OHIO CARPENTERS' HEALTH PLAN
SUMMARY PLAN DESCRIPTION

Effective May 1, 2022

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PREFACE

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

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

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

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ARTICLE 1 – DEFINITIONS

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

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

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

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

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

Child –

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

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

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

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

Consent to Out of Network Services means:

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

(b) the Plan receives notice of such consent.

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

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

(a) is undergoing a course of treatment for a serious and complex condition;

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(b) is undergoing a course of institutional or inpatient care;
(c) is scheduled to undergo nonelective surgery, including receipt of postoperative care with respect to such a surgery;
(d) is pregnant and undergoing a course of treatment for the pregnancy; or
(e) is or was determined to be terminally ill (i.e., a medical prognosis that the individual's life expectancy is 6 months or less).

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

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

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

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

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

Dependents mean a Participant's Spouse and Children.

Disabled-- a physical or mental condition, which in the opinion of a physician satisfactory to the Trustees, prevents a person from engaging in any regular occupation or employment for remuneration or profit for which contributions were received by the Plan prior to his/her disability. Notwithstanding, no person shall be deemed to have a Disability if such incapacity was contracted or incurred while he was engaged in an illegal activity or from service in the Armed Forces of any country.

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

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

Emergency Services with respect to an Emergency Medical Condition means:

(a) a medical screening examination that is within the capability of the emergency department of a hospital or of an independent freestanding emergency department, including ancillary services

routinely available to the emergency department to evaluate such emergency medical condition, and

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

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

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

Employer—Those who:

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

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

- If the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished;
- If reliable evidence shows that the drug, device, medical treatment, or procedure is the subject of ongoing phase I, II, or III clinical trials or is under study to determine maximum tolerated dose, toxicity, safety, or efficacy as compared with the standard means of treatment or diagnosis; or
- If reliable evidence shows that the consensus of opinion among experts regarding the drug, device, medical treatment, or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, toxicity, safety, or efficacy as compared with the standard means of treatment or diagnosis.

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

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

Fund is the Ohio Carpenters Health Fund, as established by the Agreement and Declaration of Trust of the Ohio Carpenters Health Fund, as amended from time to time.

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

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Health Care Agency – A facility which meets the specifications of Chapter 3701.88 of the Home Ohio Revised Code, except for the requirement that such Institution be operated within the state of Ohio, and provides nursing and other services under a plan prescribed and approved in writing by an attending Physician.

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

Hospice Facility – A facility which provides care for terminally ill patients.

Hospital – An Institution that meets the specifications of Chapter 3727 of the Ohio Revised Code, except for the requirement that such Institution be operated within the State of Ohio.

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

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

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

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

Medically Necessary (or Medical Necessity) – A service, supply, and/or Prescription Drug that is required to diagnose or treat a medical condition and which is:

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

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

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

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

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

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

Occupational Disease--A disease or sickness arising out of, or in any way resulting from, any work for pay or profit.

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

Other Professional Provider--Only the following persons or entities which are licensed as required:

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

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

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

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

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Physician--A person who is licensed and legally authorized to practice medicine.

Plan--The Ohio Carpenters' Health Fund's Plan document.

Plan Year means May 1 to the following April 30.

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

Provider--A Hospital, Other Facility Provider, Physician, or Other Professional Provider.

Psychiatric Facility--A facility which is primarily engaged in providing diagnostic services and therapeutic services for the treatment of Mental Illness on an Outpatient basis.

Psychiatric Hospital--A Hospital primarily engaged in providing treatment of Mental Illness.

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

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

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

Reasonable and Customary (R&C) means the lesser of the actual charge for services and supplies or the usual, customary, and reasonable charge for the services and supplies charged by most providers providing like services or supplies in the geographic area where such services are rendered or supplies are furnished. The Plan Administrator has complete and sole discretionary authority to decide whether a charge is Reasonable and Customary.

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

Retiree – an individual who:

(1) applies to the Plan for retiree coverage within 30 days of the last month in which he/she is eligible in the Plan as an Active Employee;

(2) is receiving a defined benefit pension from a plan affiliated with the United Brotherhood of Carpenters and Joiners of America;

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(3) Was eligible in the Plan as an Active Employee immediately preceding retirement and in the following time frames immediately preceding retirement:
- for a total of 60 months in the last ten years; and
- 9 of the 12 months immediately preceding retirement; and

(4) made no more than 12 full or partial consecutive self-payment to continue Plan coverage in the year immediately preceding retirement (or 24 months if timely and actively pursuing a Social Security Disability Award); and

(5) is a member of the Union in good standing (if your coverage under the Plan prior to retirement was based on Covered Employment as a bargaining unit member, which includes Employees of the Union who are alumni of the bargaining unit).

Serious and Complex Condition means

(a) in the case of an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or

(b) in the case of a chronic illness or condition, a condition that is life-threatening, degenerative, potentially disabling, or congenital, and requires specialized medical care over a prolonged period of time.

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

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

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

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

Surgery -- generally accepted operative and other invasive procedures.

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

Transplant Center--A facility licensed to perform transplants that is part of the Organ Procurement and Transplantation Network operated under contract with the U.S. Dept. of Health and Human Services by the United Network for Organ Sharing (UNOS) and is approved by any stop loss carrier with which the Fund has a contract or policy for stop loss coverage.

Union-- Indiana, Kentucky and Ohio Regional Council of Carpenters, or its constituent Local Unions.

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

ARTICLE 2 – ELIGIBILITY RULES

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

(a) Dollar Bank System

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

(2) The Trustees shall establish a monthly cost of coverage (Cost of Coverage) and a monthly subsidy amount (Subsidy), to be deducted from an Employee's Dollar Bank as set forth below. The Cost of Coverage and Subsidy are determined from time to time in the sole and exclusive discretion of the Trustees.

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

(b) Initial Eligibility. Provided a completed application has been provided to the Fund Office, will begin the first day of the second month following the date an Employee's Dollar Bank equals one month's Cost of Coverage plus three times the Subsidy, in the amounts established under section 2.1(a)(2), above, provided such amount was accumulated in a consecutive 12-month period. Prior to establishing initial eligibility, the Subsidy will be deducted from Contributions received and the balance of the Contributions will be credited to the Employee's Dollar Bank.

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

(1) was never previously covered by the Plan;

(2) immediately prior to entering Covered Employment was working for a non-contributing employer;

(3) within the immediate 30 days prior to entering Covered Employment, had comprehensive medical coverage meeting the minimum value standard of the Affordable Care Act (Other Coverage) as an employee (not as a dependent), and provides written proof Other Coverage satisfactory to the Trustees; and

(4) is engaged in Covered Employment as of the date he/she provides a completed application for coverage to the Fund Office.

If the above requirements are met, an Employee will be eligible for benefits the first of the month following 30 days after the Employee entered Covered Employment, provided a completed application for coverage is received within 59 days of the termination of his/her Other Coverage.

(d) Continuing Eligibility

(1) Crediting Contributions. The Dollar Bank is credited with Contributions received as follows:

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

***Eligibility Months**

Special Rule for Apprentices: Effective with hours for the work month of January 2019, for any work month during which an Apprentice attends school required by a training program in which he/she is indentured and that is affiliated with the United Brotherhood of Carpenters and Joiners of America, his/her Bank shall be credited with an amount equal to the Cost of Coverage minus the total Contributions actually received for such month, but not to exceed the number of hours in school attendance times the current contribution rate for such apprentice.

(2) Deductions from Dollar Bank to Maintain Coverage

(a) When monthly Contributions equal or exceed the sum of the Cost of Coverage and the Subsidy, this sum will be deducted for monthly eligibility. For example, if the Cost of Coverage is $890, the Subsidy is $200, and monthly Contributions are $1,090, $1,090 will be deducted.

(b) When monthly Contributions are less than the sum of the Cost of Coverage and the Subsidy but greater than the Cost of Coverage, an amount equal to the monthly Contributions will be deducted for monthly eligibility. For example, if the Cost of Coverage is $890, the Subsidy is $200, and monthly Contributions are $950, $950 will be deducted.

(c) When monthly Contributions are equal or less than the Cost of Coverage, the Cost of Coverage will be deducted for monthly eligibility. For example, if the Cost of Coverage is $890, the Subsidy is $200, and monthly Contributions are $850, $890 will be deducted. This will continue until the balance in the Dollar Bank is less than the Cost of Coverage.

(3) Self-Payments

- When the balance in the Dollar Bank is less than the Cost of Coverage, an Employee may self-pay to maintain coverage.
- The monthly self-pay equals the Cost of Coverage less any amount remaining in the Dollar Bank. Where the self-pay equals the Cost of Coverage, it is a "full self-payment."
- Full self-payments can be made for a maximum of 12 months. However, full self-payments are permitted for up to 24 months where the Employee is actively pursuing a Social Security Disability Award (SSD), provided the participant made application for SSD within 12 months of the onset of the Disability. After the 12- or 24- month period for self-payments is exhausted, the Employee will be offered COBRA if eligibility has not been re-established under the Initial Eligibility rules.
- Payments must be received by the Fund Office by the 11th of the month, or postmarked by the 8th of the month, for the month the self-payment is due (e.g., for April eligibility, the self-payment must be received by April 11th or postmarked by April 8th). Failure to timely remit self-payments will result in termination of coverage retroactive to the first of the month for which self-payment is due and COBRA will be offered. Late self-payments to reinstate eligibility are not allowed.
- If an Employee fails to make a timely self-payment and loses eligibility, the monthly Subsidy will continue to be deducted from any balance remaining in his/her Dollar Bank until the Bank is depleted or the Employee re-establishes eligibility.

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

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

(1) is temporarily Disabled, as supported by the statement of a Physician regularly treating the Active Employee confirming the Disability;

(2) is not Retired and is represented by the Union at the time the Disability was incurred, the date of application for benefits under (4), below, and remains represented by the Union,

(3) is receiving Weekly Disability benefits from this Fund, or is entitled to benefits under Workers' Compensation or occupational disease law; and

(4) submits a written application to the Fund Office for such credits within 6 months after the Disability starts. The 6-month limitation may be extended only if:

(i) the Disability is due to an on the job injury, and

(ii) the Participant returned to work following the injury, but due to a deterioration in his/her condition was unable to continue and has not returned to work again prior to the date of application, and

(iii) the Participant presents proof, acceptable in the sole discretion of the Trustees, that his initial injury was misdiagnosed, leading to prolonged treatment, and

(v) the Participant did not at any time prior to the application receive credits under this section for such injury.

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

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

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

2.2 Eligibility for Non-Bargaining Unit Employees

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

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

(ii) Employer has been a contributing Employer for at least 12 months prior to making application to cover its NBU;

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

(iv) The Employer covers all NBU who are working at least 24 hours a week for at least single coverage (no later than the first of the month following one month of employment), and is not allowed to cover those working less than 24 hours a week; and

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

(c) NBU are eligible for all benefits provided by the Fund with the exception of weekly disability benefits, retiree coverage, life insurance, and the MRA (as they do not have Banks).

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

(e) Notwithstanding this section 2.1, Union Employees who are alumni of the bargaining unit are covered under Section 2.1 and entitled to all benefits provided by the Fund.

2.3 Eligibility for Union Employees

(a) Union Office Employees. Union Office Employees will be eligible for coverage the first of the month following the month in which the Fund receives a monthly payment for coverage, in an amount determined by the Trustees, which may be changed by the Trustees from time to time in their sole discretion. Eligibility shall terminate as the first of the month for which such payment is not received. Union Office Employees do not have Banks and therefore are not eligible for the MRA.

2.3A. Eligibility for Shop Employees

(a) Dollar Bank System

(1) The Fund shall maintain a bookkeeping account for each Employee. The account shall be credited with Contributions received on behalf of each Employee, and the cumulative amount credited to the account shall be referred to as the Employee's "Dollar Bank" or "Bank." Shop Employees have Banks, but no MRA.

On a one-time basis, the Bank will be credited with the amount any Shop Employee had in his/her Bank as of 12/31/19, which was not used for coverage months prior to January 2020.

(2) The Trustees shall establish a monthly cost of coverage (Cost of Coverage) and a monthly subsidy amount (Subsidy), to be deducted from an Employee's Dollar Bank as set forth below. The Cost of Coverage and Subsidy are determined from time to time in the sole and exclusive discretion of the Trustees.

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

(b) Eligibility. Shop Employees will be eligible for coverage the first of the second month following the month in which the Fund receives contributions equal to one month's cost of coverage. Cost of coverage is an amount determined by the Trustees based on the coverage option selected, which may be changed by the Trustees from time to time in their sole discretion.

(c) Banks

(1) Crediting Contributions. The Dollar Bank is credited with Contributions received as follows:

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

***Eligibility Months**

(2) Elections and Deductions from Dollar Bank to Maintain Coverage

(i) Shop Employees may elect single or family coverage under the Shop Employees Plan or coverage under the Active Employees and Non-Medicare Retirees Plan under Section 3.2(a). Shop Employees will have the opportunity to make such elections one-time per calendar year during the open enrollment month of December for coverage for the following year. Cost of coverage per month for the Shop Plan is single $450 and family $750, or a shop employee can elect Full Plan coverage, family or single, for $950. A Shop Employee may only switch coverage options during a calendar year if the Shop Employee acquires a new Dependent as a result of marriage, birth, adoption, or placement for adoption and the request to change an

election is made within 60 days of such. If the request to change an election is timely received, coverage will be retroactive to the date of such event. If the request to change an election is not timely received, coverage will be effective the first day of the first month following the requested change. In addition, once per calendar year, a Shop Employee covered under the Active Employees and Non-Medicare Retirees Plan may elect to move to the Shop Employees Plan.

(ii) When monthly Contributions equal or exceed the sum of the cost of coverage and the subsidy, this sum will be deducted for monthly eligibility. The subsidy is currently $100. Therefore, for example, if the cost of coverage is $750, and monthly Contributions are $1,000, $850 will be deducted and $150 will be credited to the Bank.

(iii) When monthly Contributions are less than the sum of the cost of coverage and the subsidy but greater than the cost of coverage, an amount equal to the monthly Contributions will be deducted for monthly eligibility. For example, if the Cost of Coverage is $750, the subsidy is $100, and monthly contributions are $800, $800 will be deducted.

(iv) When monthly Contributions are equal or less than the cost of coverage, the cost of coverage will be deducted for monthly eligibility. For example, if the Cost of Coverage is $750, the subsidy is $100, and monthly Contributions are $700, $750 will be deducted. This will continue until the balance in the Bank is less than the cost of coverage.

(3) Self-Payments

- When the balance in the Dollar Bank is less than the Cost of Coverage, an Employee may self-pay to maintain coverage.
- The monthly self-pay equals the Cost of Coverage less any amount remaining in the Dollar Bank. Where the self-pay equals the Cost of Coverage, it is a "full self-payment."
- Full self-payments can be made for a maximum of 12 months. However, full self-payments are permitted for up to 24 months where the Employee is actively pursuing a Social Security Disability Award (SSD), provided the participant made application for SSD within 12 months of the onset of the Disability. After the 12- or 24- month period for self-payments is exhausted, the Employee will be offered COBRA if eligibility has not been re-established under the Initial Eligibility rules.
- Payments must be received by the Fund Office by the 11th of the month, or postmarked by the 8th of the month, for the month the self-payment is due (e.g. for April eligibility, the self-payment must be received by April 11th or postmarked by April 8$^{th)}$. Failure to timely remit self-payments will result in termination of coverage retroactive to the first of the month for which self-payment is due and COBRA will be offered. Late self-payments to reinstate eligibility are not allowed.
- If an Employee fails to make a timely self-payment and loses eligibility, the monthly Subsidy will continue to be deducted from any balance remaining in his/her Dollar Bank until the Bank is depleted or the Employee re-establishes eligibility.

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

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

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

(e) Reinstatement of Eligibility. In the event that the eligibility is terminated, an Employee may reinstate eligibility by satisfying the Initial Eligibility provisions in Section 2.3A(b).

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

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

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

Failure to make self-payments in the amount and within the time frame specified will result in a permanent loss of coverage. If a Retiree declines to elect Retiree coverage when first offered, he/she cannot elect such coverage at a later date. If Retiree coverage lapses or is terminated, it cannot be reinstated. No Retiree coverage is available to Union Office Employees or Shop Employees.

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

2.5 Dependent Eligibility

(a) Effective Date of Eligibility and Enrollment. Subject to the terms of this Plan, Dependents are eligible for benefits when the Participant of whom they are dependent is eligible. A completed enrollment form for Dependents must be received by the Fund Office within 30 days of an Employee's initial eligibility, in which case the Dependents are eligible as of the effective date of the Employee's eligibility. If not received within these 30 days, Dependents will be eligible the first of the month after a completed enrollment form is received (i.e. coverage will not be retroactively reinstated). An Active Employee must provide a completed enrollment form to the Fund Office for a new Dependent within 60 days of marriage, birth, adoption, etc., in which case coverage will be retroactive to date of such event. If not received within these 60 days, new Dependents will be eligible the first of the month after a completed enrollment form is received (i.e. coverage will not

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

Notwithstanding the above, the Plan will disregard the period from March 1, 2020, until the earlier of: (1) 1 year from the date a Participant or Beneficiary become eligible for an extended deadline or (2) 60 days after the announced end of the National Emergency or such other date announced by the applicable federal agency (the Outbreak Period) for all participants and dependents in determining the election periods above.

(b) Coverage Following the Death of a Participant

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

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

(2) Dependent Children. Children of a deceased Participant and a Surviving Spouse who were covered by the Fund at the time of the Participant's death will continue until the earlier of the date they no longer meet the definition of a Child or the date the Surviving Spouse's coverage terminates. Children of a deceased Participant who were covered by the Fund at the time of the Participant's death who are not Children of the Surviving Spouse may continue coverage via self-payment if an election is made for the continuation of coverage: (1) by any individual with a familial, or established caretaking, relationship with the deceased Participant's Children who assumes responsibility to make the required self-payments for continued coverage, or (2) by an adult Child of the deceased Participant who assumes responsibility on his or her own behalf to make the required self-payments for continued coverage.

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

2.6 Termination of Coverage

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

- The last day of the month the Participant maintains eligibility via the Dollar Bank or self-payments;
- The last day of the month a Participant begins active duty in the armed forces;

- The date a Participant becomes employed by an employer who does not contribute to any fund sponsored by a Regional Council or Local Union of the United Brotherhood of Carpenters and Joiners of America and who employs individuals in a trade or craft covered by a CBA;
- The date a Participant remains employed by an employer who no longer contributes to any fund sponsored by a Regional Council or Local Union of the United Brotherhood of Carpenters and Joiners of America and who employs individuals in a trade or craft covered by a CBA;
- The date an Active Employee ceases Covered Employment and is not on the Union's out-of-work list; or
- The date the Plan terminates.

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

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

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

3.1 Medical Network

The Fund has contracted with Anthem Blue Cross and Blue Shield (Anthem), a preferred provider network. A list of participating physicians and facilities, known as in-network providers, is available at the Plan Office free of charge. Covered Persons are encouraged to use in-network providers to save money for themselves and the Plan, but can choose treatment from an out-of-network provider and pay greater out of pocket expenses. Out of Network services will be reimbursed based on Reasonable and Customary charges (R&C).

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

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

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

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

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

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

3.2 Medical Benefits, Exclusions, and Other Limitations

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

	Active Employees and Non-Medicare Retirees (other than Shop Employees)		**Shop Employees**	
Medical Benefits	**In-Network**	**Out-Of Network**	**In-Network**	**Out-Of-Network**
Annual Deductibles -In/Out DO NOT Satisfy each other -Common accident deductible applies	$500/person $1,000/family	$1,000/person $2,000/family	$1,750/person $3,500/family	$3,500/person $7,000/family
Annual Out of Pocket Co-Insurance, Deductible, and Co-Payment Maximums -In/Out DO NOT Satisfy each other	$3,500/person $7,000/family	No out-of-pocket limit for out of network expenses	$ 7,350/person $ 14,700/family	$10,000/person $20,000/family

Actives and Non-Medicare Retirees (Including Shop Employees)		
Medical Benefits	**In-Network**	**Out-Of-Network**
Inpatient Hospital Precertification required. See § 3.2(c), below.		
Facility - Inpatient Hospital (Semi-private room; private room only when Medically Necessary)	75% after deductible	55% R&C after deductible
Birthing Center/Ambulatory Surgery Center	75% after deductible	55% R&C after deductible
Surgery -Two or more surgeries through same opening during one operation: coverage provided only for the most	75% after deductible	55% R&C after deductible

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

Actives and Non-Medicare Retirees (Including Shop Employees)		
complex procedure (but if such surgeries are mutually exclusive, coverage will be provided for each). -Two or more surgical procedures performed through different openings during one operation: coverage provided for the most complex procedure for the amount payable by the Plan as if it was the sole procedure, and coverage provided for the secondary procedures for half the amount payable by the Plan as if each was the sole procedure. -Multiple foot surgeries on same foot during one operation: coverage provided for the most complex procedure up to the amount payable by the Plan as if it were the sole procedure, coverage provided for the two next most complex procedures for half the amount payable by the Plan as if each was the sole procedure, and for additional procedures coverage one-fourth the amount payable by the Plan if each were the sole procedure. -Will cover second opinion for necessity of surgery, and third opinion only if first and second disagree.		
Anesthesia	75% after deductible	55% R&C after deductible
Certified registered nurse anesthetist	75% after deductible	55% R&C after deductible
Assistant Surgeon	75% after deductible	55% R&C after deductible
In-Hospital Consultations	75% after deductible	55% R&C after deductible
Diagnostic Labs and Services (radiology, ultrasound, nuclear medicine, lab, pathology, EKG, EEG, MRI, and other electronic diagnostic medical procedures)	75% after deductible	55% R&C after deductible
Labs	75% after deductible	55% R&C after deductible
Respiratory Therapy	75% after deductible	55% R&C after deductible
Kidney Dialysis	75% after deductible	55% R&C after deductible
Maternity Care/Birthing Center (including midwife) **Special Notice Regarding Maternity Benefits:** Group health plans and health insurance issuers generally may not, under federal law, restrict benefits or require authorization for any hospital length of stay in connection with childbirth for the mother or	75% after deductible	55% R&C after deductible

Actives and Non-Medicare Retirees (Including Shop Employees)		
newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable). Where an earlier discharge is not against medical advice, a home or office visit for education, physical and home assessment, feeding, and routine tests not completed due to early discharge is covered if conducted by a Physician or nurse within 72 hours of discharge.		
Organ Transplant Benefits- **Precertification Required and other restrictions apply See § 3.2(c).**	75% after deductible	55% R&C after deductible
Outpatient Care		
Surgery -Will cover second opinion for necessity of surgery, and third opinion only if first and second disagree.	75% after deductible	55% R&C after deductible
Diagnostic Labs and Services (radiology, x-ray, ultrasound, nuclear medicine, lab, pathology, EKG, EEG, MRI, and other electronic diagnostic medical procedures)	75% after deductible	55% R&C after deductible
Emergency Care for an Emergency Medical Condition	75% after $250 copay $250 waived if admitted to hospital, or if visit was due to an accidental or life-threatening event	75%* of the Recognized Amount, after $250 copayment (in-network out of pocket maximums apply and out of network co-insurance and copayment for Emergency Services count towards in-network out of pocket maximums). $250 waived if admitted to hospital, or if visit was due to an accidental or life-threatening event
Occupational/Physical/Speech Restorative Therapy - Limited combined 70 visits per year	75% after deductible	55% R&C after deductible
Respiratory Therapy	75% after deductible	55% R&C after deductible
Cardiac Rehabilitation	75% after deductible	55% R&C after deductible
Radiation and Chemotherapy	75% after deductible	55% R&C after deductible
Hemodialysis	75% after deductible	55% R&C after deductible

Actives and Non-Medicare Retirees (Including Shop Employees)		
Acute Kidney Dialysis	75% after deductible	55% R&C after deductible
Second surgical opinion	75% after deductible	55% R&C after deductible
Hyperbaric Therapy -only if provided by Hospital	75% after deductible	55% R&C after deductible
Mental Health/Substance Abuse		
Inpatient Hospital Care **-Precertification Required, see § 3.2(c).** -Includes counseling for Covered Persons who are family members	75% after deductible	55% R&C after deductible
Inpatient Residential Treatment Facility 60-day limit per year **-Precertification Required, see § 3.2(c).**	75% after deductible	No coverage
Outpatient	75% after deductible	55% R&C after deductible
Physician's Office/Urgent Care/On-Line All services received during one visit billed separately, and accordingly have separate cost sharing requirements.		
LiveHealth On-Line – see § 3.2(e) below	100%	No coverage
Physician Office Visit Illness/Injury	100% after $20 co-pay	55% R&C after deductible
Specialists & Consultations	100% after $40 co-pay	55% R&C after deductible
Pre/Post Natal Care that is not preventive care	80%* after deductible *After 1/1/19: 75%	55% R&C after deductible
Allergy Testing/Injections	75% after deductible	55% R&C after deductible
Diagnostic Lab/X-Ray	75% after deductible	55% R&C after deductible
Surgery	75% after deductible	55% R&C after deductible
Urgent Care	75% after deductible	55% R&C after deductible
Preventive Care The following, and other required preventive services, are covered only to the extent required under federal law.		
Physical/GYN/Routine PAP/Mammograms – Adult	100%	Not covered
Standard Pre- and Post-natal visits	100%	Not covered
Gestational Diabetes Screening (24-48 weeks pregnant)	100%	Not covered

Actives and Non-Medicare Retirees (Including Shop Employees)		
Prostate/Immunizations (limited to 1 per calendar year)	100%	Not covered
HPV DNA Testing (once every 3 years/women 30 & older)	100%	Not covered
Annual STI Counseling; HIV Screening & Counseling	100%	Not covered
Domestic Violence Screening & Counseling	100%	Not covered
Contraceptive Counseling Breastfeeding Support & Counseling (with birth of child)	100%	Not covered
Children's Physicals (up to age 21)	100%	Not covered
Obesity Services, if required to be covered as preventive services under federal law	100%	Not covered
Well Baby Care (up to age 12 months, including immunizations)	100%	Not covered
Immunizations for children and adults as required by Health Care Reform and recommended by the Advisory Committee on Immunization Practices, as appropriate based on age and population.1	100%	55% after deductible
Smoking Cessation	100%	Not covered
Colon/rectal screening	100%	Not covered
Any other required preventive care coverage under the Affordable Care Act	100%	Not covered
Other Providers		
Chiropractors – Limit 25 visits annually (office visits, manipulations, modalities, x-rays). Braces or molds in conjunction with chiropractic care not covered.	75% after deductible	55% R&C after deductible
Other Services		
Skilled Nursing Facility 60-day limit per year - **Precertification required, see Section 3.2(c).**	75% after deductible	No coverage
Private Duty Nursing – 90 visits per year	75% after deductible	55% R&C after deductible
Home Health Care – limit 40 visits per year	75% after deductible	55% R&C after deductible
Home Infusion Therapy	75% after deductible	55% R&C after deductible
Hospice Care -must be provided through a freestanding Hospice Facility or a hospice program sponsored by a	75% after deductible	55% R&C after deductible

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

Actives and Non-Medicare Retirees (Including Shop Employees)		
Hospital or Home Health Care Agency. Hospice services may be received in a private residence.		
Durable Medical Equipment (including rental fees not to exceed purchase price)	75% after deductible	55% R&C after deductible
Prosthetics -purchase, fitting, adjustments, repairs and replacements of prosthetic devices, including necessary supplies, that replace all or part of a missing body organ or limb and its adjoining tissues; or replace all or part of the function of a permanently useless or malfunctioning body organ or limb.	75% after deductible	55% R&C after deductible
Medical Supplies -Must serve a specific therapeutic purpose such as needles, oxygen, syringes, and surgical dressings and other similar items and be provided per physician orders.	75% after deductible	55% R&C after deductible
Ambulance -To and from the Hospital for a covered inpatient admission or initial treatment of an Emergency Medical Condition provided by a Hospital or a government-certified ambulance service.	75% after deductible	Ground ambulance 55% R&C after deductible Air ambulance: 75% of lesser of billed charges or the Qualified Payment Amount, after deductible (in-network deductible and in-network out-of-pocket maximums apply and out of network co-insurance and deductible for air ambulance counts towards in-network out of pocket maximums).
Abortion (therapeutic and elective – elective exception to medical necessity requirement)	75% after deductible	55% R&C after deductible
Sterilization -Medical Necessity not required	75% after deductible	55% R&C after deductible
Sterilization reversal if medically necessary to treat condition other than infertility	75% after deductible	55% R&C after deductible
Injections -Prescription Drugs and biologicals that cannot be self-administered and are furnished as part of a Physician's professional service, such as antibiotics and joint injections.	75% after deductible	55% R&C after deductible
Coronavirus/COVID-19		
COVID-19 testing ordered by a health care provider as required by law	100% of the negotiated rate that was in effect before	100% of the lesser of the cash price listed by the provider on a

Actives and Non-Medicare Retirees (Including Shop Employees)		
	the public health emergency was declared	public internet website or a negotiated amount
As required by law, provider fee, facility fee, or items and services furnished to an individual during a health care provider visit arising from a visit which results in order for COVID-19 testing to the extent that such items/services relate to the furnishing or administration of the test or evaluation of the individual for purposes of determining need for testing.	100% of the negotiated rate that was in effect before the public health emergency was declared	100% of the lesser of the cash price listed by the provider on a public internet website or a negotiated amount
Treatment for COVID-19 (this does not include Long- or Post-COVID-19)	100%	100% R&C
OTC COVID-19 Testing – FDA approved tests purchased on or after January 15, 2022, for personal use (e.g., not for employment purposes or resale) Maximum 8 tests per 30 day period per covered person Note: OTC COVID-19 tests covered via Pharmacy Benefit Manager.	100% coverage at retail and via direct to consumer shipping options provided by Pharmacy Benefit Manager	Until in-network options in place, reimburse 100% full price of test. On or after implementation of in-network options, reimbursement per test limited to lower of $12 or the actual price

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

(1) Not Medically Necessary;
(2) Not prescribed by or performed under the direction of a Physician or Other Professional Provider;
(3) Not performed or provided within the scope of the Provider's license;
(4) That is Experimental or Investigational;
(5) Provided by a governmental unit or agency;
(6) Arising from war, whether or not a declared war.
(7) For which the Covered Person has no legal obligation to pay in the absence of this or like coverage;
(8) Received from a facility maintained by or on behalf of an employer, mutual benefit association, labor union, trust, or similar person or group;
(9) Received from a member of the Covered Person’s Immediate Family or a person who usually lives in the Covered Person’s home;
(10) Incurred after eligibility terminates or before eligibility begins;
(11) Sustained while participating in a felonious criminal activity (not as an innocent victim);
(12) For the following:

i. Examinations required by an insurance company to obtain insurance, a governmental agency, or an employer or prospective employer;
ii. Premarital examinations;
iii. Screening examinations (such as employment related exams), or
iv. X-ray examinations made without film.

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

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

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

(16) Cosmetic surgery, including surgery to correct a deformity or birth defect for psychological reasons where there is no functional impairment, and cosmetic surgery following weight loss. Any repairs, revisions, or modifications of excluded cosmetic surgery are also excluded. This exclusion will not preclude coverage for: (a) reconstructive surgery following a mastectomy, including coverage for reconstructive surgery performed on a non-diseased breast to establish symmetry as well as coverage for prostheses and physical complications in all stages of mastectomy, including lymphedemas; and (b) surgery to correct functional or physiological impairment which was caused by disease, trauma, birth defects, growth defects, or prior therapeutic processes);

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

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

(19) For the removal of tattoos;

(20) For dietary and/or nutritional guidance or training, except as otherwise specifically provided for by this Plan;

(21) For educational, vocational, or training purposes, except as otherwise specifically provided for by this Plan;

(22) For topical anesthetics;

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

(24) Weight loss drugs, programs, or services, except as otherwise specifically provided for by this Plan;

(25) Dietary supplements, food, vitamins, and any care which is primarily dieting or exercise;

(26) Weight loss surgery and any repairs, revisions, or modifications of such surgery, including weight loss device removal;

(27) Marital counseling;

(28) Treatment of erectile dysfunction or other sexual problems not caused by a specific Illness or Injury;

(29) Transsexual or transgender surgery or any treatment leading to or in connection with transsexual or transgender surgery;

(30) For Contraceptives, except as specified;

(31) For reverse sterilization, unless medically necessary to treat condition other than infertility;

(32) Artificial insemination, in vitro fertilization, embryo transfer procedures, or other procedures related to the treatment of infertility (Fund will cover procedures related to diagnosis of infertility);
(33) Related to any surrogate parent services;
(34) Expenses in connection with dental work, dentures, or dental appliances, except: (1) for treatment made necessary by an accident and rendered by a physician or a legally licensed dentist within 90 days of such accident, or (2) in the event dental procedures are required to prevent complications arising from the treatment of a life-threatening medical condition, as supported by documentation acceptable to the Trustees, and such dental procedures will be covered to the extent not covered by any dental benefits (insured or self-insured) for which the Covered Person is eligible.
(35) For personal hygiene and convenience items;
(36) For eyeglasses, contact lenses, or examinations for prescribing or fitting them, except those for aphakic patients, keratoconus, and soft lenses or sclera shells for use as corneal bandages when needed as a result of surgery, except as otherwise specifically provided for by this Plan;
(37) For any surgical procedure for the correction of a visual refractive problem including, but not limited to, radial keratotomy and lasik;
(38) For all services related to hearing loss including hearing aids or examinations for prescribing or fitting them, except as otherwise specifically provided for by this Plan;
(39) For immunizations, except as otherwise specifically provided for by this Plan;
(40) For massotherapy or massage therapy;
(41) For hypnosis and acupuncture;
(42) For telephone and online consultations (other than services specifically covered by the Plan), missed appointments, completion of claim forms, or copies of medical records;
(43) For fraudulent or misrepresented claims;
(44) For blood which is available without charge; outpatient blood storage services; autotransfusions or cell saver transfusions occurring during or after surgery.
(45) For over-the-counter drugs, vitamins, or herbal remedies;
(46) For specialized camps;
(47) For a particular health service in the event that a Non-PPO Network Provider waived Copayments, Non-PPO Network Coinsurance (and/or the Non-PPO Network Deductible per Benefit Period); no benefits are provided for the health service for which the Copayments, Non-PPO Network Coinsurance (and/or the Non-PPO Network Deductible per Benefit Period) are waived;
(48) In connection with treatment of Temporomandibular Joint Syndrome (TMJ).
(49) Items usually stocked in the home for general use, including but not limited to corn and bunion pads, elastic bandages, support/compression stockings, thermometers; etc.
(50) Items for comfort and convenience, disposable supplies, and hygienic equipment, and self-help devices, unless otherwise specifically covered by the Plan.
(51) Genetic testing, with the exception of the following covered genetic testing: (a) genetic counseling and routine breast cancer susceptibility testing (BRCA testing), if deemed appropriate for a woman by her health care provider and if required by federal law to be covered as a preventive service; and (b) testing used to determine appropriate medical treatment for currently active, ongoing medical conditions.
(52) Wigs and hair pieces.
(53) Prosthetics that are specially designed for uses such as sporting events;
(54) Clinical trials, except for Routine Patient Costs incurred in an Approved Clinical Trial as set forth below. For purposes of this provision:

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

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

(1) the investigational item, device, or service, itself;

(2) items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or

(3) a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

Where an in-network provider is participating in an Approved Clinical Trial in the Covered Person's state of residence and this participating provider will accept the Covered Person as a participant in that trial, coverage for Routine Patient Costs will only be provided for participation in such trial. In-network and out-of-network Routine Patient Costs will be subject to the Plan's standard cost-sharing provisions for in- and out-of-network services and expenditures, which means a Covered Person may be balance billed for participating with an out-of-network provider.

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

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

(57) Electroshock therapy and related anesthesia unless provided in a Hospital or Psychiatric Hospital.

(58) Newborn care is not covered for newborns of Dependent Children (Maternity care is provided for Dependent Children.)

(59) Taxes included in the purchase of covered over the counter supplies or devices.

(60) Biofeedback.

(61) Gene therapy.

(62) Treatment for conditions related to an autistic disease, ADD, ADHD, developmental delay, learning disabilities, hyperkinetic syndromes, behavioral problems, or intellectual disability (intellectual developmental disorder).

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

(64) Hot tubs.

(c) Precertification

Inpatient: Precertification means that admissions and certain procedures are reviewed prior to delivery to ensure medical necessity and other requirements for coverage are met. It is required

prior to in-patient hospital admissions, organ transplants, residential treatment facility admissions, and skilled nursing facility admissions. If an emergency admission is required, the Covered Person must have the admission precertified within 48 hours following admission. Pre-certification of benefits is provided by American Health Holdings, except organ/tissue transplants which are precertified by Anthem. If precertification is denied, this is considered a claim denial that may be appealed per Article 14.

Outpatient: Upon request, outpatient procedures and ongoing services such as physical therapy, home health care, durable medical equipment, etc, can be reviewed by American Health Holdings to ensure medical necessity and other requirements for coverage are met. In addition, certain injections set forth in the Anthem Plan Benefit Design require precertification (contact the Fund Office for a list of injections requiring precertification).

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

(e) Live Health On-Line. Live Health On-Line is a program that allows Covered Persons to contact a Physician online (with a webcam) or through a smartphone 24 hours a day, 7 days a week, for non-emergency issues. Live Health On-Line is accessible at www.livehealthonline.com (1-888-548-3432 for technical assistance).

Telehealth: Telehealth visits through LiveHealth Online are covered 100% (in-network only).

3.3 Prescription Drugs

(a) Administration. Self-funded prescription drug coverage is administered by ExpressScripts, a Pharmacy Benefits Manager (PBM). Participants are issued a prescription drug card and must present this card at participating pharmacies for benefits. Participants that utilize a non-participating pharmacy must pay the entire cost of the drug at the time of purchase and submit original receipts for reimbursement, not to exceed the amount the Fund would have paid a participating pharmacy, to the Fund Office. Notwithstanding any provision in the Plan to the contrary, no coverage is provided for Shop Employees covered by the Shop Employees Plan.

(b) Covered Drugs. The following drugs are covered by the Plan with a prescription:

(1) Legend drugs (drugs approved by the FDA, required to be labeled: "Caution: Federal Law prohibits dispensing without prescription")
(2) Compound prescriptions where at least one ingredient is a legend drug
(3) Injectable insulin and insulin syringes
(4) Diabetic supplies and test strips (see section (d), below)
(5) Generic contraceptives (other contraceptives only covered if mandated by Health Care Reform)
(6) Prenatal vitamins
(7) Vitamins if they are Federal Legend Drugs with a prescription (no OTC vitamins covered, except Iron OTC with a prescription for children less than 12 months of age)
(8) Tobacco cessation medications (up to 180 days per year)
(9) Accutane through age 24
(10) Immunizations, without copayment, to the extent required by Health Care Reform

(11) Notwithstanding any other term of this Plan to the contrary, effective 1/1/19, the Plan will cover prescription drugs for ADD and ADHD for those up to age 18, or over age 18 with prior authorization for Medical Necessity from the PBM.

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

(1) Appetite suppressants or weight loss drugs, unless Medically Necessary for attention deficit disorders or narcolepsy
(2) Compounded prescription medications with ingredients not requiring a Physician's authorization by state or federal law
(3) Allergens
(4) Growth hormones
(5) Fertility medications
(6) Medications for smoking cessation (unless required to be covered as a preventive service)
(7) Over the counter (OTC) medications, or any prescription medication that is available as an OTC medication;
(8) Replacement prescriptions resulting from loss, theft, or breakage
(9) Oral medications for treatment of sexual dysfunction
(10) Fluoride preparations after age 5
(11) Miscellaneous medical supplies
(12) Injectable drugs (other than insulin)

(d) Co-payments and Maximum Out of Pocket Costs. Most prescription drugs will be subject to the copayments set forth in section (1), below, however specialty drugs covered by the SaveonSP Program, are subject to the copayments set forth in section (2), below:

(1) Drugs Not Subject to SaveonSP Program. The following copayments apply:

Retail (up to 30-day supply)*		
Tier 1	Generic:	$10 (effective 1/1/19, $20)
Tier 2	Preferred Brand:	$30 (effective 1/1/19, $40)
Tier 3	Non-Preferred Brand:	$75 (effective 1/1/19, $80)
Tier 4	Specialty:	$100 (effective 1/1/19, 25%, not to exceed $200)
Mail Order (up to 90-day supply)*		
Tier 1	Generic:	$20 (effective 1/1/19, $50)
Tier 2	Preferred Brand:	$60 (effective 1/1/19, $100)
Tier 3	Non-Preferred Brand:	$150 (effective 1/1/19, $200)
Tier 4	Specialty:	N/A (limited to 30-day supply, above)

*This chart sets forth amounts paid by the Covered Person at participating pharmacies. As noted above, Covered Persons that utilize a non-participating pharmacy must pay the entire cost of the drug at the time of purchase and submit original receipts for reimbursement, not to exceed the amount the Fund would have paid a participating pharmacy, to the Fund Office.

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

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

Maximum Out of Pocket Costs: There is an annual in-network maximum out of pocket costs for prescription drugs purchased with participating pharmacies, which will be adjusted annually. This maximum is the difference between the maximum in-network out of pocket for medical and prescription drugs established by Health Care Reform and the maximum out of pocket for in-network medical set forth in the chart in section 3.2(b). For example, for 2019, the maximum in-network out of pocket costs for medical and prescription drugs established by Health Care Reform is $7,900 for single coverage and $15,800 for family coverage. The maximum out of pocket for medical expenses under this Plan, as set forth in the chart at section 3.2(b), is $3,500 for single in-network coverage and $7,000 for in-network family coverage. Thus, the 2019 maximum out of pocket costs for in-network prescription drugs is $4,400 single and $8,800 family. There is no out of pocket maximum for drugs obtained from non-participating (i.e. out of network) pharmacies.

Diabetic Test Supplies: These are provided without cost sharing for the Covered Person. A list of covered diabetic test supplies is available at the Plan Office, and include blood glucose monitors, test strips, lancets, alcohol prep pads, blood ketone test strips, and insulin pumps.

Opioids: Effective September 1, 2018, initial fills will be limited to a 7 day supply, based on FDA guidelines, and opioids are otherwise subject to additional pre-authorization requirements. These requirements are available by contacting the PBM.

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

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

- 0% copayment if the Covered Person timely enrolls in the SaveonSP Program; or
- the copayment assigned by the SaveonSP Program. These copayments may be thousands of dollars per month, and do not count towards the maximum out of pocket amounts set forth in section 3.3(d)(1), above.

(e) **OTC COVID-19 Tests**: See Section 3.2(a).

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

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

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

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

4.1 Medical Benefits

(a) Medicare Eligibles Other than Niles Participants with Supplemental Only Coverage Under 4.1(b). Medicare eligible Participants and Dependents are provided medical coverage via a fully insured Medicare coordinated policy issued by UnitedHealthCare (Medicare Policy). The terms and conditions of such coverage are set forth in the Medicare Policy. This Fund does not cover any medical expenses for Medicare eligible Participants or Dependents. All such expenses are covered by Medicare or the Medicare Policy.

(b) Medicare Supplemental Coverage for Former Niles Participants (Niles). On a calendar year basis, the Plan provides medical benefits intended to complement, or supplement, Medicare coverage for Medicare eligible Former Niles Participants and Dependents who elected such coverage prior to January 1, 2013, and have maintained such coverage to date. This Medicare supplemental only coverage provides coverage for deductibles and co-insurance on Medicare approved items and services which Medicare does not pay. It does not provide coverage for any item or service not covered on a primary basis by Medicare (with the exception of care received for emergencies outside of the United States, as set forth below). The following is the Schedule of Medicare Supplemental Benefits:

(1) Part A Supplemental Benefits – Inpatient Benefits. The Plan will provide the following supplemental inpatient benefits for benefits for Medicare covered services received in a Medicare approved facility:

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

(2) Part B Supplemental Benefits – Outpatient Benefits

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

- Part B coinsurance

(3) **Providers Not Approved by Medicare.** In the event services are received by a facility or provider, inpatient or outpatient, which is not Medicare approved, benefits will be paid in an amount not to exceed the amount that would have been paid had the services been provided by a Medicare approved facility or provider.

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

4.2 **Prescription Drug Coverage for Medicare Eligible Participants and Dependents.** Medicare Eligible Participants and Dependents who are covered by the Medicare Policy under Section 4.1(a), also have prescription drug benefits under an Employer Group Waiver Plan (EGWP). Medicare Eligible Participants and Dependents who have supplemental Medicare coverage under Section 4.1(b) do not have prescription drug coverage under this Plan. The following is a summary of the EGWP. Benefits, formulary, pharmacy network, premiums and/or co-payments/coinsurance may change on January 1 of each year.

(a) **Employer Group Waiver Plan**

The Plan has contracted with a Pharmacy Benefit Manager, Express Scripts to administer a prescription drug program known as an Employer Group Waiver Plan (EGWP). This program was originally made available in 2012 to Participants that had self-insured coverage as Medicare eligible under the Cleveland and Vicinity Carpenters Health Fund or the Southwest Ohio Regional Council of Carpenters Health Fund and continued to participate in this Plan as Medicare eligible Participants and Dependents. As of January 1, 2013, the EGWP has been the prescription drug Plan for all newly eligible Medicare Participants and Dependents who otherwise have qualified for continued coverage under this Plan. As of January 1, 2021, Participants who did not have retiree coverage under the Ohio Carpenters' Health and Welfare Plan (Niles) in 2012 and elected coverage under a fully-insured Prescription Drug Plan (PDP) were transferred to this coverage also.

The amount of coverage depends upon the annual out of pocket costs incurred by a Covered Person, as follows:

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

Initial Coverage Stage: After deductible satisfied, Covered Person pays the following copayments until a Covered Person's total annual drug cost (what the Covered Person and Plan pay, combined) equals the CMS Standard to enter the Coverage Gap (in 2021, this is $4,130):

Retail (up to 31-day supply)	
Tier 1	Generic: $10
Tier 2	Preferred Brand: $30
Tier 3	Non-Preferred Brand: $75
Tier 4	Specialty: $100
Retail (32-to-60-day supply)	

Tier 1	Generic: $20
Tier 2	Preferred Brand: $60
Tier 3	Non-Preferred Brand: $150
Tier 4	Specialty: N/A (limited to 30-day supply, above)
Retail (up to 90-day supply) *	
Tier 1	Generic: $30
Tier 2	Preferred Brand: $90
Tier 3	Non-Preferred Brand: $225
Tier 4	Specialty: N/A (limited to 30-day supply, above)
Mail Order (up to 90-day supply)	
Tier 1	Generic: $20
Tier 2	Preferred Brand: $60
Tier 3	Non-Preferred Brand: $150
Tier 4	Specialty: N/A (limited to 30-day supply, above)

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

Coverage Gap Stage: After annual total costs (Covered Person and Plan) equal the CMS Standard to enter the Coverage Gap (in 2021, this is $4,130), a Covered Person will pay the following copayments until his/her own out-of-pocket drug costs reach the CMS TrOOP Limit to enter Catastrophic Coverage (in 2021 this is $6,550):

Retail (up to 31-day supply)	
Tier 1	Generic: $10
Tier 2	Preferred Brand: $30
Tier 3	Non-Preferred Brand: $75
Tier 4	Specialty: $100
Retail (32-to-60-day supply)	
Tier 1	Generic: $20
Tier 2	Preferred Brand: $60
Tier 3	Non-Preferred Brand: $150
Tier 4	Specialty: N/A (limited to 30-day supply, above)
Retail (up to 90-day supply) *	
Tier 1	Generic: $30
Tier 2	Preferred Brand: $90
Tier 3	Non-Preferred Brand: $225
Tier 4	Specialty: N/A (limited to 30-day supply, above)
Mail Order (up to 90-day supply)	
Tier 1	Generic: $20
Tier 2	Preferred Brand: $60
Tier 3	Non-Preferred Brand: $150
Tier 4	Specialty: N/A (limited to 30-day supply, above)

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

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

Catastrophic Coverage Stage: After a Covered Person's yearly out-of-pocket drug costs reach the CMS TrOOP Limit to enter Catastrophic Coverage (in 2021 this is $6,550), a Covered Person will pay the greater of 5% coinsurance or:

- a $3.70 (2021, subject to further annual adjustment) copayment for covered generic drugs, not to exceed the copayment that would be charged if the Covered Person was in the Initial Coverage stage, or
- a $9.20 (2021, subject to further annual adjustment) copayment for all other covered drugs, not to exceed the copayment that would be charged if the Covered Person was in the Initial Coverage stage.

Provisions applicable to all Coverage Stages:

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

ARTICLE 5 - MEDICAL REIMBURSEMENT ACCOUNT

5.1 Funding of Medical Reimbursement Account. When the balance in an Active Employee's Bank exceeds three times the Cost of Coverage, such excess may be used for unreimbursed medical expenses in the form of a Medical Reimbursement Account (MRA). Like all other benefits provided by the Plan, regardless of the balance in the MRA, the MRA is not a vested benefit.

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

(a) Were incurred on or after the date on which the Participant became eligible for benefits under the Plan (expenses are incurred when a Participant is provided with medical care that gives rise to the expenses, not when he is billed for or pays for the medical care);

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

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

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

(1) Deductibles and co-payments for covered medical expenses under this Plan or a qualified plan of your Spouse;
(2) Unreimbursed hospital service fees;
(3) Unreimbursed medical service fees;
(4) Unreimbursed medical items such as artificial limbs, eyeglasses, contact lenses, hearing aids, crutches, wheelchair, etc.;
(5) Unreimbursed transportation for needed medical care;
(6) Unreimbursed dental expenses;
(7) Capital expenses for equipment or improvements to your home needed for medical care;
(8) Cost and care of guide dogs or other animals aiding the blind, deaf, and disabled;
(9) Cost of lead-based paint removal;
(10) Expenses of an organ donor;

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

(11) Oxygen equipment and oxygen;
(12) Part of life-care fee paid to retirement home for medical care;
(13) Unreimbursed prescription medicines;
(14) Psychiatric care at a specially equipped medical center (includes meals and lodging);
(15) Legal abortion;
(16) Legal operation to prevent having children;
(17) Unreimbursed meals and lodging provided by a hospital during medical treatment;
(18) Special school or home for mentally or physically disabled persons;
(19) Unreimbursed treatment at a drug or alcohol center (includes meals and lodging provided by the center);
(20) Wages for nursing services;
(21) Hot Tub used for the cure, mitigation, treatment, or prevention of disease, up to $5,100.00, provided the Fund Office has received:
  (i) a statement from the participant as to who the hot tub is for – self, spouse, or dependent child;
  (ii) a written statement from the treating physician dated within six months of the participant's request setting forth the medical condition for which the hot tub is needed and why the hot tub is medically necessary for treatment of such conditions; and
  (iii) An invoice and receipt for the hot tub.

5.3 Submission of Claims

(a) For reimbursement from the MRA, the Participant must submit:
  (1) A completed reimbursement form (available from the Fund Office), and
  (2) If applicable, the explanation of benefits received from the claims processor, or original receipt and proof of payment to the Ohio Carpenters' Health Plan Benefit Office, P. O. Box 1257, Troy, Michigan 48099-1257. Unreimbursed amounts must total at least $20 for reimbursement. Separate bills may be itemized on the same claim form.

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

(c) Reimbursement of Active Employees will not be allowed if it would reduce his/her Dollar Bank Account to less than three times the (Cost of Coverage + Subsidy).

(d) The deadline for submitting reimbursement for unreimbursed medical expenses is 24 months from the date the expense was incurred.

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

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

5.5 Cancellation of Medical Reimbursement Account. The balance in the MRA will be cancelled and forfeited the earlier of: (a) the date the Participant is no longer eligible for coverage under the Plan; (b) if

there is no activity (employer contributions or claims) for three years; (c) if deemed necessary in the sole and exclusive discretion of the Trustees to meet requirements of Health Care Reform; or (d) if the Trustees in their sole discretion terminate the MRA.

ARTICLE 6 – WEEKLY DISABILITY BENEFITS

6.1 Eligibility. Weekly Disability Benefits are weekly payments paid by the Fund to an Active Employee who is unable to work due to a Disability arising from a Non-Occupational Accidental Injury or Illness, provided benefits for a Non-Occupational Accidental Injury will only be paid if the injury was incurred on a date the Active Employee was eligible for coverage under the Plan. To be eligible, an Active Employee must be under the continuous care of a Physician who has provided a certification of Disability specifying the diagnosis, dates of Disability, and the date the Physician was first consulted for the Disability. In the Fund Office's sole discretion, additional certifications may be requested during the period of Disability and must be completed and returned to continue benefits. Weekly Disability Benefits are payable the first day of a Disability due to an Accidental Injury, or the eighth day of a Disability due to Illness. No Disabilities, including those resulting from accidents, will be considered as beginning more than two days before treatment is first received by a Physician. Union Office Employees and NBU are not eligible for Weekly Disability benefits.

6.2 Schedule of Benefits

Benefit Amount	$200/week
Maximum Period of Payment per Disability	26 weeks

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

6.3 Exclusions. Weekly Disability benefits are payable only if the claim for benefits is received within 90 days after the date the Physician certifies the Disability and within 180 days following the first day of Disability. In addition, Weekly Disability benefits are not payable for:

(a) Any period of Disability during which the Active Employee is not under the regular care of a Physician;
(b) Any Disability due to sickness which is covered by a Workers' Compensation Act or similar legislation, or due to injury arising out of or in the course of any employment for wage or profit;
(c) Any period during which the Active Employee is making full self-payments to continue eligibility (unless such individual is available for work and otherwise eligible);
(d) Any day the Active Employee works for compensation or profit or receives compensation through an Employer, including unemployment benefits;
(e) Any Retiree, including a Retiree who has returned to work;
(f) Any intentionally self-inflicted injury of any kind, while sane or insane; or
(g) Any reason for which coverage of medical benefits would be denied under Section 3.2(b).

ARTICLE 7 – DENTAL BENEFITS (Active Employees, Non Medicare Participants and Dependents)

7.1 Dental Network. The Plan provides self-insured dental benefits and has contracted with Delta Dental, a preferred provider network. A list of the dentists participating in this network, known as in-network

providers, is available at the Plan Office free of charge. Participants and their Dependents are encouraged to use in-network providers to save money for themselves and the Plan, but may choose to receive treatment from an out-of-network provider and incur greater out of pocket expenses. Regardless of the provider chosen, benefits paid by the Plan will not exceed those amounts set forth in 7.2, below. Notwithstanding any provision in the Plan to the contrary, no coverage is provided for Shop Employees covered by the Shop Employees Plan.

7.2 **Covered Benefits.** Class I-IV Services are provided as outlined below, subject to an annual maximum of $1,000 per Covered Person for Class I-III Services (annual maximum not applicable to Covered Persons under age 19), and a lifetime limit of $1,000 for Class IV orthodontics. There is no deductible for Class I services, and a $50 per Covered Person/$100 per Covered Family deductible for out-of-network Class II and Class III services.

(a) Class I - Diagnostic and Preventive Services – Covered 100%
- (1) Examinations/evaluations (twice per calendar year).
- (2) Teeth cleaning (twice per calendar year).
- (3) Space maintainers (up to age 14).
- (4) Sealants (first permanent molars to age 9; second permanent molars to age 14).
- (5) Fluoride treatments (twice per calendar year up to age 19).
- (6) Brush biopsy to detect oral cancer.
- (7) Emergency palliative treatment to temporarily relieve pain.
- (8) Radiographs: (Bitewing X-rays are payable once per calendar year. Full mouth x-rays (including bitewings) are payable once in any five-year period. A panographic x-ray (including bitewings) is considered a full mouth x-ray.

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

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

(d) Class IV – Covered 50% - Orthodontic services to correct malposed teeth to age 19.

7.3 **Exclusions.** In addition to limitations imposed by Delta Dental, the exclusions applicable to medical benefits set forth in Section 3.2(b) and the following exclusions apply to dental benefits:
- (1) Services for correction of congenital or developmental malformations.
- (2) Services or appliances started before a person became eligible under this Plan, other than orthodontic treatment in progress.

(3) Prescription drugs (except intramuscular injectable antibiotics), medicaments/solutions, premedications, and relative analgesia.
(4) General anesthesia and/or intravenous sedation for restorative dentistry or for surgical procedures, unless Medically Necessary.
(5) Charges for hospitalization, laboratory tests, and histopathological examinations.
(6) Charges for failure to keep a scheduled visit with the Dentist.
(7) Treatment by other than a Dentist, except for services performed by a licensed dental hygienist under the scope of his or her license.
(8) Services or supplies for which no charge is made, for which the patient is not legally obligated to pay, or for which no charge would be made in the absence of Delta Dental coverage.
(9) Services that are covered under a hospital, surgical/medical, or prescription drug program.
(10) Fluoride rinses, self-applied fluorides, or desensitizing medicaments.
(11) Preventive control programs (including oral hygiene instruction, carries susceptibility tests, dietary control, tobacco counseling, home care medicaments, etc.)
(12) Lost, missing, or stolen appliances of any type and replacement or repair of orthodontic appliances or space maintainers.
(13) Veneers or any cosmetic procedure or service.
(14) Prefabricated crowns used as final restorations on permanent teeth.
(15) Appliances, surgical procedures, and restorations for increasing vertical dimension; for altering, restoring, or maintaining occlusion; for replacing tooth structure loss resulting from attrition, abrasion, or erosion, or for periodontal splinting. This exclusion will not apply to orthodontic services as limited by the terms and conditions of the Plan.
(16) Paste-type root canal fillings on permanent teeth.
(17) Replacement, repair, relines, or adjustments of occlusal guards, or more than one occlusal guard per lifetime.
(18) Chemical curettage.
(19) Services associated with overdentures.
(20) Metal bases on removable prostheses.
(21) The replacement of teeth beyond the normal complement of teeth.
(22) Personalization/characterization of any service or appliance.
(23) Temporary appliances.
(24) Posterior bridges in conjunction with partial dentures in the same arch.
(25) Precision attachments.
(26) Specialized implant surgical techniques.
(27) Appliances, restorations, or services for the diagnosis or treatment of disturbances of the temporomandibular joint (TMJ).
(28) Diagnostic photographs and cephalometric films, unless done for orthodontics.
(29) Myofunctional therapy.
(30) Mounted case analyses.

ARTICLE 8 – VISION BENEFITS (Actives, Non Medicare Participants and Dependents, Medicare Participants and Dependents)

8.1 Vision Network

Actives and Non-Medicare Participants and Dependents: The Fund has entered into an agreement with VSP to provide vision services to Covered Persons at reduced fees. A list of such providers is available upon request at the Plan Office. A Covered Person does not have to use one of these providers, as it is always the Covered Person's choice as to which vision service provider to use. Regardless of the provider

chosen, benefits paid by the Fund will not exceed those amounts set forth in §8.2, subject to the exclusions in §8.3, below.

Notwithstanding any provision in the Plan to the contrary, no coverage is provided for Shop Employees covered by the Shop Employees Plan.

Medicare Participants and Dependents: Do not receive the benefits set forth in §8.2, below, but do receive a discount card from VSP that provides some reduced costs at the participating providers.

8.2 **Covered Benefits - Actives and Non-Medicare Participants and Dependents.** Once every 12 months, the Plan will provide coverage for an Exam up to $50 per Covered Person. Once every 24 months, the Plan will provide coverage for Materials up to $100 per Covered Person. These limitations do not apply as required by law for medically necessary services for Covered Persons up to age 19. An Exam is defined as: (i) a case history; (ii) an external examination of the eye and adnexa; (iii) an ophthalmoscopic examination; (iv) a determination of refractive status; (v) binocular balance testing; (vi) tonometry, as needed; (vii) gross visual fields; (viii) color vision testing; (ix) summary findings; and (x) recommendations, including prescribing contact lenses. Materials are defined as: (i) single vision lenses; (ii) bifocal lenses; (iii) trifocal lenses; (iv) lenticular lenses; (v) frames; and (vi) contact lenses.

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

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

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

9.1 **Hearing Aid Provider.** The Plan provides self-insured hearing aid benefits There is no discounted in-network provider, but if the provider chosen participates with Anthem, claims will be submitted to Anthem. If not, claims may be submitted to the Fund Office. Regardless of the provider chosen, benefits paid by the Plan will not exceed the limits set forth in 9.2, below. From time to time, certain hearing aid partners may offer discounts. Names of any such partners are available at the Fund office. A Covered Person may contact these partners to inquire as to available discounts or for assistance in finding a hearing aid provider. Notwithstanding any provision in the Plan to the contrary, no coverage is provided for Shop Employees covered by the Shop Employees Plan.

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

(a) as defined below, Audiometric Examinations, Hearing Aid Evaluation Tests, Hearing Aids, and Hearing Aid Conformity Evaluations, once every four years for each ear and not to exceed a total of $2,000.00 every four years per Covered Person; and
(b) up to $250.00 annually to repair a Hearing Aid that is out of warranty.

Audiometric Examination: An examination performed by a physician specializing in hearing issues or an audiologist after or in conjunction with an examination by a physician wherein a Covered Person has been diagnosed with a potential hearing issue. Subject to above dollar limitations, the Audiometric Examination is paid at 100% in-network after a $40 copayment and 60% of Reasonable and Customary out-of-network, after a $40 copayment.

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

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

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

9.3 Exclusions. The exclusions applicable to medical benefits set forth in Section 3.2(b) and the following exclusions apply to Hearing Aid Benefits:
(a) Hearing examinations or materials ordered prior to the Covered Persons Effective Date.
(b) Hearing Aids ordered while the Covered Person is an Eligible Participant but delivered more than 60 days after coverage ends.
(c) For medical or surgical treatment related to Hearing Aids.

ARTICLE 10 – LIFE INSURANCE - ACTIVES AND CERTAIN RETIREES

10.1 Insured Basic Life and Accidental Death and Dismemberment Benefits. Active Employees and certain Retirees are eligible for coverage under a fully insured life insurance policy purchased by the Plan. The amount of coverage is:

Active Employee	
Basic Life--Principal Sum	$10,000
Accidental Death & Dismemberment Benefit	up to $10,000
Retiree (Non-Medicare and Medicare Retiree) *	
Basic Life--Principal Sum	$5,000
Accidental Death & Dismemberment Benefit	None

*These benefits do not apply to Niles' members retiring before January 1, 2013.

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

10.2 Beneficiary Designation. The benefits designated above are payable to the beneficiary(ies) designated by the Participant on the Beneficiary Designation card. Each Participant shall have the right to change his beneficiary at any time by written notice, submitted directly to the Plan Office, and the change shall become effective on the date of receipt by the Plan Office. However, no designation or change will be effective if received by the Plan Office after date of death. Notwithstanding, upon a divorce, any prior designation of the ex-spouse as Beneficiary shall be null and void unless a designation in favor of the ex-spouse is made subsequent to the divorce. In the event of any conflict between the provisions of this Plan and the insurance policy, including the proper determination of the beneficiary, the terms of the insurance policy and the determination by the insurance company controls.

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

10.4 Self-Insurance Death Benefits for Former Participants in the Cleveland and Vicinity Carpenters Health Fund (Cleveland Fund)

(a) In 2013, former participants in the Cleveland Fund who became Active Employees and Retirees in this Fund could elect an allocation to their Dollar Banks based upon the value of a death benefit provided by the Cleveland Fund. By making this election, they forfeited any claim to this self-insured death benefit.

(b) Former participants in the Cleveland Fund who became Active Employees and Retirees in this Fund and did not make the above election became eligible for a self-insured death benefit under this Plan equal to the value of the death benefit they had in the Cleveland Fund as of April 30, 2013, minus the value of any fully insured death benefit provided by this Plan, if they are eligible in this Fund at the time of death. This death benefit will be paid to the beneficiary(ies) designated in section 10.2, provided the covered person has not had a lapse in coverage under this Plan on or after May 1, 2013, and a written claim for this benefit is received by the Fund Office within one year of the date of death.

(c) Individuals who were inactive in the Cleveland Fund as of April 30, 2013, are eligible for a payout of their former death benefit in an amount equal to the present value of this death benefit as calculated by the actuary in 2013 if they present to the Fund Office a certificate of coverage issued by the Cleveland Fund. No further benefit will be payable thereafter under this section 10.4.

ARTICLE 11 – COORDINATION OF BENEFITS

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

11.2 Coordination. Plan rules regarding coordination:

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

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

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

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

(1) The other plan is primary and this Plan is secondary.

(2) The plan that covers a person directly as a participant rather than as a dependent is primary and the other is secondary.

(3) The plan that covers a person directly as an active employee rather than as a retired or laid off employee is primary and the other is secondary.

(4) The plan that covers a person as a dependent spouse is primary to the plan that covers the person as a dependent child.

(5) If a child is covered under both parents' plans, the plan that covers the parent whose birthday occurs earlier in the calendar year shall be considered the primary plan.

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

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

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

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

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

(2) if (1) does not apply:

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

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

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

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

(e) Medicare Coordination

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

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

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

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

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

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

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

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

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

Where coordination of benefits is applicable and this Plan is not the primary payor, the benefits payable under this Plan shall not exceed the difference between the benefits payable by the other plan(s) and the amount that would have been payable under this Plan in the absence of coordination of benefits. Benefits payable under another plan include the benefits that would have been payable had the claim been timely and properly filed under that plan.

Notwithstanding anything to the contrary, a Participant or Dependent will never receive less if covered by two or more plans than he would receive if covered by this Plan alone; provided, however, that this Plan will pay no more than an amount which would bring total coverage up to the amount which would have been provided under this Plan alone.

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

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

ARTICLE 12 – THIRD PARTY LIABILITY

12.1. Subrogation

(a) **Application.** Subrogation means the Plan has the right to recover from a Participant or Dependent those amounts paid by the Plan for medical care or other expenses due to an injury caused by a third party (for example, another person or company). To the extent benefits are paid by the Plan to a Participant or Dependent for medical, prescription drug, dental, wage loss, or other expenses arising out of such an injury, the Plan is subrogated to any claims the Participant or Dependent may have against the third party who caused the injury. In other words, the Participant or Dependent must repay to the Plan the benefits paid on his or her behalf out of any recovery received from a third party and/or any applicable insurer. The Plan's right of subrogation applies to any amounts recovered, whether or not designated as reimbursement for medical expenses or any other benefit provided by the Plan. The right of subrogation applies regardless of the method of recovery, i.e. whether by legal action, settlement or otherwise. The Plan's right to subrogation applies regardless of whether the injured Participant or Dependent has been fully compensated, or made whole, for his or her losses and/or expenses by the third party or insurer, as the Plan's right to subrogation applies to any full or partial recovery. This provision is intended to make it clear that this provision shall apply in lieu of the "make whole" doctrine. The Plan has first priority to any funds recovered by the injured Participant or Dependent from the third party or insurer. Further, the Plan does not have any responsibility for the injured Participant or Dependent's attorneys' fees, i.e., the common fund doctrine will not be applied. The Plan also has a lien on any amounts recovered by a Participant

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

or Dependent due to an injury caused by a third party, and such lien will remain in effect until the Plan is repaid in full for benefits paid because of the injury.

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

(1) As soon as reasonably possible, the Participant or Dependent must notify the Claims Administrator that he or she has an injury caused by a third party.
(2) Prior to the receipt of benefits for such injury, the injured Participant or Dependent must assign to the Plan his or her rights to any recovery arising out of or related to any act or omission that caused or contributed to the injury. If such assignment is not made before the receipt of benefits, then the receipt of benefits automatically assigns to the Plan any rights the Participant or Dependent may have to recover payments from any third party or insurer. (If the recovery so assigned exceeds the benefits paid by the Plan, such excess shall be delivered to the Participant or Dependent or other person as required by law.)
(3) The Participant or Dependent does not take any action that would prejudice the Plan's subrogation rights.
(4) The Participant or Dependent cooperates in doing what is necessary to assist the Plan in any recovery, which includes but is not limited to executing and delivering all necessary instruments and papers.

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

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

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

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

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

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

ARTICLE 13 – RECIPROCITY

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

ARTICLE 14 – INTERNAL CLAIMS AND APPEALS PROCESS

For benefits provided under the fully insured policies, including life insurance, claims and appeals will be governed solely by the procedures set forth in the documents governing such benefits, and not by the provisions of this Article 14 and 15.

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

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

14.2 Initial Submission of Claims. Most claims will be submitted directly from the provider to the appropriate party. However, if they are not, claims for benefits should be submitted to the Fund Office. No claim will be covered unless submitted to the Fund Office within 365 days of the date incurred. Notwithstanding, the Plan will disregard the Outbreak Period for all participants and dependents in determining the date in which claims must be submitted to the Fund Office.

14.3 Notice That Additional Information is Needed to Process Claim

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

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

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

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

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

14.5 Initial Decision on a Claim

(a) Additional Evidence

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

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

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

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

14.6 Adverse Benefit Determination

Notice of an adverse benefit determination will include:

- the specific reasons for the denial;
- the specific Plan provision or provisions on which the decision was based;
- if applicable, what additional material or information is necessary to complete the claim and the reason why such material or information is necessary;

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

- the internal rule or similar guideline relied upon in denying the claim or, if applicable, a statement that such rule or similar guideline does not exist;
- if the denial was based on medical necessity, experimental nature of treatment or similar matter, an explanation of same;
- information sufficient to identify the claim involved (including the date of service, the health care provider, the claim amount (if applicable);
- a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;
- a description of available internal appeal process and how to initiate the external review process for an adverse benefit determination which involves a medical condition of the claimant for which the timeframe for completion of the internal appeal would jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function; and
- if applicable, a statement of the Claimant's right to bring a civil action after further denial on appeal or external appeal.

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

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

14.7 Internal Appeals

(a) **Adverse Benefit Determinations.** A Claimant may appeal any Adverse Benefit Determination received Section 14.6. An Adverse Benefit Determination means any of the following:

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

(b) **Submission of Internal Appeals.** An appeal is a written request to the Trustees setting forth issues to consider related to the benefit denial, along with any additional comments the claimant may have. A Claimant, free of charge and upon request, shall be provided reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits. The Plan will not consider a request for diagnosis and treatment information, in itself, to be a request for an internal appeal. The Plan will continue to provide coverage for an ongoing course of treatment pending the outcome of an internal appeal. The review on appeal shall take into account all comments, documents, records, and other information submitted by the Claimant relating to the

claim, without regard to whether such information was submitted or considered in the initial benefit determination. Appeals should be submitted as to the Fund Office.

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

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

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

Notwithstanding the above, the Plan will disregard the Outbreak Period for all participants and dependents in determining the date on which appeals must be submitted.

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

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

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

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

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

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

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

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

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

14.8 Deemed Exhaustion of Internal Claims and Appeals Processes

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

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

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

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

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

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

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

ARTICLE 15 – EXTERNAL REVIEW PROCESS

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

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

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Plan will disregard the Outbreak Period for all participants and dependents in determining the date on which a Claimant must file a request for an external review.

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

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

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

Notwithstanding the above, the Plan will disregard the Outbreak Period for all participants and dependents in determining the date on which a Claimant must file information to perfect a request for external review.

15.4 Referral to Independent Review Organization

(a) The Fund must assign an independent review organization (IRO) to conduct the external review.
(b) The IRO will timely notify the Claimant in writing of the request's eligibility and acceptance for external review. This notice will include a statement that the Claimant may submit in writing to the IRO within ten business days additional information that the IRO must consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted after ten business days.
Upon receipt of any information submitted by the Claimant, the assigned IRO must within one business day forward the information to the Fund. Upon receipt of such information, the Fund may reconsider its final internal decision on appeal, but such reconsideration will not delay the external review. If the Fund decides to provide coverage, within one business day after such decision the Fund must provide written notice of same to the Claimant and the IRO and the IRO must then terminate the external review.
(c) Within five business days after the date of assignment, the Fund will provide to the IRO documents and any information considered in making the final decision on internal appeal, but failure to do so will not delay the conduct of the external review. If the Fund fails to timely provide this information, the IRO may terminate the external review and make a decision to reverse the adverse benefit determination and notice of such decision will be provided by the IRO to the Claimant and Fund within one business day.
(d) The IRO will review all of the information and documents timely received. In reaching a decision, the assigned IRO will review the claim de novo and not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. The IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

ARTICLE 16 – COBRA CONTINUATION COVERAGE

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

16.2. Qualifying Events

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

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

(c) The Spouse of a participant will become a qualified beneficiary if coverage is lost under the Fund because any of the following qualifying events happens:
  (1) Death of spouse;
  (2) Spouse's hours of employment are reduced such that hours are insufficient to maintain eligibility;
  (3) Spouse's employment ends for any reason other than his or her gross misconduct;
  (4) Spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
  (5) Divorce or legal separation from the Participant.

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

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

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

Notwithstanding the above, the Plan will disregard the Outbreak Period for all participants and dependents in determining the date on which individuals must notify the Plan of Qualifying event or determination of disability.

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

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

Notwithstanding the above, the Plan will disregard the Outbreak Period for all participants and dependents in determining the date in which the Plan must provide the election notice as set forth above.

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

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

(b) When the qualifying event is the end of employment or reduction of the participant's hours of employment, and the participant became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the participant lasts until 36 months after the date of Medicare entitlement.
For example, if a participant becomes entitled to Medicare 8 months before the date on which his eligibility terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months).

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

(1) Disability Extension. If the qualified beneficiary or anyone in his family covered under the Fund is determined by the Social Security Administration to be disabled, all covered family members may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. To obtain this extension, the disability would have to have started before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. The Plan Administrator must be notified of the Social Security Administration's determination within 60 days of the date of the determination and before the end of the 18-month period of COBRA continuation coverage for this extension to apply. The Plan Administrator must also be notified of any subsequent determination by the Social Security Administration that the qualified beneficiary is no longer disabled. This notice must be provided within 30 days of such determination.

(2) Second Qualifying Event Extension. If another qualifying event occurs while receiving 18 months of COBRA continuation coverage, the covered spouse and dependent children are eligible for up to an additional 18 additional months of COBRA coverage, for a maximum of 36 months. This extension may be available to the spouse and any dependent children

on COBRA if the participant or former participant dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Fund as a dependent child, but only if such event would have caused the spouse or dependent child to lose coverage under the Fund had the first qualifying event not occurred. The Plan Administrator must be notified of this second qualifying event within 60 days of such event for the extension to apply.

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

Notwithstanding the above, the Plan will disregard the Outbreak Period for all participants and dependents in determining the election period above.

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

Notwithstanding the above, the Plan will disregard the Outbreak Period for all participants and dependents in determining the due date for COBRA premium payments set forth above.

16.9. Scope of Coverage. COBRA coverage only pertains to health benefits available under the Fund. If a Qualifying Event occurs, the Plan Office will offer each Qualified Beneficiary an opportunity to elect to continue the health care coverage for full medical and prescription drug coverage subject to COBRA or medical and prescription drugs only. Note also that coverage may change while on COBRA coverage due to Plan amendments that affect all participants in the Fund. A qualified beneficiary may also be able to elect different coverage options during the period of time he is on COBRA coverage, provided such a right is available to similarly situated active employees.

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

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

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

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

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

ARTICLE 17 – ABSENCE DUE TO MILITARY SERVICE

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

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

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

(a) The Participant has given advance written or verbal notice of the military leave to the Fund Office (advance notice to the Fund Office is not required in situations of military necessity or if giving notice is otherwise impossible or unreasonable under the circumstances);

(b) The cumulative length of the leave and all previous absences from employment do not exceed five years, however, eligibility may be extended beyond five years if certain exceptions apply;

(c) Reemployment follows a release from military service under honorable conditions; and

(d) You report to, or submit an application to, Fund Office as follows:
   (1) On the first business day following completion of military service for a leave of 30 days or less; or
   (2) Within 14 days of completion of military service for a leave of 31 days to 180 days; or
   (3) Within 90 days of completion of military service for a leave of more than 180 days.

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

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

ARTICLE 18 – QUALIFIED MEDICAL SUPPORT ORDER

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

ARTICLE 19 – HIPAA PLAN SPONSOR PROVISIONS

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

ARTICLE 20 – RESCISSION OF COVERAGE

Rescission means the retroactive cancellation of coverage. Where coverage was provided as a result of fraud or an intentional misrepresentation of a material fact by a Participant or Dependent, or an individual seeking coverage on behalf of such Participant or Dependent, the Plan will rescind coverage. Providing false information to maintain or obtain coverage, or knowingly cooperating in any actions designed to provide false information to maintain or obtain coverage, is an example of a fraud or intentional misrepresentation of material fact. Examples of fraud or intentional misrepresentation of material fact also include, but are not limited to, failing to inform the Fund Office of: (1) a divorce or legal separation, (2) lapsed Union membership, which is required to maintain Retiree coverage, (3) that a Participant or Dependent is covered under another health plan, (4) employment with a noncontributing employer; (5) continuing to use the benefit cards after eligibility is terminated; or (6) any other event which makes a Participant a Dependent ineligible for coverage.

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

In the event coverage is rescinded as a result of fraud or intentional misrepresentation, in addition to any legal and equitable means of recovery available, the Plan has the right to demand and receive repayment from the Participant or Dependent, jointly and severally, for all costs incurred by the Fund after the Date of Rescission, and the Fund is also entitled to demand and receive repayment from the Participant or Dependent, on a joint

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and several basis, all costs and attorneys' fees expended in collecting such amounts owed. At the Plan's sole option, it may enforce this provision by offsetting future benefits until the amount owed has been recovered.

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

ARTICLE 21 – CHANGES TO OR TERMINATION OF COVERAGE

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

ARTICLE 22 – INTERPRETATION OF PLAN DOCUMENTS

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

ARTICLE 23 – FAMILY MEDICAL LEAVE ACT

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

ARTICLE 24 - OTHER PROVISIONS

A. **Type of Administration/Plan Administrator/Plan Sponsor.** The Board of Trustees of the Ohio Carpenters' Health Fund is the Plan Administrator and Plan Sponsor. As such, the Trustees are responsible for overall Plan administration. The current Trustees are:

LABOR TRUSTEES	MANAGEMENT TRUSTEES
Donald Crane (Chairman) Indiana/Kentucky/Ohio Regional Council of Carpenters 8065 Market Street Youngstown, OH 44512-6242	Kevin Reilly (Secretary) The Builders Association of Eastern & Western Pennsylvania 1327 Youngstown-Kingsville Road Vienna, Ohio 44473
Mike Kwiatkowski	Aaron Hall

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LABOR TRUSTEES	MANAGEMENT TRUSTEES
Indiana/Kentucky/Ohio Regional Council of Carpenters 7025 West Trafalgar Point Trafalgar, IN 46181	The Associated General Contractors, Akron Division 2181 Akron-Peninsula Road Akron, Ohio 44313
Dan Sivertson Indiana/Kentucky/Ohio Regional Council of Carpenters 3005 George Ave Parma, OH 44134	Arthur Q. Lindrose Bolton Pratt Company 271 Alpha Park Highland Heights, OH 44143
Joseph Pittman Indiana/Kentucky/Ohio Regional Council of Carpenters 204 Garver Road Monroe, MI 48050	James Melaragno Valley Interior Systems 3840 Fisher Road Columbus, Ohio 43228
Ken Lyons Indiana/Kentucky/Ohio Regional Council of Carpenters 241 Regency Circle Lexington, Kentucky 40503	Jim Lawler Lawler Construction, LLC 750 Beta Drive - Unit H Cleveland, Ohio 44143
Jason Clark Indiana/Kentucky/Ohio Regional Council of Carpenters 204 Garver Road Monroe, Ohio 45050	Tim Linville Construction Employers Association 950 Keynote Circle, Suite 10 Independence, Ohio 44131
Anthony Holbrook Ashland, Kentucky Regional Office 204 Garver Road Monroe, OH 45050	Clark Townsend OCP Contractors 370 N. Eureka Road Columbus, OH 43204
Kevin Ennis Indiana/Kentucky/Ohio Regional Council of Carpenters 2554 East 22nd Street Cleveland, OH 44115	Andrew Goetz Shook Construction 4977 Northcutt Place Daytosn, Ohio 45414
Troy Woodyard Indiana/Kentucky/Ohio Regional Council of Carpenters 1545 Alum Creek Drive Columbus, OH 43209	Joe Beischel Beischel Building 5655 Center Hill Avenue, P.O. Box 32067 Cincinnati, Ohio 45232
Antonio Di Tommaso Indiana/Kentucky/Ohio Regional Council of Carpenters 8065 Market St. Youngstown, OH 44512	Jim Fox The Great Lakes Construction Company 2608 Great Lakes Way Hinckley, Ohio 44233
William Karkoff Indiana/Kentucky/Ohio Regional Council of Carpenters 2554 East 22nd Street Cleveland, OH 44115	Brad Burkhead Cattrell Companies, Inc. 906 Franklin St., P.O. Box 367 Toronto, OH 43964

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LEGAL COUNSEL FOR THE PLAN

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

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

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

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

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

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

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

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

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

Receive Information About Your Plan and Benefits:

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

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

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

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

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

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

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

I. Termination of the Plan: **The Trustees reserve the right to amend, alter, or terminate any or all coverages provided in this Plan, for any or all classes of Participants (Actives or Retirees) or Dependents, at any time.** The Trustees also have the right to change required self-payment amounts for any benefit or class of Participants (Actives or Retirees) or Dependents, including the right to impose self-

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payment for coverage that previously had been provided without requiring such self-payments. If the Plan is terminated, plan assets shall be used to pay eligible claims and expenses incurred prior to termination and expenses incident to the termination. The Trustees will, in their discretion, allocate any remaining assets in a manner which best effectuates the purposes of the Trust. In no event will plan assets revert to or inure to the benefit of contributing employers or the Association.

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

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