OHIO CONFERENCE OF PLASTERERS AND

CEMENT MASONS HEALTH AND

WELFARE PLAN

AND

SUMMARY PLAN DESCRIPTION

IMPORTANT NOTICE: This booklet is the Plan in effect as of May 1, 2020. From time to time, you will receive supplemental bulletins and summaries about changes to this Plan.

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OHIO CONFERENCE OF PLASTERERS & CEMENT MASONS
HEALTH & WELFARE FUND

INFORMATION ABOUT THE PLAN

BOARD OF TRUSTEES

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PLAN SPONSOR/ADMINISTRATOR

BOARD OF TRUSTEES
OHIO CONFERENCE OF PLASTERERS & CEMENT MASONS
HEALTH & WELFARE FUND

ADMINISTRATIVE MANAGER / THIRD PARTY ADMINISTRATOR

BeneSys, Inc.
33 Fitch Blvd.
Austintown, Ohio 44515
(330) 779-8860

FUND COUNSEL

Allotta | Farley Co., L.P.A.
2222 Centennial Road
Toledo, OH 43617
(419) 535-0075

PLAN YEAR

May 1 – April 30

To all Participants and Beneficiaries:

This Summary Plan Description ("SPD") has been prepared to provide you with details of the coverage through the Ohio Conference of Plasterers & Cement Masons Health & Welfare Fund (the "Fund"), how you qualify for benefits, and under what circumstances you may not be eligible. This SPD also tells you how to file a claim for benefits and what action you can take if you are denied benefits.

This SPD is a summary. This booklet summarizes the most important features of the Health & Welfare Fund. No general explanation can adequately give you all the details of your Plan.

Only the Board of Trustees of the Fund has the authority to answer questions about eligibility and benefits provided through the Fund or to interpret the Rules and Regulations. No Union or management representative, individual Trustee, Union business manager, or other individual has the authority to answer questions or make decisions concerning the provisions of the Plan unless such individual has been given that authority by the Trustees and is acting on their behalf.

The Trustees have delegated the routine day to day administration of the Fund to the Third-Party Administrator and the Administrative Manager. Any questions regarding benefits or any other matters relating to claims processing should be directed to the appropriate Claims Payor. Any questions regarding eligibility or any other matters related to the Fund should be directed to the Administrative Manager, Ohio Conference of Plasterers & Cement Masons Health & Welfare Fund, 33 Fitch Blvd., Austintown, Ohio 44515.

This Plan believes it is a "grandfathered health plan" under the Patient Protection and Affordable Health Care Act (Act) of 2010. As permitted by the Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Administrator at 33 Fitch Blvd., Austintown, Ohio 44515, Phone: (330) 779-8860. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

Please read this booklet carefully so that you will know the benefits to which you and the members of your family are entitled. We suggest you put this booklet in a safe place along with other valuable papers. You will receive benefit updates and other changes to the Plan periodically. You need to insert those notices into this booklet in order to maintain a complete and current list of your benefits and requirements.

When you first become eligible for benefits, you should receive an enrollment package which includes a Summary of Benefit Coverage and forms for you to complete and return to the Administrative Manager. These enrollment forms are vital to the proper administration of your claims for benefits under this Plan. You must provide the Administrative Manager with an updated Enrollment Form whenever you change your address, acquire a new dependent, or lose a dependent through death, divorce, the dependent's reaching age 26, or otherwise.

Sincerely,
BOARD OF TRUSTEES

SCHEDULE OF BENEFITS FOR ELIGIBLE CLASS I ACTIVE PARTICIPANTS AND DEPENDENTS

BENEFITS	HIGH PLAN		MID PLAN		LOW PLAN	
MEDICAL BENEFITS	**IN-NETWORK**	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**
Annual Deductibles	$350/person	$700/person	$500/person	$1,000/person	$1,000/person	$2,000/person
	$700/family	$1,400/family	$1,000/family	$2,000/family	$2,000/family	$4,000/family
Out-of-Pocket Maximums (Includes deductibles)	$1,750/person $3,500/family	$3,500/person $7,000/family	$3,000/person $6,000/family	$6,000/person $12,000/family	$5,000/person $10,000/family	$10,000/person $20,000/family
BENEFIT %						
Physician's Office						
Visits for Illness/Injury	100% after $20 Copay	60% Allowed Amount**	80%*	60% Allowed Amount**	100% after $30 Copay	50% Allowed Amount**
Allergy Testing/Treatment	80%*	60% Allowed Amount**	80%*	60% Allowed Amount**	70%*	50% Allowed Amount**
Occupational/ Physical/ Speech/ Respiratory	80%*	60% Allowed Amount**	80%*	60% Allowed Amount**	70%*	50% Allowed Amount**
Diagnostic Lab/X-Ray	80%*	60% Allowed Amount**	80%*	60% Allowed Amount**	70%*	50% Allowed Amount**
Surgery (All Related Expenses)	80%*	60% Allowed Amount**	80%*	60% Allowed Amount**	70%*	50% Allowed Amount**
COVID-19 Testing	Covered at 100%					
Preventive Care – In Network Services described below are not subject to the deductible[1]						
Preventive Services in accordance with federal law (Please refer to "Routine, Preventive, and Wellness Service" in the SPD for more information)[2]	100%*	60% Allowed Amount**	100%*	60% Allowed Amount**	100%*	50% Allowed Amount**
Routine Colonoscopy and Sigmoidoscopy	100%*	60% Allowed Amount**	100%*	60% Allowed Amount**	100%*	50% Allowed Amount**
Routine Laboratory Tests, X-Rays, and Medical Testing Services	100%*	60% Allowed Amount**	100%*	60% Allowed Amount**	100%*	50% Allowed Amount**
Routine Mammograms	100%*	60% Allowed Amount**	100%*	60% Allowed Amount**	100%*	50% Allowed Amount**
Routine Pap Tests	100%*	60% Allowed Amount**	100%*	60% Allowed Amount**	100%*	50% Allowed Amount**
Routine Physical Exams (age 21 and over)	100%	60% of Allowed Amount**	100%	60% of Allowed Amount**	100%	50% of Allowed Amount**
Well Child Care Services	100%	60% of Allowed Amount**	100%	60% of Allowed Amount**	100%	50% of Allowed Amount**

[1] Out-of-Network services are subject to the out-of-network deductible.

[2] Preventive services include evidence based services that have a rating of "A" or "B" in the U.S. Preventive Services Task Force, routine immunizations, and other screenings as provided for in the Patient Protection and Affordable Care Act.

BENEFITS	HIGH PLAN		MID PLAN		LOW PLAN	
MEDICAL BENEFITS	**IN-NETWORK**	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**
Care in Hospital						
Semi-Private Room	80%*	60% Allowed Amount**	80%*	60% Allowed Amount**	70%*	50% Allowed Amount**
Surgery	80%*	60% Allowed Amount**	80%*	60% Allowed Amount**	70%*	50% Allowed Amount**
Anesthesia	80%*	60% Allowed Amount**	80%*	60% Allowed Amount**	70%*	50% Allowed Amount**
Assistant Surgeon	80%*	60% Allowed Amount**	80%*	60% Allowed Amount**	70%*	50% Allowed Amount**
In-Hospital Physician	80%*	60% Allowed Amount**	80%*	60% Allowed Amount**	70%*	50% Allowed Amount**
Diagnostic Lab/ X-Ray	80%*	60% Allowed Amount**	80%*	60% Allowed Amount**	70%*	50% Allowed Amount**
Respiratory Therapy	80%*	60% Allowed Amount**	80%*	60% Allowed Amount**	70%*	50% Allowed Amount**
Acute Kidney Dialysis	80%*	60% Allowed Amount**	80%*	60% Allowed Amount**	70%*	50% Allowed Amount**
Maternity Care (Employee and/or Spouse only)	80%*	60% Allowed Amount**	80%*	60% Allowed Amount**	70%*	50% Allowed Amount**
Organ Transplant Benefits	80%*	60% Allowed Amount**	80%*	60% Allowed Amount**	70%*	50% Allowed Amount**
Outpatient Care						
Pre-Admission Testing	80%*	60% Allowed Amount**	80%*	60% Allowed Amount**	70%*	50% Allowed Amount**
Surgery (All Related Expenses)	80%*	60% Allowed Amount**	80%*	60% Allowed Amount**	70%*	50% Allowed Amount**
Diagnostic Lab/X-Ray	80%*	60% Allowed Amount**	80%*	60% Allowed Amount**	70%*	50% Allowed Amount**
Emergency Care[3]	80%*	60% Allowed Amount**[3]	80%*	60% Allowed Amount**	70%*	50% Allowed Amount**
Physical/ Occupational Therapy/ Chiropractic/ Speech (Chiropractic limited to 12 visits per calendar year per person/family)	80%*	60% Allowed Amount**	80%*	60% Allowed Amount**	70%*	50% Allowed Amount**
Acute Kidney Dialysis	80%*	60% Allowed Amount**	80%*	60% Allowed Amount**	70%*	50% Allowed Amount**
Second Surgical Opinion	80%*	60% Allowed Amount**	80%*	60% Allowed Amount**	70%*	50% Allowed Amount**
Mental Health						
Inpatient Care/ Outpatient Treatment	80%*	60% Allowed Amount**	80%*	60% Allowed Amount**	70%*	50% Allowed Amount**

3 If you or your dependents receive ER treatment at an out-of-network facility for a medical emergency, that claim will be treated as an in-network claim for the purposes of both your deductible and co-insurance charges.

BENEFITS	HIGH PLAN		MID PLAN		LOW PLAN	
MEDICAL BENEFITS	**IN-NETWORK**	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**
Alcohol/Substance Abuse						
Inpatient Care	80%*	60% Allowed Amount**	80%*	60% Allowed Amount**	70%*	50% Allowed Amount**
Outpatient Treatment	80%*	60% Allowed Amount**	80%*	60% Allowed Amount**	70%*	50% Allowed Amount**
Other Services						
Skilled Nursing Facility	80%*	60% Allowed Amount**	80%*	60% Allowed Amount**	70%*	50% Allowed Amount**
Private Duty Nursing	80%*	60% Allowed Amount**	80%*	60% Allowed Amount**	70%*	50% Allowed Amount**
Home Health Care (40 visits per calendar year)	80%*	60% Allowed Amount**	80%*	60% Allowed Amount**	70%*	50% Allowed Amount**
Hospice Care	80%*	60% Allowed Amount**	80%*	60% Allowed Amount**	70%*	50% Allowed Amount**
Durable Medical Equipment	80%*	60% Allowed Amount**	80%*	60% Allowed Amount**	70%*	50% Allowed Amount**
Ambulance	80%*	60% Allowed Amount**	80%*	60% Allowed Amount**	70%*	50% Allowed Amount**

Prescription Benefits			
Retail (34 Day Supply) Mail Order (90 Day Supply)	80%	80%	70%
Death Benefit	$5,000	$5,000	$5,000
AD&D			
Loss of Life	$5,000	$5,000	$5,000
Loss of 2 Limbs, Sight of Both Eyes, 1L/1E	$5,000	$5,000	$5,000
Loss of 1 Limb or Sight of One Eye	$2,500	$2,500	$2,500
Short Term Disability	$30 per week for work-related injury, up to 26 weeks $300 per week, up to 26 weeks, for non-work related injury	$30 per week for work-related injury, up to 26 weeks $300 per week, up to 26 weeks, for non-work related injury	$30 per week for work-related injury, up to 26 weeks $300 per week, up to 26 weeks, for non-work related injury
Dental/Vision Combined	Not Available	Not Available	Not Available

* After satisfaction of In-Network Deductible

** After satisfaction of Out-of-Network Deductible

Helpful Tip: Even if you choose an in-network facility (e.g., a hospital or surgical facility), some of the providers may be out-of-network. For example, even though a hospital may be in-network, the doctors, anesthesiologists, or radiologists may be out-of-network. Therefore, you should always review your Explanation of Benefits ("EOB"). If your EOB shows out-of-network charges even though you received services at an in-network facility, please contact the Fund Office.

SCHEDULE OF BENEFITS FOR ELIGIBLE CLASS II, CLASS III AND EARLY RETIREES AND DEPENDENTS

BENEFITS		
MEDICAL BENEFITS	**IN-NETWORK**	**OUT-OF-NETWORK**
Annual Deductibles	$500/person	$1,000/person
	$1,000/family	$2,000/family
Out-of-Pocket Maximums (Includes deductibles)	$3,000/person $6,000/family	$6,000/person $12,000/family
BENEFIT %		
Physician's Office		
Visits for Illness/Injury	80%*	60% Allowed Amount**
Allergy Testing/ Treatment	80%*	60% Allowed Amount**
Occupational/ Physical/ Speech/ Respiratory	80%*	60% Allowed Amount**
Diagnostic Lab/X-Ray	80%*	60% Allowed Amount**
Surgery (All Related Expenses)	80%*	60% Allowed Amount**
Preventive Care – In-Network Services described below are not subject to the deductible		
Preventive Services in accordance with federal law (Please refer to "Routine, Preventive, and Wellness Service" in this SPD for more information)[4]	100%	60% Allowed Amount**
Routine Colonoscopy and Sigmoidoscopy	100%	60% Allowed Amount**
Routine Laboratory Tests, X-Rays, and Medical Testing Services	100%	60% Allowed Amount**
Routine Mammograms	100%	60% Allowed Amount**
Routine Mammograms	100%	60% of Allowed Amount**
Routine Pap Test	100%	60% of Allowed Amount**
Routine Physical Exams (age 21 and older)	100%	60% of Allowed Amount**
Well Child Care Services	100%	60% of Allowed Amount**

4 Preventive services include evidence-based services that have a rating of "A" or "B" in the U.S. Preventive Services Task Force, routine immunizations, and other screenings, as provided for in the Patient Protection and Affordable Care Act

BENEFITS		
MEDICAL BENEFITS	**IN-NETWORK**	**OUT-OF-NETWORK**
Care in Hospital		
Semi-Private Room	80%*	60% Allowed Amount**
Surgery	80%*	60% Allowed Amount**
Anesthesia	80%*	60% Allowed Amount**
Assistant Surgeon	80%*	60% Allowed Amount**
In-Hospital Physician	80%*	60% Allowed Amount**
Diagnostic Lab/ X-Ray	80%*	60% Allowed Amount**
Respiratory Therapy	80%*	60% Allowed Amount**
Acute Kidney Dialysis	80%*	60% Allowed Amount**
Maternity Care (Member and/or Spouse only)	80%*	60% Allowed Amount**
Organ Transplant Benefits	80%*	60% Allowed Amount**
Outpatient Care		
Pre-Admission Testing	80%*	60% Allowed Amount**
Surgery (All Related Expenses)	80%*	60% Allowed Amount**
Diagnostic Lab/X-Ray	80%*	60% Allowed Amount**
Emergency Care	80%*	60% Allowed Amount**
Physical/ Occupational Therapy/ Speech	80%*	60% Allowed Amount**
Chiropractic (Limited to 12 visits)	80%*	60% Allowed Amount **
Acute Kidney Dialysis	80%*	60% Allowed Amount**
Second Surgical Opinion	80%*	60% Allowed Amount**
Mental Health		
Inpatient Care/ Outpatient Treatment	80%*	60% Allowed Amount**
Alcohol/Substance Abuse		
Inpatient Care	80%*	60% Allowed Amount**

BENEFITS		
MEDICAL BENEFITS	**IN-NETWORK**	**OUT-OF-NETWORK**
Outpatient Treatment	80%*	60% Allowed Amount**
Other Services		
Skilled Nursing Facility	80%*	60% Allowed Amount**
Private Duty Nursing	80%*	60% Allowed Amount**
Home Health Care (40 visits per calendar year)	80%*	60% Allowed Amount**
Hospice Care	80%*	60% Allowed Amount**
Durable Medical Equipment	80%*	60% Allowed Amount**
Ambulance	80%*	60% Allowed Amount**
COVID-19 Testing	Covered at 100%	
Prescription Benefits		
Retail (34 Day Supply)	80%	
Mail Order (90 Day Supply)	80%	
Death Benefit	$5,000	
AD&D		
Loss of Life	$5,000	
Loss of 2 Limbs, Sigh of Both Eyes, 1L/1E	$5,000	
Loss of 1 Limb or Sight of One Eye	$2,500	
Dental/Vision Combined	Not Available	

* After satisfaction of In-Network Deductible

** After satisfaction of Out-of-Network Deductible

PRESCRIPTION DRUGS

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

Covered Expenses Include:

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

State Restricted Drugs - Any medicinal substance which may be dispensed by prescription only according to state law.

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

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

The Plans Prescription Administrator (currently Castia Rx), has contracted with the Operative Plasterers and Cement Masons Health and Welfare Fund to provide an efficient and cost effective program that will be easy for you and your dependents to use when you purchase your prescriptions at a Network Pharmacy. Please check with the Fund Office or call the Prescription Drug Administrator at 1-888-303-1651 directly for a participating pharmacy location near you.

The Prescription Drug Card Program requires you to present your Identification Card at the pharmacy each time you have a prescription filled. If you do not use your identification card, you will have to file a claim for payment directly with the Prescription Administrator to be reimbursed.

Your claim may be subject to deductible and co-insurance amounts. For Participants in the High and Mid Plan, the co-pay is 20%. For those in the Low Plan, the co-pay is 30%.

Helpful Tip: Check with your pharmacy to see if a generic equivalent is available. Using generic drugs lowers your out-of-pocket costs and generates savings for the Fund.

If you (or your physician) request that the pharmacist "Dispense as Written (DAW)" for a brand name drug that has an FDA approved generic equivalent, you will be responsible for paying the cost difference between the brand name drug and its generic equivalent (i.e., the "cost differential"). This amount is in addition to the general co-payment you are charged (i.e., 20% for High and Mid Plan and 30% for Low Plan).

I. Prescription Drug Home Delivery Program

Home Delivery is a convenient way to order maintenance medications and have them delivered to your home. Home Delivery offers you the opportunity to submit your maintenance prescriptions by mail or have your doctor fax in your prescriptions. The prescription is then processed and delivered directly to you.

You can continue to have maintenance medications filled at your local pharmacy for a thirty (30) day supply. You can, but are not required to, also use the Prescription Administrator Mail Order Program for a ninety (90) day supply.

By using the Mail Order Program, you will save money on your copayments for maintenance medications. Plus, you will receive:

1. Free Home Delivery of your medication; and
2. Up to a 3-month supply of medication with each order.

If you or someone under your coverage takes a maintenance medication and wants to use the Mail Order Program, then follow the steps below:

Online: Visit www.CastiaRx.com, log onto your Member account, and follow the instructions to get prescription home delivery. Please be aware that you must complete a Home Delivery Order Form (below) for your initial mail order request. Thereafter, you can manage your prescriptions through the Castia Rx website.

By Mail: First, ask your doctor to write a prescription for up to a 90-day supply of your medication (plus refills for up to one year). Second, complete a Home Delivery Order Form and either mail, email, or fax the Form to Castia Rx. You can obtain a Home Delivery Order Form by visiting www.CastiaRx.com or by calling Castia Rx at 1-888-303-1651.

Helpful Tip: The Mail Order Program is designed to allow Members on maintenance medications to receive larger quantities directly to their home. It is not useful for short-term illnesses or if your physician does not want to prescribe a ninety (90) day supply.

II. Prescription Drug Step Therapy Program

Your Plan utilizes a program called Step Therapy.

Step Therapy is a program that helps you save money, and the Trustees manage increasing prescription drug costs, by encouraging patients and doctors to choose lower-cost, effective drugs first. The program works by offering you Front-Line medication, often a generic drug, to treat your medical condition. These drugs are clinically proven to treat your underlying condition and cost much less than brand name

drugs. You doctor can then decide whether the Front-Line drug is appropriate for you. If not, he or she can prescribe a Back-Up Drug, generally a brand name. Be aware that even amongst these drugs, prices will vary. In other words, some Back-Up drugs that can you be used to treat your condition may be more cost effective than others.

Helpful Tip: If you try a Front-Line drug and you, or your physician, determine the medication is not appropriate to treat your condition, your doctor can prescribe a brand name drug. However, in addition to the usual co-payment, you will be assessed the cost difference between the brand name drug and the generic equivalent.

If a Front-Line drug is medically inappropriate (e.g., allergic reactions or side effects) and your doctor prescribes a Back-Up drug, you can file an appeal with the Board of Trustees to request that the Fund waive the cost differential. If this occurs to you or your dependents, contact the Fund Office.

III. Exclusions From Prescription Benefit Coverage

For a complete list of services, supplies and charges that are not covered, please contact the Plan's Prescription Administrator. The following is a list of some of the more common services, supplies, and charges that are not covered under the prescription benefit:

1) Emergency and abortifacient contraception;

2) Therapeutic devices;

3) Disposable insulin syringes which are not prescribed;

4) Fees for administering or injecting Prescription Drugs;

5) Charges for more than a 90-day supply of Prescription Drugs per order;

6) Any refill of a Prescription Drug, dispensed after one year from the date of the original Prescription Order;

7) Drugs you can purchase without a Prescription;

8) Fertility drugs;

9) Genetically engineered drugs (may be paid upon prior authorization);

10) Glucometer diabetic supplies;

11) Cosmetic drugs including Renova and Minoxidil;

12) Blood monitoring units;

13) Fluoride preparation;

14) B12, Testosterone;

15) Vaccinations/toxoids; and

SCHEDULE OF BENEFITS FOR MEDICARE RETIREE WITH NON-MEDICARE AGE DEPENDENTS (ACTIVE DEPENDENTS)

Calendar year annual deductible Individual/Family	$500/$1,000 In-network $1,000/$2,000 Out-of-network
Co-Insurance (After deductible)	20% per individual in network 40% per individual out-of-network
Calendar year annual out-of-pocket maximum Individual/Family	$3,000/$6,000 In-network $6,000/$12,000 Out-of-network
Prescription Drugs	
Covered Services	Maximum Payable Benefits
Physician office services Office visits, office surgeries, allergy testing/treatment/serum/injections	Preventive Care Benefits rendered in-network are covered at 100% and are not subject to the deductible. All other benefits are paid at 80% after deductible, up to the out-of-pocket maximum; 100% thereafter, unless otherwise noted
Preventive care (Family) Medical history, routine physical exams, PSA, mammograms, pelvic exams, Pap testing **Outpatient therapy** Physical/occupational therapy, spinal Manipulations (12 visits), speech therapy	
Hospital facility services – Inpatient/Outpatient	
Inpatient and outpatient professional and ancillary charges, physician and surgical services**	
Home care services/calendar year (Limited to 40 visits)	
Hospice services	
Emergency care/Urgent care Physician services and facility charges	
Ambulance services	
Maternity services	
Skilled nursing care	

Medical supplies, equipment, appliances	All benefits are paid at 80% after deductible, up to the out-of-pocket maximum; 100% thereafter, unless otherwise noted
Mental Health and Alcohol and Substance Abuse Inpatient Care Outpatient Care	
COVID-19 Testing	Covered at 100%
Out-of-pocket limits include all co-payments and deductibles incurred by a covered person in the same benefit period. *All medical benefits are subject to usual, customary and reasonable charges.*	

Other Benefits (eligible retiree (non-Medicare) age only)	
Death benefit	$2,500

MEDICARE SUPPLEMENTAL COVERAGE - SCHEDULE OF BENEFITS FOR MEDICARE RETIREES AND MEDICARE AGE DEPENDENTS

SCHEDULE OF BENEFITS – THIS SUPPLEMENTAL PLAN PAYS:

Inpatient Hospital Services	The Plan pays the Medicare Part A deductible, and the Medicare-approved Hospital charges not reimbursed by Medicare for the 61st-150th day of hospitalization, and up to 80% of eligible expenses for additional 365 days per lifetime.
Blood (Inpatient/Outpatient)	Full Medicare Part B deductible, and Medicare co-pay up to 20%.
Skilled Nursing Facility Care	The Plan pays amounts up to the Medicare Approved charges not reimbursed by Medicare per day for 21st-100th days, and up to 80% for the next 100 days.
Inpatient Prescription Drugs For Transplants	Full Medicare Part B deductible and Medicare co-pay up to 20%.
Physician's Care Inpatient/ Outpatient Services and Supplies	Full Medicare Part B deductible and Medicare co-pay up to 20%.
Outpatient Mental/Nervous	Full Medicare Part B deductible and the other 50% that Medicare does not pay.

Outpatient Physical Therapy	Full Medicare Part B deductible and Medicare co-pay up to 20%.

SCHEDULE OF BENEFITS – FOR RETIREES (OVER MEDICARE) AGE ONLY

Death Benefit	$2,500

MEDICAL BENEFITS

Use of in-network providers for your health care services generally results in the greatest savings for you and the Fund. For this reason, we urge you to seek care from providers within the medical network whenever possible. Please note that true emergency services will be treated as in-network regardless of the provider's network status.

Effective March 1, 2018, the Fund uses Anthem Blue Cross and Blue Shield Network ("Anthem") as the Plan's Network PPO. The Plan requires separate deductible and co-insurance for all medical providers (hospitals and doctors) based upon PPO Network or Non-PPO Network utilization.

EMPLOYEE CLASSIFICATIONS

Class I Employee – Any full-time employee or former employee of an Employer who is eligible for benefits consistent with the terms and provisions of a collective bargaining agreement or labor-management agreement under which contributions are due to the Fund.

Class II Employee – A representative of an association of employers that are signatory to a current collective bargaining agreement under which contributions are due to the Fund, provided that the association has executed an Assent of Participation and the employee meet all other eligibility rules adopted by the Trustees to be eligible for the benefits described herein.

Class III Employee – An Employee of a Union or employer association who has executed an Assent of Participation and meets all other eligibility rules adopted by the Trustees to be eligible for the benefits described herein.

RULES FOR ELIGIBILITY
CLASS I EMPLOYEES

Once you begin Covered Employment, you (and your dependents) will be eligible after you satisfy the Plan's Initial Eligibility Rules described below. After you satisfy those

conditions, your eligibility will be based on the continuation rules described below (see "Continuing Your Eligibility").

Important Information: When you work in Covered Employment, your Employer is required to make contributions to the Fund on your behalf based on the rates established in the collective bargaining agreement you are working under. These "Dollar Bank Credits" are used to establish and maintain your eligibility in the Plan.

Active Employment
An Employee that is currently working in Covered Employment, or actively seeking employment (unless the Employee is receiving short-term disability benefits under the Plan), in accordance with the rules established under the applicable collective bargaining agreement.

Initial Eligibility
An Employee becomes eligible for coverage once the Fund receives Dollar Bank Credits equal to 3 months of the Mid Plan cost. The cost of the Mid Plan is set by the Trustees each year, and therefore could vary from year-to-year. For Dollar Bank Credits to count towards Initial Eligibility, they must be earned in six (6) or fewer consecutive months.

Once your Dollar Bank Credits equal three (3) months of the Mid Plan cost, you will become eligible under the Fund as of the first day of the following month. You will continue to be eligible for two additional calendar months. After that, the Continuing Eligibility Rules (explained below) apply.

> **Example**: Jacob is a Member who began working for a contributing Employer in June 2019. Jacob's Dollar Bank Credits reached the Mid Plan cost once the August 2019 contributions were remitted to the Fund. As a result, Jacob will be eligible under the Plan as of September 1, 2019. He will also be eligible for the months of October and November 2019.

Important Information: After you have established Initial Eligibility, you will be automatically enrolled in the Mid-Plan. You can select one of the other plans (i.e., the High or Low Plan) at the next open enrollment period.

Rules for Newly Organized Employees

If you are an employee of a newly organized employer which, as a result, becomes newly obligated to contribute to the Plan on your behalf, then you will be immediately eligible for coverage for the first six (6) months if the employer:

A) Pre-pays for the first three (3) months of coverage; and

B) Pays the contribution rate for any hours worked in excess of 125 hours per month for the second three-month period which would result in you

receiving appropriate credit in your Dollar Bank. Thereafter, you will be subject to the Continuing Eligibility Rules *(See below).*

Initial Eligibility with Special Circumstances

A new Class I Employee working for a signatory employer that is delinquent on contributions to the Fund can satisfy Initial Eligibility if all the following apply:

A) The Employee has worked the number of hours necessary to otherwise satisfy the Initial Eligibility requirements (i.e., 3 months of the Mid Plan cost);

B) The Fund has initiated action to collect the delinquency; and

C) The Employee has not been eligible for coverage under the Plan within the last five (5) years.

Under these circumstances, the Plan will extend to the Employee a "negative Dollar Bank" equal to the amount not contributed by the delinquent employer. The Employee will then become eligible as of the first day of the month of which the employee would have otherwise met the Initial Eligibility requirements. To maintain eligibility, the Employee must self-pay the monthly cost of coverage. Once the Plan recovers the unpaid contributions, and the Fund is reimbursed the cost of extending Initial Eligibility to such an Employee, any self-payments made to continue eligibility will be reimbursed to the Employee and any excess Dollar Bank Contributions will be credited to the Employee's Dollar Bank.

Effective Eligibility Date
You will be covered on the date you become eligible if you are Available for Work on that date; otherwise, you shall not become covered until you become Available for Work.

Continuing Your Eligibility
After you have become eligible in the Plan, your continued eligibility will depend on the Dollar Bank Credits made to the Plan on your behalf. The Eligibility Chart below shows how the Plan applies Dollar Bank Credits for continuing eligibility purposes.

Work Month	**Eligibility Month**
January	April
February	May
March	June
April	July
May	August
June	September
July	October
August	November
September	December
October	January
November	February
December	March

You will remain eligible if your Dollar Bank Credits for the Work Month equal to the cost of coverage (i.e., Low, Mid, or High Plan monthly cost) for the corresponding Eligibility Month. The examples below illustrate these rules:

> **Example:** Casey met the Initial Eligibility rules (i.e., contributions equal to 3 months of the Mid Plan cost) after his August 2019 Work Hours were contributed to the Fund. That means he is eligible for coverage in the Mid Plan for the months of September, October, and November 2019. For Casey's December 2019 eligibility, the Plan will look at the Dollar Bank Contributions made on his behalf for the month of September 2019.
>
> If Casey received Dollar Bank Credits during September 2019 that are equal to or greater than the Mid Plan cost, he will continue to be eligible in the Plan. If not, he can maintain eligibility by either using any Credits in his Bank or by self-paying the difference.
>
> **Example:** At open enrollment, Craig switches from the Mid Plan to the Low Plan. This change is effective the following January 1st. That means for January's eligibility (i.e., October Work Month contributions), Craig's Dollar Bank Contributions must equal or exceed the cost of the Low Plan to maintain eligibility.

If your Dollar Bank Contributions for a Work Month do not equal or exceed the cost of coverage (i.e., Low, Mid, or High Plan monthly cost) you can use any excess contributions from your "bank" or self-pay (both explained below) to continue coverage. You can also combine self-payments with your Dollar Bank Credits to maintain eligibility.

Please be aware that Dollar Bank Credits are not a vested benefit. Therefore, the Trustees shall also have the discretion to freeze or terminate your Dollar Bank if it is determined that you are performing work in Covered Employment in the craft jurisdiction for an Employer not subject to a collective bargaining agreement. Dollar Bank credits are not a vested benefit and are subject to amendment, reduction or termination at any time and for any reason.

Important Information: If the employer contributions for a work month are less than the cost of coverage for an eligibility month, you can maintain eligibility by either using Dollar Bank Credits or by making a Self-Payment to cover the difference. You can also combine both Dollar Bank Credits and Self-Payments to cover any short-fall to maintain eligibility. These rules are explained in greater detail below

Dollar Bank Credits

Each month that you work, your employer makes contributions to the Plan based on your work hours at the rate specified in the collective bargaining agreement. These are called "Dollar Bank Credits." When your Dollar Bank Credits for a month exceed the monthly cost of coverage, the excess is placed in a "bank" which you can later use to maintain your eligibility in the Plan.

Example: Baker works 130 hours for a contributing Employer during the month of July 2020. Under the collective bargaining agreement Baker is working under, his Employer must contribute $7.10 per hour to the Fund as a health and welfare contribution. For the month of July 2020, the cost of the Mid Plan is $881.25. Therefore:

- Total July 2020 H&W Contributions = $923.00
- Mid Plan monthly cost (July 2020) = $881.25
- Dollar Bank = $41.75

When you do not have enough Credits from *employer* contributions to maintain eligibility, you can use excess Credits from your Dollar Bank.

Example: Josh worked 80 hours for a contributing Employer during the month of February 2019 before being laid off. The contribution rate was $7.10 per hour. Under Plan rules, work hours for the month of February are used to determine eligibility for the month of May. Therefore:

- Total February 2019 H&W Contributions - $568.00
- Mid Plan monthly cost (May 2019) = $881.25
- Shortfall = $313.25

Josh is $313.25 short of the Mid Plan cost for May 2019 coverage. Any balance Josh has in his Dollar Bank can be used to cover the shortfall and maintain coverage for the month of May.

Helpful Tip: Continuing Eligibility is based on a look-back method which takes into account the peaks and valley common in construction employment. That means even if your work hours for the current month exceed the applicable monthly Plan cost, you may still need to use Dollar Bank Credits and/or self-payments to maintain your eligibility.

However, because of the look-back method, even though your current hours may be below the applicable monthly Plan cost, you may still be eligible without having to use Dollar Bank Credits and/or make self-payments.

Your Dollar Bank Credits are not a vested benefit. The Trustees may reduce or otherwise adjust the number of Credits in your Dollar Bank from time to time based on medical inflation and other factors so that the Plan can remain financially healthy. You will lose any credit in the Dollar Bank upon the earlier of the following:

- When you cease to be Available for Work; or
- You do not have enough Credits to maintain your eligibility and you fail to make the timely self-payments needed to maintain that eligibility; or
- The Trustees' cancellation of Dollar Bank Credits.

Important Information: The Trustees shall also have the discretion to freeze or terminate your Dollar Bank if it is determined that you are performing work in Covered Employment in the craft jurisdiction for an Employer not subject to a collective bargaining agreement. Dollar Bank Credits are not a vested benefit and are subject to amendment, reduction, or termination.

Self-Payments

Partial Self-Payments can be made when you do not have enough Credits in your Bank to maintain your eligibility. The amount is determined by subtracting your Credits from the amount of Credits you need in the Eligibility Month to maintain your eligibility.

If you do not have any Dollar Bank Credits, you can pay the full Self-Payment amount for a six (6) consecutive month period as long you continue to be Available for Work. After six (6) months of consecutive full self-payments:

- Any Dollar Bank Credits you earn will be applied towards reestablishment of Initial Eligibility only; and

- Any further payments must be the applicable premium for COBRA continuation coverage (as explained in the COBRA Continuation Coverage Section below).

If you become Disabled so as to prevent you from performing any type of gainful employment, you may preserve your eligibility during the disability for a period not to exceed the earlier of six (6) months following recovery or your eligibility for Medicare. In order to maintain eligibility, you shall remit timely contributions established by the Trustees on forms prescribed by the Trustees and medical certification of your disability.

If you become eligible for Medicare, you will be eligible to participate in the Retiree Program. In addition, to maintain eligibility, you must semi-annually submit medical certification of your continued disability.

All Self-Payments received become the property of the Fund as of the day received. However, if you are forced to make a Self-Payment to continue your eligibility, and later receive Credits for the Work Month (i.e., late payment by a contractor or through reciprocity), your Self-Payment will be refunded.

The Trustees shall have the discretion to refuse self-contributions from you if it is determined that you are working in Covered Employment in the craft jurisdiction for an Employer not subject to a collective bargaining agreement.

Helpful Tip: If you must self-pay, you may at that time select to drop from the High Plan or Mid Plan to the Low Plan. However, you cannot return to the High Plan or Mid Plan until the next open enrollment period. If you are considering taking advantage of this rule, please contact the Fund Office before you make any Self-Payment.

ELIGIBILITY CONDITIONS – CLASS II & III

Initial Eligibility

If you are a Class II and III employees, you are only eligible to participate in the Mid Plan. You will then be covered for benefits on the first day of the month immediately following the receipt of the third (3rd) consecutive monthly payment. Prepayment shall not expedite coverage.

Initial eligibility will cover you for the remaining number of months which fall within an eligibility period as outlined under Continuation of Eligibility. However, if only one calendar month or less remains in that eligibility period, the employee also shall be eligible for the subsequent eligibility period.

Effective Eligibility Date

An Employee will be covered on the date you become eligible if you are Available for Work on that date; otherwise, you shall not become covered until you become Available for Work.

Continuing Eligibility

Once having become covered, Class II and Class III employees shall continue to be covered on a monthly basis provided a monthly contribution for such employee is received by the Welfare Fund by the 15th of the month immediately preceding. Coverage terminates if payments are not timely received. Self-payments are not permitted, other than COBRA continuation coverage.

PARTICIPANTS SERVING IN ARMED FORCES

Any Participant (i.e., Class I, II, or III) who enters the Armed Forces of the United States on a full-time basis shall have the option of freezing his Dollar Bank, if any Credits remain until discharged from active full-time military duty, or utilizing his Dollar Bank to continue coverage under the Plan, as provided hereafter.

In the event a Participant who enters into full-time military duty of the United States has no Dollar Bank Credits, an insufficient amount of Dollar Bank Credits to maintain coverage while serving in the military service, or does not elect to utilize his Dollar Bank Credits to maintain coverage while serving in active full-time military service, continuation of coverage under the Plan for the Participant and his Eligible Dependents can be continued for eighteen (18) months upon receipt of a timely application and required contributions established by the Board of Trustees.

If a Participant enters the Armed Forces on a short-term basis of thirty-one (31) days or less of continuous military service, coverage under the Plan will be continued for the

Participant and Eligible Dependents at Plan expense. For military services that exceeds thirty-one (31) days, the Participant shall be responsible for contributions for those months of service subsequent to the initial service of thirty-one (31) days.

Helpful Tip: If you have been called to military service, contact the Fund Office as soon as possible to discuss your coverage options, even if you and your dependent are covered under Tri-Care. The special rules for military service members are conditioned upon you notifying the Fund that you have been called to service.

Upon a Participant's honorable discharge from military service, the Participant's eligibility status under the Plan will be restored to the status that existed when he entered military service, with the exception of any Reserve Bank Dollars that the Participant may have elected to utilize during military service. In order to restore such eligibility in the Plan, the Participant must notify the Fund Office, in writing, within sixty (60) days of his discharge of his intent to return to covered employment. In addition to such written notice, the Participant shall also supply the Fund Office with copies of his discharge papers showing the date of his induction or enlistment in military service and the date of his discharge. Failure on the part of the Participant to file such notice and documentation with the Fund Office may be deemed an indication that the Participant does not wish to restore his eligibility status under the Plan.

Military Reinstatement - Effective Eligibility Date of Coverage

Federal law now provides certain employees who leave employment for active military service and who seek reemployment within the required period after release from military service, with certain rights under the Health and Welfare Plan, such as the right to immediate coverage upon their return from military service. Furthermore, under certain circumstances, military service is treated as a "qualifying event" for COBRA purposes for up to 18 months. HOWEVER, FEDERAL LAW REQUIRES YOU TO NOTIFY THE FUND OFFICE BEFORE ENTERING MILITARY SERVICE TO PROTECT THESE RIGHTS.

ELIGIBLE DEPENDENTS - FAMILY COVERAGE

Your Eligible Dependents include the following:

- Your legal Spouse. This means the person who is married to you in a legally recognized civil or religious ceremony. A "spouse" includes a same-sex spouse. If you become divorced or legally separated, your spouse loses eligibility. Common-law relationships are not recognized except to the extent they are recognized in your state of residence and you have furnished a satisfactory affidavit to the Board of Trustees under applicable state law.

- Your children. Your child is covered from the date of birth through the end of the month in which the child reaches age 26.

The term **Child or Children** include:

- Your natural child,
- Your adopted child or child placed in your custody, pending adoption,
- Your stepchild.

A foster child which has placed in your custody by an authorized placement agency, or judgment, decree, or other order of any court of competent jurisdiction.

Eligible Dependents also include children for whom you are required to furnish medical coverage under a Qualified Medical Child Support Order. Please contact the Fund Office for Rules and Regulations explaining the provisions which must be included in such court Orders and other requirements which must be met before the Plan will accept any children as Eligible Dependents under such Orders. Participants and Beneficiaries can obtain, without charge, a copy of this information from the Fund office.

Important Information: If a child beyond age twenty-six (26) is incapable of self-sustaining employment because of a physical handicap or mental retardation, and is dependent upon you for support and maintenance, coverage will be continued provided the child's incapacity began before the age at which the child's coverage would have terminated. You must submit proof of the child's incapacity to the Fund Office no later than thirty-one (31) days after the date such child attains the age at which their coverage would otherwise terminate. Proof of continued incapacity must be furnished to the Fund Office from time to time upon request.

You may be required to provide documentation of dependent status. Please note, the Plan does not impose pre-existing conditions limitations on either you or your dependents. Furthermore, any adopted children are eligible for coverage immediately upon placement with you and your family.

Important Information: If you get divorced, your children are still eligible for coverage under the Plan. If your children are enrolled in coverage under both you and your ex-spouse health insurance plan, the order of payment will be determined according to the Plan's coordination of benefit rules.

TRAVEL · CLASS I EMPLOYEES

When you are asked to perform work outside the Plan area, you should ask whether your Employer will continue to make contributions on your behalf to this Plan based on collective bargaining provisions for travelers.

Reciprocity Agreements with Other Plans - Class I Employees

The Trustees have entered into Reciprocity Agreements with the Trustees of certain other plans to address the problem of employees working under the jurisdiction of other locals. Under these Agreements, contributions due on your behalf while working under

another local's jurisdiction may be transferred from that local's fund to this Plan if you make a written request on a proper form. For information regarding other funds which have Agreements with this Plan, contact the Fund Office. However, unless you are a member of Operative Plasterers and Cement Masons Locals 80, 109, 132, 179, 404 and/or 886 at the time in question, you may not establish Initial Eligibility via such reciprocity payments.

Those employees eligible under this Plan who work in another jurisdiction which has a signed Agreement with this Plan may continue their coverage under this Plan. Those coming from other jurisdictions to work here and requesting reciprocity will not become eligible under this Plan. Rather, their contributions will be sent to their home local, with eligibility and benefits determined in accordance with home local's plan.

Important Information: Reciprocity payments will be credited only after they are received by the Fund Office. Until payments have been confirmed to this Plan, you must either use Dollar Bank Credits or make self-payments to maintain eligibility. Once the Plan receives contributions on your behalf, you will be refunded any Dollar Bank Credits used, or self-payments made, to maintain your eligibility.

If You Cannot Work Because You Are Temporarily Disabled - Class I Employees

If you are temporarily disabled and cannot work, you are given contribution credits to help maintain your eligibility. The Plan will give you credits up to thirty (30) hours for each week you are disabled. These Credits will be given up to a maximum of three hundred sixty (360) hours in any twelve (12) consecutive month period. This credit is given if you:

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

Credit is given the first day for an injury and beginning the eighth day for an illness. You receive credit until you are no longer receiving Disability or Sickness and Accident Benefits or until you have received three hundred sixty (360) hours in twelve (12) consecutive months, whichever comes first. The Plan may require that you be examined by the Plan's Physicians from time to time.

See also, the Eligibility for Disabled Retirees and Dependents.

FAMILY AND MEDICAL LEAVE ACT CREDITS - CLASS I, II AND III EMPLOYEES

Contribution Credits of up to twelve (12) weeks in a twelve (12) month period may be available from your Employer for Family and Medical Leave (FMLA). You must have

worked one thousand two hundred fifty (1,250) hours in a twelve (12) month period for an Employer covered by FMLA. Certain other requirements must be met.

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

- The birth of your child and to care for such child.
- Placement of a child with you for adoption or foster care;
- To care for your Spouse, Child, or parent with a serious health condition;
- For your own serious health condition that makes you unable to perform your job; or
- For any "Qualifying Exigency" arising out of the status of the employee's Spouse, son, daughter, or parent as a covered military member on "covered active duty," or To care for covered service member with a serious injury or illness who is the Spouse, son, daughter, parent, or next of kin to the employee ("military caregiver leave").

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

To exercise these rights, you and/or your Employer must comply with the following requirements:

- You must notify the Fund Office at least fourteen (14) days before the beginning of your FMLA leave, except in an emergency, and then no later than seven (7) days after your FMLA leave begins.
- You must obtain and submit to the Fund Office a certificate of eligibility for FMLA leave.
- You must notify the Fun Office of the beginning and ending date of your FMLA leave.

Military Family Leave Provisions under the FMLA

Under the FMLA military leave provisions, eligible employees make take FMLA leave for any "qualifying exigency" if the employee's spouse, son, daughter, or parent is on Covered Active duty (or has been notified of an impending call or order to Covered Active Duty). An eligible employee may also take FMLA leave to care for a covered servicemember with a serious injury or illness (i.e., military caregiver leave). To be

eligible, the covered servicemember must be the employee's son, daughter, or parent. An eligible employee is entitled to twenty-six (26) weeks of FMLA leave in a twelve (12) month period.

"Covered Active Duty" means (A) in the case of a member of a regular component of the Armed Forces, duty during the deployment of the member with the Armed Forces to a foreign country; and (B) in the case of a member of a reserve component of the Armed Forces, duty during the deployment of the member with the Armed Forces to a foreign country under a call or order to active duty under a provision of law referred to in section 101(a)(13)(B) of title 10, United States Code.

A "serious injury or illness" means (A) in the case of a member of the Armed Forces (including a member of the National Guard or Reserves), an injury or illness that was incurred by the member in line of duty on active duty in the Armed Forces (or existed before the beginning of the member's active duty and was aggravated by service in line of duty on active duty in the Armed Forces) and that may render the member medically unfit to perform the duties of the member's office, grade, rank, or rating; and (B) in the case of a veteran who was a member of the Armed Forces (including a member of the National Guard or Reserves), a qualifying injury or illness that was incurred by the member in line of duty on active duty in the Armed Forces (or existed before the beginning of the member's active duty and was aggravated by service in line of duty on active duty in the Armed Forces) and that manifested itself before or after the member became a veteran.

"Qualifying exigencies" include:

- Issues arising from a covered military member's short notice deployment (i.e., deployment on seven or less days of notice) for a period of seven days from the date of notification;

- Military events and related activities, such as official ceremonies, programs or events sponsored by the military or family support or assistance programs and informational briefings sponsored or promoted by the military, military service organizations or the American Red Cross that are related to active duty or call to active duty status of a covered military member;

- Certain childcare and related activities arising from the active duty or call to active duty status of a covered military member, such as arranging for alternative childcare, providing childcare on anon-routine, urgent, immediate need basis, enrolling or transferring a child in a new school or day care facility, and attending certain meetings at a school or a day care facility if they are necessary due to circumstances arising from the active duty or call to active duty of the covered military member;

- Making or updating financial and legal arrangements to address a covered military member's absence;

- Attending counseling provided by someone other than a health care provider for oneself, the covered military member, or the child of the covered military member, the need for which arises from the active duty or call to active duty status of the covered military member;

- Taking up to fifteen (15) days of leave to spend time with a covered military member who is on short-term temporary, rest and recuperation leave during deployment;

- Attending to certain post-deployment activities, including attending arrival ceremonies, reintegration briefings and events, and other official ceremonies or programs sponsored by the military for a period of *90* days following the termination of the covered military member's active duty status and addressing issues arising from the death of a covered military member;

- Any other event that the employee and employer agree is a qualifying exigency.

During the FMLA leave, your Employer must make contributions to the Fund on your behalf so that your health coverage will be continued. Federal law requires that you receive continued eligibility. However, arrangements will need to be made for the Eligible Employee to pay his/her applicable share of health insurance premiums while on leave.

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

Repayment of Contributions to Employer

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

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

TERMINATION OF COVERAGE

Coverage for you and your Eligible Dependents will terminate on the earliest of the following dates:

- The last day of an Eligibility Month if you have insufficient contributions and you do not have enough Dollar Bank Credits to cover the shortfall and fail to make timely self-payments; or

- When you begin active duty in the armed forces; or

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

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

- The date the Plan terminates.

Dependent coverage may also terminate for your Eligible Dependent if that class of coverage is terminated or on the date that your Dependent:

- Ceases to be your legal Dependent as provided by the Plan; or

- Becomes an Eligible Employee under this Plan or another group plan; or

- Begins active duty in the armed forces.

WITHDRAWAL OF A LOCAL UNION OR EMPLOYER FROM THIS WELFARE PLAN

If you are a member of a Local Union which withdraws from this Health & Welfare Plan or an employee of an employer who has discontinued participation in this Plan, the following will occur:

- The Credits in your Dollar Bank will be forfeited;

The Plan will not pay any claims incurred after the effective date of the withdrawal.

- Although you shall have access to and use of the amount in your medical reimbursement account as of the date of withdrawal/discontinuance of participation, disbursement to you shall only be done quarterly and a fee of $25.00 per quarter shall be assessed to the account to cover the costs of the administration of the account; and

- If you are receiving coverage under this Plan as a retiree member of the departing Local Union or employer, that coverage under this Plan shall terminate effective on the date of the withdrawal/discontinuance of participation.

SUSPENSION OF BENEFITS (CLASS I)

Your benefits may be suspended if the Trustees determine that:

- you are performing work in covered employment within the craft jurisdiction and not pursuant to a collective bargaining agreement;

- your membership in the Union has been terminated, other than retirement; or

- your membership in the Operative Plasterers and Cement Masons International Association has been terminated, other than due to retirement, and you are now a member in and/or of any other Union or Association (local and/or international) in a craft jurisdiction other than that of the Operative Plasterers and Cement Masons International Association).

SPECIAL ENROLLMENT RIGHTS

If you were eligible under the Plan and declined coverage because you were covered under another group health plan, and you or your dependent lose the other coverage, you and your Eligible Dependent(s) will be permitted to enroll in the appropriate High, Mid, or Low Plan during a special enrollment period if loss of the other coverage was due to:

- Termination of employment;
- A reduction in hours of employment;
- Termination of the other coverage;
- Termination of employer contributions towards coverage;
- The exhaustion of COBRA continuation coverage;
- The exhaustion of applicable lifetime benefits under the coverage;
- An individual ceases to be a dependent under the Plan;
- The plan terminates a benefit package option;
- If your coverage is provided through a Health Maintenance Organization (HMO) or other arrangement, and you no longer live or work in the HMO's or other arrangement's service area (and there is no other coverage available under the Plan);
- The plan no longer offers coverage to a class of similarly situated individuals that includes you (e.g., the plan terminates coverage for all part-time employees);
- Layoff; or
- The death or divorce from your spouse;

Important Information: You or your dependents can also enroll in this Plan under these "Special Enrollment Rights" rules if either you or your dependents lose coverage under a Medicaid or State child health insurance plan. To enroll, you must notify the Fund Office within sixty (60) days after the date your other coverage ends.

Enrollment must be supported by written documentation of the termination of the other coverage (including the effective date of the termination). Notice of intent to enroll must be provided to the Fund Office within 90 days of the event with coverage to be effective on the date the other coverage terminated.

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your Eligible Dependents provided that you request enrollment within 90 days after the marriage, birth, adoption, or placement for adoption.

REINSTATEMENT

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

Where Class II or III coverage has been terminated by an Employer or Eligible Person, it cannot be reinstated without the approval of the Plan's Board of Trustees.

OPTIONAL CONTINUATION COVERAGE UNDER COBRA CLASS I, CLASS II, AND CLASS III EMPLOYEES

Under the Consolidated Omnibus Budget Reconciliation Act (COBRA), all employees and qualified beneficiaries ("Eligible Dependents") currently covered under the Plan are eligible for continuation coverage if certain conditions are met.

If you are an Employee or Dependent eligible under the Plan, you have a right to choose continuation coverage for up to eighteen (18) months if you lose eligibility because of a reduction in the your hours of employment or termination of employment (for reasons other than gross misconduct on your part). The potential eighteen (18) months' duration will include any self-payments and will be measured from the beginning of the month that you begin making self-payments.

> **Example:** Bernie is an employee who gets laid off through no fault of his own in December of 2020. Based on his work history, Bernie continues to remain eligible for the months of January, February, and March of 2021. His Dollar Bank Credits cover his eligibility for the months of April and May of 2021. For coverage beginning on June 1, 2021, Bernie begins making Self-Payments to maintain his eligibility. Bernie's COBRA Continuation period begins on June 1, 2021.

The law also requires that the Plan provide you and Eligible Dependents with continued health care coverage for a period of twenty-nine (29) months if you or your Eligible Dependent becomes Disabled while eligible under the Plan (as determined by Social Security). You must inform the Fund Office of your Social Security Disability determination and of your desire to choose continuation coverage within sixty (60) days of the Disability determination. The period of any other self-payments will count toward the twenty-nine (29) months' duration.

Your Spouse (including the Spouse of an eligible retiree), has the right to choose continuation coverage for up to thirty-six (36) months for if he or she loses health care coverage for any of the following reasons:

- Your death; or
- Divorce or legal separation; or
- Entitlement to Medicare.

Additionally, your Eligible Dependent, has the right to continue coverage for up to thirty-six (36) months if eligibility is lost for any of the following reasons:

- Your death; or
- Divorce or legal separation; or
- A parent's entitlement to Medicare; or
- Loss of eligibility because the dependent ceases to be a "Dependent Child" as defined in this Plan.

The potential thirty-six (36) months' duration for spouses and other dependents will include any self-payments and will be measured from the earlier of (1) the date when coverage is lost, or (2) in the manner described in the Example above..

Important Information: You or your Eligible Dependents must inform the Fund Office, in writing, of any divorce, legal separation, or of a child losing dependent status (e.g., reaching age 27). Your Employer has the responsibility to notify the Fund Office of any death, termination of employment, reduction in hours, or Medicare Eligibility.

Once notified, the Fund Office will provide you with a continuation coverage election notice. Thereafter, you have sixty (60) day from the date you would lose coverage to inform the Fund Office that you wish to continue coverage under these special COBRA provisions.

If you choose continuation coverage, the Plan is required by law to offer you coverage that, as of the time coverage is being provided, is identical to the coverage provided under the Plan to similarly situated employees or family members (but loss of time, and any death and accidental death and dismemberment benefits are not available).

The law provides that continuation coverage may be cut short for any of the following five reasons:

- The Plan no longer provides health care coverage; or
- The contribution for your continuation coverage is not paid timely; or

- You become covered under another health care plan (unless there is a preexisting condition limitation that would result in denial of benefits); or

- You become entitled to Medicare; or

- You were divorced from a covered employee and subsequently remarry and are covered under your new spouse's health care plan (unless there is a preexisting condition limitation that would result in a denial of benefits).

You do not have to show that you are insurable to choose continuation coverage. However, under the law, you must pay the cost plus an administrative fee for continuation coverage. Disabled persons may pay a larger fee because of the cost to provide this coverage.

There may be other coverage options for you and your family. Under current law, you may be able to purchase other health insurance coverage for you and your family on a national Marketplace. Depending on your income, you could also qualify for credits towards any premium you may owe.

And, 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 U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA web site at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Eligibility for Early Retirees and Dependents (Under Age 65)

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

- have had at least sixty (60) months of eligible participation in this Welfare Plan out of the one-hundred and twenty (120) months immediately preceding the retirement date; and

- were eligible under the Plan for at least nine (9) months in the twelve (12) months immediately preceding the retirement date; and

- are receiving a pension or early retirement benefits under the Federal Social Security Act; and:

- are retired from Covered Employment in the trade.

You must notify the Fund Office in writing that you want to maintain eligibility through the retiree program within thirty-one (31) days of the last month in which you are covered as an Active Employee.

You will be notified by the Fund Office of the amount due. Self-payments must be made from the date coverage was lost. These self-payments count toward the duration of COBRA continuation coverage. If you fail to make a self-payment, you lose your coverage and it cannot be reinstated. Benefits will terminate when you become eligible for the Normal Retiree Program.

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

Eligibility for Disabled Retirees and Dependents

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

- you were an active, Eligible Employee in the Plan for a total of sixty (60) months out of the 120 months immediately before your Disability; and
- were an active, Eligible Employee in the Plan for at least nine (9) months in the twelve (12) months immediately before your Disability; and
- you were an Eligible Employee immediately before the date that the Total and Permanent Disability was incurred; and
- you have received your Social Security disability award; and
- you are retired from Covered Employment in the trade.

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

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

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

Eligibility for Normal Retirees (Over Age 65)

If you are a Normal Retiree, you are able to continue your eligibility through timely self-payments if:

- you had at least 60 months of eligible participation in this Welfare Plan out of the 120 months immediately preceding your retirement date; and
- you were eligible for at least nine (9) months in the twelve (12) months immediately preceding your retirement date; and
- you are at least sixty-five (65) years of age; and
- you are retired from Covered Employment in the trade; and
- you are receiving retirement or Total and Permanent Disability benefits from a qualified pension or corporate retirement plan and/or are receiving disability or retirement benefits under the Social Security Act.

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

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

Eligibility for Surviving Spouses

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

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

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

- The date after the eligible retiree/employee's death on which the surviving spouse first becomes covered by a plan (excluding Medicare) under which the spouse was not covered prior to the retiree/employee's death; or

- The date the Spouse remarries; or

- The date the Spouse dies.

Coverage for dependents of the deceased Eligible Employee or Retiree upon death may be continued for the same periods, as set forth above, upon timely self-payment. If the Self-Payment is made, eligible dependents may continue to be covered under the Plan until reaching age 26, unless a disability exists, as described above (see Eligible Dependents Section above).

Information Regarding Eligibility

Any questions concerning your eligibility should be directed to the Fund Office, 33 Fitch Boulevard, Austintown, Ohio 44515 or by calling telephone number (800) 435-2388.

FILING A CLAIM

In most circumstances, your claims will be forwarded to Anthem at the address presented on your enrollment card by the provider who rendered the medical services. However, if the provider does not submit a claim, you should contact the Fund Office immediately. **Properly completed claims information must be received within one (1) year from the date the services are rendered. If not, the claim is not eligible for payment from the Fund**.

Benefit Determination and General Claims and Appeal Rules

Generally, all health care benefits will be paid as soon as administratively feasible. The Plan or applicable service provider will notify you of its initial decision within certain timeframes. If a claim for post-service or concurrent care is approved, payment will be made, and the payment will be considered notice that the claim was approved. However, for urgent care and pre-service claims, the Plan or applicable service provider will give you written notice of its determination.

- Urgent Care Claims – An initial determination will be made within 72 hours following receipt of your claim. Notice of a decision on your urgent care claims may be provided to you orally within 72 hours and then confirmed in writing within 3 days after the oral notice. If additional information is needed to process your claim, you will be notified within 24 hours of receipt of your claim. You will then have up to 48 hours to response. The initial 72-hour deadline is suspended for up to 48 hours or until the information is receive, if sooner.

- Pre-Service and Post-Service Claims – An initial determination will be made within 15 calendar days from receipt of your claim for pre-service claims and 30 calendar days from receipt of your claim for post-service claims. If additional time is necessary, up to 15 additional calendar days, due to matters beyond the control of the Plan. You will be informed of the extension within the 15-day timeframe with respect to pre-service claims or within the 30-day timeframe with respect to post-service claims. In addition, if additional information is needed to process your claim, you will be notified within the 15-day timeframe (with respect to pre-service claims) or within the 30-day timeframe (with respect to post-service claims). You will then have up to 45-days to provide the requested information. After 45-days or, if sooner, upon receipt of the additional information, the Plan will make a determination within 15-days.

If your claim for benefits under the Plan is denied, you can use the Appeal Procedure described below to request that the Plan and Board of Trustees review your claim. Throughout the Appeal Procedure, you will be afforded access to all relevant information related to your claim for benefits and any determinations made. You will also have the right to submit any additional information or documentation in support of your appeal.

If your appeal requires medical judgment, the Administrative Manager and/or Board of Trustees (as the case may be) will consult with an appropriately qualified health professional to obtain his or her independent professional opinion. If requested, or otherwise required by law, the Plan will disclose both the identify of such individual and the nature of his or her professional opinion regarding any matters related to your apply and which were relied upon when rendering any determination.

APPEALS PROCEDURE

You or your authorized representative may appeal the decision by the Fund's Administrative Office to deny any claim for medical, dental, vision, sickness, death or accidental death and dismemberment benefits in whole or part. An "authorized representative" must be designated in writing to act on your behalf and the extent of the person's authority must be clearly indicated in the authorization. Additionally, any point of service purchase of prescription benefits which is not covered at the pharmacy can be appealed through this Review Procedure.

First Level Review – Eligibility Determinations

If you are denied a claim for any benefits provided under this Plan because it is determined that you (or your dependents) do not meet the eligibility rules, you may file a written notice of appeal to the Administrative Manager for the Board of Trustees at any time within 180 days after the mailing of the Notice of Adverse Benefit Determination.

The written notice of appeal only needs to include your name, contact information (i.e., address and phone number), your social security number, the date you received the Adverse Benefit Determination, and a simple statement indicating that you wish to exercise your rights to appeal. The notice of appeal should be sent to:

Administrative Manager
Ohio Conference of Plasterers & Cement Masons Health & Welfare Plan
33 Fitch Blvd.
Austintown, Ohio 44515

You will be notified of the decision of the Administrative Manager within thirty (30) days of the date the request for a First Level review is received (or sooner if the claim is considered an "Urgent Claim"). In the event that the denial is upheld, you will receive a written Notice which includes the following information:

- The specific reason for the denial;
- The sections of the Plan and/or Summary Plan Description upon which the denial was based;
- A statement advising you of any internal guidelines or protocol used in making the decision, if applicable, and your right to receive a copy;
- A notice of your right to a written explanation of any exclusion which affects your claim, if applicable; and
- A notice of your right to file a second level appeal to the Benefits Committee of the Board of Trustees.

The decision of the Administrative Manager is final and binding unless it is appealed to the Board of Trustees under the procedures provided below for Second Level Reviews.

First Level Review – Medical, Dental, Vision, Prescription Drug, and AD&D Determinations

If you were denied coverage for any benefits by a Plan service provider, you may file a written notice for appeal directly with the underlying service provider. Your appeal must be filed within 180 days after the mailing of the Notice of Adverse Benefit Determination. For example, if the Plan's network provider (currently Anthem) denies a claim for a medical procedure, your first level review claim should be sent through Anthem. Similarly, if the Plan's pharmacy benefit manager (currently Castia Rx) denies coverage for any medication or prescription, your first level review claim should be sent to the pharmacy benefit manager. The identification and contact information for all Plan service providers is located on your member enrollment card.

Second Level Review – Board of Trustee Review

You may file a written notice of appeal to the Board of Trustees at any time within sixty (60) days after you receive a Notice of Denial Following your First Level Review. the Administrative Manager's mailing of the Notice of Denial of the First Level Review. The written notice of appeal only needs to include your name, contact information (i.e., address and phone number), your social security number, the date you received the Adverse Benefit Determination, and a simple statement indicating that you wish to exercise your rights to appeal. The notice of appeal should be addressed as follows:

Board of Trustees
Ohio Conference of Plasterers & Cement Masons Health & Welfare Plan
33 Fitch Blvd.
Austintown, Ohio 44515

Again, during this Second Level Review you may request copies of obtain access to any and all relevant information related to your claim for benefits and its denial and may submit written issues and comments pertinent to the appeal. Additionally, you or your representative may submit additional information prior to any determination on your appeal.

Unless otherwise required under applicable law, your Second Level appeal will be reviewed by the Board of Trustees at the Board meeting that immediately follows your appeal. However, if you fail to submit a request at least seven (7) days prior to the Board meeting date, or if you are required to provide additional information and fail to meet this deadline, the Trustees reserve the right to table your Second Level appeal until the second meeting that follows your request for a Second Level Review. The Benefits Committee will consider your appeal of a claim for payment of services You will be notified of the decision of the Board of Trustees within thirty (30) days of the date the request for a Second Level review is received.

In the event that the denial is upheld, you will receive a written Notice which includes the following information:

- The specific reason for the denial;
- The sections of the Plan and/or Summary Plan Description upon which the denial was based;
- A statement advising you of any internal guidelines or protocol used in making the decision, if applicable, and your right to receive a copy;
- A notice of your right to a written explanation of any exclusion which affects your claim, if applicable;
- A notice of your right to file a voluntary appeal to the full Board of Trustees as provided below; and

- A notice of your right to file a lawsuit under ERISA Section 502(a).

The decision of the Benefits Committee for the Board of Trustees is final and binding. Once you have filed your appeal through the two levels of review, you have the right to file a lawsuit in federal court. However, no legal action regarding a final decision on appeal may be brought against the Board of Trustees, or the Plan, more than one (1) year after the mailing of the Board of Trustees' final decision on appeal.

DISABILITY CLAIMS AND APPEAL PROCEDURES

The Plan ensures you that all claims and appeals for disability benefits will be adjudicated in a manner designed to ensure the independent and impartiality of the persons involved in making the decisions. Accordingly, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as claims adjudicated or medical or vocational expert) must not be made based upon the likelihood that the individual will support the denial of benefits.

Disability Claims Procedures

The Board of Trustees or its Benefits Committee (as applicable) will notify you of the Plan's adverse benefit determination within a reasonable period of time, but no later than forty-five (45) days after receipt of the claim by the Plan. This period may be extended by the Plan for up to thirty (30) days, provided that the Board of Trustees or its Benefit Committee determines that such an extension is necessary due to matters beyond the control of the Plan and notifies you, prior to the expiration of the initial 45-day period, of the circumstances requiring the extension of time and the date by which the Plan expect to render a decision.

If, prior to the end of the first 30-day extension period, the Board of Trustees or its Benefit Committee determines that, due to matters beyond the control of the Plan, a decision cannot be rendered within that extension period, the period for making the determination may be extended for up to an additional thirty (30) days, provided that the Board of Trustees or its Benefit Committee determines that such an extension is necessary due to matters beyond the control of the Plan and notifies you, prior to the expiration of the initial 45-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

If, prior to the end of the first 30-day extension period, the Board of Trustees or its Benefit Committee determines that, due to matters beyond the control of the Plan, a decision cannot be rendered with that extension period, the period for making the determination may be extended for up to an additional thirty (30) days, provided that the Board of Trustees or its Benefits Committee notifies you, prior to the expiration of the first 30-day extension period, of the circumstances requiring the extension, and the date by which the Plan expects to render a decision. The notice of extension will specifically explain the standards on which entitlement to a disability benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information

needed to resolve those issues. If additional information is needed, you will be afforded at least forty-five (45) days within which to provide the specified information.

If special circumstances (such as the need to hold a hearing, if the Plan's procedures provide for a hearing) require a further extension of time for processing the claim, a benefit determination will be rendered not later than the third meeting of the Board of Trustees or its Benefit Committee following the Plan's receipt of the request for review. If such an extension of time for review is required because of special circumstances, the Board of Trustees or its Benefits Committee will provide you written notice of the extension, describing the special circumstances and the date as of which the benefit determination will be made, prior to the commencement of the extension. The Board of Trustees or its Benefits Committee also will notify you of the benefit determination as soon as possible, but not later than five (5) days after the benefit determination is made.

The term "Adverse Benefit Determination," including any rescission of disability coverage with respect to any Participant or Beneficiary (whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at that time). For this purpose, the term "rescission" means a cancellation or discontinuance of coverage that has a retroactive effect, except to the extent that it is attributable to a failure to timely pay required premiums or make contributions towards the cost of coverage. Thus, rescissions of coverage, including retroactive terminations due to alleged misrepresentations of act (e.g., for errors in applications for coverage), will be treated as adverse benefit determinations that trigger the Plan's appeal procedures. Rescissions for nonpayment of premiums are not covered by this provision.

If your disability claim is wholly or partially denied, the Board of Trustees or its Benefit Committee (as applicable) will provide you a written or electronic notification of any adverse benefit determination. Any electronic notification will comply with the standards imposed by 29 C.F.R. Section 2520.104b-1(c)(1)(i), (iii), and (iv) (relating to disclosures through electronic media). The notification will set forth, in a manner reasonably calculated to be understood by you and other claimants:

- The specific reason or reasons for the adverse determination;
- The specific Plan provisions on which the determination is based;
- A description of any additional material or information necessary for you to perfect the claim and an explanation of which such material or information is necessary; and
- A description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review.

In the case of an adverse benefit determination with respect to your disability benefit, the Board of Trustees or its Benefit Committee will provide the following additional information:

1) A discussion of the decision, including an explanation of the basis for disagreeing with or not following:

   - The views presented by you to the Plan of health care professionals treating you and vocational professionals who evaluated your condition;

   - The views of medical or vocational experts whose advice 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

   - A disability determination regarding you, presented by you to the Plan, and made by the Social Security Administration.

2) If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request.

3) The specific internal rules, guidelines, protocols, standards, or other similar criteria that the Plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards, or other similar criteria of the Plan do not exist.

4) 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 disability benefits. A document, record, or other information is considered “relevant” if it:

   - Was relied upon in making the benefit determination;

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

   - Demonstrates compliance with the administrative processes and safeguards required pursuant to this section in making the adverse benefit determination.

In the case of an adverse benefit determination with respect to disability benefits, the notification will be provided in a culturally and linguistically appropriate manner as required by applicable federal regulations.

Disability Appeal Procedures

You will have a reasonable opportunity to appeal an adverse benefit determination of your disability claim to the Board of Trustees or its Benefits Committee (as applicable), as the appropriate named fiduciary of the Plan, and under which there will be a full and fair review of the appeal and the adverse benefit determination.

Upon receipt of an adverse benefit determination on your disability claim, you (or your authorized representative) will have up to one hundred eighty (180) days to file an appeal with the Fund Office. You may submit written comments, documents, records, and other information relating to the claim for benefits, without regard to whether such information was submitted or considered in the initial benefit determination, and you will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for disability benefits.

The Board of Trustees or its Benefits Committee will make its benefit appeal determination no later than the date of the meeting that immediately follows the Plan's receipt of your request for review, unless the request for review is filed within thirty (30) days preceding the date of such meeting. In such case, a benefit appeal determination will be made by no later than the date of the second meeting following the Plan's receipt of the request for review. Any review will take into account all comments, documents, records, and other information submitted by you relating to the appeal, without regard to whether such information was submitted or considered in the initial benefit determination.

The period of time within which review of your denied disability claim is required to be made will begin at the time your appeal is filed in accordance with the reasonable procedures of the Plan, without regard to whether all the information necessary to make a benefit determination on review accompanies the filing. In the event that a period of time is extended due to your failure to submit information necessary to decide the appeal, the period for making the benefit determination on review will be tolled from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information.

Before the Plan can issue an adverse benefit determination on review of your disability benefit appeal, the Board of Trustees or its Benefits Committee will provide you, free of charge, any new or additional evidence considered, relied upon, or generated by the Plan, its insurer, or other person making the benefit determination (or at the direction of the Plan, insurer, or such other person) in connection with the claim. Such evidence will be provided to you 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 to you to give you a reasonable opportunity to respond prior to that date.

In addition, before the Plan can issue an adverse benefit determination on review on your disability benefit claim based on a new or additional rationale, the Board of Trustees or its Benefits Committee will provide you, free of charge, with the rationale, and the rationale will be provided to you 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 to you to give you a reasonable opportunity to respond prior to that date.

The Board of Trustees or its Benefits Committee will provide you written or electronic notification of its appeal determination, and any electronic notification will comply with the standards imposed by 29 C.F.R. Section 2520.1046-1 (c)(l)(i), (iii), and (iv) (relating to disclosures through electronic media). In the case of an adverse appeal determination, the notification will set forth, in a manner reasonably calculated to be understood by you and other similarly situated claimants, the following information:

- The specific reason or reasons for the adverse determination;
- Reference to the specific Plan provisions on which the benefit determination is based;
- 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 (as defined above) to your claim for disability benefits;
- A statement describing the Plan's voluntary appeal procedures, described elsewhere in this SPD, and your right to obtain the information about such procedures upon request and free of charge;
- A statement of your right to bring an action under ERISA Section 502(a); and
- A statement about the statute of limitations period that applies to your right to bring an action in court, including the specific calendar date on which the limitations period would expire for your disability claim. (In other words, this Plan has an internal deadline of one (1) year by which a claim must be filed in court, so the appeal notice must explain the 1-year rule and specify the expiration date of the 1 -year limitations period. If the deadline is within one (1) year after the final denial and the denial was finalized on November 3, 2020, the Plan's denial notice must state that you have one (1) year, or until November 3, 2021, to file your lawsuit in federal court.)

If the Plan makes an adverse benefit decision with respect to your disability benefit appeal, the Board of Trustees or Benefits Committee will provide a discussion of the decision, including an explanation of the basis for disagreeing with or not following:

- The views presented by you to the Plan of health care professionals treating you and vocational professionals who evaluated you;
- The views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination, without regard to whether the advice was relied on in making the benefit determination; and
- A disability determination regarding you, presented by you to the Plan, and made by the Social Security Administration.

If the adverse benefit determination on review is based on a medical necessity or experimental treatment or similar exclusion or limit, the Board of Trustees or Benefits Committee will provide either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request.

The Board of Trustees or Benefits Committee also will provide the specific internal rules, guidelines, protocols, standards, or other similar criteria that the Plan relied on in making the adverse determination on review or, alternatively, a statement that such rules, guidelines, protocols, standards, or other similar criteria of the Plan do not exist.

In the case of an adverse benefit determination on review with respect to disability benefits, the notification will be provided in a culturally and linguistically appropriate manner, as required by the applicable federal regulations.

If the Plan fails to strictly adhere to all the requirements of this section with respect to your disability claim or appeal, you are deemed to have exhausted the administrative remedies available under the Plan, except as provided below. Accordingly, you would be entitled to pursue any available remedies under ERISA Section 502(a) on the basis that the Plan has failed to provide reasonable claims and appeal procedures that would yield a decision on the merits of your claim. If you choose to pursue remedies under ERISA Section 502(a), the claim or appeal is deemed denied on review without the exercise of discretion by an appropriate fiduciary.

Notwithstanding the previous paragraph, the administrative remedies available under a Plan with respect to your claim for disability benefits will not be deemed exhausted based on de minimis violations that do not cause, and are not likely to cause, prejudice or harm to you, so long as the Plan demonstrates that the violation was for good cause or due to matters beyond the control of the Plan, and that the violation occurred in the context of an ongoing, good faith exchange of information between you and the Plan. This exception is not available if the violation is part of a pattern or practice of violations by the Plan.

You may request a written explanation of the aforementioned violation from the Plan, and the Plan must provide such explanation within ten (10) days, including a specific description of its bases, if any, for asserting that the violation should not cause the administrative remedies available under the Plan to be deemed exhausted. If a court denies your request for immediate review, your disability claim will be considered as re-filed on appeal upon the Plan's receipt of the decision of the court. Within a reasonable time after the receipt of the decision, the Plan will provide you a notice of the resubmission.

BASIC BENEFITS

Hospital Facility Services

You may receive treatment at a Network or an Out-of-Network Hospital. However, payment is significantly reduced if services are received at an Out-of-Network Hospital. The Plan provides covered services when the following services are medically necessary.

Network

- Inpatient Services: Covered services include a semiprivate room, general nursing care, and intensive or cardiac care. If you stay in a private room, the Maximum Allowed Amount is based on the Hospital's prevalent semiprivate rate. If you are admitted to a Hospital that only has private rooms, the Maximum Allowed Amount is based on the Hospital's prevalent room rate. Inpatient hospital services may be subject to pre-certification.

Services and Supplies

- Services and supplies provided and billed by the hospital while you are an inpatient, including the use of operating, recovery and delivery rooms. Laboratory and diagnostic examinations, intravenous solutions, basal metabolism studies, electrocardiograms, electroencephalograms, x-ray examinations, and radiation and speech therapy are also covered.
- Convenience items (such as radios, TV's, record, tape or CD players, telephones, visitors' meals, etc.) will not be covered.
- Physician Services, including surgeon, anesthesiologist, radiologist, and pathologist charges.
- Hospital benefits

If you are confined in an out-of-network hospital, your benefits will be significantly reduced, as explained in the Schedule of Benefits section.

Outpatient Hospital Treatment – The Plan provides coverage when the following outpatient services are Medically Necessary: pre-admission tests, surgery, diagnostic x-rays, and laboratory services. Certain procedures require precertification.

HOME HEALTH CARE BENEFITS

In accordance with the Schedule of Benefits, this benefit is intended to allow you to receive treatment in your home, rather than as a Hospital Inpatient. The program consists of required intermittent skilled care, which may include observation, evaluation, teaching and nursing services consistent with the diagnosis, established and approved in writing by the Participant's attending physician. Services may be performed by either Network or Out-of-Network providers.

Some special conditions apply:

- The physicians statement recommended program must be pre-certified; and
- Claims will be reviewed to verify that services consist of skilled care that is medically consistent with the diagnosis. Note: Covered Services available under Home Health Care do NOT reduce outpatient benefits available under the Physical Therapy benefits offered under the plan.

The following services are covered under this benefit:

- Visits by an RN or LPN. Benefits cannot be provided for services if the nurse is related to the Participant.
- Visited by a qualified physiotherapist or speech therapist and by an inhalation therapist certified by the National Bard of Respiratory Therapy.
- Visits to render services and/or supplies of a licensed Medical Social Services Worker when Medically Necessary to enable the Participant to understand the emotional, social and environmental factors resulting from or affecting the Participant's illness.
- Visits by a Home Health Nursing Aide when rendered under the direct supervision of an NR.
- Nutritional guidance when Medically Necessary.
- Oxygen and its administration
- When available in the Participant's area, benefits are also available for intensive in-home Behavioral Health Services. These do not require confinement to the home

Limitations

No payment will be made for:

- Food, housing, homemaker services, sitters, and home-delivered meals.
- Home Health Care services which are not Medically Necessary or of a non-skilled level of care.
- Services and/or supplies which are not included in the Home Health Care plan, as described.
- Services of a person who ordinarily resides in the Participant's home or is a member of the family of either the Participant or Participant's spouse.
- Any services for any period during which the Participant is not under the continuing care of a Physician.
- Convalescent or Custodial Care where the Participant is not under the continuing care of a Physician.
- Any services or supplies not specifically listed as Covered Services.
- Routine care and/or examination of a newborn child.
- Dietician services
- Maintenance therapy
- Dialysis treatment

- Purchase or rental of dialysis equipment
- Private duty nursing care
- See also, Exclusions and Limitations.

HOSPICE CARE BENEFITS

Eligibility
You are eligible for Hospice care if Your Doctor and the Hospice medical director certify that You are terminally ill and likely to have less than twelve (12) months to live. You may access Hospice care while participating in a clinical trial or continuing disease modifying therapy, as ordered by Your treating Provider. Disease modifying therapy treats the underlying terminal illness.

Covered Services
The services and supplies listed below are Covered Services when given by a Hospice for the palliative care of pain and other symptoms that are part of a terminal disease. Palliative care means care that controls pain and relieves symptoms but is not meant to cure a terminal illness. Covered Services include:

- Care from an interdisciplinary team with the development and maintenance of an appropriate plan of care;
- Short-term Inpatient Hospital care when needed in periods of crisis or as respite care;
- Skilled nursing services, home health aide services, and homemaker services given by or under the supervision of a registered nurse;
- Social services and counseling services from a licensed social worker;
- Nutritional support such as intravenous feeding and feeding tubes;
- Physical Therapy, occupational therapy, speech therapy, and respiratory therapy given by a licensed therapist;
- Pharmaceuticals, medical equipment, and supplies needed for the palliative care of Your condition, including oxygen and related respiratory therapy supplies; and
- Bereavement (grief) services, including a review of the needs of the bereaved family and the development of a care plan to meet those needs, both before and after the Participant's death. Bereavement services are available to surviving members of the immediate family for one year after the Participant's death. Immediate family means Your Spouse, children, stepchildren, parents, brothers and sisters.

Your Physician must agree to care by the Hospice and must be consulted in the development of the care plan. The Hospice must keep a written care plan on file and give it to the Claims Administrator upon request.

Benefits for services beyond those listed above that are given for disease modification or palliation, such as but not limited to, chemotherapy and radiation therapy, are available to a Participant in Hospice. These services are covered under other parts of the Plan.

SKILLED NURSING CARE FACILITY BENEFITS

Benefits are provided as outlined in the Schedule of Benefits. This care must be ordered by the attending Physician. All Skilled Nursing Facility admissions must be pre-certified. Claims will be reviewed to verify that services consist of Skilled Convalescent Care that is medically consistent with the diagnosis.

Skilled Convalescent Care during a period of recovery is characterized by:

- A favorable prognosis;
- A reasonably predictable recovery time; and
- Services and/or facilities less intense than those of the acute general hospital, but greater than those normally available at the Participant's residence.

Covered Services include:

- Semiprivate or wardroom charges including general nursing service, meals, and special diets. If a Member stays in a private room, this Plan pays the Semiprivate Room rate toward the charge for the private room;
- Use of special care rooms;
- Pathology and radiology;
- Physical or speech therapy;
- Oxygen and other gas therapy;
- Drugs and solutions used while a patient; or
- Gauze, cotton, fabrics, solutions, plaster and other materials used in dressings, bandages, and casts.

This benefit is available only if the patient requires a Physician's continuous care and 24 hour-a-day nursing care. Benefits will not be provided when:

- A Participant reaches the maximum level of recovery possible and no longer requires other than routine care;
- Care is primarily Custodial Care, not requiring definitive medical or 24 hour-a-day nursing service;
- No specific medical conditions exist that require care in a Skilled Nursing Facility; or
- The care rendered is for other than Skilled Convalescent Care.

BEHAVIORAL HEALTH CARE & SUBSTANCE ABUSE TREATMENT

Coverage for the diagnosis and treatment of Behavioral Health Care and Substance Abuse Treatment on an inpatient or outpatient basis will not be subject to deductibles or coinsurance/copayment provisions that are less favorable than the deductible or

coinsurance/copayment provisions that apply to a physical illness as covered under the Plan.

Covered Services include the following:

- Inpatient Services in a hospital or any facility that must be covered by law. Inpatient benefits include psychotherapy, psychological testing, electroconvulsive therapy, and detoxification.
- Residential treatment is a licensed residential treatment center that offers individualized and intensive treatment and includes:
  - Observation and assessment by a psychiatrist weekly or more often; and
  - Rehabilitation therapy and education
- Outpatient services including office visits, therapy and treatment, partial hospitalization and day treatment programs, and intensive outpatient programs.
- Online visits when available in a Participant's area. Covered services include a medical visit with a doctor using the internet by webcam, chat, or voice. Online visits do not include reporting normal lab or other test results, requesting office visits, getting answers to billing, insurance coverage or payment questions, asking for referrals to doctors outside the online care panel, benefit precertification, or doctor-to-doctor discussions. Online visits are not covered from providers other than contracted with LiveHealth Online.

Examples of providers from whom Participants can receive covered services include:

- Psychiatrist;
- Psychologist
- Licensed Clinical Social Worker
- Mental Health Clinical Nurse Specialist
- Licensed Marriage and Family Therapist
- Licensed Professional Counselor
- Any agency licensed by the state to give these services, when they must be covered by law.

SURGICAL BENEFIT

Benefits

The fees charged by the surgeon will be paid based on the appropriate amount set by the Schedule of Benefits. The operation must be recommended and performed by a Physician. Hospital confinement is not required. Some procedures require precertification.

BENEFITS FOR MOTHERS AND NEWBORNS

This child birth benefit is for any hospital length of stay in connection with childbirth for the mother or newborn child, following a normal vaginal delivery, to a minimum of forty-

eight (48) hours. This benefit is for any hospital length stay in connection with childbirth for the mother or newborn child, following a cesarean section, to a minimum of ninety-six (96) hours. This, however, 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 96 hours as applicable).

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

Medical and surgical benefits with respect to a mastectomy will be covered for an eligible Participant and Dependents of the Plan who elects breast reconstruction in connection with such mastectomy as listed below:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and/or
- Prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the patient.

Such coverage will be subject to the annual deductibles and co-insurance provisions of the Plan as may be deemed appropriate and as are consistent with those established for other benefits under the Plan.

X-RAY AND LABORATORY BENEFITS

If you or a Dependent undergo an X-ray or laboratory examination made or recommended by a Physician in connection with the diagnosis of Non-occupational Accidental Injury or Sickness, benefits will be paid in accordance with the Schedule of Benefits.

No benefits are payable for therapeutic X-ray, dental X-rays, or eye refractions; for examination made in connection with dental work or treatment or abortion, after termination of coverage, or for any sickness or injury for which benefits are payable under the Inpatient and Outpatient professional and charges provisions of the Schedule of Benefits. See also, Exclusions and Limitations.

DESCRIPTION OF BENEFITS

After you satisfy your Plan Deductible, the High and Mid Plans pay eighty percent (80%) of in-network covered Expenses and sixty percent (60%) of out-of-network covered expenses as along as those out-of-network expenses are Reasonable and Customary; the Low Plan pays seventy percent (70%) of in-network covered expenses and 50% of out-of-network covered expenses as long as those out-of-network expenses are Reasonable and Customary. The maximum payment is specified in the Schedule of Benefits. Benefits for each Eligible Dependent will be on the same basis as your own.

THE DEDUCTIBLE

The deductible is the amount of expense which you pay before you are entitled to payment of Plan Benefits.

The deductible applies only once in any Calendar Year even though you may have several different disabilities. Your Calendar Year deductibles are:

$350/person and $700/family under the High Plan in-network; and
$700/person and $1,400/family under the High Plan out-of-network

$500/person and $1,000/family under the Mid Plan in-network; and
$1,000/person and $2,000/family under the Mid Plan out-of-network

$1,000/person and $2,000/family under the Low Plan in-network; and
$2,000/person and $4,000/family under the Low Plan out-of-network

COMMON ACCIDENT

Normally, the deductible is applied separately for each injury or sickness to each Eligible Person in the family. However, if two or more Eligible Persons in your family are injured in the same accident, the Medical Expenses which result from the accident will be combined and only one deductible will be charged against all such expenses, regardless of the number of family members injured.

MEDICAL EXPENSES COVERED

Medical Expenses included under the Plan are the Reasonable and Customary charges outlined below for Necessary medical care and services that are ordered by a Physician:

- The fees for diagnosis, treatment, and surgery by a Physician;
- The charges of a registered graduate nurse for private duty nursing services (other than in-patient hospital nursing);
- Charges made by a duly constituted Hospital, except that the daily room and board charges may not exceed the Room Limitations specified in the Schedule of Benefits;
- Charges for the following: local ambulance service to the nearest facility where appropriate medical treatment can be rendered, equipment, medication, appliances, X-ray services, laboratory tests, physical therapy, anesthetic and the administration thereof, the use of radium and radioactive isotopes, oxygen, iron lung, physiotherapy, and similar Covered Medical Expenses.

ROUTINE, PREVENTATIVE, AND WELLNESS SERVICES

The Plan will cover the following routine and wellness services:

- **Health Education Service** – Behavioral Counseling to Promote a Healthy Diet: Intense behavioral dietary counseling for adults with hyperlipidemia and other known risk factors for cardiovascular and diet-related chronic diseases.

- **Immunizations**: including, but not limited to, diptheria toxoid; diptheria/tetanus toxoids (DT); hepatitis B; herpes zoster (shingles); human papillomavirus vaccine (HPV); influenza (flu vaccine); measles-mumps-rubella vaccine (MMR); meningococcal vaccine; pneumococcal; pneumococcal polysaccharide; rabies vaccine; tetanus toxoid; and varicella (chicken pox).

- **Routine Gynecological Services** – mammogram services, PAP tests, and associated examinations.

- **Routine Physical Examinations**: The following services are covered:

    - Blood glucose screenings for Type 2 diabetes for asymptomatic adults with abnormal blood pressure readings (either treated or untreated);

    - Bone density screenings (limited to women age 50 and older);

    - Chlamydia screenings, limited to pregnant and sexually active women age 24 and younger and for older women who are at an increased risk

    - Cholesterol screenings, limited to:
        - Men age 35 and older for lipid disorders;
        - Men ages 20 to 35 for lipid disorders if they are at an increased risk for coronary heart disease; and
        - Women ages 20 and older for lipid disorders if they are at an increased risk for coronary heart disease.

    - Colorectal Cancer Screenings using fecal occult blood testing, sigmoidoscopy, or colonoscopy in adults beginning at age 40 and continuing until age 74; and

    - Hepatitis B virus screenings, including screening in non-pregnant adolescents, adults, and pregnant women (during first prenatal visit).

- **Well Child Care Benefits**: Coverage for well child services will be provided for Covered Persons under the age of 21. Coverage for immunizations is also provided for Covered Persons under the age of 21.

Well child-care services include a review performed in accordance with the recommendations of the American Academy of Pediatrics. This review includes a history, complete physical examination, routine newborn hearing screening and developmental assessment. Vision tests, hearing tests, and the developmental assessment must be included as part of the physical examination in order to be provided as a part of this benefit. This review also includes anticipatory guidance, laboratory tests, and appropriate immunizations.

- **Women's Preventive Services**: Medical services in accordance with the age and frequency requirements of the Affordable Care Act, including, but not limited to, well woman visits; screening for gestational diabetes, human papillomavirus (HPV), human immunodeficiency virus (HIV) and other sexually transmitted diseases; and counseling for breastfeeding and domestic violence.

- **Additional Preventive Services**: If not shown above as a Covered Service, if provided in-network, the following services will also be covered without regard to any Deductible, Copayment, or Coinsurance requirement that would otherwise apply:

    - Evidence based medical services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force;

    - Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the Covered Person involved; and

    - With respect to Covered Persons who are infants, children, and adolescents, evidence-informed preventive care (not including any prescription drugs) and screenings provided for in the comprehensive guidelines supported by the Health Resources and Service Administration.

- **Routine Testing**: The following tests are covered under this benefit:

    - Endoscopic procedures (meaning colonoscopy and sigmoidoscopy)

    - Laboratory, x-ray, and medical testing services

Important Information: For a comprehensive list of recommended preventive services, please visit https://www.healthcare.gov/coverage/preventive-care-benefits/. However, please note that since this Plan is a grandfathered Plan, the Trustees do not have to include all services or screenings included on the recommended preventive services

list, including any newly added preventive services adopted by an advisory entity referenced in the Affordable Care Act. Therefore, please refer to the phone number on the back of your ID card if you have any questions or need to determine whether a service is eligible for coverage as a preventive service.

Helpful Tip: If you or your dependents receive Preventive Services that are covered under this Section from an in-network provider, the Plan will cover those services at 100% of the allowed amount without applying the general deductible.

COVERAGE FOR CERTAIN GENE THERAPY TREATMENT

Effective January 1, 2020, the Plan will cover certain gene therapy treatments that are approved by the U.S. Food and Drug Administration ("FDA"). Any FDA approved gene therapy treatments that the Trustees elect to cover will only be covered under the medical benefit plan and will not be eligible for coverage under the prescription drug benefit. All gene therapy treatments are subject to prior authorization and other applicable review guidelines. If you or your dependents are thinking about receiving gene therapy treatment, contact Anthem for additional information regarding the prior authorization and review process, as well as the coverage provided under the Plan.

AMBULANCE SERVICES

Medically Necessary Ambulance Services are a Covered Service when:

- You are transported by a state licensed vehicle that is designed, equipped, and used only to transport the sick and injured and staffed by Emergency Medical Technicians (EMT), paramedics or other certified medical professionals. This includes ground, water, fixed wing, and rotary wing air transportation.

And one or more of the following criteria are met:

- For ground ambulance, You are taken:
  - From Your home, the scene of an accident or Medical Emergency to a Hospital.
  - Between Hospitals, including when the Claims Administrator requires You to move from an Out-of-Network Hospital to a Network hospital.
  - Between a Hospital and a Skilled Nursing Facility or other approved Facility.
- For air or water ambulance, You are taken:
  - From the scene of an accident or Medical Emergency to a Hospital.
  - Between Hospitals, including when the Claims Administrator requires You to move from an Out-of-Network Hospital to a Network Hospital.
  - Between a Hospital and an approved Facility.

Ambulance Services are subject to Medical Necessity reviews by the Claims Administrator. Emergency ground ambulance services do not require precertification and are allowed regardless of whether the Provider is a Network or Out-of-Network Provider.

Non-Emergency Ambulance Services are subject to Medical Necessity reviews by the Claims Administrator. When using an air ambulance, for non-Emergency transportation, the Claims Administrator reserves the right to select the air ambulance Provider. If You do not use the air ambulance Provider the Claims Administrator selects, the Out-of-Network Provider may bill You for any charges that exceed the Plan's Maximum Allowed Amount.

You must be taken to the nearest Facility that can give care for Your condition. In certain cases, the Claims Administrator may approve benefits for transportation to a Facility that is not the nearest Facility. Benefits also include Medically Necessary treatment of a sickness or Injury by medical professionals from an ambulance service, even if You are not taken to a Facility. Ambulance Services are not covered when another type of transportation can be used without endangering Your health. Ambulance Services for Your convenience or the convenience of Your family or Physician are not a Covered Service.

Other non-covered Ambulance Services include, but are not limited to:

- a Physician's office or clinic; or
- a morgue or funeral home.

Important Notes on Air Ambulance Benefits

Benefits are only available for air ambulance when it is not appropriate to use a ground or water ambulance. For example, if using a ground ambulance would endanger Your health and Your medical condition requires a more rapid transport to a Facility than the ground ambulance can provide, the Plan will cover the air ambulance. Air ambulance will also be covered if You are in an area that a ground or water ambulance cannot reach.

Air ambulance will not be covered if You are taken to a Hospital that is not an acute care Hospital (such as a Skilled Nursing Facility or a rehabilitation Facility), or if You are taken to a Physician's office or Your home.

<u>Hospital to Hospital Transport</u>
If You are moving from one Hospital to another, air ambulance will only be covered if using a ground ambulance would endanger Your health and if the Hospital that first treats cannot give You the medical services You need. Certain specialized services are not available at all Hospitals. For example, burn care, cardiac care, trauma care, and critical care are only available at certain Hospitals. To be covered, You must be taken to the closest Hospital that can treat You. **Coverage is not available for air ambulance transfers simply because You, Your family, or Your Provider prefers a specific Hospital or Physician.**

DENTAL SERVICES

Related to Accidental Injury
Your Plan includes benefits for dental work required for the initial repair of an Injury to the jaw, sound natural teeth, mouth or face which are required as a result of an accident and are not excessive in scope, duration, or intensity to provide safe, adequate, and appropriate treatment without adversely affecting the Member's condition. Injury as a result of chewing or biting is not considered an Accidental Injury except where the chewing or biting results from an act of domestic violence or directly from a medical condition.

Treatment must be completed within the timeframe shown in the Schedule of Benefits.

Other Dental Services
Your Plan also includes benefits for Hospital charges and anesthetics provided for dental care if the Member meets any of the following conditions:

- the Member is under the age of five (5);
- the Member has a severe disability that requires hospitalization or general anesthesia for dental care; or
- the Member has a medical condition that requires hospitalization or general anesthesia for dental care.

DIALYSIS TREATMENT

The Plan covers Covered Services for Dialysis treatment. If applicable, the Plan will pay secondary to Medicare Part B, even if a Member has not applied for eligible coverage available through Medicare.

DIABETES

Equipment and outpatient self-management training and education, including nutritional therapy for individuals with insulin-dependent diabetes, insulin-using diabetes, gestational diabetes, and non-insulin using diabetes as prescribed by the Physician. Covered Services for outpatient self-management training and education must be provided by a certified, registered or licensed health care professional with expertise in diabetes.

OTHER BENEFITS

DEATH BENEFITS
(Active Participants and Retirees Only)

The Fund will pay the amount of death benefit set forth in the Schedule of Benefits at the time of your death. The Fund Office must receive due proof that you died while eligible for benefits under the Plan. This Benefit is payable for Non-Occupational and Occupational Injury and Diseases.

If a beneficiary is designated, the consent of the beneficiary shall not be required to change the beneficiary, or to make any other changes in the certificate, except as may be specifically provided by the Plan. If any beneficiary shall die before the covered employee, the interest of such beneficiary shall thereupon automatically terminate. If there is no beneficiary designated by the Eligible Person, or surviving at the death of the Eligible Person, payment will be made in a single sum to the first surviving class of the following classes of successive preference beneficiaries: the Eligible Person's (a) widow or widower, (b) the Eligible Person's estate.

If you become Totally and Permanently Disabled before age sixty (60) and while covered under the Fund, the death benefit in effect at the time you become disabled will be extended for twelve (12) months at no cost to you. Satisfactory proof of disability must be provided within twelve (12) months after the disability commences. You can continue this coverage by submitting proof of your continued disability to the Fund Office each year.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS
(Active Participants Only)

If you sustain any of the following losses solely through external, violent and accidental means, you will receive the following additional benefit:

Loss of Life $5,000

Loss of Two Limbs, Sight of Both Eyes or
Loss of One Limb and Sight of One Eye $5,000
Loss of One Limb or Sight of One Eye $2,500

The Accidental Death and Dismemberment Benefits are payable for Non-Occupational and Occupational Injury.

SICKNESS AND ACCIDENT BENEFITS
(Employee Only)

Non-Occupational

If you are disabled as a result of a NON-OCCUPATIONAL accident or sickness, you will be entitled to the amount of Non-Occupational benefit indicated under the Schedule of Benefits.

These benefits will be payable to you as of the first day of disability if it is due to an accident, or as of the eighth day of disability if it is due to sickness, up to the Maximum Period of Benefits specified in the Schedule of Benefits for any one continuous period of disability due to the same or related cause or causes. Successive periods of disability separated by less than two (2) weeks of continuous active employment shall be considered as one continuous period of disability unless they arise from different and unrelated causes.

It is not necessary to be confined to your home to collect benefits, but you must be under the care of a Physician. No disability will be considered as beginning more than three days before the first visit with a physician.

Occupational

If you are disabled as a result of an OCCUPATIONAL accident or sickness for which you are entitled to receive benefits under a workers' compensation or occupational disease law, you will be entitled to the Occupational Sickness and Accident benefit indicated under the Schedule of Benefits.

Note: You cannot collect State unemployment benefits and Sickness and Accidental benefits for the same period.

EXCLUSIONS AND LIMITATIONS

These limitations and exclusions apply even if a qualified practitioner has performed or prescribed a Medically Necessary procedure, treatment or supply. This does not prevent Your qualified practitioner from providing or performing the procedure, treatment or supply. Regardless, the procedure, treatment or supply will not be a covered expense.

- Any disease or Injury resulting from a war, declared or not, or any military duty or any release of nuclear energy. Also excluded are charges for services directly related military service provided or available from the Veterans' Administration or military Facilities except as required by law.

- Services for Custodial Care.

- Services for confinement for custodial or convalescent care, rest cures or long-term custodial Hospital care.

- Dental care and treatment and oral surgery (by Physicians or dentists) including dental surgery; dental appliances; dental prostheses such as crowns, bridges, or dentures; implants; orthodontic care; operative restoration of teeth (fillings); dental extractions; endodontic care; apicoectomies; excision of radicular cysts or granuloma; treatment of dental caries, gingivitis, or periodontal disease by gingivectomies or other periodontal surgery. Any treatment of teeth, gums or tooth related service except otherwise specified as covered in this Benefit Booklet.

- Charges for treatment received before coverage under this option began or after it is terminated.

- Treatments, procedures, equipment, drugs, devices or supplies (hereafter called "services") which are, in the Claims Administrator’s judgment,

Experimental or Investigational for the diagnosis for which the Member is being treated.

- Services, treatment or supplies not generally accepted in medical practice for the prevention, diagnosis or treatment of an illness or injury, as determined by the Claims Administrator.

- Foot care only to improve comfort or appearance, routine care of corns, calluses, toenail (except surgical removal or care rendered as treatment of the diabetic foot or ingrown toenails), flat feet, fallen arches, weak feet, chronic foot strain, or asymptomatic complaints related to the feet. Coverage is available, however, for Medically Necessary foot care required as part of the treatment of diabetes and for Members with impaired circulation to the lower extremities.

- Shoe inserts, orthotics (will be covered if prescribed by a Physician for diseases of the foot or systemic diseases that affect the foot such as diabetes when deemed Medically Necessary).

- Treatment where payment is made by any local, state, or Federal government (except Medicaid), or for which payment would be made if the Member had applied for such benefits. Services that can be provided through a government program for which you as a member of the community are eligible for participation. Such programs include, but are not limited to, school speech and reading programs.

- Medicare – For which benefits are payable under Medicare Parts A and/or B or would have been payable if you had applied for Parts A and/or B, except as listed in this Benefit Booklet or as required by Federal law, as described in the section titled “Medicare” in General Information. If you do not enroll in Medicare Part B, we will calculate benefits as if you had enrolled. You should sign up for Medicare Part B as soon as possible to avoid large Out-of-Pocket costs.

- Services covered under Workers’ Compensation, no-fault automobile insurance and/or services covered by similar statutory programs.

- Court-ordered services, or those required by court order as a condition of parole or probation, unless Medically Necessary and approved by the Plan.

- Outpatient prescription drugs prescribed by a Physician and purchased or obtained from a retail pharmacy or retail pharmacist or a mail service pharmacy are excluded. These may be covered by a separate drug card program but not under this medical plan. Although coverage for outpatient Prescription Drugs obtained from a retail pharmacy or pharmacist or mail service Pharmacy is excluded, certain Prescription Drugs are covered

under your medical benefits when rendered in a Hospital, in a Physician's office, or as part of a Home Health Care benefit. Therefore, this exclusion does not apply to prescription drugs provided as Ancillary Services during an Inpatient stay or an Outpatient Surgical procedure; to prescription drugs used in conjunction with a diagnostic service; Chemotherapy performed in the office; home infusion or home IV therapy, nor drugs administered in your Physician's office.

- Drugs, devices, products, or supplies with over the counter equivalents and any drugs, devices, products, or supplies that are therapeutically comparable to an over-the-counter drug, device, product, or supply.

- Care, supplies, or equipment not Medically Necessary, as determined by the Claims Administrator, for the treatment of an injury or illness. This includes, but is not limited to, care which does not meet The Claims Administrator's medical policy, clinical coverage guidelines, or benefit policy guidelines.

- Vitamins, minerals and food supplements, as well as vitamin injections not determined to be Medically Necessary in the treatment of a specific illness. Nutritional supplements, services, supplies and/or nutritional sustenance products (food) related to enteral feeding, except when determined to be Medically Necessary.

- Services for Hospital confinement primarily for diagnostic studies.

- Cosmetic Surgery, reconstructive surgery, pharmacological services, nutritional regimens or other services for beautification, or treatment relating to the consequences of, or as a result of, Cosmetic Surgery, except for reconstructive surgery following a mastectomy or when Medically Necessary to correct damage caused by an accident, an injury or to correct a congenital defect.

- Donor Search/Compatibility, except as otherwise indicated.

- In-vitro Fertilization, Artificial Insemination and as indicated on the Plan Design.

- Hair transplants, hairpieces or wigs (except when necessitated by disease), wig maintenance, or prescriptions or medications related to hair growth.

- Services and supplies primarily for educational, vocational or training purposes, including but not limited to structured teaching, applied behavioral analysis, or educational interventions, except as expressly provided in the Anthem Benefit Booklet.

- Religious, marital and sex counseling, including services and treatment related to religious counseling, marital/relationship counseling and sex therapy.

- Christian Science practitioner services.

- Services and supplies for smoking cessation programs and treatment of nicotine addiction, including gum, patches, and prescription drugs to eliminate or reduce the dependency on or addiction to tobacco and tobacco products unless otherwise required by law.

- Services provided in a halfway house.

- Treatment or services provided by a non-licensed Provider, or that do not require a license to provide; services that consist of supervision by a Provider of a non-licensed person; services performed by a relative of a Participant for which, in the absence of any health benefits coverage, no charge would be made; services provided to the Participant by a local, state or Federal government agency, or by a public school system or school district, except when the plan's benefits must be provided by law; services if the Participant is not required to pay for them or they are provided to the Participant for free.

- Routine care is not covered. Except for above stated covered preventive care services.

- Services or supplies provided by a member of your family or household.

- Charges or any portion of a charge in excess of the Maximum Allowed Amount as determined by the Claims Administrator.

- Fees or charges made by an individual, agency or facility operating beyond the scope of its license.

- Services and supplies for which you have no legal obligation to pay, or for which no charge has been made or would be made if you had no health insurance coverage.

- Charges for any of the following:

  a) Failure to keep a scheduled visit;

  b) Completion of claim forms or medical records or reports unless otherwise required by law;

  c) For physician or hospital's stand-by services;

d) For holiday or overtime rates; and

e) Membership, administrative, or access fees charged by physicians or other providers. Examples of administrative fees include, but are not limited to, fees charged for educational brochures or calling a patient to provide their test results.

- Specific medical reports including those not directly related to the treatment of the Participant, e.g., employment or insurance physicals, and reports prepared in connection with litigation.

- Separate charges by interns, residents, house physicians or other health care professionals who are employed by the covered facility, which makes their services available.

- Personal comfort items such as those that are furnished primarily for your personal comfort or convenience, including those services and supplies not directly related to medical care, such as guest's meals and accommodations, barber services, telephone charges, radio and television rentals, homemaker services, travel expenses, and take-home supplies.

- Reversal of vasectomy or reversal of tubal ligation.

- Salabrasion, chemosurgery and other such skin abrasion procedures associated with the removal of scars, tattoos, and actinic changes and/or which are performed as a treatment for acne.

- Services for outpatient therapy or rehabilitation other than those specifically listed as covered in the Anthem Benefit Booklet. Excluded forms of therapy include, but are not limited to, primal therapy, chelation therapy, rolfing, psychodrama, megavitamin therapy, purging, bioenergetic therapy, in-home wrap around treatment, wilderness therapy and boot camp therapy.

- Vision care services and supplies, including but not limited to eyeglasses, contact lenses and related or routine examinations and services. Eye refractions. Analysis of vision or the testing of its acuity. Service or devices to correct vision or for advice on such service. This exclusion does not apply for initial prosthetic lenses or sclera shells following intraocular surgery or for soft contact lenses due to a medical condition, i.e. diabetes.

- Related to radial keratotomy or keratomileusis or excimer laser photo refractive keratectomy; and surgery, services or supplies for the surgical correction of nearsightedness and/or astigmatism or any other correction of vision due to a refractive problem.

- Gastric banding

- Services for weight loss programs, services and supplies. Weight loss programs include, but are not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, and LA Weight Loss).

MEDICAL REIMBURSEMENT ACCOUNTS

The Medical Reimbursement Arrangement ("MRA") allows eligible Participants to receive tax-free reimbursements for out-of-pocket expenses incurred by you or your eligible Dependents. That means after pay the expense out-of-pocket, the reimbursement you receive from the Plan is non-taxable. Your MRA is funded through contributions made by your employer as set forth under an applicable collective bargaining agreement or Participation Agreement. The MRA shall be an individual sub-account of the Plan for each Participant for whom such contributions are made. However, these contributions shall not create or constitute a vested benefit.

This section explains how to obtain reimbursement for out-of-pocket health expenses and self-payments. Bear in mind that the description below is only a summary of the eligible expenses. The IRS determines which expenses are eligible for reimbursement under the MRA. Each year, the IRS issues a publication (i.e., IRS Publication 502) that updates these rules. The Publication lists the items that are considered "eligible medical expenses" under Code Section 213(d). Any expense that qualifies under those rules can be reimbursed from your sub-account under the MRA.

GENERAL RULES

- The expense must be incurred on or after the later of the effective date of the plan or your effective date as a participant in the Plan.

- Eligible expenses will only be reimbursed up to the amount you have in your MRA.

- If you use a Benefit Card (i.e., "Bene Card") to pay for an eligible item, you may be asked to provide documentation to validate the expense. If you fail to do so, the expense may be considered taxable and subject to both applicable income taxes and penalties.

- If you are required to submit a claim form for your expense, it must be submitted within one (1) year following the end of the calendar year in which the services were rendered.

- For expenses not covered by insurance (deductibles, amounts over reasonable and customary, etc.), you must attach the Explanation of Benefits you receive from the insurance carrier.

- Expenses not filed with insurance (eligible over-the-counter drugs, for example) must be accompanied by a bill or receipt that has an explanation of the expense.

- If the expense is eligible under another program, such as your spouse's insurance, you must file a claim with the other insurance before you can request reimbursement from the Medical Reimbursement Account. You will need the other insurance Explanation of Benefits to be reimbursed under this plan.

SELF-PAYMENTS

- Self-Payments are eligible and can be made tax free from your MRA. You must submit a claim form each time you wish to use your MRA to make a self-payment.

- Self- Payments can only be made up to the amount you have accumulated in your MRA.

SURVIVING SPOUSE & DEPENDENTS

- Surviving spouses and/or surviving dependents can continue to access a Participant's MRA after he or she has died.

- The same medical, dental, vision, and prescription expenses that are reimbursable to the Participant are eligible for reimbursement.

- Funeral expenses are not an eligible reimbursement.

- After the death of the surviving spouse or surviving dependent, any amounts left in the MRA will be forfeited.

PLEASE NOTE: Benefits are made available by the Board of Trustees as a privilege, not as a right. No person acquires a vested right to any benefits, either before or after meeting the requirements for initial eligibility of benefits. The Trustees may expand, reduce or cancel coverage, change eligibility requirements or the amount of self-payments, and/or exercise their prudent discretion at any time. These actions may be done without legal right or recourse by an eligible employee or any other person.

ELIGIBLE EXPENSES

Following is a list of common expenses that may or may not be eligible for reimbursement from your MRA. Remember, this list is not exhaustive and any expense that has already been reimbursed from another source is not eligible for reimbursement.

Insurance Premiums	Most insurance premiums for medical plans are eligible for reimbursement unless they were made on a pre-tax basis or you are claiming a credit or deduction for them. This includes premiums for Medicare Parts A, B, and D. That also includes any Self-Payments that you may be required to make to retain eligibility under this Plan.
Co-payments/Co-insurance	This includes any co-payments or co-insurance payments made on behalf of you or your spouse or eligible dependents. This applies to medical, prescription, dental, and vision co-payments or co-insurance.
Prescription Drugs	Any out-of-pocket expense for a drug prescribed by your treating physician.
Over-the-Counter Medications	Effective January 1, 2020, over-the-counter medications are eligible for reimbursement.

Important: If you use a Bene Card to complete a transaction, you may be asked to provide documentation supporting the expense. If you fail to do so, the Plan could offset future eligible expenses to recover the improper payment or the amount could become subject to taxes and penalties.

INELIGIBLE EXPENSES

The following is a list of some items that are *not* eligible for reimbursement from your MRA. Again, this list is not exhaustive and follows the IRS guidance set forth in IRS Publication 502

Cosmetic Surgery	Ineligible if the surgery is not directly related to alleviating a disease or condition. That means face lifts, hair transplants, fillers, and liposuction would generally be ineligible.
Future Medical Expenses	Ineligible
Medical Marijuana	Ineligible, even if prescribed by a doctor and legal in the states where purchased. This includes any other controlled substance that is illegal under federal law.
Nutritional Supplements	Vitamins, herbal supplements, natural medicines, etc., are ineligible unless they are recommended by a medical practitioner for the treatment of a specific medical condition diagnosed by a physician.

FILING A CLAIM

If you are required to fil a Claim Form to obtain reimbursement from your MRA, you should include all supporting documentation with your Claim Form (i.e., Explanation of Benefits, bills, receipts, etc.). This expediate processing and reimbursements. Reimbursement checks will be processed between the 15th and 20th of the month following the month the claim was submitted.

Eligible expenses must be submitted no later than one (1) year following the end of the calendar year in which the services were rendered.

BREAK IN SERVICE RULES

If the Participant does not opt out or waive future reimbursements from his MRA account, then any monies deposited in a Participant's individual MRA shall remain in such account so long as the Participant is actively employed. If a Participant is not working, but is Actively Seeking Work, then his or her account balance will be not subject to forfeiture.

However, if a Participant is no longer working and is considered to not be Actively Seeking Work, then his or her account balance will be subject forfeiture. In such an event, the MRA account will revert to the general assets of the Plan and will no longer be available for reimbursement. Please be advised that the COBRA Continuation Coverage Rules (described above) apply to the MRA.

A Participant is still eligible to seek reimbursement from his or her MRA after the Participant has terminated employment if the Participant is Available for Work. Participant's that are retired or unable to work due to a disability are still eligible to seek reimbursement from their MRA Account. (other than due to retirement or disability)

After death, the unspent MRA balance will be available to the Participant's spouse, or if unmarried or widowed, to the Participant's Dependent (as allowed by applicable provisions of the Internal Revenue Code or regulations promulgated thereunder). This individual MRA may only be used for reimbursement purposes and shall not be paid directly to the surviving Spouse or the above Dependent other than for reimbursement for eligible expenses.

The Health and Welfare Fund may assess an administrative fee against the Participant's MRA for the administrative costs of processing such reimbursement claims.

COORDINATION OF BENEFITS

Coordination of Benefits (COB) provides a framework for coordinating payment of medical and dental expenses when you and other members of your family have multiple sources for the payment of medical expenses (here called "payment source" or "plan"). For example, if your spouse has coverage under a group benefit plan sponsored by his

or her employer and is also covered under this Plan, then you and your dependents may be eligible for benefits under both your spouse's plan and this Plan. Similarly, you or your spouse may have coverage for medical or dental expenses under general liability, automobile liability, uninsured/underinsured automobile or no-fault automobile insurance policies as well as this Plan.

Coordination of Benefits provides complete payment of your allowable expenses while preventing duplicate payment for the same service. "Allowable expenses" means any Necessary, Reasonable and Customary expense for medical care or treatment provided under at least one of the plans or policies covering the Eligible Person for whom a claim is made. Although Coordination of Benefits does not guarantee one hundred percent (100%) reimbursement for all expenses, it does attempt to provide as close to one hundred percent (100%) reimbursement as the plans involved in coordination allow.

Under COB, benefits are paid using a system where one payment source is determined to be primary, and the other payment source is determined to be secondary. The primary payment source pays first, and the secondary payment source pays second. When both you and your spouse have coverage under a group health plan for the same allowable expenses, the primary payment source is the one that covers you as an employee -- it pays first for you. The secondary payment source is the one that covers you as a dependent -- it pays second. For example, let's assume you work for an Employer in the Plan and your spouse works for another company.

If the claim is for	The Primary Plan will be	The Secondary Plan will be
you	this Plan	the other plan
your spouse	the other plan	this Plan

What about other Eligible Dependents like your Children? Usually, the plan of the parent whose birthday falls earlier in the year (month and day-not year-of birth) will pay first, and the plan of the parent whose birthday falls later in the year will pay second. However, if the claim is for a dependent Child whose parents are **separated or divorced,** coverage will be determined as follows:

Special System for Eligible Dependents of Parents who are SEPARATED or DIVORCED

Order of Plan Payment	Parent with Child Custody and NOT Remarried	Parent with Child Custody and HAS Remarried
First	Plan covering parent with custody of child	Plan covering parent with custody of child
Second	Plan covering parent without custody of child	Plan covering stepparent of child
Third		Plan covering parent without custody of child

However, if there is a court decree that establishes an Eligible Employee's financial responsibility as parent - in terms of medical or other health care expenses - the plan covering the child due to the decree will pay first. However, you must be eligible in order for your Child to be eligible.

If a person is covered under more than one plan, the plan such Person was covered under longer pays first. There is an exception for a group plan that covers a person other than as a laid-off or rehired employee, or dependent of such person; that plan will pay first. A group plan that covers a person as a laid-off or rehired employee, or dependent of such person will determine the benefits that are paid second.

Payment sources which are coordinated include group coverages, vehicle insurance (uninsured/underinsured and no-fault), school-sponsored insurance, casualty and liability insurance, and governmental coverages. Vehicle, liability, and uninsured/underinsured and no-fault coverages are always primary.

Coordination of Benefits with Health Maintenance Organization (HMO)

If an HMO is primary, the Plan will process claims so that it pays secondary benefits only - even if an HMO member of your family chooses to have health care services provided by a non-HMO provider and the HMO does not have to pay for the services.

Coordination with Medicare

The Participant must be retired and currently receiving Medicare Parts A & B benefits.

The Plan will pay its benefits **before** Medicare **only**

- For an active employee who is age sixty-five (65) or;
- For an active employee's dependent spouse who is age sixty-five (65) or older (unless the employee works for an employer with less than twenty (20) employees);
- The first thirty (30) months of treatment for end-stage renal disease received by an Eligible Person who is in the Active Employee Program;
- For Disabled, Eligible Dependents of Active Employees; and
- Where otherwise explicitly required by federal law.

When the rules above do not apply, the Plan will pay its benefits only **after** Medicare has paid its benefits.

NOTE: IF YOU ARE ELIGIBLE FOR MEDICARE, THE PLAN WILL PAY BENEFITS ONLY UP TO THE AMOUNT THAT WOULD BE PAID UNDER THE ABOVE RULES WHETHER OR NOT YOU HAVE APPLIED FOR MEDICARE BENEFITS. BECAUSE

YOUR BENEFITS MAY BE AFFECTED BY MEDICARE, YOU MAY WANT TO CONTACT YOUR LOCAL SOCIAL SECURITY OFFICE FOR INFORMATION ABOUT MEDICARE. THIS SHOULD BE DONE BEFORE YOUR 65TH BIRTHDAY OR THAT OF YOUR SPOUSE, OR IF YOU OR ONE OF YOUR DEPENDENTS BECOME DISABLED. MEDICARE COVERAGE, EVEN ON A SECONDARY BASIS, CAN PROVIDE VALUABLE BENEFITS.

Right to Receive and Release Needed Information

Certain facts are needed to apply Coordination of Benefits rules. The Plan has the right to decide which facts it needs. It may get needed facts from, or give them to, any other organization or person.

The Plan need not tell, or get the consent of, any person to do this. Each person claiming benefits under this Plan must give the Plan any facts it needs to pay the claim.

SUBROGATION

The Plan shall be entitled to subrogation and reimbursement if you or your Dependent (claimant) are paid benefits under the Plan for claims due to injuries or illness for which a third-party may be obligated to pay you for any person. A Participant agrees to the subrogation provisions described in this Section by enrolling in the Plan and applying for benefits.

Right to Subrogate
The Plan is subrogated to any and all rights of recovery and causes of action that the claimant may have against any third party, whether by suit, settlement, or otherwise, that may be liable for a claimant's injury or illness for which the Plan has paid or is obligated to pay benefits on the claimant's behalf.

Rights to Reimbursement With Source of Funds Specifically Identified
The Plan shall also be entitled, to the extent of payments made or to be made on account of the claim, to the proceeds of any settlement, judgment, or payment from any source liable for making a payment relating to the claimant's injury, illness, or condition. A source includes, but is not limited to, a responsible party and/or responsible party's insurer (or self-funded protection), no-fault protection, personal injury protection, medical payments coverage, financial responsibility, uninsured or underinsured insurance coverage, an employer under the provisions of a workers' compensation law, an individual policy of insurance maintained by a claimant, and organization, corporation, or government agency.

Rejection of Make-Whole Doctrine
Such subrogation and reimbursement rights shall apply on a priority, first dollar basis to any recovery, whether by suit, settlement, or otherwise, whether there is a partial or full recovery and regardless of whether the amounts are characterized or described as medical expenses or as amounts other than for medical expenses. **This provision is intended to and does reject and superseded any “make-whole” rule/doctrine, which rule/doctrine might otherwise require that you be “made whole” before the Plan may be entitled to assert its subrogation right.**

Equitable Lien by Agreement
Once the Plan makes, or is obligated to make, payments on behalf of a claimant, the Plan is granted, and the claimant consents to, an equitable lien by agreement or a constructive trust on the proceeds of any payment, settlement, or judgment received by the claimant or dependent from any source to the extent of payments made or to be made by the Plan on the claimant's behalf.

Claimant Must Set Aside Funds
The claimant shall hold in trust for the Plan's benefit that portion of the total recovery from any source that is due for payments made or to be made. The claimant shall reimburse the Plan immediately upon recovery. The claimant shall immediately notify the Plan if he or she is involved in or suffers an accident or injury for which a third party may be liable. The claimant shall again notify the Plan if he or she pursues a claim to recover damages or other relief relating to an injury or illness for which the Plan may make payments on the claimant's behalf. The claimant shall do nothing to impair, release, discharge or prejudice the Plan's rights to subrogation and/or reimbursement. The claimant shall assist and cooperate with representatives the Plan designates. The claimant shall do everything necessary to enable the Plan to enforce its subrogation and reimbursement. The claimant shall immediately notify the Plan upon receiving a judgment, settlement offer or compromise offer and shall not settle or compromise any claims without the Plan's consent.

First-Dollar Recovery
The Plan's subrogation and reimbursement rights shall apply on a priority first-dollar basis to any recovery whether by suit, settlement, or otherwise regardless of whether a claimant is made whole.

Disavowal of "Common-Fund" Doctrine
The Plan's subrogation and reimbursement rights apply to any recovery by the claimant without regard to legal fees and expenses of the claimant. The claimant shall be solely responsible for paying all legal fees and expenses in connection with any recovery for the underlying injury, sickness, accident or condition, and the Plan's recovery shall not be reduced by such legal fees or expenses.

The Plan specifically disavows any claims that a claimant or dependent may make under any federal or state common law defense including, but not limited to, the make-whole doctrine and/or the common-fund doctrine.

Cooperation
The Plan Administrator may require the claimant to complete and/or execute certain documentation to assist the Plan in the enforcement of its subrogation rights including, but not limited to, a subrogation and reimbursement questionnaire and a repayment agreement. **The completion and/or execution of any documents requested by the Plan Administrator shall be a condition to receiving payment for a claim. Further, the Plan shall have the right to suspend all benefit payments due to a claimant, the employee of whom a claimant is a dependent, and/or any other dependent of such an employee if the claimant fails to complete and/or execute such documentation.**

ADMINISTRATION OF THE FUND

Payments of Benefits Limited to Plan
All benefits under the Plan shall be payable through employees or agents of the Trustees acting under their authority. Benefits as authorized under the Plan will be paid as long as the Plan can operate on a sound financial basis. Anything in the Plan to the contrary notwithstanding, no benefits shall be payable except those which can be provided under the Plan, and no person shall have any claim for benefits against the Union, the Association, any Employer or the Trustees. The Trustees, the Employers and the Union shall not be held liable for any benefits except as provided in the Agreement(s) between the Employers and Union.

Amendment or Termination of Plan or Benefits
The Trustees may change or terminate this Plan, or any part thereof, in their sole and exclusive discretion. Benefits will terminate when the Plan, or any applicable portion thereof, is terminated.

Payment of Claims and Assignment of Benefits
Any benefits payable under this Plan are payable to the Eligible Employee. However, unless the Eligible Person requests otherwise, in writing, not later than the time proof of loss is filed, the Plan may pay any part or all of any benefits provided on account of hospital, nursing, medical, or surgical service directly to the person or entity which provided the service or treatment. The coverage and benefits under the Plan are not assignable without the consent of the Fund. Assigned benefits shall be paid to the assignee, regardless of the intervening death of the Eligible Person. Otherwise, except as otherwise provided by law, benefits due under this Plan shall not be assignable nor subject to attachment, garnishment or other legal process for debts of Eligible Persons.

Payment of Unassigned Benefits in Event of Death
If an Eligible Person expires before the payment to him of any and all unassigned benefits, the Plan Administrator may pay the amount of the unassigned but unpaid benefits as follows:

- If a probate administration is commenced in the Probate Court of the country in which the Eligible Person was domiciled at the time of his death, the Plan Administrator shall make prompt payment of the amount of the unassigned but unpaid benefit to the legal representative of the deceased, Eligible Person appointed by the Probate Court, upon receipt of a Certificate of Official Character from said legal representative.

- If a probate administration is not commenced on behalf of the deceased Eligible Person, the Plan Administrator, in the absence of a designated beneficiary shall make prompt payment of the amount of the unassigned but unpaid benefit to the survivors in the following order of priority and upon evidence acceptable to the Plan Administrator of their status and priority, to wit: (a) spouse, (b) children, pro rata; (c) parents; (d) brothers and sisters, pro rata; and (e) next of kin.

Misstatements
If any facts relevant to the existence or amount of coverage shall be misstated, the true facts will determine whether or not, and how much, coverage is in force.

Presentment of Claims on Behalf of Person Who is Incapacitated
If an Eligible Person shall become incapacitated and be unable to prepare, complete, and/or execute the forms and documents prescribed by the Trustees and/or their Plan Administrator for the filing of claims and/or receipt of benefits, the forms and documents may be signed for and on behalf of the Eligible Person by other persons, as follows:

- If a guardian has been appointed by a court of competent jurisdiction for the Eligible Person, by the guardian;

- If no guardian has been appointed, then by the persons in the following order of priority and upon evidence acceptable to the Plan Administrator of status and priority: (1) spouse; (2) a child; (3) a parent; or (4) a brother or sister.

Claims for Medical Service Rendered Outside of the United States
Due to the increasing mobility of Eligible Persons in the Plan, claims may be paid which arise from medical treatment received outside the United States, provided certain conditions are first met:

- If there has been Emergency medical care, the Eligible Person, upon returning to the United States, should submit the bills which have been paid for the Emergency treatment in order to be reimbursed according to the provisions and limitations within the Plan.

- If there will be elective medical care, the Eligible Person must first submit to the Fund Office or utilization review group a request stating the intended medical procedures to be undergone. The Eligible Person will receive a determination on whether or not it is in accordance with accepted medical procedures within the United States and whether it is encompassed within the framework of the Plan's benefits. Until such a determination is received, the Eligible Person cannot be assured that elective medical treatment will be covered under the Plan.

- Payment will be made in accordance with the foreign exchange rate as of the date of the medical care. Foreign currency will be converted to United States values as of that date.

Recovery of Overpayment
If the Plan Administrator ascertains that an Eligible Person has received an erroneous overpayment of a benefit, the Plan Administrator shall immediately notify such Eligible Person in writing, explaining the nature of the erroneous overpayment and requesting return of the amount of such overpayment. If the initial request for restitution is not successful, the Plan Administrator shall renew the demand in writing upon the Eligible Person and may take other reasonable actions to obtain reimbursement of the erroneous overpayment

If reasonable steps taken to obtain repayment of the overpayment have been unsuccessful, the Plan Administrator may treat the overpayment of benefits as an advance payment of benefits due to the Eligible Person and offset the amount of such overpayment against any Plan benefits due or which may become due to the Eligible Person until the full amount of the overpayment has been repaid to the Plan.

Validity of Plan and Plan Provisions
This Welfare Plan is established in the State of Ohio and all questions pertaining to the validity and construction of this Plan and of the acts and transactions of the parties hereto shall be determined in accordance with the laws of the State of Ohio, except as preempted by Federal law. Where all or part of a Plan provision is declared invalid, any remaining balance of such provision will remain valid.

Construction by Trustees
Under the Plan of Benefits and the Trust Agreement creating the Plan, the Trustees or persons acting for them, such as a Trustee Review Committee, have the sole and exclusive authority to make final determinations regarding any application for benefits and the interpretation of the Plan of Benefits, the Trust Agreement, the Plan document or any other rules, regulations, procedures or administrative rules adopted by the Trustees. Any questions or interpretations about the Plan or Trust Agreement, or disputes about eligibility for and amount of benefits, shall be resolved by the Board of Trustees. Decisions of the Trustees or, where appropriate, decisions of those acting for the Trustees in such matters, are final, binding and conclusive on all persons dealing with the Plan or claiming a benefit from the Plan. If a decision of the Trustees or those acting for the Trustees is challenged in court, it is the further intention of the parties to the Trust that such a decision is to be upheld unless it is determined to be arbitrary and capricious.

Any interpretation of the Plan or Trust Agreement made by the Trustees shall, subject to the claimant's right to legal action, be final and binding on all parties.

Legal Actions
No action at law or in equity shall be brought to recover any benefits provided under this Plan before the expiration of one hundred twenty (120) days after written proof of loss has been furnished nor shall any such action be brought after the expiration of three years after the time written proof of loss is required to be furnished.

DEFINITIONS

The following terms have a specific meaning under the Anthem Benefit Book. Please refer to this Definition Section when reviewing the covered services under the medical benefit provided under the Plan. Please note that this Section is only a summary of the definitions that apply:

Accidental Injury – Bodily Injury sustained by a Member as the result of an unforeseen event and which is the direct cause (independent of disease, bodily infirmity or any other cause) for care which the Member receives. Such care must occur while this Plan

is in force. It does not include injuries for which benefits are provided under any Workers' Compensation, Employer's liability or similar law.

Active Employment – A Participant is engaged in Active Employment if he or she is working in Covered Services for an Employer that is mandated under a collective bargaining agreement to make contributions to this Fund on his or her behalf.

Available for Work or Actively Seeking Work – A Participant is "Available for Work" or "Actively Seeking Work" if he or she is eligible to be employed in Covered Services pursuant to the rules of the applicable collective bargaining agreement.

Allowed Amount – For In-Network Providers, the Allowed Amount is the less of the negotiated amount or the Covered Medical Expense. For Out-of-Network Providers, the Allowed Amount is the Non-Contracting Amount, which will likely be less than the provider's billed charges. The Non-Contracting Amount is the maximum amount allowed for Covered Medical Expenses to Eligible Persons based on various factors, including, but not limited to, market rates for that service, negotiated amounts for that service, and Medicare reimbursement for that service. The Non-Contracting Amount will likely be less than the provider's billed charges. If you receive services from an out-of-network Provider, and you are balanced billed for the differed between the Non-Contracting Amount and the bill charges, you may be responsible for the full amount up to the provider's billed charges, even if you have met your out-of-pocket maximum.

Ambulance Services – A state-licensed emergency vehicle which carries injured or sick persons to a Hospital. Services which offer non-emergency, convalescent or invalid care do not meet this definition.

Assignment of Benefits – a written request by an Eligible Person that the Plan pay any part or all of any benefits provided on account of hospital, nursing, medical or surgical service directly to the person or entity which provided the service or treatment. A written request will include a proper notation on a provider billing form.

Association – Any Employer Association who is a party to a Collective Bargaining Agreement with one or more of the Local Unions participating in the Ohio Conference of Plasterers and Cement Masons Health and Welfare Fund.

Behavioral Health Care – Includes services for Mental Health and Substance Abuse. Mental Health and Substance Abuse is a condition that is listed in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) as a mental health or substance abuse condition.

Calendar Year – that period commencing at 12:01 a.m. Standard Time and continuing until 12:01a.m. Standard Time on the immediately following January 1.

Chiropractor – an individual licensed to practice chiropractic by the applicable agency of the state in which the individual renders care or treatment, and acting within the scope of such individual's 1icense.

Claims Administrator – The company the Plan Sponsor chose to administer its health benefits. ***Anthem*** e.g., Anthem Insurance Companies, Inc. was chosen to administer this Plan. The Claims Administrator provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

Collective Bargaining Agreement – the agreement between your Union and Employer which governs the wages and conditions of your work.

Combined Limit – The maximum total of Network and Out-of-Network benefits available for designated health services in the **Schedule of Benefits**.

Complications of Pregnancy – Complications of Pregnancy result from conditions requiring Hospital confinement when the pregnancy is not terminated. The diagnoses of the complications are distinct from pregnancy but adversely affected or caused by pregnancy. Such conditions include acute nephritis, nephrosis, cardiac decompensation, missed or threatened abortion, preeclampsia, intrauterine fetal growth retardation and similar medical and surgical conditions of comparable severity. An ectopic pregnancy which is terminated is also considered a Complication of Pregnancy.

Complications of Pregnancy shall not include false labor, caesarean section, occasional spotting, Physician-prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum and similar conditions associated with the management of a difficult pregnancy which are not diagnosed distinctly as Complications of Pregnancy.

Confinement or Continuous Periods of Confinement – the number of days during which an Eligible Person is a registered Inpatient in a Hospital, Skilled Nursing or other Facility. Successive periods of Hospital Confinement shall be considered a "Continuous Period of Confinement" unless evidence acceptable to the Welfare Fund is furnished that:

- The latest Confinement is due to causes entirely unrelated to causes of all previous confinements;
- Complete recovery has taken place since the last Confinement for a related cause; or
- The Eligible Employee has returned to work for at least one (1) full day. For all other Eligible Persons, when the last date of discharge and date of readmission are separated by ninety (90) days or more.

Continuation Coverage – the opportunity offered to employees and their dependents for a temporary extension of health coverage in certain instances where coverage under the Plan would otherwise end.

Coordination of Benefits – A provision that is intended to avoid claims payment delays and duplication of benefits when a person is covered by two or more plans providing benefits or services for medical, dental or other care or treatment. It avoids claims

payment delays by establishing an order in which plans pay their claims and providing an authority for the orderly transfer of information needed to pay claims promptly. It may avoid duplication of benefits by permitting a reduction of the benefits of a plan when, by the rules established by this provision, it does not have to pay its benefits first.

Cosmetic Surgery – Any non-Medically Necessary surgery or procedure, the primary purpose of which is to improve or change the appearance of any portion of the body, but which does not restore bodily function, correct a disease state, physical appearance or disfigurement caused by an accident, birth defect, or correct or naturally improve a physiological function. Cosmetic Surgery includes but is not limited to: rhinoplasty, lipectomy, surgery for sagging or extra skin, any augmentation or reduction procedures (e.g., mammoplasty, liposuction, keloids, rhinoplasty and associated surgery) or treatment relating to the consequences or as a result of Cosmetic Surgery.

Covered Medical Expense or Covered Expense – a type of expense for services or supplies for which the Plan will provide benefits.

Covered Services – Medically Necessary health care services and supplies that are: (a) defined as Covered Services in the Member's Plan, (b) not excluded under such Plan; (c) not Experimental/Investigative and (d) provided in accordance with such Plan.

Covered Transplant Procedure – Any Medically Necessary human organ and stem cell/bone marrow transplants and transfusions as determined by the Claims Administrator including necessary acquisition procedures, collection and storage, and including Medically Necessary preparatory myeloablative therapy.

COVID-19 Test – An in vitro diagnostic test defined in Section 809.3 of Title 21 of the Code of Federal Regulations for the detection of SARS-CoV-2 or the diagnosis of the virus that causes COVID-19, and the administration of such as test that (A) is approved, cleared, or authorized under sections 510(k), 513, 515, or 564 of the Federal Food, Drug, and Cosmetic Act; (B) is developed in, and authorized by, a State that has notified the Secretary of Health and Human Services of its intention to review tests intended to diagnose COVID-19; or (C) other test that the Secretary of Health and Human Services deems appropriate and is in accordance with effective Federal and State law.

Custodial Care – Any type of care, including room and board, that (a) does not require the skills of professional or technical personnel; (b) is not furnished by or under the supervision of such personnel or does not otherwise meet the requirements of post-Hospital Skilled Nursing Facility care; (c) is a level such that the Member has reached the maximum level of physical or mental function and is not likely to make further significant improvement. Custodial Care includes, but is not limited to, any type of care the primary purpose of which is to attend to the Member's activities of daily living which do not entail or require the continuing attention of trained medical or paramedical personnel. Examples of Custodial Care include, but are not limited to, assistance in walking, getting in and out of bed, bathing, dressing, feeding, using the toilet, changes of dressings of non-infected, post-operative or chronic conditions, preparation of special diets, supervision of medication that can be self-administered by the Member, general

maintenance care of colostomy or ileostomy, routine services to maintain other services which, in the sole determination of the Plan, can be safely and adequately self-administered or performed by the average non-medical person without the direct supervision of trained medical and paramedical personnel, regardless of who actually provides the service, residential care and adult day care, protective and supportive care including educational services, rest care and convalescent care.

Dentist – an individual licensed to practice dentistry by the applicable agency of the state in which the individual renders care or treatment, and acting within the usual scope of the individual's license.

Dependent – see Pages 22-23.

Detoxification – The process whereby an alcohol or drug intoxicated or alcohol or drug dependent person is assisted, in a Facility licensed by the appropriate regulatory authority, through the period of time necessary to eliminate, by metabolic or other means, the intoxicating alcohol or drug, alcohol or drug dependent factors or alcohol in combination with drugs as determined by a licensed Physician, while keeping the physiological risk to the patient to a minimum.

Disabled – unless the context indicates otherwise, a participant is "Disabled" when such participant's physician certifies that the participant is unable to perform the participant's job because of injury, illness or pregnancy. Totally and Permanently Disabled or Totally Disabled means the participant is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or has lasted or can be expected to last for a continuous period of not less than twelve (12) months.

Durable Medical Equipment – Equipment which is (a) made to withstand prolonged use; (b) made for and mainly used in the treatment of a disease or Injury; (c) suited for use while not confined as an Inpatient at a Hospital; (d) not normally of use to persons who do not have a disease or Injury; (e) not for exercise or training.

Effective Eligibility Date – the date you become eligible for reimbursement of your Covered Medical Expenses based on the Schedule of Benefits and this Plan.

Elective Surgical Procedure – A surgical procedure that is not considered to be an emergency and may be delayed by the Member to a later point in time.

Eligible Employee – unless the context indicates otherwise, "Eligible Employee" shall mean **any** full-time employee or former employee of an Employer who is eligible for benefits consistent with the terms and provisions of collective bargaining agreements (“Class I” Employees) or other labor-management agreements, or a representative of any association representing employers who are signatories to a current collective bargaining agreement and have executed an Asset of Participation (sometimes referred to as a “Class II” Employee) or an Employee of a Union or Employer Association who

has executed Assent of Participation (“Class III” Employee) and meeting the eligibility rules adopted by the Trustees from time to time.

Eligible Person – unless the context indicates otherwise, "eligible person" shall mean an Eligible Employee, an Eligible Dependent or a qualified beneficiary who meets all requirements for continuation coverage based on the Plan's eligibility rules.

Emergency Medical Condition – a medical Condition manifesting itself by acute symptoms of sufficient severity, including severe pain, so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Placing an individual's health in serious jeopardy, or with respect to a pregnant woman, the health of the woman or her unborn child;
- Result in serious impairment to the individual's bodily functions; or
- Result in serious dysfunction of a bodily organ or part of the individual.

Emergency Services – a medical screening examination as required by federal law that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition; and such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital, as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd) to Stabilize the patient.

Employee – A person who is engaged in active employment with the Employer and is eligible for Plan coverage under the employment regulations of the Employer. The Employee is also called the Subscriber.

Employer – in the context of this Plan, the term "Employer" or "Employers" include those who:

- Have assigned their bargaining rights to an Employer Association which is a party to a collective bargaining agreement with a local union participating in the Plan which requires contributions to the Plan; or

- Have directly executed a collective bargaining agreement with a local union participating in the Plan which requires contributions to the Plan and which is acceptable to the Trustees; or

- Have executed an Employer Participation Agreement with the Plan which requires contributions to the Plan and which is acceptable to the Trustees.

Experimental/Investigative – Any Drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply used in or directly related to the diagnosis, evaluation, or treatment of a disease, Injury, illness, or other health condition which the Claims Administrator determines to be unproven.

The Claims Administrator will deem any Drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply to be Experimental/Investigative if the Claims Administrator determined that one or more of the following criteria apply when the service is rendered with respect to the use for which benefits are sought. The Drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply:

- Cannot be legally marketed in the United States without the final approval of the Food and Drug Administration (FDA), or other licensing or regulatory agency, and such final approval has not been granted;
- Has been determined by the FDA to be contraindicated for the specific use; or
- Is provided as part of a clinical research protocol or clinical trial or is provided in any other manner that is intended to evaluate the safety, toxicity, or efficacy of the Drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply; or
- Is subject to review and approval of an Institutional Review Board (IRB) or other body serving a similar function; or
- Is provided pursuant to informed consent documents that describe Drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply as Experimental/Investigative, or otherwise indicate that the safety, toxicity, or efficacy of the Drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is under evaluation.

Any service not deemed Experimental/Investigative based on the criteria above may still be deemed Experimental/Investigative by the Claims Administrator. In determining whether a service is Experimental/Investigative, the Claims Administrator will consider the information described below and assess whether:

- The scientific evidence is conclusory concerning the effect of the service on health outcomes;
- The evidence demonstrates the service improves net health outcomes of the total population for whom the service might be proposed by producing beneficial effects that outweigh any harmful effects;
- The evidence demonstrates the service has been shown to be as beneficial for the total population for whom the service might be proposed as any established alternatives; and
- The evidence demonstrates the service has been shown to improve the net health outcomes of the total population for whom the service might be proposed under the usual conditions of medical practice outside clinical investigatory settings.

The information considered or evaluated by the Claims Administrator to determine whether a Drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental/Investigative under the above criteria may include one or more items from the following list which is not all inclusive.

- Published authoritative, peer-reviewed medical or scientific literature, or the absence thereof; or
- Evaluations of national medical associations, consensus panels, and other technology evaluation bodies; or
- Documents issued by and/or filed with the FDA or other Federal, state or local agency with the authority to approve, regulate, or investigate the use of the Drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply; or
- Documents of an IRB or other similar body performing substantially the same function; or
- Consent document(s) and/or the written protocol(s) used by the treating Physicians, other medical professionals, or Facilities or by other treating Physicians, other medical professionals or Facilities studying substantially the same Drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply; or
- Medical records; or
- The opinions of consulting Providers and other experts in the field.

The Claims Administrator has the sole authority and discretion to identify and weigh all information and determine all questions pertaining to whether a Drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental/Investigative.

Facility – A Facility, including but not limited to, a Hospital, Freestanding Ambulatory Facility, Chemical Dependency Treatment Facility, Skilled Nursing Facility, Home Health Care Agency or mental health Facility, as defined in this Benefit Booklet. The Facility must be licensed, accredited, registered or approved by The Joint Commission or the Commission on Accreditation of Rehabilitation Facilities (CARF), as applicable, or meet specific rules set by the Claims Administrator.

Formulary – A document setting forth certain rules relating to the coverage of pharmaceuticals, that may include but not be limited to, (1) a listing of preferred Prescription medications that are covered and/or prioritized in order of preference by the Claims Administrator, and are dispensed to Members through pharmacies that are Network Providers, and (2) Precertification rules. This list is subject to periodic review and modification. Charges for medications may be Ineligible Charges, in whole or in part, if a Member selects a medication not included in the Formulary.

Home Health Care – Care, by a licensed program or Provider, for the treatment of a patient in the patient's home, consisting of required intermittent skilled care, which may include observation, evaluation, teaching and nursing services consistent with the diagnosis, established and approved in writing by the patient's attending Physician.

Home Health Care Agency – A Provider who renders care through a program for the treatment of a patient in the patient's home, consisting of required intermittent skilled care, which may include observation, evaluation, teaching and nursing services

consistent with the diagnosis, established and approved in writing by the patient's attending Physician. It must be licensed and accredited by the appropriate agency.

Hospice – A Provider which provides care for terminally ill patients and their families, either directly or on a consulting basis with the patient's Physician. It must be licensed and accredited by the appropriate agency.

Hospice Care Program – A coordinated, interdisciplinary program designed to meet the special physical, psychological, spiritual and social needs of the terminally ill Member and his or her covered family members, by providing palliative and supportive medical, nursing and other services through at-home or Inpatient care. The Hospice must be licensed and accredited by the appropriate agency and must be funded as a Hospice as defined by those laws. It must provide a program of treatment for at least two unrelated individuals who have been medically diagnosed as having no reasonable prospect of cure for their illnesses.

Hospital – An institution licensed and accredited by the appropriate agency, which is primarily engaged in providing diagnostic and therapeutic Facilities on an Inpatient basis for the surgical and medical diagnosis, treatment and care of injured and sick persons by or under the supervision of a staff of Physicians duly licensed to practice medicine, and which continuously provides 24-hour-a-day nursing services by registered graduate nurses physically present and on duty. "Hospital" does not mean other than incidentally:
an extended care Facility, nursing home, place for rest, Facility for care of the aged;
a custodial or domiciliary institution which has as its primary purpose the furnishing of food, shelter, training or non-medical personal services; or
an institution for exceptional or disabled children.

Identification Card – The latest card given to You showing Your identification and group numbers, the type of coverage You have and the date coverage became effective.

Immediate Relative – the Eligible Person's Spouse, parent, Child, brother or sister by blood, marriage or adoption.

Incurred – unless the context indicates otherwise, the time when a particular service or supply is rendered or obtained.

Ineligible Charges – Charges for health care services that are not Covered Services because the services are not Medically Necessary or Precertification was not obtained. Such charges are not eligible for payment.

Ineligible Provider – A Provider which does not meet the minimum requirements to become a contracted Provider with the Claims Administrator. Services rendered to a Member by such a Provider are not eligible for payment.

Infertile or Infertility – The condition of a presumably healthy Member who is unable to conceive or produce conception after a period of one year of frequent, unprotected

heterosexual vaginal intercourse. This does not include conditions for men when the cause is a vasectomy or orchiectomy or for women when the cause is tubal-ligation or hysterectomy.

Injury – Bodily harm from a non-occupational accident.

Inpatient – A Member who is treated as a registered bed patient in a Hospital and for whom a room and board charge is made.

Intensive In-Home Behavioral Health Programs – A range of therapy services provided in the home to address symptoms and behaviors that, as the result of a mental disorder or substance use disorder, put the Members and others at risk of harm.

Intensive Outpatient Programs – Structured, multidisciplinary behavioral health treatment that provides a combination of individual, group and family therapy in a program that operates no less than 3 hours per day, 3 days per week. Out-of-Network Facility-based Programs must occur at Facilities that are both licensed and accredited.

Maintenance Therapy – The repetitive services required to maintain function. Therapy is Maintenance Therapy where there is no medically appropriate expectation that the Eligible Person's condition will improve significantly from a continued therapy in a reasonable and generally predictable period of time based on Physician assessment of the Person's restoration potential.

Maternity Care – Obstetrical care received both before and after the delivery of a child or children. It also includes care for miscarriage or abortion. It includes regular nursery care for a newborn infant as long as the mother’s Hospital stay is a covered benefit and the newborn infant is an eligible Member under the Plan.

Maximum Allowed Amount – The maximum amount that the Plan will allow for Covered Services You receive.

Medical Emergency – “Emergency services,’ “emergency care” or “Medical Emergency” means those health care services that are provided for a condition of recent onset and sufficient severity, including but not limited to, severe pain, that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that his or her condition, sickness, or Injury is of such a nature that failure to obtain immediate medical care could result in: (a) placing the patient’s health in serious jeopardy; (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part. Such conditions include but are NOT limited to, chest pain, stroke, poisoning, serious breathing difficulty, unconsciousness, severe burns or cuts, uncontrolled bleeding, or convulsions and such other acute conditions as may be determined to be Medical Emergencies by the Plan.

Medically Necessary (Medical Necessity) – Procedures, supplies, equipment, or services that we conclude are:

1. Appropriate for the symptoms, diagnosis, or treatment of a medical condition; and
2. Given for the diagnosis or direct care and treatment of the medical condition; and
3. Within the standards of good medical practice within the organized medical community; and
4. Not mainly for the convenience of the Doctor or another Provider, and the most appropriate procedure, supply, equipment, or service which can be safely given.

The most appropriate procedure, supply, equipment, or service must meet the following requirements:

1. There must be valid scientific evidence to show that the expected health benefits from the procedure, supply, equipment, or service are clinically significant and will have a greater chance of benefit, without a disproportionately greater risk of harm or complications, than other possible treatments; and

Generally approved forms of treatment that are less invasive have been tried and did not work or are otherwise unsuitable; and

For Hospital stays, acute care as an Inpatient is needed due to the kind of services the patient needs or the severity of the medical condition, and that safe and adequate care cannot be given as an outpatient or in a less intensive medical setting.

The most appropriate procedure, supply, equipment, or service must also be cost-effective compared to other alternative interventions, including no intervention or the same intervention in an alternative setting. Cost-effective does not always mean lowest cost. It does mean that as to the diagnosis or treatment of Your illness, Injury or disease, the service is: (1) not more costly than another service or group of services that is medically appropriate, or (2) the service is performed in the least costly setting that is medically appropriate. For example, we will not provide coverage for an Inpatient admission for surgery if the surgery could have been performed on an outpatient basis or an infusion or injection of a specialty drug provided in the outpatient department of a Hospital if the Drug could be provided in a Physician's office or the home setting.

Network Provider – A Physician, health professional, Hospital, Pharmacy, or other individual, organization and/or Facility that has entered into a contract, either directly or indirectly, with the Claims Administrator to provide Covered Services to Members through negotiated reimbursement arrangements. A Network Provider for one Plan may not be a Network Provider for another.

Non-Covered Services – Services that are not benefits specifically provided under the Plan, are excluded by the Plan, are provided by an Ineligible Provider, or are otherwise not eligible to be Covered Services, whether or not they are Medically Necessary.

Occupational Disease or Sickness – a disease or sickness arising out of, or in any way resulting from, any work for pay or profit.

Occupational Injury – an accidental injury arising out of or in the course of any work for pay or profit, or in any way resulting from an injury which does.

Out-of-Network Provider – A Provider, including but not limited to, a Hospital, Freestanding Ambulatory Facility (Surgical Center), Physician, Skilled Nursing Facility, Hospice, Home Health Care Agency, other medical practitioner or Provider of medical services or supplies, that does not have an agreement or contract with the Claims Administrator to provide services to its Members at the time services are rendered.
Benefit payments and other provisions of this Plan are limited when a Member uses the services of Out-of-Network Providers.

Out-of-Pocket Maximum – The maximum amount of a Member's Coinsurance payments during a given calendar year. When the Out-of-Pocket Maximum is reached, the level of benefits is increased to 100% of the Maximum Allowed Amount for Covered Services exclusive of Copayments and other scheduled charges.

Outpatient – A patient who goes to the Hospital, clinic or dispensary for diagnosis and/or treatment, but does not occupy a bed or stay overnight.

Partial Hospitalization Program – Structured, multidisciplinary behavioral health treatment that offers nursing care and active individual, group and family treatment in a program that operates no less than 6 hours per day, 5 days per week. Out-of-Network Facility-based Programs must occur at Facilities that are both licensed and accredited.

Pharmacy – An establishment licensed to dispense Prescription Drugs and other medications through a duly licensed pharmacist upon a Physician's order. A Pharmacy may be a Network Provider or an Out-of-Network Provider.

Physical Therapy – The care of disease or Injury by such methods as massage, hydrotherapy, heat, or similar care.

Physician – Any licensed Doctor of Medicine (M.D.) legally entitled to practice medicine and perform surgery, any licensed Doctor of Osteopathy (D.O.) legally licensed to perform the duties of a D.O., any licensed Doctor of Chiropractic (D.C.), legally licensed to perform the duties of a chiropractor, any licensed Doctor of Podiatric Medicine (D.P.M.) legally entitled to practice podiatry, and any licensed Doctor of Dental Surgery (D.D.S.) legally entitled to perform oral surgery, Optometrists and Clinical Psychologists (PhD) are also Providers when acting within the scope of their licenses, and when rendering services covered under this Plan.

Plan – The arrangement chosen by the Plan Sponsor to fund and provide for delivery of the Employer's health benefits.

Plan Administrator – The person or entity named by the Plan Sponsor to manage the Plan and answer questions about Plan details. **The Plan Administrator is not the Claims Administrator.**

Plan Sponsor – The legal entity that has adopted the Plan and has authority regarding its operation, amendment and termination. **The Plan Sponsor is not the Claims Administrator.**

Preferred Provider – a provider or facility that participates in a network of providers with which the Plan has contracted directly or indirectly for services, supplies and/or facilities at a pre-negotiated rate. Such providers are also referred to as "network" providers or "participating" providers. These providers are independent contractors.

Prescription Drug/(Drug) (Also referred to as Legend Drug) – A medicine that is approved by the Food & Drug Administration (FDA) to treat illness or Injury. Under the Federal Food, Drug & Cosmetic Act, such substances must bear a message on its original packing label that says, "Caution: Federal law prohibits dispensing without a prescription." This includes the following:

- Compounded (combination) medications, when all of the ingredients are FDA-approved, as designated in the FDA's Orange Book: *Approved Drug Products with Therapeutic Equivalence Evaluations,* require a Prescription to dispense, and are not essentially the same as an FDA-approved product from a drug manufacturer.
- Insulin.

Primary Care Physician – A Provider who specializes in family practice, general practice, internal medicine, pediatrics, obstetrics/gynecology, geriatrics or any other Provider as allowed by the Plan. A PCP supervises, coordinates and provides initial care and basic medical services to a Member and is responsible for ongoing patient care.

Prior Authorization – The process applied to certain drugs and/or therapeutic categories to define and/or limit the conditions under which these drugs will be covered. The drugs and criteria for coverage are defined by the Pharmacy and Therapeutics Committee.

Provider – A duly licensed person or Facility that provides services within the scope of an applicable license and is a person or Facility that the Plan approves. This includes any Provider rendering services which are required by applicable state law to be covered when rendered by such Provider. Providers that deliver Covered Services are described throughout this Benefit Booklet. If You have a question if a Provider is covered, please call the number on the back of Your Identification Card.

QMCSO, or MCSO – Qualified Medical Child Support Order or Medical Child Support Order – A QMCSO creates or recognizes the right of a child who is recognized under the order as having a right to be enrolled under the health benefit plan to receive benefits for which the Employee is entitled under the Plan; and includes the name and last known address of the Employee and each such child, a reasonable description of the type of coverage to be provided by the Plan, the period for which coverage must be provided and each plan to which the order applies.

An MCSO is any court judgment, decree or order (including a court's approval of a domestic relations settlement agreement) that: Provides for child support payment related to health benefits with respect to the child of a Group Health Plan Member or requires health benefit coverage of such child in such Plan, and is ordered under state domestic relations law; or Enforces a state law relating to medical child support payment with respect to a Group Health Plan.

Residential Treatment Center/Facility – A Provider licensed and operated as required by law, which includes:

- Room, board and skilled nursing care (either an RN or LVN/LPN) available on site at least eight hours daily with 24 hours availability.
- A staff with one or more Doctors available at all times.
- Residential treatment takes place in a structured Facility-based setting.
- The resources and programming to adequately diagnose, care and treat a psychiatric and/or substance use disorder.
- Facilities are designated residential, subacute, or intermediate care and may occur in care systems that provide multiple levels of care.
- Is fully accredited by The Joint Commission (TJC), the Commission on Accreditation of Rehabilitation Facilities (CARF), the National Integrated Accreditation for Healthcare Organizations (NIAHO), or the Council on Accreditation (COA).

The term Residential Treatment Center/Facility does not include a Provider, or that part of a Provider, used mainly for:

- Nursing care
- Rest care
- Convalescent care
- Care of the aged
- Custodial care
- Educational care

Semiprivate Room – A Hospital room which contains two or more beds.

Skilled Convalescent Care – Care required, while recovering from an illness or Injury, which is received in a Skilled Nursing Facility. This care requires a level of care or services less than that in a Hospital, but more than could be given at the patient's home or in a nursing home not certified as a Skilled Nursing Facility.

Skilled Nursing Facility – An institution operated alone or with a Hospital which gives care after a Member leaves the Hospital for a condition requiring more care than can be rendered at home. It must be licensed by the appropriate agency and accredited by The Joint Commission or the Commission on Accreditation of Rehabilitation Facilities (CARF), as applicable, or meet specific rules set by the Claims Administrator.

Specialty Drugs – Typically, high cost drugs that are injected or infused in the treatment of acute or chronic diseases. Specialty Drugs often require special handling such as temperature-controlled packaging and expedited delivery. Most Specialty Drugs require preauthorization to be considered Medically Necessary.

Therapeutic Equivalent – Therapeutic/Clinically Equivalent drugs are drugs that can be expected to produce similar therapeutic outcomes for a disease or condition.

Transplant Providers:

Network Transplant Provider – A Provider that has been designated as a "Center of Excellence" for Transplants by the Claims Administrator and/or a Provider selected to participate as a Network Transplant Provider by the Blue Cross and Blue Shield Association. Such Provider has entered into a transplant Provider agreement to render Covered Transplant Procedures and certain administrative functions to You for the transplant network. A Provider may be a Network Transplant Provider with respect to:

- certain Covered Transplant Procedures; or
- all Covered Transplant Procedures.

Out-of-Network Transplant Provider – Any Provider that has NOT been designated as a "Center of Excellence" for Transplants by the Claims Administrator nor has not been selected to participate as a Network Transplant Provider by the Blue Cross and Blue Shield Association.

Blue Distinction Center (BDC) Facility: Blue Distinction Facilities have met or exceeded national quality standards for care delivery (quality only).

Blue Distinction Center+ (BDC+) Facility: Blue Distinction+ Facilities have met or exceeded national quality standards for care delivery AND have demonstrated that they operate more efficiently (quality and cost).

Designated Transplant Provider: A Provider who has achieved designation as a Blue Distinction Center+ or Blue Distinction Center for Transplant Procedures.

PAR Transplant Provider: Hospitals participating in the Claims Administrator's networks; also known as "Network" or "PAR" (are NOT designated as either Blue Distinction Center+ or Blue Distinction Center).

Non-PAR Transplant Provider: Any Provider that does not hold a contractual agreement with Blue Cross Blue Shield Plans to provide Transplant services; also known as “Out-of-Network” or “non-PAR”.

Trust Agreement – the agreement and declaration of trust establishing and providing for the maintenance of the Ohio Conference of Plasterers Health and Welfare Fund, as now stated or amended hereafter.

Union – a Union participating in this Plan, as defined in the Plan's Trust Agreement.

Utilization Review – Evaluation of the necessity, quality, effectiveness, or efficiency of medical or behavioral health services.

STATEMENT OF RIGHTS UNDER THE EMPLOYEE RETIREMENT SECURITY ACT OF 1974 (ERISA)

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

(A) Examine, without charge, at the Board of Trustees’/Funds’ office and at other specified locations, such a work sites and union halls, all plan documents, including insurance contracts, collective bargaining agreements and copies of all documents filed by the plan with the U.S. Department of Labor, such as detailed annual reports and plan descriptions.

(B) Obtain copies of all Plan documents and other Plan information upon written request to the Board of Trustees. The Board may make a reasonable charge for the copies.

(C) A complete list of the employers and employee organizations sponsoring the plan may be obtained by participants and beneficiaries upon written request to the Plan Administrator, and is available for examination by participants and beneficiaries at the Plan Administrator’s office or your union hall. Information as to whether a particular employer or employee organization upon written request of the Plan Administrator is a sponsor of the plan and, if the employer or employee organization is a plan sponsor and the sponsor’s address.

(D) The Plan is maintained pursuant to one or more collective bargaining agreements and a copy of any such agreement may be obtained by you upon written request of the Plan Administrator and is available for examination by participants or beneficiaries at the Union hall.

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

(F) Obtain a statement telling you whether you have a right to receive a pension at normal retirement age and if so, what your benefits would be at normal retirement age if you stop working under the Plan now. If you do not have a right to a pension, the statement will tell you how many more years you have to work to obtain a right to a pension. This statement must be requested in writing and is not required to be given more than once a year. The Plan must provide the statement free of charge.

(G) In addition to creating rights for Plan participants, ERISA imposes duties upon the individuals who are responsible for the operation of the employee benefit plan. The individuals 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 benefit or exercising your rights under ERISA. If your claim for a benefit is denied in whole or in part you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider you claim.

(H) Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive the within thirty (30) days, you may file suit in a federal court. In such a case, the court may require the Board of Trustees to provide the materials and pay you up to One Hundred Ten Dollars ($110) a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Board of Trustees. 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. 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 individuals 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. If you have any questions about your Plan, you should contact the Board of Trustees.

(I) If you have any questions about this statement or about your rights under ERISA, you should contact the nearest Area Office of the U.S. Labor-Management Services Administration, Department of Labor or at the Pension and Welfare Benefit Administration Office located as follows:

U.S. Department of Labor
Pension & Welfare Benefits Administration
1730 K Street
Suite 556
Washington, DC 20006
(202) 254-7013

or

U.S. Department of Labor
Pension & Welfare Benefits Administration
1885 Dixie Highway
Suite 210
Ft. Wright, KY 41011-2664
(859) 578-4680 or toll-free at
(866) 444-3272

or

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue, N.W.
Washington, DC 20210

USES AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Use and disclosure of Protected Health Information (PHI): The privacy regulations govern the use and/or disclosure of protected health information ("PHI"). "Protected health information" means individually identifiable health information that is transmitted or maintained by electronic media or is transmitted or maintained in any other form or medium. "Individually identifiable health" information is health information that either actually identifies an individual or creates a reasonable basis to believe that the information would identify an individual. The Plan will use protected health information to the extent and in accordance with the uses and disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Specifically, the Plan will use and disclose protected health information for purposes related to health care treatment, payment for health care, and health care operations.

"Payment" includes activities undertaken by the Plan to obtain premiums or determine or fulfill its responsibility for coverage and provision of plan benefits that relate to an individual to whom health care is provided. These activities include, but are not limited to, the following:

1. Determination of eligibility, coverage, and cost sharing amounts (e.g. cost of a benefit, plan maximums, and co-payments as determined for an individual's claim)

2. Coordination of benefits

3. Adjudication of health benefit claims (including appeals and other payment disputes)

4. Subrogation of health benefit claims

5. Establishing employee contributions

6. Risk adjusting amounts due based on enrollee health status and demographic characteristics

7. Billing, collection activities and related health care data processing

8. Claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes and responding to Participant (and their authorized representatives') inquiries about payments

9. Obtaining payment under a contract for reinsurance (including stop-loss and excess of loss insurance), if necessary in the future

10. Medical necessity reviews, or reviews of appropriateness of care or justification of charges

11. Utilization review, including precertification, preauthorization, concurrent review and retrospective review

12. Reimbursement to the plan

“Health Care Operations” include, but are not limited to, the following activities:

1. Quality Assessment

2. Population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting of health care providers and patients with information about treatment alternatives; and related functions.

3. Rating provider and Plan performance, including accreditation, certification, licensing, or credentialing activities.

4. Underwriting, premium rating, and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing, or placing a contract for reinsurance of risk relating to claims for health care (including stop-loss insurance and excess of loss insurance).

5. Conducting or arranging for medical review, legal services, and auditing functions, including fraud and abuse detection and compliance programs.

6. Business planning and development, such as conducting cost-management and planning-related analyses related to managing and

operating the entity, including formulary development and administration, development or improvement of methods of payment or coverage policies.

7. Business management and general administrative activities of the entity, including, but not limited to:

   a) Management activities relating to implementation of and compliance with the requirements of HIPAA Administrative Simplification;

   b) Customer service, including the provision of data analyses for policyholders, plan sponsors, or other customers.

   c) Resolution of internal grievances. Filing of governmental forms, including Form 5500 and other activities necessary to ensure compliance with applicable federal laws, including ERISA and the Internal Revenue Code. “Treatment” includes, but is not limited to, the provision, coordination or management of health care and related services. It also includes but is not limited to consultations and referrals between one or more of your providers.

The Plan will use and disclose PHI as required by law and as permitted by authorization of the Participant or Beneficiary.

For purposes of this section the Board of Trustees for the Tri-County Building Trades Health Fund is the Plan Sponsor. The Plan will disclose PHI to the Plan Sponsor only upon receipt of a certification from the Plan Sponsor that the plan documents have been amended to incorporate the following provisions:

With respect to PHI, the Plan Sponsor agrees to:

1. Not use or further disclose the information other than as permitted or required by the plan document or as required by law;

2. Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information;

3. Not use or disclose the information for employment-related actions and decisions unless authorized by the individual;

4. Not use or disclose the information in connection with any other benefit or employee benefit plan of the Plan Sponsor unless authorized by the individual;

5. Report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware;

6. Make PHI available to the individual in accordance with the access requirements of HIPAA;

7. Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;

8. Make available the information required to provide an accounting of disclosures;

9. Make internal practices, books, and records relating to the use and disclosure of PHI received from the group health plan available to the Secretary of HHS for the purposes of determining compliance by the group health plan with HIPAA;

10. If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made. If return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible.

In accordance with HIPAA, only the following employees or classes of employees may be given access to PHI.

1. The Fund's Administrative Manager;

2. Staff designated by the Fund's Administrative Manager; and

3. Board of Trustees of the Tri-County Building Trades Health Fund.

The persons described in this section B may only have access to and use and disclose PHI for plan administration functions that are performed on behalf of the Fund. If the persons described in section B do not comply with this Plan document, the Plan Sponsor shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

ADDITIONAL RIGHTS

Certain uses and disclosures of PHI require an individual authorization, including uses and disclosures for marketing purposes, disclosures that constitute a “sale” of PHI, and most uses and disclosures of psychotherapy notes.

You have the right to opt out of receiving any fundraising communications.

You have the right to direct any of your providers to restrict certain protected health information from disclosure to the Plan where you pay out of pocket in full for the care and you request such a restriction.

The Plan is prohibited from using or disclosing genetic information for underwriting purposes.

Your Rights Regarding Medical Information About You

You also have the following rights regarding medical information we maintain about you:

Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your Plan benefits. To inspect and copy such medical information, you must submit your request in writing to the Plan Office. The requested information will be provided within 30 days if the information is maintained on site or within 60 days if the information is maintained offsite. A single 30-day extension is allowed if the plan is unable to comply with deadline. If you request a copy of this information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request. We may deny your request to inspect and copy your medical information in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed.

Right to Amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan. To request an amendment, your request must be made in writing and submitted to the Plan Office. In addition, you must provide a reason that supports your request. The Plan has 60 days after the request is made to act on the request. A single 30-day extension is allowed if the Plan is unable to comply with the deadline. If the request is denied in whole or in part, the Plan must provide you with a written denial that explains the basis for the denial. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your health information.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that (1) is not part of the medical information kept by or for the Plan, (2) was not created by us, unless the person or entity -that created the information is no longer available to make the amendment, (3) is not part of the information which you would be permitted to inspect and copy, or (4) or is accurate and complete.

Right to an Accounting of Disclosures. You have a right to obtain an accounting of certain disclosures of your medical information. This right to an accounting extends to disclosures, <u>other than</u> disclosures made (1) to carry out treatment, payment or health care operations, (2) to individuals about their own medical information, (3) incident to an otherwise permitted use or disclosure, (4) pursuant to an authorization, (5) for purposes

of creation of a facility directory or to persons involved in the patient's care or other notification purposes, (6) as part of a limited data set, (7) for other national security or to correctional institutions or law enforcement officials, or (8) before April 14, 2003.

To request an accounting of disclosures, you must submit your request in writing to the Plan Office. The requested information will be provided within 30 days if the information is maintained on site or within 60 days if the information is maintained offsite. A single 30-day extension is allowed if the plan is unable to comply with deadline. Your request must specify a time period, which may not be longer than six years. Your request should indicate in what form you want the accounting (for example, paper or electronic). The first accounting you request within a 12-month period will be free. For additional accountings, we may charge you for the costs of providing the accounting. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Receive a Notice from the Plan whenever a breach of your unsecured private health information (PHI) occurs**.**

Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. We are not, however, required to agree to your request. To request restrictions, you must make your request in writing to the Plan Office. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. Such requests shall be honored if, in the sole discretion of the Plan, the requests are reasonable and can be accommodated with minimal disruption to Plan administration. However, the Plan shall accommodate such a request if the participant clearly provides information that the disclosure of all or part of that information could endanger the participant. To request confidential communications, you must make your request in writing to the Plan Office. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

Prohibition Against Discrimination Based on the Use of "Genetic Information"

This section of the Plan is intended to implement the requirements of the Genetic Information Nondiscrimination Act of 2008 (GINA).

“Genetic information” means, with respect to any individual, information about:

1. such individual's genetic tests;

2. the genetic tests of family members of such individual; and

3. the manifestation of a disease or disorder in family members of such individual.

Pursuant to GINA, the Plan:

1. may not adjust premium or contribution amounts on the basis of genetic information; need space here, will not allow me to change

2. shall not request or require an individual or a family member of such individual to undergo a genetic test;

3. shall not request, require, or purchase genetic information for “underwriting purposes”, as that term is defined at ERISA 733; and

4. shall not request, require, or purchase genetic information with respect to any individual prior to such individual's enrollment under the Plan or coverage in connection with such enrollment.

5. No use or disclosure of genetic information may be made for insurance underwriting purposes.

Notwithstanding the foregoing, the Plan may use genetic information as otherwise allowed by GINA.

IMPORTANT INFORMATION ABOUT THE FUND

This booklet describes the health and welfare benefits available to you and your beneficiaries under the Plan, known as the Ohio Conference of Plasterers and Cement Masons Health and Welfare Fund.

The Board of Trustees is responsible for the operation of the Plan, is the Plan Sponsor, and acts as Plan Administrator. It is responsible for reporting Plan information to government agencies and disclosing the same information to Plan Participants and beneficiaries. The Board consists of equal representation by the Employers and the Unions who have entered into collective bargaining agreements which are related to the Plan.

You can contact the Board of Trustees at the address:

Board of Trustees
Ohio Conference of Plasterers & Cement Masons Health and Welfare Fund
33 Fitch Blvd.
Austintown, Ohio 44515

Plan Administrator

BeneSys Inc., handles the day-to-day administration of the Fund.

BeneSys, Inc.
33 Fitch Blvd.
Austintown, Ohio 44515
(330) 779-8860

Benefits are paid through the Board of Trustees' Plan Administrator.

Identification Numbers

The number assigned to this Plan by the Board of Trustees based on the Internal Revenue Service requirements is 501.

The number assigned to the Board of Trustees by the Internal Revenue Service is 31-6051539.

Agent for Service of Legal Process

The Board of Trustees is the Plan's agent for service of legal process. Accordingly, if legal disputes involving the Plan arise, any legal documents should be served upon the Board of Trustees, upon any individual Trustee at the following address: Ohio Conference of Plasterers and Cement Masons Health and Welfare Plan and Trust, 33 Fitch Blvd., Austintown, Ohio 44515, or upon Fund Counsel, Allotta | Farley Co., L.P.A., 2222 Centennial Road, Toledo, Ohio 43617.

Plan Year

The fiscal records of the Plan are kept separately for each Plan Year. The Plan Year is a twelve-month period which begins on May 1 and ends on the following April 30.

Source of Contributions

The benefits described in the Plan generally are provided through employer contributions. Employer contributions are based on an hourly rate and are determined by the provisions of the collective bargaining agreements in effect between the participating local unions and the participating signatory employers. You may obtain a

copy of the collective bargaining agreements by writing to the Plan Administrator, or you may examine them at the Fund Office.

Additionally, certain Plan income consists of self-payments and investment income.

All assets are held in trust by the Board of Trustees for the purpose of providing benefits to covered participants and defraying reasonable administrative expenses.

A complete list of the employers and employee organizations contributing to and/or sponsoring the Plan may be obtained by Participants and Beneficiaries upon written request to the Fund office and is otherwise available for examination by Participants and Beneficiaries at the Fund office.

Union Trustees

Charles Wanat, Chairman
Cement Masons Local 404
1417 East 25th Street
Cleveland, OH 44114

Greg Daniels
Cement Masons Local Union No. 109
3975 South Hametown Rd.
Norton, OH 44203

Robert Gerst, Jr.
Cement Masons Local 526 – area 179
5204 Mahoning Avenue, Suite 108
Austintown, OH 44515

Charles Dolan
OP & CMIA Ohio Local 132
2951 Bluefield Avenue
Dayton, OH 45414

Kenneth M. Vierling, Sr.
Cement Masons Local No. 886
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Paul Metcalf
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1417 East 25th Street
Cleveland, OH 44114

Employer Trustees

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Cleveland, Ohio 44114

Michael Walter, Alternate
Cement Masons Local 404
1417 East 25th Street
Cleveland, OH 44114

IN WITNESS WHEREOF, the Trustees of the Ohio Conference of Plasterers and Cement Masons Health and Welfare Fund have adopted the Summary Plan Description in its restated form on this 17th day of September 2020, but effective as of May 1, 2020 (except as otherwise noted herein).

EMPLOYER TRUSTEES

Charles Wanat, Chairman

UNION TRUSTEES

Kevin Reilly, Secretary/Treasurer