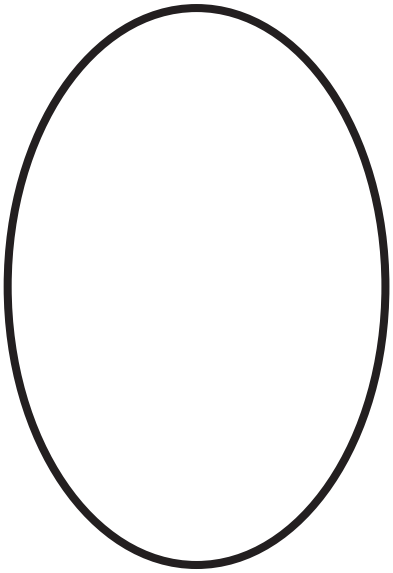
Cement Masons and Plasterers Health and Welfare Trust Benefit Booklet



FOR ACTIVE, RETIRED and NONBARGAINING UNIT EMPLOYEES and DEPENDENTS

Effective January 1, 2020

CEMENT MASONS AND PLASTERERS HEALTH AND WELFARE TRUST

BENEFIT BOOKLET

FOR ACTIVE, RETIRED AND NONBARGAINING UNIT EMPLOYEES AND DEPENDENTS

January 1, 2020

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Dear Participants:

The Trustees of the Cement Masons and Plasterers Health and Welfare Trust (the "**Plan**") are pleased to present you with this new Health and Welfare Plan book describing the Plan's benefits, including medical, prescription, dental and vision benefits. This book contains important information about the benefits available to you and your family. The Trustees urge you to carefully read this book and keep it handy for future reference.

In this book, you will find information about who is covered by the Plan and what benefits are available. This Plan book, also referred to as the Summary Plan Description or "**SPD**," supersedes and replaces all previous Plan materials.

The Trustees want the Plan to continue well into the future. However, Plan benefits are not guaranteed to always be available for you and your family (the benefits are not "vested"). Events may happen in the future that force the Trustees to change the benefits or even stop providing benefits altogether. Therefore, the Trustees have full authority to change, reduce or end any Plan benefits at any time as they deem necessary. If the Trustees change the Plan, you will be informed of any changes by first class mail.

All questions about the Plan should be made to the Plan's Administrative Office, the address of which is on page 3. The only people who are authorized to give you official answers to your questions about the Plan are the Trustees or the Administrative Office. No Employer, Employer association or labor organization, or any of their employees, can give you official answers to your questions about the Plan.

Be a Wise Consumer . . . It Will Save You Money

We all know that obtaining health care benefits has become more complicated for both the Plan and for you. This is because health care benefits have become more expensive than ever before. But there isn't an unlimited amount of money to pay for these benefits. Like your family, the Plan has a budget and needs to spend wisely the limited amount of health care money it has available.

By understanding your health care benefits and using them wisely, you will get the most benefits with the least cost to you. There are two (2) easy ways to reduce your medical costs when receiving benefits through the Plan. First, use PPO Providers whenever possible. As you can see from the descriptions of benefits in this Plan book, you pay a lower Copayment or Coinsurance for many medical services when you use PPO Providers.

The second way you can reduce your medical costs is by being a wise consumer. Be sure to ask questions of your health care providers and demand proper answers. Don't rely on your Physicians or health care providers to know your benefit Plan and use it wisely for you. You must do it. For example, if your PPO Physician refers you to another Physician or laboratory, be sure that YOU confirm that the other Physician or laboratory is on the PPO list. Don't rely on your Physician to do so.

Some services require Prior Authorization. You are responsible for confirming that your health care provider obtains Prior Authorization for certain services as described in

your Plan booklet. Don't rely on your Physician or other health care provider to obtain Prior Authorization. You must check on it yourself. If you do not obtain Prior Authorization the Plan will pay a much lower amount and you will pay a much higher amount. Your health care is your responsibility.

PRIOR AUTHORIZATION FOR ANY HEALTH CARE SERVICE OR PROCEDURE MEANS ONLY THAT THE PROPOSED SERVICE OR PROCEDURE IS MEDICALLY NECESSARY AND APPROPRIATE FOR THE DIAGNOSIS GIVEN. PRIOR AUTHORIZATION DOES NOT MEAN THAT ELIGIBILITY, PAYMENT OR BENEFITS ARE GUARANTEED. PAYMENT FOR ANY HEALTH CARE SERVICE OR PROCEDURE WILL BE DETERMINED ON THE BASIS OF THE PLAN OF BENEFITS IN EFFECT AT THE TIME THE SERVICE OR PROCEDURE IS PERFORMED, REGARDLESS OF ANY PRIOR AUTHORIZATION.

If you would like further information or assistance, please call or write the Plan Administrative Office at the address on page 3.

The Trustees believe that this Health and Welfare Plan fully complies with the Employee Retirement Income Security Act of 1974 ("**ERISA**") and other applicable laws, regulations and amendments. Any omissions or oversights will be resolved in favor of applicable laws and regulations.

This January 2020 edition of the Benefit Booklet includes the July 1, 2014 restated Plan and all Plan amendments through December 2019. Contact the Administrative Office to be sure you have all later Plan amendments.

Quick Guide to Important Phone Numbers and Addresses

Administrative Office BeneSys Administrators, Inc. 8311 W. Sunset Road, Suite 250 Las Vegas, Nevada 89113 (702) 415-2190 http://www.benesysinc.com/	**Dental HMO** Delta Dental Insurance P.O. Box 1803 Alpharetta, GA 30023 (800) 422-4234 http://www.deltadental.com
Dental PPO Diversified Dental Services, Inc. 7312 W. Cheyenne Ave., Suite 7 Las Vegas, NV 89129 (702) 869-6200 or (800) 249-3538 www.ddsppo.com ***(Claims are submitted to BeneSys Administrators, Inc.)***	**Utilization Review Organization (Prior Authorizations, Preadmission, Concurrent Reviews & Case Management)** Innovative Care Management, Inc. PO Box 22386 Portland, OR 97269 (800) 862-3338 http://www.innovativecare.com/ ***Indemnity Medical Plan only; Prior Authorization does not guarantee payment of medical benefits***
PPO Prescription Benefits Provider (Actives) Envision Rx 1100 Investment Blvd. El Dorado Hills, CA 95762 (800) 361-4542 www.envisionrx.com	**Medicare Advantage and Prescription Drug Provider (Medicare Retirees)** Humana P.O. Box 14601 Lexington, KY 40512 (866) 945-4481 www.humana.com
PPO Mental Health & Substance Abuse Benefits Provider (MAP) Behavioral Healthcare Options ("**BHO**") P.O. Box 36040 Las Vegas, NV 89133-6040 (702) 364-1484 1-800-873-2246 www.bhoptions.com	**Life Insurance Provider** Symetra Life Insurance 777 108th Ave. NE, Suite 1200 Bellevue, WA 98004 (800) 426-7784
Vision Care Provider Vision Service Plan 111 West Ocean Blvd., Ste. 1625 Long Beach, CA 90802 (800) 877-7195 www.vsp.com	**Medical PPO/Indemnity Medical Plan Network** Multiplan, Inc. 115 Fifth Avenue New York, NY 10003 (212) 780-2000 http://www.multiplan.com

Quick Guide to Benefits. This Quick Guide describes Indemnity Medical Plan benefits.

Maximum Benefits:

Annual Maximum (per Individual)	There is no annual maximum benefit except as indicated below.
Acupuncture	$300 per year
Chiropractic	Ten (10) visits per year
Hearing Aids	One (1) device per ear every five (5) years
Physical, Occupational and Speech Therapy	60 visits per year
Skilled Nursing or Extended Care Facilities	100 days per year
Orthotics / Diabetic Shoes	One (1) pair every two (2) years

Deductibles:

Individual	$150 per year PPO / $600 Non-PPO
Family Maximum	$300 per year PPO / $1,200 Non-PPO
Common Accident Maximum	$150 per year PPO / $600 Non-PPO

Copayments *(services are subject to Coinsurance as well)*:

Emergency Facility	$0 ($500 in Non-Emergency situations)*
Physician Office Visit	$15 per visit

Percentage Payable ("Coinsurance"). ***When you use contracted / PPO providers, the Plan will pay more and you will pay less. Benefits will be further reduced if you fail to obtain Precertification, Concurrent Reviews, or Prior Authorization when required. Some services have additional Copays as well. All Non-PPO benefits are based on the Plan's adopted Allowable Expense amount.***

Plan pays:	**PPO**	**No PPO Available**	**Non-PPO***
In general (includes inpatient admissions, Physician office visits, etc.)	90% of Allowable Expenses	80% of Allowable Expenses	75% of Allowable Expenses
First $300 Accident Benefit	100% of Allowable Expenses	100% of Allowable Expenses	100% of Allowable Expenses
Acupuncture	90% of Allowable Expenses	80% of Allowable Expenses	80% of Allowable Expenses
Ambulance Service	90% of Allowable Expenses	80% of Allowable Expenses	80% of Allowable Expenses
Diagnostic Lab – Outpatient & Out of Area	90% of Allowable Expenses	80% of Allowable Expenses	75% of Allowable Expenses
Diagnostic X-ray – Outpatient	90% of Allowable Expenses	65% of Allowable Expenses	65% of Allowable Expenses
Diagnostic X-ray – Out of Area	90% of Allowable Expenses	75% of Allowable Expenses	75% of Allowable Expenses
Dialysis Treatment – Outpatient	Applicable Coinsurance Percentage but based on the Usual and Reasonable (U&R) amount For more information, refer to PART 3, INDEMNITY MEDICAL BENEFITS, Section F, Covered Expenses, Subsection 10, Dialysis Treatment – Outpatient		
Hearing Aids	80% of Allowable Expenses	80% of Allowable Expenses	80% of Allowable Expenses
Home Health Care	90% of Allowable Expenses	80% of Allowable Expenses	80% of Allowable Expenses
Hospice Care	90% of Allowable Expenses	90% of Allowable Expenses	90% of Allowable Expenses
Mental Health / Substance Abuse Treatment	Refer to Part 6.		

Plan pays:	**PPO**	**No PPO Available**	**Non-PPO***
Preventive Care Benefits: Preventive Care benefits, which includes: (i) services rated "A" or "B" by the U.S. Preventive Services Task Force, (ii) immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, and (iii) preventive care and screenings for women and children as recommended by the Health Resources and Services Administration The current list of Preventive Care benefits includes, but is not limited to, the following services: mammograms and other cancer screening; abdominal ultrasounds for men 65-75 who have ever smoked; bone screens for osteoporosis; pap smears; colonoscopy / sigmoidoscopy; blood tests for syphilis, gonorrhea, HIV, cholesterol / lipid panels and blood sugar.	100% of Allowable Expenses	100% of Allowable Expenses** ***Preventive Care benefits provided by a Non-Network Provider will be 100% covered only if the particular item or service provided by the Non-Network Provider is not available from a Network Provider.*	80% of Allowable Expenses
Physical, Occupational or Speech Therapy	90% of Allowable Expenses	80% of Allowable Expenses	80% of Allowable Expenses
Prescription Drugs	See chart below.		
Second Surgical Opinion	100% of Allowable Expenses	80% of Allowable Expenses	75% of Allowable Expenses
Skilled Nursing / Extended Care Facilities	90% of Allowable Expenses	80% of Allowable Expenses	80% of Allowable Expenses

Prescription Drugs

You pay:	**Generic Drugs**	**Formulary Brand Name Drugs**	**Nonformulary Brand Name Drugs**
Retail (30 days)	10% ($5 minimum)	20% ($10 minimum)	50% ($10 minimum)
Mail Order (90 days)	$10	$30 (Specialty Drugs 10% $250 maximum per 30-day supply)	$120

Annual Out-of-Pocket Maximum. ***The Annual Out-of-Pocket Maximum applies to all cost-sharing for Essential Health Benefits. It includes all Copayments, Coinsurance amounts and Deductibles you pay each year. For non-Emergency Services provided by Non-PPO Providers, there is no Annual Out-of-Pocket Maximum. Use PPO Providers when possible for non-Emergency Services in order to minimize your potential out-of-pocket expenses.***

	PPO	**Non-PPO (Non-Emergency Services)**
Individual Annual Out-of-Pocket Maximum	$3,500	None
Family Annual Out-of-Pocket Maximum	$10,500	None

PART 1. ELIGIBILITY AND ENROLLMENT.

A. Active Employees.

1. General. Employees whose work is covered by a collective bargaining agreement that requires contributions to the Plan ("**Bargaining Unit Employees**") or other written agreement, approved by the Trustees, requiring contributions that are accepted by the Plan ("**Nonbargaining Unit Employees**") are eligible to participate in the Plan provided that enough hours are worked and reported to the Plan.

2. Bargaining Unit Employees. Your eligibility is based on your Hour Bank. The "**Hour Bank**" is a system where your hours (reported by your Employer) are accumulated in an Hour Bank account established for you by the Administrator of the Plan. This system works very much like the way one might save money in a savings account.

   a. Initial Eligibility – You will become eligible for coverage on the first day of the second calendar month following a period of not less than three (3) consecutive calendar months during which 320 or more hours are credited to your Hour Bank. For example, if you work 100 hours in January, 110 hours in February and 110 hours in March (total of 320 hours) your coverage would be effective May 1.

   b. In the event you have not acquired the necessary number of hours within a three (3) month period, you will become eligible on the first day of the month following the "reporting" month in which your accumulated hours equal 320 or more.

   c. "**Lag Month**" – In order that there will be sufficient time for Employer reports to be received and processed by the Administrator of the Plan, a "lag month" (the "reporting month") will be used in determining your monthly eligibility. The lag month is the month between the period in which the hours were worked and the month of eligibility provided by those hours. For example, you work 320 hours during the months of April, May and June. You would then become eligible on August 1 – in this example, July is the lag month.

   d. Once you have qualified for coverage, you will then receive a month of coverage for each unit of 100 hours (the number of hours required for one month of coverage) in your account in excess of the 320 hours required for initial eligibility. You will be permitted to build up a maximum reserve accumulation of 600 hours, after having deducted the current month's charge for coverage. This reserve is intended to carry your coverage through any period of

unemployment. If you have no "reportable hours" for a period of 12 consecutive months, you will lose your credit for any Hour Bank reserve that is less than 100 hours, or any accumulation of hours if you have never qualified for eligibility. If your employer has not reported your hours worked and contributions paid to the Administrator, you are able to provide proof of hours of covered work to the Administrator's Office to obtain Eligibility. You need to provide your check stubs that reflect hours worked to the Administrators

e. If an Active Employee has at least one (1) hour in his/her Hour Bank, he/she may purchase additional hours at a rate per hour as determined by the Trustees to maintain coverage. He/she will be allowed to purchase additional hours twice per calendar year and must make the payment for the month by the 20th day of the month.

f. The following examples illustrate these eligibility provisions:

(1) Example 1: If you work 80 hours in June, 90 hours in July, 100 hours in August and 80 hours in September, a total of 350 hours (at least 320) you would become eligible for benefits November 1st (hours worked are reported the month following the month worked).

Total hours June, July, August and September		350
Subtract 100 hours from total for November eligibility		-100
	Reserve	250
If no more hours worked, you would be eligible for three (3) more months	(December)	-100
	Reserve	150
	(January)	-100
	Reserve	50

If you were available for work in the jurisdiction of the Union, you could self pay for February, if you made payment to the Administrative Office by February 20th.

(2) Example 2. If you worked 100 hours in June, 100 hours in July and 90 hours in August, you would have a total of 290 hours and would not have the 320 hours needed to become eligible; however, if you then worked 110 hours in September, then you would become eligible November 1.

As long as your Hour Bank contains at least 100 hours at the beginning of each month, you would remain eligible for benefits each month.

(3) Example 3. If you worked 110 hours in June, 120 hours in July and 130 hours in August, for a total of 360 hours:

Total would start on October 1	360
	-100
Reserve	260
Then you worked 90 hours in September	+90
	350
Eligibility for November	-100
	250

Each month add the hours worked and subtract 100 hours for the next month following the reporting month. Your Employer should report your hours in the month immediately following the month you work them. You can accumulate up to a maximum of 600 hours in your Hour Bank reserve. The reserve hours will be used when you do not work at least 100 hours in a month.

g. A Bargaining Unit Employee's coverage terminates on the earliest of the following dates:

(1) An Employee will cease to be eligible on the last day of any month during which the hours in his reserve account total less than 100 hours after deduction for the current month's coverage unless provided for as a self-contributor.

(2) Forfeiture of Hour Bank:

(a) If you engage in work of the type covered by a collective bargaining agreement for a nonsignatory or nonparticipating employer in the trade, you shall immediately forfeit all hours in your Hour Bank. If you had previously established eligibility for benefits during the month in which you began covered work for a nonsignatory employer, you shall retain eligibility only through the end of that month.

(b) You may maintain eligibility under the Plan only to the extent required by COBRA Continuation Coverage provisions, if applicable.

(c) A nonparticipating employer is one who is not signed to a collective bargaining agreement that requires the employer to make contributions to this Plan.

(3) On the date of entry into full-time military, naval or air service of any country (except for a temporary military leave of absence not exceeding 31 days, or in accordance with Uniform Services Employment & Reemployment Rights Act of 1994);

(4) On the date the Plan terminates.

B. Dependents. Eligible Dependents can be covered for health care benefits (medical, prescription drug, hearing aid, dental, and vision care).

1. If you are married, your eligible Dependents are:

a. Your legal spouse.

b. Your children, including stepchildren and adopted children, from birth up to the end of the month in which they turn age 26.

c. Your unmarried children who, upon attainment of the age limit specified above, are incapable of self-sustaining employment by reason of mental retardation or physical handicap (provided the condition of the child existed before the attainment of the age limit and while eligible hereunder) and who are solely dependent upon you for support.

d. No Dependent will be considered an eligible Dependent unless the first, middle and last name, date of birth and relationship to the Covered Employee has been registered with the Administrative Office by completing an enrollment card. The Plan may also require a Social Security number for a Dependent.

2. Dependents become eligible on the same date as the Employee becomes eligible, or when the individual first meets the definition of a "**Dependen**t," whichever is later.

3. Qualified Medical Child Support Orders. Under the Omnibus Budget Reconciliation Act of 1993, the Plan must recognize any Qualified Medical Child Support Order and enroll the child of a Plan Participant as directed by the Order.

a. A Qualified Medical Child Support Order is any judgment, decree or order (including approval of a settlement agreement) issued by a court that:

(1) provides the child of a Plan Participant with child support or health benefits under the Plan; or

(2) enforces a state law relating to medical child support pursuant to the Social Security Act that provides in part that if the employee-parent does not enroll the child the other parent or a state agency may enroll the child.

b. To be Qualified, a Medical Child Support Order must clearly specify:

(1) the name and last known mailing address of the Participant and the name and mailing address of each child covered by the order;

(2) a reasonable description of the type of Plan coverage to be provided to each such child or the manner in which such type of coverage is to be determined;

(3) the period to which such Order applies; and

(4) the name of each Plan to which such Order applies.

c. Further, a Medical Child Support Order will not qualify if it would require the Plan to provide any type or form of benefit or any option not otherwise provided under the Plan, except to the extent necessary to comply with the Social Security Act.

d. Payment of benefits by the Plan under a Medical Child Support Order to reimburse expenses advanced by a child or his custodial parent or legal guardian shall be made to the child or his custodial parent or legal guardian. Further, the child may designate an agent to receive notices, including a notice of qualification.

e. No eligible Employee's child covered by a Qualified Medical Child Support Order will be denied coverage on the grounds that the child is not claimed as a Dependent of the eligible Employee's federal income tax return or does not reside with the eligible Employee.

f. Contact the Administrative Office for the procedures you should follow for approval of Qualified Medical Child Support Orders.

g. The Plan's costs in reviewing and approving QMCSOs, including legal fees, consultant's fees and auditor's fees, if any, shall be allocated to the Plan Participant and reimbursed to the Plan by the Plan Participant. Such amounts shall be applied as an "overpayment" by the Administrator and recouped from future

benefits of the Participant. The Administrator shall send a notice explaining the charge to the Participant paying it.

4. The eligibility of a Dependent will terminate on whichever of the following dates is applicable:

   a. On the date the Employee's eligibility terminates; except that in the event of the death of the Employee, coverage for the Dependent will continue for a maximum of 12 months from the date of the Employee's Hour Bank reserve is insufficient to provide eligibility or until such time as the surviving spouse remarries or the eligible Dependents no longer qualify as Dependents, whichever is earlier. Such extended coverage shall not include Life Insurance;

   b. On the date the Dependent no longer qualifies as a Dependent;

   c. On the date that the Dependent enters into full-time military, naval, or air service of any country;

   d. On the date the Plan terminates.

   e. A Non-Medicare Employee may discontinue coverage for his or her Dependents at any time. If discontinued, Dependents may be reenrolled only when they are enrolled in Medicare.

C. Enrollment.

1. By enrolling, you certify and warrant to the Plan that all information on the enrollment card is true, correct and current as of the date signed. You agree to immediately notify the Plan, in writing, of any changes in this information, including any change in eligibility status for any Dependent listed on the enrollment card. **Failure to do so will be deemed an act or omission constituting fraud or an intentional misrepresentation of material fact by both the Covered Employee and the Dependent.**

2. By enrolling, you acknowledge the right of the Plan to require from you, and promptly receive from you, proof of identity or legal status, and eligibility status, such as certified marriage certificate, birth certificates, family court orders, tax returns or any other proof of eligibility or information as the Plan's Trustees, in their sole discretion, may demand. You agree to promptly furnish such proof or information to the Plan and further agree that furnishing such proof or information satisfactory to the Plan is a precondition to the payment of any benefits for you or on your behalf or on behalf of your Dependents. You understand that health care benefits are not vested rights and that the Trustees have full authority to modify, limit or terminate health care benefits at any time the Trustees deem appropriate.

3. If the Plan pays benefits for you or on your behalf or on behalf of any person listed as a Dependent by you, when you or any such person is not in fact eligible or entitled to benefits, or if the Plan otherwise mistakenly pays benefits, you agree to promptly reimburse the Plan in full for any money so paid. You also agree that the Trustees, in their sole discretion, may deduct or offset any such money from your future benefits. If the Plan files any legal action against you to recover any such payments, you agree to pay all attorneys' fees and costs of the Plan, whether or not such an action proceeds to judgment. **Receipt of Plan benefits is consent and agreement by the ineligible person to such liability.**

4. Following initial enrollment, a Covered Employee may change his or her selection once at any time during any 12 consecutive month period, provided that the Employee has been enrolled in his or her current selection for at least 12 consecutive months. Changes in Plan selection are effective the first day of the first month following the date the Plan's Administrative Office receives the appropriate enrollment form indicating the new selection. Within 30 days after the effective date of the change, the Employee must provide all required enrollment information to the Plan Administrative Office, or claims may be delayed or denied.

5. If you did not enroll in this Plan when you were first eligible, you are also allowed to enroll, pursuant to the Children's Health Insurance Program Reauthorization Act of 2009 ("**CHIP**") , if:

    a. You or your Dependent loses coverage and eligibility under a Title XIX Medicaid plan or under a Title XXI state child health plan and you request coverage in this Plan not later than 60 days after the date of termination of the other coverage; or

    b. You or your Dependent becomes eligible for CHIP assistance to offset the cost of participating in this Plan, provided you request coverage under this Plan not later than 60 days after the date you or your Dependent is determined to be eligible for CHIP assistance.

D. Retirees. See **Part 10** for Retired Employee coverage.

E. Nonbargaining Unit Employees. The Plan may permit participation by Nonbargaining Unit Employees on behalf of Employers who contribute to the Plan on behalf of their Bargaining Unit Employees, provided that each such Employer shall execute a Nonbargaining Unit Participation Agreement approved by the Trustees.

F. Newly Signatory Employers.

1. The Trustees have discretion to grant immediate eligibility to current Employees of a Newly Signatory Employer. If so, a Bargaining Unit

Employee who is employed by a Newly Signatory Employer on the effective date of the collective bargaining agreement with the Newly Signatory Employer may receive an Hour Bank loan sufficient to enable such Employee to acquire immediate eligibility for coverage. Hours thereafter worked or paid in covered employment by such an Employee and reported to the Plan will first be credited for current or on-going eligibility. Hours remaining after the deduction for current eligibility will be applied to reduce the Hour Bank loan. The deduction of sufficient hours for current eligibility and the application of the remaining surplus hours to reduce the Hour Bank loan will be done month by month until the Hour Bank loan is paid off. No hours will accumulate in any such Employee's Hour Bank for extended eligibility until the Hour Bank loan is paid off. Thereafter, the Employee may accumulate hours for extended eligibility as normal.

2. If the contribution rate for such an Employee is less than the standard journeyman rate, then, for purposes of repaying the Hour Bank loan, the hours worked by such Employee shall be prorated by the Administrative Office.

3. Bargaining Unit Employees hired by a Newly Signatory Employer after the effective date of the collective bargaining agreement with the Newly Signatory Employer are initially eligible for coverage after working the usual number of hours in covered employment the Plan requires for initial eligibility.

4. Where the contribution rate for an Employee hired after the effective date of the collective bargaining agreement is less than the journeyman rate, the hours worked will be calculated pro rata and shown as a deficit on the Employee's Hour Bank. After the Employee acquires initial eligibility, surplus hours worked, i.e., hours remaining after deducting sufficient hours for current eligibility will be applied to reduce the deficit until the deficit is fully paid off. Thereafter, the Employee may accumulate hours for extended eligibility as normal.

5. If an Employee who acquired eligibility hereunder changes employment from a Newly Signatory Employer to any other signatory employer before his Hour Bank loan or deficit is repaid in full, his reportable hours in new covered employment will continue to be applied to pay off his Hour Bank loan or deficit, after first deducting sufficient hours for current eligibility.

6. If an Employee who acquired eligibility hereunder terminates employment before his Hour Bank loan or deficit has been repaid in full and does not become employed by another signatory employer as specified in Paragraph 5 above, coverage shall cease on the last day of the month of termination of employment.

G. Apprentices.

1. 65% apprentices are eligible for immediate eligibility through the Hour Bank loan provision. Such apprentices may receive an Hour Bank loan sufficient to enable such apprentices to acquire immediate eligibility for coverage. Hours thereafter worked or paid in covered employment by such an apprentice and reported to the Trust Fund will first be credited for current or ongoing eligibility. Hours remaining after the deduction for current eligibility will be applied to reduce the Hour Bank loan.

2. The deduction of sufficient hours for current eligibility and application of the remaining surplus hours to reduce the Hour Bank will be done month by month until the Hour Bank loan is paid off. No hours will accumulate in any such apprentice's Hour Bank for extended eligibility until the Hour Bank loan is paid off. Thereafter the apprentice may accumulate hours for extended eligibility as normal.

3. If the contribution rate for such an apprentice is less than the standard rate, then for purposes of repaying the Hour Bank loan, the hours worked by such an apprentice shall be prorated by the Administrative Office.

4. If an apprentice who acquired eligibility hereunder terminates his apprenticeship or covered employment before his Hour Bank loan or deficit has been repaid in full, and does not become employed by another signatory employer, coverage shall cease on the last day of the month of termination of apprenticeship or employment. A person's Hour Bank loan or deficit must be paid in full, notwithstanding an apprentice's graduation from the program.

PART 2. CONTINUATION COVERAGE

A. COBRA Continuation Coverage. A federal law known as Consolidated Omnibus Budget Reconciliation Act ("**COBRA**") requires that group health plans offer covered Participants the opportunity for a temporary extension of health coverage where coverage under the Plan would otherwise end. If you or your spouse and/or Dependent child(ren) are covered under this Plan, you and/or your Dependents can continue coverage for a time if coverage ends for one of several reasons (called "qualifying events"), even if you or they are already covered by another group health plan or Medicare. To receive this continuation of coverage, the Participant must pay the monthly self payments directly to the Plan. This section of the booklet is intended to inform you about your rights and obligations regarding COBRA continuation coverage. You should take the time to read this carefully.

1. Rights of an Employee. If you are an Employee covered by the Plan, you may have a right to choose this continuation coverage if you lose your Plan coverage because of:

    a. a reduction in hours resulting in loss of eligibility in accordance with the eligibility rules of a Plan;

    b. voluntary resignation; or

    c. the termination of your employment (for reasons other than gross misconduct on your part).

2. Even if the Employee does not elect COBRA continuation coverage, the Employee's spouse and each of the Employee's other eligible Dependents will have a separate right to elect it. THEREFORE, IT IS IMPORTANT THAT THE EMPLOYEE, SPOUSE AND ALL OTHER DEPENDENTS READ THIS SECTION OF YOUR BENEFIT BOOKLET.

3. Rights of a Dependent Spouse. If you are the spouse of a covered Active Employee, you may have the right to choose continuation coverage for yourself if you lose coverage under the Plan for any of the following reasons:

    a. the death of your spouse; or

    b. the voluntary resignation or the termination of your spouse's employment (for reasons other than gross misconduct), or a reduction in hours resulting in loss of eligibility in accordance with the eligibility rules of the Plan; or

    c. divorce or legal separation from your spouse.

4. Rights of Dependent Children. In the case of a Dependent child of an Active Employee covered by the Plan, he or she may have the right to continuation coverage if coverage under the Plan is lost for any of the following reasons:

   a. the death of the parent who is the Covered Employee under this Plan;

   b. the parents' divorce or legal separation;

   c. the voluntary resignation or the termination of the employed parent's employment (for any reasons other than gross misconduct), or a reduction in hours resulting in loss of eligibility in accordance with the eligibility rules of the Plan; or

   d. the Dependent ceases to be an eligible Dependent as defined under this Plan.

5. Adding Dependents. A new spouse, newborn child or a child placed for adoption may be added under your COBRA coverage as long as the Administrative Office is notified within 30 days of marriage, birth or placement. Coverage for newly-acquired Dependents lasts only for the remainder of coverage of the current COBRA Beneficiary who acquired the Dependent (new Dependents do not have their own COBRA rights).

6. Period of COBRA Continuation Coverage. If you elect COBRA continuation coverage you may continue your coverage for a maximum of three (3) years (36 months) unless coverage was lost because of a termination of employment, voluntary resignation or a reduction in earnings resulting in loss of eligibility. In these instances, the required continuation coverage period is 18 months unless you or your Dependent were Totally Disabled or become Totally Disabled at any time during the first 60 days of COBRA continuation coverage. In addition, so long as you or your Dependent receive a Social Security disability determination before the initial 18 months of continuation coverage expires, and you or your Dependent report that determination to the Administrative Office within 60 days of the date notice was received by your Dependent, you or your Dependent's coverage may be continued for an additional 11 months at increased rates up to a total of 29 months. Coverage may be extended for the disabled person or for all family members.

7. If the Covered Employee loses coverage because of a termination of employment or reduction in earnings after he becomes entitled to Medicare, his Dependents will be allowed to continue their coverage until the later of:

   a. 18 months from the date coverage was lost; or

b. 36 months from the date the Employee became entitled to Medicare.

8. If a second qualifying event occurs within the first 18-months, COBRA continuation coverage may be extended up to 36 months from the initial qualifying event for an Employee's spouse or Dependent child. For example, if an Employee's spouse is on COBRA continuation coverage for 18 months due to the termination of the Employee's employment, and during the 18-month period the former Employee dies, the spouse will be eligible to maintain his or her COBRA continuation coverage for up to 36 months from the date of the first qualifying event. However, in no event will COBRA continuation coverage extend beyond 36 months from the date of the first qualifying event, and it may end before the 18 or 36 month period expires, as explained later in this section.

9. Also, note that the maximum 18 or 36 months of continuation coverage will include the self-pay coverage provided by the Plan in case of the Employee's death.

10. Duty to Notify Administrative Office. The Employee or family member must inform the Administrative Office in writing within 60 days of a divorce, legal separation or loss of Dependent status of a child.

11. An Employee's employer will inform the Administrative Office about other qualifying events. However, we encourage the Employee or family member to inform the Administrative Office promptly of any qualifying event to assure prompt handling of your COBRA rights.

12. Deadline for Election of COBRA Continuation Coverage. When the Administrative Office is notified that a qualifying event has occurred, the Administrative Office will send you an election form and other information regarding COBRA continuation coverage. You will have at least 60 days from the later of (A) the date your coverage terminates under the Plan or (B) the date you receive the notice advising you of your election rights, to make your decision. You do not have to show that you are insurable to obtain COBRA continuation coverage.

13. If you elect COBRA continuation coverage, you will be entitled to the same health coverage that is provided to similarly situated Active Employees or family members in the Plan. However, life insurance benefits and disability benefits are not provided under COBRA continuation coverage. You may elect to continue medical and prescription benefits without continuing dental and vision, but dental and vision cannot be continued alone.

14. Payment Obligations. Payment for the required contribution must be made as follows:

a. All payments must be made by check, cashier's check or money order.

b. The initial self-payment should be received by the Administrative Office no later than the 20th day of the month prior to the month for which you desire coverage in order to avoid possible delays in claim payments and eligibility problems. However, this initial payment will be accepted if received within 45 days from the day the Participant mails the form electing COBRA Coverage. The initial payment must cover the number of months from the date coverage would otherwise have terminated, including the month in which the initial payment is made.

c. After the initial self-payment is made, self-payments must be made monthly to continue coverage. Monthly payments should be mailed by the 20th day of the month preceding each coverage month to avoid possible delays in claim payments and eligibility problems. **Failure to make a monthly payment within 30 days of the beginning of the coverage month will result in termination of coverage as of the end of the period for which the last payment has been made.**

d. The Administrative Office will not send monthly bills or warning notices. It is the responsibility of the qualified Participant to submit payments when due.

15. Termination of COBRA Continuation Coverage. Continuation coverage will terminate as of the date the maximum period has been reached as described previously. However, continuation will terminate earlier for any of the following reasons:

a. The health plan option (Fee-For-Service) you have chosen is terminated (in which case you may have the opportunity for coverage under other group health benefit options offered by the Plan);

b. Your self-payment for COBRA continuation coverage is not paid on time;

c. You become covered by another group health plan, as an employee, or spouse or dependent of an employee; or

d. You become entitled to Medicare.

16. If you change marital status, add new Dependents, or you or your spouse change your address, please notify the Administrative Office at the address on page 3.

Notice – The next page is the general COBRA notice required by law.

17. Alternatives to COBRA Coverage. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

Continuation of Health Coverage Notice and Election Procedures

General Notice (Initial COBRA Notice):

A group health plan subject to the requirements of COBRA must provide written notice to each covered employee and spouse (if applicable) within 90 days after coverage under the Plan commences of the right to continue coverage. (If a Qualifying Event occurs during the first 90 days of coverage under the Plan and before the general notice has been distributed, the Plan may provide only the COBRA election notice, as described below). In lieu of, or in addition to, such written notice, the Plan Administrator is hereby providing the general notice to the employee by delivery of the Summary Plan Description.

The Plan may notify a covered employee and the covered employee's spouse with a single general notice addressed to their joint residence, provided the Plan's latest information indicates that both reside at that address. However, when a spouse's coverage under the Plan begins later than the employee's coverage, a separate general notice must be sent to the spouse within 90 days after the spouse's coverage commences.

NOTE: It is important for the Plan Administrator to be kept informed of the current addresses of all Covered Persons under the Plan who are, or who may become, Qualified Beneficiaries,

Employer's Notice of Qualifying Event And Notices That Qualified Beneficiaries Must Provide:

Continuation of health coverage shall be available to an employee and/or his covered dependents upon the occurrence of a Qualifying Event. To continue health coverage, the Plan Administrator must be notified in writing of a Qualifying Event by:

1. The Employer, within 30 days of the later of: (1) the date of such event or, (2) the date of loss of coverage due to the event, if the Qualifying Event is:
   a. for a covered dependent, the covered employee's death;
   b. the covered employee's termination (other than for gross misconduct) or reduction in hours;
   c. for a covered dependent, the covered employee's entitlement to Medicare.
   d. the commencement of certain bankruptcy proceedings with respect to the Employer.
2. The employee or a Qualified Beneficiary, within 60 days of the later of: (1) the date of such event, (2) the date of loss of coverage due to the event, or (3) the date on which a Qualified Beneficiary is informed through the Plan's Summary Plan Description or general notice of both his obligation to provide notice and the procedures for providing such notice, if the Qualifying Event is:
   a. for a spouse, divorce or legal separation from a covered employee;
   b. for a dependent child, loss of dependent status under the Plan; or
   c. the occurrence of a second Qualifying Event after a Qualified Beneficiary has become entitled to continuation coverage with a maximum duration of 18 (or 29) months.

   An employee or Qualified Beneficiary who does not provide timely notice to the Employer of one of the above such Qualifying Events may lose his rights under COBRA.

   Upon termination of employment or reduction in hours, a Qualified Beneficiary who is determined under Title II or Title XVI of the Social Security Act to be disabled on such date, or at any time during the first 60 days of COBRA continuation coverage, will be entitled to continue coverage for up to 29 months if the Plan Administrator is notified of such disability within 60 days from the later of (and before the end of the 18-month period): (1) the date of determination, (2) the date on which the Qualifying Event occurs, (3) the date on which the Qualified Beneficiary loses coverage, or (4) the date on which the Qualified Beneficiary is informed through the Plan's Summary Plan Description or general notice of both the obligation to provide the disability notice and the Plan's procedures for providing such notice. If a Qualified Beneficiary entitled to the disability extension has non-disabled family members who are entitled to COBRA continuation coverage, the non-disabled family members are also entitled to the disability extension.

A Qualified Beneficiary who is disabled under Title II or Title XVI of the Social Security Act must notify the Plan Administrator within 30 days from the later of: (1) the date of final determination that he is no longer disabled, or (2) the date on which the individual is informed through the Plan's Summary Plan Description or general notice of both the responsibility to provide such notice and the Plan's procedures for providing such notice.

Plan Administrator's Notice Obligation — Election Notice:

The Plan Administrator must, within 14 days of receiving notice of a Qualifying Event, notify any Qualified Beneficiary of his right to continue coverage under the Plan. Notice to a Qualified Beneficiary who is the employee's spouse shall be notice to all other Qualified Beneficiaries residing with such spouse when such notice is given.

Election Procedures:

A Qualified Beneficiary must elect Continuation of Health Coverage within 60 days from the later of the date of the Qualifying Event or the date notice was sent by the Plan Administrator.

A new spouse, a newborn child, or a child placed with a Qualified Beneficiary for adoption during a period of COBRA continuation coverage may be added to the Plan according to the enrollment requirements for dependent coverage under the "Special Enrollment" section of the Plan. A Qualified Beneficiary may also add new dependents during an open enrollment period held once each year at a time **and** in accordance with the procedures established by the Plan Administrator.

Any election by an employee or his spouse shall be deemed to be an election by any other Qualified Beneficiary, though each Qualified Beneficiary is entitled to an individual election of continuation coverage.

Upon election to continue health coverage, a Qualified Beneficiary must, within 45 days of the date of such election, pay all required contributions to date to the Plan Administrator. All future contribution payments by a Qualified Beneficiary must be made to the Plan Administrator and are due the first of each month with a 30-day grace period. If the initial contribution payment is not made within 45 days of the date of the election, COBRA coverage will not take effect. If future contribution payments are not made within the allotted 30-day grace period, COBRA coverage will be terminated retroactively back to the end of the month in which the last full contribution payment was made.

Except as provided herein, if the initial coverage election and required contribution payments are made in a timely manner, as described in this section, coverage under the Plan will be reinstated retroactively back to the date of the Qualifying Event.

If a Qualified Beneficiary waives COBRA coverage, he may revoke the waiver at any time during the election period. The Qualified Beneficiary would be eligible for continuation of coverage prospectively from the date that the waiver is revoked, if all other requirements, such as timely contribution payments, are met.

Plan Administrator's Notice Obligation — Notice Of Unavailability Of Continuation Coverage:

The Plan Administrator must provide a notice of unavailability to an individual within 14 days after receiving a request for continuation coverage if the Plan determines that such individual is not entitled to continuation coverage. The notice must include an explanation as to why the individual is not entitled to COBRA. This notice must be provided regardless of the basis of the denial and regardless of whether it involves a first or second Qualifying Event or a request for disability extension.

Plan Administrator's Notice Obligation — Early Termination Notice:

The Plan Administrator must provide a notice to Qualified Beneficiaries when COBRA terminates earlier than the maximum period of COBRA applicable to the Qualifying Event as soon as practicable following its determination that continuation coverage shall terminate. This notice must contain the reason that continuation coverage has terminated earlier than the maximum period triggered by the Qualifying Event, the date of termination of continuation coverage, and any rights the Qualified Beneficiary may have under the Plan or under applicable law to elect alternative group or individual coverage (such as a conversion right).

Trade Act Of 2002:

The Plan shall fully comply with the Trade Act of 2002 as the Act applies to employee welfare benefit plans.

B. **Military Leave.** Regardless of any existing contrary Plan provisions, the Plan shall be maintained in compliance with all requirements of the Uniformed Services Employment and Reemployment Rights Act of 1994 ("**USERRA**"). Benefits for military leave prior to USERRA shall be provided in accordance with the law in place then. In no event shall benefits be provided for illnesses or Injuries determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, performance of services while in the military. Unless the terms of the collective bargaining agreement require otherwise, the following policies shall govern contributions for coverages and benefits required under USERRA.

1. Participants may self pay for coverage under this provision for up to 24 months continuation coverage required by federal law.

2. The Employer shall provide coverage through contributions for Participants whose military service is for less than 31 days.

3. The Employer shall provide (through contributions) any seniority based benefits of the Plan to which a Participant is entitled due to the provisions of USERRA.

4. Upon discharge from uniformed service, a Participant who is reemployed with an Employer in accord with the provisions of USERRA shall be entitled to coverage under the Plan and all rights and benefits under the Plan that the Participant would have had if the Participant had remained continuously employed with an Employer.

5. If the last Employer employing the Participant in uniformed services is no longer functional, USERRA-required benefits for which such last Employer is liable shall be provided by the Plan at its own expense.

C. **Self-Payments for Out-of-Work Bargaining Unit Employees.**

1. If you are an eligible active Bargaining Unit Employee whose accumulated credit for hours worked has fallen below 100 hours, you may, in order to maintain continuous coverage, make payment as a "**Self-Pay Employee**" directly to the Plan.

    a. The Self-Payment rate for an out-of-work Bargaining Unit Employee who loses coverage due to a voluntary or involuntary termination after May 31, 2010 will be 100% of the full cost of COBRA coverage (medical, prescription drug, dental and vision benefits).

    b. There may be no breaks in payment and you must be eligible for coverage at the time you wish to begin direct payment.

c. You must be listed on the Union's Hiring Hall records and must not work for a nonsignatory employer doing cement masons or plasterers work.

d. You must make payment directly to the Plan by the 20th of the month for which coverage is desired.

e. You must not be a member of the military, naval or air services of any country on a full-time basis.

2. The maximum months of self-pay coverage is based on the maximum months of continuation coverage allowed by COBRA.

3. Coverage for the Dependents of a Self-Pay Employee shall cease on whichever of the earliest of the following dates:

a. On the date the Self-Pay Employee's eligibility terminates;

b. On the date the Dependent no longer qualifies as a Dependent;

c. On the date the Dependent enters into full-time military, naval or air service of any country;

d. On the date the Plan terminates.

D. Freezing of Benefits for Disabled Employees. (Bargaining and Nonbargaining Unit Employees). If an Employee has been eligible for 12 months or more preceding an injury and becomes Totally Disabled due to an Occupational or Nonoccupational Illness or Injury, coverage may be continued for a maximum of 12 months from the end of the month during which the disability commenced, and all hours remaining in his Hour Bank shall be frozen, provided:

1. Application for extended coverage is applied for within one (1) year following the date of total disability;

2. A Physician certifies that the total disability will continue for 30 days or more;

3. The disability occurred while the Employee was eligible; and

4. A Physician certifies the Employee is unable to engage in any work for wage or profit, or the Employee is restricted to light duty work, as determined by the Trustees based on such evidence they deem sufficient, including medical records or a Social Security determination, for example.

5. These benefits will terminate upon the occurrence of any one of the following:

a. making yourself available for work in the Union's Hiring Hall; or

b. certification from your Physician or an independent medical examiner retained by the Plan that you are able to engage in any type of "work for pay or profit."

c. Entering into any "work for pay or profit."

E. Disabled Children. The maximum age limit (end of the month in which their 26th birthday occurs) may be extended for Dependent children who are disabled and incapable of self-sustaining support as a result of physical or mental disability while such condition exists, under the following rules:

1. Written evidence of disability must be submitted within 31 days of attainment of the age limit.

2. The Plan may require, at reasonable times during the two (2) years following the child's attainment of the limiting age, subsequent proof of the child's incapacity and dependency. After the two (2)-year period the Plan may require additional proof of the incapacity and dependency of the child once a year.

3. The disabled child must be and remain unmarried.

4. The incapacity must have commenced prior to the age limit stated in the eligibility rules.

5. The child must be chiefly dependent on the Covered Employee for support and maintenance.

F. Coverage During Family and Medical Leave.

1. The Family and Medical Leave Act ("**FMLA**") requires certain employers to give their employees up to 12 weeks of unpaid leave during any 12-month period for certain family and medical reasons. During FMLA leave, you may continue coverage for medical, prescription, dental and vision benefits under the Plan provided that your Employer continues to pay the required contributions for you and you continue to pay any required employee contributions.

2. FMLA permits a spouse, son, daughter, parent or next of kin to take up to 26 weeks of leave to care for a member of the Armed Forces, including a member of the National Guard or Reserves, who is undergoing medical treatment, recuperation, therapy, in outpatient status, or is otherwise on a temporary disability retired list, for a serious Injury or illness. An employee is permitted to take FMLA leave for any "qualifying exigency" (as defined by the Secretary of Labor) arising out of the fact that the spouse, son, daughter, or parent of the employee on active duty (or has

been notified of an impending call or order to active duty) in the Armed Forces in support of a contingency operation.

3. ***Whether you are entitled to FMLA leave is determined by your Employer*** and your Union, not by the Plan. It is the responsibility of the employer to notify the Administrative Office of all granted leave and provide the Administrative Office with documentation concerning the reason for your leave. If you are not receiving paychecks while on FMLA leave you must make arrangements with your Employer and/or Union to ensure that contributions to the Plan are made on your behalf. If contributions are late by 30 days or more, your coverage may be canceled until you return to work.

4. ***When you return to work your benefits will be reinstated as though you*** had not taken leave. If you do not return to work after taking FMLA leave:

    a. Your coverage will end on the date you give notice that you are not returning to work;

    b. You may be required to repay your Employer the cost of the coverage you had while on leave (unless you do not return to work because of a serious medical condition beyond your control); and

    c. You may be eligible for COBRA (explained in Part 2, Section A).

5. ***FMLA leave will not cause you to lose any accumulated benefits.*** For more information on your Employer's and Union's FMLA and other leave policies, please call your Employer or your Union.

PART 3. INDEMNITY MEDICAL BENEFITS.

This section applies to individuals enrolled in the Indemnity Medical Benefits (Part 3) provided by the Plan. Employees who lose coverage for less-than 12 consecutive months need not establish new initial eligibility, but instead become covered again as soon as they have sufficient hours in their Hour Banks for coverage.

A. Mandatory Hospital & Medical Prior Authorization Programs (Provided by the Utilization Review Organization listed on page 3).

1. "Prior Authorization" is a program designed to avoid unnecessary medical treatment. Through this review process, you and your Physician will be advised if the requested treatment is appropriate. Perhaps a recommended surgery can be performed on an outpatient basis thus saving you out-of-pocket expense. If the review organization has a question as to the necessity of Hospitalization, that organization will contact your Physician and resolve the problem. The Trustees have contracted with the Utilization Review Organization to provide this service. Benefits payable will be reduced to 50% of Allowable Expenses if Prior Authorization is not obtained.

2. Prior Authorization is required for all nonemergency Hospital Admissions (other than admissions through the MAP program) in order for you or your Dependents to have Plan benefits paid at the maximum level. Prior Authorization is also required for certain outpatient services. If it is necessary for you to be admitted to the Hospital on an Emergency basis, you do not need to get Prior Authorization, but it is necessary to have the Hospital call the Utilization Review Organization the first day you are in the Hospital. The Utilization Review Organization will then review your records to determine the necessity of your admission and the required length of stay. The following services require Prior Authorization:

Allergy testing;	Durable Medical Equipment over $500;
Cardiac monitoring;	Home Health Care;
Echocardiography;	CT/CTA;
MRI/MRA;	Outpatient surgery requiring sedation;
Myocardial perfusion Imaging (Thalium);	Outpatient surgery performed in
PET scans;	Outpatient Surgery Center

This is not a complete list of services and supplies requiring Prior Authorization. Please contact the Administrative Office for more information. All inpatient Hospitalization requires Prior Authorization. This includes admissions for Mental Health and Substance Abuse disorders. (See Part 7, Section B)

3. Prior Authorization for any health care service or procedure means only that the proposed service or procedure is medically necessary and appropriate for the diagnosis given. **Prior Authorization does not mean that eligibility, payment or benefits are guaranteed**. Payment for any health care service or procedure will be determined on the basis of the Plan of benefits in effect at the time the service or procedure is performed, regardless of any Prior Authorization.

4. How does the Program Work?

5. If the Prior Authorization requirements are not completed, your benefit payment will be reduced to 50% of Allowable Expenses.

    a. If you are recommended to have a nonemergency Hospital admission, hospice care or Home Health Care, you must tell your Physician that you are required to receive Prior Authorization.

    b. You also must call the Utilization Review Organization to confirm that your Physician has obtained Prior Authorization.

    c. You, your Physician, the Hospital and the Administrative Office will be advised if the treatment is approved. In the event there are disagreements as to whether the treatment is medically necessary, your Physician and the Physician from the Utilization Review Organization will resolve the problem.

    d. If it is not resolved, you will be advised at that time and told about the appeals procedure. However, before any expenses are incurred, you will know that your claim may be denied because the treatment is not medically necessary. This program protects you.

6. <u>Concurrent Review</u>.

    a. Once you have entered the Hospital following the Prior Authorization or following an Emergency admission, the Utilization Review Organization will continue to monitor your stay to determine the appropriate length of confinement and the necessity of medical services. Benefits payable will be reduced to 50% of the amount otherwise payable if Prior Authorization and Concurrent Review are not obtained.

    b. If the Utilization Review Organization concludes your continued Hospitalization is unnecessary, you and your Physician will be notified. You may continue to stay in the Hospital; however, you must be aware it will reduce payment of your claim. You, of course, have the right to appeal this decision.

7. Prior Authorization for MAP. If you require Hospitalization through a referral by MAP, it is not necessary to obtain Prior Authorization or a Concurrent Review through the Utilization Review Organization. All MAP referred Hospitalizations must receive Prior Authorization from MAP. If the Prior Authorization requirements are not completed, your benefit payment will be reduced to 50% of Allowable Expenses.

B. Choosing a Contract Hospital. The Plan has contracted with several Hospitals to reduce costs for Hospitalization. Therefore, your actual payment at a PPO Hospital will be less than what you would pay for the same service at a Non-PPO Hospital. Please contact the Utilization Review Organization listed on page 3 for the most current list of PPO Hospitals.

Elective services performed at Non-PPO Hospitals are generally covered by the Plan at 75% of Allowable Expenses.

C. Deductibles and Copayments. Deductibles and Copayments are amounts that you must pay, in addition to coinsurance, in certain circumstances before the Plan pays benefits. The Plan's various Deductibles and Copayments include:

1. An Individual Calendar Year Deductible of $150 of out-of-pocket PPO Covered Expenses incurred by each Eligible Individual each Calendar Year ($600 Non-PPO). A deductible is an amount that you must pay, in addition to coinsurance, before the Plan pays benefits. The Calendar Year deductible applies separately to Covered Expenses incurred by or on behalf of each Eligible Individual covered under the Plan once during each Calendar Year (except as provided under "**Family Limit**" or "**Common Accident**") even though expenses may be incurred for care of several Injuries or Sicknesses during the year. Any Covered Expenses incurred during the last three (3) months of a Calendar Year that are applied toward the deductible (whether or not it is fully satisfied) may also be applied toward the deductible for the following Calendar Year.

2. A $500 per visit Emergency Facility Copayment for Non-Emergency care ($0 for Emergency care).

3. A $15 Physician office visit Copayment.

4. Special Rules Regarding Deductibles.

    a. Family Limit – Subject to the rules regarding "Common Accident," not more than two (2) deductibles ($300 PPO / $1,200 Non-PPO) per family need be satisfied during any Calendar Year.

    b. Common Accident – If an Active Employee and one (1) or more Dependents, or if two (2) or more Dependents, are injured in the same accident, all Covered Expenses arising out of the accident will combine and only one (1) Deductible Amount above will

apply to all such expenses incurred during the Calendar Year in which the accident occurs.

c. The Deductible will not apply to the following benefits:

(1) Hearing Aid Benefits; or

(2) Accident Expense (first $300).

D. Coinsurance and Annual Out-of-Pocket Maximums.

1. Coinsurance. Except as may be stated elsewhere regarding specific items, if an Eligible Individual receives treatment for an Injury or Sickness, the Plan will, subject to the terms and conditions stated below, pay the applicable percentage, as outlined below:

a.	Contract Provider	90% of Allowable Expenses
b.	No Contract Provider Available	80% of Allowable Expenses
c.	Noncontract Provider	75% of Allowable Expenses

2. Annual Out-of-Pocket Maximums. The amount you pay each year in Copayments, Coinsurance and Deductibles on Essential Health Benefits delivered by PPO Providers will not exceed $3,500 per person or $10,500 per family. Once you (or your family) meet the Annual Out-of-Pocket Maximum on Essential Health Benefits, the Plan will not charge you any additional amounts for covered services. There is no Annual Out-of-Pocket Maximum for non-Emergency services provided by Non-PPO Providers. The Annual Out-of-Pocket Maximum you will pay for Emergency Services Provided by Non-PPO Providers will not exceed the annual limit for PPO Provider services ($3,500 per person, $10,500 per family). Use PPO Providers when possible for non-Emergency Services in order to minimize your potential out-of-pocket expenses.

E. Mandatory Case Management. The Plan has the authority to require or mandate case management. Case management means medical or other health care management services to assist patients and their health care providers and facilitate proper, effective and efficient care, including identifying and facilitating additional medical resources and treatments, providing information about treatment options, and facilitating activities and communications among professionals. Circumstances for case management include chronic illnesses, acute catastrophic Injury, infectious disease, burns, terminal illness, transplants, prescription Drugs (for example, narcotics and other addictive Drugs), high risk pregnancies, neonatal complications, AIDS and AIDS related cases, among others. Case management can also include required independent medical examinations and evaluations.

If the Participant or his / her treating health care providers, including Physicians, refuse or fail to participate in and fully cooperate with case management when it

is required by the Plan, then the Plan has the authority to reduce all Plan benefits by 75%.

F. **Covered Expenses.** The term "**Covered Expenses**" refers to the items of medical expense for which medical benefits may be payable. Covered Expenses include charges for the following services and supplies which are certified by the attending Physician and determined by the Plan to be medically necessary for treatment of Injury or Sickness, to the extent that the charges do not exceed Allowable Expenses:

1. Inpatient Hospital Benefits.

   a. PPO Hospitals. If an Eligible Individual becomes confined in a PPO Hospital, the Plan will, subject to the terms and conditions hereafter stated, pay 90% of Allowable Expenses for room and board (including confinement in an intensive care unit) and other necessary services and supplies obtained during inpatient confinement.

   b. Non-PPO Hospitals. If an Eligible Individual becomes confined in a Non-PPO Hospital, the Plan will, subject to the terms and conditions hereafter stated, pay 75% of the amount otherwise payable if the Eligible Individual had been confined in a PPO Hospital for the following:

      (1) room and board charges;

      (2) intensive care unit accommodations not to exceed an amount equal to two and one-half (2 1/2) times the Hospital's most common charge for its standard semiprivate accommodations; and

      (3) other miscellaneous charges for services and supplies that are necessary for treatment of Injury or Sickness.

   c. Exceptions to Non-PPO rates: Unless specifically stated otherwise:

      (1) If an Eligible Individual requires specialized care that can only be provided in a Non-PPO Hospital, the Plan will, subject to the terms and conditions hereafter stated, pay 80% of Allowable Expenses.

      (2) If an Eligible Individual residing within the Plan's Preferred Provider Service Area visits or is confined in a Non-PPO Hospital due to an Emergency Medical Condition, the Plan will pay 90% of Allowable Expenses for Emergency Services provided by the Non-PPO

Hospital. The Plan may require that the Eligible Individual be transferred to a PPO Hospital upon the advice of a Physician that it is medically safe to effect such transfer.

(3) Where it is medically necessary and appropriate to have medical treatment that is otherwise covered by the Plan, but which is not reasonably available through current PPO Physicians or facilities and the Eligible Individual establishes such to the satisfaction of the Board of Trustees based upon whatever evidence the Board of Trustees may require, the Plan will pay 90% of Allowable Expenses.

d. Mandatory Inpatient Care from Hospitalist Program Physician: If a Participant is admitted as an inpatient at a Hospital at which a Hospitalist Program exists, the Participant is subject to the Hospitalist Program.

(1) Inpatient care by the Hospitalist Program Physicians is required for all Participants. This is inpatient care by Primary Care Physicians only. "**Primary Care Physicians**" are general practice, family practice and internal medicine Physicians. The Hospitalist Program does not include Physician care by specialists such as cardiologists, dermatologists, oncologists or anesthesiologists. For purposes of the Hospitalist Program only, OB/GYN and Pediatric Physicians are considered specialists, not Primary Care Physicians.

(2) For inpatient Physician primary care under the Hospitalist Program, the Plan will pay the full Allowable Expense including any copays, coinsurance and deductibles. The Eligible Individuals will not have any out of pocket expenses for covered services by Hospitalist Program Physicians. Care by specialists will continue to be covered and paid as normal under the terms of the Plan.

(3) If the Eligible Individual refuses care from the Hospitalist Program Physician and instead accepts inpatient Hospital care from his or her own Primary Care Physician (not including OB/GYN and pediatric Physicians) or any other non-specialist Hospital based Physician outside of the Hospitalist Program, the Plan will pay nothing for such care and the Eligible Individual will be solely responsible for all amounts billed by such Primary Care Physician.

(4) An Eligible Individual who has been admitted and is receiving care from a Hospitalist Program Physician also

may accept care from his or her pre-established Primary Care Physician who has been actively involved in the Eligible Individual's ongoing primary care. However, his or her pre-established Primary Care Physician providing care to an admitted Eligible Individual will be reimbursed by the Plan for a consultation only and will not be the manager of the Eligible Individual's inpatient care.

2. Outpatient Hospital Benefits. If an Eligible Individual is not confined in a Hospital as a registered bed patient but:

   a. undergoes a surgical operation;

   b. undergoes Preadmission testing prior to a scheduled Hospital stay; or

   c. receives necessary outpatient treatment at a Hospital.

   The Plan will pay the percentage in accordance with the Percentage Payable Schedule for the Hospital's Allowable Expenses, incurred for necessary services and supplies, including Physicians services.

3. Accident Expense.

   a. If you or your Dependent suffers bodily Injury in an accident, and you first receive treatment within 36 hours of such accident, you will receive a benefit up to $300 at 100% and not subject to the Deductible, to help you pay the costs during the first three (3) months after the accident for the following:

      (1) medical or surgical treatment by a licensed Physician;

      (2) Hospital confinement;

      (3) laboratory and x-ray examinations;

      (4) services of a Registered Nurse, not a relative of you or your Dependent, when ordered by the attending Physician;

      (5) the services of a registered physical therapist.

   b. Limitations and Exclusions. The foregoing benefits will not be provided for:

      (1) Any Injury covered by Worker's Compensation;

      (2) Ptomaine poisoning, disease or infection (except pyogenic infection occurring through an accidental cut or wound);

(3) Eye refractions or fitting of eye glasses;

(4) A self-inflicted Injury or illness unless such Injury or illness is the result of a protected source under the Health Insurance Portability and Accountability Act ("**HIPAA**") and the Plan is made aware of that source;

(5) Accidental damage to dentures, bridgework, natural teeth or for the services of a chiropractor or acupuncturist under this benefit.

4. Acupuncture. Acupuncture will be paid at 90% of Allowable Expenses for PPO providers and 80% of Allowable Expenses for Non-PPO providers, up to a maximum of $300 each Calendar Year.

5. Anesthesia, including its administration, which may be provided by a Physician, Certified Registered Nurse Anesthesiologist (CRNA), Physician's assistant or APN.

6. Ambulance Service. The Plan will pay 90% of Allowable Expenses for PPO providers and 80% of Allowable Expenses for Non-PPO providers, for each trip to or from the Hospital, provided you are being admitted as a patient or being released from the Hospital as a bed patient, or you are receiving emergency room treatment immediately following an accident.

7. Chiropractic Care. Manipulation of musculoskeletal system by a licensed chiropractor is paid at 90% of Allowable Expenses for PPO providers and 75% of Allowable Expenses for Non-PPO providers, limited to a maximum of ten (10) visits per Calendar Year.

8. Clinical Trial. If you are a Qualified Individual and participate in an Approved Clinical Trial, the Plan will not deny (or limit or impose additional conditions on) the coverage of Routine Costs for items and services furnished in connection with, nor discriminate against you based on, your participation in the Approved Clinical Trial.

a. Definitions.

(1) A "**Qualified Individual**" is an Eligible Individual who is eligible to participate in an Approved Clinical Trial according to the trial protocol with respect to the treatment of cancer or another life-threatening disease or condition; and either: (1) the referring health care professional is a PPO Provider and has concluded that the Eligible Individual's participation in such trial would be appropriate; or (2) the Eligible Individual provides medical and scientific information establishing that the Eligible

Individual's participation in such trial would be appropriate.

(2) An "**Approved Clinical Trial**" is a phase I, II, III or IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition, and is either (i) a federally funded or approved study or investigation, (ii) a study or investigation conducted under an investigational new drug application reviewed by the Food and Drug Administration, or (iii) a study or investigation that is a drug trial exempt from having such an investigational new drug application.

(3) "**Routine Costs**" are routine patient costs including items and services consistent with the Plan's coverage for an individual who is not enrolled in a clinical trial. Routine Costs do not include (i) the investigational item, device, or service, itself; (ii) items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or (iii) a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

b. Contact Information. For questions about the coverage for Approved Clinical Trials, please contact the Administrative Office or the Centers for Medicare & Medicaid Services, Center for Consumer Information and Insurance Oversight at (888) 393-2789.

9. COVID-19 Testing. Effective January 31, 2020, the Plan will pay 100% of the costs for diagnostic and testing of COVID-19, as well as the in-network visit associated with COVID-19 testing, whether it takes place in a doctor's office, urgent care center, or emergency department. If a positive diagnoses is confirmed, treatment for COVID-19 will be covered at 100% for in-network providers.

10. Diagnostic X-Ray and Laboratory Expenses

a. Diagnostic Laboratory Expenses. Laboratory examinations for diagnostic purposes on an outpatient basis will be paid at 90% of Allowable Expenses for PPO Providers, 80% of Allowable Expenses for Non-PPO Providers when no PPO Provider is available and otherwise 75% of Allowable Expenses for Non-PPO Providers.

b. Diagnostic X-ray Expenses. X-ray examinations for diagnostic purposes on an outpatient basis will be paid at 90% of Allowable

Expenses for PPO Providers and 65% of Allowable Expenses for Non-PPO providers, including when no PPO provider is available in the service area.

c. Diagnostic laboratory and x-ray claims in excess of $5,000 for outpatient treatment will require preauthorization.

NOTE: No payment will be made for premarital examinations or x-ray treatments.

11. Dialysis Treatment – Outpatient. This Section describes the Plan's Dialysis Benefit Preservation Program (the "**Dialysis Program**"). The Dialysis Program shall be the exclusive means for determining the amount of Plan benefits to be provided to Eligible Individuals and for managing cases and claims involving dialysis services and supplies, regardless of the condition causing the need for dialysis.

a. Dialysis Program Administrator. The Board of Trustees has delegated the administration and operation of this Dialysis Program to the Dialysis Claims Administrator.

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

(1) the concentration of dialysis providers in the market in which Eligible Individuals reside may allow such providers to exercise control over prices for dialysis-related products and services,

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

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

(4) the fiduciary obligation to preserve Plan assets against charges which (i) exceed reasonable value due to factors not beneficial to Eligible Individuals, such as market concentration and discrimination in charges, and (ii) are used by the dialysis providers for purposes contrary to the

Eligible Individuals' interests, such as subsidies for other plans and discriminatory profit-taking.

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

(1) ***Application***. The Dialysis Program shall apply to all claims filed by, or on behalf of, Eligible Individuals for reimbursement of products and services provided for purposes of outpatient dialysis, regardless of the condition causing the need for dialysis ("dialysis-related claims").

(2) ***Claims Affected***. The Dialysis Program shall apply to all dialysis-related claims received by the Plan on or after February 1, 2010, regardless when the expenses related to such claim were incurred or when the initial claim for such products or services was received by the Plan with respect to the Eligible Individual.

(3) ***Mandated Cost Review***. All dialysis-related claims will be subject to cost review by the Dialysis Claims Administrator to determine whether the charges indicate the effects of market concentration or discrimination in charges. In making this determination the Dialysis Claims Administrator shall consider factors including:

(a) *Market concentration*: The Dialysis Claims Administrator shall consider whether the market for outpatient dialysis products and services is sufficiently concentrated to permit providers to exercise control over charges due to limited competition, based on reasonably available data and authorities. For purposes of this consideration multiple dialysis facilities under common ownership or control shall be counted as a single provider.

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

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

(a) Where the Dialysis Claims Administrator deems it appropriate in order to minimize disruption and administrative burdens for the Eligible Individual, dialysis-related claims received prior to the cost review determination may, but are not required to be, paid at the face or otherwise applicable rate.

(b) Where the provider is or has been a participating provider under a Preferred Provider Organization (PPO) available to the Plan's Eligible Individuals, upon the Dialysis Claims Administrator's determination that payment limitations should be implemented, the rate payable to such provider shall be subject to the limitations of this Section.

(c) *Maximum Benefit*. The maximum Plan benefit payable to dialysis-related claims subject to the payment limitation shall be the Usual and Reasonable Charge for covered services and/or supplies, after deduction of all amounts payable by coinsurance or deductibles.

(d) *Usual and Reasonable Charge*. With respect to dialysis-related claims, the Dialysis Claims Administrator shall determine the Usual and Reasonable Charge based upon the average payment actually made for reasonably comparable services and/or supplies to all providers of the same services and/or supplies by all types of plans in the applicable market during the preceding Calendar Year, based upon reasonably available data,

adjusted for the national Consumer Price Index medical care rate of inflation. The Dialysis Claims Administrator may increase or decrease the payment based upon factors concerning the nature and severity of the condition being treated.

(e) *Additional Information related to Value of Dialysis-Related Services and Supplies*. The Eligible Individual, or where the right to Plan benefits has been properly assigned the provider, may provide information with respect to the reasonable value of the supplies and/or services for which payment is claimed, on appeal of the denial of any claim or claims. In the event the Dialysis Claims Administrator, in its sole discretion, determines that such information demonstrates that the payment for the claim or claims did not reflect the reasonable value, the Dialysis Claims Administrator shall increase or decrease the payments (as applicable) to the amount of the reasonable value, as determined by the Dialysis Claims Administrator based upon credible information from identified sources. The Dialysis Claims Administrator may, but is not required to, review additional information from third-party sources in making this determination.

(f) All charges must be billed by a provider in accordance with generally accepted industry standards.

(5) **Provider Agreements**. Where appropriate, and a willing appropriate provider acceptable to the Eligible Individual is available, the Dialysis Claims Administrator may enter into an agreement or agreement establishing the rates payable for outpatient dialysis goods and/or services with the provider, provided that such agreement must identify this Section of the Plan and clearly state that such agreement is intended to supersede this Section.

(6) **Discretion**. The Dialysis Claims Administrator shall have full authority and discretion to interpret, administer and apply this Section, to the greatest extent permitted by law.

12. Doctor/Physician Visits. Treatment from a Physician at his office or in a Hospital. No allowances will be made for medications or Drugs except as specifically provided. In addition to Coinsurance, a $10 Copay applies whenever a patient visits a Physician, regardless of whether the Physician

is a PPO or Non-PPO provider. This additional Copay only applies to Physician office visits and not to any other outpatient services, such as outpatient surgery, immunizations, diagnostic and laboratory expenses, therapeutic services, etc. These other outpatient services are still subject to Coinsurance as explained in the *Quick Guide to Benefits*.

13. Hearing Aid Benefits.

    a. A hearing aid benefit will be provided upon certification by a Physician of a hearing loss that may be lessened by the use of a hearing aid. The Plan will pay 80% of Allowable Expenses incurred for the examination and the hearing aid, up to one (1) device per ear per five (5)-year period. Early replacements are not allowed without prior Plan approval. If approved, no further replacement will be allowed for three (3) years plus an additional waiting period equal to the amount of time remaining in the current five (5)-year period.

    b. No payment will be made for:

        (1) the examination without a hearing aid being obtained;

        (2) batteries or any other ancillary equipment other than that obtained upon purchase of the hearing aid; or

        (3) repairs, servicing or other alterations of a hearing aid (except for allowed replacements as set forth above).

14. Home Health Care.

    a. Services of a Registered Nurse, Licensed Practical Nurse or Nurse Aide that are provided as part of a Home Care Plan as long as prior approval is received from the Utilization Review Organization.

    b. "**Home Care Plan**" means continued care and treatment of an Eligible Person who is under the care of a Physician.

    c. The Home Care Plan must be approved in writing by a Physician, as well as by the Utilization Review Organization.

15. Hospice Care.

    a. Services and supplies that are necessary for the management of terminal illness for patients with a prognosis of less than six (6) months to live and that are provided:

        (1) under a Hospice Care Plan that has been approved by the Utilization Review Organization; and

(2) by a Hospital or related institution, Home Health Care Agency, Hospice Agency or other facility licensed by the state to operate that Hospice.

b. "**Hospice Care Plan**" means a coordinated interdisciplinary program to meet the physical, psychological and social needs of terminally ill patients and their families, by providing palliative (pain controlling) and supportive medical, nursing and other health services through home or inpatient care during the Sickness or bereavement.

c. The Plan will cover 90% of Allowable Expenses of an approved Hospice Care Plan. Bereavement counseling is available.

NOTE: Coverage for "**Respite Care**" (i.e. short-term inpatient stays that may be necessary for the patient in order to give temporary relief to a care giver who regularly assists with home care) is limited each time to stays of no more than five (5) days in a row.

16. Maternity Benefits. If an individual (other than a Dependent child) becomes confined in a Hospital due to childbirth, miscarriage or complications of abortion, the Plan will pay for Physician's fees and Hospital charges as any other illness. The Plan will pay for a minimum Hospital stay of 48 hours for the mother and newborn following a normal vaginal delivery, and 96 hours for the mother and newborn child following a cesarean delivery.

17. Medical Equipment Rental and Supplies. Rental of durable basic (i.e., nonluxury) medical equipment (but not to exceed the purchase price) or purchase of such equipment where only purchase is permitted or where purchase is more cost efficient due to a long term need for the equipment as determined through Prior Authorization. Replacement of medical equipment is covered only if medically necessary due to physical changes or the growth and/or development of a child and as approved through Prior Authorization. Medical equipment must be prescribed by a Physician and required for therapeutic use in treatment of an active Sickness or accidental Injury. For Medicare enrollees, diabetic supplies and services are covered under Medicare Part B and classified as durable medical equipment (DME). If prescribed by a Physician, and not covered under Medicare Part B, the diabetic supplies will be covered by the Plan up to $100 per calendar year.

18. Mental Health Conditions. (See Part 6 for MAP)

a. Payable under comprehensive medical benefits.

b. Inpatient coverage for treatment of mental or nervous conditions, if not authorized by MAP, is limited to 50% of Allowable Expenses.

c. Outpatient coverage for treatment of mental or nervous conditions that is not authorized by MAP is limited to 50% of Allowable Expenses.

19. Newborn Care – see the section entitled "Preventive Care."

20. Physical Exam – see the section entitled "Preventive Care."

21. Physical, Occupational and Speech Therapy. Services of a licensed physical, occupational or speech therapist are available, limited to a combined maximum of 60 visits per Calendar Year.

22. Prescription Drug Benefits. See the section entitled "Prescription Drug Benefits."

23. Preventive Care. Preventive Care benefits, which shall include (i) services rated "A" or "B" by the U.S. Preventive Services Task Force, (ii) immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, and (iii) preventive care and screenings for women and children as recommended by the Health Resources and Services Administration, will be covered at 100% of Allowable Expenses for Network Providers. Preventive care services may include, but are not limited to the following: screening for gestational diabetes, HPV testing starting at age 30, HIV screening, screening and counseling for interpersonal and domestic violence, coverage for comprehensive lactation support and counseling by a trained provider during pregnancy and/or in the postpartum period. BRCA testing and counseling for women with family histories of breast, ovarian, tubal, or peritoneal cancer or for women with a prior non-BRCA related breast cancer or ovarian cancer diagnosis, and colonoscopies (including anesthesia if the attending provider determines it is medically appropriate). For a full list of covered preventive care benefits in compliance with Health Care Reform regulations, please contact the Administrative Office. In the absence of specific guidance in a preventive care guideline or recommendation, the Plan may use reasonable medical management techniques to determine the frequency, method, treatment or setting for a recommended preventive service.

a. Non-PPO Providers. Non-PPO Providers are covered at 80% of Allowable Expenses; provided that Preventive Care Benefits provided by a Non-PPO Provider will be covered at 100% of Allowable Expenses if, and only if, the particular item or service provided by the Non-PPO Provider is not available from a PPO Provider.

b. Women's Preventive Care. Women's preventive services include, but are not limited to, the following:

(1) FDA-approved female sterilization services (e.g., tubal ligation, implants such as Essure).

(2) FDA-approved contraceptive management, including contraceptive methods and counseling for females.

(3) Prenatal visits.

(4) Well-woman visits.

(5) Breastfeeding pump and supplies and lactation counseling. For the duration of breastfeeding, coverage is provided for lactation support and counseling and a standard manual or standard electric breast pump, plus necessary breast pump supplies. Rental is payable up to the allowed purchase price of the breastfeeding pump. Repair, adjustment or servicing of a breastfeeding pump is payable. Replacement of a breastfeeding pump is payable only if there is a change in the covered person's physical condition or if the equipment cannot be satisfactorily repaired at a lesser expense.

Preventive care services related to pregnancy will be provided for dependent children when an attending provider determines the services are age and developmentally appropriate for the dependent.

24. Skilled Nursing Care Confinement. Coverage for confinement in a Skilled Nursing Care Facility is limited to 100 days per Calendar Year and is available:

a. upon the specific recommendation and under the general supervision of a legally qualified Physician; and

b. when Hospital confinement would be necessary in the absence of Skilled Nursing Care Facility confinement.

25. Specialty Drugs. Specialty Drug medications for treatment of oncology and rheumatoid arthritis, if not readily available through the prescription Drug program.

26. Substance Abuse Treatment. This benefit is payable as follows:

a. Inpatient coverage for treatment of substance abuse not authorized by MAP is limited to 50% of Allowable Expenses.

b. Outpatient coverage for treatment of substance abuse that is NOT authorized by MAP is limited to 50% of Allowable Expenses.

27. Surgical Expenses. The Plan will cover expenses of a surgeon and assistant surgeon. Covered expenses of an assistant surgeon are limited to 20% of the surgery allowance for the primary surgeon. Multiple surgeries within the same incision will be paid according to industry standards or, in the case of contracted providers, as set forth in such contracts.

28. Transplants. The Plan covers non-Experimental organ transplants as provided here.

a. All organ transplants require mandatory Case Management and must be performed at a network facility through the LifeTrac organ transplant network or Coalition (HSC) facilities, unless LifeTrac or HSC does not offer the particular type of eligible transplant. The case manager will determine whether the organ transplant procedure is medically necessary and appropriate for the specific condition of the patient.

b. With respect to allowable organ transplant surgery, Plan benefits shall be provided to an organ donor for Covered Expenses incurred by that person (whether or not such person is an Eligible Individual under the Plan), that are directly related to the transplant surgery only if the organ recipient is an Eligible Individual under the Plan and provided that such expenses are not payable by any other insurance or health plan.

c. The Plan will cover all expenses related to the allowable transplant of an organ including patient screening, organ procurement and transportation of the organ, patient and/or donor surgery for the patient and donor (subject to the conditions in the above paragraphs), follow-up care in the home or Hospital. In no case will the Plan cover expenses for transportation of surgeons or family members.

29. Well Child Care – see the section entitled "Preventive Care."

G. Limitations and Exclusions – Benefits will **NOT** be payable for the following services and supplies, except as specified otherwise.

1. Abortion. Elective abortion, other than one where the mother's life would be endangered if the fetus were carried to term.

2. Criminal Activities. Expenses incurred as a result of participation in or consequence of the commission of a felony or misdemeanor, participation in a riot or otherwise being "outside the law."

3. Cosmetic Surgery. Any loss, expense or charge that results from cosmetic or reconstructive surgery except:

   a. for accidental Injuries, provided the surgery is performed within 12 months of the date of the accident;

   b. for repair of congenital defects of newborn children; or

   c. for the initial reconstruction of a breast after a mastectomy (i.e. medically necessary removal of all or part of the breast).

      In the case of a Eligible Individual who is receiving Benefits under the Plan in connection with a mastectomy and who elects breast reconstruction, the law requires coverage in a manner determined in consultation with the attending Physician and the Patient, for:

      (1) Reconstruction of the breast on which the mastectomy was performed;

      (2) Surgery and reconstruction of the other breast to produce a symmetrical appearance; and

      (3) Prostheses and treatment of Physical complications at all states of the mastectomy, including lymphedemas.

4. Dental Care. Medical treatment of teeth and gums except treatment of tumors; any operation or treatment in connection with the fitting or wearing of dentures (refer to Dental Benefits); any treatment for Temporomandibular Joint Disorder ("**TMJ**") or related conditions. Exception: the Plan's medical benefits will provide general anesthesia for Dependent children for dental procedures when medically necessary.

5. Experimental Services. Any services or procedures that are experimental in nature, as determined by the American Medical Association or that are not within the standards of generally accepted medical or dental practice.

6. Fertility Testing and Treatment.

7. Foot Care – Routine. Nonsurgical treatment of the feet, except if medically necessary due to chronic foot conditions. Orthotics and diabetic shoes are also covered up to a maximum of one (1) pair every two (2) years.

8. Government Operated Facilities. Charges for services or supplies received from or in facilities owned or operated by the United States Government or any government, or for services and supplies which the individual is not required to pay, unless mandated by law.

9. Home Health Care and Hospice Care expense for:

   a. services and supplies that are not part of a Home Care Plan or Hospice Care Plan;

   b. services of a care giver or a person who lives in the covered person's home or is a member of the Eligible Individual's family. A "care giver" is a person who provides nonmedical services and companionship and is not associated with a covered provider;

   c. domestic or housekeeping services that are unrelated to the Eligible Individual's care;

   d. providing a protective environment when no skilled service is required (such as companionship or sitter services);

   e. services that are not directly related to the Eligible Individual's medical condition, including but not limited to:

      (1) estate planning, drafting of wills or other legal services;

      (2) pastoral counseling or funeral arrangements or services;

      (3) nutritional guidance or food services such as "meals on wheels," transportation services; or

      (4) expense for which benefits are paid under any other provisions of the Plan.

10. Immunizations. Immunizations except as provided under the section entitled "Preventive Care" in the list of Covered Expenses.

11. Medical Equipment – Rental and Purchase. Purchase or rental costs that are not medically necessary and/or exceed the original purchase price are not covered under the Plan. Costs incurred for the repair or replacement of a purchased item, including but not limited to, maintenance, upgrades, temporary replacement while repairs are being completed, parts and labor needed to repair or replace any part of the item, total replacement of equipment, batteries, etc., are not covered under the Plan. Replacement of medical equipment is covered only if medically necessary due to Physical Changes or the Growth and/or Development of a Child and as approved through Prior Authorization. Life sustaining equipment is not subject to this limit. Life sustaining equipment is defined as medical equipment designed to perform a vital function, such as breathing and heartbeat, or that is considered essential to the patient's ability to maintain his or her life or necessary to avoid a life threatening and potentially catastrophic healthcare event (i.e., oxygen, suction machines, respirators, dialysis or heart/lung machines, critical life monitoring equipment, etc.). Diabetic

supplies purchased from a Contracted PPO Provider, including Compression Stockings, will also not be subject to this limit.

12. Non-Medically Necessary. Medical examinations, services and supplies not necessary for the treatment of any Injury or Sickness, except vasectomies for the Covered Employee or Dependent Spouse.

13. Obesity. See the section entitled "Weight Reduction."

14. Other Coverage. Expenses for which you or your Dependent receives benefits under other insurance or health plan.

15. Other Examinations. Expenses for routine health examinations and normal eye and ear examinations, including the fitting of eyeglasses and hearing aids, except as specifically provided.

16. Pregnancy of a Dependent Child. Charges for a Dependent child in connection with pregnancy, childbirth or miscarriage except as provided under the section entitled "Preventive Care."

17. Relative Care. Charges for services received by any Eligible Individual that are performed by a member of the immediate family of the Employee or spouse.

18. Self-Inflicted Injury. As a result of suicide, attempted suicide, intentionally self-inflicted Injury or Sickness, unless such Injury or illness is the result of a protected source under HIPAA and the Plan is made aware of that source.

19. Vision Care. Vision training or radial keratotomy.

20. War or Active Duty. Treatment of Injury or Sickness that is occasioned by war, declared or undeclared.

21. Weight Reduction. Treatment of obesity, including gastric bypass surgery or any other type of bariatric surgery, and any related complications of such surgery, or any expense or charge for dieticians or weight loss except as provided under the section entitled "Preventive Care."

22. Work-Related Conditions. The Plan does not cover expenses incurred by you or any of your covered Dependents for any Injury, Sickness or condition arising out of or in the course of employment. The Plan may pay claims pending a workers' compensation determination regarding course and scope of employment if the appropriate Repayment Agreement is signed and all the Plan's rules and requirements are followed and satisfied. Refer to Part 13, Section B (Third Party Recovery Rules).

23. Third Party Liabilities. Any expenses caused by any third party, except as provided to individuals who, along with their attorneys, fully comply with the Plan's Third Party Recovery Rules. Refer to Part 12, Section B (Third Party Recover Rules).

PART 4. INDEMNITY PRESCRIPTION DRUG BENEFITS.

This section applies to individuals enrolled in the Indemnity Medical Benefits (Part 3) provided by the Plan.

A. Benefits.

1. If the Covered Item is obtained at a Contract Pharmacy, the Plan will pay 100% of the cost (following the applicable Copayment or Coinsurance charge to the Eligible Individual, as indicated below) for each prescription or refill obtained, subject to the limitations set forth below;

    a. Copayment for Generic Drugs – 10% ($5 minimum)

    b. Copayment for Formulary Brand Name Drugs – 20% ($10 minimum)

    c. Copayment for Nonformulary Drugs – 50% ($10 minimum)

    d. There is no copayment for Preventive Care Drugs. A list of Preventive Care Drugs can be obtained by contacting the Administrative Office.

2. If the Covered Item is obtained through mail order, a 90 day supply is available (only 30-day supply available for Specialty Drugs), and the Plan will pay 100% of the cost (following the applicable Copayment charge to the Eligible Individual, as indicated below) for each prescription or refill obtained subject to the limitations below;

    a. Copayment for Generic Drugs – $10

    b. Copayment for Formulary Brand Name Drugs – $30

    c. Copayment for Nonformulary Drugs – $120

    d. Copayment Specialty Drugs – 10%; $250 maximum at participating in-network specialty pharmacies.

    e. There is no copayment for Preventive Care Drugs. A list of Preventive Care Drugs can be obtained by contacting the Administrative Office.

B. Prescription Benefits Pharmacy and Mail Order Program.

1. The Plan's Prescription Benefits Provider is listed on page 3. Contract Pharmacies include any retail pharmacy in the Prescription Benefits Provider's national network of participating pharmacies or the Prescription Benefits Provider mail order facility. Contract pharmacies have agreed to

provide prescription Drugs to Eligible Individuals and bill the Plan directly for the cost of Drugs dispensed. To use the walk-in pharmacy program, you must show your Prescription Benefits Provider identification card to the contracting pharmacy. The pharmacy will collect only the Coinsurance from you if applicable, and bill the Plan for the remainder of the cost of Covered Items.

2. To use the Prescription Benefits Provider mail service, simply complete the mail order form and mail your prescription to Prescription Benefits Provider in the mail order envelope provided. Your prescriptions will be mailed directly to your home.

3. You may call Prescription Benefits Provider customer service at the number listed on page 3 for the name and locations of contracting pharmacies and information on how to use the mail service.

C. Covered Items.

1. "**Covered Items**" means the following when prescribed by a Physician or Dentist for the Eligible Individual's personal use:

   a. All legend Drugs;

   b. The following items, when prescribed by a Physician for the treatment of a specified illness or complaint:

      (1) Insulin and diabetic supplies including insulin syringes, needles, test strips and test reagents. These items are covered under Medicare Part B as durable medical equipment (DME) for Medicare enrollees.

      (2) Compounded dermatological agents containing a least one (1) federal legend Drug.

      (3) Eye and ear medications.

      (4) Prenatal vitamins for Employees and Dependent Spouses only: vitamins containing fluoride and folic acid;

      (5) Erectile dysfunction Drugs if medically necessary, up to a maximum of six (6) doses per 30 days. Prior Authorization is required.

   c. Injectables.

   d. Interferons.

   e. Oral contraceptives.

f. Zyrtec Syrup (over the counter).

2. Step Therapy. The Plan's prescription benefits include a step therapy program, under which you may be required to try certain less expensive first-line Drug options, sometimes generics, before other Drugs will be covered. Contact the Plan's Prescription Benefits Providers for details on the Step Therapy rules.

3. Some prescriptions require Prior Authorization. Contact the Plan's Prescription Benefits Provider for details and information.

D. Prescription Quantity. A 30-day supply is allowable per prescription or refill (90-day supply for maintenance Drugs ordered through the Contract Pharmacy mail order program), providing the Physician or Dentist prescribes that amount. Quantities may be limited to less than 30 days (90 days) based on FDA recommendations. Specialty Drugs are limited to a 30-day supply.

E. Limitations and Exclusions. Benefits are not payable for:

1. Drugs taken or administered while a patient is in the Hospital.

2. Medicines not requiring a prescription except insulin, insulin injection kits, and those items listed as Covered Items above.

3. Appliances, prosthetics, bandages, heat lamps, braces, splints.

4. Vitamins (except prenatal vitamins for Employee and Dependent Spouse only), cosmetics, dietary supplements, health and beauty aids, Mother's Milk or artificial blood.

5. Blood and blood plasma.

6. Any Drugs not reasonably necessary for the care or treatment of bodily Injuries or Sickness.

7. Nicotine patches, Nicorette gum, or any other products designed to help you quit smoking, except as may be required to be covered by the Plan as Preventive Care benefits.

8. Nose drops or other nasal preparations not requiring a prescription.

9. Routine immunization agents (except Synagis which is considered a specialty Drug and may be obtained through the Plan's Prescription Benefit Provider listed on page 3).

10. Drugs covered by any Worker's Compensation law or similar legislation.

11. Over-the-counter items.

12. Investigational or experimental Drugs.

13. Appetite suppressants.

14. Rogaine.

15. Retin-A.

16. Drugs taken or administered in a rest home, convalescent home or sanitarium, unless dispensed by a licensed pharmacy pursuant to a prescription.

17. Drugs dispensed in a Physician's office.

18. Anti-acid medications.

19. Specialty Drugs for the treatment of oncology and rheumatoid arthritis (please refer to the Indemnity Medical Benefit).

20. Charges for prescriptions containing in excess of a 30-day supply (90-day supply for mail order prescriptions).

21. Out-of-Country Claims – Claims incurred outside of the United States are only covered if they are considered an Emergency.

PART 5. DENTAL BENEFITS.

The Plan provides this comprehensive dental benefit to Eligible Individual and Dependents enrolled in the Indemnity Dental Plan. If you are enrolled in the Dental HMO, please refer to item E below.

Quick Guide to Dental Benefits:

Calendar Year Deductible	$25 per Eligible Individual/$75 per family
Maximum Dental Benefit	$2,500 per Eligible Individual per Calendar Year. There is no Calendar Year Maximum for enrollees under age 19 for dental benefits considered Essential Health Benefits.
Dental Benefit	PPO Providers: Plan pays 100% of Allowable Expenses for all preventative and diagnostic services; Plan pays 80% of Allowable Expenses for all other covered services. Non-PPO Providers: Plan pays 100% of Allowable Expenses of Dental Procedures for all preventative and diagnostic services; Plan pays 80% of Allowable Expenses for all other covered services.
Orthodontic Benefit *(Dependent children under age 19 only. Member must be eligible for at least one (1) full year and continue to remain eligible during the duration of the treatment plan.)*	PPO Providers: Plan pays 80% of Allowable Expenses *(on bills received from Dentist)* Non-PPO Providers: Plan pays 80% of Allowable Expenses of Dental Procedures *(on bills received from Dentist)* $1,500 incurred during a consecutive two (2)-year period, applicable to the extent such benefits are not considered Essential Health Benefits.

A. Details of Covered Benefits. Dental benefits are payable as follows. Benefits are subject to the limitations and exclusions described later in this section.

1. PPO Network: The Plan uses a dental PPO Network. There is a $25 Calendar Year individual deductible and a $75 Calendar Year family deductible. A deductible is an amount that you must pay, in addition to coinsurance, before the Plan pays benefits. After satisfying the deductible, the Plan pays 100% of Allowable Expenses for all covered preventative and diagnostic dental expenses received from a PPO Provider. The Plan pays 80% of Allowable Expenses for all other dental expenses received from a PPO Provider. If you use a PPO Provider, your out-of-pocket costs will likely be lower than if you use a Non-PPO Provider. A list of PPO

Providers is available from the Administrative Office or the Dental PPO Provider shown on page 3.

2. Non-PPO Benefits: There is a $25 Calendar Year individual deductible and a $75 Calendar Year family deductible. A deductible is an amount that you must pay, in addition to coinsurance, before the Plan pays benefits. After satisfying the deductible, the Plan pays 100% of Allowable Expenses for preventative and diagnostic dental expenses up to the maximum amount shown in the Non-PPO Schedule of Dental Procedures available upon request from the Administrative Office. The Plan pays 80% of Allowable Expenses for all other dental expenses up to the maximum amount shown in the Non-PPO Schedule of Dental Procedures. If you undergo a dental examination or dental treatment performed by a Dentist, or by a dental hygienist under the supervision of a Dentist, you will be reimbursed up to the maximum amount shown on the schedule. You will be responsible for paying any difference between what the Dentist charges and the maximum amount paid by the Plan. No payment will be made for any procedure not shown on the schedule.

3. Denture Benefits: Denture benefits will be provided for the Eligible Individual, other than a Dependent child, for expenses incurred for a denture or the repair of an existing denture. The allowance for any allowable denture work will be made only once in any consecutive five-(5) year period. Early replacements are not allowed without prior approval from the Plan. If any early replacement is approved, no further replacement will be allowed for five (5) years from the date of replacement plus an additional waiting period equal to the amount of time remaining in the current five (5)-year period.

4. Orthodontic Benefits: Non-medically necessary orthodontics are available for Dependent children up to age 19 only.

   Orthodontic benefits will be provided to your Dependent children, provided that you were eligible for at least one (1) full year and continue to remain eligible during the duration of the treatment plan. Orthodontic charges will be paid at 80% of Allowable Expenses for services received from a PPO Provider *(paid on bills received from the Dentist)* or 80% of Allowable Expenses for services received from a Non-PPO provider *(paid on bills received from the Dentist)*. Covered charges will be paid up to a maximum of $1,500 of Allowable Expenses incurred during a consecutive two (2)-year period. This maximum is applicable to the extent such benefits are not considered Essential Health Benefits. This benefit is available only if services are performed by a licensed Orthodontist.

B. Schedule of Services.

1. Subject to the limitations and exclusions listed in the General Limitations and Exclusions in Part 9, the services and supplies listed in the Non-PPO Schedule of Dental Procedures or on the PPO Schedule shall be considered covered dental expenses when rendered by a Dentist, or Dental Hygienist under the supervision of a Dentist, provided such services are necessary and customary as determined by generally accepted dental practice.

2. Preventive and diagnostic services will be covered, subject to any of the following applicable limitations:

   a. Oral Examinations (periodic), limited to one every six months.

   b. Prophylaxis (teeth cleaning), limited to one every six months.

   c. Full-mouth x-rays, limited to one (1) complete set during any 24-month period.

   d. Bitewing x-rays, limited to two (2) sets each Calendar Year.

   e. Topical application of fluoride, limited to once each Calendar Year to age 14.

   f. Sealants, limited to once per lifetime per tooth for posterior teeth up to age 19.

   g. Biopsy and examination of oral tissue.

   h. Bacteriologic cultures, pulp vitality tests, diagnostic models (when not required from prep) and miscellaneous tests and laboratory examinations.

   i. Space maintainers.

   j. Emergency examinations and treatment to alleviate pain are covered only if no other dental services are performed on the same day.

   k. General anesthesia for Dependent Children, if determined to be medically necessary by the treating Dentist.

3. Oral Surgery. All Hospital costs, except for general anesthesia and all related costs for Dependent Children, are the responsibility of the patient. The Plan will allow for the procedures listed in the schedule. Additional fees charged by the Dentist for performing procedures in a Hospital are the responsibility of the patient.

4. Extractions. Coverage for extractions includes local anesthesia and routine postoperative visits.

5. Dental Implants. Coverage for dental implants and any related surgery, placement and removal (once per tooth per lifetime).

C. Extended Benefits. There is no extension of benefits beyond loss of eligibility in the Plan.

D. Limitations and Exclusions. In addition to the limitations and exclusions listed in the General Limitations and Exclusions in Part 10, no benefits will be payable for:

1. Any service or supply not provided or supervised by a licensed Dentist or Orthodontist.

2. Services or supplies for cosmetic purposes, or any service not medically necessary, except orthodontia and dental implants.

3. Any service or supply not provided for in the PPO Schedule or the Non-PPO Schedule of Dental Procedures.

4. Claims incurred outside of the United States are only covered if they are medically necessary due to an Emergency as determined by the Plan.

5. Replacement of any artificial teeth or similar devices, such as crowns, bridges or prosthesis is not covered if replacement occurs within five (5)-year consecutive period.

E. Dental HMO Option. If you elect to enroll in the Dental HMO Option you will receive dental benefits directly from the Dental HMO Provider listed on page 3 instead of the dental benefits described above. A full description of the Dental HMO Option may be obtained from the Administrative Office.

PART 6. MENTAL HEALTH & SUBSTANCE ABUSE TREATMENT BENEFITS.

Membership Assistance Plan (MAP) Program. (Services provided by the Mental Health Provider listed on page 3).

A. **The "Membership Assistance Plan"** (MAP) is a program providing confidential and professional counseling for you and your family members in the event of a personal crisis. They have professional counselors, therapists and Physicians. MAP handles problems such as: marital, family, children, alcohol abuse (personal or family), other personal/emotional problems, drug abuse (personal or family).

B. **How Does This Program Work?**

1. The MAP Program provides assistance in solving problems 24 hours a day, seven (7) days a week. MAP is available to assist members in finding qualified providers for mental health and substance use disorder treatment and provides Prior Authorization for all inpatient admissions (including partial hospitalization) and residential treatment programs for mental health and substance use disorder care. Call MAP at the number listed on page 3 for crisis help or to make an appointment for counseling support.

2. If you have an Emergency and call between 5:00 p.m. and 8:00 a.m., or on the weekend or holiday, ask the operator to immediately connect you to a counselor. Counselors and Physicians are on call 24 hours a day. If your situation is not an Emergency, give your name, phone number and brief description of your problem and a counselor will call you back on that same day (Monday-Friday) and discuss the situation with you.

3. If you or your Dependent requires inpatient mental health related care for alcohol rehabilitation, drug abuse detoxification/treatment or for other problems, please call MAP at the number listed on page 3 before you admit yourself or a member of your family.

   NOTE: Prior Authorization is required through the MAP program.

C. **What Will it Cost?** There is no cost to you or your family for this service. There is no cost to call MAP in the face of a crisis, to talk to MAP about the problem, to find out what your options are, or to better understand your benefits. If you then decide to seek counseling or treatment, there may be some cost for continuing help.

D. **What Are the Benefits?** After satisfaction of the Indemnity Medical Benefits (Part 3) deductible per person (two (2) per family) the Plan will pay benefits at 90% of Allowable Expenses for approved chemical dependency problems, residential and day treatment and intensive outpatient treatment. The deductible is waived for routine outpatient therapy and outpatient medication management and MAP approved intensive outpatient treatment. A comparison of the benefits provided with and without the use of MAP are illustrated in the following table.

All amounts you pay for mental health or substance abuse/substance use disorder care with PPO Providers accumulate to your annual out-of-pocket maximum.

E. Schedules of Benefits:

Mental Health Benefits & Substance Abuse Treatment Benefits (Alcohol, Drug & Adolescent Behavior)

Treatment	In-Network Benefits with MAP Prior Authorization	Out-of-Network Benefits with MAP Prior Authorization	Benefits without MAP Prior Authorization
Acute Hospital	90% of the Allowable Expenses	75% of Allowable Expenses	50% of Allowable Expenses
Residential Inpatient, Group Homes, Half-Way Homes, Day Treatment and Intensive Outpatient Treatment	90% of the Allowable Expenses	75% of Allowable Expenses	50% of Allowable Expenses
Outpatient Care	100% of Allowable Expenses	75% of Allowable Expenses	N/A

F. Definitions.

1. Membership Assistance Plan means the organization contracted by the Plan to provide referral services for emotional, mental, nervous and substance abuse disorders.

2. Residential Facility. Any licensed social rehabilitation facility, licensed group home, licensed family home, or similar licensed facility providing 24-hour nonmedical care to persons in need of personal services essential for sustaining the activities of daily living or for the protection of the individual.

3. Adult Day Facility. Any licensed social rehabilitation facility, day care center, family day home or similar licensed facility which provides, on a less-than-24-hour basis, nonmedical care to adults in need of personal services essential for sustaining the activities of daily living or for the protection of the individual.

4. Alcohol and/or Drug Dependency Treatment Center. A facility that provides 24-hour nonmedical care to persons in need of personal services essential for sustaining the activities of daily living or for the protection of the individual, and that is state licensed and state certified as an alcohol or other drug dependency treatment center by the appropriate governmental agency.

5. Outpatient Psychiatric Care. Medically necessary psychiatric treatments, consultations, or psychological services rendered on account of emotional and personality disorders and illnesses when provided and billed by a Physician, Psychologist or outpatient Psychiatric Facility. Also, Outpatient Psychiatric Care will mean the services of a licensed Clinical Social Worker, and a licensed Marriage, Family, Child Counselor or other duly licensed mental health practitioners.

G. Limitations and Exclusions.

1. The following services require Prior Authorization:

   a. Psychological testing.

   b. Multiple inpatient psychotherapy. If Prior Authorization is not obtained, 50% of allowable expenses will be paid for one (1) psychotherapy or medical management session per day.

   c. Aversion therapy.

   d. Home and/or therapeutic passes.

   e. Experimental use of medication (nontraditional).

   f. Certain nonroutine outpatient services, including intensive outpatient programs (IOP) and partial hospitalization programs.

2. Benefits will not be payable for:

   a. Days of confinement prior to the effective day of coverage.

   b. Confinements in a Community Care Facility that is not an approved facility.

   c. Care during a period for which services, payments or reimbursements are obtained under any other similar plan to which the Employer contributes.

   d. Any services that are not necessary to, or are not customarily rendered for, the treatment of the Sickness or disorder.

PART 7. WEEKLY ACCIDENT AND SICKNESS EXPENSE BENEFIT.

A. Weekly Accidents and Sickness Benefits are only available to Employees and Self-Pay Employees.

1. If an Active Employee or Self-Pay Employee becomes totally disabled after having been eligible for a minimum of one (1) year preceding the disability or, in the case of an on-the-job or work-related Injury, for a minimum of three (3) months, as a result of an illness or accidental bodily Injury that occurred on or off the job, the Plan will, subject to the conditions, exclusions and limitations hereinafter stated, pay to the Employee or Self Contributor a weekly benefit of $500.

2. Benefit payments will begin on the eighth (8^{th}) day of disability and will continue only for the duration of the disability and only up to a maximum of 13 weeks for any one (1) period of disability.

B. Period of Disability.

1. Successive periods of total disability separated by less than two (2) weeks of full-time employment or availability for work shall be considered one (1) period of disability, unless the total disability is due to a cause(s) entirely unrelated to the previous disability and commences after you have returned to full-time employment or availability for work.

2. No period of disability will be considered to have started until the day you have been seen and treated personally by a Physician or surgeon. In order for these benefits to be payable, you must be receiving regular care and be seen by the attending Physician at least once each month.

3. Your Physician must have stated on his "Attending Physician's Statement" the period of time that he attended to you in a total disabled condition. Benefit checks will be issued weekly provided you have supplied the above-described after-the-fact proof of loss to the Administrative Office.

4. You are considered wholly and continuously disabled only while, as a result of bodily Injury or Sickness:

    a. you are prevented from engaging in your regular occupation (including a restriction to light duty work, as determined by the Trustees based on evidence they deem sufficient, including medical records or a Social Security determination, for example); and

    b. you are not engaged in any other occupation for compensation, profit or gain.

C. Limitations and Exclusions.

1. No Benefits are payable if:

   a. The attending Physician does not certify that you were under his care for the period of time for which benefits have been sought.

   b. You are engaged in any occupation for compensation, profit, or gain.

   c. Your disability is a result of participation in or a consequence of the commission of a felony, misdemeanor, or other illegal act (not to include mere traffic violations), or is the result of participation in a riot.

2. If, while disabled, you enter into work for pay or profit in an attempt to return to work, but are unsuccessful due to the same disabling condition; the following will apply:

   a. The seven (7)-day waiting period to begin disability pay will be waived.

   b. The 12-month waiting period to for freezing of hours will be waived.

   c. The disability benefit will recommence for a combined maximum of 13 weeks.

3. A disability related in any way to the use of alcohol, barbiturates, hypnotics, LSD, or any type of addiction, is limited to no more than one (1) period of disability per lifetime.

PART 8. VISION BENEFITS.

The Vision Benefits Provider listed on page 3 provides the benefits specified below to Eligible Individuals through Vision Benefits Provider Panel Doctors:

A. **Vision Examinations**: A complete analysis of the eyes and related structures to determine the presence of vision problems, or other abnormalities. Available every 12 months.

B. **Lenses:** The Panel Doctor will order the proper lenses (only if needed). The program provides the finest quality lenses fabricated to exacting standards. The Panel Doctor also verifies the accuracy of the finished lenses. Available every 12 months only if needed. Single vision, lined bifocal and lined trifocal lenses are covered in full. Charges will apply for other lens options.

1. Frames: The Plan offers a wide selection of frames and pays up to $130. However, if you select a frame that costs more than the amount allowed by the Plan (or a large frame that requires oversized lenses), there will be an additional charge. Available every 24 months only if needed. A 20% discount applies to more expensive frames.

2. Medically Necessary Contact Lenses: Contact lenses are furnished under the Plan when the Vision Benefits Provider Panel Doctor secures Prior Authorization for the following conditions: (a) following cataract surgery, (b) to correct extreme visual acuity problems that cannot be corrected with spectacle lenses, (c) certain conditions of Anisometropia, (d) Keratoconus. When Panel Doctors receive approval of such cases, costs are fully covered in full by the Vision Benefits Provider.

3. Elective Contact Lenses: You receive up to a $125 allowance towards elective contact lenses and your contact lens exam. You receive a 15% discount on the contact lens exam if you use a Panel Provider.

C. **Contact Lens Allowance**. When patients choose contact lenses for other reasons, the Vision Benefits Provider will make an allowance of $125 toward their costs in lieu of all other benefits for that eligibility period.

D. **Costs of Benefits.** When you select a Panel Doctor from a Vision Benefits Provider list, this Plan covers the visual care described herein (examination, professional services, lenses, frames) at no expense to you except a $20 deductible for examinations and materials. Deductibles are payable to the Panel Doctor at the time of the examination. Any additional care, service and/or materials not covered by this Plan may be arranged between you and your Panel Doctor.

E. How to Use the Plan.

1. You simply need to contact a Vision Benefits Provider Panel Doctor selected from the list of Vision Benefits Provider list and schedule your appointment. At that time, you will need to inform the doctor's office staff that your eye care provider is a Vision Service Plan and give them your Participant ID number, which in most instances is your social security number. The doctor's office will then contact the Vision Benefits Provider to verify your eligibility and coverage information prior to your appointment.

2. The list does not include all current Vision Benefits Provider Panel Doctors in Nevada. Should you seek services from a doctor that is not on this list, you will need to contact Vision Benefits Provider.

3. Should you have any questions, please contact the Administrative Office or Vision Benefits Provider directly at the number listed on page 3.

F. Non-Panel Providers.

1. A Participant or eligible Dependent may obtain services from a Non-Panel optometrist, ophthalmologist and dispensing optician. Participants and eligible Dependents who follow this course must call the Vision Benefits Provider to obtain an authorization number. The patient should pay the doctor his or her full fee and then submit an itemized bill to the Vision Benefits Provider at the address listed on page 3.

2. The Participant will be reimbursed by the Vision Benefits Provider in accordance with a reimbursement schedule. **THERE IS NO ASSURANCE THAT THE SCHEDULE WILL BE SUFFICIENT TO PAY FOR THE EXAMINATION OR THE GLASSES. REIMBURSEMENT BENEFITS ARE NOT ASSIGNABLE.** The Nonpanel allowances are up to:

    a. $45 for examinations

    b. $30 for single vision lenses

    c. $50 for lined bifocal lenses

    d. $65 for lined trifocal lenses

    e. $70 for frames

    f. $105 for contact lenses

3. If you or a Dependent obtain contact lenses from a nonpanel provider, determination of "necessary" verses "elective" contact lenses will be consistent with Panel Doctor services.

4. Reimbursement for contact lenses is in lieu of all benefits, including examinations and materials.

5. Availability of service for Non-Panel providers is subject to the same time limits as those described for Panel Services, and are in lieu of obtaining these services from a panel member of Vision Benefits Provider.

6. Claim for services from a Non-Panel Doctor or materials from a dispensing optician must be submitted within six (6) months of completion of services.

G. Limitations and Exclusions.

1. Extra Costs. This Plan is designed to cover your visual needs rather than cosmetic materials. If you select any of the following, there will be an extra charge: (a) blended lenses; (b) contact lenses (except as noted elsewhere herein); (c) multifocal plastic lenses; (d) oversize lenses; (e) progressive multifocal lenses; (f) coated lenses; (g) laminated lenses; or (h) a frame that cost more than the Plan allowance. There are also certain limitations on low vision care.

2. Not Covered. There are no benefits for professional services or materials connected with:

   a. Orthoptics or vision training and any associated supplement testing; plano lenses; or two (2) pairs of glasses in lieu of bifocals.

   b. Lenses and frames furnished under this program which are lost or broken will not be replaced except at the normal intervals when services are otherwise available.

   c. Medical or surgical treatment of the eye.

   d. Any eye examination, or any corrective eye wear, required by an Employer as a condition of employment.

   e. Services or materials provided as a result of any Worker's Compensation law, or similar legislation, or obtained through or required by any government agency or program whether federal, state or any subdivision thereof, except Vision Benefits Provider will pay benefits if the State of Nevada makes a charge for this benefit and if the service is provided by the State of Nevada.

PART 9. GENERAL LIMITATIONS AND EXCLUSIONS.

In addition to the Exclusions and Limitations as stated in the previous sections, the Plan will not provide benefits for the following:

A. Medical services or supplies not reasonably necessary for the care or treatment of bodily Injuries or Sicknesses or dental services or supplies not reasonably necessary for dental health. Furthermore, the Plan will not provide benefits for services, treatments or supplies for the care and treatment of bodily Injuries or Sicknesses that are in excess of the customary charges therefor or in excess of such charges as would have been made for such care and treatment in the absence of the benefits provided by the Plan. A customary charge shall mean the usual charges made by a Hospital, Physician, Dentist, Licensed Pharmacist or other professional person, or other person or firm having rendered or furnished the services, treatments, or supplies that do not exceed the general level of charges made by others rendering or furnishing such services, treatments, or supplies within the county in which the charge was incurred, for bodily Injuries or Sicknesses comparable in severity and nature to the bodily Injuries or Sicknesses treated or being treated.

B. Any condition for which benefits of any nature are recovered or found to have been recoverable, whether by adjudication or settlement, under any Worker's Compensation or Occupational Disease law, even though the Eligible Individual fails to claim his or her rights to such benefits.

C. Conditions caused by or arising out of an act of war, invasion or aggression.

D. Services performed by a person related to the Eligible Individual by blood or marriage.

E. Any supplies or services: (1) for which no charge is made; or (2) for which the Eligible Individual is not required to pay; or (3) furnished by a Hospital or facility operated by the United States Government or any authorized agency thereof or furnished at the expense of such Government or Agency; or (4) which are provided without cost by an municipal, county, or other political subdivision.

F. Expense incurred as a result of participation in or in consequence of the commission of a felony or misdemeanor or otherwise being "outside the law" (not including traffic violations) or participation in a riot.

G. An intentionally self-inflicted Injury or illness, unless such Injury or illness is the result of a protected source under HIPAA and the Plan is made aware of that source.

H. Any services or supplies incurred after the date of loss of eligibility unless specified.

I. Contact the Administrative Office for additional information regarding Homeopathic medications.

J. Fertility Drugs and testing.

K. Any services or procedures that are experimental in nature, as determined by the American Medical Association. Additionally, the procedure must be within the standards of generally accepted medical or dental practice. Refer to Medical Benefits Exclusions for information about covered transplants.

L. Treatment of obesity, including gastric bypass surgery or any other type of bariatric surgery, and any related complications of such surgery, or any expense or charge for dieticians or weight loss.

M. Any expenses caused by any third party, except as provided to individuals who, along with their attorneys, fully comply with the Plan's Third Party Recovery Rules. Refer to Part 12, Section B (Third Party Recovery Rules).

PART 10. RETIREE COVERAGE.

A. Who is Eligible for Retiree Coverage?

1. Non-Medicare Retired Employee. If you retire at age 62 through age 64, are not eligible for Medicare benefits, you were eligible under the Health and Welfare Plan as an Employee for at least one (1) or more months in each of the preceding seven (7) years and your months of eligibility total at least 42 or more months, you and your Dependents will be eligible for the following benefits:

    a. Indemnity medical and prescription drug benefits (see Parts 3, 4 and 6). These benefits are only available to you if you are eligible to receive a pension from the Cement Masons and Plasterers Joint Pension Trust for any reason other than as a result of being totally disabled. Also, you must not work for a nonsignatory employer in the trade.

    b. Dental HMO benefits through Self Payments. If you elect Dental HMO coverage, you must do so within 30 days of your initial eligibility for retiree coverage. If you choose to waive Dental HMO coverage, no dental coverage will be offered at a later time.

    c. Vision benefits.

2. Medicare Eligible Retired Employees (nondisabled). If you retire at age 65 or older and meet the same eligibility requirements as a Non-Medicare Retired Employee, or you are already retired and a Medicare eligible age, you and your Dependents will be eligible for the following benefits:

    a. A Group Medicare Advantage Plan and a Group Medicare Prescription Drug Plan.

    b. If you are age 65 or over, the Plan will treat you as if you had enrolled in Medicare Part A and Part B, without regard to Medicare eligibility. Also, if your spouse is age 65 or over, the Plan will treat your spouse as if your spouse had enrolled in Medicare Part A and Part B, without regard to Medicare eligibility. The Plan will pay on a secondary basis what remains (if anything) of the Medicare approved charges (or what Medicare would have approved) regardless whether you or your spouse actually enroll in Medicare.

    c. Your coverage as a Medicare Eligible Retired Employee will continue for you and your eligible Dependents until such time as you or your Dependents become eligible for health and welfare benefits from some other group plan, other than Medicare. Coverage will terminate on the effective date of the other coverage

or insurance. Coverage may be reinstated upon termination of other coverage or insurance. Proof of termination of other coverage is required.

3. A Non-Medicare Retired Employee may discontinue coverage for his or her Dependents at any time. If discontinued, Dependents may be reenrolled only when they are enrolled in Medicare.

4. If you are under age 62 and become totally disabled, you are eligible for continued coverage by freezing your Hour Bank for a maximum of 12 months (see Part 2, Section D for Freezing of Benefits for Disabled Employees). Your coverage may be extended further through COBRA (see Part 2, Section A).

5. If you retired prior to January 1, 2008 and are receiving retiree coverage under this Plan, your benefits will be limited to medical and prescription drugs. Optional Dental HMO coverage through Self Payments and vision benefits are also available.

6. If you return to Covered Employment, you will be required to reestablish initial eligibility. (Example: if the retiree works for less than the three (3) consecutive months required for initial eligibility, he would remain on retiree coverage.)

7. All Employees must deplete their Hour Bank to be eligible as a Retired Employee.

B. How Do You Pay for Retiree Coverage?

1. Dental HMO Self Payments for Retired Employees.

   a. If you are an eligible Retired Employee who elects Dental HMO coverage, you and your Dependents will be entitled to this coverage through monthly ACH self-payments in an amount set by the Plan.

   b. The following rules for retiree Self Payments will apply:

      (1) Self-payments must be made on a continuous and timely monthly basis.

      (2) Self-payments must be in an amount established by the Board of Trustees, which is subject to change from time to time.

2. There are no retiree Self Payments required for medical or prescription drug coverage at this time, subject to change at the sole discretion of the Board of Trustees.

C. Termination of Retiree Coverage.

1. Coverage and eligibility for you and all Dependents shall end on the earlier of the following dates:

   a. The date any required Self-Payment is not made.

   b. The date the Plan terminates.

   c. The date the Retired Employee or Dependent(s) become eligible for health and welfare benefits from some other group plan, other than Medicare.

   d. The date of the death of the Retired Employee, except that coverage for the eligible Dependents shall continue for an additional 12 months following the date of the death or until such time as the surviving spouse remarries or the Dependent children no longer qualify as Dependents. However, Dependents may continue coverage for a longer period of time as specified by COBRA Continuation of Coverage law.

   e. The date of the entrance into full-time military, naval or air service of any country.

   f. The date the Retired Employee performs work of the type covered by the collective bargaining agreement for a nonparticipating employer.

D. Medicare.

1. Any person age 65 or older may be entitled to Medicare. This is a broad program of health benefits that includes Hospital insurance (Part A) and medical insurance (Part B). Medicare coverages are limited to expenses incurred in the United States.

2. It is extremely important that every person enroll for Medicare Part B during the three (3) months before the month in which his 65th birthday occurs, so that he will be covered by Medicare as of the first of the month in which he attains age 65. If you are eligible for Medicare, you must enroll in Parts A and B to be eligible under this Plan. You should not enroll in Medicare Part D Prescription benefits, however.

3. If you or your Dependent spouse are approaching age 65, you are not automatically enrolled in Medicare unless you have filed an application and established eligibility for a monthly Social Security benefit. If you have not applied for Social Security benefits you must file a Medicare application form during the three (3)-month period prior to the month in which you become 65 years of age in order for coverage to begin at the

start of the month in which you reach age 65. Medicare may affect Plan benefits; therefore, you may want to contact your local Social Security Office for information about Medicare. This should be done before your or your Spouse's 65th birthday.

4. The Administrative Office will consider you Medicare eligible even if you have not enrolled in Medicare. Medical coverages under this Plan for all eligible persons will coordinate with Medicare benefits on the earliest date that any coverage under Medicare could become effective for that individual, whether or not the individual has signed up for Medicare. It is therefore important that you enroll when you become eligible.

5. Most workers age 65 and over do not have to pay for Medicare Part A (basic Hospital insurance). Medicare Part B (supplementary medical insurance) may be purchased for a low monthly premium.

6. Medicare has an initial seven (7)-month enrollment period which ends three (3) months after your 65th birthday month. If you fail to enroll during this period, you will have to wait until the beginning of the next Calendar Year to enroll. Your coverage will not start until the next July 1st.

7. Medicare is available to people who have been Totally Disabled continuously for two (2) years. When you or your Dependents become eligible for Medicare under this arrangement, you should enroll promptly in the extensive Medicare program of health insurance, the same as the 65-year-old Medicare eligibles.

8. Medicare prescription drug coverage, or Medicare Part D, is available to everyone with Medicare for a monthly premium (similar to the Medicare Part B premium). The Board of Trustees has determined that the prescription drug coverage offered by the Plan is, on average for all retirees, expected to pay out more than the standard Medicare prescription drug coverage will pay. Therefore, you do not need to enroll in a Medicare Part D prescription drug plan. If you decide to enroll in a Medicare prescription drug plan, you should compare your current coverage under this Plan, including which Drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area.

PART 11. DEATH, LIFE INSURANCE, AND ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS.

A. Death Benefits. If a Retired Employee dies while eligible under the Plan, the Plan will, subject to the provisions that follow, pay a death benefit of $1,000.

1. Beneficiaries. A Retired Employee may designate a Beneficiary or Beneficiaries to receive the death benefit by forwarding such designation on an acceptable form (as determined by the Plan) to the Administrative Office. A Retired Employee will have the right to change his designation of Beneficiary without consent of the Beneficiary, but no such change shall be effective unless it is received by the Administrative Office prior to the time any payments are made to the Beneficiary whose designation is on file with the Plan. If more than one (1) Beneficiary is designated, and there is no provision for how they will split the benefit, they will share equally.

2. Lack of Designated Beneficiary. If no Beneficiary has been designated, or if a designated Beneficiary dies before the Death Benefit is paid, the Death Benefit shall be paid to one (1) or more of the following surviving relatives of the Retired Employee or Retired Self-Contributor: lawful spouse, child or children, including legally adopted children, mother, father, brothers, and sisters, or to the Retired Employee's estate, as the Board of Trustees in its sole discretion may designate. Any payment in accordance with this provision shall discharge the obligation of the Plan hereunder to the extent of such payment.

B. Life Insurance Benefits.

1. This Benefit is for Active Employees, Self-Pay Employee and Retired Employees.

Benefit	**Amount**
Employee Life Insurance	$7,000
Dependent Life Insurance	
Spouse	$2,000
Child (under 14 days)	$0
Child (14 days through five (5) months)	$100
Child (six (6) months through 18 years)	$1,000
Retired Employee Death Benefit	$1,000

2. If your death occurs while you are covered under the Plan, your Beneficiary will be paid the amount of your group life insurance. If you are disabled on the date of any change in the amount of life insurance, you

will not be eligible for the increased amount until such time as you return to full-time work or availability for work.

3. Life Insurance During Total Disability for Active Employees and Self-Pay Employees.

   a. Your life insurance will stay in effect if you become totally disabled while eligible for this benefit and before you reach age 60. The full amount of your insurance will be paid to your Beneficiary if your total disability continues until the date of your death.

   b. You will be required, within one (1) year of becoming disabled, to submit proof that the total disability began while you were eligible for this benefit. Proof of continued disability will be required on a year-to-year basis.

4. Beneficiary.

   a. You may name anyone you wish as your Beneficiary (except the Plan) by filing a form furnished for that purpose with the Plan.

   b. You may change your Beneficiary at any time, without the consent of any Beneficiary, by filing a written notice of the change with the Plan.

   c. The change will become effective on the date you sign your notice; however, the Plan will not be liable for any payment made before receiving your notice of change.

   d. If you name two (2) or more Beneficiaries without specifying their shares, they shall share equally. If one of your Beneficiaries dies before you, the share that Beneficiary would have received if living will be divided among your other Beneficiaries equally, or all to the survivor if only one (1) Beneficiary survives you, unless you have provided differently in the form you filed naming your Beneficiaries.

   e. If you have not named a Beneficiary with respect to all or a part of your insurance or if no Beneficiary you have named is living when you die, payment will be made to your estate, except that the Plan may in such case, at its option, pay such benefit to your widow or widower, if living, or if not living, in equal shares to your then living children, if any; if none, to either your father or mother or to both equally if both are living.

   f. If your Beneficiary is a minor or is otherwise legally incapable of giving valid release for any payment due, the Plan may, at its option, and until claim is made by a duly appointed guardian or

committee of such Beneficiary, make payment of the amount payable to such Beneficiary at a rate not exceeding $50 a month to any person or institution appearing to the Plan to have assumed custody and principal support of such Beneficiary. The Plan shall be discharged from all liability to the extent of such payment.

g. The continued death benefit for Active Employees will be paid to the Beneficiary for your group life insurance, except that if you named a different Beneficiary for an individual policy issued in accordance with the Conversion Privilege (refer to next paragraph) and that policy is surrendered for return of premiums, your application for that policy will be considered your notice of change of Beneficiary.

5. How to Continue your Life Insurance if you Lose Eligibility. If your Plan eligibility terminates, your group life insurance will be continued for a period of 31 days and is payable in the event of death during this 31-day period. During this 31-day period, you have the right to obtain an individual policy to replace your group life insurance coverage without having to pass a medical examination. You may choose any type of individual policy then being issued by the insurance company, other than a policy containing term insurance of disability benefits. The premium cost to you will be based upon your class of risk and your age at the time of the conversion.

6. Life Benefit. For Dependents of Active Employees and Self-Pay Employees. If one of your insured Dependents dies, the amount of the insurance then in effect on the life of that Dependent will be paid to you as Beneficiary. No benefit is payable to Dependents or Spouses of Retired Employees, unless otherwise designated as Beneficiary.

C. Accidental Death and Dismemberment Benefits (for Active Employees and Self-Pay Employees).

1. Accidental Death and Dismemberment Coverage benefits for your loss of life, limbs, or the entire and irreversible loss of sight, including losses that happen on the job. Benefits are payable if the loss is a direct result of bodily Injury caused by an accident, and the loss is sustained within 90 days after the date of that accident. The full principal sum of $7,000 will be paid for the loss of:

a. Life

b. Both hands

c. Both feet

d. One (1) hand and one (1) foot

e. One (1) hand and one (1) eye

f. One (1) foot and one (1) eye

g. Both eyes

2. One-half (1/2) the principal sum ($3,500) will be paid for the loss of one (1) hand, one (1) foot, or one (1) eye. In no case will more than the full principal sum be paid for all losses sustained through any one (1) accident.

3. Since the purpose of this coverage is to provide benefits for losses due to accidents, except as required by applicable federal law, no benefits will be payable for your death or dismemberment which results from:

a. Disease or mental infirmity.

b. Self-inflicted Injury (except to the event required by applicable law, e.g., HIPAA).

c. Drug, poison, or inhalation of gas.

d. Bodily Injury sustained in the course of any medical, dental or surgical diagnosis or treatment.

e. Bodily Injury sustained as a result of any act of war.

f. Bodily Injury sustained while in or upon any aircraft except when a fare-paying passenger upon a regularly scheduled flight.

g. Bodily Injury sustained in the commission of any crime.

h. Release of nuclear energy except when being used solely for medical treatment of a disease or bodily Injury of the insured under the direction and prescription of a Physician.

i. The Injury causing the loss must occur while the insurance is in force.

PART 12. OTHER IMPORTANT PLAN RULES.

A. Coordination of Benefits ("COB").

1. If the Claimant is entitled to benefits for Hospital, medical or dental expenses from another group Plan, the benefits under this Plan and the other Plan will be coordinated. This means one Plan pays its full benefits first, then the other Plan pays. "**Claimant**" means the Eligible Individual for whom the claim is made.

    a. The Primary Plan (which is the Plan that pays benefits first) pays the benefits that would be payable under its terms in the absence of the COB provision.

    b. The Secondary Plan (which is the Plan that pays benefits after the Primary Plan) will limit the benefits it pays so that the sum of its benefits and the benefits paid by the Primary Plan will not exceed the lesser of 100% of total Covered Expenses actually incurred, or the amount of benefits it would have paid in the absence of other group coverage.

2. Benefits subject to the Provision. All benefits provided under this Plan, except weekly accident and Sickness benefits, are subject to the following additional provisions and limitations.

3. Definitions.

    a. Plan. For purposes of this section only, the term "**Plan**" means any plan providing benefits or services for or by reasons of medical, dental, or vision care or treatment, which benefits or services are provided by (1) group, blanket or franchise insurance coverage, (2) service plan contracts, group practice, individual practice and other prepayment coverage, (3) any coverage under labor-management trustee plans, union welfare plans, employer organization plans, or employer benefit organization plans, and (4) any coverage under government program, and any coverage required or provided by a statute.

        (1) The term "Plan" shall be construed separately with respect to each benefit plan or service that reserves the rights to take the benefits or services of other Plans into consideration in determining what benefits will be paid.

        (2) An individual's enrollment and eligibility for benefits as an Employee or Dependent under the Plan will not take into account the individual's eligibility for or the provision of state Medicaid assistance.

b. This Plan. For purposes of this section only, the term "**This Plan**" means that portion of this Benefits Booklet that provides Medical, Hospital, Dental, Prescription and Vision Care Benefits.

c. When a Plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered shall be deemed to be both an Allowable Expense and a benefit paid. The Plan shall not be required to determine the existence of any other Plan, or the amount of benefits payable under any Plan other than This Plan. The payment of benefits under This Plan shall be affected by the benefits payable under other Plans only if This Plan is furnished with information concerning the existence of such other Plans by the Eligible Individual or insurance company, organization, agency of government or person.

d. Claim Determination Period. The term "**Claim Determination Period**" means a period, commencing with any January 1 and ending at 12 o'clock midnight on the next succeeding December 31 or that portion of such period during which the Eligible Individual with respect to whose expense claim is based has been covered under this Plan.

4. Effects on Benefits.

a. This provision shall apply in determining the benefits due an Eligible Individual under This Plan for any Claim Determination Period if, for the Allowable Expenses incurred as to such Eligible Individual during such period, the sum of the benefits that would be payable under This Plan in the absence of this provision, and the benefits that would be payable under all other plans in the absence in them of provision of a similar purpose to this provision would exceed such Allowable Expenses.

b. As to any Claim Determination Period to which this provision is applicable, the benefits that would be payable under This Plan in the absence of this provision for the Allowable Expenses incurred as to such Eligible Individual during such Claim Determination Period shall be reduced to the extent necessary so that the sum of such reduced benefits, and all the benefits payable for such Allowable Expenses under all other plans, except as provided in item (c) of this Section 4, shall not exceed the lesser of 100% of total Covered Expenses actually incurred, or the total of such Allowable Expenses it would have paid in the absence of other group coverage. Benefits payable under another plan include the benefits that would have been payable had a claim duly been made for them.

c. If another plan covering the Eligible Individual covered by This Plan contains a similar nonduplication of benefits provision that coordinates its benefits with those of This Plan and would, according to its rules, determine its benefits after the benefits of This Plan have been determined, and the rules set forth in item (d) of this Section would require This Plan to determine its benefits before such other plan, then the benefits of such other plan will not be considered for the purposes of determining the benefits due under This Plan.

d. Order of Benefits. For the purposes of item (c) of this Section, the rules establishing the order of benefit determination are (in all cases, COBRA or other forms of continuation or self-pay coverage shall be treated based on the individual's status prior to such coverage):

(1) The benefits of a plan that covers the person on whose expense claim is based as an Active Employee shall be determined before the benefits of a Plan that covers such person as a retired employee or a dependent;

(2) The benefits of a plan that covers the person on whose expense claim is based as a dependent of an active employee shall be determined before the benefits of a Plan that covers such person as a dependent of a retired employee;

(3) When both plans cover the person on whose expense claim is based as a dependent child of an active employee, or when both plans cover the person on whose expense claim is based as a dependent child of a retired employee, the benefits of the plan that covers the parent whose birthday (month and day only) occurs first during the Calendar Year shall be determined before the benefits of the Plan that covers the parent whose birthday (month and day only) occurs later in the year, except that in the event a father and mother are not married to each other, the following rules apply:

(a) The benefits of a plan that covers the person on whose expense claim is based as a Dependent child of the parent with primary financial responsibility for the child's medical expenses by virtue of a court decree shall be determined first;

(b) If there is no court decree assigning primary financial responsibility, the benefits of a plan that

covers the person on whose expense claim is based as a Dependent child of the parent with primary physical custody shall be determined first;

(c) If there is no court decree assigning primary financial responsibility and the parent with primary physical custody is married to someone other than the Dependent's other natural parent, the order of benefit determination shall be as follows:

(i) The plan that covers the parent with primary physical custody;

(ii) the plan that covers the stepparent with primary physical custody; and

(iii) the plan that covers the parent without primary physical custody.

(4) When This Plan and another plan cover the same person.

(a) When This Plan and another plan cover the same person on whose expense claim is based as a Dependent child and such other plan does not contain the birthday rule as set forth above (d)(3), but instead uses the rules that the Plan that covers such person as a Dependent child of the father shall be determined before the benefits of a Plan that covers such person as a Dependent child of the mother, then This Plan shall also use this benefit determination provision when applicable.

(b) For a Dependent child who has coverage under either or both parents' plans and also has his or her own coverage as a dependent under a spouse's plan, the longer or shorter coverage rule in paragraph (d)(4)(e) applies. In the event the Dependent child's coverage under the spouse's plan began on the same date as the dependent child's coverage under either or both parents' plans, the order of benefits shall be determined by applying the birthday rule in paragraph (d)(3) to the Dependent child's parent(s) and the Dependent child's spouse.

e. When rule (d) does not establish an order of benefit determination, the benefits of a plan that has covered the person on whose expense claim is based for the longer period of time shall be

determined before the benefits of a plan that has covered such person the shorter period of time.

f. When this provision operates to reduce the total amount of benefits otherwise payable as to a person covered under This Plan during any Claim Determination Period, each benefit that would be payable in the absence of this provision shall be reduced proportionately, and such reduced amount shall be charged against any applicable benefit limit of This Plan.

5. Right to receive and release necessary information. For the purpose of determining the applicability of and implementing the terms of this provision of This Plan or any provision of similar purpose of any other plan the Plan may, consistent with HIPAA's Privacy Rule, release to or obtain from an insurance company or other organization or person any information, with respect to any person, that the Plan deems to be necessary for such purposes. Any Eligible Individual claiming benefits under This Plan shall furnish the plan such information as may be necessary to implement this provision.

6. Facility of Payment. Whenever payments that should have been made under This Plan in accordance with this provision have been made under any other plan, This Plan shall have the right in its sole discretion to pay any organization making such payments any amounts it shall determine to be warranted in order to satisfy the intent of this provision, and amounts so paid shall be deemed to be benefits paid under This Plan and to the extent of such payments, This Plan shall be fully discharged from liability.

7. Right of Recovery. Whenever payments have been made by This Plan with respect to Allowable Expenses in a total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this provision, This Plan shall have the right to recover such payments, to the extent of such excess, from among one (1) or more of the following, as This Plan shall determine:

a. Any persons to or for with respect to whom such payments were made.

b. Insurance companies, service plans or any other organizations.

8. Dual Coverage Penalties Inapplicable.

a. In any case where This Plan is determined to be Secondary according to the rules above, or otherwise, and if the other plan contains any provision reducing its benefits when the patient is covered by more than one (1) plan ("**Dual Coverage Penalty**"), This Plan shall pay as Secondary, and determine secondary

benefits, without regard to the other plan's Dual Coverage Penalty and as if the other plan did not contain such a provision.

b. For purposes of this rule, it makes no difference how the Dual Coverage Penalty is denominated by the other plan, whether as a "sub-plan," "wrap-around plan," an eligibility rule, coordination of benefits rule, or in some other manner. Whether the other plan contains a Dual Coverage Penalty with respect to This Plan's liability as Secondary Coverage shall be determined in the sole, absolute and complete discretion of the Trustees of This Plan, which determination shall be binding and final upon all interested parties, subject only to This Plan's Claims and Appeals Procedures.

B. Third Party Recovery Rules.

Important Note: This Plan does not provide benefits for work-related Injuries or Sicknesses, or Injuries or Sicknesses when there is another source for payment of the related claims, including but not limited to workers' compensation coverage or a third party who has caused the Injury or Sickness (collectively and interchangeable referred to as a "Third Party"). The rules below provide very limited exceptions to this general Plan exclusion so that you and your eligible Dependents may receive Plan benefits on a conditional, interim basis while you take steps to recover from workers' compensation or another Third Party responsible for the Injury or Sickness and/or related medical care expenses.

The following provisions set forth the Plan's rights and ***your obligations*** in any case where you seek conditional, interim Plan benefits while you pursue a recovery from workers' compensation or a Third Party who has caused your Injury or Sickness. The Plan is not an insurance company, nor is it a for-profit entity. The contributions that fund Plan benefits do not come from insurance premiums, but instead from limited employer contributions negotiated by the Union, and employee contributions, which must be protected and preserved for the benefit of all Plan beneficiaries as a whole. Accordingly, the Trustees shall, in their sole and complete discretion, interpret and apply these rules broadly to ensure the maximum Plan recovery in any case, and their interpretation shall be binding on all parties and any reviewing court or other tribunal.

Failure to comply with any provision of these rules may result in immediate ineligibility for any Plan benefits.

1. *"Third Party"* means the person or organization (including workers' compensation) that is or may be liable or financially responsible for the Injury or Sickness and/or related medical care expenses, even if that person is a relative and/or another Participant in this Plan. *The Plan's Third Party Recovery Rules do not extend to first-party insurance, which is an insurance policy (other than workers' compensation) under which the injured person is a named insured.*

2. "*Third Party Recovery"* means any money sought or received by an Injured or Sick Participant or Dependent (or by anyone on their behalf), as payment to themselves or any other party (including but not limited to a special needs trust, charity, fund, or any other entity), from workers' compensation or other Third Party, where the money is sought or received in relation to the Sickness or Injury (not necessarily for the payment of medical claims). The term Third Party Recovery is not limited to money recovered specifically for medical expenses or to satisfy the Plan's repayment rights under these rules. The Plan's rights under these rules apply *no matter how the recovery is labeled or denominated, which label or denomination shall be disregarded when applying these rules.* Any issue regarding whether a particular expense is related to a particular Sickness or Injury shall be resolved by the Trustees, in their sole and complete discretion. Where the Third Party Recovery is not from workers' compensation, the Plan's Third Party Recovery rights herein are limited to 100% of the Third Party Recovery obtained by the Participant or Dependent. Where the Injury or Sickness is work-related, amounts not recovered out of a workers' compensation recovery may be recovered by the Plan directly from the Participant and Injured/Sick Dependent.

3. Duty to Cooperate; Liability to Plan for Attorneys' Fees.

   a. As a condition precedent and to receive ongoing Plan benefits generally and for the conditional, interim Plan benefits described under these rules, the Participant and any Injured or Sick Dependent, their attorney or anyone acting on their behalf, must not take any action that would prejudice the Plan's rights hereunder, and must fully cooperate in doing what the Plan deems necessary to assist the Plan in obtaining the Third Party Recovery described in these rules. Such cooperation includes but is not limited to immediately and fully disclosing the amount and circumstances of any Third Party Recovery, and it shall be a violation of these rules to enter into any confidentiality agreement purporting to prevent such disclosure to the Plan.

   b. If the Participant, Dependent, their attorney or anyone acting on their behalf fails to fully cooperate with the Plan under these Third Party Recovery Rules, including but not limited to the failure to promptly response to information requests and updates, and to promptly turn over any Third Party Recovery identified by the Trustees, the Participant and Dependent shall be liable for the Plan's attorneys' fees and costs incurred pursuing such cooperation or recovery, prior to, during and after any necessary legal action, whether or not formal legal action is filed or proceeds to judgment, and any judgment in favor of the Plan in such a case shall bear interest at 18% not the applicable statutory rate.

c. Any dispute or controversy regarding application of these rules that arises before the Participant or Dependent has obtained a Third parry Recovery may be resolved by a declaratory judgment action in the appropriate state or federal court. Any right of the Participant or Dependent to challenge the ripeness of such a case is waived and attempting to do shall be a failure to cooperate under these Third Party Recovery Rules.

d. In any action to resolve any dispute regarding the application of these rules the Plan shall not be required to join any other party (including but not limited to the third party or third-party insurance provider), and shall be entitled to, and the Participant and/or Dependent shall stipulate to, a preliminary injunction preventing the distribution, transfer or dissipation of any Third Party Recovery money identified by the Plan.

4. Precondition to Eligibility for Benefits and Plan Payment of Benefits

a. The right of any person to receive Plan benefits is subject to and conditioned on that person's and his or her attorney's or other representative's, full agreement and acquiescence to every term of the Plan, including these Third Party Rules.

b. If the Participant or Dependent hires an attorney in relation the Sickness or Injury, he or she agrees to obtain the full cooperation and agreement of the attorney to fully comply with these rules and the Repayment Agreement.

c. Before the Plan pays any benefits, and in order for any person to be eligible for benefits under these Third Party Recovery Rules, the Participant and any Injured or Sick Dependent seeking Plan benefits must sign a separate agreement with the Plan, in form and substance acceptable to the Plan, to (jointly and severally) repay the Plan and otherwise fully comply with these Third Party Recovery Rules (the "Repayment Agreement"). The Repayment Agreement is a contract enforceable as a matter of state law, independently from and in addition to, enforcement of it as a Plan document, enforcement of the terms of this Plan under any applicable state or federal law, or enforcement of the Plan's rights in equity.

d. In any case where a Participant or Dependent, or an attorney or other representative, fails to fully acknowledge, comply and cooperate with these Third Party Recovery Rules, including prompt, full and accurate communication and responses to the Plan and its representatives, such Participant and each and every Dependent of such Participant shall have all Plan benefits

suspended pending full recovery by the Plan, subject to the Trustees' discretion to waive benefit suspension for good cause shown as determined in the sole discretion of the Trustees. The Board of Trustees, in its sole discretion, may, in addition to any other rights the Plan may have, deduct or offset the money it is due (including attorney's fees and interest described in subsection 3(b) above) from future benefits to Participant and/or any of his Dependents.

e. If the Injured or Sick person is a minor, the minor's parent/legal guardian must sign the required Repayment Agreement. By doing so, the parent/legal guardian certifies that he or she is the parent and/or legal guardian of the minor, has fully explained the Repayment Agreement to the minor, will take whatever legal action is required on behalf of the minor to make the Repayment Agreement and these rules legal and binding on the minor, and personally guarantee the Plan's Third Party Recovery rights.

f. A Participant and Injured or Sick Dependent seeking benefits in circumstances described in these Third Party Recovery Rules shall be required to execute a Stipulation and Order for Entry of Preliminary Injunction, on a form prescribed by the Plan, which the Plan may file in court at any time the Plan determines that there has been a failure to fully cooperate and comply with these rules.

5. Plan Rights. The Plan's Third Party Recovery Rights are cumulative and may be asserted by the Plan singly, together, or in any combination as the Board of Trustees, in its sole discretion, determines. The Plan's Third Party Recovery Rights include but are not limited to:

a. Lien and Express Trust Rights. To the extent the Participant or Dependent, their attorney, agent, assignee, trust or any other person or entity on behalf of such Participant or Dependent, recovers money from a Third Party, or as a result of workers' compensation, in relation to an Injury or Sickness for which the Plan has paid or later pays benefits, the Plan shall have a first priority lien on the amounts so recovered. The Participant or Dependent, their attorney, agent, assignee, trust or any other person or entity on behalf of such Participant or Dependent, holds all such money in trust, as expressly provided hereby, for the Plan and must pay such amount, up to the amount of claims the Plan has paid to date (or as of such later date on which the Plan demands reimbursement for additional or other claims paid) to the Plan within then (10) days of receipt by such entity or person (or demand by the Plan). Prior to payment, any person holding or

controlling such funds is a fiduciary as to the Plan's assets thus held.

b. Repayment Rights. The Participant or dependent, their attorney, agent, assignee, trust or any other person or entity on behalf of such Participant or Dependent, is obligated to fully reimburse the Plan to the extent of any recovery from a Third Party, or workers' compensation or other similar sources, in relation to an Injury or Sickness for which the Plan has paid or later pays benefits. Before the Plan pays any benefits and in order for the Participant or Dependent to be eligible for benefits, the Participant and Injured or Sick Dependent, and their attorney, must sign a separate agreement with the Plan, in form and substance acceptable to the Plan, to repay the Plan under these Rules and fully abide by them.

c. Assignment of Funds. Any funds due as the result of a Third Party's conduct or financial responsibility hereunder shall be deemed assigned to the Plan prior to receipt by the Participant or Dependent, or their agent or attorney, or payment to any person, provider or entity on behalf of the injured person. Such funds, thus assigned, are the sole property of the Plan and any party taking any action contrary to the Plan's rights to such funds does so in violation of such rights. Any party or entity in possession of such funds following such assignment to the Plan holds such funds in trust, and as a fiduciary, for the exclusive benefit of the Plan and upon demand of the Plan must immediately transfer all such amounts to the Plan.

d. Subrogation. The Plan has a right of subrogation to the extent of all benefits paid under the Plan as a result of a Third Party's wrongful act or negligence that causes an Injury to the Participant or Dependent. The Plan has the right but not the obligation to assert any and all rights the Participant or Dependent might have against the Third Party in order to recover an amount equal to the amount of benefits paid under the Plan. The Plan's subrogation rights also apply to workers' compensation Injuries or Sicknesses for which the Plan paid benefits. The Plan is subrogated and succeeds to the Participant's or Dependent's rights, which rights are assigned to the Plan.

6. Rejection of Make Whole, Common Fund, and other doctrines. The Plan's Third Party Recovery Rights, as described herein, apply without regard to whether the amount recovered is sufficient to make the injured party whole, and without reduction for costs or fees incurred by the injured party in obtaining such recovery. The "Make Whole,":Common

Fund," and any other doctrine having the effect of reducing the Plan's recoveries under these rules, are hereby specifically rejected by the Plan and any Participant or Dependent seeking Plan benefits. Should any court or other competent tribunal rule that, despite this provision, any such doctrine applies at common law, causing any reduction in the Plan's recovery under these rules, the Participant and Dependent's contractual obligations to the Plan under the Repayment Agreement shall be increased in an equal amount.

7. Future Claims. The Plan's Third Party Recovery rights extend to additional benefits paid after receiving initial (or multiple) reimbursements under these Rules to the extent of any claims incurred after the date of such reimbursement; future claims by the Plan under these rules are not extinguished by resolution of past claims. Insistence by any party that the Plan waive future claims to receive reimbursement under these rules shall be deemed a failure to cooperate.

8. Workers' Compensation Claims. Regarding workers' compensation claims, the Participant or Dependent must timely and diligently make and keep appointments, file papers, including claim forms, attend hearing and pursue all appeals available, including to the extent provided by any separate Plan policies that apply, and otherwise fully cooperate and act in good faith with other in connection with such workers' compensation claims. If workers' compensation benefits are not available for a work-related Injury due to any failure of the Participant or Dependent to comply with this provision, or misconduct of the injured person at the time of Injury or during the course of subsequent proceedings, the Plan's Third Party Recovery Rights in such cases shall be preserved and enforceable for the recovery of ineligible benefit payments against the Participant and an Injured or Sick Dependent.

C. Anticipation, Alienation, Sale or Transfer. Benefits payable hereunder shall not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge by any person; however, any Employee may direct that benefits due him be paid to an institution in which he or his eligible Dependent is Hospitalized or to any provider of medical services or supplies in consideration for medical or Hospital services rendered or to be rendered. Such direction may be honored by the Plan as a courtesy to the patient but may not in any event deemed an assignment of rights or deemed to provide standing to such institution or provider to assert any claim in any court or other tribunal against the Plan, including but not limited to filing an appeal with this Plan or a lawsuit for benefits, all of which must be done, if at all in the patient's own name and not as an assignor of rights, which is not permitted under the Plan.

D. Facility of Payment. In the event the Plan determines that the Employee is incompetent or incapable of executing a valid receipt and no guardian has been appointed, or in the event the Employee has not provided the Plan with an address

at which he can be located for payment, the Plan may, during the lifetime of the Employee, pay any amount otherwise payable to the Employee, to the spouse, or a relative by blood of the Employee, or to any other person or institution determined by the Plan to be equitably entitled to payment. In the event of the death of the Employee before all amounts payable under the Plan have been paid, the Plan may pay any such amount to any person or institution determined by the Plan to be equitably entitled to payment. The remainder of such amount shall be paid to one (1) or more of the following surviving relatives of the Employee: lawful spouse, child or children, mother, father, brothers or sisters, or to the Employee's estate, as the Board of Trustees in its sole discretion may designate. Any payment in accordance with this provision shall discharge the obligation of the Plan hereunder to the extent of such payment.

E. Disputes. No Employee, eligible Dependent, Beneficiary or other person shall have any right or claim to benefits under the Plan or any right or claim to payments from the Plan other than as specified in this Plan, the rules of the Plan and the provisions of the Trust Agreement. Any dispute as to eligibility, type, amount of duration of such benefits or any right or claim to payments from the Plan shall be resolved by the Board of Trustees, or a subcommittee thereof, under and pursuant to the Trust and the Plan and its decision regarding any such dispute, right or claim shall be final and binding upon all parties thereto, subject only to such judicial review as may be provided by applicable law.

F. Direct Payment to Providers.

1. Unless notified differently and in writing by an Eligible Individual, the Plan shall assume all Eligible Individuals desire direct payment of their benefits to their providers as a convenience and accommodation to the Eligible Individual. All such assigned Hospital, medical or surgical benefits will be paid by the Plan to the Hospital or to the provider of such services as they accrue upon receipt of written proof, satisfactory to the Plan, covering the occurrence, character, and extent of the event for which the claim is paid. Such payments are for claim purposes and the convenience of Eligible Individuals only and do not create standing for such providers to appeal claim denials or maintain a legal action against the Plan in any court or tribunal.

2. Benefits not paid directly to providers will be paid by the Plan to the Eligible Individual.

3. For any benefits to be payable by the Plan, in any case where the applicable stop-loss attachment point has been reached, or is reasonably likely to be reached, as determined by the Plan, the provider of services must submit all claims and related billing information within 30 days following the date of service, and in no event later than the deadline by which such claims must be submitted by the Plan to its stop-loss carrier for such claims to be covered by the Plan's stop-loss carrier. Such stop

loss deadline shall be provided to any such provider upon written request to the Plan's Administrator.

G. Benefits After Death.

1. In the event of the death of the Employee before all amounts payable under the Plan have been paid, the Plan may pay any amount to any person or institution determined by the Plan to be equitably entitled to receive it.

2. The remainder of any benefits will be paid to the eligible Employee's beneficiary or to the Employee's estate, as the Board of Trustees in its sole discretion may decide. If the beneficiary is unable to give a valid release or if benefits unpaid at the time of the Employee's death are not more than $1,000, benefits of up to $1,000 may be paid to any relative of the Employee who is found to be entitled to the benefits. Any payment in accordance with this provision will discharge the obligation of the Plan to the extent of such payment.

H. Reduction of Benefits. The Trustees have authority to adjust and/or reduce benefits available to Employees on whose behalf contributions are insufficient to cover the full current cost of benefits, as determined in the sole and complete discretion of the Trustees. Such an adjustment and/or reduction may include, but is not limited to, elimination of dental, vision or any other item of coverage, higher deductibles, copays, etc. The basis for such an adjustment and/or reduction may include, but is not limited to, the failure of a negotiated contribution rate to keep pace with the costs of benefits, or an Employee's failure to pay, or authorize his Employer to transfer, the Employee's portion of contributions.

I. Miscellaneous.

1. The Plan, at its own expense, shall have the right and opportunity, through the Plan's Medical Consultant, to examine the person or review any claim of any Eligible Individual when and so often as it may reasonably require during the pendency of any claim, and also the right and opportunity to make an autopsy in case of death where it is not forbidden by law. Proof of claim forms, as well as other forms, and methods of administration and procedure, will be solely determined by the Plan.

2. The benefits provided by this Plan are not in lieu of and do not affect any requirement for coverage by Worker's Compensation laws or similar legislation.

3. The provisions of this Plan Document are subject to and controlled by the provisions of the Trust Agreement, and in the event of any conflict between the provisions of this Plan Document and the provisions of the Trust Agreement, the provisions of the Trust Agreement shall prevail.

4. Trustee Discretion. The Trustees have the exclusive right, power and authority in their sole and absolute discretion, to administer, apply and interpret this Plan and all other documents that describe the Plan and Trust Fund. The Trustees may decide all matters arising in connection with the operation and administration of the Plan. Plan benefits shall be paid only if the Trustees, in their discretion, decide that an Eligible Individual is entitled to them. Except as described in the claims and appeals procedures, all determinations made by the Trustees with respect to any matter arising with regard to Plan benefits will be final and binding on all concerned. Any judicial review of any Trustee decision must be done in deference to the Trustees' decision. Without limiting the generality of the foregoing, the Trustees shall have the sole and absolute discretionary authority:

   a. To take all actions and make all decisions with respect to the eligibility for, and the amount of, benefits reimbursed under the Plan.

   b. To formulate, interpret and apply rules, regulations, interpretations, practices and policies necessary to administer the Plan in accordance with its terms.

   c. To decide questions, including legal or factual questions, relating to the calculation and payment of benefits under the Plan.

   d. To resolve and/or clarify any ambiguities, inconsistencies and omissions arising under the Plan or other Plan documents.

   e. To process, and approve or deny, benefit claims and rule on any benefit exclusions.

5. All determinations made by the Trustees with respect to any matter arising under the Plan and any other Plan document shall be final and binding on all parties.

6. Claims Payments Made in Error. If the Plan pays benefits for or on behalf of an Employee or Dependent, when the Employee or Dependent is not in fact eligible or entitled to the benefits or if the Plan otherwise mistakenly pays benefits, the Employee or Dependent will promptly reimburse the Plan in full for the amount paid in error. The Trustees, in their sole discretion, may deduct or offset any erroneous payment from future benefits, and/or cancel eligibility for the Employee and/or all his Dependents (which shall not be a COBRA qualifying event). If the Plan files any legal action against the Participant or Dependent(s) to recover any erroneous payment, the Participant will pay all attorneys' fees and costs of the Plan, whether or not such an action proceeds to judgment. **Receipt of Plan benefits is consent and agreement by the ineligible person to such liability**.

7. Amendment Procedures. The Board of Trustees may modify or amend this Plan at any time or from time to time through written, sequentially-numbered Amendments adopted by a majority vote or, and in relation to, by restating or republishing the Plan. This Plan may be modified or amended retroactively. Ordinarily, however, the Trustees will not exercise the power to amend the Plan retroactively unless it will increase benefits to the Participants. When Plan changes are made by amendment:

   a. An Amendment modifying or amending the Plan may be suggested or proposed by a Trustee or professional who works for the Plan.

   b. The Trustees will consider and discuss the Amendment at a meeting of the Board of Trustees, seeking input from the Trustees and the professionals who work for the Plan.

   c. An Amendment will be adopted by vote by a majority of the Trustees. If the Trustees are deadlocked, the procedure for resolution of a deadlock will apply. Plan changes may also be adopted from time to time when the Plan is restated in its entirety and mailed out to all Participants.

   d. Participants will be notified of material Plan changes no later than 60 days after the meeting of the Board of Trustees at which the change was approved or ratified, as the case may be.

   e. An Amendment may be signed by the Chair and Co-Chair of the Board of Trustees outside of regularly scheduled trust meetings, subject to approval of the Plan change during a Trust meeting either before or after the Amendment is signed.

8. Establishment and Verification of Identity. The Trustees have the right to verify and confirm the identity of any Participant or Beneficiary applying for, or entitled to receive, benefits. Such Participant or Beneficiary has the responsibility and obligation to establish his or her identity to the satisfaction of the Trustees. Such a Participant or Beneficiary must reimburse the Trust for the costs and expenses incurred by the Trust in verifying and confirming identity.

J. Alternative / Substitute Treatment Plan. The Plan specifies certain types, levels and limitations of benefits. In addition to those specified in the Plan, the Board of Trustees may elect to provide benefits or services pursuant to a Board-approved Alternative/Substitute Treatment Plan ("**AST Plan**") for an eligible person. The Board will only authorize an AST Plan when the Board, in its sole and absolute discretion, based upon such medical and other information and advice the Board deems sufficient and appropriate, determines that such an AST Plan is medically necessary and appropriate and that such an AST Plan is both cost effective and less costly to the Plan than treatment otherwise available under

the Plan rules. If the Board elects to approve an AST Plan, it will do so only for as long as such services are medically necessary, appropriate and cost effective for the Plan, and that the total benefits paid for such services do not exceed the total benefits to which the Claimant would otherwise be entitled under this Plan in the absence of an AST Plan. If the Board approves an AST Plan for an eligible Participant in one instance, it shall not be obligated to provide the same or similar plan for other eligible Participants in any other instance. Nor shall such election be construed as a waiver of the right of the Board to administer the Plan in strict accordance with the provisions of the Plan document and Plan rules and regulations. This provision is for AST Plans and is not a means of Plan redesign, nor is it intended to be applied to authorize procedures that are not FDA approved or otherwise experimental. It is not intended to be applied to experimental, non-FDA approved or over-the-counter Drugs or medications.

PART 13. SOME DETAILS ABOUT THE PLAN AND THE TRUSTEES.

A. Name of the Plan. This Plan is known as the Cement Masons and Plasterers Health and Welfare Trust of Southern Nevada.

B. Name, Address and Telephone Number of Plan Sponsor.

The Board of Trustees is both the Plan sponsor and administrator. This means that the Board of Trustees is responsible for seeing that information regarding the Plan is reported to government agencies and disclosed to Participants and Beneficiaries in accordance with the requirements of ERISA. The address and telephone number of the Plan sponsor are the same as the Administrative Office listed on page 3.

C. Name, Title and Principal Place of Business of Each Trustee.

Union Trustees	**Employer Trustees**
Marc Leavitt Operative Plasterers & Cement Masons Union Local 797 4231 West Oquendo Road Las Vegas, NV 89118	Thomas Pfundstein PDCA 1701 Whitney Mesa Drive Suite 104 Henderson, NV 89104
Paul Benigno Operative Plasterers & Cement Masons Union Local 797 4231 West Oquendo Road Las Vegas, NV 89118	Kim Christensen Associated General Constructors 150 N. Durango Drive Las Vegas, NV 89145
Isaac Leos Operative Plasterers & Cement Masons Union Local 797 4231 West Oquendo Road Las Vegas, NV 89118	Brady Stevens Nevada Contractors Association 150 N. Durango Drive Las Vegas, NV 89145
Pablo Leos Operative Plasterers & Cement Masons Union Local 797 4231 West Oquendo Road Las Vegas, NV 89118	Robert Campbell Western Wall & Ceiling Contractors 6280 S. Valley View Blvd., Suite 610 Las Vegas, NV 89118
Thelma Waggoner (Alternate) Operative Plasterers & Cement Masons Union Local 797 4231 West Oquendo Road Las Vegas, NV 89118	Patrick Velasquez (Alternate) Nevada Contractors Association 6600 Amelia Earhart Court, Ste. B Las Vegas, NV 89119

D. Plan Administrator and Type of Administration.

The Board of Trustees is both the Plan sponsor and administrator and is responsible for seeing to it that information about the Plan is reported to government agencies and properly disclosed to Participants and Beneficiaries, in accordance with the requirements of ERISA. Day-to-day administrative functions are performed by the Administrator listed on page 3.

E. Identification Number, Type of Plan, Plan Year. The number assigned to the Plan by the Internal Revenue Service is 88-6010564. The Plan Number is 501.

This Plan is maintained for the purpose of providing life insurance, accidental death and dismemberment, weekly disability, hospital, medical, prescription drug, dental and vision care benefits.

The records of the Plan are kept separately for each year. The Plan's fiscal year ends June 30.

F. The Plan's Source of Funding and Contributions.

The Cement Masons and Plasterers Health and Welfare Trust for Southern Nevada is sponsored by Operative Plasterers and Cement Masons International Association Local No. 797 and the Employers who have collectively-bargained agreements with the Union. The agreements require the Employers to make contributions to the Cement Masons and Plasterers Health and Welfare Trust for Southern Nevada, and the contributions are used to provide Participants with the health and welfare benefits specified in the Plan. The contribution rate is specified in the collectively-bargained agreements.

A list of Employers and unions that sponsor the Plan, and a copy of each collectively bargained agreement, is available for examination without cost by Participants and Beneficiaries at the Administrative Office of the Trust. Copying charges may apply.

G. Name and Address of Agent for Service of Legal Process. The Plan's agent for service of legal process is its Administrator, listed above.

H. Termination of Trust Provisions. The Trust shall remain in full force and effect until terminated by the action of the Trustees. In the event of termination, the Trustees shall:

1. Make provision out of the Trust for the payment of expenses incurred up to the date of termination of the Trust and expenses incident to such termination.

2. Distribute the balance, if any, of the assets of the Trust remaining in the hands of the Trustees in such manner as they determine will carry out the purpose of the Trust, including, but not limited to, the purchase of existing

insurance benefits on a pro rata basis or the transfer of such funds to a successor trust having the same or similar purposes for the benefit of Participants.

3. Arrange for a final audit and report of their transactions and accounts for the purpose of terminating their trusteeship.

4. In any event, upon termination, the Trustees may transfer group insurance policies and the balance, if any, of the assets of the Trust remaining in the hands of the Trustees, or any portion thereof, to the trustees of another fund established for the purpose of providing substantially the same or greater group coverage than that contemplated by the Plan.

5. In no event shall any of the Trust assets, except for benefits due, revert to or be recoverable by any Participant, Employer or Union.

PART 14. DEFINITIONS.

1. Active Employee. An Active Employee means any person who, by reason of his active employment, meets the eligibility requirements established by the Plan and as amended from time to time.

2. Allowable Expense. Allowable Expense is the rate, amount, or schedule on which the Plan's payment for covered services and supplies is based. Allowable Expenses are subject to deductibles, co-payments, coinsurance, and Plan limits. The Plan pays no more than the Allowable Expense or the actual billed charges, whichever is less. However, the amount actually paid by the Plan may be a percentage of the Allowable Expense. The Plan has the sole, complete and final authority and discretion in determining Allowable Expense. Allowable Expense is determined according to the following method:

    a. *In-Network Services*: Except as specified in subsections c, d and e below or as may be otherwise specified in the Plan, to the extent benefits are paid pursuant to a PPO Agreement or Contract between the Plan and a provider, the Allowable Expense is the rate, amount, or schedule stated in such Agreement or Contract.

    b. *Out-of-Network Services*: Except as specified in subsections c, d and e below or as may be otherwise specified in the Plan, for covered services and supplies provided by a Noncontracted Provider, the Allowable Expense is (i) the negotiated rate between the Plan and the provider, or (ii) the Plan's rate or schedule, or percentage thereof, for such covered services or supplies, whichever is less, as determined in the sole, exclusive, and final judgment of the Plan.

    c. *Fully Contracted Hospital Services*: For Hospital and related services and supplies covered by contracts with the Health Services Coalition rendered or delivered by a contracted provider, the Allowable Expense is the rate, amount, or schedule stated in the applicable contract with the Health Services Coalition ("**HSC**").

    d. *Hospital Services with Non-HSC Contracted Provider Inside Nevada*: For an HSC Service rendered or delivered by a non-HSC contracted provider within the Nevada geographical area serviced by the HSC, the Allowable Expense is the lowest HSC contracted rate, amount, or schedule, or percentage thereof or such other rate, amount, schedule or percentage that is the lowest "reasonable amount" that complies with the requirements of Section 2719A of the Public Health Service Act and related federal guidance, as determined in the sole, exclusive and final judgment of the Plan;

provided, however, to facilitate the transition of a provider from Contract Provider status to Noncontracted Provider status, the Plan in its sole and absolute discretion, may utilize any available wrap network for a limited period.

e. *Hospital Services with Noncontracted Provider Outside of Nevada*: For Hospital and related services and supplies rendered or delivered outside the Nevada geographical area serviced by the HSC, and not subject to any PPO Agreement or Contract, the Allowable Expense is the negotiated, discounted, or other rate, amount, or schedule, whichever is less, or such other rate, amount, schedule or percentage that is the lowest "reasonable amount" that complies with the requirements of Section 2719A of the Public Health Service Act and related federal guidance, as determined in the sole, exclusive, and final judgment of the Plan.

f. *Medicare Expenses*: For Medicare expenses, the Plan will consider the Allowable Expenses to be the Medicare approved amount, which is the amount recognized as reasonable by Medicare for health care expenses of the kinds covered by Medicare. The Medicare approve amount also includes amounts considered payable under the Medicare Part B fee schedule. The Plan will not pay charges that exceed Medicare's approved amounts.

3. Calendar Year. January 1 through December 31 of each year is a Calendar Year.

4. Concurrent Review. This refers to the process whereby the Utilization Review Organization under contract to the Plan determines the number of authorized days considered medically necessary that are eligible for unreduced benefits according to the terms of the Plan once an Eligible Individual has been confined to a Hospital.

5. Contract Pharmacy. A Contract Pharmacy is a pharmacy which has a contract with the Plan to provide prescription Drugs to Eligible Individuals on a walk-in or mail order basis at negotiated costs.

6. Contract Hospital or PPO Hospital. This means a Hospital bound to a written agreement with the Plan, through the Preferred Provider Organization, concerning the provision of health care services to Eligible Individuals of the Plan at negotiated fees.

7. Contract Provider or PPO Provider. A Physician, laboratory, radiology facility or other provider of health care services bound to a written agreement with the Plan through the Preferred Provider Organization concerning the provision of health care services to Eligible Individuals of the Plan at negotiated fees.

8. Covered Employee. An Active Employee, Retired Employee or Self-Pay Employee.

9. Covered Expense. The expense for covered service or supply. A Physician must order or prescribe the service or supply for treatment of an illness or Injury. Expense is considered incurred on the date the service or supply is received. Covered Expense does not include any charge for: services or supplies that are not medically necessary; or are in excess of the Allowable Expenses for a service or supply; or are incurred while you or your Dependent are not eligible for benefits under this Plan.

10. Dentist. A dentist who is licensed to practice dentistry in the state in which he/she renders treatment.

11. Dependent(s). Refer to Part 1 (B).

12. Drugs. Any article which may be lawfully dispensed as provided under the Federal Food, Drug and Cosmetic Act including any amendments thereto, only upon a written or oral prescription of a Physician or Dentist licensed to administer it.

13. Eligible Individual. A Covered Employee and each of his/her Dependents, if any.

14. Emergency. Means an acute medical condition or accident that requires immediate treatment because it is life threatening, disabling or disfiguring.

15. Emergency Medical Condition. A 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 (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (ii) serious impairment to bodily functions; and (iii) serious dysfunction of any bodily organ or part.

16. Emergency Services. With respect to an Emergency Medical Condition – (i) A medical screening examination 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 (ii) 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 to stabilize the patient. For purposes of this definition, stabilize means to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility, or, with respect to a pregnant woman who is

having contractions, that the woman has delivered (including the placenta).

17. Employee. Any person, including "**Nonbargaining Unit**" Employees, who perform any work under a collective bargaining agreement between an Employer and the Union, and for whom the Employer makes or is obligated to make contributions to this Plan as required or permitted by an applicable collective bargaining agreement or as permitted by the Plan, and who meets the eligibility requirements hereunder as established by this Plan and as amended from time to time; and, such other person as the Employer and Union may agree to designate as Employees within the meaning and purpose of an applicable bargaining agreement.

    The term "**Employee**" shall not include self-employed persons or a sole proprietor of a business organization that is an Employer.

    a. An "Employee" may include Participants who have moved from a position covered under a collective bargaining agreement into a position with an Employer, the Union or related trust fund that is not covered by the collective bargaining agreement and may be treated as an Employee with respect to all of the Employee's Hours of Service for the fiscal year.

    b. An Employee for whom contributions were due under a collective bargaining agreement for all hours worked in a Fiscal Year but who subsequently becomes in a position not covered by the collective bargaining agreement may be an Employee for the duration of the collective bargaining agreement applicable to that Fiscal Year, or if later, until the end of the following Fiscal Year.

    c. An Employee who was treated as an Employee pursuant to paragraphs (a) or (b) will continue to be treated as a collectively bargained Employee beyond the time period set forth in paragraphs (a) or (b), provided that the Employee is performing services for one (1) or more Employers that are parties to the Collectively Bargaining Agreement, for related trust funds, or for the Union. This paragraph (c) will apply only so long as no more the five percent (5%) of the Employees covered by this Plan are noncollectively bargained Employees (including the Employees described in paragraphs (a) or (b) above as collectively bargained Employees). Further, an Employer must sign a written agreement obligating it to payments on behalf of such an Employee.

18. Employer.

    a. Any Employer employing persons performing work covered by an agreement with the Union and bound by the terms of the Trust

Agreement, who makes or is required to make any contribution to this Plan;

b. Any other employer who is permitted to make contributions into the Plan pursuant to a written agreement after permission has been granted by the Trustees. Sole proprietors and partners shall not be considered as eligible Employees under this Plan. An employer shall not be deemed an Employer simply because it is part of a controlled group of a corporation or of a trade or business under common control, some other part of which is an Employer. To the extent consistent with applicable law and the requirements of the Code, the term "Employer" shall also include the Union or labor organization representing the Employees of Covered Employers, and any related trust fund including the Apprenticeship Council Trust Fund, provided such Union, organization or trust fund makes contributions to the Plan on behalf of its Employees with the approval of the Trustees.

19. Essential Health Benefits. Benefits specified under section 1302(b) of the Patient Protection and Affordable Care Act and applicable regulations, as may be amended from time to time. Essential Health Benefits include at least the following general categories and the items and services covered within these categories: ambulatory patient services; Emergency services; Hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

20. Extended Care Facility or Skilled Nursing Care Facility. An institution that is primarily engaged in providing inpatients with:

a. Skilled nursing care and related services for patients who require medical or nursing care; or

b. Rehabilitation services for the rehabilitation of injured, disabled or sick persons and that meets all of the following requirements:

(1) It is regularly engaged in providing skilled nursing care for sick and injured persons under 24 hours a day supervision of a Physician or a graduate Registered Nurse.

(2) It has available at all times the services of a Physician who is a staff member of a general Hospital.

(3) It has on duty 24 hours a day a graduate Registered Nurse, licensed vocational nurse, or skilled practical nurse, and it

has a graduate Registered Nurse on duty at least eight (8) hours per day.

(4) It maintains a clinical record for each patient.

(5) It is not, other that incidentally, a place for rest, a place for custodial care, a place for the aged, a place for drug addicts, a place for alcoholics, a hotel, or a similar institution.

21. Home Health Care Agency. An organization or agency that meets the requirements for participation as a "home health care agency" under Medicare.

22. Hospice Agency. A public or private agency or organization which administers and provides hospice care and meets the requirements for participation as a hospice under Medicare.

23. Hospital. An institution legally operating as a hospital that is:

a. primarily engaged in providing, for compensation from its patients, inpatient medical and surgical care for diagnosis and treatment of Sickness or Injury, and which has a laboratory and operating room; and

b. operated under the supervision of a staff of Physicians and continuously provides nursing services by registered graduate nurses for 24 hours every day.

In no event, however, shall such term include any institution, or part of an institution, which is operated principally as a rest home, nursing home, convalescent home or any institution or part thereof which is principally devoted to the care of the aged or any institution engaged in the schooling of its patients.

For the purpose of paying benefits for nervous and mental disorders, "Hospital" also shall mean a place, other than a convalescent, nursing or rest home, which has accommodations for resident bed patients, facilities for the treatment of nervous or mental disorders, a resident psychiatrist always on duty, and which as a regular practice charges the patient for the expense of confinement.

For the purpose of paying benefits for treatment of substance abuse, "Hospital" also means a place, other than a convalescent, nursing or rest home which is licensed, accredited and certified as a health care facility or primary treatment facility licensed by the state in which the treatment was received and which as a regular practice charges the patient for the expense of confinement.

24. The Hospitalist Program provides Hospital inpatient Physician services to Eligible Individuals and is mandatory for inpatient primary Physician care. The Hospitalist Program utilizes licensed nonspecialist Hospital based Physicians who have directly contracted with the Plan or with the Health Services Coalition on behalf of the Plan. Use of Hospitalist Program Physicians for inpatient care is required for all Eligible Individuals. Eligible Individuals receiving care through the Hospitalist Program will have no out of pocket expenses such as deductibles, coinsurance and copays for the covered services by Hospitalist Program Physicians. Eligible Individuals who refuse care under the Hospitalist Program are responsible for 100% of the billed charges by the non-Hospitalist Program Physicians. Physician care by specialists such as OB/GYN and Pediatric will continue to be covered and paid as normal under the plan Rules, since specialists are not part of the Hospitalist Program.

25. Injury. An accidental bodily injury that requires treatment by a Physician. It must result in a loss independent of Sickness and other causes.

26. Licensed Pharmacist. A person who is licensed to practice pharmacy by the governmental authority having jurisdiction over the licensing and practice of pharmacy.

27. Medicare. The program established under the Social Security Act (Federal Health Insurance for the Aged) as it is presently constituted or hereafter be amended.

28. Noncontract Hospital or Non-PPO Hospital. A Hospital that does not have a contract in effect with the Plan under the Preferred Provider Plan.

29. Noncontract Provider or Non-PPO Provider. A Physician, laboratory, radiology facility or other health care provider that does not have a contract in effect with the Plan under the Preferred Provider Plan.

30. Nonoccupational Injury. Physical harm sustained as the direct result of an accident effected solely through external means, provided the accident does not arise out of (or in the course of) any work for pay or profit, nor in any way results from an Injury which does.

31. Nonoccupational Illness or Sickness. A bodily disorder, infection or disease that does not arise out of (or in the course of) any work for pay or profit, nor in any way results from an illness which does, provided, however, if proof is furnished that the Eligible Individual is covered under a Worker's Compensation law or similar law but is not covered for a particular illness under such law, that illness will be considered "Nonoccupational" regardless of the cause.

32. Occupational Illness. A bodily disorder, infection or disease that arises out of (or in the course of) any work for pay or profit.

33. Orthodontist. A Dentist who specializes in orthodontics.

34. Participant. See "Eligible Individual."

35. Physician. A legally qualified medical doctor or surgeon. This definition includes a licensed chiropractor, podiatrist and acupuncturist, acting within the scope of his or her license.

36. Plan. This means the plan of benefits provided by the Cement Masons and Plasterers Health and Welfare Plan for Southern Nevada established by the Trust Agreement. The term "Plan" also means the Cement Masons and Plasterers Health and Welfare Trust for Southern Nevada and its Trustees, as the context may indicate.

37. Preferred Provider Service Area. The geographic area in which Eligible Individuals residing therein are subject to the reimbursement provision of the Preferred Provider Plan.

38. Preferred Provider Plan or Preferred Provider Organization ("PPO"). A program through which Hospitals, laboratory and radiology facilities, Physicians and other providers of health care services contract with the Plan to provide Hospitalization and medical services to Eligible Individuals payable on the basis of negotiated rates.

39. Prior Authorization. The process whereby the Utilization Review Organization under contract to the Plan determines the medical necessity of an Eligible Individual's elective confinement to a Hospital and the number of preauthorized days eligible for unreduced benefits according to the terms of the Plan, prior to such elective Hospital confinement actually occurring.

40. Registered Nurse. A registered graduate nurse who does not ordinarily reside in the active or Retired Employee's home and is not the spouse, child, brother, sister or parent of the active or Retired Employee.

41. Retired Employee. Any person who meets the retiree eligibility requirements as established by the Plan and as amended from time to time.

42. Sickness. A disease, disorder or condition that requires treatment by a Physician. It includes pregnancy, complications of pregnancy, childbirth and well child care, but not for a dependent child except for preventive care services related to pregnancy when an attending provider determines the services are age and developmentally appropriate for the dependent child. It does not include elective abortion; but it does include complications that are the result of an elective abortion.

43. Skilled Nursing Care Facility. An institution that is primarily engaged in providing inpatients with: (1) skilled nursing care and related services for

patients who require medical or nursing care or (2) rehabilitation services for the rehabilitation of injured, disabled or sick persons and which meets all of the following requirements:

a. it is regularly engaged in providing skilled nursing care for sick and injured persons under 24-hour-a-day supervision of a Physician or a graduate Registered Nurse;

b. it has available at all times the services of a Physician who is a staff member of a general Hospital;

c. it has on duty 24 hours per day a graduate Registered Nurse, licensed vocational nurse, or skilled practical nurse, and it has a graduate Registered Nurse on duty at least eight (8) hours a day;

d. it maintains a clinical record for each patient; and

e. it is not, other than incidentally, a place for rest, a place for custodial care, a place for the aged, a hotel or a similar institution.

44. Trust. The Cement Masons and Plasterers Health and Welfare Trust established by the Trust Agreement.

45. Trust Agreement. The Restated and Amended Agreement and Declaration of Trust for the Cement Masons and Plasterers Health and Welfare Trust and any modification, amendment, extension or renewal thereof.

46. Trustee. Any person designated as a Trustee pursuant to the term of the Trust Agreement, and the successor of such person from time to time in office. The term "Board of Trustees" and "Board" means the Board of Trustees established by the Trust Agreement.

47. Union. The Operative Plasterers and Cement Masons Union Local 797.

48. "Usual and Reasonable" or "U&R" shall be as defined in Part 3, INDEMNITY MEDICAL BENEFITS, Section G, Covered Expenses, Subsection 28, Dialysis Treatment – Outpatient, Paragraph (c)(4). The Trustees have the discretionary authority to decide whether a charge is Usual and Reasonable.

49. Utilization Review Organization. An organization, under contract with the Plan, that is responsible for determining the medical necessity of certain medical services specified by the Plan or the elective confinement of an Eligible Individual to a Hospital and the number of necessary days for such confinement. Such determination is to be made solely for the purpose of determining whether such Eligible Individual is to receive unreduced benefit coverage according to the terms of the Plan for Covered

Expenses incurred as a result of such Hospital confinement or specified medical services.

PART 15. LAWS THAT IMPACT YOUR BENEFITS.

A. Statement of ERISA Rights. As a Participant in the Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all Plan Participants are entitled to:

1. Examine, without charge, at the Administrative Office and at other specified locations, such as work sites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor.

2. Obtain, upon written request to the Board of Trustees, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreement, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Board of Trustees may make a reasonable charge for the copies.

3. 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.

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

5. In addition to creating rights for Participants, ERISA imposes duties on the people who are responsible for the operation of the Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan Participants and Beneficiaries. No one, including your Employer, your Union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a health and welfare benefit or exercising your rights under ERISA. If your claim for a health and welfare benefit is denied or ignored in whole or in part, you must receive a written explanation of the reason for the denial and you have the right to obtain copies of documents relating to the decision without charge. You have the right to have the Plan review and reconsider your claim. 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 them within 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 $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 that is denied or ignored, in whole or in part, you

may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

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

B. Mothers and Newborns. Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your Physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a Physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain Prior Authorization. For information on Prior Authorization, contact the Administrative Office.

C. Women's Cancer Rights. A federal law called the Women's Health and Cancer Rights Act of 1998 requires that group health plans, insurers and HMOs that provide medical and surgical benefits in connection with a mastectomy must provide benefits for certain reconstructive surgery. In the case of a Participant or

Beneficiary who is receiving benefits under the Plan in connection with a mastectomy and who elects breast reconstruction, the law requires coverage in a manner determined in consultation with the attending Physician and the Patient, for:

1. Reconstruction of the breast on which the mastectomy was performed;

2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and

3. Prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

If you have any questions about Plan coverage of mastectomies or reconstructive surgery, please contact the Administrative Office at the number on page 3.

D. Mental Health Parity (MHPA) and Mental Health Parity and Addiction Equity Act (MHPAEA). This Plan complies with MHPA, which generally does not permit annual or lifetime dollar limits for mental health benefits to be lower than those that apply to medical benefits. The Plan also complies with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) which requires group health plans to ensure that financial requirements, treatment limitations and nonquantitative limits applicable to mental health or substance abuse disorder benefits are no more restrictive than the predominant requirements or limitations applies to substantially all medical/surgical benefits.

E. Privacy of Protected Health Information.

1. The Trustees and appropriate professionals retained by the Plan, may, to the extent necessary and in accordance with federal and state privacy laws (to the extent applicable) and the Plan's HIPAA Policies and Procedures, have access to such Protected Health Information regarding Participants and Beneficiaries as is reasonably necessary to make eligibility, payment, claims and appeals decisions, or as otherwise necessary to the administration of the Plan. The preceding statement is subject to the provisions of Subsection b below.

    a. The Trustees shall develop HIPAA Policies and Procedures in accordance with HIPAA and other applicable laws, and shall furnish to each Participant and Beneficiary a Notice of Privacy Practices. Such policies and practices shall be consistent with applicable federal and state laws.

    b. The following are permitted and required uses and disclosures of Protected Health Information, as that term is defined in HIPAA, that may be made by the Plan sponsors, the Board of Trustees.

(1) The Board of Trustees may make the following permitted and required disclosures of Protected Health Information. All disclosures shall be of the Minimum Necessary information, as that term is defined under HIPAA, except in the case of Subsections (o) through (s) below.

(2) Permitted disclosure purposes:

(a) As necessary for claims payment, Plan operations and treatment, including for the purpose of deidentifying information for further permitted disclosure.

(b) Determining eligibility and amount of benefits.

(c) Determining medical necessity, utilization reviews, and precertifications.

(d) Coordination of benefits.

(e) Processing claims, auditing claims, investigating claims, responding to Participant inquiries regarding claims, and insuring proper claims payment.

(f) Subrogation and other third-party recovery processing.

(g) Determining proper Employer contributions.

(h) Processing and determining stop loss coverage.

(i) Claims and appeals processing.

(j) Quality assessment, case management, provider rating, underwriting and premium rating and other related activities, except that the Plan will not use or disclose Protected Health Information that is genetic information for underwriting purposes.

(k) Legal and auditing services, including plan compliance.

(l) Plan design analysis, including cost analysis and plan change evaluations.

(m) Implementation of HIPAA and other applicable laws.

(n) Tax and other regulatory filings.

(o) Disclosures to the covered individual.

(p) Disclosures that are subject to a specific written authorization from the covered individual.

(q) Uses that are incident to a use or disclosure otherwise permitted or required by law.

Required Disclosures:

(r) To the covered individual, when requested, to the extent required by law.

(s) To the Secretary of Health and Human Services, when requested.

(3) Further, the Board of Trustees will:

(a) Not use or further disclose the information other than as permitted or required by the Plan's HIPAA Policies and Procedures, or as required by law.

(b) Ensure that any agents, including a subcontractor, to whom it provides Protected Health Information received from the Plan agree to the same restrictions and conditions that apply to the Trustees with respect to such information.

(c) Not use or disclose the information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan sponsor.

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

(e) Make available Protected Health Information for inspection and copying in accordance with HIPAA.

(f) Make available Protected Health Information for amendment by Participants and Beneficiaries and incorporate any amendments to Protected Health Information in accordance with HIPAA.

(g) Make available the information required to provide an accounting of nonroutine disclosures in accordance with HIPAA.

(h) Make its internal practices, books, and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Secretary of Health and Human Services ("**HHS**") or any other officer or employee of HHS to whom the authority involved has been delegated for purposes of determining compliance by the Plan with the regulations requiring the Plan's HIPAA Policies and Procedures and Part 16 (E) of the Plan.

(i) To the extent feasible, return or destroy all Protected Health Information received from the Plan that the Trustees still maintain in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

(j) Ensure that the adequate separation required by the following Subsection.

(4) The Board of Trustees and the Plan shall be treated as separate and distinct entities for purposes of these privacy rules. To that end, only the Plan's Administrator and its employees, including claims adjusters, benefits and eligibility staff, and accounting personnel shall be authorized by the Trustees to have access to Protected Health Information and such access shall be solely for the specific Plan-related functions performed by such persons or entities.

(5) Noncompliance. In the event any person or entity to which the Plan has provided personal health information in accordance with this Section uses or discloses such information in a manner inconsistent with the Plan, its HIPAA Policies and Procedures, or applicable law, the Trustees shall have the right to:

(a) Notify such person or entity in writing of such violation and demand immediate correction and

remedial measures be taken to correct such use or disclosure.

(b) Assess against such person or entity the actual costs of the corrective or remedial action described in subsection (a) hereof.

(c) Send a letter of reprimand to any such person or entity that repeatedly commits such violations.

(d) Take such additional appropriate action including, to the extent feasible, terminating the Plan's relationship with such person or entity, or reporting such violations to the Secretary of Health and Human Services.

2. Security of ePHI. The Trustees shall (1) implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the electronic Protected Health Information ("**ePHI**") (if any) that they create, receive, maintain or transmit on behalf of the Plan; (2) ensure that the adequate separation required between the Trustees and the Plan, is supported by reasonable and appropriate security measures; (3) ensure that any agent, including a subcontractor, to whom it provides this information agrees to implement reasonable and appropriate security measures to protect the information; and (4) report to the full Board of Trustees any security incident of which any Trustee becomes aware. It is expected, however, that no Trustee shall engage in any of the aforementioned activity with regard to ePHI.

PART 16. CLAIMS AND APPEALS PROCEDURES.

A. These claims and appeals procedures supersede and replace all previous claims and appeals procedures adopted by the Trustees, whether such procedures are contained in a Plan document, SPD, or separate documents. These procedures are intended to comply with ERISA and the Internal Revenue Code, and all applicable regulations. Any provision of these procedures that is determined to conflict with such laws and regulations shall be deemed to be displaced by such laws and regulations, which shall govern the claims and appeal process. Any Participant or Beneficiary may request a copy of these procedures from the Administrative Office for no charge, except that a reasonable copy charge may apply. These are the procedures for when a Claim is denied and you want to appeal the denial to the Board of Trustees.

B. Benefits will be paid by the Plan only if notice of the Claim is made within 24 months from the date on which the Claim was first incurred.

C. Important note regarding unofficial claims: A "**Claim**" may be made regarding any adverse benefit determination, which is a denial, reduction or termination of, or a failure to provide or make payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of an individual's eligibility to participate in a plan. An adverse determination concerning Disability Benefits also means any rescission (cancellation or discontinuance) of your Disability Coverage, whether or not, in connection with the rescission, there is an adverse effect on any particular Benefit at that time, that has retroactive effect, except to the extent it is attributable to failure to timely pay required premiums or contributions toward the cost of Coverage. Claims, inquiries, questions and requests regarding eligibility, enrollment or available benefits made before the expense is incurred are not "Claims" for purposes of this section, and are not subject to the Plan's claims and appeals procedures, unless Prior Authorization is required by the Plan. This is true even if these types of unofficial claims are referred to as "claims" by the Administrator, Trustees or anyone acting on their behalf. Responses to such unofficial claims and questions will be issued in a prompt manner, but carry no obligation to apply these procedures and no right to appeal under these procedures.

D. *Making a Claim* – There are no fees or charges to file a Claim or to appeal a benefit decision. These procedures apply whenever a Claim for services that have already been received by you is not granted in your favor. A Claim is a written request by you, your authorized representative, or a health care provider, that the Plan pay benefits. You may authorize another person to make a Claim for you only in writing, signed by you. However, in an Emergency, your Physician may make a Claim on your behalf. An oral request is not a Claim, but a facsimile is acceptable. Once a Claim is made by you or your authorized representative, the rights of any other person or entity to make a Claim for the same benefits are terminated. Although the Plan accepts claims on your behalf directly from your

providers, doing so does not grant the provider standing to appeal a claim denial or take legal action against the Plan.

E. *Prior Authorization for Treatment* – These procedures also apply whenever you are required to obtain Prior Authorization before a course of treatment, which is also considered a Claim. You should review the Plan sections that discuss your treatment carefully to determine whether Prior Authorization is required and who to ask for authorization.

F. *Deciding a Claim* – Whether a Claim is granted in your favor will be determined independently and impartially based on the Plan Documents. The Trustees have full discretion to interpret and apply the Plan's provisions. However, the provisions of the Plan will be interpreted consistently in similar circumstances and similar past appeals, if any, will be reviewed when your appeal is decided. The Plan will not hire, promote, terminate or compensate Claims adjusters, medical or vocational experts based on the likelihood of the person denying Benefit Claims.

G. *When Will Your Claim be Decided?* – The time periods in subsections (1) through (4) apply to health care Claims. The time periods in subsection (5) apply to disability benefit Claims. For all other types of Claims, the time periods set forth in subsection (6) apply.

1. *Urgent Care* – If you have a Claim for Urgent Care and you provide sufficient information to determine whether benefits are covered, your Claim will be decided as soon as possible and not later than 72 hours after the Plan receives your Claim. If you have a Claim for Urgent care and you do not provide sufficient information to determine whether benefits are covered, you will be told within 24 hours what additional information is needed to decide your Claim. You will then have 48 hours to provide the additional information. The Plan will notify you of its decision as soon as possible and within 48 hours after (1) all necessary information is provided, or (2) the 48 hours you have in which to provide the necessary information ends, whichever is sooner.

2. *Ongoing Treatment* – If you are receiving ongoing treatment over a period of time and the Plan determines to reduce or discontinue that treatment, you will receive notice early enough for you to appeal that decision and receive a decision on your appeal before the ongoing treatment is reduced or discontinued. If you are receiving ongoing Urgent care treatment and make a Claim to continue such treatment, a decision will be made within 24 hours after receipt of the Claim.

3. *Claims Made Before Treatment* – If you make a Claim for benefits before you receive the benefits, and neither (1) nor (2) above apply, your Claim will be decided within a reasonable time no longer than 15 days after receipt of your Claim. However, an additional 15 days may be needed if

there are special circumstances beyond the Plan's control. If so, you will be given notice of the special circumstances before the end of the first 15 days and told whether additional information is needed to decide your Claim. You will have at least 45 days to provide the additional information. Keep in mind that only where Prior Authorization is required will such a request prior to receiving benefits be an official Claim.

When Prior Authorization is Required – The Plan will notify you if your request for Prior Authorization is not sufficient to be a Claim as soon as possible, but in any event not later than five (5) days (24 hours in a case of Urgent care), and tell you how to submit a proper Claim for Prior Authorization of treatment. However, you must at least provide your name, medical condition and a description of the treatment requested before the Plan will be able to help you complete your Claim.

4. *Claims Made After Treatment* – If you make a Claim for benefits after you receive the treatment, and neither (1) nor (2) above apply, your Claim will be decided within a reasonable time no longer than 30 days after receipt of your Claim. However, an additional 15 days may be needed if there are special circumstances beyond the Plan's control. If so, you will be given notice of the special circumstances before the end of the first 30 days and told whether additional information is needed to decide your Claim. You will have at least 45 days to provide the additional information.

5. *Disability Benefit Claims* – If you make a Claim for disability benefits, your Claim will be decided within a reasonable time no longer than 45 days after receipt of your Claim. However, an additional 30 days may be needed if there are special circumstances beyond the Plan's control. If so, you will be given notice of the special circumstances before the end of the first 45 days and told the requirements for receiving benefits, any unresolved issues, whether additional information is needed, and when a decision is expected. You will have at least 45 days to provide the additional information.

6. *Other Claims* – For all Claims for which the time frames in (1) through (5) above do not apply, a decision will be made within a reasonable time no longer than 90 days after receipt of your Claim. However, an additional 90 days may be needed if there are special circumstances beyond the Plan's control. If so, you will be given notice of the special circumstances before the end of the first 90 days and stating when a decision is expected.

7. The time in which to make any Claim decision is extended during any time in which the Plan is waiting to receive requested additional information.

H. *Contents of Claim Denials* – If your Claim is denied, you will be provided in writing (via facsimile if you wish) information sufficient to identify the claim:

1. The specific reasons for the denial;

2. The date of service;

3. The name of the health care provider;

4. The claim amount (if applicable);

5. Notification that the claimant may request, and the Plan will provide upon request, the diagnosis code and treatment code along with the corresponding meaning of such codes;

6. The reason for the denial, including any denial code, corresponding meaning of such code and a description of the Plan's standard, if any, that was used in denying the claim, and, for a final denial notice, a discussion of the Plan's decision, and a request for any information required from the Claimant to perfect the Claim and an explanation of why such information is necessary;

7. The Plan provisions on which the denial is based and any internal rules or guidelines that are not in the Plan, with copies of them;

8. If the denial is based on medical necessity, experimental treatment or other similar exclusions or limits, an explanation of the scientific or clinical judgment used in the decision or a statement that such explanation will be provided free of charge upon request;

9. A list of any additional information needed to obtain approval of your Claim, and why such information is needed;

10. If the denial relates to a claim involving urgent care, a description of the expedited review process applicable to such claim;

11. A reminder of your right to access and receive copies of relevant documents free of charge upon request.

12. A description of available internal appeals and external review processes, including information regarding how to initiate an appeal;

13. A reminder that these Claims and appeals procedures may be obtained from the Administrator for no charge, except for reasonable copy charges, and notice of your right to file a lawsuit if your appeal of the denial is denied; and

14. Information regarding the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman available to assist with internal claims and appeals and external review processes.

15. In the case of an Adverse Benefit Decision concerning a G(5) Disability Benefit Claim, the following additional information will be provided;

    a. An explanation of the Adverse Decision, including the views and determination of: (i) any health care professionals and vocational professionals who evaluated the Claimant, (ii) any medical or vocational experts whose advice was obtained and relied upon in the Decision, and (iii) any Social Security Administration's Disability Determination of the Claimant.

    b. If the Adverse Benefit Decision is based on medical necessity, experimental treatment or other similar exclusions or limits, an explanation of the scientific or clinical judgment used in the Decision, or a statement of such explanation, will be provided upon request free of charge;

    c. The Plan provisions on which the Adverse Benefit Decision is based and any internal rules or guidelines that are no in the Plan;

    d. A statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to all documents, records and information relevant to the Claimant's Claim for Benefits; and

    e. If the Adverse Benefit Decision relates to a Claim involving urgent care, a description of the expedited review process applicable to such Claim.

16. The information related to a Claim denial will be provided in a culturally and linguistically appropriate manner, upon request, including the availability of a verbal customer assistance program in the applicable non-English language, for those whose address is in a country where ten percent (10%) or more of the population is literate only in the same non-English language.

I. *Appealing a Claim Decision* – You have the right to appeal any adverse Claim decision. You may designate an Authorized Representative in writing on a form acceptable to the Plan. Otherwise, only you, personally, may pursue an appeal of a Claim denial. Only you may bring a legal action against the Plan regarding a denied appeal. Your Authorized Representative or providers may not do so and your rights under this Plan may not be assigned. Please keep in mind that only where (a) Prior Authorization is required by the Plan or (b) you have already received the medical service is there a Claim subject to these procedures. Certain retroactive terminations of coverage, whether or not there is an adverse effect on any particular benefit at the time are also subject to these procedures. Medical coverage for you and your Dependents will continue pending the outcome of an internal appeal. this means that the Plan will not terminate or reduce any ongoing

course of treatment without providing advance notice and the opportunity to review.

1. For all Claims to which either G(5) or (6) apply:

    a. A written appeal may be filed within sixty (60) days of notice of the Claim denial, or within one hundred eighty (180) days of notice for group health plans.

    b. You may submit any written records you wish to be reviewed and you may obtain copies of any related Plan records.

    c. You may, upon request and free of charge, receive access to all relevant documents, records and information to the Claim for benefits.

    d. You may submit all information relating to the Claim, without regard whether such information was previously submitted or considered in the initial benefit determination.

    e. Your appeal will be decided on or before the next regularly-scheduled meeting of the Board of Trustees that is at least thirty (30) days after your written appeal is received. If special circumstances require additional time to process your appeal, you will be notified of those circumstances and a decision will be made no later than the third (3^{rd}) meeting following receipt of your written appeal. If your appeal is denied, you will receive written (or electronic as permitted by law) notice, including the specific reasons for denial, reference to specific Plan provisions, and you may have access to all Plan records that were used in reaching the decision.

    f. If your Claim involves a medical judgment, a health care professional trained in the relevant field will be consulted (one who did not take part in the Claim Denial and who is not the subordinate of such a person). You may also request the names of medical professionals who gave advice on your Claim Denial.

    g. The Plan will provide you, free of charge, with any new or additional evidence considered and relied upon in making the Adverse Benefit Decision (in connection with the initial Claim) before issuing a determination on Appeal. The new or additional evidence will be provided to you, along with the rational for the Adverse Benefit Decision, with a reasonable amount of time for your response before any Appeal review.

2. For Claims made to which G(1) through (4) above apply, the following appeals procedures apply:

a. You have 180 days to appeal a Claim denial. You may submit any written records you wish to be reviewed and you may obtain copies of any related Plan records. You have the right to review your file and present evidence as part of the review. You may submit written comments, documents, records, and other information relating to the claim. No deference will be given to the initial Claim denial. Your appeal will be decided by an individual(s) who did not take part in the Claim denial and who is not subordinate of such a person. The Administrator will ensure that there is no conflict of interest with regard to the individual making the decision.

b. If your Claim involves a medical judgment, a health care professional trained in the relevant field will be consulted; one who did not take part in the Claim denial and who is not the subordinate of such a person. You may also request the names of medical professionals who gave advice on your Claim denial.

c. For Urgent care Claims, you may make a request for an expedited appeal, orally or in writing, and all necessary information may be exchanged by telephone, facsimile or other expeditious method.

d. Appeal for Urgent care Claims will be decided as soon as possible, but not later than 72 hours after receipt of the appeal.

e. Appeals of Claims made before treatment will be decided within a reasonable period of time, but not later than 30 days.

f. Appeals of Claims made after treatment and of Claims for disability benefits will be decided by the next regularly scheduled meeting of the Board of Trustees that is at least 30 days after your written appeal is received. If special circumstances require additional time to process your appeal, you will be notified of those circumstances and a decision will be made no later than the third meeting following receipt of your written appeal.

g. If your appeal is denied, you will receive written (or electronic as permitted by law) notice, including the specific reasons, reference to the specific Plan provisions, and you may have access to all records that were used in reaching that decision.

You will receive, free of charge, any new or additional rationale and/or evidence considered, relied on, or generated by the Plan (or at the direction of the Plan) in connection with your claim. You will receive this rationale and/or evidence sufficiently in advance of the date on which the notice of the adverse benefit

determination is required in order to give you a reasonable opportunity to respond prior to that date.

h. If any internal rule, guideline, protocol or other similar criterion was used in the appeal denial, you will be told about it and may have a copy of it. If the denial is based on Medical Necessity or experimental treatment, or the like, you may have a copy of whatever scientific or clinical explanation was used in the determination.

i. The appeal denial will also provide the following disclosure required by ERISA: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office."

j. If you are not satisfied with the decision made on your appeal, you may file a lawsuit in federal court against the Plan. However, you must complete the appeal to the Trustees before you may file a lawsuit. You will have 90 days after completing the appeals process, including any applicable external review as provided for in Sections L and M, and being denied to file suit, after which your Claim will be waived. Your rights under the Plan may not be assigned.

J. *Exhaustion of Remedies* – No legal or equitable action for benefits under this Plan may be brought unless and until you, in accordance with the foregoing claims and appeal procedures:

1. Have submitted a written Claim for benefits;

2. Have been notified that the Claim is denied (or the Claim is deemed denied);

3. Have filed a written appeal for review; and

4. Have been notified in writing that the denial of the Claim has been confirmed (or the Claim is deemed denied on review).

5. With regard to Disability Claims only, the Claimant is not prohibited from seeking court review of a Claim Denial based on a failure to exhaust administrative remedies under this Plan, if the Plan failed to comply with the Claim procedure requirements, unless the violation was the result of a minor error and the violation occurred in the context of an ongoing, good faith exchange of information between the Plan and the Claimant. This exception is not available if the violation is part of a pattern or practice of violations by the Plan. The Claimant may request a written explanation of the 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, the Claim or Appeal is deemed denied on review without the exercise of discretion by the Trustees, the Claimant may immediately pursue review of the Claim in Court. If the Court rejects the Claimant's request for review, the Plan will treat your Claim as re-filed on Appeal upon the Plan's receipt of the Court's Decision rejecting the Claimant's request for review.

K. No health provider shall have any right under the Plan to maintain any action against the Plan in any court or other tribunal, such right being exclusive to individual Plan Participants, and any alleged assignment of such right shall be void and ineffective against the Plan.

L. *Standard External Review* – You may request, in writing, an independent external review of certain claim denials. However, a claim denial that relates to your failure to meet the Plan's eligibility requirements does not entitle you to an external review.

1. *Request for External Review* – You may request an external review only after completing the Plan's internal claims and appeals procedures with respect to your medical claim unless the Plan fails to strictly adhere to all of the requirements of the internal claims and appeals process with respect to your medical claim. In such case, you are deemed to have exhausted the internal claims and appeals process and you may seek an external review or pursue legal remedies (as discussed below) with waiting for further action. However, this will not apply if the error was de minimis, if the error does not cause harm to the claimant, if the error was due to good cause or to matters beyond the Plan's control, if it occurs in context of good faith exchange of information, or if the error does not reflect a pattern or practice of noncompliance. It that case, you may resubmit your claim for internal review and you may ask the Plan to explain why the error is minor and why it meets this exception. Also, if your claim is an Urgent Care Claim or a claim requiring an ongoing course of treatment, you may begin an expedited external review before the Plan's internal appeals process has been completed. For all other requests, you must request an external review within 4 months after the date that you receive the Plan's final written decision. Such a request does not delay or extend the 90-day deadline to file suit following final denial of an appeal. Your written request should include:

    a. A specific request for an external review;

    b. the Eligible Individual's name, address, and member ID number;

    c. Your designated representative's name and address, when applicable;

d. the service that was denied; and

e. any new, relevant information that was not provided during the internal appeal.

You will be provided more information about the external review process at the time we receive your request.

2. *Preliminary Review* – Within five (5) business days after receiving your request, the Plan will complete a preliminary review to determine whether:

a. The denial determination is within the scope of the external review process because it involves (i) medical judgment (including, but not limited to, those based on the Plan's requirements for medical necessity, appropriateness. health care setting, level of care or effectiveness of a covered benefit, or its determination that a treatment is experimental or investigational) or (ii) a rescission of coverage (whether or not the rescission has any effect on a particular benefit at that time);

b. Your claim denial does not relate to whether you meet the requirements for eligibility under the terms of the Plan;

c. You have completed the Plan's internal claims and appeals process unless, under the regulations, you are not required to;

d. You have provided all the information and forms required to process an external review.

Within one (1) business day after completing the preliminary review, the Plan will provide you with written notification. If your request is complete but not eligible for external review, the notification will include the reasons you cannot seek external review and contact information for the Employee Benefits Security Administration. If the request is not complete, the notification will describe the information or materials needed to complete your request. You may complete your request within the 120-day request period or, within the 48-hour period after you receive the notification, whichever is later.

3. *Referral to Independent Review Organization* – If it is determined that your request is eligible for external review, the Plan will assign an Independent Review Organization ("**IRO**") to conduct your external review. External reviews are randomly assigned to one of the IROs that are contracted with the Plan. Within five (5) business days of referral to the IRO, the Plan will provide the IRO with any documents and information considered in denying your appeal.

4. *Independent Review* – The IRO will notify you in writing whether your request has been accepted for external review. This notice will inform you that you may submit in writing, within ten (10) business days following the date of receipt of the notice, additional information that the IRO must consider when conducting the external review.

The IRO will forward the information received to the Plan. If the Plan reconsiders its denial, it will provide written notice to you and the IRO of such decision. Meanwhile, the IRO will review all of the information and documents it receives within the time limit. (Provided the Plan does not reverse its decision, the IRO will make a decision within the time limit for its external review.) In addition, the IRO will consider the following items, to the extent they are available and the IRO considers them appropriate:

a. Your medical records;

b. Your attending health care professional's recommendations;

c. Reports from appropriate health care professionals and other documents submitted by you, your treating provider or the Plan;

d. The terms of the Plan to ensure that the IRO's decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law.

e. Appropriate practice guidelines, which must include applicable evidence based standards and may include any other practice guidelines developed by the federal government, national or professional medical societies, boards and associations;

f. Any applicable clinical review criteria developed and used by the Plan, unless the criteria are inconsistent with the terms of the Plan or with applicable law; and

g. The opinion of the IRO's clinical reviewer or reviewers after considering the information to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.

5. *Notice of External Review Decision* – The IRO must provide written notice of the final external review decision within 45 days after the IRO receives the request for external review. The IRO must deliver the notice of final external review decision to you and the Plan. The decision will contain:

a. A general description of the reason for the request for external review, including information sufficient to identify the claims (including the date or dates of service, the health care provider, the

claim amount, the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous denial);

b. The date the IRO received the assignment to conduct the external review and the date of the IRO's decision;

c. References to the evidence or documentation, including the specific coverage provisions and evidence based standards, considered in reaching its decision.

d. A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence based standards that were relied on in making the decision;

e. A statement that the determination is binding except to the extent that other remedies may be available under state or federal law to either you or the Plan;

f. A statement that judicial review may be available to you; and

g. Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman.

6. *Effect of Reversal of Plan's Decision* – If the IRO reverses the denial of your appeal, the Plan must immediately provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

M. Expedited External Review

1. *Request for Expedited External Review* – You may make a request for an expedited external review, if you receive:

a. A claim denial that involves a medical condition for which the time for completing the expedited internal appeal would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, provided that you have also filed a request for an expedited appeal with the Plan; or

b. A claim denial that has been upheld by the Plan, if you have a medical condition for which the time for completing the standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or if the claim denial concerns an admission, availability of care, continued stay, or health care item or service for which you

received Emergency Services, but for which you have not been discharged from a facility.

2. *Preliminary Review* – Once the request is received, the Plan must immediately determine whether the request meets the reviewability requirements for standard external review. The Plan must immediately send you a notice that meets the requirements for standard external review of its eligibility determination.

3. *Referral to Independent Review Organization* – If it is determined that your request is eligible for external review, the Plan must assign an IRO pursuant to the requirements for standard review. The Plan must provide all necessary documents and information considered in making the claim denial to the IRO.

4. *Independent Review* – The assigned IRO must consider the information or documents described in the standard review procedures, to the extent the information or documents are available and the IRO considers them appropriate.

5. *Notice of External Review Decision* – The IRO must provide notice of the final external review decision, in accordance with the requirements for standard review, within 72 hours after the IRO receives the request. If the notice is not in writing, within 48 hours after the date of providing notice, the IRO must provide written confirmation of the decision to you and the Plan.

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