Northwestern Ohio Plumbers & Pipefitters Local 50
Health & Welfare Plan
Summary Plan Description
Active and Retired Participants
Effective January 1, 2024

CONTENTS

PART I:
GENERAL INFORMATION

WHY AM I RECEIVING THIS SUMMARY PLAN DESCRIPTION?

The Northwestern Ohio Plumbers and Pipefitters Active and Retiree Health and Welfare Plans have been combined into one plan as of January 1, 2024, to better serve you. The New Northwestern Ohio Plumbers & Pipefitters Health & Welfare Plan is furnishing this Summary Plan Description ("SPD") to you so that you have a summary of your benefits. Additionally, Federal law requires that you, as a participant under the Plan (the "Participant") periodically be provided with an SPD. This SPD incorporates all the amendments and benefit updates. **This SPD will supersede and replace all prior Active and Retiree Plan SPDs, as well as any Summary of Material Modifications that you may have received since that time. This SPD is effective as of January 1, 2024.** You are advised to read this SPD in its entirety and keep it for your records.

As a reminder, this is only a summary of your benefits and rights. The legal rules that govern those benefits and rights are contained in the actual Plan Document. If you wish to view the Plan Document or obtain a copy of it, you can do so by contacting the Benefits Office, whose contact information is listed within this SPD. **In the event of any discrepancy or conflict between this SPD and the provisions of the Plan Document, the Plan Document controls.**

Also, if certain provisions in this SPD are amended or are changed after you receive this document, you will be sent a Summary of Material Modifications ("SMM"), which will explain those changes to you.

WHAT IS THE PURPOSE OF THIS SPD?

The SPD provides a general description of the benefits that are available to both you and your Dependents, including the answers to questions such as:

- → How you or your Dependents become eligible to participate?
- → How you or your Dependents stay eligible?
- → What benefits the Plan does and does not pay for?
- → How much your cost-sharing is, including your co-insurance and deductibles?
- → How you file a claim or appeal a claim that has been denied?

DEFINED TERMS

There are certain terms that will be used in this SPD that have a specific meaning. These terms are defined below and will be *italicized* or capitalized when they appear throughout the SPD. Those defined terms are listed in the attached *Appendix A*.

ARE THE BENEFITS THIS PLAN PROVIDES GUARANTEED TO ME?

No. The benefits provided by this Plan are not vested, guaranteed, or considered lifetime benefits. The Board of Trustees may modify or discontinue benefits at any time. If the Plan is terminated, any claim for benefits pending at the time of such termination will be considered a priority claim against the remaining assets of the Plan, to the extent permitted by law.

WHO IS RESPONSIBLE FOR THE ADMINISTRATION OF THE PLAN?

As required by federal law, your Plan is operated by the Board of Trustees made up of an equal number of representatives from the sponsoring *Union*, the *Employers***,** as well as various *Employer* associations who contribute to the Plan as required by the *Collective Bargaining Agreement*. The Plan Trustees are known as the "named fiduciaries," are subject to the Employee Retirement Income Security Act of 1974 ("ERISA"), and, as such, will have the maximum possible discretionary authority to administer all aspects of the Plan's operations, including but not limited to, the exclusive right and discretion to interpret all terms and provisions of the Plan's Governing Documents, such as this Plan, the Trust Agreement, Summary Plan Description, Summary of Material Modifications, policies and procedures, resolutions, directives, or any document, instrument, or record used in the administration of the Plan, as well as any amendments or modifications thereof and to apply the same as they deem appropriate.

The Board of Trustees' original intent is and continues to be the ability to exercise their discretionary authority to the fullest extent permitted by the law, and all Trustee determinations made pursuant to this authority, whether prospectively or retroactively, will be entitled to the highest possible deference allowed by law, in case of review by any court or governmental authority of competent jurisdiction. Unless otherwise expressly provided by applicable law, the Board of Trustees' determination on all matters pertaining to the Plan will be final and binding on all concerned parties to the extent permitted by law.

WHO ARE THE MEMBERS OF THE BOARD OF TRUSTEES?

Union Trustees

Mr. Eric Osborn
UA Local 50
7570 Caple Blvd. Suite A
Northwood, Ohio 43619

Mr. Richard Salisbury
UA Local 50
7570 Caple Blvd. Suite A
Northwood, Ohio 43619

Mr. Tim Pollauf
UA Local 50
7570 Caple Blvd. Suite A
Northwood, Ohio 43619

Mr. Michael Short (alternate)
UA Local 50
7570 Caple Blvd. Suite A
Northwood, Ohio 43619

Mr. Chad Bolander (alternate)
UA Local 50
7570 Caple Blvd. Suite A
Northwood, Ohio 43619

Mr. Paul Cordell (alternate)
UA Local 50
7570 Caple Blvd. Suite A
Northwood, OH 43619

Employer Trustees

Mr. Pete Vavrinek
Campbell, Inc.
2875 Crane Way
Northwood, Ohio 43619

Mr. Scott Kepp
GEM, Inc.
6842 Commodore Drive
Walbridge, Ohio 43465

Mr. Anne Saloff
7550 Caple Blvd.
Northwood, Ohio 43619

Ms. Bobbie Strayer (alternate)
RMF Nooter
915 Matzinger
Toledo, Ohio 43612

Ms. Dean Beamont (alternate)
387 Freedom Drive
Napoleon, Ohio 43545

Ms. Rosa Coyle (alternate)
Coyle Mechanical
940 Matzinger Road
Toledo, Ohio 43612

WHAT IF I HAVE QUESTIONS?

Throughout this SPD, you will be referred to the Benefits Office for questions and assistance. The Benefits Office is located at 7570 Caple Blvd., Suite B, Northwood, Ohio 43619. You can also call the Benefits Office at (419) 662-1388.

WHAT IF I WANT TO REVIEW ANY GOVERNING DOCUMENTS?

If you want to review a copy of the Plan Document (and its amendments), Trust Agreement (and its amendments), or latest annual report, please notify the Benefits Office in writing of your request. You may be subject to a fee where permitted by law not to exceed the lesser of: (a) the actual cost of production; or (b) $0.25 per page.

GENERAL INFORMATION ABOUT YOUR PLAN

The name of your Plan is The Northwestern Ohio Plumbers and Pipefitters Local 50 Health and Welfare Plan for Active and Retired Participants (the "Active Plan" or the "Plan"). The Plan's tax identification number is 34-443218. The Plan number is 501. The provisions of your Plan became effective March 1, 2006 (known as the Effective Date of the Plan), even though you may have participated in a predecessor plan prior to that date. This Plan provides some benefits on a self-funded basis, meaning that the Plan pays claims out of its general assets, while others are provided by purchasing contracts of insurance. The assets of the Plan come from *Employer Contributions* and investment earnings on these contributions. The Board of Trustees reserves the right to modify which part of the benefits schedule is insured, if any, through an insurance carrier and which part will be self-funded.

WHO IS THE PLAN'S LEGAL COUNSEL?

The Plan's legal counsel is Novara Tesija Catenacci McDonald & Baas PLLC. Their address is 888 West Big Beaver Road, Suite 600, Troy, Michigan 48084, and their phone number is (248) 354-0380. The Plan's attorneys are responsible for handling all legal matters that affect the Plan and its operation.

HOW ARE LEGAL DOCUMENTS SERVED ON THE PLAN?

If you wish to serve legal documents on the Plan, the documents should be delivered to the Benefits Office and/or the Plan's legal counsel.

WHEN IS OPEN ENROLLMENT?

Open enrollment is available only for *Dependents* who were previously declined coverage, who were not eligible for coverage, or who were not previously enrolled in the Plan.

The open enrollment period runs from October 1st through November 30th of each year for coverage to begin on January 1. This is the period where new *Dependents* can enroll in coverage or those who previously missed an earlier opportunity to enroll. The conditions for coverage are the following: (a) the *Dependent* must be under the age of twenty-six (26) on January 1 of the year in which coverage would begin; and (b) the annual Open Enrollment Form must be completed and signed in its entirety and submitted to the Benefits Office by November 30th to enroll for the next year.

Note, a *Dependent Child's* coverage under the Plan will terminate on the last day of the month in which he or she turns twenty-six (26) years of age.

SPECIAL NOTICES

Federal law requires that the Plan inform you about certain benefits. The Benefits Office also will provide the following notices on an annual basis, or with certain benefit statements when required by law:

→ **Rights under the Women's Health and Cancer Rights Act**. The Plan, as required by the Women's Health and Cancer Rights Act of 1998 ("WHCRA"), provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema. Please contact the Benefits Office for more information

→ **Rights under the Newborns' and Mothers' Health Protection Act**. Under the Newborns' and Mothers' Health Protection Act ("Newborns' Act"), group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than forty-eight (48) hours following a vaginal delivery, or less than ninety-six (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 forty-eight (48) hours (or ninety-six (96) hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of forty-eight (48) hours (or ninety-six (96) hours).

→ **Notice Regarding Special Enrollment**. When the requirements for eligibility under this Plan have been met and you or your *Dependents* are offered an opportunity to enroll in coverage, under some circumstances you may choose to decline coverage. If you are declining 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 30 days after your or 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 30 days. To request special enrollment or obtain more information, contact the *Plan Administrator*. These rights and obligations are also discussed again in detail in the "What Are My Rights and Responsibilities" section of this *SPD,* which begins on Page 37.

→ **Non-Discrimination.** The *Plan* complies with all applicable civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The *Plan* does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. The *Plan* further provides free aids and services to people with disabilities to communicate effectively with us, such as: qualified sign language interpreters, written information in other formats (large print, audio, accessible electronic formats, other formats), and provides free language services to people whose primary language is not English, such as qualified interpreters, and information written in other languages. If you need these services, please contact the Benefits Office. If you believe that the Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F HHH Building
Washington, D.C. 20201
Toll Free: 1-800-368-1019
800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

→ **Provider Non-Discrimination.** The Plan will not discriminate with respect to participation under the Plan against any *Medical Provider* or other health care provider who is acting within the scope of his/her licensee or certification under applicable state law.

→ **Notice of Privacy Practices.** The Plan maintains a Notice of Privacy Practices for Protected Health Information which informs you about your rights and the Fund's legal duties and privacy practices concerning your protected health information. This Notice has previously been provided to all participants. A copy of this Notice can be obtained by contacting the Benefits Office.

RECIPROCITY FOR WORK IN OTHER UNION JURISDICTIONS

The Board of Trustees has entered into reciprocity agreements with other health and welfare plans covering the plumbing, pipefitting, and related crafts throughout the country. *Employer Contributions* made on your behalf will be transferred from one plan to another, in accordance with the prevailing UA reciprocity agreement. The hours worked for which the contributions are transferred to this Plan will be prorated for eligibility purposes in this Plan.

PART II:
ESTABLISHING AND CONTINUING ELIGIBILITY FOR BENEFITS

ELIGIBILITY IN GENERAL

You become eligible for benefits as a *Participant* in this Plan by satisfying the conditions that apply to you, depending on what type of Participant you are. For example, different eligibility rules apply to Active or Retired participants, as well as to various categories of office employees.

The Benefits Office will automatically determine your *Initial Eligibility*. All classes of *Participants* must complete all requested enrollment forms to begin receiving benefits. Some benefits also require you, in addition to satisfying the eligibility requirements, to meet certain deductible, co-pay and/or other requirements before you can receive those benefits.

If you make a false statement, material misrepresentation, or commit an act of fraud, coverage for you and your *Dependents* may be retroactively rescinded.

Also, please note eligibility for coverage does *not* automatically make you eligible for all benefits offered by the Plan. You also, as condition of receiving benefits, agree to complete any required enrollment forms and comply with requests for documentation, such as birth certificates, marriage certificates, proof of custodial arrangements, evidence of other coverage, etc.

The coverage of *Spouses* and *Dependent Children* are tied to the eligibility of the primary Participant (meaning the person who is the Class I, Class II, Retiree, or *Disabled Participant*). If the Primary *Participant* loses coverage, so do his or her *Spouse* and *Dependent Children*.

ELIGIBILITY FOR CLASS I PARTICIPANTS/ACTIVE EMPLOYEES WORKING IN THE FIELD

How do I become eligible for benefits?

Active or Class I *Employees* are those Participants who work in the field in *Covered Employment* for a *Contributing Employer*. To establish Initial Eligibility, you must work at least 160 hours in *Covered Employment* in any consecutive two-month period. Once you complete this requirement, you will have coverage for the three months that follow the month in which you worked your 160th hour.

EXAMPLE: If you work your 160th hour in the month of February, then you will have coverage for March, April, and May.

You must also fill out any requested enrollment forms prior to beginning coverage. Please note, if you are a Residential *Employee*, you will be considered an *Active Employee*, but there are certain benefits in which you will not be eligible for. These benefits are noted throughout this SPD.

How do I stay eligible for benefits?

Once you have established eligibility as an Active Participant, you remain eligible in the Plan by (1) working sufficient hours each month or (2) if you do not work enough hours in a month, by using your Hour Bank or making self-payments if you are eligible to do so. To continue eligibility solely through working, you must work at least 135 hours each month. Continuing eligibility is tracked using a three-month bookkeeping method, which is summarized for you in the chart below:

Hours you work in		Count for eligibility in
January	→	April
February	→	May
March	→	June
April	→	July
May	→	August
June	→	September
July	→	October
August	→	November
September	→	December
October	→	January
November	→	February
December	→	March

Once the plan has received a total of 2,050 *Contribution Hours* on your behalf, all hours that you work in excess of 135 in any month are placed into your *Hour Bank*. You may bank up to 1,620 hours in the Hour Bank, or one year of coverage.

If in any month you do not work at least 135 hours, then your eligibility will be automatically continued by drawing from your *Hour Bank* the number of hours that you are short. If you do not have enough hours in the bank to continue eligibility, then you can continue your coverage by making a self-payment if you are eligible to do so.

Continuing Coverage by Making Self-Payments

If you are continuing your coverage as an Active Participant by making a self-payment, you can elect to make self-payments for up to 15 consecutive months. The premium for this coverage is capped at 120 hours multiplied by the current contribution rate. Any hours you work reduce the 120-hour multiplier, and therefore reduce the amount of your self-payment. For example, if you work zero hours, then the premium for Full Coverage is 120 multiplied by the contribution rate. If you worked 30 hours, then your self-payment would be 90 hours multiplied by the contribution. While you may make up to a maximum of 15 consecutive self-payments, you may not exceed in combination with continuation of coverage under the disability provisions of this Plan, 30 months of coverage. Upon reaching this maximum, you will be offered coverage under COBRA, if you are eligible.

To be eligible to make self-payments, you must be available for work from a Contributing Employer to the Plan. You demonstrate availability for work by registering on the Union's out of work list. If you fail to register, or drop your book with the Union, it will be presumed you are no longer available for work. This requirement will not apply if you are disabled or on a leave of absence, such as a medical or military leave. Participants who are not eligible to continue coverage through self-payments will be offered coverage under COBRA if they qualify.

SELF-PAYMENTS FOR CLASS I PARTICIPANTS ARE DUE BY THE END OF THE MONTH. For example, payment for February coverage would be due by the last day of January.

If I lose eligibility for benefits, how can I reinstate my coverage?

Your Active Participant coverage will terminate if you fail to meet the requirements for Continuing Eligibility, fail to make a required self-payment, or your total allotment of coverage (self-payments along with any coverage you may elect under COBRA) expires. The requirements to reinstate your coverage are based on how long your coverage was terminated:

→ If your period of termination is *less* than twelve (12) months, you need to work 135 hours within a consecutive two (2)-month period.

→ If your period of termination is *more* than twelve (12) months, you need to work 160 hours within a consecutive two (2)-month period.

ELIGIBILITY FOR RETIRED PARTICIPANTS

The eligibility requirements for Retired Participants are discussed below. **Please note that Class I/Active Participants working under a Residential CBA are NOT eligible for Retiree coverage.**

How do I become eligible for benefits if I retire before I turn age 65?

To qualify for coverage as an "early" Retiree, you must meet the following criteria:

→ Be at least 55 years old.
→ Have been eligible as a Class I/Active Participant at the time of your retirement.
→ Participate in the Active Plan for at least 10 years prior to retirement.
→ Worked in Covered Employment and was a Participant in the Active Plan for at least 60 of the 120 months immediately preceding your retirement.
→ Worked in Covered Employment and was a Participant in the Active Plan for at least 12 of the 24 months immediately preceding your retirement.
→ Run out the balance of your Hour Bank, if any.
→ Complete the required enrollment forms.

How do I become eligible for benefits if I retire AFTER I turn age 65?

To qualify for coverage as a "regular" Retiree, you must meet the following criteria:

→ Be at least 65 years old.
→ Have been eligible as a Class I/Active Participant or Class II Participant at the time of your retirement.
→ Participate in the Active Plan for at least 10 years prior to retirement.
→ Worked in Covered Employment and was a Participant in the Active Plan for at least 60 of the 120 months immediately preceding your retirement.
→ Worked in Covered Employment and was a Participant in the Active Plan for at least 12 of the 24 months immediately preceding your retirement.
→ Run out the balance of your Hour Bank, if any.
→ Complete the required enrollment forms.

How do I stay eligible for retiree benefits?

You remain eligible by making timely self-payments to the Plan. The amount of the self-payments for retiree coverage is established by the Board of Trustees and is subject to change at their discretion. If the rate is

changed, you will be notified of the new rate. Arrangements can be made to have your self-payment deducted from your pension benefit by contacting the Plan Administrator.

What if my retiree eligibility terminates, can I reinstate my coverage?

If you fail to make a timely self-payment, your coverage will be terminated. Loss of retiree coverage due to a failure to make a self-payment generally will not be reinstated, absent extraordinary circumstances.

What if I return to work while I am retired?

Retirees who return to work will, once they work sufficient hours to become Active Participants again, be subject to the terms and conditions applicable to coverage for Class I/Active Participants. You must continue to make self-payments during this period, contributions made on your behalf will go the benefit of the Plan.

If you return to work during a period where the Pension Fund has NOT lifted the suspension of benefits rule, when you go to retire again you will have to meet the requirements AGAIN to qualify for Initial Eligibility as a Retiree.

ELIGIBILITY FOR CLASS II PARTICIPANTS

There are four categories of Class II *Participants:* (1) Owners; (2) Non-Campus Office Workers; (3) Alumni; and (4) Campus Office Workers.

Owners are those persons who own or control an *Employer* and who were not previously eligible as a Class I/Active Participant.

Non-Campus Office Workers are the non-collectively bargained office staff of an Employer.

Campus Office Workers are employees of the Plan and the Union. This category also includes employees of the MCA Office and the Training Center.

Alumni are those individuals who were previous Class I/Active Participants who are now either Owners or working for an Employer in a non-bargained position.

How do I become eligible for benefits as a Class II Participant?

The criteria for establishing eligibility depends on which category of Class II Participant you are.

→ **Owners and Non-Campus Office Workers**: you may select single, two-person, or family coverage. There is a separate premium payment for each category of coverage, which includes funds allocated toward the *SCRA*. Your coverage will commence the first day of the month following the month in which the Plan receives the required premium payment from your *Employer*.

→ **Alumni**: you become eligible benefits on the first day of the calendar month following the Plan's receipt of the greater of your actual hours worked or 144 multiplied by the current contribution rate.

→ **Campus Office Workers**: you become eligible the first day of the calendar month following the receipt by the Plan of 144 Contribution Hours multiplied by the current contribution rate.

Absent a waiver from the Board of Trustees, all Owner, Non-Campus, Campus, and Alumni workers of an Employer must participate in this Plan for coverage to be offered. In addition, coverage will be lost if the Employer becomes delinquent in its contribution obligations for any Class I/Active Participants.

In addition, please note that Class II Participants are NOT eligible for an Hour Bank, nor are they eligible for Short Term Disability Benefits

How do I stay eligible as a Class II Participant?

→ **Owners and Non-Campus Office Workers**: Your coverage continues provided your employer timely remits the required monthly premium for the coverage you selected (single, two-person, or family).

→ **Alumni**: the premium rate is set by the Board of Trustees in its discretion but is currently 144 *Contribution Hours* multiplied by the contribution rate. Your employer will be notified if the rate changes. Provided the required premium is timely paid, your coverage will continue.

→ **Campus Office Workers**: the premium rate is set by the Board of Trustees in its discretion but is currently 144 Contribution Hours multiplied by the contribution rate. Your employer will be notified if the rate changes. Provided the required premium is timely paid, your coverage will continue.

Are Class II Participants able to continue coverage by making self-payments?

No. No category of Class II Participants may continue coverage by making self-payments. However, Alumni will be permitted to retain any hours in their *Hour Bank* and any funds in their SCRA accumulated while they were a Class I/Active Participant. On the date the contribution rate increases, the balance in their *Hour Bank* will be discounted by the percentage of the rate increase.

SELF-PAYMENTS FOR ALL CLASS II PARTICIPANTS ARE DUE BY THE 20TH OF THE MONTH. For example, payment for February coverage would be due by the 20th day of January.

ELIGIBILITY FOR DISABLED PARTICIPANTS

How do I establish eligibility as a Disabled Participant?

You establish eligibility as a Disabled Participant by meeting the following criteria:

→ You are *Disabled*.
→ You have exhausted any eligibility for Short Term Disability benefits.
→ You have exhausted any balance in your *Hour Bank*.
→ You were eligible as a Class I/Active Participant. Class II Participants are NOT eligible for coverage as a Disabled Participant.

How do I continue eligibility?

You stay eligible by making timely self-payments to the Plan at the rates and under conditions established from time to time by the Board of Trustees. You must also remain *Disabled*.

If you fail to make a timely self-payment, your coverage will be terminated as of the last day of the month for which you made a timely payment, and cannot be reinstated, except under extraordinary circumstances as determined by the Board of Trustees. If you return to *Covered Employment* or no longer are *Disabled*, you must reinstate eligibility as a Class I/Active Participant.

The Trustees retain the right to, at their discretion, verify that you continue to meet the Plan's definition of Disabled. As a condition of coverage as a Disabled Participant, you agree to submit to an Independent Medical Examination if requested by the Board of Trustees, and upon reasonable notice and terms based upon your medical condition.

ELIGBILITY FOR SURVIVING SPOUSES AND DEPENDENTS

What classes of Participants are eligible for this coverage?

Surviving *Spouses* and surviving *Dependent Children* of Class I/Active *Participants* working under a commercial agreement, Retired Participants, and Disabled Participants provided that the primary Participant was eligible for benefits at the time of his or her death. In addition, you must not be eligible for any other group health coverage (other than Medicare) as an employee.

Surviving *Spouses* or a *Dependent Child* of a deceased Class I/Active Participant working under a Residential agreement are NOT eligible for this coverage.

Surviving *Spouses* and *Dependent Children* of Class II *Participants* are NOT eligible for this coverage; however, these persons may continue coverage through COBRA upon the death of the Class II *Participant*.

How do I continue coverage as a Surviving Spouse or surviving Dependent Child?

After exhausting any balance of the primary *Participant's Hour Bank*, you will be required to make monthly self-payments at the rates established by the Board of Trustees.

If the primary *Participant* was continuing coverage in the Plan through Short Term Disability benefits, self-payments at the prevailing rate will be required after all Short-Term Disability credits AND any balance in the *Hour Bank* has been exhausted.

When does coverage terminate?

Your coverage will terminate the first day of the month following the occurrence of any of the events listed below. Once terminated, coverage cannot be reinstated.

- → If you are a Surviving *Spouse* and you remarry.
- → You become eligible for group coverage as an employee of any employer.
- → If you are a Dependent Child, upon your 26th birthday.
- → If you fail to make a timely self-payment.

OTHER COVERAGE SITUATIONS

How does the Plan treat court ordered coverage for minor children?

Coverage will be provided in accordance with any valid order of a court, determined by the Board of Trustees to be a Qualified Medical Child Support Order under applicable law, which creates or recognizes the right of an alternate recipient to benefits as an eligible *Dependent* under the *Plan*. A QMCSO must create or recognize an alternative recipient's right to receive benefits for which an eligible *Dependent* is eligible to receive under this *Plan*, provide a reasonable description of the benefits of this *Plan*, and the period to which the QMCSO applies is specified.

The Benefits Office will establish reasonable methods to notify individuals affected by the order, segregate any amounts payable under the order, determine whether the order is qualified and distribute the benefits under the QMCSO. Any payment made by the *Plan* under a QMCSO or reimbursement for expenses paid by the *Dependent Child* or the *Dependent Child's* custodial parent or legal guardian will be made in accordance with applicable law.

What if I am eligible for benefits but am also a Spouse or Dependent Child of a Class I/Active Participant?

If your Spouse or parent has coverage, and your coverage is lost, you may choose to freeze your Hour Bank and continue coverage under your Spouse's or parent's coverage (provided you are under age 26).

If you later lose this coverage and continue to meet the Plan's definition of a *Spouse* or *Dependent Child*, you can turn back to your *Hour Bank* or any balance in your *SCRA* to continue your coverage before being

required to make self-payments. Please note you will in this instance be required to be available for work. If you fail to meet this requirement, you will be able to continue coverage through COBRA, if eligible.

What coverage is available under the Family Medical Leave Act?

An *Employer* which is a "covered employer" as that term is defined by the Family Medical Leave Act ("FMLA"), is required to notify the Plan when an eligible *Participant* has been granted family or medical leave. Both the *Employer* and the *Participant* are required to provide the notices, information, and documentation as may be required by the Board of Trustees and by law. The *Plan* will continue coverage during the period of any leave for which you are eligible for under the provisions of the FMLA provided the *Employer* remits the required contributions and fully complies with all requirements established by the Board of Trustees. If you have questions about ensuring you and your *Employer* are complying with FMLA leave, contact the Benefits Office.

What if I go out on military leave?

Under the Uniformed Services Employment and Reemployment Rights Act ("USERRA"), if you leave *Covered Employment* to enter service in the Armed Forces, or other uniformed services of the United States, you may continue coverage under the Plan. The cost for continuing coverage depends on the length of your service:

- → **If your period of service is 30 days or less**: if you were continuing coverage through self-payments at the time you are called up for service, the Plan will provide coverage to you at no cost. If were eligible through contributions from your Employer at the time you were called up for duty, your *Employer* must continue to make contributions on your behalf to continue your coverage during this period. If your *Employer* is delinquent or fails to make these contributions, the Plan will provide coverage for this period.

- → **If your period of service is greater than 30 days**: you continue coverage by making self-payments at the Plan's applicable rate for coverage under COBRA for up to 24 consecutive months.

During this period, you may elect to use the balance in your *Hour Bank* or funds from your *SCRA* to continue coverage. If you elect not to use your *Hour Bank* or *SCRA,* these balances will be held until you return from your period of service.

You must return to *Covered Employment* or register on the *Union's* out-of-work list within ninety (90) days of your discharge under honorable conditions from the services or within twenty-four (24) months of discharge if you are recovering from an illness or injury incurred during or aggravated by your service.

Upon return to *Covered Employment* or registration on the *Union's* out-of-work list, you will be eligible for coverage without having to reestablish eligibility. However, if the period of military service exceeds five (5) years, you must again establish *Initial Eligibility* before your coverage will be reinstated. You will also need to submit copies of your induction and discharge papers to the Benefits Office.

CONTINUATION OF COVERAGE UNDER COBRA

The Consolidated Omnibus Budget Reconciliation Act ("COBRA") offers *Participants* and their *Dependents* the opportunity to temporarily extend their health care coverage at group rates, in certain instances, after coverage under the *Plan* would normally end. The Board of Trustees sets the cost of COBRA coverage; however, it is subject to maximums imposed by law.

How do you become eligible to receive COBRA coverage?

To be eligible for coverage under COBRA, you must experience a Qualifying Event. Persons who experience a qualifying event are called qualified beneficiaries under COBRA and can elect COBRA coverage provided they comply with the *Plan's* notice requirements.

When will I receive information regarding COBRA?

The Benefits Office will provide COBRA information in the following two (2) instances:

→ Within the first ninety (90) days of you and your *Dependents* receiving coverage under this *Plan*, you will receive a general notice that describes your rights under COBRA; and;

→ If a qualifying event occurs, you and your *Dependents* will receive an election notice within fourteen (14) days of receiving notice that the qualifying event has occurred. Such election notice will describe your COBRA rights and how to elect COBRA coverage.

What are Qualifying Events for COBRA?

If you are a Class I/Active or Class II Participant:

→ Reduction in your hours of employment
→ Termination of your employment for reasons other than gross misconduct
→ Your former Employer files a Chapter 11 petition for bankruptcy
→ You are determined to be disabled by the Social Security Administration

If you are a Spouse or Dependent Child:

→ The death of your Class I/Active Participant or Class II Participant parent or Spouse.
→ Divorce or legal separation.
→ Eligibility for Medicare.
→ Loss of status as a Dependent Child (i.e. turning age 26).

What are the notice requirements if I experience a qualifying event?

When you experience a qualifying event, written notice is required to the Benefits Office. The requirements for this notice are summarized below.

→ **If the qualifying event is due to divorce, marital separation, or loss of dependency status**: You (NOT YOUR EMPLOYER) must notify the Benefits Office within sixty (60) days starting from the latest of (1) the

date the qualifying event occurred; (2) the date the *Participant* or *Dependent* would lose coverage under the *Plan* as a result of the qualifying event; or (3) the date the *Participant* or *Dependent* is informed (through furnishing of the SPD or COBRA general notice) of the responsibility to notify the *Plan*. In the case of divorce or legal separation, the *Participant* or *Dependent* must provide the *Plan* with a copy of the decree of divorce or legal separation to qualify for COBRA continuation coverage.

→ **For all other qualifying events**: your *Employer* or former *Employer* must notify the Benefits Office within thirty (30) days starting from the latest of (a) the date the qualifying event occurred; (b) the date the *Participant* or *Dependent* would lose coverage under the *Plan* as a result of the qualifying event; or (c) the date the *Participant* or *Dependent* is informed (through furnishing of the SPD or COBRA general notice) of the responsibility to notify the *Plan*.

Failure to provide timely notice to the Plan of Qualifying Event will result in the immediate termination of coverage and the denial of any incurred but yet to be paid claims. In addition, the Plan may take legal action to recoup the amount of claims paid or the COBRA premiums that should have been paid to the Plan had the required notice been provided to the Plan.

How long does COBRA coverage last?

The length of coverage available is summarized in the chart below.

Qualifying Event	Maximum Continuation Period		
	Employee	Spouse	Child
Reduction in work hours	18 months	18 months	18 months
Termination (other than for misconduct)	18 months	18 months	18 months
You are determined to be disabled by the SSA	29 months	29 months	29 months
You die	N/A	36 months	36 months
You and your *Spouse* divorce	N/A	36 months	36 months
Your child no longer qualifies as a *Dependent*	N/A	N/A	36 months

Under what circumstances can COBRA coverage be extended after the initial Qualifying Event?

The initial period of COBRA coverage can be extended if you experience a second qualifying event and provide the required notice to the Plan.

→ **If you become Disabled**: if the initial Qualifying Event was due to a reduction in work hours or the termination of your employment, your COBRA coverage can be extended for a total period of

twenty-nine (29) months for the following reasons; (1) you are found to be disabled as determined by the Social Security Administration ("SSA"); and (2) there is a second and independent qualifying event during the first eighteen (18) months of coverage under COBRA.

To be eligible for the extension, you must notify the Benefits Office in writing of the Social Security Disability award within the first eighteen (18) months of your COBRA coverage and within sixty (60) days of the last of the following events to occur:

1. The date the SSA determined you were disabled.

2. The date which coverage was lost due to a reduction in hours or termination of employment (i.e. the qualifying event),

3. The date on which a qualified beneficiary (such as your *Spouse* or *Child*) would lose coverage because of your loss of coverage due to your termination or reduction in hours (i.e. the qualifying event).

4. The date the qualified beneficiary is informed (by provision of the SPD or COBRA general notice) of the responsibility to notify the *Plan* and the procedures for doing so.

If you fail to timely provide the required notice of your Social Security Disability Award you will NOT be eligible for the extension of your coverage.

Also, if you lose your SSD status, you must notify the Benefits Office within 30 days of the date the Social Security Administration notifies you of its position and provide a copy of the notice to the Benefits Office.

Can I extend my COBRA coverage again after a second qualifying event?

→ **If a second Qualifying Event occurs:** If you and your family are on COBRA due to your termination or reduction in hours (i.e. the first qualifying event), you and your *Dependents* may be entitled to an additional eighteen (18) months of coverage under COBRA, for a total coverage period of thirty-six (36) months, in the event of your (1) your death, (2) due to divorce, (3) becoming eligible for Medicare, or (4) your Dependent Child turns age 26 or otherwise ceases to meet the Plan's definition of a Dependent. The second qualifying event must cause a loss of coverage as if the first qualifying event had not occurred in order for the extension to be offered.

You must provide the Benefits Office with written notice of the second qualifying event within sixty (60) days of the later of: (a) the date of the second qualifying event; (b) the date that your *Spouse* or *Child* would lose coverage under the *Plan* due to the second qualifying event (such as turning age 26); or (c) the date you or your *Spouse* or *Child* is informed (by provision of the SPD or COBRA general notice) of the responsibility to notify the *Plan*.

If you fail to timely provide the required notice you will NOT be eligible for the extension of your coverage. If you are unsure on how or when to provide this notice, please contact the Benefits Office for assistance.

PART THREE:
BENEFITS UNDER THIS PLAN

WHAT BENEFITS ARE AVAILABLE UNDER THIS PLAN?

The Schedules of Benefits for this Plan are incorporated in this SPD within the following Appendices to this SPD:

- → Appendix B for the Schedule of Benefits for Class I and Class II Participants
- → Appendix C for the Schedule of Benefits for Retired Participants not on Medicare
- → Appendix D for coverage for Medicare Eligible Retirees
- → Appendix E for Out of Network Dialysis Claims

WHAT BENEFITS AM I ELIGIBLE FOR?

The chart below summarizes the types of benefits which are available to each class of Participant. The benefits are explained in more detail within the subsequent sections of this SPD, as well as within the Appendices.

Benefit Type	Participant Class					
	Active	Alumni	Campus	Non-Campus	Owners	Retirees
Medical, Surgical, & RX	√	√	√	√	√	√
Death/AD&D Benefit	√	√	√		√	√
Dental & Vision	√	√	√	√	√	√
Short Term Disability	√	√				
Hour Bank	√	√	√			
SCRA	√	√	√	√	√	
Retiree Coverage	√	√	√	√	√	√

DEATH BENEFITS

The Plan provides a death and accidental death ("Death") benefit to the appropriate *Beneficiary* upon proof of the eligible *Participant's* death. The amount of the Death benefit is two-thousand dollars ($2,000) plus an additional two-thousand dollars ($2,000) if the death is due to an accident. You should designate a Beneficiary by filling out a form with the Benefits Office.

Subject to any legal restrictions, or to the rights of any irrevocably appointed *Beneficiary*, you may from time to time change the *Beneficiary*. In the absence of a subsequent appointment or change in *Beneficiary*, the *Beneficiary* who is named at the time of the *Participant's* termination of service, will remain the *Beneficiary* for purposes of receiving the Death benefit.

Unless there is a legal requirement requiring a different distribution, if you have not designated *Beneficiaries*, the benefit will pass in descending order to the following individuals:

→ Your surviving *Spouse*; but if there is no surviving *Spouse*, then to
→ Your surviving *Children*, in equal shares; but if there are no surviving *Children*, then to
→ Your surviving parent(s), in equal shares; but if there are no surviving parents, then to
→ Your surviving siblings, in equal shares; but if there are no surviving siblings, then to
→ Your estate.

What if the named Beneficiary is a minor?

If any named *Beneficiary* is a minor or otherwise incapable of giving a valid release for any payment due, Death benefit proceeds payable to such *Beneficiary* will be paid to the *Beneficiary's* duly appointed guardian.

What happens if the named Beneficiaries die before me?

Should any legally designated *Beneficiary* die before you, the insurance proceeds designated will be payable equally to the remaining legally designated *Beneficiaries*, if any, who survive the *Participant,* unless otherwise specified by you or unless the law requires a different distribution.

SHORT-TERM DISABILITY BENEFITS

Active *Participants* and Alumni receive Short-Term Disability Benefits in the amount of four-hundred fifty dollars ($450) per week for a maximum of twenty-six (26) weeks during any twelve (12)-consecutive month period or for any single disability. These benefits are taxable, and appropriate income taxes will be withheld from your payments, and they will be coordinated with any other benefits you may receive during your disability period.

To qualify for these benefits, you must:

→ Be an Active *Participant* or an Alumni who is eligible for benefits under the Plan.

→ Suffer from a *non-occupational* injury or illness that prevents you from working at your occupation; and

→ Be under the regular care of a qualified *Medical Provider*.

Short Term Disability benefits are NOT payable under the following conditions:

→ For any period of disability during which you are not under the direct care of a *Medical Provider*.

→ For a disability due to accidental bodily injuries arising out of and in the course of your employment.

→ For a disability due to occupational disease. Occupational disease means a disease for which the *Participant* submitting the claim is entitled to receive workers compensation or other benefits provided by law.

→ For a disability because of an automobile accident.

→ For a disability resulting from alcoholism or drug abuse.

→ For any disability caused by or related to engaging in a criminal act.

Absences you have resulting from a disability within eight (8) weeks of active employment will be treated as within a single disability period unless the new disability is a result of a different cause from any prior disability. In addition, no disability will be considered as starting more than three (3) days prior to your first visit to a *Medical Provider*.

Who do I need to contact regarding my disability benefits?

You must provide notice to the Benefits Office within twenty (20) days of the accident or *Sickness* causing the disability or within a reasonable time if notice cannot practicably be given within this period.

When will Short-Term Disability benefits be paid?

Disability payments will be made to you beginning:

→ With the first (1st) day of disability due to the accident or injury.

→ The first (1st) day of hospitalization.

→ The first (1st) day of a surgical procedure performed in an outpatient facility.

→ With the eight (8th) day of disability due to an illness.

→ For disabilities triggered by a COVID-19 virus induced illness, benefit payments will begin on the 1st day of disability.

Any balance of benefits that has not been paid by the end of the disability period will be paid only if your *Medical Provider* provides the Benefits Office with the required medical evidence or a certification of disability.

Short Term Disability benefits are NOT payable during period in which you work, whether in Covered Employment or otherwise. IF YOU RETURN TO WORK, YOU MUST NOTIFY THE BENEFITS OFFICE IMMEDIATELY. If you fail to notify the Plan of your return to work, you will be required to refund any benefits that were improperly paid to you. The Plan reserves the right to offset against any of your current or future benefits to recoup improperly paid benefits.

If you are unsure about when or how to provide the required notice, please contact the Benefits Office.

SUPPLEMENTAL CREDIT RESERVE ACCOUNT

The *SCRA* is a form of Health Reimbursement Account ("HRA"), which is funded by a portion of *Employer Contributions* which, for bookkeeping purposes, is treated as if it has been set aside into an account in the individual *Participant's* name. The *SCRA* can only be used to cover medical expenses allowed by the IRS and the Board of Trustees that are not otherwise covered by the Plan (e.g., copayments deductibles, coinsurance, self-payments, and other medical expenses). For a list of expenses permitted to be reimbursed from the SCRA, you can refer to IRS Publication 502. The Trustees may offer use of a debit card for the SCRA, but use of it is subject to rules and regulations adopted by the Trustees, including requirements to substantiate your expenses.

The *SCRA* will not be available during any period that you are not receiving coverage from this Plan or any other health plan providing "minimum value" under the Patient Protection and Affordable Care Act ("PPACA"). You also cannot use your *SCRA* to obtain, purchase, or offset the cost of insurance coverage on a state or federal "Marketplace" where individual insurance policies under *PPACA* or "healthcare reform" are sold.

The *SCRA* is <u>not</u> a vested benefit. This benefit is not available for Residential *Employees*. For further information or additional questions, please contact the Benefits Office. Once annually, and again upon termination of your eligibility under the *Plan*, if you have not previously opted out, you will be able to opt out of the *SCRA* and discontinue receiving reimbursements from your account. Note, however, if you do so, you will <u>*not*</u> receive any additional funds in your paycheck and you will <u>*not*</u> be able to access the balance in your *SCRA*. If you opt out and later reinstate eligibility, you will regain access to amounts which are not forfeited. However, upon reinstatement, the SCRA may not be used to reimburse expenses incurred during the period after you opted-out or for expenses incurred in any period prior to your reinstatement when you were not eligible for benefits. If you wish to opt out, you should contact the Benefits Office.

<u>Is my SCRA balance transferable to my Dependents if I die?</u>

Yes. When you die, your *SCRA* balance can be used by your surviving spouse provided they were eligible for coverage at the time of your death and continue to be eligible during the periods they wish to seek reimbursement.

<u>Can I lose my SCRA balance?</u>

Yes, if you lose coverage under the Plan and fail to reinstate within 5 years, your balance will be forfeited to the Plan.

PART FOUR:
RESTRICTIONS ON YOUR COVERAGE

ARE ANY SERVICES EXCLUDED UNDER THE PLAN?

There are some services that this Plan does not cover or only covers under certain conditions. Some of these exclusions are listed below, but this is not a complete list. If you are uncertain whether a particular condition or service is covered, you should contact the Benefits Office. The following are some exclusions:

→ For injury received while working for pay or profit by any *Participant* or any *Dependent* including any extra side job, weekend job, a job being performed by a friend or relative on which the *Participant* is assisting (working or viewing).

→ For loss or expense from sickness, or disease, or as a result of any accidental bodily injury which arises out of or in the course of employment, which entitles the covered person to benefits under any Workers' Compensation Law, or any Occupational Disease Law.

→ For pre-employment or insurance exams.

→ For treatment of injury or illness caused by war.

→ For any hospital confinement, surgery, treatment, service or supply for which the *Participant* is not legally obligated to pay.

→ For any period of hospital confinements that occur before the *Effective Date* of eligibility, upon becoming eligible however, the *Plan* will assume coverage.

→ For injuries or claims incurred as part of or related to the commission of an illegal act.

→ For educational or self-help therapy, other than diabetic self-management in a hospital setting.

→ For expense incurred for any type of family planning (other than those associated with contraceptive management or as otherwise required by the Affordable Care Act).

→ For weight loss or diet control treatment, unless *Medically Necessary;* comprehensive nutritional programs; visits with specialists in endocrinology; visits when required solely for the purpose of weight loss; treatment of obesity only; dietary supplements; nutritional lectures; and quick weight loss programs and clinics.

→ For sterilization reversals.

→ For payment of surcharge or nonresident tax levied by community hospitals.

→ For installation of air conditioning units, humidifiers for environmental controls, whirlpools, air filters, bathroom rails, special toilet seats, commodes, chair lifts, or other non-essential home-installed conveniences even when prescribed by a *Medical Provider*, including ergometers and exercycles, bicycles, etc.

→ For elective surgery, including cosmetic surgeries that are not necessary by reason of sickness, injury or disease or for the protection of the health of the individual, including services or supplies for treating hair loss or to restore hair growth.

→ For medical treatment or services, if any, that are not recommended and approved or prescribed by a legally qualified *Medical Provider*.

→ For treatment of injuries sustained in an automobile accident or motorcycle or other motor vehicle accident or complications resulting from such injuries or accident, unless a subrogation agreement is executed in favor of the *Plan*.

→ For television, telephone, guest trays or other non-essential personal items and services including take-home prescription drugs and supplies.

→ For immunization injections, unless required under the Patient Protection and Affordable Care Act or other applicable law;

→ Any deductible required by the *Plan* or reimbursement of deductibles under the *Plan* or prescription deductible, if any.

→ For expense incurred (or from complications resulting from) for cosmetic surgery or experimental surgery, except as specifically covered by this *Plan*.

→ For court ordered hospital confinements and treatment required by court orders, which is the result of an order of any court of law to any eligible *Participant*, even when prescribed by a *Medical Provider*, unless required under the Mental Health Parity and Addiction Equity Act (MHPAEA).

→ For the use of a private room. If used, the average semi-private room rate of that hospital will be paid, except private room accommodations required by the hospital for treatment in quarantine purposes and not for the comfort of the patient.

→ For hospitalization for dental care other than when concurrent hazardous medical condition necessitates hospitalization.

→ For voluntary abortions, except in those cases where such surgery is performed to protect the health of the mother.

→ For radial keratotomies (and/or for Lasik), except as covered under the dental/vision benefit.

→ For purchase of sun lamps required for any cause.

→ For Experimental or Investigational Treatment, supplies and devices, unless required under the Patient Protection and Affordable Care Act.

→ For temporomandibular joint (TMJ) services, except for surgery and except as covered under the dental/vision benefit. Pre-certification may be required.

→ For *Custodial Care*.

→ For prescription drugs that are primarily for elective or cosmetic purpose.

→ For expenses incurred by an organ donor, unless the donor is a covered Participant of the Plan.

→ For maternity and obstetrical benefits for *Dependent* children, except as required by the Patient Protection and Affordable Care Act ("*PPACA*").

→ For charges in excess of reasonable and customary charges.

→ For travel, even if prescribed by a *Medical Provider*.

→ For chelation therapy, except for acute arsenic, gold mercury and lead poisoning.

→ For coverage for services related to gender dysphoria, unless such services are medically necessary and required by applicable law.

→ For over-the-counter drugs, unless specifically provided as a covered benefit or required by the Patient Protection and Affordable Care Act.

→ For food supplements or augmentation, unless specifically provided as a covered benefit or required by the Patient Protection and Affordable Care Act.

→ For vitamins, unless injectable, provided as a covered benefit or required by the Patient Protection and Affordable Care Act or other applicable law.

→ For appetite suppressants, unless *Medically Necessary* to treat attention deficit disorders or narcolepsy.

→ For diabetic supplies or disposable medical supplies, unless specifically provided as a covered benefit.

→ For any medical services provided by or paid for by the United States government, state government, local government, or any instrumentality of the foregoing.

COORDINATION OF BENEFITS WITH OTHER POLICIES AND INSURANCE

Coordination of Benefits ("COB") is a set of rules for the order of payment of covered charges when two (2) or more plans (not including a motor vehicle policy where the *Participant* or *Dependent* has not signed a subrogation agreement) cover the same individual to avoid duplicate or overlapping payments. The COB rules apply generally to all medical, surgical, as well as dental and vision benefits provided by this *Plan*. The COB rules do not apply to death benefits.

The plan that pays first (primary) according to the rules will pay as if there were no other plans involved. The other plans (secondary) will pay the balance due up to one hundred percent (100%) of the allowable expenses under the terms of that plan. When this Plan pays secondary, it will not make payments until the other insurance has fully paid up to its policy limits.

If my Spouse is eligible for other, employer sponsored coverage, do they have to use it?

Yes. If a Spouse who is a full-time employee is eligible to enroll in employer sponsored coverage through their own work, they must do so as soon as that coverage becomes available. The Plan will apply the coordination of coverage provisions as if the working Spouse had elected the employer-sponsored coverage, unless the working Spouse has family coverage, in which case the normal coordination of benefits provisions will apply.

What happens if I, my Spouse, or my Dependent Children are covered under more than one Plan?

COB rules are in effect whenever any individual has coverage under this Plan and or any other health and welfare plan, or plan providing dental or vision coverage. The COB rules are generally summarized in the chart below:

COVERAGE TYPE	PRIMARY	SECONDARY
Coverage under two (2) employer-sponsored plans	Other employer-provided plan	This Plan
Employer-sponsored coverage	Plan covering individual as an Employee	Plan covering individual as Spouse or Child
Coverage for a Child	Plan covering parent whose birthday is earlier in the year***	Plan covering parent whose birthday is later in the year***

Coverage for a Child with divorced parents with court order	Plan of the parent as specified as primary insurer under Judgement of Divorce	Other parent's plan
Coverage for a Child with divorced parents without court order	Plan covering parent with physical custody	Plan of Spouse with physical custody
Motor vehicle coverage	Motor vehicle plan	This Plan

****If the parents have the same birthday, the plan and coverage in effect for the longest will be primary.*

If one of the policies or plans is issued in another state that does not use birthdays for coordination of benefits and each policy or plan by its terms is secondary, then the out-of-state policy or plan will be secondary. Each policy or plan will then be responsible for a maximum of fifty percent (50%) of his or her allowed expense or benefit.

The above table is representative of some common scenarios, but not all possible scenarios. You should always keep the Plan informed of any other coverage that you or your *Spouse* maintains. If you have specific questions on coordination with Medicare, please contact the Benefits Office.

COVERAGE FOR CAR AND MOTORCYCLE ACCIDENTS

In the case of a car or motorcycle accident, this Plan provides only secondary, or "excess" coverage, for medical claims resulting from, or related to, a motor vehicle or motorcycle accident and only if you sign a reimbursement agreement. This *Plan* directly disavows coverage and shifts the burden to any automotive or motorcycle insurance carrier or coverage covering any injured person seeking benefits under this *Plan* for any claim for which the claimant had any no-fault, third-party, or any other insurance coverage (including uninsured motorist coverage) that is applicable to any motor vehicle or motorcycle accident. **It is strongly recommended that you review you review your insurance policy with your insurance agent or carrier to ensure you have selected the proper coverage options for your policy.**

THE PLAN'S SUBROGATION RIGHTS

The *Plan* has subrogation rights, which means that if it pays benefits on your behalf and you later recover money or other property from a third party to compensate you, your rights to that recovery are "subrogated" to the *Plan* up to the amount of benefits the *Plan* provided to you. The *Plan* also is automatically granted a lien against any settlement, judgment, or other payment that you may receive. By receiving benefits, you also agree to assist the *Plan* in preserving its subrogation and lien rights. The *Plan* may require you to sign a subrogation or similar agreement before paying claims.

MEDICAL MANAGEMENT PROGRAMS

In an effort to ensure participants are provided with the appropriate and medically necessary care for their particular condition, the Trustees have adopted the following medical management programs:

→ **Prior Authorization**. The Fund's Prior Authorization Program helps to ensure the appropriate usage of certain medications by applying Food and Drug Administration (FDA) approved indications and manufacturer guidelines for using certain drugs. Certain medical procedures may also have to be authorized in advance. A list of services and medications subject to the Prior Authorization Program is available from American Health Holding, Inc. You can also visit the member portal at www.optumrx.com, or call the toll-free number on the back of your OptumRX card. In addition, a copy can be obtained from the Benefits Office. The Prior Authorization Program is not applicable to emergency services.

→ **Step Therapy**. The Step Therapy Program addresses participants using prescription drugs to treat certain chronic or ongoing medical conditions. Many of the drugs used to manage these conditions have serious side effects. The Step Therapy Program is designed to ensure that the condition is being managed with a medication that is safe, medically appropriate and cost effective. It also aids the Plan in controlling the costs of prescription drug coverage. Prescription drugs that are placed under the Step Therapy Program generally require a Participant to have failed therapy with one or more alternative drugs before coverage for the drug included within the Step Therapy Program will be approved. The Step Therapy Program can be bypassed in whole or in part where the treating Medical Provider establishes that certain clinical criteria have been met. A list of medications subject to step therapy, as well a list of the clinical criteria to bypass the Step Therapy Program, is available from the OptumRX online member portal, via telephone at the number on the back of your OptumRX card, or from the Benefits Office.

→ **Quantity Limits & Mail-Order Program**. Certain medications will only be dispensed in quantity limits that are set by the drug's manufacturer, the FDA, or the pharmacy benefit manager. In addition, certain medications may be required to be filled through the Fund's mail-order pharmacy. A list of drugs subject to these limitations and requirements is available from the OptumRX online member portal, via telephone at the number on the back of your OptumRX card, or from the Benefits Office.

→ **Establishment of Formulary**. The Fund has contracted with a pharmacy benefit manager, OptumRX, which is responsible for establishing the Fund's prescription drug formulary. The formulary sets the tiering of covered prescription drugs and identifies what drugs are, and are not, included within the formulary and therefore covered by the Fund. A copy of the formulary is available from the OptumRX online member portal, via telephone at the number on the back of your OptumRX card, or from the Benefits Office.

→ **Case Management.** In selected cases involving high-risk, complicated, or high-cost treatment, professional advisers from American Health Holding, Inc. will offer, on a voluntary basis, counsel and education regarding alternative treatment options and methods to improve clinical outcomes. Information on the Plan's Case Management Program is available from American Health Holding, Inc. at (855) 248-1859, or from the Benefits Office.

→ **Utilization Review**. Utilization review is a process to make sure that the care you receive is medically necessary, delivered in the most appropriate location, and follows common medical practice. American Health Holding, Inc. performs utilization review for the Plan. Information on the Fund's U/R Program is available from American Health Holding, Inc. at (855) 248-1859, or the Benefits Office.

→ **Other Programs**. The Fund may also implement additional disease management and wellness programs that are necessary to ensure that participants are provided with an appropriate medical care and to help control costs. If such additional programs are adopted, you will receive a notice and supplement to this Summary Plan Description.

PART FIVE
CLAIMS AND APPEALS

If you are aged 65 or older, or are on Medicare due to disability, and are covered by the Plan's Medicare benefit with Anthem, claims for medical and prescription drug benefits as well as appeals of denied claims are NOT handled by the Benefits Office nor under this section of this SPD. You must instead contact the insurance company, Anthem, that provides your medical and prescription drug benefits, by contacting the number listed on your insurance card.

STANDARD OF REVIEW

The *Claims Administrator* will ensure that all *Claims* and *Appeals* are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in the benefit determination. The *Claims Administrator* will further ensure decisions regarding hiring, compensation, termination, promotion, or similar matters are not made based upon the likelihood that the individual would support the denial of benefits.

HOW TO SUBMIT A CLAIM FOR BENEFITS

Most claims will be submitted for payment by the doctor or hospital that performed the service and will be handled by the Benefits Office. For Claims that you submit for reimbursement, you must completely fill out a Claim form and attach an ORIGINAL copy of all bills for services rendered (keep photocopies for your records) and mail the Claim form(s) with the original copy of the bills to the Claims Administrator. All bills must show:

- → Name of Plan.
- → Employee's name.
- → Employee's social security number.
- → Name of patient.
- → Name, address, telephone number and tax ID number of the provider of care.
- → Type of services rendered, with diagnosis and/or procedure codes.
- → Dates of service.
- → Charges.

HOW LONG DO I HAVE TO SUBMIT A CLAIM FOR BENEFITS?

Claims must be submitted within one year of their occurrence. *Claims* filed later than that date may be declined/reduced unless it was not reasonably possible to submit the *Claim* within the one-year period.

AFTER A CLAIM IS SUBMITTED, WHEN WILL I BE NOTIFIED OF A DECISION?

The notification period can depend on the type of claim you have submitted. The types of claims and the associated time periods are described below. The time periods for review begin when a *Claim* if filed correctly (i.e., identifies the individual and condition and is sent to the proper department), even if some additional information is needed to decide the *Claim*. If an extension of time is needed, the period to decide a *Claim* is generally suspended until the additional information is provided, or the period given to you to provide the information expires.

→ **Urgent Care Claims.** If submitted properly, these Urgent Care Claims will be decided within seventy-two (72) hours. If more information is needed to decide an Urgent Care Claim, you will be notified within twenty-four (24) hours of the receipt of the Claim. Such notification may be oral unless you request written notification. You will then have at least forty-eight (48) hours to provide the information needed. You will then be notified of the decision within forty-eight (48) hours of the receipt of the information, or within the forty-eight (48) hours you had to supply it. You may be notified orally of the decision, but you still will be provided a written decision on the Claim within three (3) days of the oral notification.

→ **Pre-Service Claims**. If enough information is available, Pre-Service Claims will be decided within fifteen (15) days of the receipt of the Claim. If more information is required, this period can be extended by an additional fifteen (15) days. The notice will explain the reason for the delay and provide an estimate of when the Claim will be decided. If more information is required to decide your Claim, then you will be given at least forty-five (45) days to provide that information. The Claim will then be decided within fifteen (15) days of you supplying the information, or by the end of the forty-five (45)-day period you had to supply that information, whichever period expires first.

→ **Post-Service Claims.** If enough information is available, Post-Service Claims will be decided within thirty (30) days of the receipt of the Claim. If more time is needed, this period can be extended by fifteen (15) days. You will be notified prior to the expiration of the initial thirty (30)-day period if an extension is needed. The notice will explain the reason for the delay and give an estimate of when the Claim will be decided. If more information is required to decide your Claim, then you will be given at least forty-five (45) days to provide that information. The Claim will then be decided within fifteen (15) days of you supplying the information, or by the end of the forty-five (45)-day period you had to supply that information, whichever period expires first.

→ **Concurrent Care Claims.** If the length of treatment approved is reduced or terminated prior to the end of the period or the full number of treatments (unless the reduction or termination occurs as the result of a Plan amendment or termination), you will be provided with written notice within a sufficient amount of time prior to the reduction or termination for you to Appeal that decision. If you request to extend a course of treatment approved, you will be notified within twenty-four (24) hours of its receipt of your request for that extension if you requested the extension at least twenty-four (24) hours prior to the expiration of the approved length of treatment.

→ **Disability Claims.** Disability Claims will generally be decided within forty-five (45) days after the receipt of the Claim. If more time is needed to decide your Claim, this period can be extended by thirty (30) days. In such an instance, prior to the 45-day period, you will be given notice of the reasons for the extension and give an estimate of when the Claim will be decided. This period may be extended again for an additional thirty (30) days. If this occurs, you will be given notice of this second extension prior to the end of the first thirty (30)-day extension period, which will explain the reasons for the second extension and give an estimate of when the Claim will be decided. If more information is required to decide your Claim during either extension period, then you will be given at least forty-five (45) days to provide that information. The Claim will then be decided within thirty (30) days of you supplying the information, or by the end of the forty-five (45)-day period you had to supply that information, whichever period expires first.

→ **All other claims**: the Claims Administrator may extend the time to reach a decision up to an additional ninety (90) days. Written notice of the extension will be furnished to you prior to the termination of the initial ninety (90) day period and will explain the circumstances requiring an extension of time, as well as identify the time and date by which the Claims Administrator expects to reach a decision.

WHAT HAPPENS IF MY CLAIM IS DENIED?

In the event your Claim is denied, the Plan will send you a notice (called an "Adverse Benefit Determination") explaining the reasons for the denial and outlining your rights to appeal. If more information is needed to decide your claim, the notice will explain what information is required.

WHAT ARE MY RIGHTS TO APPEAL A DENIED CLAIM?

There are levels of appeal when a Claim has been denied. The Benefits Office or network provider will review your Claim during the Step 1 Appeal. If your first Appeal is denied, then you may proceed to a second appeal directly to the Board of Trustees.

How do I file the first appeal?

You have one-hundred eighty (180) days from the mailing date of your Claim denial to file your first Appeal with the Benefits Office. You may submit your Appeal yourself, or you may have an authorized representative submit the Appeal on your behalf. Once your Appeal has been timely filed, you:

→ Can review necessary and pertinent documents on which the denial in whole or in part is based and may submit written comments, documents, records, and other information relating to the Claim for benefits; and

→ Will be provided, 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 is considered relevant to the Claim if the document:

- Was relied upon in making the benefit determination.

- Was submitted, considered, or generated while making the benefit decision.

- Demonstrates compliance in making the benefit decision with the requirement that the benefit determination must follow the terms of the Plan and be consistent when applied to similarly situated Claimants.

When considering your Appeal, the Claims Administrator will:

→ Consider all comments, documents, records, and other information submitted by the Claimant relating to the Claim, without regard to whether such information was submitted or considered in the initial determination.

→ Not afford deference to the initial denial of your Claim.

→ Ensure a different person other than the individual, including his/her subordinate, who initially denied your Claim considers your Appeal.

→ May consult with an independent health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment when your Appeal is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is Experimental or Investigational, or not Medically Necessary or appropriate and who was not consulted in the initial denial of your Claim. The Benefits Office will provide you the identity of this individual even if his or her opinion is not relied upon when considering your Appeal.

→ For an Urgent Care Claim, offer an expedited review process whereby the request may be provided by you orally or in writing; and all information, may be provided to you by telephone, facsimile, or any other similar method.

→ For disability Claims, if a decision is based upon any new evidence, provide you with the new evidence in advance of the date on which the notice of the Adverse Benefit Determination is due.

IF MY FIRST APPEAL IS DENIED, HOW DO I APPEAL TO THE BOARD OF TRUSTEES?

Following the denial of your first Appeal, you will again receive a notice explaining the reasons for the denial and an explanation of your appeal rights. You then have one-hundred eighty (180) days after your first Appeal was denied to submit your Appeal to the Benefits Office to be heard by the Board of Trustees. The written notice should: (a) state your name, address, and the fact you are appealing from the decision of the Benefits Office; and (b) give the date of the decision appealed from.

When the Board of Trustees reviews your Step 2 Appeal, any new evidence or additional rationale that is considered, relied upon, generated by (or at the discretion of) the Board of Trustees (or its professional advisors)

will be provided to you automatically and free of charge. This information will be provided to you within sufficient time before the Board of Trustees decides on your Appeal, so you have an opportunity to respond to it.

If this new evidence or additional rationale is received too late for you to have a reasonable opportunity to respond to it before the Board of Trustees is required to decide your Appeal, the time for issuing a final decision on your Claim will be suspended for a reasonable period of time until you have responded to the new evidence or rationale, or failed to respond within the time given to you. In this instance, a decision will be made as soon as possible, considering any medical exigencies.

In the event of a denial by the Board of Trustees, you will receive a notice (often called a Final Adverse Benefit Determination) explaining the reason for the decision and advising you of your rights relative to their decision under ERISA, including the right to an external Appeal (discussed later). You will also be notified if your Claim is approved.

WHEN WILL I BE NOTIFIED OF A DECISION ON MY APPEAL?

Whether your appeal is a first level appeal or a second level appeal to the Board of Trustees, you will be notified of a decision within the following timeframes:

Type of Appeal	Urgent	Pre-Service	Post-Service	Disability
Notification of Decision	72 hours	15 days	30 days	45 days*

**The timeframe for deciding Disability Appeals may be extended by an additional 45 days. In such an instance, you will be notified prior to the expiration of the initial 45-day period, with an explanation of the reasons for the extension, identification of any information needed, and the date a decision is expected to be made.*

EXTERNAL APPEALS

If the Board of Trustees denies your appeal, you may be eligible to seek an external appeal if your appeal involved:

→ **Claims** involving an exercise of medical judgment.
→ **Claims** that resulted in a *Rescission* of coverage.
→ Coding errors, but only to the extent a coding error involved an exercise of medical judgment.

Claims regarding the application of other provisions of this *Plan*, for example, whether or not you met the eligibility requirements, are not subject to an external *Appeal*.

If the Board of Trustees denies your Claim (you receive a Final Adverse Benefit Determination), you have four (4) months to request an external review. If there is no corresponding date four (4) months after the date of

receipt of the denial, then the request must be filed by the first (1st) day of the fifth (5th) month following the receipt of the notice that the Board of Trustees denied your second appeal.

Requests for external appeals are to be filed with the Benefits Office. If the Benefits Office receives a request for an external appeal, the following rules apply:

→ **Preliminary Review.** Within five (5) business days following the receipt of the request for an external review, the Plan will complete a preliminary review of the request to determine the following:

1. Whether you were covered under the Plan at the time the health care item or service was requested, or, in the case of a retrospective review, you were covered under the Plan at the time the health care item or service was provided.

2. Whether the Adverse Benefit Determination or the Final Adverse Benefit Determination relates to your failure to meet this Plan's requirements for eligibility (e.g., worker classification or similar determination)

3. Whether you have exhausted the Plan's internal Appeal process unless you were not required to exhaust the internal Appeals process.

4. Whether you have provided all the information and forms required to process an external review.

→ **Post-Preliminary Review.** Within one (1) business day after completion of the preliminary review, the Plan will issue a written notice to you noting the reasons, if the Claim is not eligible for external review, along with contact information for the Employee Benefits Security Administration ("EBSA"), or, the information needed if the application for the review is not complete. You will have the latter of: (a) the four (4)-month filing period, or (b) the forty-eight (48)-hour period following your receipt of the notification to provide any additional information that is needed.

→ **Referral to Independent Review Organization ("IRO").** At the conclusion of the preliminary review, the Plan will then refer eligible Claims to a randomly selected IRO and immediately provide coverage if the decision of the Plan is overturned. The Plan will adhere to all terms of the contract with the IRO. No costs will be imposed on you for filing an external review.

IS THERE AN OPTION FOR AN EXPEDITED EXTERNAL APPEAL?

Yes. You may request an expedited external review at the time you receive either of the following:

→ An Adverse Benefit Determination that involves a medical condition where delay would jeopardize your health or ability to regain maximum function and you made a request for an expedited internal Appeal; or

→ A Final Adverse Benefit Determination that involves a medical condition where the timeframe for a normal external review would jeopardize your health or ability to regain maximum function, or, if the determination involves an admission, availability of care, continued stay, or a health care or service for which you received emergency services but have not yet been discharged.

The process for seeking an expedited external Appeal is outlined below:

→ **Preliminary Review**. Immediately upon receipt of the request for an expedited external review, the Plan will determine whether the request meets the requirements for external review. This determination is made by applying the criteria for a standard external preliminary review set forth in the preceding paragraphs.

→ **Post Preliminary Review**. Within one (1) business day after completion of the preliminary review, the Plan will issue a written notice to you. It will note the reasons, if the Claim is not eligible for external review, along with contact information for EBSA, or, the information needed if the application for the review is not complete. You will have the *latter* of (a) the four (4)-month filing period, or (b) the forty-eight (48)-hour period following your receipt of the notification to provide any additional information that is needed.

→ **Referral to Independent Review Organization**. If the Plan determines your request is eligible for external review, then an IRO must be assigned the Claim in the same manner as for a standard external review. The Plan will provide the IRO with all the information used in making the benefit determination in the most expeditious manner available. If the IRO overturns the decision of the Board of Trustees, the Plan will immediately provide coverage. No costs will be imposed on you for filing an expedited external Appeal.

DO I HAVE TO GO THROUGH THE APPEALS PROCESS?

You are generally required to exhaust the internal Claims and Appeals processes of this Plan before you are permitted to seek external Appeal or file a lawsuit with respect to your Claim. However, if the Benefits Office or the Board of Trustees fails to strictly adhere to the Claims and Appeals process outlined in this section, and its error is of a serious nature, you can be deemed to have exhausted the internal Appeals process and can proceed directly to requesting an external Appeal or filing a civil action in court under ERISA.

However, if the error of the Benefits Office or the Board of Trustees is only minor or "de minimis," then you must complete the internal Appeals process first before proceeding with an external Appeal or filing a lawsuit. A minor error is, generally, one that is not material and does not prejudice the outcome or the review of your Appeal, or that is part of a good faith exchange of information between you and the Benefits Office or the Board of Trustees. In these instances, you must complete both levels of the internal Appeals process before seeking an external Appeal or filing a lawsuit.

If you believe the Claims process has not been strictly adhered to, you may request a statement from the Benefits Office or the Board of Trustees. The Benefits Office or the Board of Trustees will provide you with a response within ten (10) days. If you pursue an external Appeal or a lawsuit, and a court or the entity that considers the external Appeal rejects your assertion that the Benefits Office or the Board of Trustees did not strictly adhere to the Claims process, you will be able to return to the internal Claims and Appeals processes of this Plan.

PART SIX
YOUR RIGHTS AND RESPONSIBILITIES

WHAT ARE MY RIGHTS UNDER ERISA?

As a *Participant* in this *Plan*, you are entitled to certain rights and protections under ERISA. ERISA provides that all *Participants* are entitled to:

→ Examine, without charge, the Governing Documents, including the *Plan Document*, insurance contracts, the *Collective Bargaining Agreements*, updated *Summary Plan Description*, copies of the latest annual report (Form 5500 series), and any documents filed by the *Plan* with the U.S. Department of Labor, such as detailed financial reports, etc. This examination may take place at the Benefits Office and at other specified locations such as the work site or the union hall;

→ Obtain, upon written request to the Benefits Office, copies of documents governing the *Plan*, including the *Plan Document*, insurance contracts, the *Collective Bargaining Agreement*, updated *Summary Plan Description*, and copies of the latest annual report (Form 5500 series). The Benefits Office may make a *Reasonable and Customary Charge* for the copies.

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

→ Obtain a statement telling you what rights you have with respect to benefits offered by the *Plan*. *This statement must be requested in writing and is not required to be given more than once a year*. The *Plan* must provide the statement free of charge;

→ Continue health care coverage for yourself or your *Dependents* if there is a loss of coverage under the *Plan* because of a Qualifying Event. You or your *Dependents* may have to pay for such coverage; and

→ Review this *Summary Plan Description* and the documents governing the *Plan* on the rules governing your COBRA continuation coverage rights.

In addition to creating rights for *Participants*, ERISA imposes duties upon the people who are responsible for the operation of the *Plan*. The Board of Trustees, who operate your plan and are called "fiduciaries" of the plan, have a duty to do so prudently, and in the interest of you and other *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 plan benefit or exercising your rights under ERISA. In addition:

→ If your *Claim* for a benefit is denied 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, within certain time schedules.

→ Under ERISA, there are steps you can take to enforce your rights. For instance, if you request materials from the *Plan* and do not receive them within thirty (30) days, you may file a suit in a federal court. In such a case, the court may require the Benefits Office to provide the materials and pay you up to one-hundred ten dollars ($110) a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Benefits Office.

→ If you have a *Claim* for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the *Plan's* decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court.

→ If 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 concerning a QDRO or QMCSO, you may file suit in federal court. Furthermore, if the *Plan's* 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 if, for example, it finds your claim is frivolous.

If you have any questions about this statement, or about your rights under ERISA, you should first contact the Benefits Office and then contact the nearest Area Office of the U.S. Labor-Management Services Administration, Department of Labor, listed in your telephone directory or the Division of Technical Assistance & Inquires, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

CIVIL ACTIONS AGAINST THE PLAN

You must file a lawsuit to challenge any denial by the *Plan* of your right to current or future benefits within one (1) year after your *Claim* for benefits (or to establish a right to future benefits) is finally denied by the *Plan*. Other *Plan*-based lawsuits must be brought within one (1) year after they accrue. How this limitation works in practice is explained below. The Board of Trustees will provide you with periodic additional notices of the limit

at least annually and at other appropriate times (i.e., in letters from the *Plan* itself concerning your benefit claims). These requirements apply even though all *Plan* communications may not remind you of them.

The One (1)-Year Limit. The one (1)-year limit begins on the date your right to *Plan* benefits is fixed (without judicial action). For example, the one (1)-year limit will begin:

→ On the day following the date on which the *Plan* finally denies your *Claim* for benefits (or right to future benefits);

→ On the day following the last day for you to appeal a *Plan* denial of your *Claim* for benefits or future benefits (if you decide not to appeal that denial); or

→ On the day following the last date on which you could file a *Claim* for benefits under the Plan (if you do not file a *Claim* before the applicable *Claim*-filing deadline).

The Plan generally requires you to exhaust your internal remedies before filing a civil action. If you do not exhaust these remedies, you may be foreclosed from pursuing a civil action until you have done so.

If you are unsure about when or how to provide the required notice, please contact the Benefits Office.

The one (1)-year limit does not apply to *Plan*-related rights that you have that are not based on the *Plan* itself. For example, the one (1)-year limit does not apply to *Claims* that *Plan* fiduciaries have violated their ERISA fiduciary duties.

WHAT ARE MY RIGHTS UNDER HIPAA, HITECH, AND GINA?

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and The Health Information Technology for Economic and Clinical Health Act ("HITECH"), enacted as part of the American Recovery and Reinvestment Act of 2009, require that health plans protect the confidentiality of your private health information. A complete description of your rights under HIPAA can be found in the Plan's privacy notice, which was distributed to you upon enrollment and is available from the Benefits Office. If you have questions about the privacy of your health information please contact the Plan's legal counsel, set forth above. If you wish to file a complaint under HIPAA, please contact the Benefits Office. In addition, under the Genetic Information Non-Discrimination Act ("GINA"), the Plan will not discriminate based on and cannot request genetic information when making determinations regarding your eligibility for coverage.

NOTIFICATIONS TO THE PLAN & SPECIAL ENROLLMENT RIGHTS

Under some circumstances, you will be required to notify the Benefits Office of certain events. Your failure to do so may affect your coverage. These events also qualify as Benefit Events that allow you to add individuals to coverage outside of the normal enrollment period. Accordingly, the Benefits Office must be notified in writing of any changes regarding the following:

→ **Marriage** - To add a *Spouse* and any eligible stepchildren to coverage, the marriage must be reported within thirty (30) days. A copy of the certificate of marriage must be filed with the Benefits Office. The *Spouse* and any eligible stepchildren will then be covered from the moment of marriage.

→ **New Children** - To add your newborn *Child* to coverage, the birth must be reported within thirty (30) days. A copy of the birth certificate must be filed with the Benefits Office. The *Child* will be covered from the moment of birth, as provided herein.

→ **Adoptions** - Adoption or placement of a *Child* must be reported within thirty (30) days to add the *Child* as an eligible *Dependent* and a copy of the legal adoption papers or court order for placement must be filed with the Benefits Office.

→ **Foster Children** - To add a foster *Child* to coverage, you must provide the *Plan* with a true copy of the court order placing the foster *Child* with you within thirty (30) days of the entry of the order. Upon the *Child* leaving your care either by the *Child* attaining the age of majority, by court order, or by another means (the "Triggering Event"), you must notify the *Plan* within thirty (30) days of the Triggering Event and coverage will end on the last day of the month in which the Triggering Event occurs.

→ **Guardianship** - To add any person to coverage for whom a Court has appointed you as his/her legal guardian, you must notify the *Plan* within thirty (30) days of the entry of the court order, and a copy of the court order must be filed with the Benefits Office.

→ **Change of Address** - Any change of address must be reported immediately.

→ **Name Change** - Any name change must be reported immediately.

→ **Deaths** - Deaths must be reported immediately. A certified copy of the death certificate is required.

→ **Divorce** - Divorce must be reported immediately and a copy of the judgment of divorce must be filed in the Benefits Office. A former *Spouse* is no longer eligible for benefits as of the date of the divorce, except as provided under COBRA. Eligible *Children* will continue to be covered if they continue to qualify as *Children* under this *Plan*.

→ **26th Birthday** - Children attaining the age of twenty-six (26) are no longer eligible for coverage as of the last day of the month in which they turn age twenty-six (26). Once no longer eligible for coverage, children who age out of coverage may elect continuation of coverage under the COBRA provision of the *Plan*.

→ **Change of Employment Status** - If you or your *Spouse* switches employers, returns from a leave of absence, moves to full or part-time employment, then you must notify the Benefits Office within thirty (30) days.

Note, you may still enroll yourself, your *Spouse*, and/or your *Child*, if you do not notify the Benefits Office within the thirty (30) days. However, coverage will begin on the date of notification and will not apply retroactively back to the date of the Benefit Event.

WHAT HAPPENS WHEN CIRCUMSTANCES OR BENEFITS CHANGE?

If an amendment or termination is made to the provisions of the Plan, you will receive a notice describing the changes and how they affect you. These notices are typically referred to as a Summary of Material Modifications ("SMM").

The Plan may be terminated, in whole or in part, merged, or combined with another plan. The Board of Trustees may also terminate the Plan when a *Collective Bargaining Agreement* requiring *Employer Contributions* to the Plan no longer exists, or as otherwise permitted by law.

While the Board of Trustees has broad authority to make changes, it may not amend the *Plan* in a way that would: (a) authorize or permit any part of the *Plan* assets to be used for purposes other than the exclusive benefit of *Participants* or their *Beneficiaries*; or (b) cause any part of the *Plan's* assets to revert to the *Employers*.

APPENDIX A
DEFINITIONS

→ **Adverse Benefit Determination:** A denial, reduction, termination of, or failure to provide or make payment (in whole or in part) of a *Claim*, including any such denial, reduction, termination of, or failure to provide or make payment (in whole or in part) that is based upon your eligibility to participate in the *Plan* or resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be an *Experimental or Investigational,* or not *Medically Necessary* or appropriate. A rescission of coverage is included in this definition, irrespective of whether the rescission had an adverse effect on any particular benefit at that time. Rescissions will be treated in accordance with 45 CFR §147.128, as amended, and any person affected by a rescission will receive thirty (30) days advance written notice.

→ **Appeal:** An *Appeal* of an *Adverse Benefit Determination* that is filed in accordance with this *Plan's* procedures for filing an *Appeal*.

→ **Association** –means the Mechanical Contractors Association of Northwest Ohio, which has executed a Collective Bargaining Agreement (CBA) with the Union requiring contributions to the *Plan*.

→ **Beneficiary(ies):** Person(s) who, because of a relationship to the *Participant*, may be entitled benefits from the Plan, or who are designated by a *Participant* to receive benefits from the Plan in the event of his/her death, or in the absence of an effective designation, if such designated person(s) will have died, the first of the following classes of *Beneficiaries*, then surviving, in successive preference, the *Participant's*: (a) *Spouse*; (b) *Children*; (c) parents; (d) brothers and sisters; and (e) estate.

→ **Benefit Year or Calendar Year:** The twelve (12)-month period starting on January 1 of any year and ending on December 31 of that year.

→ **Child(ren):** Any *Child(ren)* of the *Participant*, including:

- A son, daughter, stepchild, adopted child, child lawfully placed for adoption, a child meeting the definition of a "foster child" under applicable law that is lawfully placed with the *Participant* by an authorizing placing agency or by court order, and is under the age of twenty-six (26). In case of divorce, proof of the *Participant's* obligation to provide coverage for a child shall be required, such as a judgment of divorce;

- Any illegitimate children under the age of twenty-six (26), so long as the *Participant* provides the Benefits Office with proof of paternity by presenting a registered birth certificate, naming the *Participant* as the father, order of filiation, or adoption order;

- Any handicapped child who is incapable of self-sustaining employment because of a mental or physical handicap; and who the *Participant* is required by court-order to provide support and maintenance; and whose handicap began before age twenty-six (26);

- An individual named under the terms of a Qualified Medical Child Support Order; and

- Any person for whom a court has appointed the *Participant* as his/her legal guardian; and who is under the age of twenty-six (26).

→ **Claim:** A request for a *Plan* benefit made by a *Claimant* in accordance with this *Plan's* procedures for filing or appealing a *Claim* for benefits. A *Claim* must generally name a specific *Claimant*, identify a specific medical condition or symptom, identify a specific treatment, service, or produce for which approval is requested, and be received by a person or organizational unit of the *Claims Administrator* that is customarily responsible for handling benefit matters.

→ **Claimant:** A person or his/her authorized representative, who has submitted a *Claim* for a *Plan* benefit in accordance with this *Plan's* procedures for filing or appealing a *Claim* for benefits.

→ **Claims Administrator:** The entity responsible for processing and adjudicating *Claims* or *Appeals*, and for providing notices to you or your *Beneficiaries* of *Claim* determinations and adjudications, as well as *Appeal* determinations. The *Claims Administrator* is the Benefits Office in all instances.

→ **Collective Bargaining Agreement:** A contract or participation agreement between an *Employer* and the *Union* that requires fringe benefit contributions to be made to this Health and Welfare Fund.

→ **Concurrent Care Claims:** Any *Claim* regarding an on-going course of treatment to be provided over a period of time or number of treatments, which has previously been approved by the *Plan*.

→ **Continuing Eligibility:** The requirements for a *Participant* to continue eligibility for benefits under the Plan after (s)he has met the requirements for *Initial Eligibility*.

→ **Contribution Hours:** The hours an *Employee* worked in *Covered Employment* for which an *Employer* has made actual contributions to this Health and Welfare Fund pursuant to a *Collective Bargaining Agreement*, or other written agreement. Only the hours for which contributions are actually received by the Fund (i.e. an *Employer* has paid the contributions to the Plan) will be deemed *Contribution Hours*.

→ **Covered Employment:** Employment with an *Employer*, for which the *Employer* has agreed, through a *Collective Bargaining Agreement* with the *Union*, or other written agreement, to make contributions to this Plan for work performed by an *Employee* covered by that *Collective Bargaining Agreement*.

→ **Custodial Care:** Service provided to a *Participant*, and his/her *Dependents* when all of the following are true:

- The service is aimed at providing personal care and assistance for activities of daily living;

- The service does not seek to cure a medical condition or is provided during a period where the patient's medical condition is not changing; and

- The service is not required to be administered by a trained or licensed *Medical Provider* in order for it to be administered safely and effectively.

→ **Dependent:** The *Spouse* and/or *Child* of a *Participant*. Your *Spouse*; provided, however, that a *Spouse* who is a full-time *Employee* and who is eligible to enroll in employer-sponsored coverage from his/her employer must enroll in such coverage as soon as such coverage becomes available to the working *Spouse*. The Plan will apply its coordination of coverage provisions as if the working *Spouse* had elected the employer-sponsored coverage, unless the working *Spouse* has family coverage, in which case the Plan's normal coordination of benefits provisions will apply. The cost of the working *Spouse's* coverage may be reimbursed from the *Participant's SCRA,* provided however, the *SCRA* may not be used to reimburse the cost of individual coverage purchased on an Exchange or Marketplace**.**

- Your son, daughter, stepchild, adopted *Child*, *Child* lawfully placed for adoption or guardianship, or *Child* meeting the definition of a "foster child" under applicable law that is lawfully placed with you by an authorizing placing agency or by court order, and is under the age of twenty-six (26). A copy of the order of adoption, guardianship or placement order must be provided to the Benefits Office;

- Any illegitimate *Child*, so long as the *Participant* provides the Benefits Office with proof of paternity by presenting a registered birth certificate, naming the *Participant* as the father, order of filiation or adoption order;

- Each handicapped *Child*, who is incapable of self-sustaining employment because of a mental or physical handicap, and who is dependent on you for support and maintenance. (S)he will remain your *Dependent* and be eligible for coverage so long as: you remain eligible for benefits as a *Retiree*, early *Retiree* or *Disabled Participant*; and (b) such incapacity began before the date the *Child's* coverage would otherwise terminate under the *Plan* (for example, the disability began before the *Child* was age twenty-six (26). Proof of the *Child's* incapacity must be submitted to the Benefits Office within thirty-one (31) days of the date such *Dependent's* coverage would have otherwise terminated;

- An individual through a valid order of a court, by the Board of Trustees to be a QMCSO under applicable federal law, which creates or recognizes the right of an alternate recipient to benefits as your eligible *Dependent* under the *Plan*; or

- Any person for whom a court has appointed you as his/her legal guardian and who is under the age of twenty-six (26).

→ **Designated Beneficiar(ies):** A *Designated Beneficiary* means any person who is designated by a *Participant* to receive benefits from the *Plan* in the event of his/her death. In the absence of an effective

designation, if such *Designated Beneficiar(ies)* will have died, the first of the following classes of *Beneficiaries*, then surviving, in successive preference, the *Participant's*: (a) *Spouse*; (b) *Children*; (c) parents; (d) brothers and sisters; and (e) estate.

→ **Disabled:** As a result of a physical or mental condition, that the Board of Trustees finds, on the basis of medical evidence, to permanently and totally prevent the *Participant* from engaging in any work within the jurisdiction claimed by the United Association ("UA") for remuneration or profit. The disability must be, on the basis of medical evidence, expected to continue during the remainder of his/her life or which will be expected to continue for at least one (1) year. To be *Disabled*, such disability cannot have been caused by: (a) the use of illegal narcotics; (b) the performance of or engagement in illegal activity; or (c) the result of a self-inflicted injury that is not the result of a medical condition.

→ **Effective Date:** The effective date of this SPD, the effective date of a specific benefit, or the date an *Employee* or *Dependent* becomes eligible for benefits. The *Effective Date* of this Plan will be January 1, 2024.

→ **Employee:** Any person who is or has been employed by an *Employer* in *Covered Employment*, or such other employment for which the *Employer* is obligated by a *Collective Bargaining Agreement*, or any other written agreement, to contribute to the *Plan*.

→ **Employer:** Any of the following:

- Any member of an *Employer Association* and any other individual, partnership, corporation or business entity which is employing the services of individuals performing work that is within the trade jurisdiction of the *Union* and which has a *Collective Bargaining Agreement* or any other written agreement in effect, requiring contributions to the Plan;

- Any other *Employer* engaged in work coming within the trade, craft, and geographical jurisdiction of the *Union*, who is obligated by a *Collective Bargaining Agreement*, or such other written agreement, to make contributions to this Plan on behalf of its *Employees*;

- The *Union*, its related international bodies, solely to the extent that it acts in the capacity of an *Employer* of its business representative or its *Employees*, provided it agrees to make contributions to the Plan on behalf of such *Employees;*

- Any training or other similar program operated in whole or in part by the *Union*, or with its approval, or in which the *Union* participates;

- Any board of trustees, committee or other agency established to administer or be responsible for fringe benefit plans, educational or other programs established through collective bargaining by the *Union*, the members of which maintain a collective bargaining relationship with the *Union* or one of its constituent Locals;

- Any council, committee, or other body composed of representatives of one or more labor organizations of which the *Union* or one of its constituent Locals is a member and agrees in writing to participate herein; or

- Any sponsoring *Employer Association*, whose members maintain a collective bargaining relationship with the *Union*, solely in its capacity as an *Employer* of *Employees*, on whose behalf it has agreed in writing to make contributions to this Plan.

→ **Employer Contributions:** Those sums required to be paid to the Plan pursuant to the governing *Collective Bargaining Agreement* between an *Employer* and the *Union*.

→ **Experimental or Investigational:** Means any drug, service, supply, care, or treatment that, at the time provided or sought to be provided, is not recognized as conforming to accepted medical practice or to be a safe, effective standard of medical practice for a particular condition. This includes, but is not limited to:

- Items within the research, investigational, or experimental stage of development or performed within or restricted to use in Phase I, II, or III clinical trials (unless identified as a covered service elsewhere);

- Items that do not have strong, research-based evidence to permit conclusions and/or clearly define long-term effects and impact on health outcomes (i.e., that have not yet been shown to be consistently effective for the diagnosis or treatment of the specific condition for which it is sought). Strong, research-based evidence is identified as peer-reviewed published data derived from multiple, large, human, randomized, controlled clinical trials or at least one or more large, controlled, national, multi-center, population-based studies;

- Items based on anecdotal and unproven evidence (literature consisting only of case studies or uncontrolled trials), i.e., items that lack scientific validity, but may be common practice within select practitioner groups even though safety and efficacy is not clearly established;

- Items that have been identified through research-based evidence to not be effective for a medical condition and/or to not have a beneficial effect on health outcomes;

- FDA and/or Medicare approval does not guarantee that a drug, supply, care, or treatment is accepted medical practice; however, lack of such approval will be a consideration in determining whether a drug, service, supply, care, or treatment is considered Experimental Investigational, or Unproven. In assessing cancer care claims, sources such as the National Comprehensive Cancer Network (NCCN) Compendium, Clinical Practice Guidelines in Oncology, TM or National Cancer Institute (NCI) standard of care compendium guidelines, or similar material from other or successor organizations will be considered along with benefits provided under the Plan and any

benefits required by law. Furthermore, off-label drug or device use (sought for outside FDA-approved indications) is subject to medical review for appropriateness based on prevailing peer-reviewed medical literature, published opinions and evaluations by national medical associations, consensus panels, technology evaluation bodies, and/or independent review organizations to evaluate the scientific quality of supporting evidence;

- The foregoing definition shall not apply to any clinical trials or other experimental services required to be covered under the Patient Protection and Affordable Care Act (PPACA).

→ **Final Adverse Benefit Determination:** An *Adverse Benefit Determination* that has been upheld by the Board of Trustees at the completion of the internal *Appeals* process.

→ **Hour Bank:** A notional account (available only to Class I *Participants*) where *Contribution Hours* in excess of the amount required to establish or maintain eligibility are stored.

→ **Initial Eligibility:** The requirements that a covered individual and his/her *Dependents* must meet to become initially eligible for coverage under the Plan.

→ **Medical Provider or Physician:** Any of the following:

- A doctor of medicine, osteopathy, chiropractor, podiatry or optometry, legally qualified and licensed to practice medicine, perform surgery, or provide services at the time and place services are performed;

- A person who is licensed or certified as a psychologist (but not including a person acting within the scope of a partial or limited license or certification);

- A person who is a Member or Fellow of the American Psychological Association if there is no licensure or certification in the jurisdiction where such person renders service; and

- A Physician's Assistant, nurse, or person of a similar position working under the direction of the treating *Physician*. The Plan will provide coverage for services administered by a Physician's Assistant or an otherwise qualified person working under a *Physician*, however, the Plan or its network provider may seek *Physician* verification prior to approving payment for any claims or benefits or audit claims.

→ **Medically Necessary:** Means any health care services provided for the purpose of preventing, evaluating, diagnosing, or treating an illness, injury, mental illness, substance use disorder, condition, or disease or its symptoms, that generally meet the following criteria as determined by the Trustees or their designee, within their sole discretion:

- In accordance with Generally Accepted Standards of Medical Practice; and

- Clinically appropriate, in terms of type, frequency, extent, site, and duration, and considered effective for the Participant's illness, injury, mental illness, substance use disorder, or disease or its symptoms; and

- Not mainly for the person's convenience or that of the person's doctor or other health care provider; and

- Is the most appropriate, most cost-efficient level of service(s), supply, or drug that can be safely provided to the person and that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the person's illness, injury, disease, or symptoms.

The fact that a Medical Provider has performed, prescribed, recommended, ordered, or approved a service, treatment plan, supply, medicine, equipment, or facility, or that it is the only available procedure or treatment for a condition, does not, in itself, make the utilization of the service, treatment plan, supply, medicine, equipment, or facility Medically Necessary.

Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. The Trustees reserve the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Medical Provider specialty society recommendations, the choice of expert, and the determination of when to use any such expert opinion will be within the Trustees' sole discretion.

→ **Participant:** An *Employee* who has met the requirements established by the Board of Trustees to be eligible for benefits under this *Plan*.

→ **Plan Year or Fiscal Year:** The time period of January 1 through December 31.

→ **Post-Service Claims:** Any *Claim* that is not a *Pre-service*, *Urgent Care*, or *Concurrent Care Claim*.

→ **Pre-Service Claim:** Any *Claim* that, under the terms of the *Plan*, conditions receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

→ **Qualified Medical Child Support Order:** A medical support order:

- Which creates or recognizes the existence of an alternate recipient's right to receive benefits as a *Dependent* under this *Plan*, and

- Includes:

  - The name and the last known mailing address (if any) of the *Participant* and the name and mailing address of each alternate recipient covered by the order;

  - A reasonable description of the type of coverage to be provided by the Plan to each such alternate recipient, or the manner in which such type of coverage is to be determined (not to exceed the level of coverage offered by the Plan);

  - The period to which such order applies; and

  - The legal name of this *Plan*.

→ **Reasonable and Customary Charge:** Charges which do not exceed charges normally made by other hospitals, physicians, or service providers in this geographic area. For purposes of foregoing, covered charges will mean the actual cost or charge to an eligible *Participant* or *Dependent*, but only to the extent they will be deemed *Reasonable and Customary Charges* for *Medically Necessary* care and services which are ordered by a legally-qualified *Physician*, but not to exceed the maximums provided in the Schedule of Benefits.

→ **Rescission:** A cancellation of coverage that has a retroactive effect and that is not the result of fraud or an intentional misrepresentation of a material fact. Cancellation of coverage due to non-payment of premiums or contributions toward the cost of coverage, including self-payments or COBRA premiums, is not a *Rescission*. Prospective cancellations of coverage will not be based upon any health factor, as defined in 26 CFR 54.9802-1.

→ **Residential Treatment Center:** A licensed facility setting offering a defined course of therapeutic intervention and special programming in a controlled environment which also offers a degree of security, supervision, structure and is licensed by the appropriate state and local authority to provide such service. Patients with such facilities are medically monitored with twenty-four (24)-hour medical availability and twenty-four (24)-hour onsite nursing services for patients with Mental Illness and/or Substance Abuse disorders. It *does not* include half-way houses, supervised living, group homes, wilderness, equine or similar programs, boarding houses or other facilities that provide primarily a supportive environment and address long term social needs, even if counseling is provided in such facilities; any services, irrespective of whether they are based on *Medical Necessity*, at the specified and/or related facilities *will not* be covered under the *Plan*.

→ **Retiree:** An individual who has met the initial eligibility requirements for coverage as a Retiree under the *Plan* and who has established and continuously maintained eligibility for benefits under this Plan. Residential *Employees* and their *Dependents* are not eligible for coverage under the *Plan*.

→ **Sickness:** Disease, mental, emotional, or nervous disorders, and covered pregnancy. A recurrent *Sickness* will be considered as one (1) *Sickness.* All related *Sicknesses* will be considered as one (1) *Sickness*. Concurrent *Sicknesses* will be deemed to be one (1) *Sickness* unless such *Sicknesses* are totally unrelated.

→ **Spouse:** The individual to whom a *Participant* is legally married to (a marriage certificate will be required as proof of spousal relationship).

→ **State Benefits –** means the full amount of unemployment compensation benefits payable to an Employee for a full or partial week of unemployment under the Ohio Unemployment Compensation Act or similar act of any state.

→ **Supplemental Credit Reserve Account:** A notional account that functions as a Health Reimbursement Account ("HRA") that does not vest, and may be used to pay for some expenses not covered by the Plan. Only certain expenses approved by the Internal Revenue Service ("IRS") and the Board of Trustees can be reimbursed through the *Supplemental Credit Reserve Account* ("*SCRA***"**). Residential *Employees* are not eligible for a *SCRA*.

→ **Union:** The Northwestern Ohio Plumbers and Pipefitters Local 50, its affiliate Local *Unions*, or any successor thereto.

→ **Urgent Care Claims:** Any *Claim* for medical care or treatment which cannot be decided under normal time frames because: (a) it can seriously jeopardize the life or health of the claimant or the ability of the *Claimant* to regain maximum function, or (b) in the opinion of a *Medical Provider* with knowledge of the *Claimant's* medical condition, would subject the *Claimant* to severe pain that cannot be adequately managed without the care or treatment that is the subject of the *Claim*. Any *Claim* that a *Medical Provider* with knowledge of the *Claimant's* medical condition determines is an *Urgent Care Claim* will be treated as an *Urgent Care Claim* by the *Plan*. Otherwise, the determination regarding whether a *Claim* involves *Urgent Care* will be made by an individual acting on behalf of the *Plan* applying the judgment of a prudent layperson that possesses an average knowledge of health and medicine.

APPENDIX B
SCHEDULE OF BENEFITS
CLASS I & CLASS II PARTICIPANTS AND THEIR DEPENDENTS
EFFECTIVE JANUARY 1, 2024

This Plan offers coverage for various benefits, some of which require the satisfaction of applicable deductibles, co-pays, limitations, exclusions or separate eligibility requirements. Full credit will be given for deductibles and co-pays satisfied under the terms of the Predecessor Plan in the current benefit year. The following benefit levels currently apply:

BENEFIT ITEM	IN-NETWORK	OUT-OF-NETWORK
Lifetime or Annual Plan Maximums	None	
Participant Responsibility	Deductibles, copays, coinsurance and out-of-pocket maximums. If an in-network provider refers you to an out-of-network provider, all covered services obtained from the out-of-network provider will be subject to applicable cost sharing including potential balance bill amounts.	
Prior Authorization Requirement – Medical and Surgical	Coverage will be denied if your Medical Provider does not obtain prior authorization from the Plan's utilization review vendor for certain medical and surgical services, which are noted throughout this Schedule of Benefits. Services requiring prior authorization are as follows: • Non-emergency in-patient care • In-patient mental health & substance abuse treatment • Certain maternity services • Skilled nursing care • Hospice • Home infusion therapy • Home health care • Private duty nursing • Outpatient surgeries requiring general anesthesia • Medically necessary cosmetic surgery • Tempo-mandibular joint repair • Physical therapy after the 24th visit • Outpatient dialysis • High-cost medications administered on-site • Durable Medical Equipment (DME) Only motorized, scooters or wheelchairs and pneumatic compression devices	
Prior Authorization Requirement – Prescription Drugs	Coverage will be denied if your prescribing Medical Provider does not obtain prior authorization from the Plan's Pharmacy Benefit Manager (PBM) for all specialty drugs, compound drugs costing $100 or more, and any non-specialty or non-compound drugs costing $5,000 or more.	

Calendar Year Deductible	$400 per individual; $1,200 per family	
Calendar Year Out-of-Pocket Maximum (Excludes deductibles and copays)	$1,500 Individual $3,000 Family	
Co-Insurance	Covered 80% after deductible up to out-of-pocket maximum; 100% thereafter	Covered 70% after deductible up to out-of-pocket maximum; 100% thereafter
PREVENTIVE SERVICES		
Preventive health benefits include regular periodic health evaluation for adults and children, well baby care from birth, and routine adult and child immunizations. All preventive health benefits required by the Patient Protection and Affordable Care Act of 2010 (PPACA) and its implementing regulations will be covered without cost-sharing when received from an in-network provider.		
Health Evaluation Visit – Children Regular and periodic well-baby and well-child check-ups from birth.	Covered 100% No deductible	Covered at 70% after deductible; up to out-of-pocket maximum; 100% thereafter
Health Evaluation Visit – Adults (Chest x-ray, EKG, cholesterol screening, and other select lab procedures) – once per calendar year	Covered 100% No deductible	Covered 70% after deductible up to out-of-pocket maximum; 100% thereafter
Immunizations – routine immunizations for adults and children	Covered 100% No deductible	Covered at 70% after deductible; up to out-of-pocket maximum; 100% thereafter
Gynecological Exam – once per calendar year	Covered 100% No deductible	Covered 70% after deductible up to out-of-pocket maximum; 100% thereafter
Pap smear screening – once every other calendar year up to age 50, then once per calendar year	Covered 100% No deductible	Covered 70% after deductible up to out-of-pocket maximum; 100% thereafter
Voluntary sterilization for females	Covered 100% No deductible	Covered 70% after deductible up to out-of-pocket maximum; 100% thereafter
Routine Fecal occult blood screening – once per calendar year	Covered 100% No deductible	Covered 70% after deductible up to out-of-pocket maximum; 100% thereafter

Routine Flexible sigmoidoscopy exam- once per calendar year	Covered 100% No deductible	Covered 70% after deductible up to out-of-pocket maximum; 100% thereafter
Prostate specific antigen (PSA) screening- once per calendar year	Covered 100% No deductible	Covered 70% after deductible up to out-of-pocket maximum; 100% thereafter
Routine mammogram and related reading – once per calendar year (Subsequent medically necessary mammograms performed in the same calendar year are subject to deductibles and coinsurance)	Covered 100% No deductible	Covered 70% after deductible up to out-of-pocket maximum; 100% thereafter
Sports physical exam –once per calendar year	Covered 80% after deductible up to the out-of-pocket maximum; 100% thereafter	Covered at 70% after deductible up to out-of-pocket maximum; 100% thereafter
Colonoscopy – covered in accordance with prevailing guidance from the US Preventative Services Task Force. Otherwise, medically necessary colonoscopies are subject to your deductible and coinsurance	Covered 100% No deductible	Covered 70% after deductible up to out-of-pocket maximum; 100% thereafter
Smoking cessation – up to two cessation attempts per calendar year (includes four cessation counseling sessions and FDA-approved cessation medications for a 90-day treatment prescribed by a Medical Provider)	Covered 100% No deductible	Covered 70% after deductible up to out-of-pocket maximum; 100% thereafter
COVID-19 Preventive Services and Vaccinations	Covered 100% No deductible	Covered 70% after deductible up to out-of-pocket maximum; 100% thereafter
PHYSICIAN OFFICE SERVICES		
Outpatient Physician consultations & office visits	Covered 80% after deductible up to out-of-pocket maximum; 100% thereafter	Covered 70% after deductible up to out-of-pocket maximum; 100% thereafter
URGENT AND EMERGENCY MEDICAL CARE		

Emergency Room (Copay waived if admitted at in-network or out-of-network hospital)	$100 copay per visit. Covered 80% up to out-of-pocket maximum; 100% thereafter	$100 copay per visit. Covered 80% up to out-of-pocket maximum; 100% thereafter
Ambulance/Transportation	Covered 80% after deductible up to out-of-pocket maximum; 100% thereafter	Covered 80% after deductible up to out-of-pocket maximum; 100% thereafter
Urgent care	Covered at 80% after deductible up to out-of-pocket maximum; 100% thereafter	Covered at 80% after deductible up to out-of-pocket maximum; 100% thereafter
DIAGNOSTIC SERVICES		
Diagnostic Test (X-Ray, blood work)	Covered 80% after deductible up to out-of-pocket maximum; 100% thereafter	Covered 70% after deductible up to out-of-pocket maximum; 100% thereafter
Imaging (CT/PET scans, MRIs)	Covered 80% after deductible up to out-of-pocket maximum; 100% thereafter	Covered 70% after deductible up to out-of-pocket maximum; 100% thereafter
MATERNITY SERVICES		
Note: Mothers who are Dependent children are excluded from coverage for maternity services, with the exception of those services which are required to be provided under the PPACA. Covered maternity services also include those provided by a certified nurse midwife, in which the nurse midwife is legally authorized to perform.		
Prenatal and postnatal care visits	Covered 80% after deductible up to out-of-pocket maximum; 100% thereafter	Covered 70% after deductible up to out-of-pocket maximum; 100% thereafter
Delivery and nursery care – Prior authorization required for in-patient delivery in excess of 48 hours for vaginal delivery or 96 hours for cesarean delivery	Covered 80% after deductible up to out-of-pocket maximum; 100% thereafter	Covered 70% after deductible up to out-of-pocket maximum; 100% thereafter
Lactation counseling, breast pumps and supplies	Covered 100% No deductible	Covered 70% after deductible up to out-of-pocket maximum; 100% thereafter. Breast pumps and supplies

		covered 100% of the reasonable and customary amount.
HOSPITAL CARE		
Unlimited days in a semiprivate room, inpatien physician care, general nursing care, hospital services and supplies – Prior authorization required for non-emergency in-patient care	Covered 80% after deductible up to out-of-pocket maximum; 100% thereafter	Covered 70% after deductible up to out-of-pocket maximum; 100% thereafter
Inpatient consultations	Covered 80% after deductible up to out-of-pocket maximum; 100% thereafter	Covered 70% after deductible up to out-of-pocket maximum; 100% thereafter
Chemotherapy – Prior Authorization Required	Covered 80% after deductible up to out-of-pocket maximum; 100% thereafter	Covered 70% after deductible up to out-of-pocket maximum; 100% thereafter
ALTERNATIVES TO HOSPITAL CARE		
Skilled Nursing care – Prior authorization required	Covered 80% after deductible up to out-of-pocket maximum; 100% thereafter	Covered 70% after deductible up to out-of-pocket maximum; 100% thereafter
Hospice Care – Prior authorization required	Covered 80% after deductible up to out-of-pocket maximum; 100% thereafter	Covered 70% after deductible up to out-of-pocket maximum; 100% thereafter
Home Infusion Therapy – Prior authorization required	Covered 80% after deductible up to out-of-pocket maximum; 100% thereafter	Covered 70% after deductible up to out-of-pocket maximum; 100% thereafter
Home Health Care & Medically Necessary Private Duty Nursing – Prior authorization required	Covered 80% after deductible up to out-of-pocket maximum; 100% thereafter	Covered 70% after deductible up to out-of-pocket maximum; 100% thereafter
Rehabilitation Services	Covered 80% after deductible up to out-of-pocket maximum; 100% thereafter	Covered 70% after deductible up to out-of-pocket maximum; 100% thereafter

Habilitation Services	Covered 80% after deductible up to out-of-pocket maximum; 100% thereafter	Covered 70% after deductible up to out-of-pocket maximum; 100% thereafter
SURGICAL SERVICES		
Surgery – includes related surgical services and medically necessary facility services at an approved ambulatory surgical center. Charges for services rendered by an assisting physician or surgeon may not exceed one third (1/3) the cost of the primary physician. – Prior authorization required for non-emergency in-patient surgery.	Covered 80% after deductible up to out-of-pocket maximum; 100% thereafter	Covered 70% after deductible up to out-of-pocket maximum; 100% thereafter
Pre-surgical consultations	Covered 80% after deductible up to out-of-pocket maximum; 100% thereafter	Covered 70% after deductible up to out-of-pocket maximum; 100% thereafter
Voluntary sterilization for males	Covered 80% after deductible up to out-of-pocket maximum; 100% thereafter	Covered 70% after deductible up to out-of-pocket maximum; 100% thereafter
HUMAN ORGAN TRANSPLANTS		
Organ & tissue transplants – Case management may be required	Covered 80% after deductible up to out-of-pocket maximum; 100% thereafter	Covered 70% after deductible up to out-of-pocket maximum; 100% thereafter
MENTAL HEALTH AND SUBSTANCE ABUSE TREATMENT		
Mental health outpatient services	Covered 80% after deductible up to out-of-pocket maximum; 100% thereafter	Covered 70% after deductible up to out-of-pocket maximum; 100% thereafter
Substance abuse outpatient service	Covered 80% after deductible up to out-of-pocket maximum; 100% thereafter	Covered 70% after deductible up to out-of-pocket maximum; 100% thereafter

Mental health inpatient services – Prior authorization required	Covered 80% after deductible up to out-of-pocket maximum; 100% thereafter	Covered 70% after deductible up to out-of-pocket maximum; 100% thereafter
Substance abuse inpatient services – Prior authorization required	Covered 80% after deductible up to out-of-pocket maximum; 100% thereafter	Covered 70% after deductible up to out-of-pocket maximum; 100% thereafter
Employee assistance program	8 visits per incident	Not covered
HEARING BENEFITS		
Audiometric exam – once per calendar year	If in conjunction with hearing aid prescription, covered at 100% up to the $1,000 per year hearing aid benefit; otherwise covered at 80% after deductible up to the out-of-pocket maximum	If in conjunction with hearing aid prescription, covered at 100% up to the $1,000 per year hearing aid benefit; otherwise covered at 70% after deductible up to the out-of-pocket maximum
Hearing aids – once per calendar year	Up to $1,000 per year ($1,000 limit does not apply to Dependent children).	
OTHER COVERED SERVICES		
Allergy testing & treatment	Covered 80% after deductible up to out-of-pocket maximum; 100% thereafter	Covered 70% after deductible up to out-of-pocket maximum; 100% thereafter
Chiropractic – Up to 12 visits per calendar year	Covered 80% after deductible up to annual benefit maximum. Includes X-rays	Covered 70% after deductible up to annual benefit maximum. Includes X-rays
Durable Medical Equipment; Prosthetics & Orthotics – Prescription must be sent with claim***; prior authorization required***	Covered 80% after deductible up to out-of-pocket maximum; 100% thereafter	Covered 70% after deductible up to out-of-pocket maximum; 100% thereafter
Oral Surgery related to: Accidents		

Tempo-mandibular joint repair up to $1,000 – Prior authorization required Bruxism Osseous Surgery	Covered 80% after deductible up to out-of-pocket maximum; 100% thereafter

DENTAL BENEFITS

Effective January 1, 2017, Delta Dental will be the Plan's dental PPO network. The following schedule of benefits shall apply to all Class I and Class II Participants, and their Spouses and Dependents.

Delta Dental PPO (Point-of-Service) Summary of Dental Plan Benefits

	Delta Dental PPO Dentist	Delta Dental Premier Dentist	Nonparticipating Dentist
Covered Services	**Plan Pays**	**Plan Pays**	**Plan Pays***
DIAGNOSTIC & PREVENTIVE			
Diagnostic and Preventive Services – exams, cleanings, fluoride, and space maintainers	100%	100%	100%
Emergency Palliative Treatment – to temporarily relieve pain	100%	100%	100%
Sealants – to prevent decay of permanent teeth	100%	100%	100%
Brush Biopsy – to detect oral cancer	100%	100%	100%
Radiographs – X-rays	100%	100%	100%
BASIC SERVICES			
Minor Restorative Services–filings, crown repair	80%	80%	80%
Endodontic Services – root canals	80%	80%	80%
Periodontic Services – to treat gum disease	80%	80%	80%
Oral Surgery Services–extractions, dental surgery	80%	80%	80%
Other Basic Services – misc. services	80%	80%	80%
Relines and Repairs–to bridges, implants, dentures	80%	80%	80%
MAJOR SERVICES			
Major Restorative Services – crowns	50%	50%	50%

Prosthodontic Services – bridges, implants, and dentures	50%	50%	50%
ORTHODONTIC SERVICES			
Orthodontic Services – braces	50%	50%	50%
Orthodontic Age Limit -	Up to age 19	Up to age 19	Up to age 19
*The coinsurance indicated for services from a Nonparticipating Dentist are based on Delta Dental's Nonparticipating Dentist Fee.			
• Oral exams (including evaluations by a specialist) are payable twice per calendar year. • Prophylaxes (cleanings) are payable twice per calendar year. • People with specific at-risk health conditions may be eligible for additional prophylaxes (cleanings) or fluoride treatment. The patient should talk with his or her dentist about treatment. • Fluoride treatments are payable twice per calendar year for people up to age 19.			

VISION BENEFITS

STANDARD EYEWEAR

Covered Services	**In-Network Cost**	**Out-of-Network Reimbursement**
Exam	$10 copay	Up to $35
Exam under 19 years of age	$0 copay	Up to $35
Retinal Imaging	Up to $39	Not Covered
Frames	$0 copay, $170 Allowance, 20% of balance over $170	Up to $45
Standard Plastic Lenses		
• Single Vision	$25 copay	Up to $25
• Bifocal	$25 copay	Up to $40
• Trifocal	$25 copay	Up to $55
• Lenticular	$25 copay	Up to $80
• Progressive -Standard	$75 copay	Up to $40
• Progressive Premium Tier 1 – 3	$95 - $120 copay	Up to $40
• Progressive – Premium Tier 4	$75 copay, 20% off retail price less $120 allowance	Up to $40

Lens Options • UV Treatment • Tint (solid and gradient) • Standard Plastic Scratch Coating • Standard Polycarbonate • Standard Polycarbonate under 19 years of age • Anti-Reflective Coating – Standard • Anti-Reflective Coating Premium Tier 1 – 2 • Anti-Reflective Coating – Premium Tier 3 • Photochromic– Non-Glass • All Other Lens Options	 $15 $15 $15 $40 $0 copay $45 $57 - $68 20% off retail price $75 20% off retail price	 Not Covered Not Covered Not Covered Not Covered Up to $20 Not Covered Not Covered Not Covered Not Covered Not Covered
Contact Lens Fit and Follow Up • Fit & Follow Up – Standard • Fit & Follow Up -Premium	Up to $40; contact lens fit and two follow up visits 10% off retail price	Not Covered Not Covered
Contact Lenses • Contacts – Conventional • Contacts – Disposable • Contacts – Medically Necessary	$0 copay, 15% balance over $120 allowance $0 copay, 100% balance over $120 allowance $0 copay, paid-in-full	Not Covered Not Covered Not Covered
LASIK or PRK from U.S. Laser Network	15% off retail price or 5% off promotional price; call 1.800.988.4221	Not Covered
Hearing Care (Amplifon Hearing Network)	Discounts on hearing exams and aids; call 1.877.203.0675	Not Covered

Frequency • Exam • Lenses • Frames • Contact Lenses	 Kids: Once every 12 months; Adults: Once every 24 months Kids: Once every 12 months; Adults: Once every 24 months Kids: Once every 12 months; Adults: Once every 24 months Kids: Once every 12 months; Adults: Once every 24 months (Plan allows member to receive either contacts and frame, or frames and lens services)

SAFETY EYEWEAR		
Covered Services	**In-Network Cost**	**Out-of-Network Reimbursement**
Frames	$0 copay, 20% of balance over $170 allowance	Up to $70
Standard Plastic Lenses • Single Vision • Bifocal • Trifocal • Lenticular • Progressive -Standard • Progressive Premium Tier 1 – 3 • Progressive – Premium Tier 4	 $0 copay $0 copay $0 copay $0 copay $65 copay $85 - $110 copay $65 copay, 20% off retail price less $120 allowance	 Up to $30 Up to $50 Up to $70 Up to $70 Up to $50 Up to $50 Up to $50
Lens Options • UV Treatment • Tint (solid and gradient) • Standard Plastic Scratch Coating • Standard Polycarbonate • Anti-Reflective Coating – Standard • Anti-Reflective Coating Premium Tier 1 – 2 • Anti-Reflective Coating – Premium Tier 3 • Photochromic – Non-Glass • All Other Lens Options	 $15 $15 $15 $0 copay $45 $57 - $68 20% off retail price	 Not Covered Not Covered Not Covered Up to $32 Not Covered Not Covered Not Covered

	$75 20% off retail price	Not Covered Not Covered
Frequency • Exam • Lenses	Adults: Once every 12 months from the date of service Adults: Once every 12 months from the date of service	
PRESCRIPTION DRUG BENEFITS ADMINISTERED BY OPTUM-RX		
Prior authorization	Prior authorization must be obtained for all specialty drugs, compound drugs costing $100 or more, and all non-specialty and non-compound drugs costing $5,000 or more.	
Quantity limits	Up to 34 or 90 day supply for non-specialty drugs. 30 day supply only for specialty drugs	
One copay per 34 day supply for non-specialty drugs. Specialty drugs are only available in a 30 day supply.	$10-Generic, $35-Tier 2 Name Brand; $70-Tier 3 Name Brand; Covered 80% of cost up to $210 copay-Specialty Drugs	$10-Generic, $35-Tier 2 Name Brand; $70-Tier 3 Name Brand; 20% coinsurance up to $210-Tier 4 Name Brand; (Must submit a claim for reimbursement when using a non-network pharmacy; Specialty drugs not covered out-of-network, unavailable at an in-network pharmacy
Mail Order 90 day supply	$20-Generic; $70-Tier 2 Name Brand; $140-Tier 3 Name Brand; N/A – Specialty Drugs	Not Covered
Contraceptive coverage, including oral contraceptives, injections, IUD insertion and devices.	No copay generic; $35 Tier 2 Name Brand (no copay if no generic Equivalent); $70 Tier 3 Name Brand (no copay if no generic equivalent); Covered 80%-Specialty Contraceptives	No copay generic; $35 Tier 2 Name Brand (no copay if no generic Equivalent); $70 Tier 3 Name Brand (no copay if no generic equivalent). Must submit a claim for reimbursement when using a out-of-network pharmacy; Specialty contraceptives not covered out-of-network
Specialty Drugs – Prior authorization required and limited to 30-day supply	Covered 80% of cost up to $210 copay	Not Covered

Compound Drugs – Prior authorization required for compound drugs costing $100 or more	Copays vary
DEATH AND ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT	
Death Benefit	$2,000
Accidental Death Benefit	$4,000
SHORT TERM DISABILITY	
$450 per week paid the first day for an accident, the eighth day for a sickness that is non-occupational for up to 26 weeks.	

APPENDIX C
SCHEDULE OF BENEFITS
EARLY RETIREES AND THEIR DEPENDENTS WHO ARE NOT ON MEDICARE
EFFECTIVE: JANUARY 1, 2024

This Plan offers coverage for various benefits, some of which require the satisfaction of applicable deductibles, co-pays, limitations, exclusions or separate eligibility requirements. Full credit will be given for deductibles and co-pays satisfied under the terms of the Predecessor Plan in the current benefit year. The following benefit levels apply:

Benefit Item	In-Network	Out-of-Network
Lifetime or Annual Plan Maximums	None	
Participant Responsibility	Deductibles, copays, coinsurance and out-of-pocket maximums. If an in-network provider refers you to an out-of-network provider, all covered services obtained from the out-of-network provider will be subject to applicable cost sharing including potential balance bill amounts.	
Prior Authorization Requirement – Medical and Surgical	Coverage will be denied if your Medical Provider does not obtain prior authorization from the Plan's utilization review vendor for certain medical and surgical services, which are noted throughout this Schedule of Benefits. Services requiring prior authorization are as follows: • Non-emergency in-patient care • In-patient mental health & substance abuse treatment • Certain maternity services • Skilled nursing care • Hospice • Home infusion therapy • Home health care • Private duty nursing • Outpatient surgeries requiring general anesthesia • Medically necessary cosmetic surgery • Tempo-mandibular joint repair • Physical therapy after the 24th visit • Outpatient dialysis • High-cost medications administered on-site	

	• Durable Medical Equipment (DME), limited to motorized wheelchairs, scooters and pneumatic devices	
Prior Authorization Requirement – Prescription Drugs	Coverage will be denied if your prescribing Medical Provider does not obtain prior authorization from the Plan's Pharmacy Benefit Manager (PBM) for ***all*** specialty drugs, compound drugs costing $100 or more, and any non-specialty or non-compound drugs costing $5,000 or more.	
Calendar Year Deductible	$400 per individual; $1,200 per family	
Calendar Year Out-of-Pocket Maximum (Excludes deductibles and copays)	$1,500 Individual $3,000 Family	
Co-Insurance	Covered 80% after deductible up to out-of-pocket maximum; 100% thereafter	Covered 70% after deductible up to out-of-pocket maximum; 100% thereafter
PREVENTIVE SERVICES		
Preventive health benefits include regular periodic health evaluation for adults and children, well baby care from birth, and routine adult and child immunizations. All preventive health benefits required by the Patient Protection and Affordable Care Act of 2010 (PPACA) and its implementing regulations are covered without cost-sharing if received from an in-network provider.		
Health Evaluation Visit - Children Regular and periodic well-baby and well-child check-ups from birth.	Covered 100% No deductible	Covered 70% after deductible; up to out-of-pocket maximum; 100% thereafter
Health Evaluation Visit – Adults (Chest x-ray, EKG, cholesterol screening, and other select lab procedures) - once per calendar year	Covered 100% No deductible	Covered 70% after deductible up to out-of-pocket maximum; 100% thereafter
Immunizations – routine immunizations for adults and children	Covered 100% No deductible	Covered 70% after deductible; up to out-of-pocket maximum; 100% thereafter
Gynecological Exam - once per calendar year	Covered 100% No deductible	Covered 70% after deductible up to out-of-pocket maximum; 100% thereafter

Pap smear screening - once every other calendar year up to age 50, then once per calendar year	Covered 100% No deductible	Covered 70% after deductible up to out-of-pocket maximum; 100% thereafter
Voluntary sterilization for females	Covered 100% No deductible	Covered 70% after deductible up to out-of-pocket maximum; 100% thereafter
Routine Fecal occult blood screening - once per calendar year	Covered 100% No deductible	Covered 70% after deductible up to out-of-pocket maximum; 100% thereafter
Routine Flexible sigmoidoscopy exam- once per calendar year	Covered 100% No deductible	Covered 70% after deductible up to out-of-pocket maximum; 100% thereafter
Prostate specific antigen (PSA) screening- once per calendar year	Covered 100% No deductible	Covered 70% after deductible up to out-of-pocket maximum; 100% thereafter
Routine mammogram and related reading - once per calendar year (Subsequent medically necessary mammograms performed in the same calendar year are subject to deductibles and coinsurance)	Covered 100% No deductible	Covered 70% after deductible up to out-of-pocket maximum; 100% thereafter
Sports physical exam –once per calendar year	Covered 80% after deductible up to out-of-pocket maximum; 100% thereafter	Covered 70% after deductible up to out-of-pocket maximum; 100% thereafter
Colonoscopy – over age 50 once every five years. Otherwise, medically necessary colonoscopies are subject to your deductible and coinsurance	Covered 100% No deductible	Covered 70% after deductible up to out-of-pocket maximum; 100% thereafter
Smoking cessation - up to two cessation attempts per calendar year (includes four cessation counseling sessions and FDA-approved cessation medications for a 90-day treatment prescribed by a Medical Provider)	Covered 100% No deductible	Covered 70% after deductible up to out-of-pocket maximum; 100% thereafter
COVID-19 Preventive Services and Vaccinations	Covered 100% No deductible	Covered 70% after deductible up to out-of-pocket maximum; 100% thereafter

PHYSICIAN OFFICE SERVICES		
Outpatient Physician consultations & office visits *(includes telehealth visits)*	Covered 80% after deductible up to out-of-pocket maximum; 100% thereafter	Covered 70% after deductible up to out-of-pocket maximum; 100% thereafter
URGENT AND EMERGENCY MEDICAL CARE		
Emergency Room (Copay waived if admitted at in-network or out-of-network hospital)	$100 copay per visit. Covered 80% up to out-of-pocket maximum; 100% thereafter	$100 copay per visit. Covered 80% up to out-of-pocket maximum; 100% thereafter
Ambulance/Transportation	Covered 80% after deductible up to out-of-pocket maximum; 100% thereafter	Covered 80% after deductible up to out-of-pocket maximum; 100% thereafter
Urgent care (includes telehealth visits)	Covered 80% after deductible up to out-of-pocket maximum; 100% thereafter	Covered 80% after deductible up to out-of-pocket maximum; 100% thereafter
DIAGNOSTIC SERVICES		
Benefit Item	**In-Network**	**Out-of-Network**
Diagnostic Test (X-Ray, blood work)	Covered 80% after deductible up to out-of-pocket maximum; 100% thereafter	Covered 70% after deductible up to out-of-pocket maximum; 100% thereafter
Imaging (CT/PET scans, MRIs)	Covered 80% after deductible up to out-of-pocket maximum; 100% thereafter	Covered 70% after deductible up to out-of-pocket maximum; 100% thereafter
MATERNITY SERVICES		
Covered maternity services also include those provided by a certified nurse midwife, in which the nurse midwife is legally authorized to perform. Dependent children maternity coverage is limited to those benefits which are required to be provided under the PPACA.		
Prenatal and postnatal care visits	Covered 80% after deductible up to out-of-pocket maximum; 100% thereafter	Covered 70% after deductible up to out-of-pocket maximum; 100% thereafter
Delivery and nursery care – Prior authorization for vaginal delivery in excess of 48 hours or 96 hours for cesarean delivery	Covered 80% after deductible up to out-of-pocket maximum; 100% thereafter	Covered 70% after deductible up to out-of-pocket maximum; 100% thereafter

Lactation counseling, breast pumps and supplies	Covered 100% No deductible	Covered 70% after deductible up to out-of-pocket maximum; 100% thereafter Breast pumps and supplies covered 100% of the reasonable and customary amount
HOSPITAL CARE		
Unlimited days in a semiprivate room, inpatient physician care, general nursing care, hospital services and supplies – Prior authorization required for non-emergency in-patient care	Covered 80% after deductible up to out-of-pocket maximum; 100% thereafter	Covered 70% after deductible up to out-of-pocket maximum; 100% thereafter
Inpatient consultations	Covered 80% after deductible up to out-of-pocket maximum; 100% thereafter	Covered 70% after deductible up to out-of-pocket maximum; 100% thereafter
Chemotherapy – Prior Authorization Required	Covered 80% after deductible up to out-of-pocket maximum; 100% thereafter	Covered 70% after deductible up to out-of-pocket maximum; 100% thereafter
ALTERNATIVES TO HOSPITAL CARE		
Skilled Nursing care - Prior authorization required	Covered 80% after deductible up to out-of-pocket maximum; 100% thereafter	Covered 70% after deductible up to out-of-pocket maximum; 100% thereafter
Hospice Care - Prior authorization required	Covered 80% after deductible up to out-of-pocket maximum; 100% thereafter	Covered 70% after deductible up to out-of-pocket maximum; 100% thereafter
Home Infusion Therapy - Prior authorization required	Covered 80% after deductible up to out-of-pocket maximum; 100% thereafter	Covered 70% after deductible up to out-of-pocket maximum; 100% thereafter
Home Health Care & Medically Necessary Private Duty Nursing – Prior authorization required	Covered 80% after deductible up to out-of-pocket maximum; 100% thereafter	Covered 70% after deductible up to out-of-pocket maximum; 100% thereafter
Rehabilitation Services	Covered 80% after deductible up to out-of-pocket maximum; 100% thereafter	Covered 70% after deductible up to out-of-pocket maximum; 100% thereafter

Habilitation Services	Covered 80% after deductible up to out-of-pocket maximum; 100% thereafter	Covered 70% after deductible up to out-of-pocket maximum; 100% thereafter
SURGICAL SERVICES		
Surgery – includes related surgical services and medically necessary facility services at an approved ambulatory surgical center. Charges for services rendered by assisting physician may not exceed one third (1/3) the cost of the primary physician. - Prior authorization required for non-emergency in-patient surgery	Covered 80% after deductible up to out-of-pocket maximum; 100% thereafter	Covered 70% after deductible up to out-of-pocket maximum; 100% thereafter
Pre-surgical consultations	Covered 80% after deductible up to out-of-pocket maximum; 100% thereafter	Covered 70% after deductible up to out-of-pocket maximum; 100% thereafter
Voluntary sterilization for males	Covered 80% after deductible up to out-of-pocket maximum; 100% thereafter	Covered 70% after deductible up to out-of-pocket maximum; 100% thereafter
HUMAN ORGAN TRANSPLANTS		
Organ & tissue transplants – Case management may be required	Covered 80% after deductible up to out-of-pocket maximum; 100% thereafter	Covered 70% after deductible up to out-of-pocket maximum; 100% thereafter
MENTAL HEALTH AND SUBSTANCE ABUSE TREATMENT		
Mental health outpatient services	Covered 80% after deductible up to out-of-pocket maximum; 100% thereafter up to annual maximum	Covered 70% after deductible up to out-of-pocket maximum; 100% thereafter up to annual maximum
Substance abuse outpatient service	Covered 80% after deductible up to out-of-pocket maximum; 100% thereafter up to annual maximum	Covered 70% after deductible up to out-of-pocket maximum; 100% thereafter up to annual maximum
Mental health inpatient services – Prior authorization required	Covered 80% after deductible up to out-of-pocket maximum; 100% thereafter up to annual maximum	Covered 70% after deductible up to out-of-pocket maximum; 100% thereafter up to annual maximum

Substance abuse inpatient services – Prior authorization required	Covered 80% after deductible up to out-of-pocket maximum; 100% thereafter up to annual maximum	Covered 70% after deductible up to out-of-pocket maximum; 100% thereafter up to annual maximum
Employee assistance program	8 visits per incident	Not covered
HEARING BENEFITS		
Audiometric exam – once per calendar year	If in conjunction with hearing aid prescription, covered at 100% up to the $1,000 per year hearing aid benefit; otherwise covered at 80% after deductible up to the out-of-pocket maximum	If in conjunction with hearing aid prescription, covered at 100% up to the $1,000 per year hearing aid benefit; otherwise covered at 70% after deductible up to the out-of-pocket maximum
Hearing aids – once per calendar year	Up to $1,000 per year	
OTHER COVERED SERVICES		
Allergy testing & treatment	Covered 80% after deductible up to out-of-pocket maximum; 100% thereafter	Covered 70% after deductible up to out-of-pocket maximum; 100% thereafter
Chiropractic -- Up to 12 visits per calendar year	Covered 80% after deductible up to annual benefit maximum. Includes X-rays	Covered 70% after deductible up to annual benefit maximum. Includes X-rays
Durable Medical Equipment; Prosthetics & Orthotics–Prescription must be sent with claim	Covered 80% after deductible up to out-of-pocket maximum; 100% thereafter	Covered 70% after deductible up to out-of-pocket maximum; 100% thereafter
Oral Surgery related to: • Accidents • Tempo-mandibular joint repair up to $1,000 – Prior authorization required • Bruxism • Osseous Surgery	Covered 80% after deductible up to out-of-pocket maximum; 100% thereafter	

PRESCRIPTION DRUG BENEFITS ADMINISTERED BY OPTUM-RX	
Prior authorization	Prior authorization must be obtained for all specialty drugs, compound drugs costing $100 or more, GLP-1s, and all non-specialty and non-compound drugs costing $5,000 or more

Day Supply Limits	Up to 34, or 90-day supply for non-specialty drugs. 30-day supply only for specialty drugs	
One copay per 34-day supply for non-specialty drugs. Only a 30-day supply is available for specialty drugs.	$10-Generic, $35-Tier 2 Name Brand; $70-Tier 3 Name Brand; Covered 80% of cost up to $210 copay-Specialty Drugs	$10-Generic, $35-Tier 2 Name Brand; $70-Tier 3 Name Brand; 20% coinsurance up to $210-Tier 4 Name Brand; (Must submit a claim for reimbursement when using a non-network pharmacy; Specialty drugs not covered out-of-network, unless not available at in-network pharmacy
Mail Order 90-day supply	$20-Generic; $70-Tier 2 Name Brand; $140-Tier 3 Name Brand; N/A-Specialty Drugs	Not Covered
Contraceptive coverage, including oral contraceptives, injections, IUD insertion and devices.	No copay generic; $35 Tier 2 Name Brand (no copay if no generic Equivalent); $70 Tier 3 Name Brand (no copay if no generic equivalent); Covered 80%-Specialty Contraceptives	No copay generic; $35 Tier 2 Name Brand (no copay if no generic Equivalent); $70 Tier 3 Name Brand (no copay if no generic equivalent). Must submit a claim for reimbursement when using a out-of-network pharmacy; Specialty contraceptives not covered out-of-network
Specialty Drugs - Prior authorization required and limited to 30-day supply	Covered 80% of cost up to $210 copay	Not Covered
Compound Drugs - Prior authorization required for compound drugs costing $100 or more	Copays vary	
GLP-1s – Prior authorization required.	Copays vary	
DEATH BENEFIT		
Death Benefit	$1,000	
DELTA DENTAL PPO (POINT-OF-SERVICE) SUMMARY OF DENTAL PLAN BENEFITS		

	Delta Dental PPO Dentist	Delta Dental Premier Dentist	Nonparticipating Dentist
Covered Services	Plan Pays	Plan Pays	Plan Pays*
Diagnostic & Preventive			
Diagnostic and Preventive Services – exams and cleanings	100%	100%	100%
Bitewing Radiographs – bitewing X-rays	100%	100%	100%

* When you receive services from a Nonparticipating Dentist, the percentages in this column indicate the portion of Delta Dental's Nonparticipating Dentist Fee that will be paid for those services. This amount may be less than what the Dentist charges or Delta Dental approves and you are responsible for that difference.

- Oral exams (including evaluations by a specialist) are payable once per calendar year.
- Prophylaxes (cleanings) are payable once per calendar year. Periodontal maintenance procedures and full mouth debridement are not Covered Services.
- People with specific at-risk health conditions may be eligible for additional prophylaxes (cleanings) or fluoride treatment. The patient should talk with his or her dentist about treatment.
- Bitewing X-rays are payable once per calendar year. Full mouth X-rays (which include bitewing X-rays) are not Covered Services.
- Caries risk assessment is not a Covered Service.
- Biologic materials to aid in tissue regeneration are not Covered Services.
- Full and complete dentures, and services related to dentures are not Covered Services.
- Implants and implant related services are not Covered Services.
- Crowns over implants and their related services are not Covered Services.
- Occlusal guards are not Covered Services.

Having Delta Dental coverage makes it easy for you to get dental care almost everywhere in the world! You can now receive expert dental care when you are outside of the United States through our Passport Dental program. This program gives you access to a worldwide network of dentists and dental clinics. English-speaking operators are available around the clock to answer questions and help you schedule care. For more information, check our Web site or contact your benefits representative to get a copy of our Passport Dental information sheet.

Maximum Payment – $300 per person total per Benefit Year on all services.

Deductible – None.

VISION BENEFITS

Covered Services	In-Network Cost	Out-of-Network Reimbursement
Exam	$10 copay	Up to $35
Exam (under age 19)	$0 copay	Up to $35
Retinal Imaging	Up to $39	Not Covered
Contact Lens Fit and Follow Up		
• Standard Contact Lens Fit & Follow Up	Up to $40; contact lens fit and two follow up visits	Not Covered
• Premium Contact Lens Fit & Follow Up	10% off retail price	Not Covered
Frames	$0 copay, 20% of balance over $170 allowance	Up to $45
Standard Plastic Lenses		
• Single Vision	$25 copay	Up to $25
• Bifocal	$25 copay	Up to $40
• Trifocal	$25 copay	Up to $55
• Lenticular	$25 copay	Up to $80
• Standard Progressive	$75 copay	Up to $40
• Premium Progressive Tier 1, 2, 3	$95-$120 copay	Up to $40
• Premium Progressive Tier 4	$75 copay, 20% off retail price $120 allowance	Up to $40
Lens Options		
• Standard Anti-Reflective Coating	$45 copay	Not Covered
• Premium Anti-Reflective Coating Tier 1-2	$57-$68 copay	Not Covered
• Premium Anti-Reflective Coating Tier 3	20% off retail price	Not Covered
• Photochromic – Non-Glass	$75 copay	Not Covered
• Polycarbonate - Standard	$40 copay	Not Covered
• Polycarbonate – Standard (under age 19)	$40 copay	Up to $20
• Scratch Coating - Standard Plastic	$15 copay	Not Covered
• Tint - Solid or Gradient		
• UV Treatment		
• All Other Lens Options		

	$15 copay $15 copay 20% off retail price	Not Covered Not Covered Not Covered
• Contact Lenses – Conventional • Contact Lenses – Disposable • Contact Lenses - Medically Necessary	$0 copay, 15% balance over $120 allowance $0 copay, 100% balance over $120 allowance $0 copay, paid-in-full	Up to $105 Up to $105 Up to $210
Hearing Care (Amplifon Hearing Network)	Discounts on hearing exams and hearing aids	Not Covered
Lasik or PRK from U.S. Laser Network	15% off retail price or 5% off promotional price	Not Covered
Frequency • Examination • Frames • Lenses • Contact Lenses	Kids: Once every 12 months; Adults: Once every 24 months Kids: Once every 12 months; Adults: Once every 24 months Kids: Once every 12 months; Adults: Once every 24 months Kids: Once every 12 months; Adults: Once every 24 months	
(Plan allows Participants to receive either contacts and frame, or frame and lens services).		

APPENDIX D
SCHEDULE OF BENEFITS
RETIREES AND THEIR DEPENDENTS WHO ARE ON MEDICARE

Contact the Benefits Office for Current Schedule

APPENDIX E
SCHEDULE OF BENEFITS FOR PARTICIPATS AND DEPENDENTS WHO ARE NOT MEDICARE ELIGIBLE OR FOR WHOM MEDICARE IS NOT THE PRIMARY PAYOR FOR OUT-OF-NETWORK DIALYSIS CLAIMS

Effective July 1, 2016

This Plan offers coverage for dialysis-related services and supplies within the Preferred Provider Organization ("PPO") network(s), for both inpatient and outpatient treatment, in accordance with the Schedule of Benefits found in Appendix A. For any outpatient dialysis-related claims falling outside of the PPO provider's network(s), the Plan has established the Dialysis Preservation Program, which is described as follows:

SCHEDULE OF MEDICAL BENEFITS		
	PPO Provider	**Non-PPO Provider**
Dialysis Treatment - Outpatient	**Administered in accordance with the Schedule of Benefits found in Appendix A.**	**100% of the usual and reasonable charge after all applicable deductibles and coinsurance.**

1. Dialysis Treatment - Outpatient.

This Appendix B describes the Plan's Dialysis Benefit Preservation Program (the "Dialysis Program"). The Dialysis Program shall be the exclusive means for determining the amount of Plan benefits to be provided to Participants and for managing cases and claims involving dialysis-related services and supplies from providers

who are not a part of the PPO network(s) ("Out-of-Network Providers"), regardless of the condition causing the need for dialysis.

A. Reasons for the Dialysis Program. The Dialysis Program has been established for the following reasons:

(1) the concentration of dialysis providers in the market in which the Plan resides may allow such providers to exercise control over prices for dialysis-related products and services;

(2) the potential for discrimination by dialysis providers against the Plan because it is a non-governmental and non-commercial health plan, which discrimination may lead to increased prices for dialysis-related products and services charged to Plan Participants;

(3) evidence of (i) significant inflation of the prices charged to non-governmental and non-commercial health plans by dialysis providers, (ii) the use of revenues from claims paid on behalf of such plans to subsidize reduced prices to other types of payers as incentives, and (iii) the specific targeting of non-governmental and non-commercial plans, such as the Plan, by dialysis providers as profit centers; and

(4) the fiduciary obligation to preserve Plan assets against charges which (i) exceed reasonable value due to factors not beneficial to Plan Participants, such as market concentration and discrimination in charges, and (ii) are used by the dialysis providers for purposes contrary to the interests of Plan Participants, such as subsidies for other plans and discriminatory profit-taking.

B. Dialysis Program Components. The components of the Dialysis Program are as follows:

(1) Application. The Dialysis Program shall apply to all claims filed by, or on behalf of, Plan Participants for reimbursement of products and services provided by Out-of-Network Providers for purposes of outpatient dialysis, regardless of the condition causing the need for dialysis ("Dialysis-Related Claims").

(2) Claims Affected. The Dialysis Program shall apply to all Dialysis-Related Claims received by the Plan for expenses incurred on or after July 1, 2016, regardless when the expenses related to such claims were incurred or when the initial claim for such products or services was received by the Plan with respect to the Plan Participant.

(3) Mandated Cost Review. Upon first receiving Dialysis-Related Claims, the Plan Administrator will review relevant information to determine whether the charges indicate the effects of market concentration or discrimination in charges. In making this determination the Plan Administrator shall consider factors including:

i. **Market concentration:** The Plan Administrator shall consider whether the market for outpatient dialysis products and services is sufficiently concentrated to permit providers to exercise control over charges due to limited competition, based on reasonably available data and authorities. For purposes of this consideration multiple

dialysis facilities under common ownership or control shall be counted as a single provider.

ii. <u>Discrimination in charges</u>: The Plan Administrator shall consider whether the Dialysis-Related Claims reflect potential discrimination against the Plan, by comparison of the charges in such claims against reasonably available data about payments to outpatient dialysis providers by governmental and commercial plans for the same or materially comparable goods and services.

(4) In the event that the Plan Administrator's charge review indicates a reasonable probability that market concentration and/or discrimination in charges have been a material factors resulting in an increase of the charges for outpatient dialysis products and/or services for the Dialysis-Related Claims under review, the Plan Administrator may, in its sole discretion, determine that there is a reasonable probability that the charges exceed the reasonable value of the goods and/or services. Based upon such a determination, the Plan Administrator may subject the Dialysis-Related Claims and all future Dialysis-Related Claims from the same Out-of-Network Provider with respect to the Participant, to the following payment limitations, under the following conditions:

i. Where the Plan Administrator deems it appropriate in order to minimize disruption and administrative burdens for the Participant, Dialysis-Related Claims received prior to the cost review determination may, but are not required to be, paid at the face or otherwise applicable rate.

ii. <u>Maximum Benefit</u>. Except as provided in the preceding subsection or where an acceptable provider agreement is entered into, the maximum Plan benefit payable to Dialysis-Related Claims subject to the payment limitation shall be the usual and reasonable charge for covered services and/or supplies, after deduction of all amounts payable by coinsurance or deductibles.

ii. <u>Usual and Reasonable Charge</u>. With respect to Dialysis-Related Claims, the Plan Administrator shall determine the usual and reasonable charge based upon the average payment actually made for reasonably comparable services and/or supplies to all providers of the same services and/or supplies by all types of plans in the applicable market during the preceding calendar year, based upon reasonably available data, adjusted for the national Consumer Price Index medical care rate of inflation. The Plan Administrator may increase or decrease the payment based upon factors concerning the nature and severity of the condition being treated.

iv. <u>Additional Information related to Value of Dialysis-Related Services and Supplies</u>. The Participant, or where the right to Plan benefits has been properly

assigned to the Out-of-Network Provider, may provide information with respect to the reasonable value of the supplies and/or services, for which payment is claimed, on appeal of the denial of any claim or claims. In the event the Plan Administrator, in its sole discretion, determines that such information demonstrates that the payment for the claim or claims did not reflect the reasonable value, the Plan Administrator shall increase or decrease the payments (as applicable) to the amount of the reasonable value, as determined by the Plan Administrator based upon credible information from identified sources. The Plan Administrator may, but is not required to, review additional information from third-party sources in making this determination.

v. All charges must be billed by the Out-of-Network Provider in accordance with generally accepted industry standards.

2. **Provider Agreements.** Where appropriate, and where a willing and appropriate Out-of-Network Provider acceptable to the Plan Participant is available, the Plan Administrator may enter into an agreement establishing the rates payable for outpatient dialysis goods and/or services with the Out-of-Network Provider, provided that such agreement must identify this Appendix B of the Plan and clearly state that such agreement is intended to supersede this Appendix B.

3. **Discretion.** The Plan Administrator shall have full authority and discretion to interpret, administer and apply this Appendix B, to the greatest extent permitted by law. It is the express intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of this Appendix B, to make determinations regarding issues which relate to eligibility for benefits under this Appendix B, to decide disputes which may arise relative to a Plan's rights under this Appendix B, and to decide questions of interpretation of this Appendix B and those of fact relating to the application of this Appendix B. The decisions of the Plan Administrator will be final and binding on all interested parties.

4. **Secondary Coverage.** Plan Participants who are eligible for secondary coverage by any other health plan are encouraged to obtain such coverage. Failure to obtain secondary coverage may result in the Participant incurring costs which are not covered by the Plan and which would otherwise be covered by the secondary coverage. The Plan will not pay for any costs which would have been payable by such secondary coverage, except to the extent that such costs are payable in any event by the Plan.

5. **Provider Acceptance.** An Out-of-Network Provider that accepts the payment from the Plan under this Appendix B will be deemed to consent and agree that (i) such payment shall be for the full amount due for the provision of services and supplies to a Plan Participant, and (ii) it shall not "balance bill" a Plan Participant for any amount billed but not paid by the Plan.