United Brotherhood of Carpenters and Joiners of America

General Office and Staff Health and Welfare Plan

SUMMARY PLAN DESCRIPTION

Active Employees and Retirees

1/1/2022

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United Brotherhood of Carpenters and Joiners of America General Office and Staff Health and Welfare Plan for Employees and Retirees

This Summary Plan Description ("SPD") is your guide to the United Brotherhood of Carpenters and Joiners of America General Office and Staff Health and Welfare Plan. It describes the plan's eligibility rules, claims procedures and the medical, prescription drug, dental, vision, life insurance and accidental death & dismemberment coverage available to eligible employees, retirees and dependents as of January 1, 2022, except for those provisions that specifically indicate other effective dates. This SPD replaces all other SPDs and Plan documents previously provided to you. Unless otherwise indicated, this SPD will also serve as the plan document for the United Brotherhood of Carpenters and Joiners of America General Office and Staff Health and Welfare Plan.

Please review this document carefully to ensure that you understand and can make the most effective use of your benefits. If you have any questions that aren't answered here, including questions about benefit claims, eligibility or medical pre-certification requirements, contact the Plan Administrative Office at the following address or telephone number:

BeneSys Administrators
Mailing Address: P.O. Box 400008, Las Vegas, NV 89140
8311 W. Sunset Road, Suite 250, Las Vegas, NV 89113
Toll-Free: (855) 550-1696
www.UBCBenefits.org

The Plan Administrative Office is the only party authorized by the Board of Trustees to answer questions about the Trust Fund and benefits described in this booklet. To keep the Plan's eligibility records accurate, please keep the Administrative Office informed of any change in address, dependent status and designated beneficiary by submitting a completed enrollment card (available from the Administrative Office).

Note: Throughout this booklet, terms shown in *italics* are defined in the Glossary in Article XVIII of this summary.

This Summary Plan Description provides details of the benefits available to eligible participants in the United Brotherhood of Carpenters and Joiners of America General Office and Staff Health and Welfare Plan. Nothing in this document will alter the terms of the contractual arrangements the Trustees have with Union Labor Life Insurance Company with regard to life insurance, accidental death and dismemberment coverages and preferred provider services. In case of questions about specific benefit provisions, the Board of Trustees has the sole, exclusive, and discretionary authority to make any and all determinations under the Plan, including eligibility for benefits, the amount of benefits payable, and the meaning of Plan and SPD language. No Trustee, Employer, Employer Association, or Labor Organization, nor any of their employees or representatives, has any authority in this regard. The Plan cannot be bound by any oral or written communication that conflicts with the terms of the Plan. The Board of Trustees reserves the right to make the final determination. The Board of Trustees reserves the right to change the terms of the Plan described in this document at any time.

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ARTICLE I Eligibility

Section 1.01 Employee Eligibility

(a) Who Is Eligible?

If you are an *employee*, you are eligible to participate in the *Plan* if all of the following requirements are met:

(1) your employer authorizes your participation and makes the required contributions to the *Plan* on your behalf, and

(2) you are in one of the following classifications:

(i) an officer, representative or staff employee of the United Brotherhood of Carpenters and Joiners of America (UBCJA) and you reside in the United States.

(ii) an officer, representative or staff employee of the UBCJA, you reside in Canada, but are not eligible for your Local or Council Health Plan.

(iii) an employee of the Carpenters International Training Fund, UBC Job Corps Training Fund, Jobsite Steel Manufacturing, LLC, the Millwright Industry Trust, or Placid Investors, Inc. or Mission Venture, LLC who has been accepted by the Trustees for participation in the *Plan.* To qualify, the Trustees must approve of your participation in the *Plan.*

(iv) an employee of a Council affiliated with the UBCJA who was an employee of the UBCJA and a participant in this *Plan* on the day preceding the commencement of employment with the Council and who has been accepted by the Trustees for participation in the *Plan.* To qualify, the Trustees must approve of your participation in the *Plan.*

(v) attorneys employed by DeCarlo & Shanley, a Professional Corporation are eligible to participate in the *Plan* subject to the terms of the Participation Agreement between DeCarlo & Shanley and the Trust entered into on January 30, 2017.

(b) Types of Coverage Available

(1) Eligible Employees Residing in the United States Who Participate In the Plan

Medical, prescription drug, dental, vision, life insurance and accidental

death & dismemberment (AD&D) coverage is available to eligible *employees* who reside in the United States and participate in this *Plan.*

(2) Eligible Employees Residing in Canada Who Participate In the Plan

Prescription drug, dental, vision, life insurance, AD&D is available to eligible *employees* residing in Canada who participate in this *Plan.* Such *employees* are not eligible for medical benefits under the *Plan,* except for the following benefits set forth in the *Plan:* Hearing Aids, Outpatient Mental Health Care, and Outpatient Substance Abuse Treatment.

Section 1.02 Retiree Eligibility

(a) Who is Eligible?

If you are a *retiree,* you are eligible to participate in the *Plan* if all of the following requirements are met:

(1) you retired from employment with a contributing employer to the *Plan* and immediately began to receive pension benefits from the *Pension Fund,*

(2) you were a participant in the *Plan* on your last day of employment with a contributing employer to the *Plan;*

(3) your former employer authorizes your continued participation in the *Plan* as a retiree;

(4) your former employer makes required contributions to the *Plan* on your behalf;

(5) you pay your share of the monthly cost of coverage, if your retirement date is after March 1, 1997 (or after January 1, 1998 if you were an employee covered by a collective bargaining agreement between OPEIU Local 2 and a contributing employer on the last day your employment prior to retirement);

(6) you were a participant in the *Plan* for at least 5 consecutive years immediately preceding your retirement, if your retirement date is on or after January 1, 2003 but before January 1, 2009;

(7) you are not covered or eligible for coverage under any other group health plan, if your retirement date is on or after April 1, 2005; and

(8) if your retirement date is on or after January 1, 2009, you satisfy the requirements set forth in at least one of the following subparagraphs:

(A) you were a participant in the *Plan* for at least 5 consecutive years immediately preceding your retirement.

(B) you were a participant in the *Plan* for at least 12 consecutive months immediately preceding your retirement, you left employment with the United Brotherhood of Carpenters and Joiners of America ("UBCJA") after having been employed by the UBCJA for at least 14 years to serve as a full-time officer or employee of a labor organization affiliated with the UBCJA and subsequently returned to employment with the UBCJA immediately following your employment with the labor organization affiliated with the UNCJA and remained employed by the UBCJA until your retirement, and you were employed by the UBCJA for the 12 consecutive month period immediately preceding your retirement.

You are also eligible to participate in the *Plan* and receive retiree coverage if all of the following requirements are met: 1) you *are* a retired former employee of the Lathers International Union 2) your retirement date was on or before March 1, 1997 3) you were a participant in the *Plan* with retiree coverage on March 1, 1997 4) a contributing employer authorizes your participation and makes required contributions to the *Plan* on your behalf, and 5) you have remained a participant in the *Plan* on a continuous basis since you became a participant.

You are also eligible to receive retiree coverage from this *Plan* if you retire on or after August 1, 2020 and you worked for one of the Regional Councils of the United Brotherhood of Carpenters and Joiners of America for at least ten (10) consecutive years and you were an active participant in this Plan for at least four (4) consecutive years immediately preceding your retirement date.

You are also eligible to receive retiree coverage from this *Plan* if you retire on or after August 1, 2021 and you worked for one of the Regional Councils of the United Brotherhood of Carpenters and Joiners of America for at least twenty-five (25) consecutive years and you were an active participant in this Plan for at least two years and six months (2 ½ years) consecutive years immediately preceding your retirement date.

You are also eligible to receive retiree coverage from this *Plan* if you retire on or after September 1, 2021 and you performed professional services for one of the Regional Councils of the United Brotherhood of Carpenters and Joiners of America and/or the United Brotherhood of Carpenters and Joiners for at least twenty-five (25) consecutive years and you were an active participant in this *Plan* for at least two years and six months (2 ½ years) consecutive years immediately preceding your retirement date.

(b) Types of Coverage Available

A description of the coverage available to eligible *retirees* who reside in the United States and participate in the *Plan* is set forth in the table below:

Date of Retirement	Available Coverage

On or before March 1, 1997 (or on or before January 1, 1998 if covered by OPEIU Local 2 collective bargaining agreement on last day of employment prior to retirement)	Medical, prescription drug, dental, vision, life Insurance and accidental death & dismemberment (AD&D).
After March 1, 1997 (or after January 1, 1998 if covered by an OPEIU Local 2 collective bargaining agreement on last day of employment prior to retirement) but before January 1, 2003.	Medical or medical and prescription drug - as long as you continue to pay your share of the monthly cost of coverage.
On or after January 1, 2003 but before April 1, 2005	Medical, life insurance and accidental death and dismemberment (AD&D) or medical, prescription drug, life insurance and accidental death and dismemberment (AD&D) - as long as you continue to pay your share of the monthly cost of coverage.
On or after April 1, 2005	Medical, life insurance and accidental death and dismemberment (AD&D) or medical, prescription drug, life insurance and accidental death and dismemberment (AD&D) - as long as you continue to pay your share of the monthly cost of coverage and are not covered or eligible for coverage under any other group health plan

A description of the coverage available to eligible *retirees* who reside in Canada and participate in the ***Plan*** is set forth in the table below:

Date of Retirement	Available Coverage
On or before March 1, 1997	Coverage is limited to prescription drug, dental, vision, life insurance and accidental death & dismemberment (AD&D), Hearing Aids, Outpatient Mental Health Care, and Outpatient Substance Abuse Treatment.

After March 1, 1997 but before January 1, 2003	Coverage is limited to prescription drug, Hearing Aids, Outpatient Mental Health Care, and Outpatient Substance Abuse Treatment as long as you continue to pay your share of the monthly cost of coverage at rates determined by the Trustees from time to time.
On or after January 1, 2003 but before April 1, 2005	Coverage is limited to prescription drug, life insurance and accidental death and dismemberment (AD&D), Hearing Aids, Outpatient Mental Health Care, and Outpatient Substance Abuse Treatment- as long as you continue to pay your share of the monthly cost of coverage at rates determined by the Trustees from time to time.
On or after April 1, 2005	Coverage is limited to prescription drug, life insurance and accidental death and dismemberment (AD&D), Hearing Aids, Outpatient Mental Health Care, and Outpatient Substance Abuse Treatment- as long as you continue to pay your share of the monthly cost of coverage at rates determined by the Trustees from time to time.

Section 1.03 Dependent Eligibility

(a) Who Is An Eligible Dependent

If you are an eligible *employee* or *retiree,* your eligible dependents generally include:

(1) your lawful spouse,

(2) your *children* through the end of the calendar month in which they reach age 26, except for your adult children who are eligible to enroll in an employer-sponsored health plan other than a group health plan of a parent.

(i) The coverage for unmarried, dependent *children* whose coverage would otherwise terminate solely due to reaching the limiting age set forth above will continue to be eligible for dependent coverage if:

(A) the child must have been covered by the Plan when he or she turned age 26 and be unable to work due to mental retardation, which is genetic or results from severe trauma, or physical handicap which began before the child was 26. Acceptable proof of incapacity shall be in the form of a determination by an independent review organization that it is accredited by the Utilization Review Accreditation Commission.;

(B) written evidence of such incapacity is sent to the Plan's Administrative Office within 31 days after notification that such child may be ineligible for continued coverage;

(C) proof that he or she continues to be so incapable is sent to the Plan's Administrative Office from time to time at the Administrative Office's request;

(D) proof must be provided to the *Plan* that the dependent is wholly dependent on the employee for support;

(E) the dependent is not covered by other insurance benefits from other sources; and

(F) the child is claimed as a dependent on the employee's/retiree's federal tax return for each year for which coverage is provided.

NOTE: If your spouse or other dependent is eligible for coverage under the *Plan* as an eligible *employee* or eligible *retiree*, he or she will not be eligible for coverage as an eligible dependent under the Plan. See Section 1.05 below.

(b) Available Coverage for Eligible Dependents

<u>Dependents of Employees, or Dependents of Retirees who retired on or prior to March 1,1997</u>
If you are an eligible *employee* or an eligible *retiree* with a pension fund annuity starting date on or before March 1, 1997 (or on or before January 1, 1998 if you were covered by an OPEIU Local 2 collective bargaining agreement on the last day of your employment prior to retirement), you may also choose to enroll your eligible dependents for medical, prescription

drug, dental and vision coverage.

Dependents of Retirees who retired after March 1, 1997
If you are an eligible *retiree* with a pension fund annuity starting date after March 1, 1997 (or after January 1, 1998 if you were covered by an OPEIU Local 2 collective bargaining agreement on the last day of your employment prior to retirement), you may choose to enroll your eligible dependents for the medical or medical/prescription drug coverage—that you have chosen for yourself. In addition to your share of the premium for yourself, you will also be required to pay an amount for any eligible dependent who you chose to enroll.

If you are an eligible *employee* or *retiree* who resides in Canada and participates in the *Plan,* the coverage available for your eligible dependents is as follows:

Dependents of Employees, or Dependents of Retirees who retired on or prior to March 1,1997
If you are an eligible *employee,* or an eligible *retiree* with a pension fund annuity starting date on or before March 1, 1997, you may also choose to enroll your eligible dependents for limited medical, prescription drug, dental and vision coverage. Any eligible dependent that you enroll is not entitled to medical benefits under the *Plan,* except for the following: Hearing Aids, Outpatient Mental Health Care, and Outpatient Substance Abuse Treatment.

Dependents of Retirees who retired after March 1, 1997
If you are an eligible *retiree* with a pension fund annuity starting date after March 1, 1997, you may choose to enroll your eligible dependents for the same limited medical or limited medical/prescription drug coverage you have chosen for yourself. Any eligible dependent that you enroll is not entitled to medical benefits under the *Plan,* except for the following: Hearing Aids, Outpatient Mental Health Care, and Outpatient Substance Abuse Treatment. In addition to your share of the premium for yourself, you will also be required to pay an amount for any eligible dependent who you chose to enroll.

Section 1.04 Surviving Dependents

(a) Coverage

In the event of your death while an active *employee* or a *retiree* covered under the *Plan,* whether or not there is coverage available for your eligible dependents following your death and the type of coverage available depends on when you die if you are an active *employee* at the time of your death or the effective date of your retirement under the *Pension Fund* if you are a *retiree* at the time of your death.

(1) Surviving eligible dependents of an *active employee* who dies before March 1, 1997 while covered under this *Plan* and surviving eligible dependents of a *retiree* covered under this *Plan* at the time of death whose effective date of retirement under the *Pension Fund* is prior to March 1, 1997 are covered for medical, prescription drug, dental, and vision coverage. The cost of coverage is paid in full by the employer/former employer.

(2) Surviving eligible dependents of an active *employee* who dies between March 1, 1997 and December 31, 1998 while covered under this *Plan*

and surviving eligible dependents of a *retiree* covered under this *Plan* at the time of death whose effective date of retirement under the *Pension Fund* is between March 1, 1997 and December 31, 1998, are covered for medical or medical and prescription drug coverage as long as they continue to pay their share of the monthly cost of coverage. The cost of coverage paid by dependents depends on the coverage they choose.

(3) Surviving eligible dependents of an active *employee* who dies on or after January 1, 1999 while covered under this *Plan* and surviving eligible dependents of a *retiree* covered under this *Plan* at the time of death whose effective date of retirement under the *Pension Fund* is on or after January 1, 1999, may be eligible for medical or medical and prescription drug coverage, depending on the age of the participant's spouse and the participant's years of active service under the United Brotherhood of Carpenters Pension Fund at the time of death. If you die on or after January 1, 1999, while an active *employee* covered under this *Plan* or if you die while a covered *retiree* under this *Plan* and your effective retirement date under the *Pension Fund* is on or after January 1, 1999, and your spouse is:

A) age 65 or over at your death, medical and prescription drug coverage for your eligible dependents will continue for up to two years. The cost of coverage is paid in full by your employer. To qualify, you must have been continuously employed and covered under the United Brotherhood of Carpenters Pension Fund for at least five years and have at least five years of credited service under the United Brotherhood of Carpenters Pension Fund at the time of your death.

B) **under age 65 at your death,** coverage for your eligible dependents may continue until the earlier of the date your spouse reaches age 65 or the end of the period shown in the following table, as long as they pay their share of the cost of coverage:

Years of Service	**Coverage Period**
30 or more	4 years
20-29	3 years
10-19	2 years
5-9	**1** year
Less than 5	No coverage

If your spouse has not reached age 65 at the end of the period shown in the table, he or she may choose to continue coverage to age 65 by paying 50% of

the actual cost of the medical and prescription drug coverage.

Notwithstanding anything in this subparagraph B) to the contrary, if you had 30 or more years of credited service under the United Brotherhood of Carpenters Pension Fund at the time of your death (while covered under this ***Plan)*** and your spouse was over 62 but under age 65 at the time of your death, he or she may choose to continue coverage for a period of up to two years after the date of your death, provided he or she pays his or her share of the cost of coverage up until the time he or she reaches 65 and 50% of the actual cost of the medical and prescription drug coverage for any coverage on or after the date he or she attains age 65.

For purposes of this subparagraph, Years of Service means years of credited service under the United Brotherhood of Carpenters Pension Fund.

(b) Termination of Coverage

In addition to the limitations for coverage of surviving eligible dependents set forth above, coverage under the plan for surviving eligible dependents will be terminated:

(1) the first of the month for which your dependents fail to pay any required premium.

(2) the date your surviving spouse remarries.

(3) for a dependent child, the date he or she is no longer eligible for coverage under the *Plan.*

When coverage ends for a dependent, he or she may be eligible to continue coverage for a period of time by self-paying the full cost of coverage. See **COBRA** in Article XIV for more information.

NOTE: Surviving eligible dependents of covered *employees* and *retirees* in Canada are not eligible for medical benefits under the *Plan*, except for the following: Hearing Aids, Outpatient Mental Health Care, and Outpatient Substance Abuse Treatment.

Section 1.05 Non-Duplication of Coverage

An individual may not be covered under this *Plan* as both an eligible *employee* (or eligible *retiree)* and an eligible dependent. Notwithstanding anything in the *Plan* to the contrary, in the event that an individual is eligible for coverage under the *Plan* as an eligible *employee* or eligible *retiree,* such individual shall not be entitled to coverage as an eligible dependent under the *Plan.*

ARTICLE II Enrollment

Section 2.01 Employee Enrollment

If you are an eligible *employee* who wishes to participate in the *Plan*, you need to enroll yourself for employee coverage by completing and returning an enrollment form to the Plan Administrative Office within 31 days of the date you become eligible for such coverage. If you are an eligible *employee* and you do not enroll within 31 days from the date you become an eligible for coverage, you will not be able to enroll for coverage at a later date, except as described in Sections 2.04, 2.05 and 2.06 below. Individuals enrolled during a special enrollment period have the same opportunity to select plan benefit options at the same costs and the same enrollment requirements, as are available to similarly-situated employees at initial enrollment.

Section 2.02 Retiree Enrollment

If you are an eligible *retiree* who wishes to participate in the *Plan*, you need to enroll yourself for retiree coverage by completing and returning an enrollment form to the Plan Administrative Office within 31 days of the date you become eligible for such coverage. If you are an eligible *retiree* who does not enroll within this 31-day time frame, you will not be able to enroll yourself for coverage at a later date, except as described in Section 2.04 below.

Section 2.03 Enrollment of Eligible Dependents

If you are an eligible *employee* or *retiree* who participates in this *Plan*, any eligible dependent(s) who you wish to enroll in the *Plan* must be enrolled in the *Plan* by you within 31 days after you become eligible for employee or retiree coverage, except as described in Sections 2.04 and 2.05 below.

Section 2.04 Waiver of Coverage, Late Enrollment and Re-Enrollment

(a) If you are an eligible *employee* or *retiree* who waives medical, dental, prescription and vision coverage for yourself or your dependents because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents for coverage. To qualify for this special enrollment, you need to request enrollment within 30 days after your other coverage ends and the conditions set forth in Section 2.04(b) below must be met.

(b) If the other coverage was under COBRA, the COBRA coverage must have run out for you or your dependents to be eligible for a special enrollment. If your other coverage was not under COBRA, you or your dependents' loss of coverage or loss of eligibility for coverage must have resulted from loss of eligibility for coverage due to legal separation, divorce, death, termination of employment, reduction in hours of employment, or termination of employer contributions toward coverage.

(c) If you are a *retiree* who retired on or after April 1, 2005 and you were not eligible for coverage under this *Plan* at the time of retirement solely because

you were covered or eligible for coverage under another group health plan, you may be able to enroll in the *Plan* if you later are no longer covered or eligible for coverage under another group health plan if you are eligible to participate in this *Plan* pursuant to Section 1.02. To qualify for this late enrollment, you must be eligible to participate in the *Plan* under Section 1.02, you must request enrollment within 30 days after the other group health coverage or eligibility for coverage ends, and the conditions set forth in Section 2.04(b) above must be met.

(d) If you are a *retiree* who retired on or after April 1, 2005 with retiree health coverage under this *Plan* and you later become ineligible for coverage under this *Plan* because you become covered or eligible for coverage under another group health plan, you may be able to re-enroll in this *Plan* if you later are no longer covered or eligible for coverage under another group health plan and are eligible to participate in the *Plan* pursuant to Section 1.02. To qualify for this re-enrollment, you must be eligible to participate in the *Plan* under Section 1.02, you must request re-enrollment within 30 days after the other group health coverage or eligibility for such coverage ends, and the conditions set forth in Section 2.04(b) above must be met.

Section 2.05 New Dependent(s)

(a) If you are an eligible *employee* and gain one or more new eligible dependents as a result of marriage, birth, adoption or placement for adoption, you may enroll such dependent(s) (and yourself, if not otherwise enrolled) in the *Plan* within 30 days after the marriage or 60 days following the birth, adoption or placement for adoption.

(b) If you are an eligible *retiree* who is a participant in this *Plan* and you gain one or more new eligible dependents as a result of marriage, birth, adoption, or placement for adoption, you may enroll such dependents in the *Plan* within 30 days after the marriage or 60 days following the birth, adoption or placement for adoption.

Section 2.06 Special Enrollment in the Case of Medicaid or a State Children's Health Insurance Program (CHIP)

You and your dependents may also enroll in this Plan if you (or your eligible dependents):

(a) have coverage through Medicaid or a State Children's Health Insurance Program (CHIP) and you (or your dependents) lose eligibility for that coverage. However, you must request enrollment in this Plan within 60 days after the Medicaid or CHIP coverage ends; or

(b) become eligible for a premium assistance program through Medicaid or CHIP. However, you must request enrollment in this Plan within 60 days after you (or your dependents) are determined to be eligible for such premium assistance.

Section 2.07 Rescission of Eligibility Obtained by Fraud, Misrepresentation or Concealment

In addition to the recovery remedies provided by Section 16.05, or which otherwise exist under applicable agreements or law, any individual whose eligible status is obtained by intentional fraud, misrepresentation or concealment, may lose eligible status retroactively to the date of such misconduct. In addition, the Trustees may in their discretion, deny eligibility prospectively on a permanent or temporary basis, with respect to any individual who alone, or in concert with others, engaged in such misconduct.

The Plan will comply with the applicable requirements of the Patient Protection and Affordable Care, as amended ("PPACA") and applicable regulations issued thereunder with respect to the rescission of coverage. For purposes of this section, the term "rescission" shall have the meaning assigned to such term under applicable regulations issued under PPACA pertaining to the rescission of coverage.

ARTICLE III WHEN ELIGIBLE/ EFFECTIVE DATE OF COVERAGE

Section 3.01 Employee Coverage

If you are an eligible *employee,* as identified in Section 1.01, you are eligible for coverage under the *Plan* on the first day of the month following your date of hire with a participating employer. To obtain coverage, you must enroll in the *Plan* within 31 days after the first day of the month following your date of hire or within a time period allowed under Sections 2.04 or 2.05 of the *Plan,* if applicable. If you enroll in the *Plan* within 31 days from the first day of the month following your date of hire with a participating employer, your coverage under the *Plan* will be effective from the first day of the month following your date of hire. If you enroll at a later date under Sections 2.04 or 2.05 of the *Plan,* your coverage will be effective from the first day of the month following the date the Administrative Office receives a completed enrollment form.

Section 3.02 Retiree Coverage

If you are an eligible *retiree,* as identified in Section 1.02, on the first day of your retirement, you are eligible for coverage on the first day of your retirement. To obtain coverage, you must enroll in the Plan for retiree coverage within 31 days of your retirement (or within the enrollment period permitted under Section 2.04 of the Plan, if applicable) and pay any required share of the monthly cost of coverage. If you are an eligible retiree who enrolls within 31 days of your retirement and pays any required share of the monthly cost of coverage, the coverage that you elect will become effective from the first date of retirement. If you are an eligible *retiree* who enrolls or re-enrolls at a later date pursuant to Section 2.04 of the *Plan* and pays any required share of the monthly cost of coverage, your coverage under this *Plan* begins as of the first day of the month following the date the Plan Administrative Office receives a completed enrollment form.

Section 3.03 Dependent Coverage

Coverage for your eligible dependents who you enroll within 31 days from the date that you become eligible for coverage begins on the same date you are eligible for coverage, provided that you also enroll for employee or retiree coverage within 31 days from the date that you become eligible for such coverage. If you are an eligible *employee* or an eligible *retiree* who is a participant in the *Plan,* coverage for new eligible dependents you later enroll in the *Plan* in accordance with Section 2.05 of the *Plan* begins as follows:

(a) eligible *children* are covered from the date of birth, adoption, or placement for adoption.

(b) eligible spouses are covered as of the first of the month following the date the *Plan* Administrative Office receives a completed enrollment form.

If you are an eligible *employee* or an eligible *retiree* who is a participant in the *Plan,* coverage for dependents enrolled under Section 2.04 of the *Plan* begins as of the first

day of the month following the date the Plan Administrative Office receives a completed enrollment form.

Section 3.04 Qualified Medical Child Support Orders

(a) Eligibility for coverage extends to any child of an *employee* or *retiree* who is recognized as an alternate recipient under a Qualified Medical Child Support Order (QMCSO) as having a right to enrollment under the Plan. Coverage begins as of the first day of the month following the date that the Plan Administrative Office receives a medical child support order that is determined to be a QMCSO.

(b) In the event that a medical child support order is received by the Plan, the Plan Administrative Office shall promptly notify the affected *employee* or *retiree* (including the alternate recipient named in the medical child support order) of the receipt of such order and the Plan's procedures for determining the qualified status of such order under Section 609 of ERISA. The Plan shall then, within a reasonable period after receipt of such order, determine whether such order is a QMCSO in accordance with written procedures adopted by the Board of Trustees for such purpose and notify the affected *employee* or *retiree* and each alternate recipient of its determination.

(c) Any benefits paid for expenses incurred on behalf of an alternate recipient may be made to the alternate recipient or alternate recipient's custodial parent or legal guardian.

(d) Copies of QMCSO procedures are available upon request, at no charge, from the Plan Administrative Office.

ARTICLE IV Monthly Cost of Coverage

Section 4.01 Costs for Employees and Retirees Who Retired on or Before March 1, 1997

If you participate in the *Plan* as one of the following, monthly costs of coverage under the *Plan* are currently paid in full by your employer/former employer for you and your eligible dependents:

(a) an eligible *employee;*

(b) an eligible *retiree* who retired on or before March 1, 1997 (or on or before January 1, 1998 if you were covered by a collective bargaining agreement between OPEIU Local Union 2 and a contributing employer on the last day of your employment prior to retirement).

Section 4.02 Costs for Retirees Who Retire After March 1, 1997

If you retired after March 1, 1997 (or after January 1, 1998 if you were covered by a collective bargaining agreement between the OPEIU Local Union 2 and a contributing employer on the last day of your employment prior to your retirement), you and your former employer share the monthly cost of medical and prescription drug coverage. Your share of the cost depends on whether you elect medical coverage or medical/prescription drug coverage for yourself and/or your dependents. Required payments must be received by the Plan Administrative Office no later than the 15th of the month to which the payment applies.

Section 4.03 More About Costs of Coverage

Costs of coverage are reviewed on a regular basis and may change. You will be notified of your cost of coverage when you become eligible to enroll and if your share of the cost of coverage subsequently changes.

Keep in mind that any monthly costs for coverage are in addition to costs you may be required to pay, such as copays, coinsurance, non-covered services and a *deductible*, when you receive services.

ARTICLE V Medical Benefits

Section 5.01 Choice of Providers

Medical coverage under this *Plan* pays benefits for specified *preventive care* and *medically necessary* services and supplies which covered eligible *employees, retirees* and dependents receive from licensed health care providers.

(a) you may receive care from any provider you choose, but it may be to your advantage to receive care from *preferred providers.* These are physicians, hospitals and other health care providers that have contracted with the *Plan* to provide services to you and your family at negotiated rates. (The Fund has a contract with Anthem Blue Cross .) A list of *preferred providers* within each network can be found online or you may call their toll free numbers as noted below:

Anthem Blue Cross website: www.anthem.com

For Provider Finder (PPO) 1-800-810-2583 (toll free)

For Precertification – Medical including Transplant review, please contact Hines & Associates at 1-800-323-3454 (toll free)

For Precertification – Behavioral Health, please contact Hines & Associates at 1-800-323-3454 (toll free)

Choosing to receive care from a *preferred provider* offers you the following advantages:

(1) benefits for most covered services are paid at 100%, after you pay any applicable copays at the time of service. Limits apply to certain covered services. You may also be required to pay a $50 annual *deductible* in some circumstances. (See Section 5.04(b)).

(2) your costs for covered services are lower because *preferred providers* have agreed to negotiated fees.

(3) you won't ever have to pay charges above *Allowable Charges (AC)* amounts that are considered for payment by the *Plan.*

(4) you don't need to file claims for reimbursement because your *preferred provider* will submit claims for you.

(5) you are assured of receiving care from providers who have agreed to meet established standards for providing high quality and necessary medical care.

(b) if you choose to receive care from a provider that has not joined the preferred network, benefits generally will be paid at 80% of *AC* charges, after you pay a $50 annual *deductible.* In addition, you will need to file claims for reimbursement if your provider does not offer that service. A claim form can be found at the Plan's website www.ubcbenefits.org

(c) The Plan's annual out-of-pocket maximum is the most you will have to pay for covered medical, mental health and substance abuse expenses incurred in-network or out-of-network each calendar year. Annual out-of-pocket maximum is $1,050 per individual per calendar year. The $50 deductible and $1,000 coinsurance are your share of the costs of a covered service calculated as a percentage of the allowed amount for service.

(1) Preferred Provider (In-Network)

Under the Plan in-network covered medical, mental health and substance abuse expenses are covered at 100% of the contracted rate. The member's responsibility is $0 except for $5.00 co-pays.

After you have paid $1,050 out-of-pocket during the year for covered expenses, the Plan pays the cost of covered services you receive from preferred providers at 100% of the contracted rate.

(2) Non-Preferred Providers (Out-of-Network)

The Plan's out-of-network annual out-of-pocket is $1,050 per individual per calendar year. Only your deductible $50 and coinsurance for covered medical, mental health and substance abuse expenses apply to the out-of-pocket maximum. Coinsurance is the member's share of the costs of a covered service, calculated as a percentage of the allowed amount for the service. Services received from a non-preferred provider are paid at 80% of the Allowable Charge (AC).

In addition, you will also be responsible for amounts that exceed the Plan's Allowable Charge (AC). These amounts do not count toward your annual out-of-pocket maximum.

For example, if the Plan's allowed charge for a service is $1,000, the Plan pays 80% or $800 and the Member's coinsurance payment is 20% or $200. That $200 is counted toward the member's maximum out -of-pocket. Amounts that exceed the Plan's AC do not count toward the annual out-of pocket maximum. For example, if a covered service is $1300 and the Plan's allowed charge is $1,000, the member's out of pocket would be $200 (20%) plus an additional $300, which is the amount above AC. The 20% is applied to your out-of-pocket; however, the additional $300 does not count toward the out-of-pocket maximum.

After you have reached the out-of-pocket maximum of $1,050 during the year for covered expenses, the Plan pays the cost of most covered services you receive from non-preferred providers at 100%. The member will still pay for charges above the AC.

(d) If No Preferred Provider In Service Area For Required Medical Services

Subject to any applicable exclusions, limitations, deductibles and copays set forth in the SPD, in the event that there is no *preferred provider* for the required medical services within 25 miles from a participant's permanent place of residence and the participant (or dependent of the participant who is covered by this Plan) obtains the required medical services from a non-preferred provider, covered medical services and supplies provided by such non-preferred provider will generally be paid up to 100% of *AC* charges (or the amount of the covered charges if less than *AC.)* In such case, the $50 annual deductible shall not apply to such services or supplies.

(e) Special Rule if the Medical Facility Involved is a Preferred Provider But a Provider at the Medical Facility That Provides the Services is Not a Preferred Provider

Subject to any applicable exclusions, limitations, deductibles and copays set forth in the SPD, in the event that the medical facility at which a participant (or dependent of a participant who is covered under this Plan) obtains medical services is a *preferred provider* and the participant (or dependent of the participant who is covered under this Plan) obtains medical services or supplies from a provider within the facility who is not a *preferred provider*, covered medical services or supplies received from such non-preferred provider within such medical facility will generally be paid up to 100% of *AC* charges (or the amount of the covered charges if less than *AC*). In such case, the $50.00 annual deductible shall not apply to such services or supplies.

(f) Special Rule if A Preferred Provider Physician Makes a Referral to a Non-Preferred Provider Medical Facility

Subject to any applicable exclusions, limitations, deductibles and copays set forth in the SPD, in the event that a *preferred provider* physician refers a participant (or a dependent of a participant who is covered by this Plan) to a medical facility or medical provider that is not a *preferred provider*, covered medical services and supplies received at such medical facility or by such medical provider as a result of such referral will generally be paid up to 100% of *AC* charges (or the amount of the covered charges if less than *AC*). In such case, the $50 annual deductible shall not apply to such services or supplies.

Section 5.02 Hospital Review Services

The *Plan* includes the following services to help ensure that you receive *hospital* care that is appropriate and cost effective. Remember, no benefits will be paid for services that the *Plan* determines are not *medically necessary*, whether you follow the pre-authorization review and concurrent review process or not.

Pre-authorization review is to help determine that a proposed hospitalization is *medically necessary* and, therefore, eligible to be covered by the *Plan.* It applies to all *hospital* admissions, except for *hospital* stays due to childbirth.

The Plan will not impose more restrictive administrative requirements on out-of-network Emergency Services than in-network ones.

Pre-authorization review is a required service. You, your *physician* or a responsible family member must obtain pre-authorization review within seven days prior to a scheduled *hospital* admission or within two days after a hospital admission for an *urgent or emergency hospitalization.* To complete the pre-authorization process, you need to call Hines & Associates, toll-free at: 1-800-323-3454.

If you don't obtain pre-authorization within the specified time limits, benefits for covered hospitalization expenses will be reduced 25%.

After you contact Hines & Associates, you will be informed of the *Plan's* decision regarding coverage of your proposed hospitalization within the following time frames:

(1) pre-authorization of scheduled admissions (which are not for *claims involving urgent* care): within 15 days of the date your pre-authorization review request is received. If additional time is needed to process your request due to matters beyond the control of the *Plan,* the time for the *Plan* to respond may be extended an additional 15 days. If an extension is necessary, you will be notified prior to the expiration of the initial 15 day period of the circumstances requiring the extension and the date by which the *Plan* expects to render a decision.

If an extension is necessary due to your failure to submit necessary information, the notice of extension will specifically describe the required information and you will have at least 45 days from the date of receipt of the notice within which to provide the specified information. In the event that the period of time is extended due to your failure to submit information necessary to decide the claim, the period for making the benefit determination shall be suspended from the date on which the notification of extension is sent to you until the date on which you respond to the request for additional information. In such case, the *Plan* will notify you of its decision no later than 15 days after receipt of the specified information.

(2) pre-authorization of *claims involving urgent care:* within 72 hours of the date your pre-authorization review request is received, unless you fail to provide sufficient information to determine whether, or to what extent, benefits are covered under the *Plan*. The *Plan* may provide oral notice of the benefit determination, followed up with a written or electronic confirmation within three days.

(3) In the event you fail to provide sufficient information to determine whether, or to what extent, benefits are covered under the *Plan,* you will be notified by the *Plan* as soon as possible, but not later than 24 hours after receipt of the preauthorization request by the *Plan,* of the specific information necessary to complete the claim. You will then be afforded a reasonable amount of time of at least 48 hours to provide the specified information. In such case, the *Plan* will notify you of the Plan's determination as soon as possible but no later than 48 hours after the earlier of the Plan's receipt of the specified information or the end of the period afforded to you to provide the additional information.

(b) Concurrent stay review is to ensure that your length of stay in a *hospital* is appropriate.

(1) If the *Plan* has approved of an ongoing course of treatment to be provided over a period of time or a number of treatments, the *Plan* will notify you of any reduction or termination of such course of treatment (other than by plan amendment or termination) before the end of such period of time or number of treatments at a time sufficiently in advance of the reduction or termination to allow you to file an appeal and obtain a determination on review before the benefit is reduced or terminated.

(2) Any request by you to extend the course of treatment beyond the approved period of time or number of treatments that is a *claim involving urgent care* will be decided as soon as possible, taking into the account the medical exigencies, and the *Plan* will notify you of the decision within 24 hours of receipt of the claim by the *Plan,* provided that such claim is made to the *Plan* within 24 hours prior to the expiration of the prescribed period of time or number of treatments.

(c) Individual case management is a voluntary benefit intended to help you find effective alternatives to hospitalization or other high cost medical care. The *Plan,* through individual case management, may offer alternatives to long term care at a hospital or skilled nursing facility. Acceptance of any alternative benefits by you or your eligible dependents is voluntary.

Regardless of what the *Plan* determines is covered, it is always up to you and your *physician* to determine what, if any, care you need. The pre-authorization review and concurrent review processes don't provide medical advice; they determine only the extent to which the *Plan* will pay benefits. If you and your *physician* disagree with the *Plan's* determination, you may appeal the decision. See **Appeals Process** in Section 15.06 for more information.

Section 5.03 How the Plan Pays Benefits

Unless noted otherwise, the *Plan* pays *medically necessary* covered expenses as follows:

(a) most covered services and supplies received from *preferred providers* are paid at 100%, after you pay any required *copays.* Limits apply to specified services and supplies where noted in Section 5.04, Section 5.05, or elsewhere

in the Plan.

Note: A $50 per person annual deductible applies to *non-emergency* treatment or treatment for *illness* received in the *emergency* room from preferred providers. (See Section 5.04(b)).

(b) most covered services and supplies received from non-preferred providers are paid at 80%, after you pay a $50 annual *deductible* per person. Except as provided in Sections 5.01(d)-(f) of the SPD, and subject to any applicable limitations, exclusions, deductibles and copays set forth in the SPD, coverage for covered medical services and supplies received from non-preferred providers is limited to 80% of *AC* charges (after the $50 per person annual deductible) and you are responsible for paying the remaining 20% of *AC* charges and any charges above *AC* charges. Limits also apply to specified services and supplies where noted in Section 5.04, Section 5.05, or elsewhere in the Plan. After an enrolled person pays $1,050 in covered expenses in a calendar year, most covered expenses for that person are paid at 100% (up to *AC* charges for non-preferred providers) for the remainder of the calendar year. C*opays* paid to *preferred providers,* and charges above *AC* charges from non-preferred providers do not apply toward meeting this $1,050 expense limit.

(c) *Essential health benefits* are not subject to annual or lifetime limits.

Section 5.04 Covered Medical Expenses

Subject to the exclusions, limitations, deductibles, and copays set forth in the *Plan,* covered medical expenses include the following if for *medically necessary* services or supplies ordered and/or provided by a *physician* for the treatment of a covered *illness* or *injury* (or for *preventive care* as described in Section 5.04(h)(1) or Well Child Care as described in Section 5.04(h)(2)(ii)):

(a) General Medical Expenses

(1) *ambulatory surgical facility* charges.

(2) chiropractic care, up to a maximum of 50 visits per person per calendar year.

(3) dental services required for tumors, cysts or to repair accidental *injury* to the teeth that occur while you are covered under the *Plan.* See Dental Benefits in Article VII of this summary for additional coverage of dental services.

(4) durable medical equipment, including:

(i) initial truss, brace, or support;

(ii) casts, splints, and crutches; and

(iii) rental of wheelchairs or *hospital* type beds, up to the purchase price.

(5) customized orthotics up to 1 pair a calendar year.

(6) *extended care facility* following *a hospital* confinement of at least three days. Note: Benefits for Medicare eligible *retirees* are limited to the amount excluded under Part A of Medicare for the 21st through 100th day in an *extended care facility.*

(7) Hearing aid devices are covered at 100% up to a maximum of $3,000 per ear in a 36-month period. Hearing aid batteries are covered at 100% subject to this $3,000 benefit. The hearing exam visit, and audiology-related tests received to obtain hearing aids are covered at 100%. The cost of the exam and related tests do not count towards the $3,000 maximum hearing aid benefit.

(8) *hospital* charges for daily room and board, up to the *hospital's* regular rate for semi-private rooms, intensive care units, or coronary care units, as applicable. If the *hospital does* not have semi-private rooms, then covered expenses will be calculated as the average rate for semi-private rooms charged by other *hospitals* in the surrounding geographic area. However, if a private room is *medically necessary,* coverage for *hospital* charges for daily room and board for a private room will be up to the hospital's regular rate for private rooms.

(9) *hospital* charges for *medically necessary* hospital services (other than room and board) if they are incurred while you are an *inpatient* during a period in which room and board charges are made and payable, surgery has been performed, or *emergency* treatment has been provided as a result of an *injury* occurring within 24 hours of an accident. Covered services include those incurred for:

(i) medical care and treatment (other than room and board).
(ii) special and floor nursing care.
(iii) professional services.
(iv) other per diem charges.
(v) charges made by *a physician* or professional anesthetist for administration of anesthesia.
(vi) professional ambulance service to and from the *hospital* (if *medically necessary).*

(10) oxygen and rental of equipment for its administration, up to the purchase price.

(11) physical therapy.

(12) *physician's inpatient* and outpatient services. Coverage for *inpatient* visits is

limited to up to one visit per *physician* per day. Outpatient services from *preferred providers* are covered at 100%, after you pay a $5 *copay* per visit.

(13) pre-admission testing, including diagnostic tests and X-rays provided by a *hospital* outpatient department within seven days of a scheduled admission for a covered *injury* or *illness*. To be covered, the tests and X-rays must be ordered by a *physician and* be for the diagnosis of a covered *injury* or *illness*. Under the following circumstances, preadmission testing expenses will be covered even if the admission is postponed or cancelled:

(i) the tests show a condition that requires treatment before the admission to the *hospital*.

(ii) a medical condition develops that delays the admission.

(iii) a *hospital* bed is not available on the scheduled admission date.

(iv) the tests indicate that the admission is not necessary.

(14) private duty nursing services provided by a Registered Nurse (RN) or Licensed Practical Nurse (LPN).

(15) prosthetic devices, including artificial limbs and eyes required for the initial replacement of natural eyes and limbs.

(16) radium and radioactive isotopes.

(17) skilled nursing facility, in place of confinement in a *hospital* or home health care services, up to a maximum of 90 days per confinement.

(18) sterilization (eligible *employee*, eligible *retiree*, and spouse of eligible *employee* or eligible *retiree* only). Coverage for *sterilization of the reproductive system* includes outpatient unilateral vasectomy, bilateral vasectomy, and tubal ligation. *Medically necessary* charges for use of a facility or for anesthesia are also covered.

(19) surgery performed on an *inpatient* or outpatient basis.

(20) temporomandibular joint syndrome (TMJ) and other expenses incurred for treatment of facial pain are paid at 80% of *AC* charges. Covered services include treatment of conditions called, referenced or diagnosed as myofascial pain dysfunction syndrome (MPD), Costen's syndrome, facial pain and mandibular dysfunction, cranio-cervical-mandibular syndrome, and cranio-facial pain and dysfunction.

(21) X-rays and laboratory tests received on an outpatient basis, including basal metabolism determinations and electrocardiograms.

(b) **Emergency Treatment**

emergency treatment, within 24 hours of a covered *injury,* covered at 100% from *preferred providers* and 100% of *AC* charges from non-preferred providers. However, charges for emergency ambulance service to and from the hospital from non-preferred providers will be covered at the same level as charges from a comparable *preferred provider* with the same or similar standing in the locality where the charge is incurred. *Non-emergency* treatment or treatment for *illness* received in the emergency room is covered at 80% from *preferred providers* after the $50 *deductible* or 80% of *AC* charges from non-preferred providers after the $50 *deductible.*

(c) **Home Health Care**

home health care provided by a *home health care agency,* covered up to a maximum of 40 visits per year, unless additional visits are approved by the Board of Trustees pursuant to Section 5.04(c)(3) below. Each visit by a member of a *home health care agency* team and each four hours of home health aide service provided by a *home health care agency* shall be considered as one home health care visit.

(1) Covered home health care services include:

(i) part-time or intermittent home nursing care by an RN, or if the services of an RN aren't available, by an LPN under the supervision of an RN.

(ii) part-time or intermittent home health aide services consisting primarily of medical or therapeutic care for the patient provided by a home health aide who is not an RN or LPN.

(iii) physical, occupational or speech therapy, if provided by the *home health care agency,* and

(iv) medical supplies, drugs or medications prescribed by a *physician* and laboratory services provided by or on behalf of a *home health care agency* to the extent that they would have been covered if the patient had been hospitalized or in a *skilled nursing facility.*

(2) to be covered, home health care must meet all of the following requirements:

(i) *be medically necessary*

(ii) begin within seven days of a *hospital* confinement that lasted at least three days.

(iii) be provided as an alternative to a *hospital* or *skilled nursing facility* stay.

(iv) be in accordance with a *home health care plan.*

(v) be due to an *injury* or *illness* that is not employment related.

(vi) be services that are not provided by a person who lives with you or is a member of your spouse's or your immediate family.

(vii) not be for transportation services.

(viii) be provided during a period when you (or your dependent) is under the continuing care of a physician.

(3) Additional Home Health Care Visits – If additional home health care visits that exceed the maximum number covered under Section 5.04(c) above are recommended by the Plan's medical review provider in a particular case, the Board of Trustees may, in its sole discretion, approve additional home health care visits if it determines that good cause exists and that it would be cost effective to the Plan to do so. Any additional home health care visits that are approved by the Board of Trustees must satisfy the requirements set forth in Sections 5.04(c)(1) and (2) to be covered by the Plan and are also subject to any applicable limitations, exclusions, and deductibles set forth elsewhere in the Plan.

(d) Hospice Care

Hospice care, covered up to a maximum of $20,000 per person per lifetime.

(1) to be covered, hospice care services must comply with each of the following. They must be:

(i) provided for an eligible terminally ill person who does not have a reasonable prospect for a cure and has a life expectancy of six months or less, as certified in writing by the attending physician.

(ii) provided during the six-month period that begins on the date the patient first receives hospice care services, after having been certified as terminally ill. Coverage for bereavement services begins on the date of the patient's death and may continue for up to three months.

(iii) provided by a facility that is approved by the *Plan* as meeting all applicable legal requirements of the state, province, or local authority that has jurisdiction over licensing and approval of *hospice care* facilities.

(2) covered *hospice care* services and supplies include:

(i) *inpatient* care, on a consecutive or intermittent basis for:

room and board.
physician's services.
skilled nursing facility care.
respiratory therapy and life support systems.
pain relief therapy, drugs and medicines.

psychological counseling and spiritual support services.

(ii) outpatient care, with at least 80% of care provided in the home, for:

part time (intermittent) nursing care provided by an RN, LPN or licensed public health nurse, if such individual does not live with you or is not a member of your or your spouse's immediate family.
visits by full time hospice staff.
physical and respiratory therapy.
oxygen and equipment for its administration.
rental of wheelchairs, hospital-type beds and other medical equipment.
medicines and drugs.
homemaker services.

(iii) bereavement services, including professional counseling of immediate family members to help them cope with the death of the patient.

(e) Mastectomies

mastectomies. If you or an enrolled dependent receive benefits under the *Plan* for a mastectomy and choose to have breast reconstruction in connection with the mastectomy, coverage will be provided for the following, as determined by you and your *physician:*

(1) reconstruction of the breast on which the mastectomy was performed.

(2) surgery and reconstruction of the other breast to produce a symmetrical appearance.

(3) prostheses and treatment of physical complications of all stages of the mastectomy, including lymphedemas.

(f) Maternity and Pregnancy Related Conditions

maternity and pregnancy related conditions for eligible female *employees* and legal spouses only. For covered *hospital* stays due to childbirth, benefits for the mother or newborn cannot be limited to less than 48 hours for a vaginal delivery or 96 hours for a caesarian section and do not require preadmission or concurrent authorization. The health care provider, after consulting with the mother, may choose to discharge the mother or newborn before 48 or 96 hours. Complications of pregnancy are covered for eligible female *employees,* spouses and eligible dependent *children.*

(g) Mental Health Care

Mental health care, including *inpatient* and outpatient care, as follows:

(1) outpatient mental health care received from *preferred providers* is covered at 100%. If you receive outpatient mental health services from a non-preferred provider, after the $50 annual *deductible,* the *Plan* pays 80% of Allowable Charge (*AC)* charges and you are responsible for paying the remaining 20% of *AC* charges and any charges above *AC* charges. However, once you pay $1,050 in covered expenses in a calendar year, the Plan will pay 100% of *AC* charges for outpatient mental health care from non-preferred providers for the remainder of the calendar year and you are responsible for any charges above *AC* charges. Copays paid to preferred providers and charges above *AC* charges from non-preferred providers do not apply toward meeting this $1,050 expense limit.

(2) inpatient mental health care is covered at 100% from *preferred providers* or 80% of *AC* charges, after the $50 annual deductible from non-preferred providers. However, once you pay $1,050 in covered expenses in a calendar year, the Plan will pay 100% of *AC* charges for inpatient mental health care from non-preferred providers for the remainder of the calendar year and you are responsible for any charges above *AC* charges. Copays paid to preferred providers and charges above *AC* charges from non-preferred providers do not apply toward meeting this $1,050 expense limit.

(3) Notwithstanding any inconsistent provision in the preceding paragraphs (1) and (2) of this subsection (g), if there is no preferred provider within 25 miles of the participant's permanent place of residence and the participant (or dependent of the participant who is covered by this Plan) obtains required treatment for mental health care from a non-preferred provider, covered services from such non-preferred provider will be paid up to 100% of AC charges (or the amount of the covered charges if less than AC).

(h) Preventive and Well Child Care

(1) Preventive Care

(i) specified *preventive care* services performed on an outpatient basis for eligible *employees, retirees,* legal spouses and dependents over the age of 18. Subject to exclusions set forth in Section 5.04(h)(1)(iii) below, specified *preventive care* services are as follows:

(A) Covered exam services:

I) Immunizations.

II) Routine medical exams.

III) Physical exams related to school, sports and employment.

(B) Outpatient routine or preventive diagnostic services:

I) Diagnostic images and scans (such as X-rays and EKG's).

II) Laboratory services, including routine and preventive.

III) Pap Smears and PSA tests.

IV) Pathology tests.

(ii) A single baseline mammogram and an annual screening mammogram are also covered. These mammogram exams are not subject to a deductible.

(iii) Exclusions: The Preventive Care benefit does not cover:

(A) Services not named as covered.

(B) Routine or other dental care.

(C) Routine vision and hearing exams.

(D) Services that are related to a specific illness, injury or definitive set of circumstances, or a definite set of systems of the person.

(E) Physical exams for life or disability insurance.

(F) Work related disability evaluations or medical disability evaluations.

(G) Services not performed on an outpatient basis.

(H) Allergy testing.

(I) Outpatient diagnostic services performed from a hospital or emergency room billed in conjunction with other hospital or emergency room benefits.

(J) Diagnostic surgeries, including biopsies, and scope insertion procedures, such as endoscopy.

(K) Charges exceeding *AC*.

(L) Services and supplies that are excluded from coverage under other applicable exclusions or limitations set forth elsewhere in the Plan.

(2) Well Child Care

Well childcare coverage for eligible *children* including coverage for:

(i) *illness* or sickness, including the necessary care of medically diagnosed congenital defects, birth abnormalities, and prematurity.

(ii) preventive and primary care services, as recommended by your *physician* for *children* under 12 years old and up to three visits per year for *children* age 12 to 18 years old. Covered services include physical examinations, measurements, sensory screening, neuropsychiatric evaluation, and developmental screening. As recommended by your *physician*, covered services also include hereditary and metabolic screening at birth, immunizations, urinalysis, tuberculin tests and appropriate blood tests (such as hematocrit, hemoglobin, and tests to screen for sickle hemoglobinopathy).

(i) Substance Abuse Treatment

Substance abuse treatment, including inpatient and outpatient care as follows:

(1) outpatient substance abuse treatment received from *preferred providers* is covered at 100%. If you receive outpatient substance abuse services from a non-preferred provider, after the $50 annual deductible, the Plan pays 80% of *AC* charges and you are responsible for paying the remaining 20% *AC* charges and any charges above *AC* charges. However, once you pay $1,050 in covered expenses in a calendar year, the Plan will pay 100% of *AC* charges for outpatient substance abuse treatment from non-preferred providers for the remainder of the calendar year and you are responsible for any charges above *AC* charges. Copays paid to preferred providers and charges above *AC* charges from non-preferred providers do not apply toward meeting this $1,050 expense limit.

(2) inpatient substance abuse treatment is covered at 100% from *preferred providers* or 80% of *AC* charges after the deductible from non-preferred providers. However, once you pay $1,050 in covered expenses in a calendar year, the Plan will pay 100% of *AC* charges for inpatient substance abuse treatment from non-preferred providers for the remainder of the calendar year and you are responsible for any charges above *AC* charges. Copays paid to preferred providers and charges above *AC* charges from non-preferred providers do not apply toward meeting this $1,050 expense limit.

(3) Notwithstanding any inconsistent provision in the preceding paragraphs (1) and (2) of this subsection (i), if there is no preferred provider within 25 miles of the participant's permanent place of residence and the participant (or dependent of the participant who is covered by this Plan) obtains required treatment for substance abuse from a non-preferred provider, covered services from such non-preferred provider will be paid up to 100% of AC charges (or the amount of the covered charges if less than AC).

(j) Transplant Services

(1) To qualify for benefits, a proposed transplant must:

(i) be preauthorized by the *Plan* before you are placed on a transplant list. To obtain pre-authorization, call Hines and Associates at 800-433-3232,

(ii) meet the *Plan's* transplant criteria for coverage. This is determined based on a review of your eligibility for benefits and medical condition, your provider's qualifications and experience, the procedure's documented effectiveness in treating the condition, and the outcome of medical alternatives, and

(iii) not be considered an *experimental or investigative procedure* for the treatment of your condition.

(2) Covered transplant services include:

(i) eligible costs incurred by a *Plan* participant for the following transplants:

(A) heart.
(B) heart/double lung.
(C) single lung.
(D) liver.
(E) kidney.
(F) pancreas.
(G) pancreas/kidney.
(H) bone marrow (autologous and allogenic).
(I) stem cell (autologous).

(ii) donor costs, limited to $10,000 per transplant. This includes removal of the donor organ, bone marrow or stem cell after initial screening and identification of the potential donor.

(iii) anti-rejection drugs (paid under Prescription Drug benefits).

(iv) transportation and reasonable and necessary meal and lodging expenses, when authorized in advance by the *Plan.* To qualify, the recipient must live more than 50 miles away from the approved transplant center. Covered costs are limited to $80 per day for an adult recipient, or $125 per day for a dependent minor child recipient and two companions up to a maximum of $7,500 per transplant.

(iv) corneal transplants, skin grafts and transplants of blood derivatives (except for bone marrow or stem cells) are covered under other parts of the *Plan.*

(k) **Acupuncture and Naturopathic providers**. Coverage is provided for up to twenty (20) visits annually provided they are licensed in the State in which the treatment is provided.

NOTE: Eligible *employees* and *retirees* (and their eligible dependents) who reside in Canada and participate in the *Plan* are not eligible for medical benefits under the *Plan,* except for the following benefits set forth in the *Plan:* Hearing Aids; Outpatient Mental Health Care; and Outpatient Substance Abuse Treatment.

Section 5.05 Exclusions and Limitations (What Is Not Covered)

The following is a list of expenses that are not covered medical benefits. In addition to the exclusions and limitations which describe the health benefits, the below are specific limitations and exclusions which apply to all medical benefits. Since it is not possible to list every excluded service or supply, you should call the Plan Administrative Office if you have any questions about coverage.

(a) charges exceeding *AC;*

(b) *hospital* room and board charges in excess of the semi-private rate (except as provided in Section 5.04(a)(8)).

(c) charges for services that are not *medically necessary* (except as described in Section 5.04(h)(1) for ***preventive care*** **services** and Section 5.04(h)(2)(ii) for **well child care)** for the diagnosis or direct care or treatment of a medical condition.

(d) charges for *hospital confinement* (or any portion of such confinement) that is not *medically necessary* or that is not ordered by a *physician* who is practicing within the scope of his or her license.

(e) charges that you or your dependent are not required to pay, or that are incurred when you are not enrolled in the *Plan.*

(f) *confinement* or services in a *hospital* owned or operated by the federal government, except for covered expenses incurred at a Veteran's Administration facility or for expenses incurred by you, as an armed forces retiree, or a dependent for services and supplies that are not related to military service.

(g) charges for treatment of any *illness* or *injury* that occurs as a result of employment and is covered by Workers' Compensation, occupational disease act or law or similar law.

(h) cosmetic surgery, unless it is required: 1) because of an accidental bodily injury 2) as reconstructive surgery when service is incidental to or follows surgery which results in trauma, infection, or other disease of the involved part, 3) as reconstructive surgery because of congenital disease or anomaly of an eligible

dependent child which has resulted in a functional defect, or 4) reconstructive surgery following a mastectomy, as described in Section 5.04(e) of the *Plan.*

(i) *custodial care.*

(j) dental care, except as described under **Covered Medical Expenses** in Section 5.04. See **Dental Benefits** in Article VII of this summary for covered dental services.

(k) drugs and medicines, except while hospitalized. See **Prescription Drug Benefits** in Article VI of this summary for prescription drugs.

(I) elective abortions, except where the life of the mother would be endangered if the fetus were to be carried to term, or for complications of abortion.

(m) *experimental or investigative procedures,* as defined by the *Plan.*

(n) eye refractions, eyeglasses and their fitting; radial keratotomy or any other surgical procedure to correct myopia (nearsightedness) or hyperopia (farsightedness). See **Vision Benefits** in Article VIII of this summary for covered vision care expenses.

(o) home health care services that are not included in a *home health care plan,* are for transportation, or that are not provided while you are under the continuing care of a *physician.*

(p) in vitro fertilization (except where required under law), in vivo fertilization, artificial insemination.

(q) maternity expenses for dependent *children,* except for complication of pregnancy.

(r) personal care items.

(s) intentional self-inflicted injuries unless the injury is a direct result of an underlying health factor or an act of domestic violence.

(t) services provided by a person who normally lives in your home or is a member of your immediate family or your spouse's immediate family.

(u) sex reassignment or any treatment related to sexual dysfunction or reversal of elective sterilization procedures.

(v) transplant costs, except as specifically described in Section 5.04(j) for **transplant services.** Expenses that are not covered include services or supplies that are payable by any government, foundation or charitable grant; donor costs that are covered under other group or individual coverage; or transplantation of non-human or mechanical organs, unless the *Plan* determines that it is not an

experimental or investigative procedure.

(w) transportation, except by local ambulance service or as specifically described in Section 5.04(j) for **transplant services.**

(x) therapeutic X-rays or dental X-rays, except when required in connection with an accidental *injury.*

(y) treatment that is provided as a condition of obtaining or continuing employment or for the purposes of obtaining insurance coverage.

(z) treatment for any *injury* or *illness* that is a result of war, declared or undeclared, or the result of participation in a felony, riot or insurrection.

Section 5.06 Protections Against Surprise Medical Billing

(a) Preventing surprise medical bills for emergency services. A Participant or Dependent cannot be billed for charges beyond their Cost-Sharing for Emergency Services rendered by an out-of-network provider in a hospital or Independent Freestanding Emergency Department. The Plan will cover such Emergency Services until the provider or facility determines that the Participant or Dependent is able to travel using nonmedical transportation or nonemergency medical transportation to an in-network facility. In this case, Emergency Services include post stabilization services and services provided as part of outpatient observation or an inpatient or outpatient stay related to an Emergency Medical Condition.

(b) Preventing surprise medical bills for non-emergency services performed by nonparticipating providers at certain participating facilities. A Participant or Dependent cannot be billed for charges beyond their Cost-Sharing for treatment for non-Emergency Services from an out-of-network provider at an in-network facility unless consent is given as explained below.

(c) The amount of Cost-Sharing (including deductibles, coinsurance, copays, and the out-of-pocket limit) owed by a Participant or Dependent with respect to Emergency Services rendered by an out-of-network provider or non-Emergency Services rendered by an out-of-network provider in an in-network facility will be determined based on the Recognized Amount. The Recognized Amount is the amount specified by a state all-payer model agreement or if none, the Recognized Amount is the lesser of the billed amount or the Qualifying Payment Amount (QPA).

(d) There is no out-of-pocket maximum limit on the use of out-of-network providers. However, cost-sharing for such out-of-network services shall count toward amounts owed for deductibles, coinsurance, copays, and the out-of-pocket maximums.

(e) Upon confirmation that claims are subject to the federal No Surprises Act, the Plan will make an initial payment or issue a notice of denial of payment within 30 calendar days of receiving a complete or perfected claim from the non-participating provider. The 30-calendar-day period begins on the date the Plan receives the information necessary to decide a claim for payment of the services. If the Plan, provider, or facility requests Independent Dispute Resolution under the No Surprises Act, the Plan will comply with federal regulations.

(f) The amount paid to the provider or facility with respect to Emergency Services rendered by an out-of-network provider or non-Emergency Services rendered by an out-of-network provider in an in-network facility will be based on the Qualifying Payment Amount (QPA) except where there is a state All-Payer Model Agreement. Payment for Emergency Services rendered by an out-of-network provider in a hospital or Independent Freestanding Emergency Department, or for non-Emergency Services rendered by an out-of-network provider at an in-network facility will be covered based on the Plan's Allowable Charges.

(g) Notice and Consent Exception to Prohibition on Balance Billing. If the Participant or Dependent gives written, informed consent to treatment by an out-of-network provider at an in-network facility, the Plan will pay benefits at the Out-of-Network Rate.

1) Exceptions to the Availability of Notice and Consent. Written consent cannot be given by the Participant or Dependent if the health care provider is a provider of Ancillary Services.

(h) Preventing surprise medical bills for air ambulance services. If you receive Air Ambulance services that are otherwise covered by the Plan from an out-of-network provider, those services will be covered by the Plan as follows:

2) The Air Ambulance services received from an out-of-network provider will be covered with a cost-sharing requirement that is no greater than the cost-sharing requirement that would apply if the services had been furnished by an in-network provider.

3) In general, you cannot be balance billed for these items or services. Your cost-sharing will be calculated as if the total amount that would have been charged for the services by an in-network provider of Air Ambulance services were equal to the lesser of the Qualifying Payment Amount or the billed amount for the services.

4) Any cost-sharing payments you make with respect to covered Air Ambulance services will count toward your in-network out-of-pocket maximum in the same manner as those received from an in-network provider.

Section 5.07 Special Rule with Respect to Provider Directories

A list of in-network providers and facilities is available to you without charge by visiting the website (www.Anthem.com) or by calling the phone number on your ID card (1-800-810-2583). If you obtain and rely on incorrect information about whether a provider is a network provider from the directory, the Plan will apply in-network cost-sharing to your claim, even if the provider was out-of-network.

Section 5.08 Continuity of Coverage

If you are a Continuing Care Patient, and the Plan terminates its contract with your in-network provider or facility, or your benefits under a group health plan are terminated because of a change in terms of the providers' and/or facilities' participation in the Plan (other than a change due to failure to meet a quality criteria), the Plan will do the following:

1. Notify you in a timely manner of the Plan's termination of its contracts with the in-network provider or facility and inform you of your right to elect continued transitional care from the provider or facility, and

2. Allow you ninety (90) days of continued coverage at in-network cost sharing to allow for a transition of care to an in-network provider or facility.

Only certain Continuing Care Patients qualify for these continuity of care protections. A patient must be undergoing a course of treatment for a Serious and Complex Condition or for institutional or inpatient care—or be scheduled for non-elective surgery, pregnant, or terminally ill. In each instance, the patient must already be receiving care or treatment from the provider or facility.

ARTICLE VI Prescription Drug Benefits

Section 6.01Covered Prescriptions

The *Plan* covers a large array of prescription drugs that are prescribed by a *physician* for treatment of non-employment related *injuries or illnesses,* including injectable insulin, for 1) eligible *employees 2)* eligible *retirees* and 3) eligible dependents, who have prescription drug coverage under the *Plan.* (See Article 1 for information on what coverage is available).

To be covered, the prescription must meet the following requirements. It must:

(a) be obtainable only through a *physician's* written prescription;

(b) be dispensed by a licensed pharmacist (including *hospital* pharmacists for take-home prescriptions);

Note: Prescriptions received while you are hospitalized are covered under the hospital benefit described in under **Covered Medical Expenses** in Section 5.04(a)(9).

(c) be for the treatment of a non-employment related *injury* or *illness* (except for a contraceptive that is prescribed for preventive purposes and that is not excluded from coverage under Section 6.04); and

(d) not be excluded from coverage under the *Plan.* (See Section 6.04 of Plan).

Section 6.02 Retail Pharmacy Prescriptions

(a) Covered non-specialty prescriptions that you purchase at a participating retail pharmacy are covered at 100%, after you pay the following *copay* per 30-day (or 100 unit doses, if greater) prescription or refill:

(1) Generic: $ 5

(2) Preferred Brand: $ 10

(3) Non-Preferred Brand: $15

You may order up to a 30-day (or 100 unit doses, if greater) covered non-specialty prescription or refill at a participating retail pharmacy for the $5, $10, or $15 copay, as applicable.

(b) Covered specialty prescriptions that you purchase through the Plan’s designated specialty prescription pharmacy are covered at 100%, after you pay the following *copay* per 24-day (or 100 unit doses, if greater) prescription or refill:

(1) Generic: $12

(2) Preferred Brand: $ 25

(3) Non-Preferred Brand: $38

You may order up to a 30-day (or 100 unit doses, if greater) covered non-specialty prescription or refill at a participating retail pharmacy for the $12, $25, or $38 copay, as applicable.

(c) **Be sure to show your Prescription Drug ID Card to your participating pharmacist to be assured of receiving full *Plan* benefits.** Otherwise, you will need to pay the full cost of the prescription and then complete and submit a Direct Reimbursement form to Express Scripts for reimbursement of your costs (minus applicable *copays).*

(d) If you purchase your prescription at a non-participating pharmacy, you'll need to pay the full cost of the prescription and then complete and submit a Direct Reimbursement form to Express Scripts for reimbursement of your costs (minus applicable *copays).* (The applicable copay amounts are the same as set forth in Section 6.02(a) above.) Express Scripts can be reached at 800-282-2881 or www.express-scripts.com for more information on the Plan's prescription drug program.

(e) Pre-Authorization Procedure for Specialty Drugs. Pre-Authorization is required for covered specialty prescriptions that you purchase through the Plan's designated specialty prescription pharmacy where the cost of the drug is in excess of $4,000. You or your doctor must call Express Scripts/Accredo at 877-222-7336 to obtain pre-authorization.

Section 6.03 Mail Order Prescriptions

You may choose to order prescriptions by mail if you or an eligible dependent regularly take medication for a chronic condition, such as high blood pressure, diabetes or arthritis. You may order up to a 90-day supply of any covered maintenance prescription, postage paid for the following copay:

(1) Generic: $12

(2) Preferred Brand: $ 25

(3) Non-Preferred Brand: $38

To begin ordering covered maintenance prescription by mail, please contact Express Scripts at 800-282-2881 or by visiting their website at www.express-scripts.com.

Section 6.04 Prescription Drugs—Exclusions and Limitations

The following is a list of expenses that are not covered prescription drug benefits. Since it is not possible to list every excluded drug, service or supply, you should contact Express Scripts if

you have any questions about drug coverage.

(a) charges for administration of prescription *Legend drugs* or injectable insulin.

(b) contraceptives, oral or otherwise, regardless of their therapeutic use, including contraceptive devices, all contraceptive medications (Card and Direct), Oral, Transdermal, Intravaginal and Injectable contraceptives, Emergency Contraceptives, and Seasonale birth control, except for Oral (other than Seasonale birth control and Emergency Contraceptives), Transdermal, Intravaginal and Injectable contraceptives for participants and spouses only that are purchased by mail order.

(c) drugs and injectable insulin dispensed during *confinement* in a *hospital,* rest home, *extended care facility, skilled nursing facility,* convalescent *hospital,* nursing home or similar institution that operates a facility for dispensing pharmaceuticals on its premises.

(d) drugs labeled "Caution limited by law to investigational use," or experimental drugs, even if a charge is made.

(e) drugs that are lawfully obtainable without a prescription, except injectable insulin.

(f) *experimental or investigative procedures,* as defined by the *Plan.*

(g) prescription drugs that may be properly received without charge under local, state or federal programs.

(h) prescription refills in excess of the number of refills specified by your *physician.* drugs, supplies or services that are not *medically necessary.*

NOTE: This does not apply to contraceptives that are prescribed for preventive purposes and that are not excluded from coverage under other subparagraphs of Section 6.04)

(i) therapeutic devises or appliances, including hypodermic needles, syringes, support garments and other non-medical substances (diabetic supplies are covered).

(j) Non-Federal Legend Drugs

(k) Drugs to treat Impotency (except in injectable forms)

(l) Vitamins (except Legend Prenatal Vitamins)

(m) Antiobesity Preparations

(n) Dental Fluoride Products

(o) Glucowatch Products

(p) Mifeprex

(q) Drugs whose sole purpose is to promote or stimulate growth or cosmetic purposes only.

(r) Hypopigmentation Agents

(s) Hydroquinone Bulk Powder

(t) Allergy Sera

(u) Biologicals, Immunization agents or Vaccines

(v) Blood or blood plasma products

Section 6.05 Prescription Drugs – Product Discounts

As a condition of eligibility for prescription drug benefits under the Plan, all eligible employees, retirees and their eligible dependents, agree to sign any document that is necessary for the Trust or its pharmacy benefits manager to secure any product discounts available from manufacturers of covered prescription drugs.

ARTICLE VII Dental Benefits

Dental coverage provided through the *Plan* is intended to encourage you to receive regular *preventive care* while helping you pay the cost of a wide range of other *medically necessary* dental services and supplies.

Section 7.01 Covered Dental Services

The *Plan* covers the following services and supplies for covered eligible *employees*, eligible *retirees* who retired on or before March 1, 1997 (or on or before January 1, 1998 for eligible retirees who were covered by a collective bargaining agreement between OPEIU Local 2 and a contributing employer on the last day of employment prior to retirement), and eligible dependents who have Dental coverage under this *Plan* at 80% of *Allowable Charges (AC)*, up to a combined total of $1,500 per person per calendar year for Actives effective April 1, 2013 and $1040 per person for Retirees:

(a) routine preventive and diagnostic care, including:

(1) routine oral examinations by a dentist:

(2) prophylaxis performed by a dentist or dental hygienist.

(3) X-rays.

(4) diagnosis.

(5) preparation of a complete treatment plan.

(b) basic dental services received in connection with dental disease, defect or *injury*, including:

(1) fillings.

(2) crowns.

(3) partial dentures and bridges.

(4) initial complete dentures.

(5) extractions and other oral surgery.

(6) periodontal treatment.

(7) root canal therapy.

(8) implants.

(c) Orthodontics:

(1) orthodontic services and supplies for eligible dependent *children* up to age 18 are covered at 100% of *AC* charges. Benefits are limited to a lifetime maximum of $1,300 per person.

(2) benefits for eligible orthodontic services are paid as incurred. When there is a single charge for orthodontic services, this means:

(i) for a treatment plan of **two or more years,** one-eighth of the charge is considered to be incurred on the date the first treatment is provided. An additional one-eighth of the charge is considered to be incurred in each following three-month period.

(ii) for a treatment plan of **less than two years,** an equal portion of the charge is considered to be incurred every three months during the treatment period, beginning with the date the first treatment is provided.

(3) payment will be made following submission of proof that orthodontic treatment was provided during each complete three-month period.

Section 7.02 Alternative Dental or Orthodontic Treatments

Many dental or orthodontic conditions may be properly treated in more than one way. If two or more covered options are available for treating a given condition, the *Plan* will base benefit payments on the cost of the treatment that provides professionally satisfactory results in the most cost-efficient way.

Example:

Let's say a standard amalgam filling is sufficient to restore your tooth to health. If you and your *dentist* choose to use a most expensive gold filling, the *Plan* will pay 80% of covered costs, based on the cost of the amalgam filling. In this case, you will need to pay the remaining 20% of covered costs after the *Plan* pays benefits plus the difference in cost for the gold filling.

Section 7.03 Dental Services—Exclusions and Limitations

The following is a list of expenses that are not covered under the *Plan.* Since it is not possible to list every excluded service or supply, you should call the Plan Administrative Office if you have any questions about coverage.

(a) charges exceeding *AC.*

(b) charges that you or your dependent are not required to pay, or that are incurred when you are not enrolled in the *Plan.* (Ongoing maintenance costs for

orthodontics started before coverage began under this *Plan* are covered.)

(c) charges for treatment of *illness* or *injury* that occurs as a result of employment and is covered by Workers' Compensation, occupational disease act or law or law.

(d) *confinement* or treatment in a *hospital* owned or operated by the federal government, except for covered expenses incurred at a Veteran's Administration facility or for expenses incurred by you, as an armed forces *retiree,* or a dependent for services and supplies that are not related to military service.

(e) cosmetic treatment, unless it is required to correct an accidental *injury* that occurred while covered under this *Plan.*

(f) crowns for teeth that are restorable by other means; crowns, fillings and appliances that are used to splint teeth, or change the way teeth meet for example, to alter the vertical dimension or to restore the bite.

(g) *experimental or investigative procedures,* as defined by the *Plan.*

(h) services and supplies that are not listed under **Covered Dental Services** in Section 7.01, including:

(1) oral hygiene, plaque control programs or dietary instructions.

(2) orthognathic surgery.

(3) personalization of dentures.

(4) replacement of lost or stolen dental or orthodontic appliances.

(i) services provided by a person who normally lives in your home or is a member of your immediate family or your spouse's immediate family.

(j) services that are not *medically necessary,* except diagnostic and *preventive care* services recommended by your *dentist,* as described under **Covered Dental Services** in Section 7.01.

(k) treatment that is required as a result of participation in a felony, riot, or insurrection.

(I) treatment that is required as a result of war, declared or undeclared, or an act of war or aggression.

ARTICLE VIII Vision Benefits

Section 8.01 Covered Vision Expenses

The *Plan* will pay the following vision care expenses for covered eligible *employees*, eligible *retirees* who retired on or before March 1, 1997 (or on or before January 1, 1998 for eligible retirees who were covered by a collective bargaining agreement between OPEIU Local 2 and a contributing employer on the last day of their employment prior to retirement) and eligible dependents who have Vision coverage under this *Plan, at* 100%, up to a maximum of $350 per person in each calendar year period:

(a) routine vision examinations by a licensed optometrist or ophthalmologist, up to *AC* charges.

(b) lenses prescribed by an optometrist or ophthalmologist, including eyeglass lenses, contact lenses, tinted lenses and sunglass lenses.

(c) eyeglass frames.

Section 8.02 Vision Service—Exclusions and Limitations

Vision coverage is intended to help pay the cost of your routine vision care needs. It does not cover the following:

(a) charges for routine annual examinations that are required by an employer in connection with your occupation or a dependent's occupation.

(b) charges that you or your dependent are not required to pay or that are incurred when you are not enrolled in the *Plan.*

(c) charges for treatment of *illness* or *injury* that occurs as a result of employment and is covered by Workers Compensation law, occupational disease act or law or similar law.

ARTICLE IX Life Insurance Benefits

Life insurance benefits provide financial protection to your beneficiary(ies) in the event that you die from any natural or accidental cause while covered under the *Plan.* If you are an eligible *employee* or an eligible *retiree* who retired on or before March 1, 1997 (or on or before January 1, 1998 if you are an eligible retiree who was covered by a collective bargaining agreement between OPEIU Local 2 and a contributing employer on the last day of your employment prior to retirement) who participates in this *Plan,* life insurance coverage is automatically provided to you through Union Labor Life Insurance Company. Beginning January 1, 2003, life insurance coverage is also available to eligible *retirees* participating in the *Plan* with a retirement date on or after January 1, 2003. Your employer/former employer pays the full cost of this coverage if you are eligible for such coverage. You will need to complete an enrollment/beneficiary designation form for these benefits. This form may be obtained from the Plan's Administrative Office.

Section 9.01 Life Insurance Amount

(a) *employee* life insurance coverage amount is based on your *annual salary,* as shown in the following chart:

Annual Salary	Coverage Amount
Less than $20,000	100% of annual salary + $5,000
$20,000 or more but less than $25,000	$25,000
$25,000 or more	100% of annual salary, up to $100,000

Examples:

Matt is an eligible *employee* whose *annual salary* was $17,575 in 2002. Since he earned less than $20,000, his life insurance coverage is calculated at 100% of his *annual salary* + $5,000, or $17,575 + $5,000 = $22,575.

James is an eligible *employee* whose *annual salary was* $62,300 in 2012. Since he earned more than $25,000, his life insurance coverage is calculated at 100% of his *annual salary* (up to $100,000), or $62,300.

Your coverage amount is automatically adjusted at the time of any salary change.

(b) If you are a ***retiree*** who has life insurance coverage under the *Plan,* your employer paid life insurance coverage equals 50% of the amount of coverage provided to you on the day before your retired.

NOTE: Life insurance coverage is not available to *retirees* participating in this Plan who retired after March 1, 1997 (or after January 1, 1998 for eligible retirees who were covered by a collective bargaining agreement between OPEIU Local 2 and a contributing employer on the last day of their employment prior to retirement) but before January 1, 2003.

Section 9.02 Beneficiary

Your beneficiary is the person, persons or organization that you choose to receive your life insurance benefit if you die while covered under the *Plan.* Your beneficiary can be anyone you choose and you may name more than one beneficiary. You may name or change beneficiaries at any time by completing and returning an enrollment card to the Plan Administrative Office.

If you name more than one beneficiary, but do not indicate how much each is to receive, benefits will be paid in equal shares to each beneficiary. If you do not name a beneficiary, or if your beneficiary is not living at the time of your death, payment will be made to your first survivor(s) on the following list:

(a) your spouse

(b) your children, in equal shares

(c) your parents, in equal shares

(d) your brothers and sisters, in equal shares

(e) your estate

Section 9.03 How Benefits Are Paid

(a) Life insurance benefits are paid as soon as administratively practical following the date Union Labor Life Insurance Company receives written notice of loss. Claims must be submitted within one year of your death.

(b) Your beneficiary will receive any life insurance benefits payable in the form of a lump sum payment.

ARTICLE X. Accidental Death & Dismemberment Benefits

To provide financial protection in the event of accidental *injury* or death, the *Plan* includes Accidental Death & Dismemberment (AD&D) Insurance to covered eligible *employees* and eligible *retirees* who retired on or before March 1, 1997 (or on or before January 1, 1998 if the eligible retiree was an employee covered by a collective bargaining agreement between OPEIU Local 2 and a contributing employer on the last day of employment prior to retirement). Beginning January 1, 2003, AD&D insurance coverage is also available to eligible *retirees* participating in the *Plan* with a retirement date on or after January 1, 2003. AD&D Insurance covers you 24 hours a day, on or off the job. Benefits that may become payable under the *Plan* are in addition to any other benefits you or your beneficiary(ies) may be qualified to receive.

If you are eligible, AD&D coverage is automatically provided to you through Union Labor Life Insurance Company. Your employer/former employer pays the full cost of this coverage.

Section 10.01 Your Beneficiary

Your beneficiary for AD&D benefits is the same person, persons or organization that you choose to receive your life insurance benefits in the event of your death.

Section 10.02 AD&D Coverage Amount

If you are an eligible *employee*, an eligible *retiree* who retired on or before March 1, 1997 (or on or before January 1, 1998 if you are an eligible retiree who was an employee covered by a collective bargaining agreement between OPEIU Local Union 2 and a contributing employer on the last day of your employment prior to retirement), or an eligible *retiree* who retired on or after January 1, 2003, AD&D coverage available through the *Plan* is in the same amount as your life insurance coverage, as described in Section 9.01.

Full or partial AD&D benefits for a covered loss are paid as shown in the following table. To be covered, the loss must occur within 90 days of the date of injury.

For this covered loss... *	**The Plan pays this percentage of full AD&D benefits**
Life	100%
Any of the following: two hands two feet sight in both eyes one hand and one foot one hand and sight in one eye one foot and sight in one eye	100%
One hand, foot or sight in one eye.	50%

* To be a covered loss, a hand must be severed at or above the wrist and a foot must be severed

at or above the ankle. Loss of sight requires irrevocable and complete loss of sight.

If you have more than one loss in a covered accident, benefits will be paid only for the loss that results in the larger benefit.

Section 10.03 How Benefits Are Paid

AD&D benefits are paid as soon as administratively practical following the date Union Labor Life Insurance Company receives written notice of loss. Claims must be submitted within one year of your loss or death.

You or your beneficiary will receive AD&D benefits in the form of a single lump sum payment.

Section 10.04 What Is Not Covered

AD&D benefits are not payable for deaths or losses caused directly or indirectly, or in whole or in part, by any of the following:

(a) bodily or mental *illness,* infirmity or disease of any kind.

(b) ptomaine, hernia, or bacterial infections (except infections caused by pyogenic organisms occurring with and through an accidental wound or cut).

(c) suicide or attempted suicide while sane or insane.

(d) intentional self-inflicted *injury.*

(e) participation in, or the result of participation in, the commission of an assault, or a felony, or a riot, or a civil commotion.

(f) war or any act of war, declared or undeclared, or any act related to war, or insurrection

(g) service in the armed forces of any country while that country is at war.

(h) police duty as a member of any military, naval or air organization.

NOTE: Accidental Death & Dismemberment benefits are not available to *retirees* participating in the *Plan* who retired after March 1, 1997 (or after January 1, 1998 for eligible retirees who were covered by a collective bargaining agreement between OPEIU Local 2 and a contributing employer on the last day of their employment prior to retirement) but before January 1, 2003.

ARTICLE XI COORDINATION OF BENEFITS

This section describes how your *Plan* benefits are affected when you have other group medical, dental or vision coverage.

Section 11.01 If You Have Other Health Care Coverage

(a) If you are covered by more than one group health plan, it is to your advantage to file claims under both or all plans, because this *Plan* has a Coordination of Benefits (COB) provision. This means, when benefits under this *Plan* are:

(1) primary – that is, they are paid before benefits from another plan, benefits are calculated as usual under *Plan* provisions. Then, benefits are calculated under the other plan(s), based on their COB rules.

(2) secondary — that is, they are paid after benefits from another plan, they are calculated as if you had no other coverage. Benefits are paid so that, when combined with benefits from the primary coverage, your total benefits can equal but not exceed 100% of *allowable expenses.*

(b) Coordination of benefits applies to group medical, dental or vision plans, including:

(1) group blanket or franchise insurance.

(2) group Anthem Blue Cross, group practice and any other prepayment coverage.

(3) any coverage provided under labor-management trustee plans, union welfare plans, employer organization plans.

(4) no-fault motor vehicle insurance, unless not allowed under law.

(5) any coverage under governmental programs, and any coverage required or provided by any law, except for governmental programs with which this *Plan* is not allowed under law to coordinate.

(c) Coordination of benefits does not apply to any coverage for which you or your dependent pays the entire cost. (e.g. individual policy)

(d) If you need help determining how COB will work in your case, contact the Plan Administrative Office. Here are some basic COB rules:

(1) plans without a COB provision pay benefits before plans with a COB provision.

(2) plans that pay you as an employee pay before plans that cover you as a dependent.

(3) if you're married and your spouse has coverage under this *Plan* and under another group plan, the other plan pays for your spouse first, and this *Plan* pays second.

(4) if none of the above rules apply, generally the plan that has covered the individual the longest will pay first.

(5) for dependent *children* who are living at home with both natural parents, the plan that covers the parent whose birthday is earlier in the year pays first. (Different rules may apply if the other plan hasn't adopted this "birthday rule.")

Example:

Jeff and Sara are married. Each parent has health care coverage and chooses to cover their daughter. Jeff's birthday is August 17 and Sara's birthday is October 9. Since Jeff has the earlier birthday, his plan pays first when their daughter needs medical care.

(6) for *children* whose parents are separated or divorced:

(i) the plan of the parent with custody of the child pays first.

(ii) if the parent with custody has remarried, that parent's plan pays first and the custodial step-parent's plan pays second.

(iii) if a court decree states that one of the parents is responsible for the child's health care expenses, that parent pays first. Otherwise, the parent with custody of the child pays first.

(e) If this *Plan* pays benefits that are in excess of the amount allowed under COB, the Plan Administrative Office has the right to recover the excess amount form any party that has received it. (See Section 16.05)

Section 11.02 Coordination with Medicare

(a) This *Plan* pays benefits first and then benefits are determined under Medicare for:

(1) you, if you are an *employee* who is eligible for Medicare.
(2) your spouse if you are an *employee* and he or she is eligible for Medicare.
(3) you and your eligible dependents until eligible for Medicare, if you retired before you were eligible for Medicare.
(4) you or an enrolled dependent who qualifies for Social Security Disability benefits if you are an *employee*.
(5) the first 30 months of Medicare entitlement, if you or an eligible dependent under age 65 becomes eligible for Medicare due to end-stage renal disease (ESRD).

(b) Medicare pays benefits first if you are eligible for Medicare and you are retired or have end-stage renal disease (ESRD). In these situations, you should file claims with Medicare first. Then, this *Plan* will pay benefits for remaining covered expenses so that, when combined with benefits from the primary Medicare coverage, your total benefits can equal but not exceed 100% of *allowable expenses.*

(c) For eligible *retirees* participating in this Plan who become eligible for Medicare after January 1, 1995, the purchase of Medicare Part B is required to receive benefits under this Plan. The exception would be if Medicare is not available. Upon becoming eligible for Medicare, eligible *retirees* (and eligible dependent spouses of eligible *retirees* who are covered by the Plan) must sign up for Part A of Medicare and subscribe to Part B of Medicare. Medicare will then become primary and this coverage secondary.

Note: If you are or will soon be eligible for Medicare, you should contact your local Social Security office for more information. If you are eligible for Medicare, but have not enrolled for Part B, benefits under this *Plan* will be calculated and paid as if you had received Medicare Part B (and Medicare Part A) benefits. You and/or your spouse may choose to be covered under Medicare alone. If you do, claims should be submitted to Medicare only.

ARTICLE XII Circumstances that Affect Your Coverage

Section 12.01 If You Become Disabled

(a) If you are unable to work due to a disability, you may choose to continue medical, prescription drug, dental, and vision coverage by self-paying the cost of coverage. See **COBRA** in Article XIV for more information.

(1) AD&D coverage ends 30 days following the last day of the month in which your employment ends.

(b) If you become *totally disabled* while you are a covered eligible *employee* and before age 60, life insurance coverage may continue at no cost to you for up to 12 months from the date of your disability. The amount of this coverage is the same amount that was provided to you on the date you became disabled, subject to reduction or termination at specified ages or retirement.

(1) Life insurance may continue for up to 12 months if you remain totally *disabled* and submit satisfactory written proof (initial Proof) to Union Labor Life Insurance Company ("ULLICO") within 12 months from the date of your disability showing that the *total disability:*

(i) began while you had life insurance coverage under the group life insurance policy maintained by the *Plan,*

(ii) began before you attained age 60, and

(iii) has existed continuously for 9 consecutive months.

(2) Life insurance coverage may continue for further successive 12-month periods if:

(i) you remain *totally disabled;* and

(ii) you provide acceptable written proof of your continuing *total disability* to ULLICO within three months prior to each anniversary date of the date ULLICO receives the Initial Proof.

(3) To verify that you are *totally disabled,* ULLICO may require periodic examinations by a *physician* chosen by ULLICO.

(4) The extension of life insurance coverage due to disability may continue until the earliest of the following dates:

(i) 31 days after the date you are no longer *totally disabled.*

(ii) the date you fail to furnish ULLICO with proof of your continued disability, or

(iii) the date you fail to be examined as required by a physician designated by ULLICO.

(c) The information required to be furnished to ULLICO under paragraph (b)(1) above may be sent to the Plan's Administrative Office for forwarding to ULLICO.

Section 12.02 If You Take an Approved Leave of Absence

(a) If you are on an approved leave of absence, including leave under the Family Medical and Leave Act (FMLA) of 1993 or the Uniformed Services Employment and Reemployment Rights Act (USERRA) of 1994, you may choose to continue your coverage under this *Plan.* To qualify, you must meet the following requirements:

(1) Elect to continue medical, prescription drug, dental, vision, life insurance and accidental death and dismemberment coverage.

(2) During a period of FMLA leave, you continue to be responsible to pay your share of the cost of coverage. See subsection (c) for further details. During a period of USERRA leave, you must self-pay the full cost of coverage, unless prohibited by law or if your leave is due to military service of fewer than 31 days. See subsection (d) for further details.

(b) If coverage lapses while you are on an approved leave of absence, it will be reinstated as of the first of the month following your return to work. If you don't return from leave, you may choose to continue medical, prescription drug, dental and vision coverage by self-paying its cost. See **COBRA** in Article XIV for more information.

(c) The Family Medical Leave Act, 29 USC §2601 *et seq.* provides that you are entitled to 12 weeks (26 weeks for military caregiver leave and qualifying exigency leave) of unpaid leave for specified family or medical purposes, such as the birth or adoption of a child, to provide care for a Spouse, child or parent who is seriously ill, or for your own illness. If you are taking FMLA leave that has been approved by your employer, your employer is responsible for making contributions to the Plan on your behalf, as if you are working, in order to maintain your eligibility. To find out more about Family or Medical Leave and the terms on which you may be entitled to it, contact your Employer.

(d) Uniformed Services Employment and Reemployment Rights Act (USERRA)

(1) If you are absent from employment because of service in the uniformed services, as defined in chapter 43 of title 38, United States Code, you can elect to continue coverage for your eligible Dependents under the provisions of USERRA.

(2) The period of coverage available under USERRA begins on the date on

which your absence begins and ends on the earlier of:

(i) The end of the 24-month period beginning on the date on which the absence begins; or

(ii) The day after the date on which you are required to, but fail to, apply under USERRA for or return to a position of employment for which contributions must be made to the Fund.

(3) Notice and Election of USERRA Coverage. If you wish to elect USERRA coverage, you must notify the Fund Office of your absence from employment due to military service, unless giving notice is precluded by military necessity or unless, under all the relevant circumstances, notice is impossible or unreasonable. In addition, your election to receive USERRA coverage must be received within 60 days of the last day of Covered Employment; otherwise, you lose your right to continue your coverage under USERRA.

(4) Paying for USERRA Coverage. You may be required to pay all or a portion of the cost of coverage. If the period of military service is less than 31 days, coverage under the Plan will continue as if you were still working in Covered Employment. USERRA continuation coverage operates in the same way as COBRA coverage and premiums for USERRA coverage will be 102% of the cost of coverage. Payment of USERRA and termination of coverage for non-payment of USERRA works just like with COBRA coverage. See the COBRA chapter for more details.

When you return to Covered Employment after receiving an honorable discharge within the time periods required by law, you will be eligible to continue your coverage from the Fund.

Section 12.03 If You End Employment

Coverage for you and your dependents ends on the last day of the month in which you end employment. When coverage ends, you may choose to continue medical, prescription drug, dental and vision coverage by self-paying the cost of coverage. See **COBRA** in Article XIV for more information.

Section 12.04 If You Retire

(a) Employee coverage under the *Plan* for you and your dependents ends on the last day of the month in which you are actively employed. If you are eligible for coverage as a *retiree* and you retire:

(1) on or before March 1, 1997 (or on or before January 1, 1998 if you were covered by a collective bargaining agreement between OPEIU Local 2 and a contributing employer on your last day of work prior to

retirement), you may continue retiree medical, prescription drug, dental and vision coverage for you and your eligible dependents. You may also continue 50% of your life insurance and accidental death and dismemberment coverage under the *Plan.* Costs of coverage are paid in full by your former employer.

(2) after March 1, 1997 (or after January 1, 1998 if you were covered by a collective bargaining agreement between OPEIU Local 2 and a contributing employer on your last day of work prior to retirement) but before January 1, 2003, you may choose to continue medical or medical and prescription drug coverage, as long as you continue to pay your share of the monthly cost of coverage. Your share of the cost of coverage is based on the coverage you choose and the number of eligible dependents enrolled. Alternatively, you may choose to continue medical, prescription drug, dental and vision coverage for a limited period of time by self-paying the full cost of coverage. See **COBRA** in Article XIV for more information.

(3) on or after January 1, 2003, you may choose to continue medical, accidental death and dismemberment (AD&D) and life insurance coverage or medical, prescription drug, accidental death and dismemberment (AD&D) and life insurance coverage, as long as you continue to pay your share of the monthly cost of coverage. Your share of the cost of coverage is based on the coverage you choose and the number of eligible dependents enrolled. Alternatively, you may choose to continue medical, prescription drug, dental and vision coverage for a limited period of time by self-paying the full cost of coverage. See **COBRA** in Article XIV for more information.

NOTE: Eligible *retirees* who reside in Canada and participate in the *Plan* are not eligible for medical benefits under the *Plan*, except for the following benefits set forth in the *Plan:* Hearing Aids; Outpatient Mental Health Care; and Outpatient Substance Abuse Treatment. See Section 1.02(b) for more information regarding available coverage.

(b) Retiree or COBRA coverage begins as of your first day of retirement if you enroll within 31 days of becoming eligible for retiree coverage or 60 days of becoming eligible for COBRA coverage.

Section 12.05 If Your Retirement Date Is On Or After April 1, 2005 and You Obtain Other Group Health Plan Coverage

If you are an eligible *retiree* who retired on or after April 1, 2005 and you participate in this *Plan,* you will no longer be eligible to participate in this *Plan* (or for any coverage under the *Plan)* if you obtain coverage under another group health plan or are eligible for coverage under another group health plan. In this regard, your coverage and participation in this *Plan* will cease on the date that you begin coverage or are eligible for coverage under the other group health plan. If you obtain coverage or are eligible for coverage under another group health plan, it is

your responsibility to immediately notify the Plan Administrative Office that you have such coverage or are eligible for such coverage. If you later no longer have or are eligible for coverage under another group health plan, you may be able to re-enroll in this *Plan* if you are eligible to participate in this *Plan* pursuant to Section 1.02. See Section 2.04 for information regarding re-enrollment.

ARTICLE XIII Termination of Coverage

Section 13.01When Coverage Ends

Coverage ends under the United Brotherhood of Carpenters and Joiners of America General Office and Staff Health and Welfare Plan for you and your eligible family members on the earliest of the following dates:

(a) the date this *Plan* terminates.

(b) the date you are no longer in an eligible class.

(c) the date you are no longer eligible to participate in the Plan under the terms of the Plan.

(d) the date you or your employer fail to pay any required premium payments.

(e) the date of your death.

(f) for *employees* and your dependents, the last day of the month in which you stop active work.

(g) for your dependents, on the earliest of the following dates:

(1) the date your coverage ends (unless your dependents are eligible for surviving dependent coverage under the terms of the *Plan).*

(2) the date dependent coverage is terminated under the *Plan.*

(3) the date they or your employer fail to make any required premium payments.

(4) for a given dependent, the date the dependent no longer meets the requirements of an eligible dependent, for example, due to age or marital status.

(5) the date this *Plan* terminates.

In the unlikely event the Plan is terminated, any and all monies and assets remaining in the Trust Fund, after payment of expenses, shall be used for the exclusive benefit of participants, as determined solely and absolutely at the discretion of the Board of Trustees in accordance with the Trust Agreement.

(h) The date a retiree becomes employed by a labor organization.

Section 13.02 Factors That Could Affect Your Receipt of Benefits

Certain factors could interfere with payment of benefits from the Plan resulting in your disqualification or ineligibility, denial of your claim, or loss, forfeiture, or suspension of benefits you might reasonably expect. Examples of such factors include the following:

(a) **Failure to submit properly completed enrollment forms.** The effective date of your health coverage is contingent upon the date the Administrative Office receives properly completed enrollment forms. See Article II – Enrollment.

(b) **Loss of Eligibility for misconduct.** Eligibility obtained through fraud, misrepresentation or concealment is subject to retroactive rescission. See Section 2.07.

(c) **Failure to report other health coverage.** It is to your advantage to inform the Administrative Office of other health coverage so that the maximum amount of your claims may be covered by both this Plan and the other coverage. See Section 11.01 regarding Coordination of Benefits.

(d) **Failure to follow the Plan's provisions for pre-authorization.** If you wish to receive the maximum benefits available, you must comply with the Plan's pre-authorization requirements. See **Hospital Review Services** in Section 5.02 for pre-authorization requirements, including timing of *urgent care claims* and scheduled hospitalization claims. See **Transplant Services** in Section 5.04(j).

(e) **Failure to use contracting providers.** You will not receive the highest level of coverage available for many services unless you use contracting ("PPO," "participating," "network," "direct contract") providers. See Section 5.01 regarding **Choice of Providers**. See Sections 6.02 and 6.03 regarding **Retail Pharmacy Prescriptions** and **Mail Order Prescriptions**.

(f) **Failure to pay premiums or comply with notification requirement for COBRA continuing coverage.** Loss of COBRA continuation coverage may result from failure to pay the full amount of premiums in a timely manner or failure by you or a beneficiary to provide the Administrative Office with notice of a qualifying event within the time limits set forth in **How to Elect Extended Coverage Under COBRA** in Section 14.04.

(g) **Failure to give notice of COBRA qualifying events.** Loss of rights to COBRA continuation coverage may result from failure to give notice of a qualifying event within the time limits set forth in Section 14.06 **Procedure for Notifying the Plan**.

(h) **Failure to submit claims in a timely way.** You should submit all Fee-for-Service health care claims and appeals and required information **within the time frames described in "Claims and Appeals Procedures" set forth in Article XV.**

(i) **Failure to sign agreement or assignment in cases of third party liability.** You will not be eligible for *Plan* benefits related to the sickness, *illness,* or accidental *injury or* other condition caused by a third party unless you sign an agreement or assignment of your recovery against such third party, See Section 16.04 regarding **Reimbursement and Subrogation**.

(j) **Failure to update your address or enrollment cards.** If you move, it is your responsibility to keep the Administrative Office informed about where it can reach you. Otherwise, you may not receive important information about your benefits. In addition, you must contact the Administrative Office regarding any changes in your family status. You will be held liable for benefit payments based on incorrect information about family members (for example, if you fail to notify the Administrative Office that you have divorced or a child has ceased to be an eligible Dependent). In addition you may be liable for other costs incurred by the Trust as a result of the incorrect information. These costs include (but are not limited to) attorney's fees, administrative costs, and reasonable interest.

Any factors affecting your receipt of benefits will depend on your particular situation. If you have questions, contact the Administrative Office at 1-855-550-1696..

Section 13.03 Certificate of Coverage

When coverage for you or your enrolled dependents ends under this *Plan*, you will automatically receive a certificate of group health coverage. This certificate provides proof of your health coverage under this *Plan* in case you later become eligible under a group health plan that excludes coverage for certain medical conditions you have before you enroll, or if you buy individual coverage. You may also obtain a certificate of coverage by submitting a written request within 24 months after the date coverage ended under this Plan. The written request must be filed with the Administrative Office and must include the names of the individuals for whom a certificate is requested (including spouse and dependent children) and the address where the certificate should be mailed.

ARTICLE XIV COBRA

In many cases, when coverage ends, you and your enrolled dependents have the right to purchase continued health care coverage (medical, prescription drug, dental and vision coverage) under this *Plan.* The federal law that gives you this right is the Consolidated Omnibus Budget Reconciliation Act (COBRA). COBRA coverage is the same health care coverage (medical, prescription drug, dental and vision coverage) as that provided under this *Plan* to active *employees* with similar family situations. if the *Plan* changes for active *employees,* the *Plan* will also change for COBRA participants.

Under COBRA, you and your dependents are entitled to continue health care coverage for a period of time by paying the full cost of coverage. The law also allows a small administrative fee to be added to the COBRA cost.

Generally, continued coverage under COBRA is not available to people covered by Medicare or other group health insurance, except as explained in Sections 14.03(d) and (e) below.

Section 14.01 How Long Can COBRA Coverage Continue?

The event that causes your group health coverage to end (the "COBRA qualifying event") determines how long you or your family members can purchase COBRA coverage.

(a) You may purchase up to **18 months** of continued coverage for yourself and your dependents if you lose coverage because of termination of employment (unless due to gross misconduct), reduction in work hours, or retirement.

(b) If you are on a leave of absence under the Family and Medical Leave Act of 1993 (FMLA) and do not return to active employment following such leave, a qualifying event will occur that allows you and your dependents to continue coverage for up to **18 months,** on the later of:

  (1) the date the Plan Administrative Office receives notice that you will not be returning to work.

  (2) the date your FMLA leave ends.

(c) Your spouse or dependent *children* will qualify to purchase up to **36 months** of continued coverage if they lose coverage due to any of the following:

  (1) you and your spouse divorce or become legally separated.

  (2) you become entitled to Medicare.

  (3) you die.

(d) If a child ceases to be an eligible dependent, that child will qualify to purchase up to **36 months** of COBRA coverage.

(e) If another qualifying event occurs while you are covered under COBRA, both of the following apply:

(1) the COBRA coverage period begins on the date coverage is lost.

(2) the number of months of COBRA coverage is determined by the event with the longer coverage period. Only one period applies; the different coverage periods are not added together. In no event will the total continuation coverage period exceed 36 months.

(f) Extension of COBRA Coverage

Notwithstanding any other provision to the contrary, in consideration of the ongoing public health emergency caused by the COVID-19 pandemic, the maximum period of COBRA shall be extended for up to 18 months for any Participant, spouse or dependent child who would otherwise lose COBRA coverage on or after January 1, 2022 because of the exhaustion of their initial 18-month or 36-month period of COBRA coverage. This extended period of COBRA shall end no later than August 31, 2023.

Section 14.02 If Disability Follows a COBRA Qualifying Event

During an 18-month COBRA coverage Period, you or your dependent may receive a determination from the Social Security Administration that you or your dependent was disabled before or during the first 60 days following your qualifying event. In this case, the COBRA eligibility period may be extended for an additional 11 months for the disabled person and other covered family members for a combined total of up to 29 months of COBRA coverage. To qualify, you must provide the Plan Administrative Office with a copy of the Social Security Determination within 60 days of the date it was made and no later than 18 months after the COBRA qualifying event. You will be charged higher premiums, up to 150% of the premium cost, for the 11-month extension of coverage.

If a determination is subsequently made by the Social Security Administration that you or your dependent are no longer disabled, you or your dependent must notify the Plan Administrative Office of the determination within 30 days after the determination.

Section 14.03 When COBRA Coverage Ends

COBRA continued health care coverage ends on the earliest of the following dates:

(a) the required premiums are not paid on time.

(b) your maximum COBRA coverage period expires.

(c) the ***Plan*** terminates all group health coverage.

(d) you obtain coverage under Medicare **after** the date of the COBRA election.

(e) coverage is obtained under another group health care plan, except for a person who has a pre-existing condition that is not covered under the other group plan,

(f) if continuing due to disability, the disabled person is determined to have recovered. In this case, you are required to notify the Plan Administrative Office within 30 days of the determination that the person is no longer disabled.

Section 14.04 How to Elect Extended Coverage Under COBRA

(a) The *Plan* will offer COBRA Continuation Coverage to qualified beneficiaries only after the *Plan* has been notified that a qualifying event has occurred.

(b) You or your dependents must notify the Plan Administrative Office, in writing, of any of the following qualifying events within 60 days of the occurrence of the event:

(1) divorce

(2) legal separation

(3) loss of eligibility of a dependent

In the event of divorce or legal separation, you must also furnish a copy of the divorce decree or legal separation papers to the Plan Administrative Office. If a child ceases to qualify as a covered dependent, you must furnish a copy of the child's birth certificate or other proof of date of birth, if this information has not already been provided to the Plan.

(c) When the qualifying event is the end of employment, reduction of hours, or the death of employee, the employer will notify the Plan Administrative Office of the qualifying event. However, qualifying beneficiaries are encouraged to also contact the Plan Administrative Office when the qualifying event is an employee's death so that the notification of death can be made as timely as possible.

(d) You or your dependents have 60 days to elect continued coverage from the date that you are notified of your loss of eligibility, or the date your group coverage ends, whichever is later. To elect COBRA coverage, you must complete the Election Form provided by the *Plan* and return it to the Plan Administrative Office according to the directions on the form. Each qualified beneficiary, including your spouse and/or your children, if applicable, has an independent right to elect continuation coverage. A parent may elect COBRA coverage on behalf of any dependent children. The employee or the employee's spouse can elect COBRA coverage on behalf of all of the qualified beneficiaries. If you or your dependents do not elect coverage within the sixty day time period, the right to continue group health insurance under the *Plan* will end.

(e) You or your dependents have 45 days from the date that you submit your application electing COBRA coverage to pay all applicable premiums. If you or

your dependents do not make your first payment for continuation coverage, in full, within 45 days after the date of your election (the date the Election Notice is post-marked, if mailed), you and your dependents will lose all continuation coverage rights under the *Plan.*

(f) Extended COBRA Coverage When a Second Qualifying Event Occurs During the Initial 18-month Period of COBRA. If, during an 18-month period of COBRA coverage your family experiences another qualifying event, your spouse and dependent children may be able to obtain additional months of continuation coverage, up to a combined maximum of 36 months. This extension is available to your spouse and dependent children if you die, get divorced or legally separated and to a dependent child when that child stops being eligible for coverage as a dependent child. In all of these cases, you or your dependent(s) must make sure that the Plan Administrative Office is notified of the second qualifying event within 60 days of the second qualifying event. This notice must be sent to the Plan Administrative Office, in writing, along with proof of the divorce or date of birth of the dependent child, as applicable. In no event, however, will the total continuation period exceed 36 months. Your COBRA rights are subject to change. Coverage will be provided only as current law provides. If the law changes, your rights will change accordingly.

Section 14.05 Adding New Family Members to Your COBRA Coverage

(a) **Addition of Newly Acquired Dependents**.
If, while you (the *employee* or *retiree*) are enrolled in COBRA continuation coverage, you marry, have a newborn child, adopt a child, or have a child placed with you for adoption, you may enroll that spouse, or child for coverage for the balance of the period of COBRA continuation coverage if you do so within 31 days after the marriage, birth, adoption, or placement for adoption. Adding a spouse or dependent child may cause an increase in your COBRA premiums. Contact the Plan Administrative Office to add a new dependent.

(b) **Loss of Other Group Health Coverage**.
If, while you (the *employee* or *retiree*) are enrolled in COBRA continuation coverage your spouse or dependent loses coverage under another group health plan, you may enroll the spouse or dependent for coverage for the balance of the period of COBRA continuation coverage. The spouse or dependent must have been eligible to enroll in COBRA continuation coverage as of the date of the initial Qualifying Event; and when COBRA continuation coverage was initially offered to the Dependent and declined, the Dependent must have been covered under another group health plan or had other health insurance coverage.

The loss of the spouse's or other Dependent's coverage must be due to:

(1) loss of eligibility for that coverage including loss resulting from legal separation, divorce, death, voluntary or involuntary termination of employment or reduction in hours (but does not include loss due to failure of

employee to pay premiums on a timely basis or termination of the other coverage for cause);
(2) termination of employer contributions toward that other coverage (an employer's reduction but not cessation of contributions does not trigger a special enrollment right); or
(3) the exhaustion of COBRA Continuation Coverage under another plan;
(4) moving out of an HMO service area if HMO coverage terminated for that reason and, for group coverage, no other option is available under the other plan;
(5) the other plan ceases to offer coverage to a group of similarly situated individuals;
(6) the loss of dependent status under the other plan's terms;
(7) the termination of a benefit package option under the other plan, unless substitute coverage is offered; or
(8) the loss of eligibility due to reaching the lifetime benefit maximum on all benefits under the other plan. For Special Enrollment that arises from reaching a lifetime benefit maximum on all benefits, an individual will be allowed to request Special Enrollment in this Plan within 31 days after a claim is denied due to the operation of a lifetime limit on all benefits.

If all of the preceding conditions are met, the Qualified Beneficiary may enroll the Dependent(s) for the remaining period of his COBRA continuation period upon the proper application and payment of the applicable premium with 31 days from the date the Dependent's other coverage terminates.

Section 14.06 Procedure for Notifying the Plan

The employee, retiree or a dependent must provide the Administrative Office with notice of any qualifying event or second qualifying event involving:

- divorce,
- legal separation,
- a spouse's or other dependent's loss of eligibility under this Plan or another group health plan,
- or an *employee*, *retiree* or dependent's becoming totally and permanently disabled so as to be entitled to Social Security Disability Income (SSDI) benefits.

If written notification of these events is not submitted to the Administrative Office within sixty (60) days of such event, continuation coverage, or an extension of such coverage in the event of disability or a second Qualifying Event, will not be available to the individuals whose Plan coverage terminates as a result of the event.

Contents of Notices. All notices required under this Section, must be in writing and submitted to the Administrative Office at the following address:

United Brotherhood of Carpenters and Joiners of America
General Office and Staff Health and Welfare Plan
c/o BeneSys Administrators
8311 W. Sunset Road
Suite 250
Las Vegas, NV 89113

Such notices must contain the following information: (i) the *employee's or retiree's* name, (ii) the *employee's or retiree's* social security number, (iii) the eligible Dependents' names and social security numbers, (iv) the *employee's or retiree's* mailing address and/or the eligible Dependents' mailing addresses, (v) the date and nature of the Qualifying Event, and (vi) for notice of disability, a copy of the Social Security Administration determination letter. The Trustees may request that other supporting documentation (such as a divorce decree) be submitted.

ARTICLE XV. CLAIMS AND APPEALS PROCEDURES

Section 15.01 How To File a Claim

Claim forms are available from the Administrative office.

(a) To receive medical, dental or vision benefits from the *Plan,* you or your provider must file a written claim with the Plan Administrative Office, BeneSys Administrators, within one year (or at the earliest possible date) after receiving a covered service or supply. Any reimbursement form for prescription drugs must be filed with Express Scripts or BeneSys Administrators within one year from the date of purchase. Some health care providers, including *preferred providers* for medical care, will file claims on your behalf. See **Hospital Review Services** in Section 5.02 for pre-authorization requirements, including timing of *urgent care claims* and scheduled hospitalization claims.

(b) For life insurance and/or accidental death and dismemberment benefits, you or your beneficiary must file a written claim with Union Labor Life Insurance Company ("ULLICO") within one year (or at the earliest possible date) after incurring a covered loss. A written proof of loss must also be filed within one year of the covered loss, unless it was not reasonably possible to do so and the proof of loss was provided as soon as reasonably possible.

Section 15.02 Authorized Representative

An authorized representative, such as your spouse, may complete the claim form for you if you are unable to complete the form yourself and you have previously designated the individual to act on your behalf, in writing, with respect to claims under the *Plan.* A form may be obtained from the Administrative Office to designate an authorized representative. The *Plan* may request additional information to verify that the person is authorized to act on your behalf.

In the case of *urgent care claims,* a health care professional, with knowledge of your medical condition, will be permitted to act as your authorized representative.

Section 15.03 If Your Claim Is Improperly Filed

(a) Pre-Service Claim

If you fail to follow the *Plan's* procedures for filing a *pre-service claim* that is not *a claim involving urgent care,* the Plan Administrative Office will notify you (or your authorized representative, if applicable) of the failure and of the proper procedures to be followed in filing a claim. Such notice will be provided to you as soon as possible but not later than 5 days after receipt of the claim. Notice may be oral, unless written notification is requested by you (or your authorized representative, if applicable).

You will only receive notice of an improperly filed pre-service claim under this section if your communication is received by the Plan Administrative Office and

includes (i) your name (ii) your specific medical condition or symptom, and (iii) a specific treatment, service, or product for which approval is requested.

(b) Urgent Care Claim

If you fail to follow the *Plan's* procedures for filing a *claim involving urgent care,* Anthem Blue Cross will notify you (or your authorized representative) as soon possible but not later than 24 hours after receipt of the claim of such failure and the proper procedures to be followed in filing a claim. Notice may be oral, unless written notification is requested by you (or your authorized representative, if applicable).

You will only receive notice of an improperly filed *claim involving urgent care* under this section if your communication is received by Anthem Blue Cross and includes (i) your name (ii) your specific medical condition or symptom, and (iii) a specific treatment, service, or product for which approval is requested.

Section 15.04 When Notice of Determination Will Be Provided

(a) Urgent Care Claims

If you properly file a *claim involving urgent care,* Anthem Blue Cross will notify you of the *Plan's* benefit determination as soon as possible, but not later than 72 hours after the *Plan's* receipt of the claim, unless you fail to provide sufficient information to determine whether, or to what extent, benefits are covered under the *Plan.*

In the event your claim is *a claim involving urgent care* and you fail to provide sufficient information to determine whether, or to what extent, benefits are covered by the *Plan,* you will be notified as soon as possible, but not later than 24 hours after the *Plan's* receipt of the claim of the specific information necessary to complete the claim. You will be afforded not less than 48 hours to provide the specified information. In such case, you will be notified of the *Plan's* determination no later than 48 hours after the earlier of: (i) the *Plan's* receipt of the specified information, or (ii) the end of the period afforded to you to provide the specified additional information.

(b) Pre-Service Claims

If you properly filed a *pre-service claim* that is not a *claim involving urgent care,* the Plan Administrative Office will notify you of the *Plan's* benefit determination within 15 days after the *Plan's* receipt of the claim unless additional time is needed. The Plan may extend the period for making a determination for up to 15 days if the Plan Administrative Office determines that such an extension is necessary due to matters beyond the control of the *Plan.* You will be notified prior to the expiration of the initial 15 day period of the circumstances requiring an extension and the date by which the *Plan* expects to render a decision. If such an extension is necessary due to your failure to submit

the information necessary to decide the claim, the notice of extension will describe the information required and you will be afforded at least 45 days from receipt of the notice to supply the specified information. In such case, the period for making a determination will be suspended from the date that the extension notice is sent to you until the date on which you respond to the request for additional information. The Plan Administrative Office will notify you of the *Plan's* decision no later than 15 days after the *Plan's* receipt of the additional information.

(c) Post-Service Claims

If you file *a post-service claim,* the Plan Administrative Office will notify you of the *Plan's* determination within 30 days after the *Plan's* receipt of the claim. The *Plan* may extend the period for making a determination for up to 15 days if the Plan Administrative Office determines that the extension is necessary due to matters beyond the control of the *Plan.* In such case, you will be notified prior to the expiration of the initial 30 day period of the circumstances requiring an extension and the date by which the *Plan* expects to render a decision.

If an extension is necessary due to your failure to submit information necessary to decide the claim, the notice of the extension will describe the required information and you will be afforded at least 45 days from receipt of the notice to provide the required information. In such case, the period for making the determination will be suspended from the date on which the notification is sent to you until the date on which you respond to the request for additional information. The Plan Administrative Office will notify you of the *Plan's* determination no later than 15 days after the *Plan's* receipt of the additional information.

(d) Concurrent Care Decisions

If the *Plan* has approved of an ongoing course of treatment to be provided over a period of time or a number of treatments, the *Plan* will notify you of any reduction or termination of such course of treatment (other than by plan amendment or termination) before the end of such period of time or number of treatments at a time sufficiently in advance of the reduction or termination to allow you to file an appeal and obtain a determination on review before the benefit is reduced or terminated.

Any request by you to extend the course of treatment beyond the approved period of time or number of treatments that is a *claim involving urgent care* will be decided as soon as possible and the *Plan* will notify you of the decision within 24 hours of receipt of the claim by the *Plan,* provided that such claim is made to the *Plan* within 24 hours prior to the expiration of the prescribed period or number of treatments.

(e) Life Insurance and AD&D Claims

Life insurance and AD&D claims — 90 days.

Section 15.05 Notification That Your Claim Has Been Denied

(a) If your claim has been denied, in whole or in part, you will receive written notice that your claim has been denied. The notice will include each of the following:

(1) the specific reason(s) for the denial.

(2) reference to the specific *Plan* provision(s) on which the denial is based.

(3) a description of any additional material or information necessary to complete your claim and an explanation of why such additional information or material is necessary.

(4) a description of the *Plan's* claim review procedures, including applicable time limits.

(5) a statement of your right to bring a civil action under ERISA following a denial of your claim on review.

(6) if an internal rule, guideline, protocol or similar criterion was relied on in denying your claim, you will receive either a copy of the rule, guideline, protocol, or other similar criterion or a statement that such rule, guideline, protocol or similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol or similar criterion will be provided to you free of charge upon request.

(7) if a denial is based on lack of medical necessity, or because the service or supply is considered experimental or investigational, you will either be provided with an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request.

(8) for *claims involving urgent care,* a description of the expedited review process available for such claims.

(b) For denials of *claims involving urgent care,* notice of denial may be provided orally. If notice of the denial is provided orally, you will also be furnished with written notice of such denial not later than three days after the oral notification.

Section 15.06 Appeals Process

(a) **Filing of Appeal**

(1) **Time for Filing Appeal**

Within 180 days after receiving a denial, you or your authorized representative may appeal the decision in writing by submitting written comments, documents, records or other information relating to your claim for benefits.

(2) **Expedited Review Process: Urgent Care Claims**

For appeals pertaining to *urgent care claims*, all necessary information, including the appeal decision may be transmitted between you and the *Plan* by telephone, fax or other expeditious method. A request for an expedited appeal of a denial of a *claim involving urgent care* may be made orally or in writing.

(b) **Access to Information**

(1) Upon request and free of charge, the *Plan* will provide you with reasonable access to and copies of all documents, records or other information relevant to your claim. For purposes of this paragraph, a document, record, or other information is considered relevant to your claim if it:

(i) was relied upon in making the benefit determination,

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

(iii) demonstrates compliance with the administrative process and safeguards required under 29 CFR §2560.503-1(b)(5) in making the benefit determination, or

(iv) constitutes a statement or policy or guidance with respect to the *Plan* concerning the denied treatment option or benefit for the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

(2) Upon request, the medical or vocational experts, if any, that gave advice to the *Plan* on your claim will be identified, without regard to whether the advice was relied upon in making the benefit determination.

(c) Review of Appeal

The review of your appeal will take into account all comments, records and other information submitted by you relating to your claim, without regard to whether such information was submitted or considered in the initial benefit determination.

Your appeal will be reviewed by the *Plan's* Board of Trustees or a subcommittee of the Board of Trustees. For all appeals that come before the Board of Trustees, the Board of Trustees has the power and sole discretion to interpret, apply, construe and amend the provisions of the Plans of benefits including this SPD and make all factual determinations regarding the construction, interpretation, and application of the Plans including this SPD. The person(s) who review your appeal will be other than those who made the initial denial that is the subject of the appeal and will also not be subordinates of the individual(s) who made the initial denial.

If your claim was denied on the basis of medical judgment (such as a determination that the treatment or service was not medically necessary, or was investigational or experimental), a health care professional who has appropriate training and experience in the field of medicine involved will be consulted. Such professional will not be an individual who was consulted in connection with the initial determination that is the subject of the appeal, or any subordinate of such individual.

If your claim was determined to be unrelated to an Emergency Service, Non-Emergency Service provided by an out-of-network provider at an in-network facility, and/or Air Ambulance service, and you wish to appeal that determination, you may request an external review by an Independent Review Organization ("IRO").

(d) Timing of Notice of Decision on Review

You will be notified of the *Plan's* determination on review as follows:

(1) *Claims Involving Urgent Care—You* will be notified of the *Plan's* decision on review within 72 hours of the *Plan's* receipt of your appeal.

(2) *Pre-Service Claims*— You will be notified of the *Plan's* decision on review within 30 days from the *Plan's* receipt of your appeal.

(3) *Post-Service Claims* - You will be notified of the *Plan's* decision on review within 60 days of the *Plan's* receipt of your appeal.

(4) Life insurance and AD&D claims — You will be notified of the decision within 60 days of the *Plan's* receipt of your appeal, with up to an

additional 60-day extension if necessary to process your appeal. If an extension is necessary, written notice of the extension will be furnished to you prior to the termination of the initial 60 day period and such notice shall indicate the special circumstances requiring an extension and the date by which the *Plan* expects to render a decision.

(e) Notice of Decision on Appeal

You will receive written notice of the *Plan's* decision regarding your appeal. If your appeal is denied, the notification that your appeal has been denied will include the following:

(1) the specific reason(s) for the denial.

(2) reference to the specific *Plan* provision(s) on which the denial is based.

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

(4) if an internal rule, guideline, protocol or similar criterion was relied on in denying your appeal, you will either be provided with a copy of the specific, guideline, rule or similar criterion or you will be informed that the such rule, guideline, protocol or similar criterion was relied upon in making the adverse benefit determination and that a copy of the rule, guideline, or other similar criterion will be provided free of charge to you upon request.

(5) if the denial is based on lack of medical necessity, or because the service or supply is considered experimental or investigational, you will be provided with an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request.

(6) a statement of your right to bring a civil action under Section 502(a) of **ERISA** following a denial of your claim on review.

Section 15.07 Exhaustion of Administrative Remedies/Limitation on When a Lawsuit May be Started

You may not file a lawsuit to obtain benefits until after you have requested a review and a final decision has been reached on review (or until the appropriate time frame described above has elapsed since you filed a request for review and you have not received a final decision or notice that an extension will be necessary to reach a final decision). Notwithstanding any other potentially applicable statute of limitations, a civil action under Section 502(a) of ERISA shall commence not later than the first anniversary of the date of the written notice of decision on appeal.

ARTICLE XVI Administrative Information

This summary plan description is intended to describe the main features of the benefits available through the United Brotherhood of Carpenters and Joiners of America General Office and Staff Health and Welfare Plan to eligible *employees, retirees* and dependents. As a summary, it cannot cover every circumstance that might apply to you. For more information about the plan, you should contact the Plan Administrative Office.

The Board of Trustees of the United Brotherhood of Carpenters and Joiners of America General Office and Staff Health and Welfare Plan reserves the right to alter, amend, delete, cancel or otherwise change the *Plan* or any provisions of the *Plan* at any time. If the *Plan* is terminated, coverage for you and your eligible family members will end. Benefits for any legitimate covered claims incurred before the *Plan's* termination will be paid.

Plan benefits and eligibility rules: a) are not vested b) may be changed or discontinued, c) are subject to the rules and regulations adopted by the Trustees of the *Plan*, d) are subject to the provisions of United Brotherhood of Carpenters and Joiners of America General Office and Staff and Welfare Plan policies purchased by the Plan.

The Trustees have full discretionary authority to determine eligibility to participate, to determine eligibility to receive benefits and to construe and determine the meaning of all terms of the *Plan*, including without limitation questions arising in the administration, interpretation and application of the Plan.

Section 16.01Protection of Benefits

Benefits under the *Plan* cannot be assigned, sold, transferred, encumbered or used to secure debts. Benefits cannot be subject to attachment, garnishment or any other legal process. However, state *Qualified Medical Child Support Orders (QMCSOs)* issued by a court or state agency that require you to provide health care coverage for eligible *children* are allowed.

Section 16.02 Facility of Payment

If you or your dependent are not legally capable of providing a valid receipt for a benefit payment and there is no legal guardian, the *Plan* has the right to pay benefits to the party it believes is entitled to payment. Once payment is made in this case, the *Plan* has no further obligations with regard to the benefit payment.

Section 16.03 Privacy Statement

In its function as Plan Administrative Office, BeneSys Administrators may collect, use, or disclose certain information about you. This protected personal information may include health information or personal data, such as your address, telephone number or Social Security number, as permitted by law. BeneSys Administrators or the *Plan* may receive this information from, or release it to, health care providers, insurance companies, or other sources.

To safeguard your privacy, BeneSys Administrators takes care to ensure that your information

remains confidential by having a company confidentiality policy and by requiring all of its employees to sign it. If a disclosure of protected personal information is not related to a routine business function, BeneSys Administrators removes anything that could be used to easily identify you or will obtain your prior written authorization.

(a) this information is collected, used or released for conducting routine business operations, such as:

(1) determining your eligibility for benefits and paying claims.
(2) coordinating benefits with other health care plans.
(3) conducting *hospital* review services.
(4) fulfilling other legal obligations.

(b) this information may also be collected, used or released as required or permitted by law. In certain situations, the *Plan* may request your authorization prior to releasing information.

Section 16.04 Reimbursement and Subrogation

In the event you or a covered dependent incurs a sickness, *illness,* accidental *injury* or other condition that results from an act or omission of a third party, *Plan* coverage is subject to the following conditions:

(a) you pay to the *Plan* all proceeds received as a result of a judgment, settlement or other action arising out of claims for damages, up to the amount of *Plan* benefits paid or to be paid for which the third party may be responsible, including amounts recovered due to no-fault, uninsured or underinsured motorist coverage. By accepting benefits from the *Plan,* you agree that you are making a present assignment of your rights against the third party for any full or partial recovery, up to the amount of these benefits, and that this right of reimbursement takes priority over your right to be made whole. The Plan Administrator may require that all settlement proceeds or assets collected from judgments be subject to the imposition of a constructive trust and may also request that you sign an agreement to reimburse and/or an assignment of recovery. If you fail to sign such an agreement or assignment within a reasonable time after receiving the request, you will not be eligible for *Plan* benefits related to the sickness, *illness,* or accidental *injury or* other condition. If you receive *Plan* benefits and fail to reimburse the *Plan* as described above, the *Plan* will withhold payment of additional benefits, up to the amount you have failed to reimburse.

(b) by accepting payments from the *Plan,* you agree that the *Plan* may intervene in any legal action brought against a third party or any insurance company. A lien will exist in favor of the *Plan* upon all sums of money recovered by you against the third party, including, but not limited to, amounts recovered due to no-fault, uninsured or underinsured motorist coverage. The lien may be filed with the third party, the third party's agents, or the court. You will take no action, including, but not limited to settlement of any cause of action, which may prejudice the rights of the *Plan* without the Plan Administrator's prior written

consent.

(c) if you settle or compromise a third party liability claim so that the *Plan* is reimbursed an amount less than its lien, or which results in the third party or its insurance carrier being relieved of any future liability for medical costs, then you will receive no further *Plan* benefits in connection with the sickness, *illness*, accidental *injury* or other condition unless the *Plan* has previously approved the settlement or compromise in writing.

(d) the *Plan* reserves the right to subrogate to any claims in which proceeds are payable to a participant or beneficiary as a result of an act or omission of a third party.

(e) the *Plan* shall not be barred from any confidentiality agreement that is entered into between a participant or beneficiary and any other party arising out of a suit or a settlement for injuries for which the participant or beneficiary has obtained or seeks benefits for under the *Plan.*

(f) the *Plan* shall have a right to demand that a participant or beneficiary make periodic reports to the *Plan* on the status of any claim, litigation, or settlement involving the participant or beneficiary and any other party arising out of a suit for injuries for which the participant or beneficiary has obtained or seeks coverage for under the *Plan.* Written notice of any settlement reached between the participant and any other party relating to injuries for which the participant or beneficiary has obtained or seeks benefits for under the *Plan* shall be provided to the *Plan* within seven days of settlement.

Section 16.05 Right of Recovery

In the event you receive a benefit payment under the *Plan* that is in excess of the benefit payment that should have been made, the *Plan* has the right to recover the excess amount, from one or more of the following:

(a) any persons to whom such payments were made.
(b) any insurance companies.
(c) any other organization.
(d) any subsequent benefits payable to you.

Section 16.06 Your Rights Under ERISA

As a participant in the United Brotherhood of Carpenters and Joiners of America General Office and Staff Health and Welfare Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all participants shall be entitled to:

(a) examine without charge, at the Plan Administrative Office's office and at other specified locations, all documents governing the Plan, including insurance contracts and a copy of the latest annual report (form 5500 series) filed by the *Plan* with the U.S. Department of Labor (available in the Public Disclosure

Room of the Employee Benefits Security Administration).

(b) obtain, upon written request to the Plan Administrative Office, copies of documents governing the operation of the *Plan*, including insurance contracts and copies of the latest annual report (Form 5500 series) and an updated summary plan description. The Plan Administrative Office may make a reasonable charge for the copies.

(c) receive a summary of the *Plan's* annual financial report. The Plan Administrative Office is required by law to furnish each participant with a copy of this summary annual report.

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

(e) be provided with a certificate of creditable coverage, free of charge, from your group health plan when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. The written request must be filed with the Plan Administrator and must include the names of the individuals for whom a certificate is requested (including spouse and dependent children) and the address where the certificate should be mailed.

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," have the 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.
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 for reasons beyond the control of the administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file a suit in state or Federal Court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of 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 Questions

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

Section 16.07 Uses and Disclosure of Protected Health Information By Plan Sponsor

The Board of Trustees may use or disclose *Protected Health Information* to carry out *Plan Administrative Functions.* With respect to the use and disclosure of *Protected Health Information,* the Board of Trustees and each Trustee agrees to:

a. Not use or further disclose the information other than as permitted or required by the plan documents or as *Required By Law*,

b. Ensure that any agents, including a subcontractor, to whom the Board of Trustees provides such *Protected Health* Information agree to the same restrictions and conditions that apply to the Board of Trustees with respect to such information

c. Not use or disclose such *Protected Health Information* for employment related actions and decisions or in connection with any other benefit or employee benefit plan of the plan sponsor;

d. Report to the Plan any use or disclosure *of Protected Health Information* that is inconsistent with the uses and disclosures provided for and of which it becomes aware, and of any Security Incident of which it becomes aware.

e. Make available *Protected Health information* for amendment and incorporate any amendments to *Protected Health Information* in accordance with 45 CFR §164.526.

f. Make available the information required to provide an accounting of disclosures in accordance with 45 CFR §164.528.

g. Make its internal practices, books and records relating to the use and disclosure of *Protected Health Information* available to the Secretary of HHS for the purpose of determining compliance by the *Plan* with *HIPAA.*

h. If feasible, return or destroy all *Protected Health Information* received from the *Plan* that the Board of Trustees still maintains in any form and retain no copies of such information when no longer needed for the purposes for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and

i. Ensure that adequate separation between the *Plan* and the Board of Trustees as required by 45 CFR §164.504(f)(2)(iii) is established.

j. Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the *Electronic Protected Health Information* that it creates, receives, maintains, or transmits on behalf of the group health plan.

k. Ensure that the adequate separation required by 45 CFR §164.504(f)(2)(iii) is supported by reasonable and appropriate security measures.

I. Ensure that any agent, including a subcontractor, to whom it provides *Electronic Protected Health Information* agrees to implement reasonable and appropriate security measures to protect the information.

Section 16.08 Disclosure of Protected Health Information

The Plan will disclose *Protected Health Information* to the Board of Trustees, or to one or more individual Trustees serving as an authorized subcommittee of the Board of Trustees, only upon receipt of a certification from the Board that the plan documents have been amended to incorporate the provisions set forth in Article XVI, Section 16.07 and that the Board of Trustees agrees to those provisions.

Section 16.09 Adequate Separation Between the Plan and Plan Sponsor

For purposes of 45 CFR §164.504(f)(2)(iii), the following classes of persons will have access to *Protected Health Information:*

1. Trustees

2. Employees of delegates of the Board of Trustees who perform Plan Administration Functions, including certain employees of Plan Administrative Office, insurers, or similar entities, and employees who perform mail, filing and document disposal functions.

The persons described above may access and use *Protected Health Information* received from, or created on behalf of the Plan, only for *Plan Administrative Functions*, except as permitted by Section 16.10 below. Issues of noncompliance with this paragraph will be resolved in accordance with the Plan's Privacy Policies and Procedures.

Section 16.10 Disclosure to Plan Sponsor for Certain Purposes

Notwithstanding any other provision set forth herein, the Plan may disclose *Summary Health Information* to the Board of Trustees, if the Board of Trustees requests the *Summary Health Information* for the purpose of obtaining premium bids from health plans for providing health insurance coverage under the group health plan, or modifying, amending, or terminating the group health plan. The Plan may also disclose to the Board of Trustees information on whether the individual is participating in the Plan or is enrolled in or has disenrolled from a health insurance issuer or HMO offered by the Plan.

Section 16.11 Security Breach Notification

The Plan will comply with the relevant provisions of the breach notification requirements of 42 U.S.C. §17932 as added by the HITECH Act by notifying each individual whose *unsecured Protected Health Information* has been or is reasonably believed to have been accessed, acquired, used or disclosed as a result of such breach.

Section 16.12 Medicaid

(a) Payment for benefits with respect to a participant under the plan will be made in accordance with any assignment of rights made by or on behalf of such participant or a beneficiary of the participant as required by a State plan for medical assistance approved under Title XIX of the Social Security Act pursuant to section 1912 (a)(1)(A) of such Act.

(b) In enrolling an individual as a participant or beneficiary or in determining or making any payments for benefits of an individual as a participant or beneficiary the fact that the individual is eligible for or is provided medical assistance under a Medicaid state plan will not be taken into account.

(c) To the extent that payment has been made under a State plan for medical assistance approved under Title XIX of the Social Security Act in any case in which the plan has a legal liability to make payment for items or services constituting such assistance, payment for benefits under the Plan will be made in accordance with any State law which provides that the State has acquired the rights with respect to a participant to such payment for such items or services.

Section 16.13 Rescission of Coverage

The Plan will comply with the applicable requirements of the Patient Protection and Affordable Care, as amended ("PPACA") and applicable regulations issued thereunder with respect to the

rescission of coverage. For purposes of this section, the term "rescission" shall have the meaning assigned to such term under applicable regulations issued under PPACA pertaining to the rescission of coverage.

ARTICLE XVII Administrative Facts

Name of Plan:	United Brotherhood of Carpenters and Joiners of America General Office and Staff Health and Welfare Plan
Plan Number:	205
Type of Plan:	Welfare plan providing medical, prescription drug, dental, vision, life insurance, and accidental death and dismemberment (AD&D) benefits.
Plan Year:	January 1 through December 31
Plan Sponsor:	Board of Trustees of the United Brotherhood of Carpenters and Joiners of America General Office and Staff Health and Welfare Plan Home Office: 101 Constitution Avenue, N.W. Washington, DC 20001 (202)546-6206
	BeneSys Administrators 8311 W. Sunset Road, Suite 250, Las Vegas, NV 89113 855-550-1696
Type of Administration:	The Plan is administered by a Board of Trustees made up of General Officers of the United Brotherhood of Carpenters and Joiners of America. The Board of Trustees has delegated authority to construe and interpret Plan provisions to: BeneSys Administrators 8311 W. Sunset Road, Suite 250, Las Vegas, NV 89113 855-550-1696 Service of legal process may also be made on members of the Board of Trustees for the Plan. The Plan is administered in accordance with Plan documents, administrative agreements and insurance contracts.
Employer Identification Number (EIN):	52-1911622

Participating Employers: A complete list of employers who participate in the Plan is available upon written request to the Plan Administrative Office and is available for examination by participants and beneficiaries.

Source of Contributions: The Plan is funded through employer contributions and any required employee and retiree after-tax contributions.

Funding Medium: Self-funded medical, prescription drug, dental and vision claims are paid from the assets of United Brotherhood of Carpenters and Joiners of America General and Office Staff Health and Welfare Plan. Life insurance and accidental death and dismemberment benefits are provided through purchase of insurance from:

Union Labor Life Insurance Company
111 Massachusetts Avenue, NW
Washington, D.C. 20001

Trustees:

Andris J. Silins
United Brotherhood of Carpenters and Joiners of America
101 Constitution Avenue, NW
Washington, D.C. 20001

Douglas J. Banes
United Brotherhood of Carpenters and Joiners of America
101 Constitution Avenue, NW
Washington, D.C. 20001

Michael V. Draper
United Brotherhood of Carpenters and Joiners of America
805 S.W. Industrial Way, Suite 1
Bend, OR 97702

Phil Newkirk
United Brotherhood of Carpenters and Joiners of America
3707 North East 160th Street
Ridgefield, WA 98642

Agent for Legal Process:

BeneSys Administrators
8311 W. Sunset Road, Suite 250,
Las Vegas, NV 89113
855-550-1696

Service of legal process may also be made on members of the Board of Trustees for the Plan.

ARTICLE XVIII. Glossary

The following defined terms are shown in *italics* in the text of this benefits summary.

(a) ***Air Ambulance service*** means medical transport by helicopter or airplane for patients.

(b) ***allowable expenses*** **-** as used for coordination of health care benefits, means the *Allowable Charges under (CCC) below* for care provided, in whole or part, under at least one of the plans covering the individual who has filed a claim.

(c) ***ambulatory surgical facility*** any private or public establishment that is all of the following:

(1) it is licensed by the state.

(2) it has an organized medical staff of physicians.

(3) it has permanent facilities that are equipped and operated primarily for the purpose of performing surgical procedures.

(4) it provides continuous physician and RN services whenever a patient is on the premises.

An ambulatory surgical facility is **not** a *physician* or *dentist's* office, a facility whose primary purpose is to terminate pregnancy or a facility that provides services or other accommodations for patients to stay overnight.

(d) **Ancillary Services** means:
(1) Items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether provided by a physician or non-physician practitioner;
(2) Items and services provided by assistant surgeons, hospitalists, and intensivists;
(3) Diagnostic services, including radiology and laboratory services; and
(4) Items and services provided by an out-of-network provider if there is no in-network provider who can furnish such item or service at such facility.

(e) ***annual salary*** **--** means base yearly salary, excluding payments for overtime, bonuses, expenses, allowances, and accrued vacation.

(f) ***children*** – means the following:

(1) your biological children, stepchildren, foster children, and adopted children;

(2) your grandchildren who are totally dependent upon you for financial support and maintenance, for whom you have taken full parental responsibility and control, and for whom you claim as a dependent on your federal tax return.

The *Plan* reserves the right to require acceptable legal documentation

Notwithstanding the above, for purposes of Article IX, Section 9.02(b), the term "children" shall have the meaning assigned to such term in the applicable insurance policy.

(g) ***claim involving urgent care*** **—** See *"urgent care claim"* under (nn) below.

(h) ***confinement*** **—** admission as an *inpatient* to a *hospital.* For purposes of determining benefits coverage, successive *confinements* are considered as a single continuous *confinement* unless they meet any one or more of the following criteria:

(1) they are due to entirely unrelated causes.

(2) you or your dependent have fully recovered from the *injury or illness* that caused the initial *confinement* before the next *confinement* begins.

(3) the *confinements* are separated by more than six consecutive months.

(4) for you only, you have returned to work for at least one full working day before being hospitalized again.

(i) ***Continuing Care Patient*** means an individual who, with respect to a provider or facility –

(1) Is undergoing a course of treatment for a Serious and Complex Condition from the provider or facility;

(2) Is undergoing a course of institutional or inpatient care from the provider or facility;

(3) Is scheduled to undergo non-elective surgery from the provider, including receipt of postoperative care from such provider or facility with respect to such surgery;

(4) Is pregnant and undergoing a course of treatment for the pregnancy from the provider or facility; or

(5) Is determined to be terminally ill (as determined under section 1861(dd)(3)(A) of the Social Security Act) and is receiving treatment for such illness from such provider or facility.

(j) ***copay*** **—** a small amount you pay to your provider at the time you receive a service or supply.

(k) ***Cost-sharing*** means the amount a Participant, Dependent, or enrollee is responsible for paying for a covered item or service under the terms of the group health plan or health insurance coverage. Cost sharing generally includes copayments, coinsurance, and amounts paid towards deductibles, but does not include amounts paid towards premiums, balance billing by out-of-network providers, or the cost of items or services that are not covered under a group health plan or health insurance coverage.

(l) ***Covered Functions*** **—** shall have the meaning set forth in 45 C.F.R.§164.103 and include those functions of a covered entity the performance of which makes the entity a "health plan," "health care provider," or "health care clearinghouse" as those terms are defined in 45 C.F.R. §160.103.

(m) ***custodial care*** **--** services and supplies, including room and board, provided primarily to assist in the activities of daily living. Examples of such services include: 1) help in walking 2) getting in and out of bed 3) bathing 4) dressing 5) eating, and 6) taking medicine. They are considered *custodial care* whether or not the patient is disabled and regardless of the practitioner or provider who prescribes them.

(n) ***deductible*** **—** an amount each covered person pays each year for covered medical services received from a non-preferred provider before the *Plan* begins to pay benefits for that person. (The term also refers to the amount that a covered person pays each year for covered non-emergency treatment or treatment for *illness* received in an emergency room from a *preferred provider* before the *Plan* begins to pay benefits for such treatment.)

(o) ***dentist*** **—** an individual who is licensed to practice dentistry by the government authority that has jurisdiction over the licensing and practice of medicine.

(p) ***durable medical equipment*** **—** equipment that can withstand repeated use, is provided for the treatment of a medical condition and that is not generally useful in the absence of the medical condition.

(q) ***Electronic Protected Health Information*** **—** shall have the meaning set forth in 45 C.F.R. §160.103 and include *Protected Health Information* that is transmitted by electronic media or maintained in electronic media.

(r) ***emergency*****--** an unforeseen medical situation that requires immediate medical treatment to prevent the loss of life or permanent damage to the organs or systems of the body.

(s) ***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 the absence of immediate medical attention to result in a condition described in

clause (i), (ii), or (iii) of section 1867(e)(1)(A) of the Social Security Act (42 U.S.C. 1395dd(e)(1)(A)). (In that provision of the Social Security Act, clause (i) refers to 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; clause (ii) refers to serious impairment to bodily functions; and clause (iii) refers to serious dysfunction of any bodily organ or part.)

(t) ***Emergency Services*** means:

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

(2) Within the capabilities of the staff and facilities available at the hospital or the independent freestanding emergency department, as applicable, such further medical examination and treatment as are required to stabilize the patient (regardless of the department of the hospital in which such further examination or treatment is furnished).

(u) ***employee* —** an individual employed by one of the contributing employers to the *Plan.*

(v) ***essential health benefits*** – shall mean "essential health benefits," as such term is defined under Section 1302(b) of the Patient Protection and Affordable Care Act and applicable regulations issued thereunder.

(w) **experimental or investigative procedure-** treatments, equipment, drugs, devices or supplies which in the Plan's judgment are experimental or investigational. Experimental or investigational procedures include, but are not limited to, any procedures which all the time proposed or provided and for the purposes and manner in which they are proposed or used are characterized by one or more of the following:

(1) the treatment has not been accepted by the medical community as standard therapy at the time proposed or provided.

(2) the treatment is undergoing clinical investigation and is not generally recognized by the medical community as established and accepted practice.

(3) the treatment has not been approved by the Food and Drug Administration (FDA) or other governmental agency for other than experimental, investigational or clinical testing.

(4) the treatment is of uncertain therapeutic benefit, restricted to use in clinical trials, or of questionable safety and effectiveness for your condition.

(5) the treatment is provided under a written investigational protocol or is the same treatment provided to other patients under written investigational protocol for diagnosis.

(6) The treatment is determined by the *Plan* in consultation with medical or dental advisors to be in a research status prior to general use in the medical community (or dental community as appropriate).

(7) the treatment is the subject of a Phase I, II or III clinical trial.

(8) one or more of the following is applicable:

(i) the treatment has not been the subject of a study published in peer reviewed medical (or dental) literature. "Peer reviewed medical (or dental) literature means a U.S. scientific publication which requires that manuscripts be submitted to acknowledged experts inside or outside the editorial office for their considered opinions or recommendations regarding publication of the manuscript. Additionally, in order to qualify as peer reviewed medical (or dental) literature, the manuscript must actually have been reviewed by acknowledged experts before publication.

(ii) the treatment has been the subject of one or more studies published in peer reviewed medical (or dental) literature, but such studies indicate the need for further investigation of dosage, means of administration, long term effects or other factors important to efficacy and patient safety, or

(iii) no federal governmental agency or national professional medical (or dental) society which has done a formal evaluation has declared the treatment to be appropriate medical or dental practice.

(x) ***extended care facility*** **—** a facility or institution that is approved as such under Title XVIII of the Social Security Act of 1965, as amended (Medicare).

(y) ***health care professional*** **—** means a physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with State law.

(z) ***Health Information*** **—** shall have the meaning set forth in 45 C.F.R. §160.103 and include any information, whether oral or recorded in any form or medium, that (1) is created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse; and (2) relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual.

(aa) ***HIPAA*** **-** shall mean the Health Insurance Portability and Accountability Act of

1996, as amended and its implementing regulations.

(bb) ***home health care agency*** **—** an agency or organization that meets all of the following criteria:

(1) is primarily engaged in providing nursing and other therapeutic services.

(2) is federally certified and duly licensed if such licensing is required.

(3) has policies governing provided services that are established by a professional group associated with the agency that includes at least one *physician* and one registered nurse (RN).

(4) provides for full time supervision of provided services by a *physician* or RN.

(5) has its own administrator.

(6) maintains a complete medical record on each patient.

(cc) ***home health care plan --*** a program provided for you or your dependent's continued care and treatment that meets the following criteria:

(1) is established and approved in writing by the attending physician.

(2) is certified by the attending physician as requiring confinement in a hospital or skilled nursing facility in the absence of the services and supplies provided by a home health care agency.

(dd) ***hospice*** **care —** a facility that provides a *hospice care program* provided by medical personnel, counselors and other individuals who have received special training. It operates as a unit or program that admits only terminally ill patients and is separate from any other facility. It may, however, be affiliated with a hospital or *home health care* agency.

(ee) ***hospice care program*** a coordinated plan of *inpatient* and outpatient home care that treats a terminally ill patient and his/her family as a unit. It is intended to meet the physical, social, psychological needs of the patient as well of those of the family during the final stages of terminal *illness* and during bereavement.

(ff) ***hospital*** an institution that meets all of the following criteria:

(1) is primarily engaged in providing *inpatient* diagnostic, surgical, and therapeutic services by or under the supervision of *physicians* for the diagnosis, treatment, and rehabilitation of injured, disabled, or sick persons.

(2) maintains clinical records on all patients.

(3) has bylaws in effect with respect to its staff of *physicians;* has a requirement that every patient be under the care of a *physician.*

(4) provides 24-hour nursing service provided or supervised by a registered, professional nurse.

(5) has a hospital utilization review plan in effect.

(6) is licensed by the state or agency of the state responsible for licensing *hospitals.*

(7) has accreditation under one of the programs of the Joint Commission on Accreditation of Hospitals.

Unless specifically provided, a *hospital* is not an institution, or part of an institution, that is used primarily as a rest facility, nursing facility, convalescent center, facility for the aged, home for drug addicts or alcoholics, or any institution that charges for care you or your dependent are not required to pay.

(gg) ***illness --*** a sickness, disorder or disease that is not employment related.

(hh) ***Independent Freestanding Emergency Department*** means: A health-care facility that is geographically separate and distinct and licensed separately from a hospital under applicable State law and provides any Emergency Services.

(ii) ***Individually Identifiable Health Information —*** shall have the meaning set forth in 45 C.F.R. §164.103 and include information that is a subset of *Health Information,* including demographic information collected from an individual, and: 1) is created or received by a health care provider, health plan, employer, or health care clearinghouse, and 2) relates to the past, present, or future physical or mental health or condition of an individual; the provision or health care to an individual, or the past, present, or future payment for the provision of health care to an individual; and (i) that identifies the individual, or (ii) with respect to which there is a reasonable basis to believe the information can be used to identify the individual.

(jj) ***injury —*** physical bodily damage caused purely by accidental means, independent of all other causes. The *Plan* covers only injuries that are not employment related, except for life insurance or accidental death and dismemberment (AD&D) benefits that may become payable. For purposes of AD&D coverage, the term *"injury'* means bodily harm that (a) the Person sustains while this benefit is in force; and (b) is not the result of an Illness. For purposes of AD&D coverage, the term "Illness" means a disorder of disease of the body or mind and shall include (a) pregnancy (b) childbirth, and (c) related medical conditions.

(kk) ***inpatient--*** a person who, while confined to a *hospital for* more than 23 hours, is assigned to a bed in any department other than the *hospital's* outpatient department and is charged for room and board.

(ll) ***Legend drugs—*** drugs that have the following statement printed on the bottle or container: "Federal law prohibits dispensing without a prescription."

(mm) ***medically necessary --*** a drug, service or supply that meets all of the following criteria, as reasonably determined by the *Plan:*

(1) it is required to diagnose or treat a condition.

(2) it is consistent with the symptoms or the diagnosis and treatment of the symptom.

(3) it is the most appropriate supply of level of service that is essential to your needs.

(4) with regard to *inpatient* care, it can't be safely provided on an outpatient basis.

(5) it is good medical practice.

(6) it is not primarily for your convenience or for the convenience of your provider.

(7) it is not an investigational drug, service or supply.

The fact that a drug, service or supply is furnished, prescribed, recommended or approved by a physician or other provider does not, of itself, make it medically necessary. A drug, service or supply may be medically necessary in part only.

(nn) The term ***Out-of-Network Rate*** means one of the following amounts, less any cost sharing from the participant, beneficiary, or enrollee: (1) An amount determined by an applicable All-Payer Model Agreement under section 1115A of the Social Security Act; (2) if there is no such applicable All-Payer Model Agreement, an amount determined by a specified state law; (3) in the absence of an applicable All-Payer Model Agreement or specified state law, if the plan or issuer and the provider or facility have agreed on a payment amount, the agreed on amount; or (4) if none of those three conditions apply, and the parties enter into the IDR process and do not agree on a payment amount before the date when the IDR entity makes a determination of the amount, the amount determined by the IDR entity.

(oo) ***Pension Fund*** means the United Brotherhood of Carpenters Pension Fund (or any plan that was merged into this fund).

(pp) ***physician --*** any of the following legally licensed providers when performing services that are not specifically excluded from coverage under this *Plan* and that are within the scope of their license:

(1) Doctor of Medicine (MD).

(2) Doctor of Osteopathy (DO).

(3) Podiatrist (DPM).

(4) *Dentist* (DDS).

(5) Dental Surgeon (DMD).

(6) Chiropractor (DC).

(7) Optometrist.

(8) Dispensing Optician (OD).

(9) Registered Nurse (RN).

(10) Nurse Anesthetist

(11) Physician's Assistant (PA).

(12) Psychologist (PhD).

(13) for mental health and substance abuse care, a clinical Social Worker (CSW), Licensed Clinical Social Worker (LCSW), Certified Masters Social Worker (CMSW), Education Doctorate (EdD), or Master of Education (MeD), who is certified and/or licensed by the state to provide counseling.

(14) for maternity care, a midwife who is licensed and certified in the state in which services are provided.

(qq) ***Plan*** — the United Brotherhood of Carpenters and Joiners of America General Office and Staff Health and Welfare Plan.

(rr) ***Plan Administration Functions*** means administration functions performed by the plan sponsor of a group health plan on behalf of the group health plan and excludes functions performed by the plan sponsor in connection with any other benefit or benefit plan of the plan sponsor.

(ss) ***Plan Sponsor*** shall have the meaning set forth in ERISA Section 3(16)(B) and

as used herein shall refer to the Board of Trustees.

(tt) ***post-service claim*** — a claim for benefits under a group health plan that is not a *pre-service claim.*

(uu) ***preferred provider*** -- *a physician, hospital* or other health care provider

contracted with a Preferred Provider Organization that has contracted with the *Plan* to provide medical services to you and your family at negotiated rates that do not exceed *AC.* Most medical services you receive from *preferred providers* are paid at 100%, after applicable *copays.*

(vv) ***pre-service claim*** — any claim for a benefit with respect to which the receipt of the benefit, in whole or part, is conditioned on approval of the benefit in advance of obtaining the medical care. In this *Plan,* it currently applies to the pre-authorization requirement for *hospital* care.

(ww) ***preventive care*** — means preventive care for which medical necessity has not been established, such as routine medical exams performed by a physician and immunizations, Pap smears and PSA tests, if medical necessity has not been established.

(xx) ***Protected Health Information*** - shall have the meaning set forth in 45 CFR §160.103 and include *Individually Identifiable Health Information* that is transmitted or maintained in any form or medium, but exclude (i) Education records covered by the Family Educational Rights and Privacy Act, as amended, 20 U.S.C. 1232g (ii) records described at 20 U.S.C. §1232g(a)(4)(B)(iv); and (iii) employment records held by a covered entity in its role as an employer.

(yy) ***qualified medical child support order (QMCSO)*** -- a medical child support order that satisfies the requirements for a qualified medical child support order under Section 609 of ERISA.

(zz) The term ***Recognized Amount*** means:

1. An amount determined by an All-Payer Model Agreement under section 1115A of the Social Security Act;
2. If no All-Payer Model Agreement exists, an amount determined by specified state law; or
3. If no All-Payer Model Agreement or specified state law exists, the lesser of:
    a. the amount billed by the provider/facility or
    b. the Qualifying Payment Amount (QPA) for the item or service.

(aaa) The ***Qualifying Payment Amount*** means the amount that is calculated using the methodology described in 29 CFR § 716-6(c) as determined by the Network claims administrator.

(bbb) ***Required By Law*** - shall have the meaning set forth in 45 CFR §164.103.

(ccc) ***retiree*** — an individual who is retired from employment with a contributing

employer to this *Plan* and is receiving a pension from the United Brotherhood of Carpenters Pension Fund. A retired former employee of the Lathers International Union who is eligible to participate in the *Plan* and is a participant in the *Plan* shall also be considered to be a *"retiree"* for purposes of the *Plan.*

(ddd) ***Security Incident***- shall have the meaning set forth in 45 CFR §164.304 and include attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system.

(eee) The term ***"Serious and Complex Condition"*** means, with respect to a participant or beneficiary under a group health plan or group health insurance coverage-

1. 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
2. in the case of a chronic illness or condition, a condition that-
    a. is life-threatening, degenerative, potentially disabling, or congenital; and

b. requires specialized medical care over a prolonged period of time.

(fff) ***skilled nursing facility*** — an institution or facility where the primary purpose is rehabilitation

(ggg) ***sterilization of the reproductive system*** — unilateral or bilateral vasectomy or tubal ligation.

(hhh) ***Summary Health Information*** - shall mean information, that may be *Individually Identifiable Information,* and that: 1) summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom a plan sponsor has provided health benefits under a group health plan, and 2) from which the information described at 45 CFR §164.514(b)(2)(i) has been deleted, except that geographic information described in § 164.514(b)(2)(i)(B) need only be aggregated to the level of a five digit zip code.

(iii) ***totally disabled*** -(or *total disability)* as used for life insurance purposes means a person's complete inability, due to Injury or Illness, to engage in any business, occupation or employment for which the person is qualified or becomes qualified by reason of education, training or experience for pay, profit or compensation. For purposes of life insurance coverage, the term "Injury" means bodily harm that: (a) the Person sustains while this benefit is in force; and (b) is not the result of an Illness. For purposes of life insurance coverage, the term "Illness" means a disorder or disease of the body or mind and shall include (a) pregnancy; (b) childbirth; and (c) related medical conditions.

(jjj) ***AC*** — See *Allowable Charges* under (ccc) below.

(kkk) ***unsecured Protected Health Information*** – shall have the meaning set forth in 42 U.S.C. §17932(h) and shall include *Protected Health Information* that is not secured through the use of a technology or methodology specified by the Department of Health and Human Services (HHS).

(lll) ***urgent care claim*** **(or** ***"claim involving urgent care")*** a claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations-

(1) could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or

(2) in the opinion of a *physician* with knowledge of the claimant's medical condition, would subject the claimant to severe pain that can't be adequately managed without the care or treatment that is the subject of the claim.

A claim is considered an *urgent care claim* if your doctor decides that it is or, otherwise, if the *Plan* decides it is by applying the judgment of the "prudent layperson who possesses an average knowledge of health and medicine."

(mmm) ***urgent or emergency hospitalization —*** a *confinement* required as a result of an unforeseen medical situation that requires immediate medical treatment to prevent the loss of life or permanent damage to the organs or systems of the body.

(nnn) ***Allowable Charges (AC) --*** charges that do not exceed the general level of charges being made by others of similar standing in the locality where the charge is incurred for the same or comparable treatment, services, or supplies for the same or similar *injury* or *illness.* Locality as used here is a county or such greater area as is necessary to establish a representative cross-section of people or other entities that regularly provide the type of treatment, services, or supplies for which the charge was made.

NOTICE OF GRANDFATHERED STATUS

This group health plan believes that this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (PPACA). As permitted by the PPACA, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the PPACA that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the PPACA, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the United Brotherhood of Carpenters and Joiners of America General Office and Staff Health and Welfare Plan

c/o BeneSys Administrators
8311 W. Sunset Road, Suite 250,
Las Vegas, NV 89113
855-550-1696.

You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered plans.