Self-payments must be made from the date coverage was lost, and will be counted toward any required COBRA continuation coverage. If you fail to make a self-payment, you lose your coverage and it cannot be reinstated.

Coverage for the Normal Retiree's Dependents as of the Retiree's effective retirement date may be continued for the same periods, as set forth above, upon timely self-payment. Dependents acquired after the Retiree's effective retirement date will not be eligible for benefits under this Plan.

Retiree benefits have been made available by the Trustees as a privilege, not a right. No person acquires a vested right to such benefits, either before or after their retirement. The Trustees may expand, reduce or cancel coverage for Retirees, change eligibility requirements or the amount of self-payments and otherwise exercise their prudent discretion at any time without legal right or recourse by a Retiree or any other person.

6.3.3 Eligibility for Surviving Spouses and Eligible Dependents Upon Date of Death

The Surviving Spouse of an Early Retiree, Disabled Retiree, Normal Retiree or Employee Eligible hereunder at death shall terminate at the end of the Eligibility month in which the Retiree had last obtained eligibility. The Surviving Spouse may continue coverage by making required self-payments so long as such coverage is elected within 60 days following the Employee's or Retiree's death.

If the surviving spouse fails to join the surviving spouse program within 60 days after the death of the Eligible Retired Employee or Eligible Employee, or if the surviving spouse, upon joining the program, fails to make the contributions required by the Trustees, eligibility for participation shall terminate and the surviving spouse shall not be able to be reinstated to the surviving spouse program in the future.

Coverage for Surviving Spouses would also cease on the earliest of the following:

- The date they no longer meet the definition of a Dependent; or

- The date they become covered by another group plan (excluding Medicare); or
- The date the Spouse remarries; or
- The date the Spouse dies.

Coverage for dependents of the deceased Eligible Employee or Retiree upon death may be continued for the same periods, as set forth above, upon timely self-payment.

Surviving spouse benefits have been made available by the Trustees as a privilege, not a right.

No surviving spouse or dependent acquires a vested right to benefits, either before or after the Employee's death. The Board of Trustees may expand, reduce or cancel coverage for surviving spouses and/or dependents, change eligibility requirements and/or the self-pay rate and otherwise exercise its discretion at any time without legal right to recourse by a surviving spouse, dependent or any other person.

6.3.4 Information Regarding Eligibility

Any questions concerning your eligibility should be directed to the Fund Office:

BeneSys, Inc.
3660 Stutz Drive, Suite 101
Canfield, OH 44406
Phone: (330) 779-8861
www.mahoningtrumbullbenefits.org

6.4 Non-Bargained Employee Participation Program

The intention of this Program is to allow participation in the Plan by the non-collectively bargained office staff of signatory Participating Employers ("Employer" or "Employers"). In general, eligible office staff includes but is not limited to non-trades craftsmen such as office clerical employees, estimators and others employed by the signatory employer as part of its business operations. For ease of reference, the non-collectively bargained office staff employees are hereinafter referred to as "Non-Bargained Employees." In the event Employers employ building and construction trades craftsmen working outside of the Plan's jurisdiction, this Program is not designed to include any such trades craftsmen.

Non-Bargained Employees of an Employer who work at least thirty (30) hours per week but are not within the jurisdiction of an applicable collective bargaining agreement may participate in the Plan and be eligible for benefits under the Plan subject to the following terms:

1. The Employer must be signed to a collective bargaining agreement ("CBA") which requires the Employer to make contributions to the Plan for its employees within the jurisdiction of the CBA (Bargained Employees) and the Employer must otherwise be in compliance with the CBA and the Plan's Trust Agreement.

2. At least 50% of the Employer's employees must be Bargained Employees. For purposes of the 50% requirement, the following guideline shall apply: Exclude from the census any trades craftsman who worked outside the Plan's jurisdiction and was not a member of the affiliated participating local union under this Plan and Trust *but only if* such craftsman worked in the same craft as the Bargained Employees during the 12-month measurement period. For example, if the Employer employed on average 10 Bargained Employees, 10 same craftsmen, and 5 office clericals, the 50% requirement is satisfied because the Bargained Employees comprise more than 50% of the Employer's overall employee count (since the 10 same craftsmen are excluded from the census).

3. On an annual basis, or as otherwise requested by the Trustees, each Employer participating in this Program must submit the employee-census data for the preceding 12-month period and this data will determine Program eligibility for the immediate-next 12-month period.

4. An Employer must make contribution to the Plan for its Bargained Employees according to the terms of the CBA for the twelve-month period immediately prior to Non-Bargained Employees being eligible for benefits under the plan.

5. Employers shall pay the Plan the monthly amount computed at 135 work hours multiplied by the then-current contribution rate under the applicable CBA for each Non-Bargained Employee per month, in advance together with reporting forms as may be required by the Trustees, to maintain eligibility in the Plan for such Non-Bargained Employees. Employers shall make such contributions to the Plan for all of its Non-Bargained Employees, regardless of waiver or usage of benefits under the Plan by a Non-Bargained Employee. Contributions for Non-Bargained Employees shall be due on the same date as contributions are due for Bargained Employees according to the applicable CBA, receipt of which shall establish eligibility for coverage of the Non-Bargained Employees as of the first day of the following calendar month. The penalties and other costs for delinquent payment of contributions for Non-Bargained Employees shall be the same as for Bargained Employees as set forth in the Fund's Collection and Audit Policy, as revised from time to time, as well as the applicable CBA. The contribution rate for Non-Bargained Employees shall be subject to change at the discretion of the Trustees.

6. Non-Bargained Employees of an Employer participating in the Plan may not exceed 50% of an Employer's total employees. See item #2 guideline for purposes of the 50% requirement.

7. Sole Proprietors and their spouses shall not be eligible for benefits as Non-Bargained Employees. Partners of an Employer that is a partnership, and their spouses, shall not be eligible for benefits as Non-Bargained Employees.

8. Non-Bargained Employees shall be entitled to the same benefits under the Plan as Bargained Employees, except that Non-Bargained Employees shall not be eligible for the following under the Plan:

    a. Lost time/disability/weekly indemnity benefits

    b. Retiree benefits (early, disabled or otherwise)

    c. Dollar bank accumulation

d. Sick credit accumulation

e. Death or accidental death/dismemberment benefits

f. Personal care account/medical savings account (or similar) contributions or accumulations

g. Self-payments/contribution options

9. All Employers must sign a participation agreement in a form adopted by the Trustees and must be approved for participation in the Non-Bargained Employee Participation Program by the Trustees prior to any Non-Bargained Employee being eligible for benefits under the Plan. The Trustees may require Employers to provide necessary payroll, medical underwriting information, and other business records to determine initial or continuing eligibility for the Non-Bargained Employee Participation Program.

10. The Trustees may terminate or modify the Non-Bargained Employee Participation Program or terminate the participation agreement of an Employer in their sole discretion. Plan benefits are not vested and may be terminated in whole or part at any time by action of the Trustees.

11. The Non-Bargained Employee Participation Program shall be administered in a manner that shall not jeopardize the tax-exempt status of the Plan, including, but not limited to, limiting the number of Non-Bargained Employees eligible for benefits under the Plan to no more than 10% of the combined total of all Bargained Employees and Non-Bargained Employees eligible for coverage under the Plan.

6.5 Termination of Coverage

Coverage for you and your Eligible Dependents will terminate on the earlier of the following dates (unless you qualify for and elect Continuation of Benefits as described in Section 7):

- The last day of an Eligibility Period if you have insufficient contributions and/or Reserve Hours, and fail to make timely self-payments;

- When you begin active duty in the armed forces;

- The last day of an Eligibility period in which you die except that your Eligible Dependents will be allowed to remain eligible until any of your accumulated Reserve Hours are exhausted;

- The date the union that represents you for collective bargaining purposes ceases to participate in the Fund (in which case only the disabilities incurred prior to the withdrawal of the union from the Fund will be honored);

- The date you cease to be available for work under Covered Employment; or

- The date the Plan terminates.

Dependent coverage may also terminate for your Eligible Dependent(s) if that class of coverage is

terminated or on the date that your Dependent:

- Ceases to be your legal Dependent as provided by the Plan; or
- Becomes an Eligible Employee under this Plan or another group plan; or
- Begins active duty in the armed forces.

6.6 Suspension of Benefits

Your benefits may be suspended if the Trustees determine that you are:

1) performing work in covered employment within the craft jurisdiction and not pursuant to a collective bargaining agreement; or

2) your membership in the Union has been terminated, other than by retirement.

6.7 Reinstatement

Active Employees who lose coverage will be required to again meet the Plan's Initial Eligibility rules.

7. Consolidated Omnibus Budget Reconciliation Act (COBRA) Summary of Rights and Obligations Regarding

7.1 General Notice of COBRA Rights

Introduction

This section has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Fund. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Fund and under federal law, you should review the remainder of the Fund's Summary Plan Description or contact the Fund Office.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Fund coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Fund is lost because of the qualifying event. Under the Fund, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Fund because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Fund because of the following qualifying events:

- Your spouse dies;

- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Fund because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Fund as a "dependent child."

When is COBRA continuation coverage available?

The Fund will offer COBRA continuation coverage to qualified beneficiaries only after the Fund Administrator has been notified that a qualifying event has occurred. The employer must notify the Fund Office of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Fund Office within 60 days after the qualifying event occurs. You must provide this notice to: Administrative Manager, Mahoning & Trumbull County Building Trades Insurance Fund.

How is COBRA continuation coverage provided?

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

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Fund is determined by Social Security to be disabled and you notify the Fund Office in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Fund is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Fund as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Fund had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at **www.healthcare.gov**.

Can I enroll in Medicare instead of COBRA continuation coverage after my Fund coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[1] to sign up for Medicare Part A or B, beginning on the earlier of

[1] https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods.

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Fund may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

If you have questions

Questions concerning the Fund or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit **www.dol.gov/ebsa**. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit **www.HealthCare.gov**.

Keep your Fund informed of address changes

To protect your family's rights, let the Fund Office know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information

BeneSys, Inc.
3660 Stutz Drive, Suite 101
Canfield, OH 44406
Phone: (330) 779-8861
www.mahoningtrumbullbenefits.org

8. Basic Medical Expenses

8.1 Hospital Expense Benefits – For Eligible Employees, Early Retirees and Eligible Enrolled Dependents

8.1.1 Benefits Provided in Accredited Hospitals

When you are admitted for treatment as an inpatient to an accredited hospital, benefits will be provided for semi-private room accommodations and all other services provided by the hospital for the diagnosis and treatment for your condition including treatment in an intensive care unit, blood and blood plasma and ambulance service. If you occupy a private room in an accredited hospital, you will be entitled to all of the above-described benefits, but you will be required to pay the hospital the excess, if any, of its regular charge for the private room over the hospital's most common charge for semi-private rooms.

The following requirements must be met for covered hospital benefit consideration:

(a) Maintains permanent and full-time facilities for ten or more resident patients.

(b) Has a licensed physician or surgeon in regular attendance.

(c) Continuously provides 24-hour-a-day nursing service by registered nurses.

(d) Is primarily engaged in providing diagnostic and therapeutic facilities for medical and surgical care for injured and sick persons on a basis other than as rest home, nursing home, convalescent home, a place for the aged, a place for alcoholics, or a place for drug addicts.

8.1.2 Benefits Provided in Other Hospitals

If you are admitted to a non-accredited hospital, you will be entitled for covered hospital services in accordance with the following schedule:

(a) up to $25.00 for the first day of hospitalization, and

(b) up to $10.00 per day for each additional day of hospitalization, for the remaining number of days for which you are eligible under this program, as set out below.

8.1.3 Maternity Benefits

The benefits provided under the Program are only available to a female Participant or a Participant's spouse for hospital confinement in a pregnancy case.

8.1.4 Inpatient Hospitalization – Dental Cases

The hospital benefits provided under the Plan are available if you are admitted to a hospital (a) for extraction of boney impacted teeth, or (b) for extraction of teeth other than impacted teeth or for other dental processes provided hospitalization is certified by a licensed physician or a doctor of dental surgery as being necessary to safeguard the health of the person confined.

8.1.5 Outpatient Treatment – Surgical Cases

The hospital benefits provided under the Plan are available if you receive surgical treatment for medically necessary procedures in the outpatient department of an accredited hospital.

8.1.6 Outpatient Treatment - Radiation Therapy

If you receive radiation treatments in the outpatient department of a covered hospital, such treatments are covered to the extent that they are provided as a hospital service.

8.1.7 Outpatient Laboratory Service

Benefits are available for outpatient laboratory services.

8.1.8 Inpatient Admissions and Outpatient Visits for Diagnostic Study

Hospital benefits are provided for inpatient admissions for diagnostic study when the study is directed toward the diagnosis of a definite condition of illness or injury.

Hospital benefits are also available for the following diagnostic services performed in the outpatient department of a covered hospital which provides such services, when directed toward the diagnosis of a definite condition of illness or injury:

> X-ray examinations with films, metabolism testing, radioactive isotope studies, and cardiographic and encephalographic examinations, but excluding work-up procedures performed in the outpatient department when the patient is to be admitted as an inpatient unless provided for under the section titled BENEFITS PROVIDED IN ACCREDITED HOSPITAL in Section 8.1.1.

Hospital benefits are not provided for the following services:

> Audiometric testing; eye refractions, examinations for the fitting of eyeglasses or hearing aids; dental examinations; premarital examinations; research studies, screening; or routine physical examinations or check-ups.

8.2 FDA-Approved Gene Therapies

FDA-approved Gene Therapies are excluded from coverage under the Plan's Prescription Drug Benefits. However, FDA-Approved Gene Therapies are covered under the Plan's Basic Medical Expenses. Please contact the Fund Office in the event that you have any questions about the Plan's provisions related to FDA Approved Gene Therapies.

8.3 Telehealth and Virtual Office Visits

Benefits are available for telehealth and virtual office visits, subject to the copayment and annual deductible.

8.4 COVID-19 Support for Participants

Effective March 18, 2020, through the end of the National Emergency Concerning the Novel Coronavirus Disease (COVID-19) Outbreak on May 11, 2023, the Plan will waive cost sharing for the following services:

- Diagnostic tests to detect the virus that causes COVID-19 that are approved or authorized by the FDA, including the administration of such tests; and

- Items and services furnished to individuals during provider office visits (whether in-person or via telehealth), urgent care visits, and emergency room visits that result in an order for, or the administration of, the test described above, but only to the extent such items or services relate to the furnishing or administration of the test or the evaluation of whether the person needs the test.

8.5 Surgical Benefits

Benefits are provided for surgical services consisting of operative and cutting procedures (including the usual post-operative care) for the treatment of illnesses, fractures or dislocations, which are performed in or out of a hospital by a licensed physician and, in the case of reduction of fractures or dislocations of the jaw, which are performed either by a licensed physician or by a doctor of dental surgery. If you are an inpatient in a covered hospital benefits will also be provided for the services of a licensed physician, who actively assists the operating surgeon in the performance of such surgical services when the condition of the patient and the type of surgical services requires such assistance and when the hospital does not employ interns, residents, or house staff.

Benefits are also provided for operative and cutting procedures for the treatment of diseases and injuries of the jaw or for the extraction of impacted teeth and if the surgical services is performed by a licensed physician or a doctor of dental surgery.

Surgical services which would be covered if performed by a licensed physician shall also be covered when performed by a duly licensed podiatrist acting within the scope of his or her license.

An internal penile prosthesis will be considered medically necessary for the treatment of erectile dysfunction for individuals 18 years of age or older who meet the following medically appropriateness criteria:

- paraplegia or quadriplegia

- pelvic trauma with urinary system injury

- Peyronie’s disease

- history of radiation therapy to the pelvis

- history of radical pelvic or perineal surgery (such as cystectomy, prostatectomy, partial penectomy, abdominal-perineal resection, anterior exenteration or total pelvic

exenteration)

- For coverage of other organic diagnoses, documentation must indicate all other forms of therapy have failed and impotence has existed for over one year.

- The use of an internal penile prosthesis is considered not medically necessary for the treatment of psychogenic erectile dysfunction.

- The prosthesis used must have FDA approval.

This coverage is subject to the Plan's annual deductibles and co-insurance provisions.

8.6 Physicians' Services Benefits– For Members, Early Retirees, and Eligible Enrolled Dependents

Payment for providers that are not part of the PPO are based on the Usual, Customary, and Reasonable fee. This means that, subject to certain deductibles and co-payments specified in the Schedule of Benefits, the Fund pays the charge of the physician for a covered service, but not more than the prevailing fee for such service as determined by the Fund.

In determining what constitutes the usual, customary and reasonable fee, the Fund will consider the following:

(a) The usual fee which the individual physician most frequently charges to the majority of his or her patients for a similar service or medical procedure.

(b) The fees which fall within the customary range of fees charged in a locality by most physicians of similar training and experience for the performance of a similar service or medical procedure.

(c) Unusual circumstances or medical complications requiring additional time, skill, and experience in connection with a particular service or medical procedure.

These provisions are designed to recognize that there will be differences in physicians' charges because of such factors as the prevailing fees or charges in the geographical locality, skill of the physician, and complexity of the service performed.

The Fund makes the determination as to the prevailing fee. If you become obligated to a physician for a charge in excess of the prevailing fee as determined by the Fund, the Fund will not pay such excess.

Benefits will be not provided for the following: X-ray examinations in connection with care of teeth, research studies, screening, routine physical examinations or check-ups, premarital examinations, routine procedures provided on admission to a hospital, fluoroscopy without films, or any examination not necessary to diagnosis of an illness or injury.

8.6.1 Obstetrical Benefits

Benefits are provided for obstetrical services, including necessary prenatal and postnatal care, furnished to a female employee or a member's spouse either in or out of a hospital by the licensed physician in charge of the case.

8.6.2 Anesthesia Services

Benefits are provided for the administration of anesthetics, except local infiltration anesthetic, provided either in or out of a hospital in surgical, obstetrical cases, or medically necessary dental cases when administered and billed by a licensed physician, other than the operating surgeon or his assistant, who is not an employee of, not compensated by, a hospital, laboratory, or other institution.

8.6.3 Radiation Therapy Benefits

Benefits are provided for treatment by X-ray, radium, external radiation or radioactive isotopes (including the cost of materials unless supplied by a hospital), provided either in or out of a hospital, when performed and billed by the licensed physician in charge of the case.

When your condition requires radiation therapy services in conjunction with medical, surgical or obstetrical services payment will be made for such radiation therapy services in addition to the payment for such other types of services if the physician performing the radiation therapy services is not the same physician who performs the medical, surgical or obstetrical services.

8.6.4 Diagnostic X-Ray Services

Benefits are provided as specified below for a diagnostic X-ray examination, either in or out of a hospital, which is required in the diagnosis of any condition of illness or injury, which is customarily billed by the physician who made such examination, and which is:

(a) Ordered by a licensed physician or a doctor of dental surgery who is engaged in general or special practice other than radiology, and when so ordered, is made by a licensed physician (excluding a doctor of dental surgery or the doctor ordering such X-ray) who limits his practice to radiology;

(b) Made by a licensed physician (excluding a doctor or dental surgery) qualified to undertake radiological examinations within the confines of a single specialty; or

(c) Made by a licensed physician in an emergency or emergency traumatic case.

8.6.5 Mental Health - Inpatient Services

If you or your dependents are receiving treatment of psychiatric related conditions on an Inpatient basis, the Plan will pay for covered, subject to annual deductibles, co-insurance and co-payments.

The following services are payable for treatment of Psychiatric Treatment - Nervous/Mental Disorders:

- Individual psychotherapy
- Group psychotherapy
- Electroshock therapy and related anesthesia in a hospital or psychiatric hospital
- Psychological testing, limited to one battery of covered person per calendar year

All charges applied to the Mental Health Service Benefit will subject to completion of the program(s) and/or treatment(s) prescribed by a licensed physician, psychologist, or professional clinical counselor.

8.6.6 Mental Health - Outpatient Services

Subject to annual deductibles, co-insurance and co-payments, the Fund will pay for all Covered Charges incurred on an outpatient basis as a result of a nervous and/or mental disorder for professional psychiatric treatment under the clinical supervision of a licensed Physician, a licensed Psychologist, or a Licensed Professional Clinical Counselor, whether performed in an office, Hospital or a community mental health facility approved by the Commission on Accreditation of Hospitals or Certified by the Department of Mental Health and Mental Retardation.

All charges applied to the Mental Health Service Benefit will be subject to completion of the program(s) or treatment(s) as prescribed by a licensed physician, psychiatrist, psychologist, or professional clinical counselor.

8.6.7 Substance Abuse Services - Inpatient/Outpatient

The Fund will cover treatment of drug abuse and alcoholism related conditions, if you or your dependents are being treated as an Inpatient/Outpatient in a network facility, subject to annual deductibles, co-insurance and co-payments. Services not covered under this benefit include:

- Treatment not prescribed and supervised by a physician, psychiatrist, or licensed psychologist;
- Legal services, recreational, vocational, financial, or educational counseling, except as part of a chemical dependency treatment program;
- Detoxification or drug withdrawal programs not rendered by a hospital or as part of a maintenance program;
- Personal comfort items; and
- Marriage or family counseling.

8.7 Benefits for Mothers and Newborns

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn

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

8.8 Women's Health and Cancer Rights Act of 1998

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

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the Plan. ***Please refer to the Schedule of Benefits in Section 4.2 for deductibles and coinsurance applicable to these benefits.***

If you would like more information on WHCRA benefits, call the Fund Office at (330) 779-8861 or (800) 435-2388.

8.9 Routine Preventative Care Benefit

The Plan will pay charges for:

- One routine Papanicolaou test (pap smear) per calendar year and any office visit incidental to such test;
- Routine mammograms and any office visit incidental to such test;
- Well Care Child Care as follows:
    - Birth to 1 Year - Coverage for History and Physical examination, development assessment, anticipatory guidance and laboratory services and immunizations at birth, 1 month, 2 months, 4 months, 6 months, 9 months, 12 months/1 year. Intervals are based on the current Recommendations for Preventative Pediatric Health Care of the American Academy of Pediatrics. Immunizations will be covered based on physician recommendation as the AAP schedule for immunizations varies based on the latest medical findings or research.

- Year to Age 9 - Benefits will be provided for a History and Physical examination development assessment, anticipatory guidance and laboratory services and immunizations at 15 months, 18 months, 24 months, 3 years, 4 years, 5 years, 6 years, and 8 years. Immunizations will be covered based on physician recommendation as the AAP schedule for immunizations varies based on the latest medical findings or research.

- Vasectomies

- Surgical sterilization

8.10 Convalescent Nursing Home Care

Expenses incurred for convalescent nursing home care as described in this paragraph are also included in the term Covered Medical Expenses. They include ward or semi-private rate charges (for private room, the charges up to the home's most common semi-private room rate) for room, board, and services provided by professional and practical nursing personnel, excluding custodial and personal type care, for not more than 365 days for the same or related cause or causes, subject to the following:

(a) Confinement must in a convalescent nursing home which qualifies as an Extended Care Facility under Medicare or is otherwise approved by the Fund. A home will be approved by the Fund if it is accredited as an Extended Care Facility or a Nursing Care Facility by the Joint Commission on Accreditation of Hospitals. (Before you or your dependent enter a nursing home, you should, if possible, inquire of the Fund as to whether such home meets the above requirements).

(b) Nursing home care will be covered only if confinement immediately follows prior inpatient hospitalization involving surgery, or if not involving surgery, immediately follows an inpatient hospitalization of at least three days, and is ordered by a physician as necessary for convalescence from an illness or injury, or treatment of a terminal condition or a long term disability, where nursing home facilities are required and the care required is not principally custodial.

8.11 Physical Therapy and Chiropractic Care

Subject to the annual deductible and coinsurance amounts, and as provided below, the Plan will cover physical therapy and chiropractic visits for restorative purposes. The Plan does not cover physical therapy or chiropractic treatment for maintenance purposes or to address congenital defects.

If the Plan has not received notice that you underwent surgery and/or incurred an injury related to your treatment, the Plan will cover eighteen (18) physical therapy or chiropractic visits without requiring medical review. After eighteen (18) visits, the Plan will not cover additional visits without pre-authorization.

If the Plan has received notice that you underwent surgery and/or incurred an injury related to your treatment, the Plan will cover thirty-six (36) physical therapy or chiropractic treatments without

requiring medical review. The Plan must pre-authorize any visits after thirty-six (36).

8.12 Autism Spectrum Disorders (Effective January 1, 2023)

Benefits are payable for the screening, diagnosis, and treatment of autism spectrum disorders, subject to accepted medical clinical guidelines as well as the Plan's policies, cost-sharing, terms and limits.

Covered Services include:

- Speech/language therapy, occupational therapy and physical therapy performed by a licensed therapist.
- Clinical therapeutic intervention which includes, but is not limited to, applied behavior analysis. The intervention must be provided by, or be under the supervision of, a Professional who is licensed, certified, or registered by an appropriate state agency to perform such services in accordance with a treatment plan.
- Mental/behavioral health Outpatient services performed by a licensed Psychologist, psychiatrist, or Physician providing consultation, assessment, development, or oversight treatment plans
- Prescription Drugs.

Treatment for autism spectrum disorders means evidence-based care and related equipment prescribed or ordered for a Covered Person diagnosed with an autism spectrum disorder by a licensed Physician who is a developmental pediatrician or a licensed Psychologist trained in autism who determines the care to be Medically Necessary.

All Covered Services must be prescribed or ordered by either a developmental pediatrician or a Psychologist trained in autism spectrum disorders and require Preauthorization.

8.13 Usual, Customary and Reasonable Charge

The Usual, Customary and Reasonable (UCR) maximum is the highest allowable expense that your Plan will cover for a given treatment or procedure.

When your claim is filed, the charge for each treatment will be compared with charges for the same treatment made by other health providers. The maximum amount allowed for a covered service is based on the following criteria:

- The UCR will never exceed the actual amount billed by the physician or professional provider for a given service.

- The UCR may be limited to the customary charge based on the distribution of charges billed by all physicians and/or other professional providers for a given service within a given specialty and geographic area.

- The UCR must also be reasonable with respect to customary charges for services of comparable complexity and difficulty.

8.14 Date Expenses Are Incurred

Covered Medical Expenses are considered to have been incurred on the date when the applicable medical services, supplies, or treatments are rendered.

8.15 Exclusions and Limitations

Benefits are not provided for services, supplies or charges:

1. Not prescribed by, or under the direction of, a Physician or Professional Provider
2. Not performed within the scope of the Provider's license
3. Which are Experimental/Investigative
4. Which are not Medically Necessary, as determined by the Plan
5. To the extent governmental units or their agencies provide benefits
6. For an injury, ailment, condition, disease, disorder or illness that occurs as a result of any act of war, or during the commission of a felony by the Covered Participant
7. For which you have no legal obligation to pay in the absence of this or like coverage
8. Received from a member of your Immediate Family
9. Received in a military facility for a military service-related injury, ailment, condition, disease, disorder or illness
10. Primarily for education, vocational or training purposes
11. Exogenous obesity: The following criteria must be met in order for Gastric Restrictive Surgery to be considered medically necessary:

    a. Documented five (5) year history of morbid obesity (body mass index (BMI) over 40 kg/m^2) or a BMI greater than 35 and a clinically serious condition such as coronary heart disease, type 2 diabetes mellitus, obstructive sleep apnea, or hypertension; and

    b. The Participant or Dependent must be treated in a surgical program with experience in obesity surgery and includes a multi-disciplinary preoperative and postoperative approach; and

    c. The Participant or Dependent must participate in a six-month treatment plan within the year preceding surgery which includes a multi-disciplinary nonsurgical program including a low or very low-calorie diet, increased physical activity, and behavior reinforcement under the direction of the physician who refers the patient for such surgery; and

d. Documented failure of non-surgical methods of weight reduction; and

e. Absence of significant pyschopathology that can limit an individual's understanding of the procedure or ability to comply with medical/surgical recommendations; and

f. Documentation that the Participant or Dependent has received counseling post-operatively regarding cosmetic difficulties and that the patient has agreed to post-operative treatment plans; and

g. Participant or Dependent must be at least eighteen (18) years of age.

h. Any Gastric Restrictive Surgery must be pre-certified and coordinated with The Fund Office. However, Gastric Banding is not covered under this Plan as an Eligible Expense. If it is determined you meet these criteria, the Plan will pay for the Gastric Restrictive Surgery and all related expenses (including post-operative treatment) up to a lifetime maximum of $25,000 subject to the applicable co-payment. This lifetime maximum will not be subject to any of the Plan's other out-of-pocket maximums.

12. For family and marital counseling

13. Services of more than one Physician rendering treatment for the same condition

14. Sex-change operations, gender dysphoria, penile and breast implant, infertility, artificial insemination, invitro fertilization, gamete intrafallopian transfer (GIFT), and services of a surrogate mother

15. For reverse sterilization

16. For or related to the treatment of temporal mandibular joint syndrome with intraoral prosthetic devices or by any other method to alter vertical dimension; for the treatment of temporal mandibular joint dysfunction

17. Personal hygiene and convenience items (such as, but not limited to, air conditioners, humidifiers, hot tubs, whirlpools, sunbeds, waterbeds, physical fitness equipment or like items), weight control programs, transportation vehicles or home improvements, health club or country club memberships even though a Physician may prescribe them

18. For hypnosis, acupuncture, or any related expense

19. For missed appointments or completion of a claim form

20. For fraudulent or misrepresented claims

21. For expenses of care for conditions that State or local law require be treated in a public facility

22. For topical anesthetics or stand-by anesthesia

23. Evaluation and treatment of sleep disorders (unless determined to be medically necessary which will then be limited to one study per year)

24. Any loss sustained or contracted as a result of an Eligible Participant or Eligible Dependent being under the influence of any narcotic or other drug or as a consequence of the use thereof, unless administered upon the advice of a legally qualified Physician or the result of a medical condition

25. Charges related to massotherapy

26. Milieu therapy

27. Chelation therapy

28. Loss caused by (a) accidental bodily injury which arises out of or occurs in the course of any occupation or employment for wage or profit, or (b) sickness for which the Covered Participant is entitled to benefits under any Worker's Compensation or Occupational Disease Law, unless specifically provided for in the Schedule of Benefits

29. Loss caused by war or any act of war (declared or undeclared) or military or naval service of any country

30. Expenses for or in connection with hearing aids

31. Expenses for or in connection with cosmetic surgery, except cosmetic surgery which is not primarily for beautification but is performed to correct or improve a bodily function or congenital malformation, or to restore facial appearance following an accident, or as provided for under the Women's Health and Cancer Rights Act (see Section 8.8)

32. Expenses for travel or transportation except ambulance charges to the closest facility where appropriate service can be obtained

33. Charges for services furnished by an institution which is primarily a rest home, a home for the aged, a nursing home, a convalescent home, or any institution of like character providing custodial care

34. Treatment on or for treatment of gingival tissues (gums) other than for tumors, physician's services for extraction of teeth; non-surgical treatment of dental abscesses

35. Charges for services of a dentist except for the treatment necessary to alleviate the damage to sound natural teeth or to extract broken or injured teeth, as a result of an accidental bodily injury including the replacement of such teeth in whole or in part, occurred while insured hereunder within one year of injury

36. Charges for services of a dentist except for the surgical removal of impacted

37. (Whole or partial) wisdom teeth extraction including anesthesia

38. Charges for dental x-rays, except when performed in connection with an accidental bodily injury

39. Routine physical examinations, elective procedures (except elective sterilization and well person care)

40. Medical treatment received in connection with a pregnancy by dependent children

41. Any expenses when participant is not eligible for benefits

42. Hospice care

43. Eye refractions, eyeglasses or their fitting

44. Eyeglasses, contact lenses (except for one pair of eyeglasses or contact lenses and examinations for the prescription or fitting thereof following a cataract operation), dentures, hearing aids or other devices or their fitting and related services

45. Maintenance Therapy

46. Charges for keratotomies or keratoplasties

47. No benefits are payable for services or supplies related to the treatment for abuse of nicotine from tobacco and other sources

48. Air ambulance costs, where no life-threatening medical emergency is established or to the extent costs exceed $3,000

49. Surgery performed for the removal of excess fat of skin after weight loss or pregnancy unless Medically Necessary

50. Over-the-counter drugs or vitamins

51. An injury for which you are reimbursed or entitled to be reimbursed by a third party for which such third party is liable

52. Food supplements or augmentation

53. Corrective shoes, arch supports and foot care only to improve comfort or appearance such as subluxation (except capsular or bone surgery)

54. Court-ordered services

55. Services of any practitioner who is not legally licensed to practice medicine and surgery, except to the extent specifically provided in the "Physician Services Benefits" or as required by law

56. Treatment of corns, bunions (except capsular or bone surgery therefore), callouses, nails of the feet except surgery for ingrown nails, flat feet, fallen arches, chronic foot strain, or systematic complaints of the feet

57. Expenses for which payment or reimbursement is received by or for the account of the individual as a result of a legal action or settlement

58. Occupational therapy, physical therapy, and speech therapy when covered therapy does not restore or no further improvement can be expected

59. Cost of social workers, education, and job training

60. Any injury sustained while engaged in any conduct which was in violation of any federal, state, or local criminal statute (felony), and regardless of whether charged, indicted, or convicted.

61. Services, supplies, and treatment before you become eligible or after your eligibility terminates

62. Charges in excess of those which are Usual, Reasonable and Customary (see definition in Section 8.12);

63. Primarily for education, vocational, or training purposes; and

64. Weight management programs.

9. Death Benefit – For Eligible Employees and Early Retirees

In event of your death, $6,500 is payable in a lump sum to the beneficiary you select.

If you become permanently and totally disabled prior to your 65th birthday, this benefit may be continued without further cost to you until you become eligible for the normal retirement benefits, provided you submit satisfactory evidence of such disability.

Please notify the Fund office immediately if you wish to change your beneficiary.

10. Accidental Death or Dismemberment Benefit – For Eligible Employees and Early Retirees

Six thousand five hundred dollars ($6,500) is payable to your beneficiary in the event of accidental death. If you lose both hands, both feet, sight of both eyes, one hand or one foot and sight of one eye, or one hand and one foot, within 90 days after and as a result of an accident, you will receive a $6,500 dismemberment benefit.

One half the amount of the dismemberment benefit is payable to you for loss of one hand, one foot, or sight of one eye within 90 days after and as a result of an accident.

Loss as used in the above clauses with reference to hand or foot means complete severance through or above the wrist or ankle joint, and with reference to eye means the irrevocable loss of the entire sight thereof. Benefits will not be paid for more than one of the above losses (the greatest) sustained as the result of any one accident.

11. Weekly Indemnity – For Eligible Employees Only

The Weekly Indemnity Benefit is $400.00 and is payable if you are unable to work because of an accident occurring off the job, or a sickness not connected with employment. You must be under the continuing care of a licensed medical doctor.

Benefits begin the first (1st) day of a disability if due to an accident and the eighth (8th) day of disability if due to illness.

There is no limit to the number of separate periods of disability for which benefits are payable. The maximum number of Weekly Indemnity Benefit payments for any period of disability is twenty-six (26). Successive terms of disability for the same or related cause and separated by less than two (2) weeks of full-time work will be considered one period of disability. The maximum number of Weekly Indemnity Benefit payments in any twelve (12) month period, regardless of the number of separate periods of disability, shall be twenty-six (26).

Participants drawing this benefit are also given four hours per day for each day he draws this benefit for his credited hours account. The purpose of this additional benefit is to make it less costly for the temporarily disabled member to maintain eligibility. Similarly, a Participant is also credited four hours per day for each day he draws benefits from the State as the result of an industrial disability. In order to gain this credit, be sure to notify the Fund when you have been awarded Worker's Compensation benefits.

Participants whose domicile is not in the jurisdiction of a participating union, or whose usual representative for collective bargaining purposes is not a participating union, shall not be eligible for weekly indemnity benefits for disabilities commencing after the Participant has terminated employment with a contributing employer.

12. Genetic Information Nondiscrimination Act

The Plan shall not adjust its contributions amounts for its Participants on the basis of any genetic information. The Plan will not request or require any Participant or family member to undergo a genetic test provided, however, that the Plan is not prohibited from adjusting an employer's contributions based on the manifested disease of an individual covered under the policy. However, the Plan will not use the manifested disease to further increase the employer's contributions since, it also constitutes genetic information about family members covered under the Plan.

The Plan shall not request or require a Participant or family member to undergo a genetic test. Provided that such prohibition does not: (1) limit the authority of a health care professional to request an individual to undergo a genetic test: or (2) preclude the Plan from obtaining or using the results of a genetic test to make a determination regarding payment. The Plan shall request only the minimum amount of information necessary to accomplish the intended purpose.

The Plan is prohibited from requesting, requiring, or purchasing genetic information: (1) for underwriting purposes or (2) with respect to any individual prior to such individual's enrollment in connection with such enrollment.

13. Normal Retired and Permanently Disabled Employee Programs

Upon retirement at or after age 65, a covered employee who was eligible for benefits under the active program may elect to continue his coverage under the retired employee program as set forth in the benefit schedule by paying the required monthly payment. He may also continue the coverage of his spouse by paying the specified additional monthly payment. The monthly payments are announced from time to time by the Board of Trustees and are always subject to review and change within the sole and exclusive discretion of the Trustees. The current rates can be obtained upon written request from the Board of Trustees.

Employees who qualify for extended life insurance coverage under the waiver-of contribution coverage provided to employees who become totally disabled while eligible for benefits under the active employee program may elect to continue the active program exclusive of the weekly indemnity benefits and accidental death and dismemberment benefits by making the required monthly payment. The monthly payments are announced from time to time by the Board of Trustees and are always subject to review. The current rates can be obtained upon written request from the Board of Trustees. Upon attainment of age 65, coverage would then be provided pursuant to the terms of the retired employee program.

No Eligible Person - active, disabled or retired - has any vested rights to benefits, to retiree benefits, or coverages. The Board of Trustees' decisions on eligibility requirements and Plan provisions shall be final and binding upon all affected parties.

The schedule of Benefits listed below is for the Retired Medicare Employee and his or her dependents.

	BENEFIT	EMPLOYEE	DEPENDENT
1.	Life Insurance	$1,500	None
2.	Accidental Death	$1,500	None
3.	First Hospital Confinement	$52	$52
4.	Hospital Confinements between 61 and 90 days (Daily Rate)	$13	$13
5.	Out-patient hospital charges for emergencies due to accident	$20	$20
6.	Up to the first $50.00 of Surgery plus 20% of co-insurance on the balance using a $300.00 surgery schedule as a basis for determining the benefit payable.		
7.	Retirees' insured dependents under the age of 65 can be covered under the Early Retired Employees Program.		
8.	The retired Employee, for his or her own protection, should enroll himself or herself and his or her dependent for Medicare and the Supplemental Medical Insurance when they are eligible for these coverages.		

14. Medicare

Any Participant or dependent who has attained age 65 will be considered to be covered by Part A (Hospital Insurance Benefits) and Part B (Supplemental Medical Insurance Benefits) of Health Insurance for the Aged, Title XVII of the Social Security Act (Medicare) as of the first day of the month in which the Participant or dependent's 65th birthday occurs, regardless of whether the Participant or dependent actually enrolls for such Medicare benefits, and the following shall apply to such Participant or dependent:

> To the extent that the benefits of the Program are provided under Medicare Part A and Part B, they shall not be provided under the Program.

It is most important that any member of dependent who is approaching age 65 enroll for Medicare, by going to the nearest Social Security office during the three-month period before his or her 65th birthday, and thus avoid a serious gap in this protection against medical expenses.

Participants who are eligible for Medicare should consider electing Medicare coverage under Medicare Part B. If the Participant rejects Part B coverage, the Plan will treat his or her coverage as if he or she had selected such coverage. Once the Participant is Medicare eligible, unless he or she is actively working as explained below, Medicare is the primary provider of coverage and this Plan becomes a secondary provider. The Plan, as a secondary provider, will only pay for benefits if provided by the Plan that are not otherwise covered by Medicare.

Active Participants. As required under the Tax Equity and Fiscal Responsibility Act (TEFRA), the Plan will offer to actively working Participants over the age of 65 (Medicare eligible) or Participants who are on Medicare by reason of disability and their covered Dependents, the same benefits as are available to non-Medicare Participants and their Dependents. The actively working Participant may choose to be covered under the Plan's group medical plan if otherwise eligible. Medicare will then become the secondary provider of coverage. An actively working Participant is one who has a current employment status in the industry employing his trade as set forth in the Code of Federal Regulations, Section 411.104. If a Participant who is disabled and under the age of 65 and is Medicare eligible has a spouse who is covered under a large group health plan provided by reason of employment, then the spouse's insurance is the primary payer and Medicare is the secondary payer. Any benefits then-currently offered to active and early retired Participants, which are not provided for under Medicare, shall be paid to an eligible actively working Participant even though the Participant is Medicare eligible.

Plan rules are subject to change at any time in the sole and exclusive discretion of the Trustees.

15. Filing a Claim for Benefits

15.1 How to File Claims for Medical Benefits

The procedures to properly file a claim are constantly changing in order to ensure more efficient and timely processing of your benefits. You will be provided with any future changes to the procedures in a separate document. When you receive health care services:

- Show your identification card to the service provider; and
- Ask the provider to file a claim for you.

If the provider of the medical service is a Participating Provider in the PPO Network, he or she will submit all necessary claim information to Anthem on your behalf. Anthem will forward the claims to the Fund's Administrative Office to be reviewed and paid. The Fund's Administrative Office will provide reimbursement from the Fund to the provider directly.

If you do not use a provider who is part of the PPO Network, you may have to submit a claim for benefits directly to the Fund. If you must submit a claim for health care services received, you should:

- Obtain an itemized bill from the hospital, doctor, medical facility, dentist or vision facility;
- Obtain a claim form from the Fund's Administrative Office;
- Complete the claim form and attach the itemized bill to the form; and
- Send the claim form and bill to the address on the claim form.

An itemized bill generally includes all of the following:

- Participant's name and address;
- Patient's name and address;
- Date of Service;
- Type of Service and diagnosis;
- Itemized charges; and
- Provider's complete name, address and tax identification number.

Payment for eligible benefits will be made to the health care provider unless your claim includes a paid receipt. If a receipt is submitted with your claim, payment will be sent to you.

A claim is not filed until received by the Plan.

15.1.1 Benefit Determination for Urgent Care Claims

What is an Urgent Care Claim?

An Urgent Care Claim is a claim for medical care or treatment for which applying the time periods for making non-urgent care determinations:

- Could seriously jeopardize the life or health of the patient, or the patient's ability to retain maximum function; or

- In the opinion of a physician with knowledge of the patient's medical condition, would subject the patient to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

The Plan will only consider a claim to be an Urgent Care Claim if:

- An individual acting on behalf of the plan, possessing an average knowledge of health and medicine, determines the claim to be an Urgent Care Claim; or

- A physician with knowledge of the patient's medical condition determines the claim to be an Urgent Care Claim.

When will the Plan make a Benefit Determination for an Urgent Care Claim?

The Plan will notify you of its benefit determination for an Urgent Care Claim no later than 72 hours after it receives the claim, unless you fail to provide enough information for the Plan to make a benefit determination.

If you do not provide information required to make a benefit determination, the Plan will notify you, no later than 24 hours after it receives the claim, of the specific information necessary to make the determination. You will then have 48 hours to provide the requested information. The Plan will notify you of its benefit determination no later than 48 hours after the earlier of:

- The receipt of the requested information; or

- The end of the period you were afforded to provide the requested information.

The Fund's Administrative Office will notify you if your claim is denied in whole or part with an explanation of the reasons for the denial. This notification, which is called a Notice of the Adverse Benefit Determination, shall be in writing and will contain the information described in Section 15.7.

15.1.2 Benefit Determination for Pre-Service Claims

What is a Pre-Service Claim?

A Pre-Service Claim is a claim for medical care or treatment for which the Plan requires advance approval of the benefit.

When will the Plan make a Benefit Determination for a Pre-Service Claim?

If the Pre-Service Claim provides all the information the Plan needs to make a benefit determination, the Plan will notify you of its determination no later than 15 days after it receives the claim. If, due to matters beyond the Plan's control, the Plan cannot make a benefit determination within 15 days, the Plan may extend this period by 15 days, so long as it notifies you of the circumstances requiring the extension, and the date by which the Plan expects to make a determination.

If the Pre-Service Claim is missing information, the Plan will notify you no later than 15 days after it receives the claim, and will specifically describe the required information. You will then have 45 days to provide the requested information.

The Fund's Administrative Office will notify you if your claim is denied in whole or part with an explanation of the reasons for the denial. This notification, which is called a Notice of the Adverse Benefit Determination, shall be in writing and will contain the information described in Section 15.7.

15.1.3 Benefit Determination for Post-Service Claims

What is a Post-Service Claim?

A Post-Service Claim is a claim for medical care or treatment that is not a Pre-Service Claim.

When will the Plan make a Benefit Determination for a Post-Service Claim?

If the Post-Service Claim provides all the information the Plan needs to make a benefit determination, the Plan will notify you of its determination no later than 30 days after it receives the claim. If, due to matters beyond the Plan's control, the Plan cannot make a benefit determination within 30 days, the Plan may extend this period by 15 days, so long as it notifies you of the circumstances requiring the extension, and the date by which the Plan expects to make a determination.

If the Post-Service Claim is missing information, the Plan will notify you within 30 days after it receives the claim, and will specifically describe the requested information. You will then have 45 days to provide the requested information.

The Fund's Administrative Office will notify you if your claim is denied in whole or part with an explanation of the reasons for the denial. This notification, which is called a Notice of the Adverse Benefit Determination, shall be in writing and will contain the information described in Section 15.7.

15.1.4 Benefit Determination for Concurrent Care

What is Concurrent Care?

Concurrent Care is an ongoing course of treatment that the Plan already approved for a certain period of time or number of treatments.

When will the Plan make a Benefit Determination regarding Concurrent Care?

If the Plan decides to reduce or terminate your Concurrent Care (other than by Plan amendment or termination), the Plan will notify you before the end of the previously approved period of time or number of treatments, sufficiently in advance of the reduction or termination, to allow you to appeal and obtain a determination on review before the benefit is reduced or terminated.

If you request to extend the Concurrent Care beyond the period of time or number of treatments that, the request will be determined as an Urgent Care Claim (see Section 15.1.1) or Pre-Service Claim (see Section 15.1.2).

The Fund's Administrative Office will notify you if your claim is denied in whole or part with an explanation of the reasons for the denial. This notification, which is called a Notice of the Adverse Benefit Determination, shall be in writing and will contain the information described in Section 15.7.

15.2 Claims Under Prescription Program

You will receive a personalized Prescription Benefits Identification Card once you become eligible in this Fund. You must present your Prescription Benefits Identification Card along with your doctor's prescription to any participating pharmacy.

The pharmacist will fill the prescription and charge you the co-payment, which is the amount you pay. The pharmacist will generally ask you to sign the form to indicate that you received the prescription. It is permissible for any of your eligible Dependents to present your identification card with a prescription to the pharmacist and sign for receipt of the prescription. This point of sale purchase of a prescription is not a claim for benefits. If you do not receive your prescription at the retail pharmacy due to a denial of coverage, you need to contact the Administrative Office to make a claim for benefit coverage.

If you elect to have your prescription filled by a pharmacy other than a participating pharmacy, do not use your Prescription Benefits Identification Card. Follow the Claim Reimbursement Procedure described herein to obtain reimbursement of prescription expenses.

You can obtain a Direct Reimbursement form from the Fund's Administrative Office. You are to complete the top portion. Either have the pharmacist complete the remainder of the form or attach an itemized receipt that includes all of the requested information. Pay the charge for the prescription in full to the pharmacy and mail the completed form to Rx Option's address on the form. Reimbursement will be made directly to you by on the same basis as benefits would have been paid to a participating pharmacy.

If you are not eligible for benefits at the time you contact the pharmacy or in the event that the prescription is not a covered drug under the Fund, you must contact the Fund's Administrative Office for additional information. The Fund's Administrative Office will review your claim for benefits and if the claim is denied in whole or part, provide you with a Notice of the Adverse Benefit Determination in writing that contains the information listed in Section 15.7.

15.3 How to File a Claim for Weekly Indemnity Benefits

Claims should be submitted to the Fund's Administrative Office as soon as possible; do not delay in filing any claims. Claims submitted must be accompanied by any information or proof requested and reasonably required to process such claims. You must obtain a claim form from the Fund's Administrative Office to be completed by you and your treating physician. This documentation should be completed as soon as possible in order to begin receiving your weekly benefits after you complete the waiting period.

The Fund's Administrative Office will make a decision on the claim and notify you of the decision within 45 days. If the Fund requires an extension of time due to matters beyond its control, you will be notified of the reason for the delay and when the decision will be made. This notification will occur before the expiration of the 45-day period. A decision will be made within 30 days of the time the Fund's Administrative Office notifies you of the delay. If the Fund's Administrative Office needs additional information from you to make its decision, you will be notified as to what information must be submitted. You will have at least 45 days to submit the additional information. Once the Fund's Administrative Office receives the information from you, you will be notified of the decision on the claims within 30 days.

In the event that your claim for benefits is denied in whole or part, the Fund's Administrative Office will provide you with a Notice of the Adverse Benefit Determination in writing that contains the information listed in Section 15.7.

15.4 How to File Claims for Life Insurance and Accidental Death and Dismemberment Benefits

Claims should be submitted to the Fund's Administrative Office as soon as possible; do not delay in filing any claims. Claims for Death, Accidental Death and Accidental Dismemberment benefits will be provided through the Fund's Administrative Office. Claims submitted must be accompanied by any information or proof requested and reasonably required to process such claims. This will generally include a death certificate and documentation to establish the death or dismemberment is the result of an accident.

Generally, the Fund's Administrative Office will notify your beneficiary of the decision on the claim for benefits within 90 days. In the event that the Fund's Administrative Office needs additional time to review the claim for benefits or needs additional information, he or she will be provided with the information on the status prior to the expiration of the initial 90-day period.

When the claim for life insurance benefits falls within the Fund's exclusions, your beneficiary will be notified by the Administrative Office that the claim is denied with an explanation of the reasons for the denial. He/ she will receive a Notice of the Adverse Benefit Determination in writing that contains the information listed in Section 15.7.

15.5 Proof of Claims

Written proof of claims for payment of Covered Services must be furnished as soon as you have incurred covered expenses. Itemized copies of your bills should be sent with the claim form. **All claims must be submitted by you or the Provider no later than 90 days from the date on**

which the services were incurred. Failure to furnish the claim within that time will neither invalidate nor reduce any claim if it is shown that it was not reasonably possible to furnish written proof of the claim within that time period and that written proof was provided as soon as reasonably possible. **However, all claims must be filed within one (1) year from the date the claim was incurred and if they are not submitted, they will be denied as untimely.**

No action at law or in equity shall be brought to recover on your claim prior to the exhaustion of the reasonable claims and appeals procedures set forth in this Section. Additionally, no action shall be brought at all unless brought within three (3) years from the expiration of the time which the proof of claim is required.

15.6 Physical Examination

The Fund at its own expense shall have the right and opportunity to examine an individual for whom benefits are being claimed under this Fund when and so often as the Trustees may reasonably require while a claim is pending. Unless otherwise legally prohibited, the Trustees are entitled to an autopsy in the case of death.

15.7 Benefit Determination Notices

The Fund's Administrative Office will notify you if your claim is denied in whole or part with an explanation of the reasons for the denial. This notification, which is called a Notice of the Adverse Benefit Determination, shall be in writing and will contain the following:

- The specific reasons for the adverse benefit determination;
- Reference to the specific Plan provisions on which the adverse benefit determination was based;
- A description of any additional material or information necessary to process the claim and an explanation of why such material or information is necessary;
- Notice of any internal guidelines or protocols used in making the decision, if applicable, and your right to receive a copy;
- Notice of the availability of, and contact information for, an applicable office of consumer assistance established under the Public Health Service Act section 2793, if one is available;
- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to you upon written request;
- If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon

request; and

- A description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on review.

A Notice of Adverse Benefit Determination regarding a disability claim must also include:

- Either the specific internal rules, guidelines, protocols, standards, or other similar criteria the Plan relied upon in making the adverse determination, or, alternatively, a statement that such rules, guidelines, protocols, standards, or other similar criteria of the plan do not exist; and

- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits.

A document, record, or other information is "relevant" to your claim if such document, record, or other information:

- Was relied upon in making the benefit determination;

- Was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination;

- Demonstrates compliance with the administrative processes and safeguards in making the benefit determination; or

- Constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for your diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

16. Coordination of Benefits – Order of Benefit Determination

A policy covering a person as an employee will pay benefits first. A policy covering a person as a dependent will pay second.

If a dependent child is covered by both parents' policies, the benefits of the policy, which covers the child, of the parent whose date of birth, excluding year of birth, occurs earlier in a calendar year will be determined first. The benefits of the policy, which covers the child, of the parent whose date of birth, excluding year of birth, occurs later in a calendar year, will be determined second.

When the parents are divorced or separated, the order is:

a) The policy of the parent with custody pays first. The policy of the parent without custody pays second.

b) If the parent with custody has remarried, the order is:

   1. The policy of the parent with custody;

   2. The policy of the step-parent;

   3. The policy of the parent without custody.

If a court decree states that one parent is responsible for the child's health care expenses, that parent's policy will pay first. That order will supersede any order given in a) or b).

If a person is covered under more than one policy, the policy he or she was covered under longer pays first. The exception to this rule is:

> A group policy that covers a person other than as a laid-off or retired employee, or dependent of such person, will determine the benefits that are paid first. A group policy that covers a person as a laid-off or retired employee, or dependent of such person will determine the benefits that are paid first. A group policy that covers a person as a laid-off or retired employee, or dependent of such person, will determine the benefits that are paid second.

17. Subrogation

The Fund will take advantage of its right to subrogation if you or your dependent is paid benefits by the Plan due to any injury or illness arising from the acts or omissions of any person or entity, or under any no-fault coverage (for the purpose of Section 17, "Other Coverage").

The term Covered Person as used in Section 17 shall include the employee, participant, or any eligible dependent as defined elsewhere in the Plan, and any person or party acting for, or on behalf, of any such employee, participant, or eligible dependent.

17.1 Subrogation

In the event of any payment under the Plan, the Plan shall, to the extent of such payment, be subrogated to all the rights of recovery of a Covered Person arising from the acts or omissions of any person or entity, or any Other Coverage. The Plan is subrogated to all rights of recovery of a Covered Person regardless of whether the Covered Person obtains a full or partial recovery from such person, entity or Other Coverage. The Plan's subrogation interest shall take priority over any and all rights of recovery held by a Covered Person against such person, entity, or Other Coverage arising out of the event(s) that triggered the Plan's payment of Medical Benefits. The Plan's subrogation interest shall apply regardless of whether the Covered Person has incurred fees or costs in order to obtain a recovery from any person, entity, or Other Coverage. The "make-whole" rule shall not apply.

In the event the Plan has a subrogated interest or right of recovery, no Covered Person shall release any party, person, corporation, entity, insurance company, insurance policies, or funds that may be liable or obligated to the Covered Person for the acts or omissions of any person or entity without the written approval of the Plan.

In the event a Covered Person pursues a claim against any person, entity or Other Coverage, the Covered Person agrees to include the Plan's subrogated interest and rights of recovery in that claim, and if there is a failure to do so, the Plan shall be legally presumed to be included in such claim. In the event a Covered Person does not pursue a claim against any person, entity or Other Coverage, the Plan shall have the right to pursue, sue, compromise, or settle any such claims in the Covered Person's name and to execute any and all documents necessary to pursue said claim in the Covered Person's name.

17.2 Reimbursement

Each Covered Person hereby agrees to reimburse the Plan, for any Medical Benefits paid by the Plan, out of any money recovered from any person, entity or Other Coverage as the result of judgment, settlement, or otherwise, regardless of how the money is classified. The Plan has the right to be reimbursed in an amount equal to the amount of Medical Benefits paid hereunder, regardless of whether the Covered Person obtains a full or partial recovery from such person, entity or Other Coverage. The Plan shall be reimbursed on a first priority basis, regardless of whether or not the Covered Person has been or will be made whole and regardless of whether the Covered Person has incurred fees or costs in order to obtain a recovery from any person, entity, or Other Coverage.

17.3 The "Make-Whole" Rule Shall Not Apply

In the event a Covered Person settles, recovers, or is reimbursed by any person, entity, or Other Coverage, the Covered Person shall hold any such money in trust for the benefit of the Plan. If a Covered Person fails to reimburse the Plan in accordance with this provision, the Covered Person shall be liable to the Plan for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Covered Person. Each Covered Person also agrees to execute and deliver all necessary instruments, to furnish such information and assistance, and to take any action the Plan Administrator may require to facilitate enforcement of its rights under this Plan.

The Plan will not pay or be responsible for, without the written consent of the Board of Trustees, any fees or costs associated with a Covered Person pursuing a claim against a third party or any other coverage. The Plan's subrogation interest and the Plan's reimbursement interest shall not be subject to offset for any fees or costs associated with a Covered Person pursuing a claim against a third party or any other coverage.

You are also advised that when submitting a claim to this Plan for injury or illness, you will be required to complete and execute a form with the following information:

1. How the injury or illness occurred;

2. The identity of any potentially responsible third parties, including their insurer, adjusters, and claim numbers;

3. Accident reports; and

4. An assignment of your beneficial interest in any monetary recovery as a result of such injury or illness, to the extent of the Plan's subrogated interest.

You may also be required to sign other documents and do whatever is reasonably necessary to secure this Plan's Right of Subrogation. The Plan is entitled to full reimbursement prior to any other disbursement of any recovery, including fees and/or expenses.

Neither you nor your eligible dependent(s) shall do anything to impair or negate this Plan's Right of Subrogation. If you or your eligible dependent(s) perform any act or fail to act, and such should compromise the Plan's Right of Subrogation in full, this Plan will immediately seek reimbursement of all benefit amounts paid in that regard either by legal action or otherwise.

Furthermore, the Plan shall have the right to offset any future benefit payments to either you or your eligible dependent(s) in the amount of any outstanding lien.

If the Plan should provide benefits to you or your eligible dependent(s) and, for whatever reason, such payment is not required under the terms of this Plan, the Plan shall have the right to offset any future benefit payments to either you or your eligible dependent(s), in the amount of any mistaken payment. The Plan may recover mistaken payments in any other lawful manner as well.

17.4 Rescission of Benefits

In accordance with the Patient Protection and Affordability Care Act ("PPACA"), the Fund will only "rescind", or cancel, or discontinue coverage retroactively in cases where a Participant or the Participant's Eligible Dependent (or a person seeking coverage on behalf of such individual) has performed an act, practice, or omission that constitutes fraud, or in cases where such an individual makes an intentional misrepresentation of a material fact, as prohibited by the terms of the Fund. If the Fund seeks to rescind benefits on such grounds, it will provide the individual with thirty (30) calendar days' advance written notice prior to rescission, along with information about appeal rights. Please note that a retroactive termination of coverage due to a Participant's failure to timely pay premiums is not a rescission.

17.5 Recovery of Overpayment

If the Fund makes an overpayment, the Fund may, at any time:

- Recover the overpayment from the party to whom it made the overpayment or the party on whose behalf it made the overpayment; or

- Offset the overpayment amount from future claim payment(s).

By accepting benefits and/or assignment of benefits under the Plan, you:

- Create an equitable lien by agreement under which the Fund may seek recovery of any overpayment; and

- Agree that the Fund, in seeking recovery of any overpayment, may pursue your general assets, and/or the assets of the entity to whom or on whose behalf the Fund made the overpayment.

18. Family and Medical Leave Act of 1993

The Family and Medical Leave Act of 1993 ("FMLA") was enacted on February 5, 1993 and became effective on February 5, 1994. Generally, FMLA requires your employer to provide you with up to twelve (12) weeks of unpaid leave during any twelve (12) month period for specified family and medical reasons, if you are eligible. During the period, your employer must provide health coverage for you on the same terms and conditions that you would receive if you continued to work.

To be eligible for leave under FMLA, you must work for the same contributing employer for at least twelve (12) months and for at least 1,250 hours during the twelve (12) month period before the leave begins. Generally, your employer is obligated to provide Family and Medical leave only if your employer employs fifty (50) or more employees each working day during each of twenty (20) or more work weeks during the current or preceding calendar year.

During the FMLA leave, your employer must make contributions to the Fund on your behalf so that your health coverage will be continued. Federal law requires that you received continued eligibility.

A covered employer must grant an eligible Participant up to a total of twelve (12) workweeks of unpaid leave during any twelve (12) month period for one or more of the following reasons:

- For the birth or placement of a child for adoption or foster care;
- To care for an immediate family member (spouse, child or parent) with a serious health condition; or
- To take medical leave when the Active Participant is unable to work because of a serious health condition.

Eligible employees are entitled to up to twelve (12) weeks of leave because of "any qualifying exigency" arising out of the fact that the spouse, son, daughter, or parent of the employee is on active duty, or has been notified of an impending call to active duty status, in support of a contingency operation.

An eligible employee who is the spouse, son, daughter, parent, or next of kin of a covered service member who is recovering from a serious illness or injury sustained in the line of duty on active duty is entitled to leave up to twenty-six (26) weeks in a single twelve (12) month period to care for the service member. This military care giver leave is available during "a single twelve (12) month period" during which an eligible employee is entitled to a combined total of twenty-six (26) weeks of all types of FMLA leave.

Arrangements will need to be made for Active Participants to pay their share of health insurance premiums while on leave.

Upon return from FMLA leave, an Active Participant must be restored to his or her original job or to an equivalent job. In addition, an Active Participant's use of FMLA leave cannot result in the loss of any employment benefit that the employee earned or was entitled to before using FMLA

leave.

Please contact the Fund office if you have any questions regarding your options under the FMLA.

Repayment of Contributions to Employer.

If you take leave under the FMLA and you fail to return to your Employer for any reason after such absence under the Act, your Employer has the right to collect all contributions made on your behalf during such leave of absence. Thus, to ensure your continuing coverage under this Plan and to prevent possible repayment of all contributions to your employer, you should return to work at the end of your leave under the FMLA.

19. Appeal Procedures

19.1 Review Procedure for Claims Under the Fund

You or your authorized representative may appeal the Fund's decision to deny any claim for medical, weekly indemnity or life insurance/accidental death and dismemberment benefits, in whole or part. You may also appeal any point of service purchase of prescription benefits which is not covered at the pharmacy through these Appeal Procedures. If you are not handling your own claim, then you must designate, in writing, an authorized representative to act on your behalf and the extent of the person's authority must be clearly indicated in the authorization.

19.2 First Level Review

You may file a written notice of appeal to the Administrative Manager for the Board of Trustees at any time within 180 days after the mailing of the Notice of Adverse Benefit Determination. The written notice only needs to state your name, address, social security number, phone number, and the fact that you are appealing from the decision of the Fund's Administrative Office, giving the date of the Notice. The Appeal should be addressed as follows:

Administrative Manager
Mahoning & Trumbull County Building Trades Insurance Fund
3660 Stutz Drive, Suite 101
Canfield, OH 44406

Under the appeal process, there will be a full and fair review of the claim in accordance with applicable law. The first level review will consider all comments, documents, medical records and other information submitted by you and your provider relating to the appeal, without regard to whether such information was submitted or considered in the initial benefit determination.

The first level review of an adverse benefit determination that is based in whole or part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate shall include consultation with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment.

During the appeals process, you will also be afforded access to all relevant information related to your claim for benefits and its denial and may submit written issues and comments pertinent to the appeal. The health care professional engaged for purposes of this consultation shall be an individual who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such person.

You will be provided with the identification of medical and/or vocational experts whose advice was obtained in connection with your adverse benefit determination, regardless of whether the advice was relied upon in making the benefit Additionally, you or your authorized representative may submit additional information prior to any determination on your appeal.

19.2.1 Urgent Care Claims

You are entitled to an expedited review process for Urgent Care Claims (as defined in Section

15.1.1). You may request an expedited appeal orally or in writing, and all necessary information, including the Fund's benefit determination on review, shall be transmitted to you by telephone, facsimile, or other available similarly expeditious method.

The Fund will notify you of its benefit determination on review no later than 72 hours after the Fund receives your request for review.

19.2.2 Pre-Service Claims

The Fund will notify you of its benefit determination on review for Pre-Service Claims no later than 30 days after the Fund receives your request for review.

19.2.3 Post-Service Claims

The Fund will notify you of its benefit determination on review for Post-Service Claims no later than 5 days after the benefit determination on review is made.

The Fund will make a benefit determination on review for Post-Service Claims no later than the date of the Board of Trustees meeting that immediately follows the Fund's receipt of your request for review, unless the request for review is received within 30 days preceding the date of that meeting. In such case, the Fund will make a benefit determination no later than the date of the second meeting. If special circumstances require additional time for the Fund to make a determination and the Fund provides you with written notice of the circumstances and date on which the Fund will make the determination, the Fund will make a benefit determination no later than the date of the third meeting.

19.2.4 Disability Claims

The Fund will notify you of its benefit determination on review for Disability Claims no later than 5 days after the benefit determination on review is made.

The Fund will make a benefit determination on review for Disability Claims no later than the date of the Board of Trustees meeting that immediately follows the Fund's receipt of your request for review, unless the request for review is received within 30 days preceding the date of that meeting. In such case, the Fund will make a benefit determination no later than the date of the second meeting. If special circumstances require additional time for the Fund to make a determination and the Fund provides you with written notice of the circumstances and date on which the Fund will make the determination, the Fund will make a benefit determination no later than the date of the third meeting.

19.2.5 Benefit Determination on Review Notices

The Fund will notify you if your appeal is denied in whole or part with an explanation of the reasons for the denial. This notification, which is called a Notice of the Benefit Determination on Review, shall be in writing and will contain the following:

- The specific reason for the denial;
- The sections of the Plan and/or Summary Plan Description upon which the denial was based;
- A statement advising you of any internal guidelines or protocol used in making the decision, if applicable, and your right to receive a copy;

- A notice of your right to receive, upon written request, free of charge, copies of all documents, records, and other information relevant to your claim;
- If an internal rule, guideline, protocol or similar criteria was relied upon in making the adverse benefit determination, this will be disclosed, or you will be advised that information about the rule, guideline, protocol or similar criteria will be provided free of charge upon written request;
- If the adverse benefit determination was based on a medical necessity, experimental treatment, or similar exclusion or limit, an explanation of the scientific or clinical judgment used for the determination applying the terms of the Plan to your circumstances will be disclosed, or you will be advised that this explanation will be provided free of charge upon request;
- A notice of your right to bring a civil action under ERISA Section 502(a); and
- A notice of your right to file a second level appeal to the Benefits Committee of the Board of Trustees.

For disability claims, notices on appeal will contain the following additional information:

- An explanation as to why the Plan disagreed with the views of (i) health care or vocational professionals who evaluated you or advised the Plan, or (ii) a disability determination of the Social Security Administration.
- If a denial is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination or a statement that such explanation will be provided free of charge upon request.
- Either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in denying the claim or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist or were not used.
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim.
- If the denial is a final internal denial, a statement of your right to bring an action under Section 502(a) of ERISA, including a description of any applicable contractual limitations period that applies to your right to bring such an action, including the calendar date on which the contractual limitations period expires for the claim.
- Denial notices will be provided in a culturally and linguistically appropriate manner.

19.3 Second Level Review

You may file a written notice of appeal to the Benefits Committee for the Board of Trustees at any

time within sixty (60) days after the mailing of the Notice of Denial of the First Level Review. The written notice only needs to state your name, address, phone number, social security number and the fact that you are appealing from the decision of the Fund's Administrative Manager, giving the date of the Notice. The Appeal should be addressed as follows:

Benefits Committee
Mahoning & Trumbull County Building Trades Insurance Fund
3660 Stutz Drive, Suite 101
Canfield, OH 44406

During the appeals process, you will also be afforded access to all relevant information related to your claim for benefits and its denial and may submit written issues and comments pertinent to the appeal. Additionally, you or your representative may submit additional information prior to any determination on your appeal.

If an appeal requires medical judgment, the Benefits Committee shall consult an appropriate health professional and will disclose the identity of such individual to you upon request.

If the Benefits Committee denies your second level appeal, you will receive a notice with the information provided in Section 19.2.5.

The decision of the Benefits Committee for the Board of Trustees is final and binding.

19.3.1 Pre-Service Claims

The Fund will notify you of the Benefits Committee's decision regarding your second level appeal of a Pre-Service Claim no later than 30 days after the Fund receives your request for review.

19.3.2 Post-Service Claims

The Fund will notify you of the Benefits Committee's decision regarding your second level appeal of a Post-Service Claim no later than 5 days after the benefit determination on review is made.

The Benefits Committee will make a decision regarding your second level appeal of a Post-Service Claim no later than the date of the Board of Trustees meeting that immediately follows the Fund's receipt of your request for review, unless the request for review is received within 30 days preceding the date of that meeting. In such case, the Benefits Committee will make a benefit determination no later than the date of the second meeting. If special circumstances require additional time for the Benefits Committee to make a determination and the Fund provides you with written notice of the circumstances and date on which the Benefits Committee will make the determination, the Benefits Committee will make a benefit determination no later than the date of the third meeting.

19.4 Voluntary Appeal to The Board of Trustees

Once you have filed your appeal through the two levels of review, you have the right to file a lawsuit in federal court. However, prior to instituting federal court action, you can file a voluntary appeal to the full Board of Trustees. You must file the Notice of Voluntary Appeal to the Board of Trustees within sixty (60) days of the mailing Notice of Final Decision by the Benefits

Committee. The Appeal should be addressed as follows:

Board of Trustees
Mahoning & Trumbull County Building Trades Insurance Fund
3660 Stutz Drive, Suite 101
Canfield, OH 44406

19.4.1 Pre-Service Claims

The Fund will notify you of the Board of Trustees' decision regarding your appeal of a Pre-Service Claim no later than 30 days after the Fund receives your request for review.

19.4.2 Post-Service Claims

The Fund will notify you of the Board of Trustees' decision regarding your appeal of a Post-Service Claim no later than 5 days after the benefit determination on review is made.

The Board of Trustees will make a decision regarding your appeal of a Post-Service Claim no later than the date of the Board of Trustees meeting that immediately follows the Fund's receipt of your request for review, unless the request for review is received within 30 days preceding the date of that meeting. In such case, the Board of Trustees will make a benefit determination no later than the date of the second meeting. If special circumstances require additional time for the Board of Trustees to make a determination and the Fund provides you with written notice of the circumstances and date on which the Board of Trustees will make the determination, the Board of Trustees will make a benefit determination no later than the date of the third meeting.

19.4.3 Your Rights Upon Filing a Voluntary Appeal

In the event that you file a voluntary appeal with the Board of Trustees:

1. You are entitled to a full and fair review of your claim. The appeal will take into account all comments, documents, records and other information submitted by you and your provider(s) relating to the claim without regard to whether such information was submitted or considered in the internal mandatory appeal.

2. The Fund will not assert a failure to exhaust administrative remedies;

3. The Fund agrees that any Statute of Limitations applicable to pursuing the claim in court will be tolled during the period of the voluntary appeal process;

4. The Fund requires that the voluntary level of appeal is available only after the Claimant has pursued the required appeal(s);

5. Upon request, you will be provided sufficient information relating to the voluntary level of appeal to enable you to make an informed decision about whether to submit a benefit dispute to this procedure including:

    - A statement that using this procedure will have no effect on your right to receive other

benefits under this Fund;

- A statement that you have the right to have a personal representative with regard to your claim;

- A notice of any circumstances which may impair the impartiality of the Board of Trustees;

6. The Fund will not impose any fees or costs on you as part of this voluntary appeal process.

In the event the denial is upheld, you will receive a written notice which includes the information listed in Section 19.2.5.

19.5 Rules Regarding Appeals for Weekly Indemnity Benefit Claims

If you are appealing a denial/adverse benefit determination of a claim for Weekly Indemnity Benefits, the following provisions will apply:

All notices of an Adverse Benefit Determination will include:

a. An explanation as to why the Plan disagreed with the views of (1) a health care or vocational professional who evaluated the claimant or advised the Plan or (2) a disability determination of the Social Security Administration.

b. If an Adverse Benefit Determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination or a statement that such explanation will be provided free of charge upon request.

c. If the Adverse Benefit Determination is following a Second Level Review or Voluntary Appeal to the Board of Trustees, the calendar date by which the claimant must file a civil action under ERISA Section 502(a).

Adverse Benefit Determination Notices will be provided in a culturally and linguistically appropriate manner.

The Plan's decision to hire, compensate, terminate or promote any individual such as a claims adjudicator or medical or vocational expert, will not be based on the likelihood that the individual will support a denial of benefits.

Before the Plan denies an appeal, the Plan Administrator will provide the claimant, free of charge, with any new or additional rationale or evidence considered, relied upon, or generated by the Plan. Any such rationale or evidence will be provided to the claimant sufficiently in advance of the date on which a notice of decision is required to give the claimant a reasonable opportunity to respond prior to that date.

19.6 Limitation of Actions Under ERISA Section 502(A)

No civil action under ERISA Section 502(a) can be filed in any court against the Plan more than three (3) years (i.e., thirty-six months) after the initial denial of a claim for benefits.

19.7 Choice of Law and Venue

An Employee, Participant, Retiree, Pensioner, Beneficiary, Dependent, Surviving Spouse, or any other individual or entity asserting any right under this Plan, or hereby bound directly or indirectly or with rights or obligations hereunder, shall only bring an action in connection with the Plan exclusively in the United States District Court for the Northern District of Ohio at Youngstown, Ohio.

This Plan shall be construed under and in accordance with the law and the laws of the United States of America. In the event there is a matter involving state law which is not preempted by federal law, Ohio law shall be the controlling state law.

20. Personal Care Accounts

20.1 Establishment and Maintenance of Personal Care Accounts

The Trustees have established Personal Care Accounts, also known as medical reimbursement accounts, ***only*** for Participants for whom contributions are made pursuant to collective bargaining agreements. Review your employer's collective bargaining agreement to determine if your employer is required to make contributions on your behalf.

Medical expenses not covered elsewhere will be paid to the Participant's Medical Reimbursement Account as provided herein.

Spouses and Dependents of deceased Participants may continue to be reimbursed for medical care expenses up to an amount equal to the unused reimbursement amount remaining at the time of death.

These contributions do not create or constitute a vested benefit.

20.2 Eligible Medical Expenses

Reimbursable medical expenses are those medical expenses identified in Internal Revenue Code ("Code") §213 which have not been paid under the Mahoning and Trumbull County Building Trades Insurance Fund or other plan or arrangement. Such expenses, to the extent the participant has funds in his/her individual Personal Care Account, include, but are not limited to:

- Deductibles and co-payments applied to covered medical expenses under any qualified hospitalization plan or a qualified plan or a qualified plan of a dependent spouse;
- Self-payments to maintain eligibility under any qualified hospitalization plan or premium or other payments required to maintain coverage under the Plan of an Employee's Spouse;
- Unreimbursed prescription medicines (prescribed by a doctor), including co-pays;
- Unreimbursed medical services fees (from doctors, chiropractors, dentists, surgeons, registered nurses, specialists, and other medical practitioners);
- Unreimbursed special items (artificial limbs, eyeglasses, contact lenses, hearing aids, crutches, wheelchair, etc.);
- Unreimbursed treatment at a drug or alcohol center (includes meals and lodging provided by the center);
- Unreimbursed dental expenses;
- Any other medical expenses identified in Internal Revenue Code §213.

20.3 Ineligible Medical Expenses

Unreimbursable medical expenses are those medical expenses excluded by Internal Revenue Code ("Code") §213. Such expenses include, but are not limited to:

- Expenses for which the Employee claims or will claim a medical expense deduction on the Employee's tax returns;
- Expenses incurred before the Employee became Initially Eligible for medical benefits under this Mahoning and Trumbull County Building Trades Insurance Fund;
- Expenses incurred after termination of employment and eligibility.

Medical Expenses will be reimbursed only to the extent that reimbursement for such Medical Expenses is not available to the Eligible Person under any health insurance policy or plan provided through any employer of the Eligible Person. If there is such a policy or plan in effect, providing for reimbursement or payment in whole or in part, then to the extent of the coverage under such other policy or plan, the Plan shall be relieved of any liability hereunder.

20.4 Non-Covered or Excluded Expenses

The Plan will reimburse you for any and all claims for expenses which are considered non-covered and/or excluded by the Mahoning and Trumbull County Building Trades Insurance Fund or any other health and welfare fund or insurance plan, except for over-the-counter medicine or drugs unless prescribed by a physician or insulin. Such reimbursement shall be limited to the amount of the Participant's Personal Care Account balance.

20.5 How to Obtain Reimbursement

When an Eligible Employee or Dependent has unreimbursed medical expenses and a balance in the Employee's Medical Reimbursement Account, the Employee should submit proof of such out-of-pocket expenses on forms available (see Appendix) from the Fund:

3660 Stutz Drive, Suite 101
Canfield, OH 44406

Separate bills may be itemized on the same claim form. Forms must be accompanied by receipts for bills. The Fund will send reimbursement checks quarterly. Claims for medical expense reimbursement from Medical Reimbursement Accounts (also known as Personal Care Accounts) must be filed no later than twenty-four (24) months following the date of service. The Fund may assess an administrative fee against the Eligible Person's Account for processing reimbursement claims. Any unused balances in the Employee's Medical Reimbursement Account will be carried over to the next Plan Year, subject to provisions below about "Cancellation of Account" and "Changes."

Eligible Employees will also be issued a debit account card, called a BeneCard, to pay for eligible medical expenses which are not otherwise paid or payable by the Fund. BeneCards will be subject to an administrative fee. Payment for eligible medical expenses will be limited to the balance of

an Employee's Personal Care Account.

20.6 Earnings

Periodically, the Trustees may credit interest or other earnings, less administrative expenses, to Eligible Employees Personal Care Account.

20.7 Opt-Out/Cancellation of Account

Any Employee or former Employee, or the Spouse or Dependents of a deceased Employee, may at any time permanently opt-out of coverage and waive future reimbursement under this Section.

The account of any participant who is no longer working under the terms and conditions of the applicable collective bargaining agreement and who is otherwise available for employment in his/her trade shall be canceled and the balance of his/her account shall revert to the Fund's sub-trust for medical reimbursement, regardless if such participant waives future reimbursement as set forth above**.**

20.8 Changes

This Personal Care Account Program is based on existing law, as currently interpreted. If there are legislative changes, governmental announcements, or financial considerations which affect this Program, the Trustees reserve the right to change or cancel the Program, including cancellation of existing Personal Care Accounts. If the Program is to be discontinued or changed, the Trustees will provide Eligible Persons with as much written notice as possible.

21. Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

21.1 Effective Date

The effective date of this Notice is January 1, 2024.

21.2 Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say "no" if it would affect your care.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for

six years prior to the date you ask, who we shared it with, and why.

We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.

- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.

- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.

- We will not retaliate against you for filing a complaint.

21.3 Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care

- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we *never* share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

We will not use or disclose psychotherapy notes about you from your therapist without your written permission. However, we may use and disclose such notes when needed to defend against litigation filed by you.

21.4 Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Help manage the health care treatment you receive

We can use your health information and share it with professionals who are treating you.

Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

Example: We use health information about you to develop better services for you.

Pay for your health services

We can use and disclose your health information as we pay for your health services.

Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan

We may disclose your health information to your health plan sponsor for plan administration.

Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential

protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

21.5 Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

21.6 Changes to The Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

21.7 For Information on or to Exercise Your Individual Privacy Rights

For information on or to exercise your Individual Privacy Rights, contact:

Privacy Official
Mahoning and Trumbull County Building Trades Insurance Fund Plan
3660 Stutz Drive, Suite 101
Canfield, OH 44406
Phone: (330) 779-8861

22. Statement of Rights Under the Employee Retirement Income Security Act of 1974 (ERISA)

As a participant in the Plan, 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:

22.1 Receive Information About Your Plan and Benefits

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

22.2 Continue Group Health Plan Coverage

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

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

22.3 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.

22.4 Enforce Your Rights

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

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

22.5 Assistance with Your Questions

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

23. Appendix

Mahoning and Trumbull County Building Trades Insurance Fund
3660 Stutz Drive, Suite 101
Canfield, OH 44406
Phone: (330) 779-8861
Toll Free (800) 435-2388

AUTHORIZATION FOR DISBURSEMENT FROM
MEDICAL REIMBURSEMENT ACCOUNT
REQUEST FOR REIMBURSEMENT OF MEDICAL EXPENSES

EMPLOYEE NAME _____
ADDRESS _____
PHONE NO. _____
SOCIAL SECURITY NO. _____

I am requesting payment for the following charges for which I have not been reimbursed, and for which I have not and will not be claiming a federal income tax deduction:

AMOUNT OF DEDUCTIBLE	$ _____
AMOUNT OF CO-INSURANCE	$ _____
VISION CARE (attach receipts)	$ _____
DENTAL CARE (attach receipts)	$ _____
OTHER MEDICAL EXPENSES (attach receipts) (not covered by the Health & Welfare Fund)	$ _____
SELF PAYMENT BILLING (attach copy of billing)	$ _____

___ Check here if you elect to have your self-payment remitted directly to your health fund

Please complete the above, attach a copy of your EOB (Explanation of Benefits) from the Insurance Fund where applicable, and receipts showing payments were made for expenses not covered by the Insurance Fund, sign and return this form to:

Mahoning & Trumbull County Building Trades Insurance Fund
3660 Stutz Drive, Suite 101
Canfield, OH 44406
Phone: (330) 779-8861
Toll Free (800) 435-2388

All expenses submitted for a quarter will be reimbursed in the months of March, June, September and December. For example, claims received during the months of December, January and February will be reimbursed in March. Please call first to check the status of your account before filing large dollar claims and PLEASE MAKE A COPY FOR YOURSELF OF ALL CHARGES SUBMITTED IN THE EVENT OF LOSS.

EMPLOYEE SIGNATURE _____ DATE _____
****Not valid unless signed and dated by Employee****