

**I.U.P.A.T. WELFARE FUND
OF WESTERN PENNSYLVANIA
SUMMARY PLAN DESCRIPTION**

As in Effect June 1, 2022

**I.U.P.A.T. WELFARE FUND
OF WESTERN PENNSYLVANIA**

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OF WESTERN PENNSYLVANIA**

SUMMARY PLAN DESCRIPTION

Introduction

The Board of Trustees of the I.U.P.A.T. Welfare Fund of Western Pennsylvania (the "Board of Trustees") is pleased to present this Summary Plan Description ("SPD") that describes your benefits and the eligibility requirements of the Plan. Also included in this SPD are the procedures that you should follow when filing a claim, and certain information concerning the administration of the Plan as required by the Employee Retirement Income Security Act of 1974 as amended (ERISA). This SPD is current as of June 1, 2022. You will be notified in writing of any changes to the Plan as required by law.

The benefits described in this SPD are the result of continuous efforts of the Board of Trustees to offer an excellent program of benefits that will help meet the needs of your family. We urge you to read this SPD carefully so that you understand the complete package of benefits available to you and your eligible family members. You should share this SPD with your family and keep it in a convenient place for future reference.

The Plan is designed to help you and your family to meet the continuing rising costs of medical care as well as provide a measure of protection if you are unable to work due to layoff or disability. This SPD summarizes the key features of the Plan. Complete details of the Plan are also contained in the other documents pertinent to the Plan, including but not limited to, the Plan's contracts with its benefit providers, and Collective Bargaining Agreements between the Union and Employers that legally govern the operation of the Plan. All official Plan documents are available for your inspection at the office of the Contract Administrator during normal business hours. All statements made in this SPD are subject to the provisions and terms of the official Plan documents. In case of a conflict or inconsistency between the official Plan documents and this SPD, the official Plan documents will govern in all cases.

This SPD is not a contract of employment – it neither guarantees employment or continued employment with any Contributing Employer, nor diminishes in any way the right of Contributing Employers to terminate the employment of any Employee.

Keep this SPD in a safe place and refer to it whenever you have questions.
If you still have questions after reading this SPD, contact the Contract Administrator.

The Contract Administrator is:
Central Data Services, Inc.
5 Hot Metal Street, Suite 200,
Pittsburgh, PA 15203-2352
Phone: (866) 487-2857; (412) 432-0435 ♦ Fax: (412) 431-4067

I

DEFINITIONS

Certain terms used in this SPD have special meanings. These terms will be capitalized and will have the meaning set forth below:

1.1 Certificate of Coverage. The term "Certificate of Coverage" means the document provided to you by the insurance company, if any, chosen by the Trustees to provide coverage under this Plan. Its purpose is to explain the provisions of the Group Contract(s).

1.2 Collective Bargaining Agreement. The term "Collective Bargaining Agreement" will mean any agreement between the Union and an Employer that requires the payment of periodic Contributions to the Fund.

1.3 Contract Administrator. The term "Contract Administrator" will mean the person or entity designated by the Board of Trustees to handle certain of its day-to-day administrative duties with regard to the Plan.

1.4 Contributions. The term "Contributions" will mean those payments made to the Fund as required by the Collective Bargaining Agreement or other written agreement reduced by the administrative fee as established by the Trustees from time to time and as may be adjusted by the Trustees from time to time.

1.5 Covered Employment. The term "Covered Employment" will mean employment of a type covered by a Collective Bargaining Agreement or other written agreement and requiring Contributions to the Fund.

1.6 Eligible Dependent. The term "Eligible Dependent" means for purposes of medical coverage.

(a) your legally married spouse (your "Spouse");

(b) your child(ren) from date of birth until twenty-six (26) years of age who is:

- a blood descendant (child), or
- a legally adopted child (including a child living with you during the adoption probationary period or a child placed for adoption), or
- a stepchild.

(c) any unmarried child(ren) age twenty-six (26) or older if they are disabled and incapable of self-support because of the disability (certification of disability must be on file with the office of the Contract Administrator).

1.7 Employee. The term "Employee" means any person employed by an Employer and covered by a Collective Bargaining Agreement or other written agreement.

1.8 Employer. The term "Employer" will mean (1) employers who are required under the terms of a Collective Bargaining Agreement between the employer and I.U.P.A.T. District Council #57 (or its affiliated local unions) to make Contributions to the Plan; and (2) employers that sign written participation agreements to make Contributions to the Plan for one or more employees or owners.

Employers must be members of either the Western Pennsylvania Chapter of the Painters Contractors Association, the Master Interior Contractors Association of Greater Pittsburgh, or other employers that are obligated by signed agreements.

1.9 Fund. The term "Fund" will mean the I.U.P.A.T. Welfare Fund of Western Pennsylvania pursuant to the terms set forth in the Collective Bargaining Agreement, together with all the income, earnings and profits thereon received by the Fund, less any expenses paid therefrom.

1.10 Group Contract(s). The term "Group Contract(s)" will mean any insurance contract or contracts used by the Trustees to provide benefits.

1.11 Participant. The term "Participant" means eligible Employees who are covered by the Plan.

1.12 Plan. The term "Plan" will mean the plan of benefits of the Fund adopted by the Trustees setting forth the eligibility rules for the benefits to be paid from the Fund.

1.13 Plan Administrator. The term "Plan Administrator" will mean the Board of Trustees of the I.U.P.A.T. Welfare Fund of Western Pennsylvania.

1.14 Plan Year. The term "Plan Year" will mean the twelve month period beginning on January 1 and continuing to the following December 31.

1.15 Retiree. The term "Retiree" will mean a person who has reached age fifty-five (55) and has retired from the bargaining unit of Employees covered by the Collective Bargaining Agreement who has received a retirement certificate from the I.U.P.A.T. Pension Fund.

1.16 Trustees. The term "Trustees" means the Board of Trustees of the I.U.P.A.T. Welfare Fund of Western Pennsylvania.

1.17 Union. The term "Union" means I.U.P.A.T. District Council # 57, its affiliated local unions and their successors and assigns.

II
GENERAL INFORMATION ABOUT THE PLAN

This Section contains certain general information that you may need to know about the Plan.

A. General Plan Information

The name of the Plan is the I.U.P.A.T. Welfare Fund of Western Pennsylvania.

The provisions of the Plan became effective on May 9, 1953, which is called the Effective Date of the Plan. This Summary Plan Description describes the provisions of the Plan that are in effect as of January 1, 2022.

The records of the Plan are maintained on a twelve-month period of time. This is known as the Plan Year. The Plan Year is the twelve-month period beginning January 1 and ending the following December 31.

B. Plan Administrator

The Plan is sponsored by the Board of Trustees who also serves as the Plan Administrator. The Board of Trustees is responsible for the overall operation and administration of the Plan.

The address of the Plan Administrator is: Board of Trustees, I.U.P.A.T. Welfare Fund of Western Pennsylvania, c/o Central Data Services, 5 Hot Metal Street, Suite 200, Pittsburgh, PA 15203-2352.

The employer identification number of the Plan is 25-1010829. The Trustees have assigned plan number 501 to the Plan.

The following individuals comprise the Board of Trustees as of May 18, 2022:

Employer Trustees:

Art Avalotis
Avalotis Corporation
P.O. Box 6
Verona, PA 15147

Fred Episcopo
Wyatt, Inc.
4545 Campbells Run Road
Pittsburgh, PA 15205

Josh Kerestesi
Patrinos Painting and Contracting
3191 Industrial Boulevard
Bethel Park, PA 15102

Union Trustees

Chris Geronimos
101 Ewing Road
Carnegie, PA 15106-1523

Andrew Cross
101 Ewing Road
Carnegie, PA 15106

David Lovelace
101 Ewing Road
Carnegie, PA 15106

Ray Maioli
101 Ewing Road
Carnegie, PA 15106

Chris Kucherawy
John B. Conomos
198 Carriage Lane
Pittsburgh, PA 15241

Terry Manuel, Jr.
101 Ewing Road
Carnegie, PA 15106-1523

Neal Rivers
Easley & Rivers
207 Townsend Drive
Monroeville, PA 15146

Steve Olash
101 Ewing Road
Carnegie, PA 15106-1523

Highmark, Inc. is responsible for the administration of medical coverage claims and appeals for the Highmark PPOBlue High Plan and Highmark PPOBlue Low Plan.

UPMC Health Plan, Inc. is responsible for the administration of medical coverage claims and appeals for the UPMC High Plan and UPMC Low Plan.

Please remember that no one except the Board of Trustees (and other Plan fiduciaries and individuals to whom the Board of Trustees has delegated responsibility for administration of the Plan) has the authority to interpret the Plan, including this SPD or the other official Plan documents, to make any promises to you about it, or to change the provisions of the Plan. The Board of Trustees (or its duly authorized designee) has the exclusive right and power, in its sole and absolute discretion, to interpret the Plan documents and to decide all matters under the Plan, including, without limitation, the right to make all decisions with respect to eligibility for, and the amount of, benefits payable under the Plan and the right to resolve any possible ambiguities, inconsistencies or omissions concerning the Plan. All determinations by the Board of Trustees (or its duly authorized designee) are final and binding on all persons and will be given full force and effect.

C. Administrator Information

The Trustees have delegated certain day-to-day administrative duties to a Contract Administrator. The name and address of the current Contract Administrator is:

Central Data Services, Inc.
5 Hot Metal Street, Suite 200,
Pittsburgh, PA 15203-2352
Phone: (866) 487-2857; (412) 432-0435 ♦ Fax: (412) 431-4067

The Contract Administrator also keeps the records for the Plan. The Board of Trustees has authorized the Contract Administrator to respond in writing to any questions you may have about the Plan. As a courtesy, the Contract Administrator may respond informally to your oral questions. However, oral questions and answers are not binding upon the Board of Trustees and cannot be relied upon in a dispute concerning your benefits. If you have an important question, you should contact the Contract Administrator for a written response.

D. Service of Legal Process

The name and address of the Plan's agent for service of legal process is:

Jo-Anne Mineweaser, Esq.
Meyer Unkovic & Scott LLP
535 Smithfield Street, Ste. 1300
Pittsburgh, PA 15222

Legal process may also be served on the Plan Administrator or any individual Trustee.

E. Resolution of Disputes; Venue; Limitation Period

No legal action may be taken against the Plan or Fund more than three (3) years after a claim for benefits has been made by you or submitted on your behalf to the Fund, a provider, or insurance company for payment.

Any and all disputes concerning the Plan or Fund shall be resolved exclusively in Allegheny County, Pennsylvania. The venue for any suit or cause of action arising out of the Plan shall be exclusively in the federal courts for the Western District of Pennsylvania or the state courts of Allegheny County, Pennsylvania.

F. Type of Plan

The Plan is a welfare benefit plan providing medical coverage, health care reimbursement, death benefit, accident and sickness benefit, accidental death and dismemberment benefit, and vacation and holiday pay benefits. All benefits are provided on a self-insured basis paid from the Fund.

The Plan is maintained pursuant to one or more collective bargaining and other written agreements. A copy of any such agreement may be obtained by Participants and beneficiaries upon written request to the Plan Administrator, and is available for examination by Participants and beneficiaries. In addition, Participants and beneficiaries may receive from the Plan Administrator, upon written request, information as to whether a particular Employer or employee organization participates in the Plan and, if so, the Employer's address.

G. Reciprocity

The Trustees have bound the Plan to reciprocal agreements with various other union health and welfare plans throughout the United States. Individuals meeting the requirements of the reciprocal agreements can request to have contributions to the I.U.P.A.T. Welfare Fund of Western Pennsylvania sent to their "home" health and welfare plan (if the I.U.P.A.T. Welfare Fund is not their "home" fund), or direct another local union health and welfare plan to send contributions to the I.U.P.A.T. Welfare Fund (if the I.U.P.A.T. Welfare Fund is their "home" fund). For individuals whose "home" fund is not the I.U.P.A.T. Welfare Fund, the amount reciprocated is generally based on the lesser of the contribution rate of the individual's "home" fund or the contribution rate of the I.U.P.A.T. Welfare Fund.

Individuals designate their "home" fund using forms available from the Contract Administrator. Contributions will be transferred to the individual's "home" fund from wherever they are earned as soon as administratively feasible. If an individual designates their "home" fund as any fund other than the I.U.P.A.T. Welfare Fund of Western Pennsylvania, the individual

shall not be entitled to any benefit under the terms and provisions of the I.U.P.A.T. Welfare Fund. These individuals shall look solely to their “home” funds for the benefits attributable to contributions made on their behalf and those benefits shall be determined solely by the terms and provisions of their “home” funds.

Contributions reciprocated to the Fund from another health and welfare plan will be credited to a Participant's accounts based on the amount actually reciprocated by the other health and welfare plan. It may take up to three months or longer for amounts credited based on reciprocal contributions to be reflected in a Participant's accounts.

Additional information on reciprocity and reciprocity applications can be obtained from the Contract Administrator.

III PERSONAL ACCOUNTS

A. Tax Free vs. Taxable Benefits

For purposes of determining your eligibility for benefits under the Plan, the Plan Administrator will create and maintain individual bookkeeping accounts on your behalf.

A Health Care Account will provide you with tax-free medical benefits.

A Wage Account will provide you with taxable Paid Time Off (PTO) benefits.

The law prohibits the transfer of any balance in your TAX FREE accounts to your TAXABLE accounts and vice versa.

Each account will include a record of Contributions received on your behalf, benefits paid, and fees and expenses charged against the account. The maintenance of these accounts is for record keeping purposes only. You do not have a vested right to the balance in the accounts or in any benefit offered by the Plan. Accounts are used only to determine your eligibility for benefits and actual segregation of monies does not occur.

B. Allocation of Contributions

The basis on which Contributions made to the Plan on your behalf will be divided between your accounts will depend on the medical coverage level, if any, you are receiving from the Plan. After you have accumulated Contributions in your Health Care Account of at least \$1,000, Contributions (less any administrative fee) will be credited to your accounts as they are received by the Plan from your Employer. The following table summarizes the percentages in which your Contributions will be allocated between the Health Care and Wage accounts.

Medical Coverage Level	Health Care Account	Wage Account
Member Only	50%	50%
Member + Spouse	80%	20%
Member + Child(ren)	80%	20%
Member + Family	90%	10%
No Coverage (opt out)	20%	80%

If you do not elect a medical plan option when you first become eligible, you will be enrolled in the Highmark PPOBlue High Plan.

Upon enrollment and from time to time thereafter, the Plan Administrator (or any insurer providing coverage) may require that you present satisfactory proof (as determined by the Plan Administrator, in its sole and absolute discretion) of the initial and/or continuing eligibility of your dependents.

Annual Open Enrollment. Before the beginning of each plan year, you will have the opportunity to waive coverage (if you meet the waiver requirements described above) or change your medical plan option. Your choices for the plan year remain in effect for the entire plan year, except as described below. If you do not make an election during open enrollment, your choices from the prior year will carry forward to the new plan year.

Special Enrollment Rights. If you decline medical coverage for a plan year, you can later add medical coverage mid-year if Special Enrollment Rights under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) apply. In general, these Special Enrollment Rights apply under the following circumstances:

- **Loss of Other Medical Coverage.** You declined medical coverage for yourself, your spouse or other Eligible Dependent because of other health coverage and the other health coverage is lost. If the other health coverage was COBRA coverage, COBRA has to be exhausted. If the other health coverage was not COBRA, then the coverage must be lost for any of the following reasons: (1) employer contributions terminate; (2) loss of eligibility (including loss of eligibility as a result of legal separation, divorce, cessation of dependent status, termination or reduction in hours of employment or death); (3) the other coverage was an HMO and the individual losing coverage no longer resides, lives or works in the HMO service area and no other medical coverage option is available to the individual; or (4) the other health coverage no longer covers the class of individuals to which the individual belongs. ***You must notify the Contract Administrator by no later than thirty (30) days after the termination of the other coverage.***
- **You Marry or Gain a New Dependent.** If you marry, then you, your new spouse and any new Eligible Dependents you acquire as a result of the marriage have the right to enroll for medical coverage. In addition, if you gain a new Eligible Dependent as a result of birth, adoption or placement for adoption, then you, your spouse and the new child may enroll for medical coverage. ***You must notify the Contract Administrator by no later than thirty (30) days after the marriage, birth, adoption or placement (as applicable).***
- **Termination of Medicaid or CHIP Coverage.** If you or your Eligible Dependent is covered under a state Medicaid plan or under a state Child Health Insurance Program (CHIP) and the Medicaid or CHIP coverage is terminated as a result of loss of eligibility, you and/or your Eligible Dependents may enroll for medical coverage. ***You must notify the Contract Administrator by no later than sixty (60) days after the loss of Medicaid or CHIP coverage (as applicable).***
- **Eligibility for Premium Assistance through Medicaid or CHIP.** If you or your Eligible Dependent becomes eligible through Medicaid or CHIP for premium assistance to pay for medical coverage under this Plan, you and/or your Eligible Dependent may enroll for medical coverage. ***You must notify the Contract Administrator by no later than sixty (60) days after you and/or your Eligible Dependent become eligible for the premium assistance.***

1. Benefits. You may elect medical coverage under one of four options offered under the Plan. They are Highmark PPOBLUE High Plan, Highmark PPOBLUE Low Plan, UPMC High Plan, and UPMC Low Plan. Each plan is a Preferred Provider Organization (PPO), which is a network of physicians and hospitals that have agreed to charge certain negotiated rates for medical procedures. A listing of network providers is available on Highmark's and UPMC's websites. You may also ask the Contract Administrator for a copy.

A Summary of the medical care services and supplies, co-pays, deductibles, etc. covered by each plan option is attached as an Appendix to this document (Appendix A for the Highmark PPOBLUE High Plan; Appendix B for the Highmark PPOBLUE Low Plan; Appendix C for the UPMC High Plan; and Appendix D for the UPMC Low Plan). When you enroll, you will receive a booklet containing a complete description of the Highmark or UPMC Plan that you select. A copy of the booklet is also available free of charge upon request to the Contract Administrator.

2. Claims and Appeals Procedures. Highmark, Inc. handles claim administration for medical coverage under the Highmark PPOBLUE Plans, and UPMC Health Plan, Inc. handles claim administration for medical coverage under the UPMC Plans. The procedures for filing claims and appeals are set forth in booklets which will be provided to you by Highmark or UPMC. If you need an additional copy, you may obtain one free of charge from the Contract Administrator.

3. Termination of Eligibility. Unless you are eligible for and elect to continue coverage under COBRA (See the Section of this SPD entitled COBRA Continuation Coverage), your medical coverage will end on the last day of the month in which occurs the earlier of:

- (a) Your Health Care Account balance is not at least \$1,000 (except as permitted under the Self Payment Requirement section below), and you fail to remit the required self payments to the Contract Administrator; or
- (b) You are no longer actively working or seeking work in Covered Employment; or
- (c) no Contributions have been made on your behalf for six (6) consecutive months.

It is very important to note that you must have at least \$1,000 in your Health Care Account to be eligible for medical coverage. If you do not have at least \$1,000 in your Health Care Account, you will not be provided with medical coverage. If you have at least \$1,000 in your Health Care Account, but the amount in your Health Care Account is not enough to cover the monthly charge for medical coverage without causing the amount in your Health Care Account to go below \$1,000, you may self-pay the amount needed to continue medical coverage without causing the amount in your Health Care Account to go below \$1,000.

Your eligibility for medical coverage will be determined on a month-to-month basis. A monthly statement will be mailed to you on approximately the tenth (10th) day of each month. The monthly statement will tell you whether you are eligible for medical coverage for the upcoming month. If you are eligible for medical coverage for the upcoming month, (that is, you have at least \$1,000 in your Health Care Account) and the amount in your Health Care Account is enough to cover the monthly charge for medical coverage without causing the amount in your

Health Care Account to go below \$1,000, the monthly charge will be paid out of the Health Care Account and you will not need to take any action.

4. Self-Payment Requirement. If, on the other hand, you are eligible for medical coverage for the upcoming month, (that is, you have at least \$1,000 in your Health Care Account), but the amount in your Health Care Account is not enough to cover the monthly charge for medical coverage without causing the amount in your Health Care Account to go below \$1,000, the monthly statement will tell you the amount that you must self-pay in order to continue medical coverage.

The monthly self-pay charges for medical coverage will include the monthly premium under the Highmark PPOBLUE High Plan, the Highmark PPOBLUE Low Plan, the UPMC High Plan, and the UPMC Low Plan, which will be determined by the Plan in conjunction with the third party administrator from time to time and will be reflected in the enrollment material for each Plan Year. Additionally, the monthly self-pay charges also will include the administrative fee as established by the Trustees from time to time and as may be adjusted by the Trustees from time to time.

If no Contributions are made on your behalf during a month, and the amount in your Health Care Account is at least \$1,000, you may self-pay the full monthly charge amount for a maximum of nine (9) consecutive months. After the sixth (6th) full self-payment, you may then draw from your \$1,000 balance either to pay your monthly charge or for reimbursement of medical expenses and you will be notified of any rights to continue coverage under COBRA (see COBRA Continuation Coverage Section for details). If you do not make self-payments to maintain eligibility and have six (6) consecutive months of no contribution activity, you may draw from your \$1,000 balance after such six (6) months for reimbursement of medical expenses.

You are required to pay the self-payment, if any, listed on your monthly statement by the twenty-fourth (24th) day of the month in which the monthly statement is mailed to you. If the self-payment is not received by the Contract Administrator by the due date, your medical coverage will end as of the last day of the month in which the self-payment is due. ***There will be no grace period for late payment of the self-pay amount.*** If you fail to make a timely self-payment, you will be notified of any rights to continue coverage under COBRA (see COBRA Continuation Coverage Section for details). If medical coverage ends for the month, you must meet the Plan's eligibility requirements to regain eligibility.

B. Medical Coverage--Retirees

COBRA. Retirees, spouses and Eligible Dependent children who have Medical Coverage at the Retiree's retirement will be offered COBRA. (See COBRA Section for details about continuing coverage through COBRA).

Self-Payment until Age Sixty-Five (65). Retirees who meet the eligibility conditions (see below) who have Medical Coverage at retirement have the option to continue to receive Medical Coverage until they reach age sixty-five (65) by making self-payments. Spouses of such eligible Retirees may continue to receive Medical Coverage until the spouse reaches age sixty-five (65) by making self-payments. Eligible Dependent children of such eligible Retirees may continue to receive Medical Coverage if the Retiree elects to make self-payments for coverage until the earliest to occur of: (1) the Plan's limitation age for Eligible Dependent children; the date the Retiree reaches age sixty-five (65); or the date the Retiree fails to make timely self-payments. **The option to make self-payment for Medical Coverage until the Retiree reaches age sixty-five (65) is available only if COBRA is waived.**

Eligibility to Continue Medical Coverage to Age 65 by Self-Paying After Retirement. In order to be eligible for Medical Coverage as a Retiree, you must satisfy the following conditions:

- (a) You must be a Retiree as defined in this SPD and have Medical Coverage immediately prior to your retirement;
- (b) You must not have reached age sixty-five (65); and
- (c) You must complete the necessary enrollment forms as provided by the Plan Administrator and/or insurer.

You are required to make the self-payment listed on your monthly statement by the twenty-fourth (24th) day of the month in which the monthly statement is mailed to you. If the self-payment is not received by the Contract Administrator by the due date, Medical Coverage will end for all covered persons as of the last day of the month in which the self-payment is due. There is no grace period for late payment of the self-pay amount.

Termination of Eligibility to Make Self-Payments Until Age 65. Coverage for the Retiree, Spouse, and Eligible Dependent children, will end at the earliest to occur of:

- (a) when the required self-payments are not timely made; or
- (b) when the Retiree reaches age sixty-five (65) (except that spouses who have not reached age sixty-five (65) may continue until the spouse reaches age sixty-five (65) by making self-payments and may cover their Eligible Dependent children);
- (c) the Retiree's death (except that spouses who have not reached age sixty-five (65) may continue until the spouse reaches age sixty-five (65) by making self-payments and may cover their Eligible Dependent children);
- (d) for the spouse, upon divorce if the Retiree and spouse divorce;
- (e) for an Eligible Dependent child, upon the child reaching the Plan's limitation age for Eligible Dependent children.

C. Health Care Reimbursement

If you have over \$1,000 in your Health Care Account, you may receive reimbursement for amounts you have expended for qualified health care expenses incurred for yourself and any individual for whom you can deduct medical expenses for federal income tax purposes. However, you may not receive reimbursement for any Health Care Expense that is reimbursable under any insurance policy or otherwise; for which you have taken a deduction; or that was incurred before the Health Care Account was started or before you were enrolled in the Health Care Account.

Qualified health care expenses are the same expenses that taxpayers who itemize their personal federal income tax returns may deduct. The office of the Contract Administrator can provide you with additional information on qualified health care expenses.

If you are a Retiree, you must have \$1,000 in your Health Care Account for a period of six (6) months following the date that you become a Retiree. Thereafter, you and any individual for whom you can deduct medical expenses for federal income tax purposes may receive reimbursement for qualified health care expenses to the extent of the balance remaining in your Health Care Account or you may use that amount to make premium payments for Medical Coverage under the Plan or other premiums permitted by law.

If you leave Covered Employment, you and any individual for whom you can deduct medical expenses for federal income tax purposes may receive reimbursement for qualified health care expenses to the extent of the balance remaining in your Health Care Account.

If you die, any individual for whom you can deduct medical expenses for federal income tax purposes may receive reimbursement for Health Care Expenses to the extent of the balance remaining in your Health Care Account. Any balance remaining in your Health Care Account at the time of your death cannot be provided as a death benefit or for any reason other than to continue medical coverage or reimbursement for Health Care Expenses.

Notwithstanding the above, the Health Care Account may not be used for reimbursement of premiums for an individual medical insurance policy.

Automatic Forfeiture of Balance in Health Care Account. In the event that for any two (2)-year period:

- (a) no Contributions have been made to the Plan on your behalf; and
- (b) you have not made any self-payments to the Plan; and
- (c) you have not made any request for reimbursement under the Health Care Reimbursement section of this SPD; and
- (d) you have not completed the necessary enrollment forms as provided by the Plan Administrator and/or insurer for medical coverage under the Plan;

then any balance in your Health Care Account at the end of such two (2)-year period will be forfeited and added to the Fund's reserves.

Voluntary Forfeiture of Balance in Health Care Account. You may be eligible for a premium tax credit if you enroll in insurance coverage offered through the Health Care Marketplace. However, in order to qualify for the tax credit, you must permanently forfeit the balance in your Health Care Account. Each year at open enrollment, you will have the opportunity to forfeit this balance so that you are not disqualified from receiving the premium tax credit (assuming you are otherwise eligible for the credit). If you elect to forfeit your balance, any future employer contributions will be allocated 100% to your Wage Account unless and until you notify the Plan Administrator that you are no longer receiving the premium tax credit.

Monthly Health Care Account Fee. The Board of Trustees shall charge a monthly fee for all Health Care Accounts. The amount of the fee may be changed from time to time at the discretion of the Board of Trustees. As of January 1, 2019, the monthly fee charged to each Health Care Account is \$25.

Use of WEX Health Card. When your Health Care Account is established, you will be mailed a debit card called a “WEX Health Card,” which can be used at the point of sale just like a Visa or Mastercard for all of your eligible Health Care Expenses. The amount available on your WEX Health Card is equal to the amount in your Health Care Account less the \$1,000 minimum needed to maintain your eligibility. However, if you use the entire balance of funds on your WEX Health card to pay for Health Care Expenses, you may not have enough to pay your premiums for the next month and you would be required to self-pay.

Please keep in mind that the WEX Health Card system cannot verify all claims at point-of-sale. **In some cases, additional information is required by the IRS to verify that the charge is a reimbursable expense. Therefore, please keep your receipts and any Explanation of Benefits you receive from Highmark or UPMC or other provider.** You may be requested to provide this documentation for verification at a later date.

Submitting Claims for Reimbursement. If for some reason you do not use your WEX Health Card, you may submit a claim to the Contract Administrator at any time and a reimbursement check will be issued provided you have a sufficient balance in your Health Care Account.

To submit a claim for reimbursement from your Health Care Account, you must submit to the Contract Administrator a medical reimbursement request form (available from the Contract Administrator) and a bill or receipt issued by the provider for the medical services that includes the following information:

- patient name,
- a description of the services,
- the date of the services,
- the charge for the services, and
- the total patient responsibility after any insurance payments and/or adjustments (an explanation of benefits, or EOB, may be submitted in addition to the bill or receipt if the insurance information is not included on the bill or receipt).

A claim for reimbursement must be submitted within twelve (12) months from the date that the related Health Care Expense was incurred.

Claim Processing. A Claim that requires no additional information to process will be approved or denied by the Contract Administrator no later than thirty (30) days after receipt. Generally, for request forms submitted by the tenth (10th) day of the month, a check will be mailed to you on the fifteenth (15th) day of that month. Written or electronic notice of the approval or denial will be given to the claimant by the Contract Administrator.

If special circumstances require, the initial thirty (30)-day period to decide the claim may be extended for up to an additional fifteen (15) days. The Contract Administrator will provide written or electronic notice of such extension to the claimant before the end of the initial thirty (30)-day period. The notice will specify the circumstances requiring the extension and the date by which the Contract Administrator expects to decide the claim.

If a claimant does not submit sufficient information to allow the Contract Administrator to decide a claim, the Contract Administrator will provide the claimant with written or electronic notice of the specific information required to decide the claim. Such notice shall be provided before the end of the initial thirty (30)-day period, and the Participant will have forty-five (45) days to provide the required information. The Contract Administrator will then approve or deny the claim no more than fifteen (15) days following the earlier of: (1) the date the Contract

Administrator receives the claimant's response; or (2) the date such forty-five (45)-day period ends.

Extension of Time by Claimant. A claimant may voluntarily agree to extend any of the above periods for the Contract Administrator to make a decision on a claim for benefits.

Approval of Claim. The claimant will be notified of the approval of a claim for benefits by the Contract Administrator via a written or electronic statement that includes the following information:

- Actual charges.
- Amount paid.
- Any amount that is claimant's responsibility.

Denial of Claim. The claimant will be notified of the denial, in whole or in part, of a claim for benefits by the Contract Administrator via a written statement that includes the following information:

- The reasons the claim was denied.
- Reference to the Plan provisions that caused the claim to be denied.
- A description of any additional information necessary to complete the claim and an explanation of why the information is necessary.
- Any internal rule, guideline, protocol or other similar criterion that was relied on in the denial of the claim, or a statement that it was relied upon. A copy will be provided free of charge upon the claimant's request.
- If the denial of the claim was based upon medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the denial, applying the Plan provisions to the claimant's medical circumstances, will be provided free of charge upon the claimant's request.
- An explanation of the appeal procedure
- A statement of the claimant's right to bring a civil action under ERISA following an adverse determination upon appeal.

Right of Appeal. A claimant has the right to appeal to the Board of Trustees any decision to deny a claim or any decision as to the amount of benefit paid.

In connection with an appeal, the claimant is entitled to review all relevant documents and receive copies free of charge and to submit any comments, documents, records and information that support the claimant's claim for benefits. In order to appeal, the claimant must submit a written request for a review of the decision within **one hundred eighty (180) days** of the date of receipt of the decision to the following:

***The Board of Trustees
I.U.P.A.T. Welfare Fund of Western Pennsylvania
5 Hot Metal Street
Suite 200
Pittsburgh, PA 15203-2352***

Appeal Processing. A claim on appeal, regardless of type, shall be subject to a full and fair review by the Board of Trustees of the Fund in accordance with the following:

The review shall take into account all comments, documents, records and information submitted by the claimant in connection with the appeal, whether or not previously submitted or considered.

The review shall not afford any deference to a prior determination on the claim, and it shall not be made by the individual who made the prior determination or by a subordinate of that individual.

If the prior determination on the claim was based on a medical judgment, including a determination with regard to whether a particular treatment, drug or item is experimental, investigational or not medically necessary or appropriate, the review shall be made after consultation with a health care professional who has appropriate training and experience in the relevant field of medicine. Such health care professional shall not be an individual who was consulted with respect to the prior determination or a subordinate of that individual.

The review shall provide for the identification of any medical or vocational experts whose advice was obtained in connection with the claim that is the subject of the review, without regard to whether the advice was relied upon in making the prior determination on the claim.

If the Board of Trustees holds regularly scheduled meetings at least quarterly. The Board of Trustees will make a decision on the appeal by the date of the first meeting of the Board of Trustees that follows receipt of the appeal, provided the Board of Trustees holds regularly scheduled meetings at least quarterly. However, if your appeal is received within the thirty (30)-day period preceding the date of the first meeting, the Board of Trustees will make its decision by the date of its second meeting that follows the receipt of your appeal. If special circumstances, such as the need to hold a hearing, require an extension, you will be notified of that extension, thus the Board of Trustees will make its decision by the date of its third meeting that follows the receipt of your appeal. In the event of an extension, you will receive notification describing the special circumstances and the date by which a decision on your appeal is expected. The Board of Trustees issues its written decision on appeals within five (5) days of the meeting at which the decision is made.

If the Board of Trustees does not hold regularly scheduled meetings at least quarterly If the Board of Trustees does not hold regularly scheduled meetings at least quarterly, the Board of Trustees will review your appeal and issue a written final decision within sixty (60) days of its receipt of the appeal. If special circumstances require, the sixty (60)-day period may be extended for up to an additional sixty (60) days. In such case, you will be provided with a written notice of extension setting forth the reasons for the extension and the date by which a decision is expected.

Extension of Time by Claimant. A claimant may voluntarily agree to extend any of the above periods for the Board of Trustees to make a decision on appeal.

D. Federal Requirements for Group Health Plans

1. Hospital Stays in Connection with Childbirth - Rights Under the Newborns' and Mothers' Health Protection Act. Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than forty-eight (48) hours following a vaginal delivery, or less than ninety-six (96) hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with

the mother, from discharging the mother or her newborn earlier than forty-eight (48) hours (or ninety-six (96) hours) as applicable. In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the Plan or the issuer for prescribing a length of stay not in excess of forty-eight (48) hours (or ninety-six (96) hours) as applicable.

2. Reconstructive Breast Surgery. Under federal law, group health plans and health insurance issuers that provide medical and surgical benefits with respect to a mastectomy must provide certain benefits to a Participant or beneficiary who is receiving benefits in connection with mastectomy and who elects breast reconstruction. Specifically, the group health plan and issuer must provide coverage, in a manner determined in consultation with the attending physician and the patient, for: (i) reconstruction of the breast on which the mastectomy has been performed; (ii) surgery and reconstruction of the other breast to produce a symmetrical appearance; and (iii) prostheses and physical complications during all stages of mastectomy, including lymphedemas. This coverage may be subject to annual deductibles and coinsurance provisions, consistent with other benefits under the Plan.

3. Mental Health Parity Act. As required by a federal law called the Mental Health Parity Act of 1996 (as amended), if you are eligible for mental health benefits under the Plan, the Plan generally may not impose limits on your mental health benefits that are more stringent than the limits imposed on medical and surgical benefits under the Plan. You should consult the benefit booklet for information on available mental health benefits.

4. Genetic Information Nondiscrimination Act of 2008 (GINA). The Genetic Information Nondiscrimination Act of 2008 expands genetic nondiscrimination protection under the Plan. The Plan will not engage in using genetic information about an individual to adjust the Plan's premiums, deny coverage, or impose a pre-existing condition exclusion. The Plan will not require or request genetic testing and request, require or purchase genetic information for underwriting purposes. Genetic information is defined as information about an individual's genetic test (i.e., analysis of human DNA or RNA), the genetic test of family members of such individual, and the manifestation of a disease or disorder in family members of such individuals.

5. Qualified Medical Child Support Orders (QMCSOs). ERISA requires the Plan to extend health care coverage to children of a parent-Participant who is divorced, separated, or never married when ordered to do so by state authorities. Generally, a State court or agency may require the Plan to provide health benefits coverage to children (referred to as "alternate payees") by issuing a medical child support order. The Plan is required to determine whether such an order is "qualified."

In order to be "qualified," the order must contain the following information:

- The name and last known mailing address of the Participant and each alternate recipient. The order may substitute the name and mailing address of a State or local official for the mailing address of any alternate recipient;
- A reasonable description of the type of health care coverage to be provided to each alternate recipient (or the manner in which such coverage is to be determined); and
- The period to which the order applies.

In general, the order may not require the Plan to provide any type or form of benefit, or any option, not otherwise provided under the Plan.

Within a reasonable period of time after receiving the order, the Contract Administrator, or its designee, will determine whether a medical child support order is qualified. The Contract Administrator maintains written procedures for making these types of determinations. You can request a copy from the Contract Administrator.

6. USERRA (Military Service). The Uniformed Services Employment and Reemployment Act (USERRA) provides certain protections to anyone absent from civilian employment because of uniformed service. If your uniformed service is covered by USERRA, you will continue to be covered by the Plan's group health plan for up to twenty-four (24) months.

The Plan will regard you as being covered by USERRA if:

- You are available for work (i.e., you are working in Covered Employment or you are on the union's out of work list) at the time you leave for uniformed service;
- You provide advance written or verbal notice of the leave for uniformed service to the Business Manager of District Council 57 or the Contract Administrator (unless giving notice is impossible, unreasonable, or precluded by military necessity);
- Your cumulative length of absences for uniformed services does not exceed five years;
- You make yourself available for work (i.e., you return to Covered Employment or sign the out of work list) within 90 days after release from service; and,
- You are not separated from uniformed service with a dishonorable or bad conduct discharge, or your separation from service was for other reasons causing you to lose your reemployment rights under USERRA.

If your leave is covered by USERRA, you and your covered Eligible Dependents will continue to be covered by the Plan's medical benefits for the lesser of: 1) Twenty-four (24) months, beginning on your first day of absence for uniformed service; or, 2) the actual period of your absence due to uniformed service, beginning with your first day of absence, and ending on the date you make yourself available for work after separation from uniformed service.

If you elect to continue your health coverage (or your Dependents' coverage) pursuant to USERRA, you will be required to pay 102% of the full premium for the coverage elected (the same rate as COBRA). However, if your Uniformed Service leave of absence is less than 31 days, you are not required to pay more than the amount that you pay as an active employee for that coverage.

Alternatively, if you so elect, your coverage will be suspended immediately if you enter the Uniformed Services, as that term is defined in USERRA. Your coverage and accounts will be reinstated on the first day of the month following notice to the Contract Administrator of your discharge, provided you have not been on active duty for more than five years (except in situations where your initial enlistment did not terminate within the five-year period, or where, through no fault of your own, you were otherwise required to serve beyond the five-year period), and provided you return to Covered Employment within the time frames set forth in USERRA. If you fail to return to Covered Employment within those time frames, you will forfeit any coverage and accounts that you previously accumulated in accordance with the rules of the Plan. You must notify the Contract Administrator prior to entering the Uniformed Services and again when discharged, so that the Contract Administrator may assist you with rights you have under USERRA and any COBRA benefits that may be available to you or your Dependents.

E. Coverage Exclusions

Notwithstanding anything contained in this SPD or in the materials provided by UPMC or Highmark, the following items are not covered by the Plan:

Effective January 1, 2020, expenses for gene therapies, including, but not limited to, Chimeric Antigen Receptor T-Cell (CAR-T) therapies (e.g., Kymriah and Yescarta), ocular gene therapy (e.g., Luxturna), gene therapy for spinal muscular atrophy (e.g., Zolgensma), and gene therapy for treating beta thalassemia (e.g., Zynteglo) are excluded from coverage.

F. Special Coverage for COVID-19 Related Testing and Services

Effective March 18, 2020 and continuing throughout the period of the public health emergency declared by the Secretary of the Department of Health and Human Services ("HHS"), the Plan will cover the cost of any in vitro diagnostic COVID-19 test that is (a) FDA approved, (b) FDA emergency use authorized, (c) State authorized as reported to HHS, or (d) otherwise approved by HHS.

Effective March 18, 2020 and continuing throughout the period of the public health emergency declared by HHS, any applicable cost sharing, prior authorization or medical management requirements for items or services furnished for office (in person or virtual), urgent care, and emergency room visits that result in an order for, or the administration of, an approved or authorized in vitro COVID-19 test shall be waived (but only to the extent such items or services relate to the furnishing or administration of the test or the evaluation of whether the individual needs the test).

Effective January 1, 2021, the Plan will provide coverage for government-approved COVID vaccines and administration within 15 business days after a recommendation of the vaccine by the Advisory Committee on Immunization Practices (ACIP) or the United States Preventive Service Task Force (USPSTF). Coverage will be provided with no cost-sharing and no balance-billing to the participant, whether provided in-network or out-of-network.

Effective January 15, 2022 and continuing throughout the period of the public health emergency declared by HHS, the Plan will reimburse you for the cost of up to eight (8) over-the-counter COVID tests for each of you, your covered Spouse and your covered Dependents. For example, for a family of four, you can get reimbursed for up to 32 tests per month. If you purchase the test at a preferred retail location or through Highmark's or UPMC's mail order process, the full amount will be paid by the Plan at the point of sale. If you purchase the test at an out-of-network location, your reimbursement will be capped at \$12 per test. Tests may not be reimbursed if they are used for employment purposes.

V WAGE ACCOUNT

Paid Time Off. Your Wage Account provides you with Paid Time Off. You are entitled to up to 75 days of Paid Time Off per calendar year. The amount of the Paid Time Off per day is \$200, but these benefits will not exceed the balance in your Wage Account. Additionally, in order to receive Paid Time Off, you must have enough funds in your Wage Account to cover all applicable taxes in order to net the \$200 per day pay.

If, as of November 15 each year, a balance remains in your Wage Account, you will automatically receive a payment of the balance remaining after payment of all applicable taxes. However, the total net amounts paid to you from the Wage Account cannot exceed \$15,000 in any calendar year. Any balance remaining in your Wage Account after the payment of the net amount of \$15,000 in any calendar year will be rolled over to the next calendar year.

Note Regarding Taxes. Since payments from the Wage Account are considered income to you, they are subject to income tax withholding. Note that both your portion of the payroll taxes AND your employer's portion of the payroll taxes will be withheld from your payment.

Forfeiture of Balance in Wage Account. In the event that for any two (2)-year period:

(a) no Contributions have been made to the Plan on your behalf; and

(b) you have not completed the necessary enrollment forms as provided by the Plan Administrator to receive payments from the Wage Account; then any balance in your Wage Account at the end of such two (2)-year period will be forfeited and added to the Fund's reserves.

Payment of Wage Account Upon Your Death. Subject to the Forfeiture of Balance provision above, any balance remaining in your Wage Account upon your death will be paid to your beneficiary on file with the Contract Administrator. Absent an effective designation of a beneficiary, the remaining balance will be paid to your survivors in the following order: spouse, children, parents, brothers and sisters, your estate.

VI ACCIDENT AND SICKNESS

If you have Medical Coverage under the Plan and are not a Retiree, you are eligible for the Plan's weekly Accident and Sickness Benefits.

Under the Plan's Accident and Sickness Benefits, if a sickness or injury disables you from working in your regular occupation, you will be paid a weekly benefit of \$324.85 for up to a maximum of thirteen (13) weeks.

Medical evidence of disability must be furnished to the Contract Administrator on a monthly basis, and you must be under the care of a licensed physician for the period of the disability.

Benefits begin on the first (1st) day of disability resulting from an accident. Benefits begin on the eighth (8th) day of disability resulting from sickness, or if hospital confinement or disabling

out-patient surgery occurs before the eighth (8th) day, benefits begin at the time of confinement or surgery. The benefits are payable for a maximum period of thirteen (13) weeks for any one disability. Successive periods of disability will be considered separate periods if due to unrelated causes or are separated by at least one day of active work.

You may not receive Accident and Sickness Benefits at the same time that you are receiving unemployment compensation benefits or workers' compensation benefits.

Exclusions:

Benefits are not payable with respect to any disability:

1. Resulting from intentionally self-inflicted injury, while sane or insane.
2. Resulting from accidental bodily injury or sickness caused by war or riot, act of terrorism, or as a result of the commission of a felony.
3. Resulting from aircraft accidents, except when the Employee is a fare paying passenger on a regular scheduled airline.
4. Resulting from accidental bodily injury or sickness arising out of or in the course of employment.
5. Commencing prior to the effective date of coverage.
6. Unless the Employee is under the care of a qualified physician or surgeon.
7. Resulting from operations for cosmetic or beautifying purposes except for injuries resulting from a covered accident.

Currently, there is no charge to the Employee for Weekly Accident & Sickness Benefits.

Claims for Accident and Sickness Benefits:

You must apply to receive Accident and Sickness Benefits. To apply, contact the Contract Administrator for the application form.

Your claim for Accident and Sickness Benefits is decided by the Contract Administrator. A decision on your claim will normally be made within forty-five (45) days of the receipt of the claim by the Contract Administrator. The forty-five (45)-day period may be extended for up to thirty (30) days if the Contract Administrator determines that such an extension is necessary due to matters beyond its control. If an extension is necessary, the Contract Administrator will provide you with written notice of the extension before the expiration of the initial forty-five (45)-day period.

If prior to the end of the first thirty (30)-day extension period, the Contract Administrator determines that due to matters beyond its control, a decision cannot be rendered within the extension period, the Contract Administrator may extend the period for up to an additional thirty (30) days. The Contract Administrator will notify you of this extension prior to the expiration of the first thirty (30)-day extension period.

If an extension is necessary due to your failure to submit information necessary to decide the claim, you will be given forty-five (45) days from the end of the initial forty-five (45)-day period or the end of the first thirty (30)-day extension period (as applicable) to supply the requested information. In the case of such an extension, the Plan's thirty (30)-day period for making the decision on extension will begin to run on the earlier of:

The date on which you respond to the request for the information; or

The date by which you are required to respond to the request for the information.

If an extension is taken for any other reason, the thirty (30)-day extension period for making the decision will begin to run at the end of the initial forty-five (45)-day period or the end of the first thirty (30)-day extension period (as applicable).

If your claim is wholly or partially denied:

Written (or electronic) notice of the denial will be provided to you within the applicable time frame for deciding the claim.

The denial notice will specify:

- (1) the specific reasons for the denial;
- (2) specific references to the pertinent provisions of the Plan;
- (3) a description of any additional material or information necessary for you to perfect your claim and an explanation of why it is necessary;
- (4) an explanation of the procedure to appeal the denied claim including the applicable time limits;
- (5) a statement of your rights to bring a civil action under ERISA following an adverse determination upon review;
- (6) any internal rule, guideline, protocol or other similar criterion relied on for the denial, or a statement that none was relied on;
- (7) if the denial was based on a medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the denial, applying the Plan terms to your medical circumstances, or a statement that such explanation will be provided free of charge upon your request;
- (8) a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits; and
- (9) a discussion of the decision, including an explanation of the basis for disagreeing with or not following:
 - a. the views you presented to the Plan of health care professionals treating you and vocational professionals who evaluated you;
 - b. the views of medical or vocational experts whose advices was obtained on behalf of the Plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and
 - c. a determination of your disability made by the Social Security Administration which you presented to the Plan.

Appeal of Adverse Benefit Decision:

You may appeal an adverse decision on your claim for Accident and Sickness Benefits to the Board of Trustees, I.U.P.A.T. Welfare Fund of Western Pennsylvania, c/o Central Data Services, 5 Hot Metal Street, Suite 200, Pittsburgh, PA 15203-2352. **The appeal must be made in writing and received by the Trustees no later than one hundred eighty (180) days after the date you received the adverse benefit determination.**

You will be entitled to review all relevant documents and to receive copies free of charge.

You will be entitled to submit written comments, documents, records and other information related to the claim, and have the same taken into account in the review whether or not previously submitted or considered.

Review of your appeal is made by the Board of Trustees and it will not afford any deference to the initial benefit determination.

If the initial benefit determination was based on a medical judgment, the determination will be made after consultation with a health care professional who has appropriate training and experience in the relevant field of medicine. The health care professional will not be an individual who was consulted with respect to the initial benefit determination or a subordinate of that individual.

The review will provide for the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with an adverse benefit determination, without regard to whether the advice was relied on in making the determination.

For so long as the Board of Trustees holds regularly scheduled meetings at least quarterly, the Trustees' decision on review of an appeal of a claim will be made no later than the date of the first meeting of the Trustees that follows receipt of the request for review. However, if your appeal is received within the thirty (30) days preceding the date of the meeting, the decision on appeal will be made no later than the date of the second meeting of the Trustees that follows receipt of the appeal. If special circumstances (such as the need to hold a hearing) require a further extension of time for processing, the decision on appeal will be made no later than the third meeting of the Trustees that follows receipt of the appeal. A written (or electronic) notice of the extension that describes the special circumstances and the date by which the Trustees expect to decide the request for review will be provided to you before the commencement of the extension. Written (or electronic) notice of the Trustees' decision on review will be provided to you within five (5) days of the meeting of the Trustees at which the decision on appeal is made.

If the Trustees do not hold regularly scheduled meetings at least quarterly, the Trustees' decision on appeal will be made and written (or electronic) notice of the Trustees' decision provided to you within a reasonable period of time following of the request for review, but not later than forty-five (45) days after receipt. If special circumstances (such as the need to hold a hearing) require, the initial forty-five (45)-day period may be extended by an additional forty-five (45) days. A written (or electronic) notice of the extension that describes the special circumstances and the date by which the Trustees expect to decide the request for review will be provided to you before the commencement of any such extension.

Before the Plan can issue an adverse benefit determination on appeal, the Plan must provide you, automatically and free of charge:

- (1) Any new or additional evidence considered, relied upon, or generated by the Plan in connection with your claim; and
- (2) Any new or additional rationale that is the basis for an adverse benefit determination.

The evidence and rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided, so as to give you a reasonable opportunity to respond prior to that date.

If the decision on appeal is adverse:

The notice of the decision shall set forth: (1) the specific reasons for the decision; (2) specific references to the pertinent provisions of the Plan; (3) a statement that the claimant is entitled to review all relevant documents and to receive copies free of charge; (4) a statement of the claimant's right to bring a civil action under ERISA; (5) any internal rule, guideline, protocol or other similar criterion relied on for the decision, or a statement that it was relied on and a copy will be provided free of charge upon the claimant's request; and (6) if the decision was based on a medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the decision, applying the Plan terms to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon the claimant's request.

Representative:

You may designate a duly authorized representative to file an application for benefits on your behalf and/or to appeal a benefit denial to the Board of Trustees on your behalf. You will generally be required to provide a written statement of the designation, along with an authorization to release information to your representative.

VII MATERNITY LEAVE BENEFITS

Employees who are working and have Contributions being made to the Plan on their behalf are eligible for paid leave under the Plan's Maternity Leave Benefits if they meet the eligibility requirements below. Only the Employee is eligible for these benefits, not a spouse or dependent.

Eligibility. You are eligible for this benefit if you meet the following requirements:

- (a) You take a leave of absence due to your pregnancy or the birth of your child on or after January 1, 2022;
- (b) Contributions to the Plan were being made on your behalf immediately prior to your leave;

(c) You submit certification of your pregnancy from your medical doctor verifying that you are unable to perform the duties of your trade due to physical limitations arising from your pregnancy (for pre-delivery leave only);

(d) You submit certification of the date of birth of your child, and, if applicable, certification that the birth was by cesarean section (post-delivery leave only);

(e) You have worked at least 100 hours over the three months prior to your leave and were eligible for coverage under the Plan as of the date of your leave; and

(f) You did not use this benefit within the 24 months prior to your leave.

Time Periods for Eligibility.

Pregnancy (Pre-Delivery/Birth): For paid Maternity Leave benefits to commence prior to delivery/birth, you must be deemed unable to work by your medical doctor. This certification must indicate that you are not able to work due to physical limitations arising from the pregnancy, but eligibility for the benefit shall not begin until the onset of the 4th month of pregnancy. The pre-delivery/birth benefit may be intermittent, but the cumulative pre-delivery/birth benefit may not exceed six months. After six months, the paid Maternity Leave benefit payments will stop regardless of whether you are able to return to work or not.

From time to time, the Plan may require you to provide recertification from your doctor of your inability to work during your pregnancy.

Post-Delivery/Birth: Regardless of what was covered pre-delivery, you are eligible for up to six (6) weeks of paid leave after the birth of your child. If delivery of your child was done by cesarean section, you are eligible for up to eight (8) weeks of paid leave after the birth of your child.

Benefit Amount. The weekly benefit payable is equal to 66.67% of your normal weekly earnings, to a maximum of \$800. Weekly earnings shall be determined to be the hourly wage based on a 40-hour work week. Benefits shall be calculated at the rate of 1/7 of the weekly benefit for each day of eligible leave, if leave is taken for less than a full week. Benefit payments are calculated using the formula below:

$$66.67\% \text{ of Normal Hourly Wage} \times 2080 \div 52 = \text{Weekly Benefit } (\$800 \text{ cap})$$

Exclusions. Maternity Leave benefits are not available under the Plan:

- If you are a Canadian resident;
- If contributions are not being made to the Plan on your behalf immediately prior to your leave;
- For surrogate-related pregnancies;
- For adoption of a child; or
- For foster care of a child.

Claims for Maternity Leave Benefits and Appeal of Adverse Decisions. You must apply for Maternity Leave benefits on an application form available from the Contract Administrator.

The remainder of the procedures for making claims for Maternity Leave benefits and for the appeal of adverse decisions are identical to the claims and appeal procedures set forth under the Accident and Sickness benefits.

VIII DEATH BENEFIT

If you have Medical Coverage under the Plan and you are not eligible for Accidental Death and Dismemberment Benefits due to loss of life as described in Section IX, you are eligible for the Plan's Death Benefit.

A death benefit of \$15,000 is payable to your beneficiary in the event of your death from any cause at any time or place, unless your death meets the requirements for the Accidental Death and Dismemberment Benefit described in Section IX.

It is important that you have a proper beneficiary on record with the office of the Contract Administrator. Call the Contract Administrator for the necessary forms to name or change your beneficiary. Absent an effective designation of a beneficiary, the death benefit will be paid to your survivors in the following order: spouse, children, parents, brothers and sisters, your estate.

In addition to the death benefit amount described above, the Plan provides a death benefit for the loss of a spouse or eligible child as shown below. The benefit is paid to you, as the Employee or Retiree.

Spouse - **\$2,000**

Child (who meets the definition of Dependent Child below) - **\$1,000**

Dependent Child for purposes of the dependent death benefit includes:

Unmarried Child(ren) of the Employee from date of birth up to age nineteen (19) years who is:

- a blood descendant (child), or
- a legally adopted child (including a child living with the adopting parents during the probationary period or a child placed for adoption), or
- a stepchild residing in the Employee's household, or
- a child permanently residing in the Employee's household and being supported solely by the Employee, provided the Employee is related to the child by blood or marriage or is the child's legal guardian.

Unmarried children over age (nineteen) 19 are also eligible:

- **To Any Age**
if disabled and incapable of self-support because of the disability (certification of disability must be on file with the Contract Administrator).
- **To Age Twenty-Five (25)**
provided they are enrolled as full-time students in an accredited school, college or university and are solely dependent upon the Employee for support. Verification must be submitted each semester that the child is a full-time student. Verification shall be in the form of a copy of a class schedule, or confirmation of status on the attending school's letterhead signed by authorized personnel.

Currently, there is no cost for Employees or for Retirees who have not reached age sixty-five (65).

Retirees who have reached age sixty-five (65) must pay a quarterly premium for the death benefit and may choose a \$5,000 benefit or a \$10,000 benefit. The amount of the premium is available from the Contract Administrator.

Death benefit coverage is provided automatically upon satisfying the eligibility conditions (including payment of the quarterly premium payment for Retirees), but you must complete a beneficiary designation.

Coverage ends when you no longer meet the eligibility requirements or fail to make timely payments for the benefit.

Claims For Death Benefits and Appeal of Adverse Decisions

Death of Employee or Retiree

Your beneficiary must make application for benefits with the Contract Administrator.

Death of Dependent

The Employee or Retiree must make application for benefits with the Contract Administrator.

Decision on Application

In most cases, a decision on an application will be made by the Contract Administrator within ninety (90) days of its receipt. If special circumstances require, the ninety (90)-day period may be extended for an additional ninety (90) days. In such case, you will be provided with a written notice of extension setting forth the reasons for the extension and the date by which a decision is expected.

Denied Application

If your application is denied, you will receive a written explanation setting forth:

- the reasons for the denial;
- reference to pertinent Plan provisions for the denial;
- a description of any additional information you must provide to support your application and an explanation why it is necessary;
- an explanation of the appeal procedure for further review of your application; and
- a statement of your right to bring a lawsuit under ERISA in the event of an adverse decision upon review of the denial.

Appeal of Denied Application

You have a right to appeal any denial of the application to the Board of Trustees by submitting a written request to the Board of Trustees, I.U.P.A.T. Welfare Fund of Western Pennsylvania, c/o Central Data Services, 5 Hot Metal Street, Suite 200, Pittsburgh, PA 15203-2352.

Your written request for appeal must be received within **sixty (60)** days of the date you receive the denial. Otherwise, you will forfeit your right to have the denial of your application reviewed in appeal.

Your appeal should set forth the reasons why you believe your application should not have been denied. You may submit any documents, records or other information you believe have a bearing on your application. In preparing your appeal, you may review relevant documents and receive copies free of charge.

Review of Appeal

The Board of Trustees has the authority and discretion to interpret and apply the terms of the Plan and to resolve any legal and factual issues regarding the Plan and the benefits thereunder.

For so long as the Board of Trustees holds regularly scheduled meetings at least quarterly, the Board of Trustees will make a decision on your appeal by the date of the first meeting of the Board of Trustees that follows receipt of your appeal. However, if your appeal is received within the thirty (30)-day period preceding the date of the first meeting, the Board of Trustees will make its decision by the date of its second meeting that follows the receipt of your appeal. If special circumstances (such as the need to hold a hearing) require an extension, you will be notified of the extension, and the Board of Trustees will make its decision by the date of its third meeting that follows the receipt of your appeal. The notice of extension will describe the special circumstances and the date by which a decision on your appeal is expected. The Board of Trustees will issue its written decision on your appeal within five (5) days of the meeting at which the decision is made.

If the Board of Trustees does not hold regularly scheduled meetings at least quarterly, the Board of Trustees will review your appeal and issue a written final decision within sixty (60) days of its receipt of the appeal. If special circumstances require, the sixty (60)-day period may be extended for up to an additional sixty (60) days. In such case, you will be provided with a

written notice of extension setting forth the reasons for the extension and the date by which a decision is expected.

If adverse, the written decision will include:

- the reasons for the decision;
- reference to pertinent Plan provisions for the decision;
- a statement of your right to examine documents that are relevant to your application and to receive copies free of charge; and
- a statement of your right to bring a lawsuit under ERISA.

Representative

You may designate a duly authorized representative to file an application for benefits on your behalf and/or to appeal a benefit denial to the Board of Trustees on your behalf. You will generally be required to provide a written statement of the designation, along with an authorization to release information to your representative.

**IX
ACCIDENTAL DEATH AND DISMEMBERMENT**

If you have Medical Coverage under the Plan, you are eligible for the Plan's Accidental Death and Dismemberment coverage.

Accidental Death and Dismemberment coverage -- "AD&D" -- provides benefits when an Employee or Retiree by accidental means, loses his life, or suffers a dismemberment. If an Employee or Retiree is eligible for these AD&D benefits due to loss of life, then he or she is not eligible for the Death Benefit described in Section VIII.

When the Employee or Retiree has an accident either at or away from work and, as a result of the accident suffers any of the losses shown below within ninety (90) days, benefits, in the amount reflected on the applicable Schedule of Benefits, will be paid as follows:

	Principal Sum as Shown in Schedule of Benefits
Loss of Life	\$30,000
Loss of both hands, both feet, the sight of both eyes, or any combination of these	\$30,000
Loss of one hand, one foot, or the sight of one eye.....	\$15,000

Payment for the loss of life will be made to the named beneficiary. Absent an effective designation of a beneficiary, benefits will be paid to your survivors in the following order: spouse, children, parents, brothers and sisters, your estate. It is important that you have a

proper beneficiary on record with the Plan - call the Contract Administrator for the necessary forms to name or change your beneficiary.

Payment for the other losses will be made to the Employee or Retiree.

No payment is made for losses occurring as a result of drug overdose, self-destruction or attempted self-destruction or self-inflicted injury, insurrection, war, participating in a riot, committing an assault or felony, disease of the body, mental infirmity, medical or surgical treatment or diagnosis therefore, ptomaines, bacterial infection, taking of poison, asphyxiation from or inhaling of gas.

No more than \$30,000 shall be paid for all losses resulting from any one accident.

Currently, there is no cost for AD&D coverage.

There is no need to enroll for AD&D coverage. The coverage is provided automatically upon satisfying the eligibility conditions, but you must complete a beneficiary designation.

Coverage ends when you no longer satisfy the eligibility requirements.

Claims For Accidental Death and Dismemberment Benefits and Appeal of Adverse Decisions

Accidental Death of Employee or Retiree

Your beneficiary must make application for benefits with the Contract Administrator.

Dismemberment of Employee or Retiree

The Employee or Retiree must make application for benefits. The application is available from the Contract Administrator.

The remainder of the procedures for making claims for Accidental Death and Dismemberment benefits and for the appeal of adverse decisions are identical to the claims and appeal procedures set forth under the Death Benefit Section of this SPD.

X AMENDMENT AND TERMINATION

The Trustees may amend, modify or terminate the Plan, in whole or in part, at any time and for any reason. Any amendment may reduce or eliminate any benefit provided under the Plan and may result in the forfeiture of the balance of your accounts. Under no circumstances will any Plan benefit become vested or non-forfeitable at any time with respect to any Participant (active, inactive or retired) or beneficiary.

The Trustees have established this Plan with the intent that it will be maintained for an indefinite period of time. However, the funding for the Plan is conditioned on Collective Bargaining and other Agreements remaining in effect that provide for continued Employer Contributions to the Plan that are to fund the Plan. Therefore, the Trustees reserve the right to terminate the Plan or reduce benefits, in whole or in part, at any time.

XI COBRA CONTINUATION COVERAGE

COBRA is a federal law that requires that most employers or other organizations that sponsor group health plans offer employees and their family members the opportunity to extend their group health plan coverage temporarily at their own expense (at group rates) if a “qualifying event” causes a loss of coverage. If you choose COBRA coverage, you will be required to pay the entire premium for the coverage plus a two percent (2%) administrative charge. If COBRA coverage is extended in the event of disability (as explained later), you can be charged up to 150% of the premium.

COBRA coverage is available only in connection with the medical coverage under the Plan. COBRA coverage is not available in connection with any other benefits described in this SPD or any other benefits you may have been receiving prior to the date that your coverage terminates.

If you are the **employee** (“covered employee”), you have a right to choose COBRA coverage if you lose group health coverage because of the qualifying event that is a reduction in your hours of employment or the termination of your employment (for reasons other than gross misconduct on your part).

The **spouse** of a covered employee has the right to choose COBRA coverage if group health coverage is lost as a result of any of the following four qualifying events:

- A termination of the covered employee’s employment (for reasons other than gross misconduct) or reduction in the covered employee's hours of employment;
- The death of the covered employee;
- Divorce or legal separation from the covered employee; or
- The covered employee becomes enrolled in Medicare (Part A or Part B or both).

A **dependent child** of a covered employee has the right to choose COBRA coverage if group health coverage is lost as a result of any of the following five qualifying events:

- A termination of the covered employee’s employment (for reason other than gross misconduct) or reduction in the covered employee's hours of employment;
- The death of the covered employee;
- The divorce or legal separation of the covered employee;
- The covered employee becomes enrolled in Medicare (Part A or Part B or both); or
- The dependent ceases to be an Eligible Dependent under the terms of the group health plan.

In addition, a dependent child born to or adopted by the covered employee during a period of COBRA coverage has the right to choose COBRA coverage. Such a child may be added to COBRA coverage upon written notification to the **COBRA Administrator, I.U.P.A.T.**

Welfare Fund of Western Pennsylvania, c/o Central Data Services, 5 Hot Metal Street, Suite 200, Pittsburgh, PA. 15203-2352.

Each person who is eligible for COBRA coverage is entitled to make a separate election of COBRA coverage. For example, a spouse or dependent child is entitled to elect COBRA coverage even if the covered employee does not make that election. The covered employee or spouse of the covered employee (or person who was the spouse of the covered employee on the day before the qualifying event) may elect COBRA coverage on behalf of other family members who are entitled to elect COBRA coverage with respect to the qualifying event and a parent or legal guardian may elect COBRA coverage on behalf of a minor child.

YOU MUST GIVE NOTICE OF A QUALIFYING EVENT IN ORDER TO ELECT COBRA COVERAGE

Under the law, the covered employee, spouse, dependent or personal representative of the employee, spouse or dependent has the responsibility of providing written notice to the COBRA Administrator, I.U.P.A.T. Welfare Fund of Western Pennsylvania, c/o Central Data Services, 5 Hot Metal Street, Suite 200, Pittsburgh, PA 15203-2352 of a divorce, legal separation, or a child's loss of dependent status under the group health plan. This written notice to the COBRA Administrator must be given within sixty (60) days of the date of any such event. If notice is not given within the sixty (60)-day period, the spouse or dependent (as applicable) will not be entitled to COBRA coverage.

The COBRA Administrator determines the covered employee's termination of employment or reduction in hours, death or Medicare enrollment.

When the COBRA Administrator determines that a qualifying event described above has happened, the COBRA Administrator will in turn notify you that you have the right to elect, and the procedures for electing, COBRA coverage.

Under the law, you have sixty (60) days from the date you would lose coverage because of one of the qualifying events described above to inform the COBRA Administrator that you want COBRA coverage. If you do not choose COBRA coverage for a group health plan, your coverage will end under that plan. You can change a decision you make to reject COBRA coverage any time up until the end of the sixty (60) day election period.

If you choose COBRA coverage and pay the required premiums, the group health plan is required to give you coverage which, as of the time coverage is being provided, is identical to the coverage provided by the Plan to similarly situated active employees, spouses or family members. If the coverage for similarly situated employees, spouses or family members changes, your coverage will change. In addition, each person who elects COBRA coverage has the same rights as other covered persons under the group health plan including open enrollment, election change and special enrollment rights, as applicable.

Duration of COBRA Coverage

The law requires that you be given the opportunity to maintain COBRA coverage for thirty-six (36) months from the date coverage ends as a result of the qualifying event unless you lost coverage because of the covered employee's termination of employment or reduction in hours. In that case, the required COBRA coverage period is eighteen (18) months from the date you lose coverage as a result of the termination of employment or reduction in hours. However, the eighteen (18)-month coverage period may be extended under the following circumstances.

Disability. If any person entitled to COBRA coverage (the covered employee, spouse or dependent) was disabled (as determined by the Social Security Administration) at any time during the first sixty (60) days of the COBRA coverage period, then all such persons entitled to elect COBRA coverage may be able to continue coverage for up to twenty-nine (29) months, rather than eighteen (18) months.

In order to be eligible for the additional eleven (11) months of COBRA coverage, the covered employee, spouse or dependent or personal representative of the covered employee, spouse, or dependent must send written notice to the COBRA Administrator, I.U.P.A.T. Welfare Fund of Western Pennsylvania, c/o Central Data Services, 5 Hot Metal Street, Suite 200, Pittsburgh, PA 15203-2352 within sixty (60) days after the latest of: (1) the date of the disability determination by the Social Security Administration; (2) the date on which the qualifying event occurred; (3) the date on which you would lose coverage under the Plan as a result of the qualifying event. In addition, the notice must also be provided before the end of the initial eighteen (18)-month coverage period.

The additional eleven (11) months of coverage provided on account of a disability will end as of the earlier of: (1) the first (1st) day of the month beginning more than thirty (30) days after a final determination by the Social Security Administration that the disability no longer exists; or (2) the last day of the twenty-ninth (29th) month of total coverage. **The covered employee, spouse, dependent or a personal representative of the employee, spouse, or dependent must provide written notice to the COBRA Administrator, I.U.P.A.T. Welfare Fund of Western Pennsylvania, c/o Central Data Services, 5 Hot Metal Street, Suite 200, Pittsburgh, PA 15203-2352 within thirty (30) days of a determination by the Social Security Administration that the disabled party is no longer disabled.**

Covered Employee's Entitlement to Medicare Before Qualifying Event. If the termination of employment or reduction in hours occurs less than eighteen (18) months after the date the covered employee becomes enrolled in Medicare, the covered employee's **spouse and dependent(s)** may be able to continue COBRA coverage for a period ending thirty-six (36) months after the date of Medicare enrollment, if longer than the eighteen (18)-month period after the termination of employment or reduction in hours. For example, if a covered employee becomes entitled to Medicare eight (8) months before the date on which his employment terminates, COBRA coverage for his spouse and children can last up to thirty-six (36) months after the date of Medicare entitlement, which is equal to twenty-eight (28) months after the date of the qualifying event (thirty-six (36) months minus eight (8) months).

Subsequent Qualifying Events. If, *during the eighteen (18)-month period of COBRA coverage (or within the twenty-nine (29)-month maximum coverage period in the case of a disability extension)*, the covered employee and the spouse divorce, the covered employee dies, the employee becomes entitled to Medicare, or a dependent ceases to be a dependent under the terms of the Plan, then the **spouse and/or dependent(s)** (as applicable) may be able to extend COBRA coverage for up to **thirty-six (36) months** from the date of loss of coverage as a result of the termination of employment or reduction in hours, but only if the second event would have caused the spouse or child to lose coverage under the group health plan had the first qualifying event not occurred. **The covered employee, spouse or dependent or personal representative of the employee, spouse or dependent must provide written notice to the COBRA Administrator, I.U.P.A.T. Welfare Fund of Western Pennsylvania, c/o Central Data Services, 5 Hot Metal Street, Suite 200, Pittsburgh, PA 15203-2352 of the subsequent event no later than sixty (60) days after its occurrence. If such written notice is not given, the spouse and/or dependent will not be entitled to the additional COBRA coverage.**

The law provides that COBRA coverage may end earlier than explained above for any of the following reasons:

- The Plan no longer provides the group health coverage to any employees;
- The premium for COBRA coverage is not paid on time;
- After the date of the COBRA election, you become covered under another group health plan;
- After the date of the COBRA election, you first become enrolled in Medicare; or
- You cancel COBRA coverage.

You do not have to show that you are insurable to choose COBRA coverage. However, COBRA coverage is offered subject to your eligibility for such coverage. The Plan Administrator reserves the right to terminate COBRA coverage retroactively if you are determined to be ineligible for COBRA coverage.

Central Data Services handles COBRA administration for the Plan. The name and address of Central Data Service is as follows:

Central Data Services
5 Hot Metal Street
Suite 200
Pittsburgh, PA 15203-2352
(412) 432-0435

There are no individual conversion options available at the end of COBRA coverage.

IF YOU HAVE QUESTIONS

Questions concerning the group health coverage or your COBRA continuation coverage rights should be addressed to Central Data Services, 5 Hot Metal Street, Suite 200, Pittsburgh, PA 15203-2352 (412) 432-0435.

For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

KEEP THE PLAN INFORMED OF ADDRESS CHANGE

In order to protect your family's rights, you should keep the Plan informed of any changes in the addresses of your family members. You should also keep a copy for your records of any notices that you send to the Plan or COBRA Administrator.

XII YOUR RIGHTS UNDER ERISA

As a Participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974, as amended (“ERISA”). ERISA provides that all Plan Participants shall be entitled to:

Receive Information About Your Plan and Benefits.

Examine, without charge, at the Plan Administrator’s office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and Collective Bargaining Agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and Collective Bargaining Agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

Receive a summary of the Plan’s annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

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

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within thirty (30) days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan’s

decision or lack thereof concerning the qualified status of a 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 party you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

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

XIII NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Protected health information. This section applies to "protected health information," which is health information that:

- is created or received by a health care provider, health plan, employer, or health care clearinghouse, and
- 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, and
- identifies the individual (or with respect to which there is a reasonable basis to believe that the information can be used to identify the individual).

Please note that employment records maintained by an Employer in its capacity as employer are not "health information" and therefore cannot be "protected health information." This includes, for example, records of date of hire, employment classification, and hours worked (even though that information may bear on eligibility for the Plan), as well as medical information developed to administer employment policies relating to paid time off, disability, and workers' compensation, for example.

In this description, we will call protected health information "PHI" for short.

Treatment, payment, and health care operations. The privacy rules generally allow the use and disclosure of your PHI without your permission (known as an authorization) for purposes of health care treatment, payment activities, and health care operations.

- Treatment includes providing, coordinating, or managing health care by health care providers or doctors. Treatment can also include coordination or management of care between a provider and a third party, and consultation and referrals between providers. For example, the Plan may share PHI about you with physicians who are treating you.

- Payment includes activities by the Plan, other plans, or providers to obtain premiums, make coverage determinations, and provide reimbursement for health care. This can include eligibility determinations, reviewing services for medical necessity or appropriateness, utilization management activities, claims management, and billing, as well as risk adjustment, collection, or reinsurance. For example, the Plan may share information about your coverage or the expenses you have incurred with another health plan in order to coordinate payment of benefits.

- Health care operations include activities by the Plan (and in limited circumstances other plans or providers) such as wellness and risk assessment programs, quality assessment and improvement activities, customer service, and internal grievance resolution. Health care operations also include vendor evaluations, credentialing, training, accreditation activities, underwriting, premium rating, arranging for medical review and audit activities, and business planning and development. For example, the Plan may use information about your claims to review the effectiveness of wellness programs.

Treatment, payment, and health care operations may also include contacting you to provide appointment reminders or information about alternative treatments or about other health-related benefits and services that may be of interest to you.

The amount of PHI used or disclosed will be limited to the minimum necessary for these purposes, as defined under the HIPAA rules. The Plan may also contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Other disclosures. In certain cases, your PHI can be disclosed without authorization to a family member, close friend, or other person you identify who is involved in your care or payment for your care. Information describing your location, general condition, or death may be provided to a similar person (or to a public or private entity authorized to assist in disaster relief efforts). You'll generally be given the chance to agree or object to these disclosures (although exceptions may be made, for example if you are not present or if you are incapacitated). In addition, your PHI may be disclosed without authorization to your legal representative.

The Plan is also allowed to use or disclose your PHI without your written authorization for uses and disclosures required by law, for public health activities, and other specified situations, including:

- disclosures to workers' compensation or similar legal programs, as authorized by and necessary to comply with such laws,
- disclosures related to situations involving threats to personal or public health or safety,
- disclosures related to situations involving judicial proceedings or law enforcement

activity,

- disclosures to a coroner or medical examiner to identify the deceased or determine cause of death; and to funeral directors to carry out their duties,
- disclosures related to organ, eye or tissue donation, and transplantation after death,
- disclosures subject to approval by institutional or private privacy review boards and subject to certain assurances by researchers regarding necessity of using your PHI and treatment of the information during a research project, and
- disclosures related to health oversight activities, specialized government or military functions and Health and Human Services investigations.

Except as described in this notice, other uses and disclosures will be made only with your written authorization. You may revoke your authorization as allowed under the HIPAA rules. However, you can't revoke your authorization if the Plan has taken action relying on it. In other words, you can't revoke your authorization with respect to disclosures the Plan has already made.

Request for restrictions. You may ask the Plan to restrict the use and disclosure of your PHI to treatment, payment, and health care operations, except for uses or disclosures required by law. You may ask the Plan to restrict the use and disclosure of your PHI to family members, close friends, or other persons you identify as being involved in your care or payment for your care. You also have the right to ask the Plan to restrict use and disclosure of PHI to notify those persons of your location, general condition, or death or to coordinate those efforts with entities assisting in disaster relief efforts.

Your request to the Plan must be in writing. The Plan is not required to agree to a requested restriction. If the Plan does agree, a restriction may later be terminated by your written request, by agreement between you and the Plan (including an oral agreement), or unilaterally by the Plan for PHI created or received after you're notified that the Plan has removed the restrictions. The Plan may also disclose PHI about you if you need emergency treatment, even if the Plan has agreed to a restriction.

Confidential communication of PHI. If you think that disclosure of your PHI by the usual means could endanger you in some way, the Plan will accommodate reasonable requests to receive communications of PHI from the Plan by alternative means or at alternative locations.

Your request to the Plan must be in writing and you must include a statement that disclosure of all or part of the information could endanger you. This right may be conditioned on your providing an alternative address or other method of contact and, when appropriate, on your providing information on how payment, if any, will be handled.

Inspecting and copying PHI. With certain exceptions, you may inspect or obtain a copy of your PHI in a "designated record set." This may include medical and billing records maintained for a health care provider; enrollment, payment, claims adjudication, and case or medical management record systems maintained by a plan; or a group of records the Plan uses to make decisions about individuals. As an exception, you do not have a right to inspect or obtain copies of psychotherapy notes or information compiled for civil, criminal, or administrative proceedings.

Your request to the Plan must be in writing. If your request is denied, you may request a review of the denial. If the Plan doesn't maintain the PHI but knows where it is maintained, you will be informed of where to direct your request.

Amending inaccurate or incomplete PHI. With certain exceptions, you may request that the Plan amend your PHI in a designated record set. Your request may be denied if the PHI is accurate and complete, was not created by the Plan (unless the person or entity that created the information is no longer available), is not part of the designated record set, or is not available for inspection (e.g., psychotherapy notes or information compiled for civil, criminal, or administrative proceedings). Your request to the Plan must be in writing, and you must include a statement to support the requested amendment.

Accounting of disclosures. You have the right to a list of certain disclosures the Plan has made of your PHI. This is often referred to as an “accounting of disclosures.” Generally, you can get an accounting of disclosures if the disclosure is required by law, in connection with public health activities, or in similar situations listed above, unless otherwise indicated below. You may be entitled to an accounting of disclosures that the Plan should not have made without authorization from you. You may receive information on disclosures of your PHI going back for six (6) years from the date of your request.

You do not have a right to receive an accounting of any disclosures made:

- For treatment, payment, or health care operations,
- to you about your own PHI,
- incidental to other permitted or required disclosures,
- where authorization was provided,
- to family members or friends involved in your care (where disclosure is permitted without authorization),
- for national security or intelligence purposes or to correctional institutions or law enforcement officials in certain circumstances, or
- as part of a “limited data set” (PHI that excludes certain identifying information).

In addition, your right to an accounting of disclosures to a health oversight agency or law enforcement official may be suspended at the request of the agency or official.

Your request to the Plan must be in writing. You may make one request in any 12-month period at no cost to you, but the Plan may charge a fee for subsequent requests. You’ll be notified of the fee in advance and have the opportunity to change or revoke your request.

Paper copy of this notice. If you are not receiving this notice on paper, you may have a paper copy from the Plan on request. Just contact the Contract Administrator.

Breaches. In the event of a “breach” of “unsecured” PHI, as defined in 45 C.F.R. § 164.402, if your PHI has been, or is reasonably believed to have been, accessed, acquired, used or disclosed, you will be notified as provided in the regulation.

Effective date and changes. This privacy policy originally took effect with the applicable regulations (generally, April 14, 2003) . Changes may be made in accordance with the normal procedure for amending the Plan, in which event you will receive a copy of the new policy as soon as possible.

Complaints. Complaints relating to your PHI should be directed to the Plan Administrator. You may also complain to the Secretary of the federal Department of Health and Human Services, 200 Independence Ave., Washington, D.C. 20201. You will not be retaliated against for filing a complaint.

XIV SHARING PHI WITH THE TRUSTEES

Besides the general policy on privacy practices (in the previous section of this document), the regulations under the Health Insurance Portability and Accountability Act of 1996 call for Plan provisions detailing how PHI may be shared with the Board of Trustees. This section functions as the HIPAA plan amendment referred to in the regulations at 45 C.F.R. § 164.504(f). Words used in this section have the same meaning as in the previous section of this document, particularly "protected health information" or PHI.

Employment records. Employment records maintained by an Employer in its capacity as employer are not "health information" and therefore cannot be "protected health information." This includes, for example, records of date of hire, employment classification, and hours worked (even though that information may bear on eligibility for the Plan), as well as medical information developed to administer employment policies relating to paid time off, disability, and workers' compensation, for example.

Disclosure to and use by the Board of Trustees. PHI may be disclosed to, and used by, the Board of Trustees for the purpose of carrying out plan administration functions that the Board performs, as long as the disclosure and use comply with the rest of this section. For example, this may include:

- determining eligibility for the Plan or actual coverage under the Plan,
- determining benefits under the Plan, including coordination of benefits and subrogation,
- determination of premiums,
- billing, claims management, collection activities, collecting on stop-loss insurance, and related data processing,
- determinations of medical necessity, appropriateness, or justification of charges,
- utilization review, pre-certification, and concurrent and retrospective review,
- case management,
- credentialing doctors and hospitals, as well as training, accreditation, certification, and licensing,
- underwriting, premium rating and other activities relating to creating, renewing or replacing a health insurance contract or stop-loss contract (provided some additional rules are met),
- conducting or arranging for medical review, legal services, and auditing functions,
- business planning and development, such as conducting cost management and other analyses relating to managing and operating the entity, including development of formularies, methods of payment and coverage policies, and
- management and general administration of the Plan, including customer service, resolution of grievances, and due diligence in connection with a sale or transfer of assets to another plan.

In addition, the Board of Trustees may avail itself of any other exemption provided in the regulation.

PHI may not be disclosed to, or used by, the Board for any purpose other than carrying out the Plan administration functions that the Board performs. Specifically, PHI may not be disclosed to, or used by, the Board for the purpose of employment-related actions or decisions or in

connection with any other benefit or employee benefit plan.

Summary health information. The Plan (or any insurance company) may also disclose PHI to the Board of Trustees if the Board requests it for the purposes of (a) obtaining premium bids from health plans for providing health insurance coverage under the Plan or (b) modifying, amending, or terminating the Plan, as long as the information is in summary form. Summary form means that the information summarizes claims history, claims expenses, or types of claims under the Plan and is "disidentified" in accordance with the regulation, except that it need only be aggregated to the level of five-digit zip codes.

Other protections for PHI. Except as just described with respect to summary health information, the Board of Trustees agrees:

- not to use or further disclose PHI except as permitted or required by the Plan (including this section) or as required by law;
- to ensure that any agents, including a subcontractor, to whom it provides PHI agree to the same restrictions and conditions that apply to the Board, including implementation of reasonable and appropriate security measures;
- not to use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan;
- to report to the Plan any use or disclosure of the PHI which it receives under this section that is inconsistent with these rules of which it becomes aware;
- to provide access to PHI about an individual to that individual in accordance with the regulations (45 C.F.R. § 164.524);
- to make PHI available for amendment and incorporate any amendments in accordance with the regulations (45 C.F.R. § 164.526);
- to make available the information required to provide an accounting of disclosures in accordance with the regulation (45 C.F.R. § 164.528);
- to make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of Health and Human Services for the purpose of determining compliance with the regulation by the Plan;
- to implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan;
- to ensure that the adequate separation required by the regulation (45 C.F.R. § 164.504(f)(2)(iii)) is established and supported by reasonable and appropriate security measures; and
- if feasible, to return or destroy all PHI received from the Plan that the Board still maintains in any form, and retain no copies, when no longer needed for the purpose for which the disclosure was made and, if not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

Disclosure to and use by others. PHI may be disclosed to and used by entities other than the Board of Trustees only pursuant to a “business associate” agreement assuring that the PHI will be used only for treatment, payment, or health care operations.

XV SUBROGATION AND REIMBURSEMENT RIGHTS

The Plan has the right to recover the full amount of benefit payments made to or on behalf of you or your Eligible Dependents (including your spouse and Eligible Dependent children) if:

- Some other party (“third party”) caused the injury, illness or condition for which Plan payments were made (for example, you are injured in a slip and fall accident and the Plan made payments for medical treatment you received arising from injuries you sustained in that accident); or
- An insurance carrier or self-insured party (“insurer”) including, but not limited to, an insurer that provides medical payments, uninsured or underinsured motor vehicle insurance or worker's compensation insurance, is responsible for making payments for the medical bills or wage replacement benefits that the Plan paid (for example, you slip and fall on a job site and the Plan made payments for wages you lost as a result of your fall).

The Plan's right to recover is called "subrogation". The Plan's subrogation rights also apply to your estate or your dependent's estate in the event that the estate receives or benefits from payments from the Plan. The Plan has the right to be "reimbursed" or paid back those monies paid to you or on your behalf.

The Plan's subrogation right allows the Plan or the Plan Administrator to take legal action in your name against the third party or insurer. If you (or your dependent) take legal action against the third party, the Plan or the Plan Administrator may, but has no duty to, intervene in that legal action.

The Plan's subrogation right becomes a lien on the proceeds of any claim against the third party or insurer for the full amount of Plan benefits paid. This means that the Plan has the right to receive, before you, the full amount of Plan benefits paid. This lien applies regardless of whether you assert the claim yourself (or as a co-claimant with others) or whether the Plan or the Plan Administrator asserts the claim in your name. This lien applies to the proceeds of any claim, regardless of whether the proceeds were recovered as a result of a lawsuit, settlement, compromise and release, or otherwise.

At the option of the Trustees, the Plan's lien will not be reduced by any costs involved in the recovery of the proceeds such as attorneys' or experts' fees, legal costs, or other out-of-pocket expenses. In addition, the Plan's lien will not be reduced by the failure of the recovery to make you (or your dependent) whole. For example, assume the Plan paid \$50,000 for medical services you received in connection with injuries you sustained as a result of a slip and fall in a store. You make a claim against the store for \$125,000. Your \$125,000 claim includes the

\$50,000 of medical expenses and \$75,000 for lost wages. You recover \$50,000. The Plan is entitled to the entire \$50,000 even though you did not recover the full amount of your claim.

If you (or your dependent) assert a claim against a third party or insurer on your own behalf (or as a co-claimant with others) and monies are recovered from the third party or insurer, it will be conclusively presumed that the recovery is subject to the Plan's subrogation right regardless of how the recovery is allocated among the claimants, and no matter whether the payments are characterized in the same manner as described in the Plan. For example, assume you filed a lawsuit against a third party who caused injuries to you in a slip and fall accident. The Plan made payments in the amount of \$75,000.00 for your medical bills. You settle with the third party for \$125,000. The manner in which the settlement is structured allocates \$75,000.00 of the settlement proceeds to lost wages, \$50,000 to your spouse for loss of consortium, and allocates nothing to medical expenses. The Plan has the right to be reimbursed for the \$75,000 of medical benefits paid despite the fact that the settlement allocated no amount to medical expenses.

If you (or your dependents) receive any recovery from a third party or insurer, you are obligated to immediately and fully reimburse the Plan from the proceeds to the full extent of the dollar amount of Plan benefits that are payable or paid. If the proceeds are less than the amount paid by the Plan, the Plan has the right to receive the entire amount of the proceeds.

If the Plan's reimbursement/subrogation rights are not satisfied at the time payment of the recovery is made by the third party, the party to which the payment is made shall hold all monies in constructive trust on behalf of the Plan to the extent of the Plan's rights. The Plan's rights to recover shall not be subject to the common fund doctrine and shall not be subject to any reduction for attorneys' fees, except as may be specifically agreed to by the Plan in writing. The Plan may recover from a party to whom benefits were paid either by receiving direct payment from the party or by offsetting the erroneous payment against any other benefits payable to the participant, dependent or other payee, or any of them, in the future.

The Plan specifically disavows any claims that the participant, dependent or other payee may make under any federal or state common law defense including, but not limited to, the make-whole doctrine, double-recovery doctrine and the common fund doctrine.

The Plan may appoint an agent for purposes of these subrogation and reimbursement rights.

By accepting benefits from the Plan, you and your dependents:

- Grant the Plan a lien on the proceeds of any payment, settlement or judgment that is secured relating to the injuries that caused such benefits to be provided.
- Agree to sign and deliver any documents necessary to secure the Plan's subrogation and reimbursement rights;
- Agree to notify the Plan promptly of a claim against or settlement with any third party or any insurer for benefits paid or that may be paid under the Plan;

- Will cooperate with the Plan with regard to and take no action to jeopardize the Plan's subrogation and reimbursement rights.

Overpayments or Mistaken Payments

In addition to, and without limiting those rights specified above under "Subrogation and Reimbursement Rights," the Plan has the right to recover from you, (or your dependent) any overpayments or mistaken benefit payments made to or on behalf of you (or your dependent), including but not limited to payment of such benefits pending approval or settlement of any workers' compensation benefits. The Plan Administrator may act as the Plan's agent for purposes of recovery of such over or mistaken payment.

If the Plan has made a payment to you or your Eligible Dependent, or on behalf of you or your Eligible Dependent to a provider of services, in an amount in excess of the amount due under the Plan, the Plan shall be entitled to recover such excess payment, including attorneys' fees expended in connection with such recovery, by proceeding directly against the payee for such amount or against any other applicable individuals to whom the benefits are payable under the Plan.

At the Plan Administrator's option, the Plan may also recoup such over or mistaken payments by: (1) reducing future payments due under the Plan to you (or your dependent) by the amount of such over or mistaken payment(s); and/or (2) by bringing a legal action to recover the over or mistaken payment(s).

If you divorce your spouse, the Contract Administrator **must** be notified immediately. If benefits are paid on behalf of your former spouse as a result of your failure to notify the Contract Administrator within sixty (60) days, you are responsible for repayment of any amount paid by the Plan. **FAILURE TO REPAY THE ERRONEOUS PAYMENTS FOR YOUR FORMER SPOUSE WILL RESULT IN TERMINATION OF YOUR ENTITLEMENT TO BENEFITS. ANY PARTICIPANT OR OTHER PERSON WHO ATTEMPTS TO SUBMIT FALSE, MISLEADING OR INCOMPLETE INFORMATION, OR WHO IN ANY WAY ATTEMPTS TO DEFRAUD THE PLAN, MAY BE PROSECUTED IN SUCH A MANNER AS THE BOARD OF TRUSTEES DEEMS ADVISABLE.**

APPENDIX A

Summary of Benefits Under PPOBlue High Option

As of June 1, 2022



IUPAT - High option – Groups numbers 11656-00,01,70

With your PPO, or Preferred Provider Organization, if you receive services from a provider who is in the PPO network, you'll receive the highest level of benefits. If you receive services from a provider who is not in the PPO network, you'll receive the lower level of benefits. In either case, you coordinate your own care. There is no requirement to select a Primary Care Provider (PCP) to coordinate your care. Below are specific benefit levels that apply during your benefit period.

Benefit	Network	Out-of-Network
Benefit Period (1)	Calendar Year	
Deductible (per benefit period)		
Individual	\$250	\$500
Family	\$500	\$1,000
Plan Payment Level – Based on the provider's reasonable charge (PRC)	80% after deductible	60% after deductible
Out-of-Pocket Maximums (Once met, plan payment level becomes 100%)		
Individual	\$1,500	\$3,000
Family	\$3,000	\$6,000
Total Maximum Out of Pocket (Includes deductible, prescription drug expenses and coinsurance, network only. Once met, plan pays 100% for the rest of the benefit period)		
Individual	\$1,750	Not Applicable
Family	\$3,500	
Lifetime Maximum (per person)	Unlimited	
Primary Care Provider Office Visits	100% after \$20 copayment	60% after deductible
Specialist Office Visits	100% after \$40 copayment	60% after deductible
Urgent Care Center Visits / Retail Clinic Visits	100% after \$50 copayment	60% after deductible
Telemedicine (7)	100% (no copayment)	Not Covered
Preventive Care (3)		
Routine Adult		
Physical exams	100% (deductible does not apply)	Not Covered
Adult immunizations	100% (deductible does not apply)	60% after deductible
Colorectal cancer screening	100% (deductible does not apply)	60% after deductible
Routine gynecological exams	100% (deductible does not apply)	60% (deductible does not apply)
Mammograms, annual routine and medically necessary	100% (deductible does not apply)	60% after deductible
Diagnostic services and procedures	100% (deductible does not apply)	60% after deductible
Routine Pediatric		
Physical exams	100% (deductible does not apply)	Not Covered
Pediatric immunizations	100% (deductible does not apply)	60% (deductible does not apply)
Diagnostic services and procedures	100% (deductible does not apply)	60% after deductible
Emergency Room Services	100% after \$100 copayment (waived if admitted)	
Spinal Manipulations	100% after \$40 copayment	60% after deductible
	Limit: 20 visits/benefit period	
Physical Medicine	100% after \$40 copayment	60% after deductible
	Limit: 20 visits/benefit period	
Speech Therapy	100% after \$40 copayment	60% after deductible
	Limit: 20 visits/benefit period	
Occupational Therapy	100% after \$40 copayment	60% after deductible
	Limit: 20 visits/benefit period	
Allergy Extracts and Injections	80% after deductible	60% after deductible

Benefit	Network	Out-of-Network
Ambulance (8)	80% after network deductible	
Applied Behavior Analysis for ASD (2)	80% after deductible	60% after deductible
Assisted Fertilization Procedures	Not Covered	
Dental Services Related to Accidental Injury	80% after deductible	60% after deductible
Diabetes Treatment	80% after deductible	60% after deductible
Diagnostic Services <i>Advanced Imaging</i> (MRI, CAT, PET scan, etc.)	80% after deductible	60% after deductible
<i>Basic Diagnostic Services</i> (standard imaging, diagnostic medical, lab/pathology, allergy testing)	80% after deductible	60% after deductible
Durable Medical Equipment, Orthotics and Prosthetics	80% after deductible	60% after deductible
Enteral Formulae	80% (deductible does not apply)	60% (deductible does not apply)
Home Infusion Therapy	80% after network deductible	
Home Health Care	80% after deductible	60% after deductible
Hospice	80% after deductible	60% after deductible
Hospital Services		
Inpatient	80% after deductible	60% after deductible
Outpatient	80% after deductible	60% after deductible
Infertility Counseling, Testing and Treatment (4)	80% after deductible	60% after deductible
Maternity (non-preventive facility & professional services)	80% after deductible	60% after deductible
Medical/Surgical Expenses (except office visits)	80% after deductible	60% after deductible
<i>Mental Health</i>		
Inpatient	80% after deductible	60% after deductible
Outpatient	100% after \$20 copayment	60% after deductible
Private Duty Nursing	80% after network deductible	
Respiratory Therapy	80% after network deductible	
Skilled Nursing Facility Care	80% after deductible	60% after deductible
Substance Abuse		
Inpatient Detoxification	80% after deductible	60% after deductible
Inpatient Rehabilitation	80% after deductible	60% after deductible
<i>Outpatient</i>	100% after \$20 copayment	60% after deductible
Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	80% after deductible	60% after deductible
Transplant Services	80% after deductible	60% after deductible
Precertification Requirements (5)	Yes	
Prescription Drug Deductible		
Individual	None	
Family	None	

Benefit	Network	Out-of-Network
<p>Premier Prescription Drug Program Mandatory Generic(6) <i>Defined by Premier Pharmacy Network - Not Physician Network. Prescriptions filled at a non-network pharmacy are not covered.</i></p>	<p>Retail Drugs 34-day Supply (Mandatory Generic) \$10 generic copayment \$20 brand copayment - formulary \$40 brand copayment – non-formulary Specialty Drugs – \$100 brand copayment</p> <p>Maintenance Drugs through Mail Order 90-day Supply (Mandatory Generic) \$20 generic copayment \$40 brand copayment - formulary \$80 brand copayment – non-formulary</p>	

- (1) Your group's benefit period is based on a Calendar Year which runs from January 1 to December 31.
- (2) Coverage for eligible members to age 21. Services will be paid according to the benefit category (e.g. speech therapy). Treatment for autism spectrum disorders does not reduce visit/day limits.
- (3) Services are limited to those listed on the Highmark Preventive Schedule. Gender, age and frequency limits may apply.
- (4) Treatment includes coverage for the correction of a physical or medical problem associated with infertility. Infertility drug therapy may or may not be covered depending on your group's prescription drug program.
- (5) Highmark Healthcare Management Services (HMS) must be contacted prior to a planned inpatient admission or within 48 hours of an emergency or maternity-related inpatient admission. Some facility providers will contact HMS and obtain precertification of the inpatient admission on your behalf. Be sure to verify that your provider is contacting HMS for precertification. If not, you are responsible for contacting HMS. If this does not occur and it is later determined that all or part of the inpatient stay was not medically necessary or appropriate, you will be responsible for payment of any costs not covered.
- (6) The member is responsible for the payment differential when a generic drug is authorized by the physician and the **patient** elects to purchase a brand drug. The member payment is the price difference between the brand drug and generic drug in addition to brand drug copayment or coinsurance amounts which may apply.
- (7) Services are provided for acute care for minor illnesses. Services must be performed by a Highmark approved telemedicine provider. Virtual Behavioral Health visits provided by a Highmark approved telemedicine provider are eligible under the Outpatient Mental Health/Substance abuse benefit
- (8) Medically necessary Air Ambulance services rendered by out-of-network providers will be covered at the highest network tier level of benefits.

APPENDIX B

Summary of Benefits Under PPOBlue Low Option

As of June 1, 2022



IUPAT - Low option - Group #'s 13164-00,01,70

With your PPO, or Preferred Provider Organization, if you receive services from a provider who is in the PPO network, you'll receive the highest level of benefits. If you receive services from a provider who is not in the PPO network, you'll receive the lower level of benefits. In either case, you coordinate your own care. There is no requirement to select a Primary Care Provider (PCP) to coordinate your care. Below are specific benefit levels that apply during your benefit period.

Benefit	Network	Out-of-Network
Benefit Period ⁽¹⁾	Calendar Year	
Deductible (per benefit period)		
Individual	\$1,000	\$2,000
Family	\$2,000	\$4,000
Plan Payment Level – Based on the provider's reasonable charge (PRC)	80% after deductible	60% after deductible
Out-of-Pocket Maximums (Once met, plan payment level becomes 100%)		
Individual	\$5,000	\$10,000
Family	\$10,000	\$20,000
Total Maximum Out of Pocket (Includes deductible, prescription drug expenses and coinsurance, network only. Once met, plan pays 100% for the rest of the benefit period)		
Individual	\$6,000	Not Applicable
Family	\$12,000	
Lifetime Maximum (per person)	Unlimited	
Primary Care Provider Office Visits	100% after \$20 copayment	60% after deductible
Specialist Office Visits	100% after \$40 copayment	60% after deductible
Urgent Care Center Visits / Retail Clinic Visits	100% after \$50 copayment	60% after deductible
Telemedicine ⁽⁷⁾	100% (no copayment)	Not Covered
Preventive Care ⁽³⁾		
Routine Adult		
Physical exams	100% (deductible does not apply)	Not Covered
Adult immunizations	100% (deductible does not apply)	60% after deductible
Colorectal cancer screening	100% (deductible does not apply)	60% after deductible
Routine gynecological exams	100% (deductible does not apply)	60% (deductible does not apply)
Mammograms, annual routine and medically necessary	100% (deductible does not apply)	60% after deductible
Diagnostic services and procedures	100% (deductible does not apply)	60% after deductible
Routine Pediatric		
Physical exams	100% (deductible does not apply)	Not Covered
Pediatric immunizations	100% (deductible does not apply)	60% (deductible does not apply)
Diagnostic services and procedures	100% (deductible does not apply)	60% after deductible
Emergency Room Services	100% after \$100 copayment (waived if admitted)	
Spinal Manipulations	100% after \$40 copayment	60% after deductible
	Limit: 20 visits/benefit period	
Physical Medicine	100% after \$40 copayment	60% after deductible
	Limit: 20 visits/benefit period	
Speech Therapy	100% after \$40 copayment	60% after deductible
	Limit: 20 visits/benefit period	
Occupational Therapy	100% after \$40 copayment	60% after deductible
	Limit: 20 visits/benefit period	
Allergy Extracts and Injections	80% after deductible	60% after deductible

Benefit	Network	Out-of-Network
Ambulance (8)	80% after network deductible	
Applied Behavior Analysis for ASD(2)	80% after deductible	60% after deductible
Assisted Fertilization Procedures	Not Covered	
Dental Services Related to Accidental Injury	80% after deductible	60% after deductible
Diabetes Treatment	80% after deductible	60% after deductible
Diagnostic Services		
<i>Advanced Imaging</i> (MRI, CAT, PET scan, etc.)	80% after deductible	60% after deductible
<i>Basic Diagnostic Services</i> (standard imaging, diagnostic medical, lab/pathology, allergy testing)	80% after deductible	60% after deductible
Durable Medical Equipment, Orthotics and Prosthetics	80% after deductible	60% after deductible
Enteral Formulae	80% (deductible does not apply)	60% (deductible does not apply)
Home Infusion Therapy	80% after network deductible	
Home Health Care	80% after deductible	60% after deductible
Hospice	80% after deductible	60% after deductible
Hospital Services		
Inpatient	80% after deductible	60% after deductible
Outpatient	80% after deductible	60% after deductible
Infertility Counseling, Testing and Treatment(4)	80% after deductible	60% after deductible
Maternity (non-preventive facility & professional services)	80% after deductible	60% after deductible
Medical/Surgical Expenses (except office visits)	80% after deductible	60% after deductible
<i>Mental Health</i>		
Inpatient	80% after deductible	60% after deductible
Outpatient	100% after \$20 copayment	60% after deductible
Private Duty Nursing	80% after network deductible	
Respiratory Therapy	80% after network deductible	
Skilled Nursing Facility Care	80% after deductible	60% after deductible
Substance Abuse		
Inpatient Detoxification	80% after deductible	60% after deductible
Inpatient Rehabilitation	80% after deductible	60% after deductible
<i>Outpatient</i>	100% after \$20 copayment	60% after deductible
Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	80% after deductible	60% after deductible
Transplant Services	80% after deductible	60% after deductible
Precertification Requirements(5)	Yes	
Prescription Drug Deductible		
Individual	None	
Family	None	

Benefit	Network	Out-of-Network
<p>Premier Prescription Drug Program Mandatory Generic(6) <i>Defined by Premier Pharmacy Network - Not Physician Network. Prescriptions filled at a non-network pharmacy are not covered.</i></p>		<p style="text-align: center;">Retail Drugs</p> <p style="text-align: center;">Generic \$10 copayment Brand Formulary 20% coinsurance \$20 minimum Brand Nonformulary 30% coinsurance \$40 minimum Specialty Drugs – \$100 brand copayment Mandatory Generic 34 day supply or 100 units whichever is greater Maintenance Drugs through Mail Order</p> <p style="text-align: center;">Generic \$20 copayment Brand Formulary 20% coinsurance \$40 minimum Brand Nonformulary 30% coinsurance \$80 minimum Mandatory Generic Up to 90-day supply</p>

- (1) Your group's benefit period is based on a Calendar Year which runs from January 1 to December 31.
- (2) Coverage for eligible members to age 21. Services will be paid according to the benefit category (e.g. speech therapy). Treatment for autism spectrum disorders does not reduce visit/day limits.
- (3) Services are limited to those listed on the Highmark Preventive Schedule. Gender, age and frequency limits may apply.
- (4) Treatment includes coverage for the correction of a physical or medical problem associated with infertility. Infertility drug therapy may or may not be covered depending on your group's prescription drug program.
- (5) Highmark Healthcare Management Services (HMS) must be contacted prior to a planned inpatient admission or within 48 hours of an emergency or maternity-related inpatient admission. Some facility providers will contact HMS and obtain precertification of the inpatient admission on your behalf. Be sure to verify that your provider is contacting HMS for precertification. If not, you are responsible for contacting HMS. If this does not occur and it is later determined that all or part of the inpatient stay was not medically necessary or appropriate, you will be responsible for payment of any costs not covered.
- (6) The formulary is an extensive list of Food & Drug Administration (FDA) approved prescription drugs selected for their quality, safety and effectiveness. It includes products in every major therapeutic category. The formulary was developed by the Highmark Pharmacy and Therapeutics Committee made up of clinical pharmacists and physicians. Your program includes coverage for both formulary and non-formulary drugs at the specific copayment or coinsurance amounts listed above. The member is responsible for the payment differential when a generic drug is authorized by the physician and the patient elects to purchase a brand drug. The member payment is the price difference between the brand drug and generic drug in addition to the brand drug copayment or coinsurance amounts, which may apply.
- (7) Services are provided for acute care for minor illnesses. Services must be performed by a Highmark approved telemedicine provider. Virtual Behavioral Health visits provided by a Highmark approved telemedicine provider are eligible under the Outpatient Mental Health/Substance abuse benefit.
- (8) Medically necessary Air Ambulance services rendered by out-of-network providers will be covered at the highest network tier level of benefits.

APPENDIX C

Summary of Benefits Under UPMC High Option

As of June 1, 2022

Schedule of Benefits

IUPAT Welfare Fund of Western Pennsylvania High Option
PPO - Premium Network
Deductible: \$250 / \$500
Coinsurance: 20%
Total Annual Out-of-Pocket: \$1,750 / \$3,500

Primary Care Provider: \$20 Copayment per visit

Specialist: \$40 Copayment per visit

Emergency Department: \$100 Copayment per visit

Urgent Care Facility: \$50 Copayment per visit

Rx: \$10/20/40/100

This Schedule of Benefits will be an important part of your Certificate of Coverage (COC) or your Summary Plan Description (SPD). If your plan has an SPD, it is issued by your employer or labor trust fund. It is not issued by UPMC Health Plan. It is important that you review and understand your COC and/or SPD because they describe in detail the services your plan covers. The Schedule of Benefits describes what you pay for those services.

For Covered Services to be paid at the level described in your Schedule of Benefits, they must be Medically Necessary.

They must also meet all other criteria described in

your COC and/or SPD. Criteria may include Prior Authorization requirements.

Please note that your plan may not cover all of your health care expenses, such as Copayments and Coinsurance. To understand what your plan covers, review your COC and/or SPD. You may also have Riders and Amendments that expand or restrict your benefits.

If you have any questions about your benefits, or would like to find a Participating Provider near you, visit www.upmchealthplan.com. You can also call UPMC Health Plan Member Services at the phone number on the back of your member ID card.

For more information on your plan, please refer to the final page of this document.

Plan Information	Participating Provider	Non-Participating Provider
Benefit Period	Plan Year	
Primary Care Provider (PCP) Required	Encouraged, but not required	
Prior Authorization Requirements	Provider Responsibility	Member Responsibility
		If you fail to obtain Prior Authorization for certain services, you may not be eligible for reimbursement under your plan. Please see additional information below.

Member Cost Sharing	Participating Provider	Non-Participating Provider
Annual Deductible		
Individual	\$250	\$500
Family	\$500	\$1,000

Member Cost Sharing	Participating Provider	Non-Participating Provider
<p>Your plan has an embedded Deductible, which means the plan pays for Covered Services in these two scenarios — whichever comes first:</p> <p>*When an individual family member reaches his or her individual Deductible. At this point, only that person is considered to have met the Deductible; OR</p> <p>*When a combination of family members' expenses reaches the family Deductible. At this point, all covered family members are considered to have met the Deductible.</p>		
<p>Deductible applies to all Covered Services you receive during the Benefit Period, unless the service is specifically excluded.</p>		
Coinsurance		
	You pay 20% after Deductible.	You pay 40% after Deductible.
Copayments may apply to certain Participating Provider services.		
Any covered services for which cost-sharing is not specified in the "Covered Services" table below will pay subject to the applicable Deductible and Coinsurance identified above.		
Annual Coinsurance Limit		
Individual	\$1,500	\$3,000
Family	\$3,000	\$6,000
<p>The Annual Coinsurance Limit is the maximum amount you will have to pay in Coinsurance before your benefits are covered without a Coinsurance cost share. Any amount paid in Coinsurance during the plan year will be applied towards the satisfaction of your plan's Total Annual Out-of-Pocket Limit.</p>		
Total Annual Out-of-Pocket Limit		
Individual	\$1,750	Not applicable
Family	\$3,500	Not applicable
<p>Your plan has an embedded Out-of-Pocket Limit, which means the Out-of-Pocket Limit is satisfied in one of two ways — whichever comes first:</p> <p>*When an individual within a family reaches his or her individual Out-of-Pocket Limit. At this point, only that person will have Covered Services paid at 100% for the remainder of the Benefit Period; OR</p> <p>*When a combination of family members' expenses reaches the family Out-of-Pocket Limit. At this point, all covered family members are considered to have met the Out-of-Pocket Limit and Covered Services will be paid at 100% for the remainder of the Benefit Period.</p>		
<p>Out-of-Pocket costs (Copayments, Coinsurance, and Deductibles) for Covered Services apply toward satisfaction of the Out-of-Pocket Limit specified in this Schedule of Benefits. NOTE: For Covered Services rendered by Non-Participating Providers, only Coinsurance applies toward this Limit.</p>		

Preventive Services	Participating Provider	Non-Participating Provider
<p>Preventive Services will be covered in compliance with requirements under the Affordable Care Act (ACA). Please refer to the Preventive Services Reference Guide for additional details.</p>		
Pediatric preventive/health screening examination	Covered at 100%; you pay \$0.	Not Covered
Pediatric immunizations	Covered at 100%; you pay \$0.	You pay 40%. Deductible does not apply.
Well-baby visits	Covered at 100%; you pay \$0.	Not Covered
Adult preventive/health screening examination	Covered at 100%; you pay \$0.	Not Covered
Adult immunizations required by the ACA to be covered at no cost-sharing	Covered at 100%; you pay \$0.	You pay 40% after Deductible.

Preventive Services	Participating Provider	Non-Participating Provider
Screening gynecological exam, including a Pap test	Covered at 100%; you pay \$0.	You pay 40%. Deductible does not apply.
Mammograms, annual routine and medically necessary	Covered at 100%; you pay \$0.	You pay 40% after Deductible.
Diagnostic services and procedures required by the ACA	Covered at 100%; you pay \$0.	You pay 40% after Deductible.

Covered Services	Participating Provider	Non-Participating Provider
Hospital Services		
Hospital inpatient	You pay 20% after Deductible.	You pay 40% after Deductible.
Outpatient/Ambulatory surgery	You pay 20% after Deductible.	You pay 40% after Deductible.
Observation stay	You pay 20% after Deductible.	You pay 40% after Deductible.
Maternity – hospital services associated with delivery	You pay 20% after Deductible.	You pay 40% after Deductible.
Emergency Services		
Emergency department	You pay \$100 Copayment per visit. Copayment waived if you are admitted to hospital.	
Emergency transportation	You pay 20% after Deductible.	
Surgical Services		
Surgical services (professional provider services)	You pay 20% after Deductible.	You pay 40% after Deductible.
Provider Medical Services		
Inpatient medical care visits, intensive medical care, consultation, and newborn care	Covered at 100%; you pay \$0.	You pay 40% after Deductible.
Adult immunizations not required to be covered by the ACA	You pay 20% after Deductible.	You pay 40% after Deductible.
Primary care provider office visit	You pay \$20 Copayment per visit.	You pay 40% after Deductible.
Specialist office visit	You pay \$40 Copayment per visit.	You pay 40% after Deductible.
Convenience care visit	You pay \$20 Copayment per visit.	You pay 40% after Deductible.
Urgent care facility	You pay \$50 Copayment per visit.	You pay 40% after Deductible.
Virtual Visits		
UPMC AnywhereCare – Virtual Urgent Care and Children’s AnywhereCare	Covered at 100%; you pay \$0.	You pay 40% after Deductible.
Virtual visit – Primary Care	You pay \$20 Copayment per visit.	You pay 40% after Deductible.
Virtual visit – Specialist	You pay \$40 Copayment per visit.	You pay 40% after Deductible.
Virtual visit – Behavioral Health	You pay \$20 Copayment per visit.	You pay 40% after Deductible.
UPMC MyHealth 24/7 Nurse Line		
If you would like to speak to a registered nurse about a specific health concern or when to seek treatment, call our UPMC MyHealth 24/7 Nurse Line at 1-866-918-1591 (TTY: 711) for care 365 days/year. You may also send an email for non-urgent issues using the web nurse request system at www.upmchealthplan.com and a nurse will respond within 24 hours.		
Allergy Services		
Treatment, injections, and serum	You pay 20% after Deductible.	You pay 40% after Deductible.
Diagnostic Services		
Advanced imaging (e.g., PET, MRI)	You pay 20% after Deductible.	You pay 40% after Deductible.

Covered Services	Participating Provider	Non-Participating Provider
Other imaging (e.g., x-ray, sonogram)	You pay 20% after Deductible.	You pay 40% after Deductible.
Laboratory services	You pay 20% after Deductible.	You pay 40% after Deductible.
Diagnostic testing	You pay 20% after Deductible.	You pay 40% after Deductible.
Rehabilitation/Habilitation Therapy Services		
Note: See the Behavioral Health Services section below for Rehabilitation/Habilitation Therapy services prescribed for the treatment of a Behavioral Health condition.		
Physical therapy	You pay \$40 Copayment per visit.	You pay 40% after Deductible.
	Covered up to 20 visits per Benefit Period.	
Occupational therapy	You pay \$40 Copayment per visit.	You pay 40% after Deductible.
	Covered up to 20 visits per Benefit Period.	
Speech therapy	You pay \$40 Copayment per visit.	You pay 40% after Deductible.
	Covered up to 20 visits per Benefit Period.	
Cardiac rehabilitation	You pay 20% after Deductible.	You pay 40% after Deductible.
	Covered up to 12 weeks per Benefit Period.	
Pulmonary rehabilitation	You pay \$40 Copayment per visit.	You pay 40% after Deductible.
	Covered up to 24 visits per Benefit Period.	
Medical Therapy Services		
Chemotherapy, radiation therapy, dialysis therapy	You pay 20% after Deductible.	You pay 40% after Deductible.
Injectable, infusion therapy, or other drugs administered or provided by a medical professional in an outpatient or office setting	You pay 20% after Deductible.	You pay 40% after Deductible.
Respiratory therapy	You pay 20% after Deductible.	
Pain Management		
Pain management program	You pay \$40 Copayment per visit.	You pay 40% after Deductible.
Mental Health and Substance Use Disorder Services		
Contact UPMC Health Plan Behavioral Health Services at 1-888-251-0083.		
Inpatient services (including inpatient hospital services, inpatient rehabilitation, detoxification, non-hospital residential treatment)	You pay 20% after Deductible.	You pay 40% after Deductible.
Office visits, including psychotherapy and counseling	You pay \$20 Copayment per visit.	You pay 40% after Deductible.
Outpatient services (includes intensive outpatient and partial hospitalization programs)	You pay 20% after Deductible.	You pay 40% after Deductible.
Laboratory services related to a Behavioral Health condition	You pay 20% after Deductible.	You pay 40% after Deductible.
Physical, occupational, or speech therapy related to a Behavioral Health condition	You pay \$20 Copayment per visit.	You pay 40% after Deductible.
	Visit limits do not apply.	

Covered Services	Participating Provider	Non-Participating Provider
Other Medical Services		
Refer to the Certificate of Coverage (COC) for specific Benefit Limitations that may apply to the services listed below.		
Applied behavior analysis for the treatment of Autism Spectrum Disorder	You pay 20% after Deductible.	You pay 40% after Deductible.
Corrective appliances	You pay 20% after Deductible.	You pay 40% after Deductible.
Dental services related to accidental injury	You pay 20% after Deductible.	You pay 40% after Deductible.
Durable medical equipment	You pay 20% after Deductible.	You pay 40% after Deductible.
Fertility testing	You pay 20% after Deductible.	You pay 40% after Deductible.
Home health care	You pay 20% after Deductible.	You pay 40% after Deductible.
Home infusion therapy	You pay 20% after Deductible.	
Hospice care	You pay 20% after Deductible.	You pay 40% after Deductible.
Medical nutrition therapy	You pay 20% after Deductible.	You pay 40% after Deductible.
Nutritional counseling	You pay 20% after Deductible.	You pay 40% after Deductible.
	Covered up to two visits per Benefit Period.	
Nutritional products	You pay 20%. Deductible does not apply.	You pay 40%. Deductible does not apply.
	Nutritional products for the treatment of PKU and related disorders are not subject to Deductible.	
Oral surgical services	You pay 20% after Deductible.	You pay 40% after Deductible.
Podiatry care	You pay \$20 Copayment per visit.	You pay 40% after Deductible.
Private duty nursing	You pay 20% after Deductible.	
Skilled nursing facility	You pay 20% after Deductible.	You pay 40% after Deductible.
Therapeutic manipulation	You pay \$40 Copayment per visit.	You pay 40% after Deductible.
	Covered up to 20 visits per Benefit Period.	
Diabetic Equipment, Supplies, and Education		
Diabetic equipment and supplies (NOTE: If you have prescription drug coverage through a program other than Express Scripts, Inc., that plan will pay for diabetic supplies and equipment first.)		
Glucometer, test strips, and lancets, insulin and syringes	Must be obtained at a Participating Pharmacy. See applicable pharmacy rider for coverage information.	
Diabetic education	You pay 20% after Deductible.	You pay 40% after Deductible.

Prescription Medication Coverage

For additional information on your pharmacy benefits, refer to your Prescription Medication Rider.

Tier names describe the most common type(s) of medication (such as brands and generics) within that tier.

The Your Choice pharmacy program will apply (mandatory generic).

Not subject to Plan Deductible

<p>Retail prescription medication</p> <ul style="list-style-type: none"> • Prescriptions must be dispensed by a participating pharmacy. • 34-day supply or 100 units, whichever is greater. 	<p>Tier 1: You pay \$10 Copayment for preferred generic medications.</p> <p>Tier 2: You pay \$20 Copayment for preferred brand medications.</p> <p>Tier 3: You pay \$40 Copayment for nonpreferred medications (brand and generic).</p> <p>Tier 5: You pay \$0 Copayment for preventive medications.</p>
<p>Specialty prescription medication</p> <ul style="list-style-type: none"> • Specialty medications are limited to a 34-day supply. See Prescription Medication Rider for additional information. • Most specialty medications must be filled at our contracted specialty pharmacy provider (list available upon request). 	<p>Tier 4: You pay \$100 Copayment for specialty medications (brand and generic).</p> <p>34-day maximum supply</p>
<p>Mail-order prescription medication</p> <ul style="list-style-type: none"> • A three-month supply (up to 90 days) of medication may be dispensed through the contracted mail-service pharmacy. 	<p>Tier 1: You pay \$20 Copayment for preferred generic medications.</p> <p>Tier 2: You pay \$40 Copayment for preferred brand medications.</p> <p>Tier 3: You pay \$80 Copayment for nonpreferred medications (brand and generic).</p> <p>Tier 5: You pay \$0 Copayment for preventive medications.</p> <p>90-day maximum mail-order supply</p>
<p>If a provider demonstrates that the brand-name medication is Medically Necessary and appropriate, you will pay only the nonpreferred brand-name medication Copayment.</p>	

Prior Authorization for out-of-network services

Certain out-of-network non-emergent care must be Prior Authorized in order to be eligible for reimbursement under your plan. This means you must contact UPMC Health Plan and obtain Prior Authorization before receiving services. A list of services that must be Prior Authorized is available 24/7 on our website at www.upmchealthplan.com. You can also contact Member Services by calling the phone number on the back of your member ID card. Your out-of-network provider may also access this list at www.upmchealthplan.com or your provider may call Provider Services at 1-866918-1595 to initiate the Prior Authorization process on your behalf. Regardless, you must confirm that Prior Authorization has been given in advance of your receiving services in order for those services to be eligible for reimbursement in accordance with your plan. Please note, the list of services that require Prior Authorization is subject to change throughout the year. You are responsible for verifying you have the most current information as of your date of service.

The capitalized words and phrases in this Schedule of Benefits mean the same as they do in your Certificate of

Coverage (COC). Also, the headings under the Covered Services section are the same as those in your COC.

At all times, UPMC Health Plan administers the coverage described in this document in full compliance with applicable laws and regulations. If any part of this Schedule of Benefits conflicts with any applicable law, regulation, or other controlling authority, the requirements of that authority will prevail.

Your plan documents will always include the Schedule of Benefits, the COC, and the Summary of Benefits and Coverage. You can log into *MyHealth OnLine* to view these documents. If you have questions, call Member Services.

UPMC Health Plan is the marketing name used to refer to the following companies, which are licensed to issue individual and group health insurance products or which provide third party administration services for group health plans: UPMC Health Network Inc., UPMC Health Options Inc., UPMC Health Coverage Inc., UPMC Health Plan Inc., UPMC Health Benefits Inc., UPMC *for You* Inc., Community Care Behavioral Health Organization, and/or UPMC Benefit Management Services Inc.

UPMC Health Plan
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Grant Street
Pittsburgh, PA 15219

www.upmchealthplan.com

APPENDIX D

Summary of Benefits Under UPMC Low Option

As of June 1, 2022

Schedule of Benefits

IUPAT Welfare Fund of Western Pennsylvania Low Option Primary Care Provider: \$20 Copayment per visit	Specialist: \$40 Copayment per visit
PPO - Premium Network	Emergency Department: \$100 Copayment per visit
Deductible: \$1,000 / \$2,000	Urgent Care Facility: \$50 Copayment per visit
Coinsurance: 20%	Rx: \$10/20/40/100
Total Annual Out-of-Pocket: \$6,000 / \$12,000	

This Schedule of Benefits will be an important part of your Certificate of Coverage (COC) or your Summary Plan Description (SPD). If your plan has an SPD, it is issued by your employer or labor trust fund. It is not issued by UPMC Health Plan. It is important that you review and understand your COC and/or SPD because they describe in detail the services your plan covers. The Schedule of Benefits describes what you pay for those services.

For Covered Services to be paid at the level described in your Schedule of Benefits, they must be Medically Necessary.

They must also meet all other criteria described in

your COC and/or SPD. Criteria may include Prior Authorization requirements.

Please note that your plan may not cover all of your health care expenses, such as Copayments and Coinsurance. To understand what your plan covers, review your COC and/or SPD. You may also have Riders and Amendments that expand or restrict your benefits.

If you have any questions about your benefits, or would like to find a Participating Provider near you, visit www.upmchealthplan.com. You can also call UPMC Health Plan Member Services at the phone number on the back of your member ID card.

For more information on your plan, please refer to the final page of this document.

Plan Information	Participating Provider	Non-Participating Provider
Benefit Period	Plan Year	
Primary Care Provider (PCP) Required	Encouraged, but not required	
Prior Authorization Requirements	Provider Responsibility	Member Responsibility
		If you fail to obtain Prior Authorization for certain services, you may not be eligible for reimbursement under your plan. Please see additional information below.

Member Cost Sharing	Participating Provider	Non-Participating Provider
Annual Deductible		
Individual	\$1,000	\$2,000
Family	\$2,000	\$4,000

Member Cost Sharing	Participating Provider	Non-Participating Provider
Your plan has an embedded Deductible, which means the plan pays for Covered Services in these two scenarios — whichever comes first:		
*When an individual family member reaches his or her individual Deductible. At this point, only that person is considered to have met the Deductible; OR		
*When a combination of family members' expenses reaches the family Deductible. At this point, all covered family members are considered to have met the Deductible.		
Deductible applies to all Covered Services you receive during the Benefit Period, unless the service is specifically excluded.		
Coinsurance		
	You pay 20% after Deductible.	You pay 40% after Deductible.
Copayments may apply to certain Participating Provider services.		
Any covered services for which cost-sharing is not specified in the "Covered Services" table below will pay subject to the applicable Deductible and Coinsurance identified above.		
Annual Coinsurance Limit		
Individual	\$5,000	\$10,000
Family	\$10,000	\$20,000
The Annual Coinsurance Limit is the maximum amount you will have to pay in Coinsurance before your benefits are covered without a Coinsurance cost share. Any amount paid in Coinsurance during the plan year will be applied towards the satisfaction of your plan's Total Annual Out-of-Pocket Limit.		
Total Annual Out-of-Pocket Limit		
Individual	\$6,000	Not applicable
Family	\$12,000	Not applicable
Your plan has an embedded Out-of-Pocket Limit, which means the Out-of-Pocket Limit is satisfied in one of two ways — whichever comes first:		
*When an individual within a family reaches his or her individual Out-of-Pocket Limit. At this point, only that person will have Covered Services paid at 100% for the remainder of the Benefit Period; OR		
*When a combination of family members' expenses reaches the family Out-of-Pocket Limit. At this point, all covered family members are considered to have met the Out-of-Pocket Limit and Covered Services will be paid at 100% for the remainder of the Benefit Period.		
Out-of-Pocket costs (Copayments, Coinsurance, and Deductibles) for Covered Services apply toward satisfaction of the Out-of-Pocket Limit specified in this Schedule of Benefits. NOTE: For Covered Services rendered by Non-Participating Providers, only Coinsurance applies toward this Limit.		

Preventive Services	Participating Provider	Non-Participating Provider
Preventive Services will be covered in compliance with requirements under the Affordable Care Act (ACA). Please refer to the Preventive Services Reference Guide for additional details.		
Pediatric preventive/health screening examination	Covered at 100%; you pay \$0.	Not Covered
Pediatric immunizations	Covered at 100%; you pay \$0.	You pay 40%. Deductible does not apply.
Well-baby visits	Covered at 100%; you pay \$0.	Not Covered
Adult preventive/health screening examination	Covered at 100%; you pay \$0.	Not Covered
Adult immunizations required by the ACA to be covered at no cost-sharing	Covered at 100%; you pay \$0.	You pay 40% after Deductible.

Preventive Services	Participating Provider	Non-Participating Provider
Screening gynecological exam, including a Pap test	Covered at 100%; you pay \$0.	You pay 40%. Deductible does not apply.
Mammograms, annual routine and medically necessary	Covered at 100%; you pay \$0.	You pay 40% after Deductible.
Diagnostic services and procedures required by the ACA	Covered at 100%; you pay \$0.	You pay 40% after Deductible.

Covered Services	Participating Provider	Non-Participating Provider
Hospital Services		
Hospital inpatient	You pay 20% after Deductible.	You pay 40% after Deductible.
Outpatient/Ambulatory surgery	You pay 20% after Deductible.	You pay 40% after Deductible.
Observation stay	You pay 20% after Deductible.	You pay 40% after Deductible.
Maternity – hospital services associated with delivery	You pay 20% after Deductible.	You pay 40% after Deductible.
Emergency Services		
Emergency department	You pay \$100 Copayment per visit. Copayment waived if you are admitted to hospital.	
Emergency transportation	You pay 20% after Deductible.	
Surgical Services		
Surgical services (professional provider services)	You pay 20% after Deductible.	You pay 40% after Deductible.
Provider Medical Services		
Inpatient medical care visits, intensive medical care, consultation, and newborn care	Covered at 100%; you pay \$0.	You pay 40% after Deductible.
Adult immunizations not required to be covered by the ACA	You pay 20% after Deductible.	You pay 40% after Deductible.
Primary care provider office visit	You pay \$20 Copayment per visit.	You pay 40% after Deductible.
Specialist office visit	You pay \$40 Copayment per visit.	You pay 40% after Deductible.
Convenience care visit	You pay \$20 Copayment per visit.	You pay 40% after Deductible.
Urgent care facility	You pay \$50 Copayment per visit.	You pay 40% after Deductible.
Virtual Visits		
UPMC AnywhereCare – Virtual Urgent Care and Children’s AnywhereCare	Covered at 100%; you pay \$0.	You pay 40% after Deductible.
Virtual visit – Primary Care	You pay \$20 Copayment per visit.	You pay 40% after Deductible.
Virtual visit – Specialist	You pay \$40 Copayment per visit.	You pay 40% after Deductible.
Virtual visit – Behavioral Health	You pay \$20 Copayment per visit.	You pay 40% after Deductible.
UPMC MyHealth 24/7 Nurse Line		
If you would like to speak to a registered nurse about a specific health concern or when to seek treatment, call our UPMC MyHealth 24/7 Nurse Line at 1-866-918-1591 (TTY: 711) for care 365 days/year. You may also send an email for non-urgent issues using the web nurse request system at www.upmchealthplan.com and a nurse will respond within 24 hours.		
Allergy Services		
Treatment, injections, and serum	You pay 20% after Deductible.	You pay 40% after Deductible.
Diagnostic Services		
Advanced imaging (e.g., PET, MRI)	You pay 20% after Deductible.	You pay 40% after Deductible.

Covered Services	Participating Provider	Non-Participating Provider
Other imaging (e.g., x-ray, sonogram)	You pay 20% after Deductible.	You pay 40% after Deductible.
Laboratory services	You pay 20% after Deductible.	You pay 40% after Deductible.
Diagnostic testing	You pay 20% after Deductible.	You pay 40% after Deductible.
Rehabilitation/Habilitation Therapy Services		
Note: See the Behavioral Health Services section below for Rehabilitation/Habilitation Therapy services prescribed for the treatment of a Behavioral Health condition.		
Physical therapy	You pay \$40 Copayment per visit.	You pay 40% after Deductible.
	Covered up to 20 visits per Benefit Period.	
Occupational therapy	You pay \$40 Copayment per visit.	You pay 40% after Deductible.
	Covered up to 20 visits per Benefit Period.	
Speech therapy	You pay \$40 Copayment per visit.	You pay 40% after Deductible.
	Covered up to 20 visits per Benefit Period.	
Cardiac rehabilitation	You pay 20% after Deductible.	You pay 40% after Deductible.
	Covered up to 12 weeks per Benefit Period.	
Pulmonary rehabilitation	You pay \$40 Copayment per visit.	You pay 40% after Deductible.
	Covered up to 24 visits per Benefit Period.	
Medical Therapy Services		
Chemotherapy, radiation therapy, dialysis therapy	You pay 20% after Deductible.	You pay 40% after Deductible.
Injectable, infusion therapy, or other drugs administered or provided by a medical professional in an outpatient or office setting	You pay 20% after Deductible.	You pay 40% after Deductible.
Respiratory therapy	You pay 20% after Deductible.	
Pain Management		
Pain management program	You pay \$40 Copayment per visit.	You pay 40% after Deductible.
Mental Health and Substance Use Disorder Services		
Contact UPMC Health Plan Behavioral Health Services at 1-888-251-0083.		
Inpatient services (including inpatient hospital services, inpatient rehabilitation, detoxification, non-hospital residential treatment)	You pay 20% after Deductible.	You pay 40% after Deductible.
Office visits, including psychotherapy and counseling	You pay \$20 Copayment per visit.	You pay 40% after Deductible.
Outpatient services (includes intensive outpatient and partial hospitalization programs)	You pay 20% after Deductible.	You pay 40% after Deductible.
Laboratory services related to a Behavioral Health condition	You pay 20% after Deductible.	You pay 40% after Deductible.
Physical, occupational, or speech therapy related to a Behavioral Health condition	You pay \$20 Copayment per visit.	You pay 40% after Deductible.
	Visit limits do not apply.	

Covered Services	Participating Provider	Non-Participating Provider
Other Medical Services		
Refer to the Certificate of Coverage (COC) for specific Benefit Limitations that may apply to the services listed below.		
Applied behavior analysis for the treatment of Autism Spectrum Disorder	You pay 20% after Deductible.	You pay 40% after Deductible.
Corrective appliances	You pay 20% after Deductible.	You pay 40% after Deductible.
Dental services related to accidental injury	You pay 20% after Deductible.	You pay 40% after Deductible.
Durable medical equipment	You pay 20% after Deductible.	You pay 40% after Deductible.
Fertility testing	You pay 20% after Deductible.	You pay 40% after Deductible.
Home health care	You pay 20% after Deductible.	You pay 40% after Deductible.
Home infusion therapy	You pay 20% after Deductible.	
Hospice care	You pay 20% after Deductible.	You pay 40% after Deductible.
Medical nutrition therapy	You pay 20% after Deductible.	You pay 40% after Deductible.
Nutritional counseling	You pay 20% after Deductible.	You pay 40% after Deductible.
	Covered up to two visits per Benefit Period.	
Nutritional products	You pay 20%. Deductible does not apply.	You pay 40%. Deductible does not apply.
	Nutritional products for the treatment of PKU and related disorders are not subject to Deductible.	
Oral surgical services	You pay 20% after Deductible.	You pay 40% after Deductible.
Podiatry care	You pay \$20 Copayment per visit.	You pay 40% after Deductible.
Private duty nursing	You pay 20% after Deductible.	
Skilled nursing facility	You pay 20% after Deductible.	You pay 40% after Deductible.
Therapeutic manipulation	You pay \$40 Copayment per visit.	You pay 40% after Deductible.
	Covered up to 20 visits per Benefit Period.	
Diabetic Equipment, Supplies, and Education		
Diabetic equipment and supplies (NOTE: If you have prescription drug coverage through a program other than Express Scripts, Inc., that plan will pay for diabetic supplies and equipment first.)		
Glucometer, test strips, and lancets, insulin and syringes	Must be obtained at a Participating Pharmacy. See applicable pharmacy rider for coverage information.	
Diabetic education	You pay 20% after Deductible.	You pay 40% after Deductible.

Prescription Medication Coverage

For additional information on your pharmacy benefits, refer to your Prescription Medication Rider.

Tier names describe the most common type(s) of medication (such as brands and generics) within that tier.

The Your Choice pharmacy program will apply (mandatory generic).

Not subject to Plan Deductible

<p>Retail prescription medication</p> <ul style="list-style-type: none"> • Prescriptions must be dispensed by a participating pharmacy. • 34-day supply or 100 units, whichever is greater. 	<p>Tier 1: You pay \$10 Copayment for preferred generic medications.</p> <p>Tier 2: You pay \$20 Copayment for preferred brand medications.</p> <p>Tier 3: You pay \$40 Copayment for nonpreferred medications (brand and generic).</p> <p>Tier 5: You pay \$0 Copayment for preventive medications.</p>
<p>Specialty prescription medication</p> <ul style="list-style-type: none"> • Specialty medications are limited to a 34-day supply. See Prescription Medication Rider for additional information. • Most specialty medications must be filled at our contracted specialty pharmacy provider (list available upon request). 	<p>Tier 4: You pay \$100 Copayment for specialty medications (brand and generic).</p> <p>34-day maximum supply</p>
<p>Mail-order prescription medication</p> <ul style="list-style-type: none"> • A three-month supply (up to 90 days) of medication may be dispensed through the contracted mail-service pharmacy. 	<p>Tier 1: You pay \$20 Copayment for preferred generic medications.</p> <p>Tier 2: You pay \$40 Copayment for preferred brand medications.</p> <p>Tier 3: You pay \$80 Copayment for nonpreferred medications (brand and generic).</p> <p>Tier 5: You pay \$0 Copayment for preventive medications.</p> <p>90-day maximum mail-order supply</p>
<p>If a provider demonstrates that the brand-name medication is Medically Necessary and appropriate, you will pay only the nonpreferred brand-name medication Copayment.</p>	

Prior Authorization for out-of-network services

Certain out-of-network non-emergent care must be Prior Authorized in order to be eligible for reimbursement under your plan. This means you must contact UPMC Health Plan and obtain Prior Authorization before receiving services. A list of services that must be Prior Authorized is available 24/7 on our website at www.upmchealthplan.com. You can also contact Member Services by calling the phone number on the back of your member ID card. Your out-of-network provider may also access this list at www.upmchealthplan.com or your provider may call Provider Services at 1-866918-1595 to initiate the Prior Authorization process on your behalf. Regardless, you must confirm that Prior Authorization has been given in advance of your receiving services in order for those services to be eligible for reimbursement in accordance with your plan. Please note, the list of services that require Prior Authorization is subject to change throughout the year. You are responsible for verifying you have the most current information as of your date of service.

The capitalized words and phrases in this Schedule of Benefits mean the same as they do in your Certificate of

Coverage (COC). Also, the headings under the Covered Services section are the same as those in your COC.

At all times, UPMC Health Plan administers the coverage described in this document in full compliance with applicable laws and regulations. If any part of this Schedule of Benefits conflicts with any applicable law, regulation, or other controlling authority, the requirements of that authority will prevail.

Your plan documents will always include the Schedule of Benefits, the COC, and the Summary of Benefits and Coverage. You can log into *MyHealth OnLine* to view these documents. If you have questions, call Member Services.

UPMC Health Plan is the marketing name used to refer to the following companies, which are licensed to issue individual and group health insurance products or which provide third party administration services for group health plans: UPMC Health Network Inc., UPMC Health Options Inc., UPMC Health Coverage Inc., UPMC Health Plan Inc., UPMC Health Benefits Inc., UPMC *for You* Inc., Community Care Behavioral Health Organization, and/or UPMC Benefit Management Services Inc.

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