

CONSTRUCTION WORKERS' TRUST FUND

REGULAR PLAN

SUMMARY PLAN DESCRIPTION

Booklet No. 21

August 2023

CONSTRUCTION WORKERS' TRUST FUND

Plan Administrator: Board of Trustees, care of Fund Office, 7130 Columbia Gateway Drive, Suite A, Columbia, MD 21044, 410-884-1406. Daily administrative services are provided by Carday Associates (a part of BeneSys, Inc.), referred to as the "Administrator" in this Booklet.

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Plan Year: October 1-September 30

Agent for Service of Process: Board of Trustees, care of Fund Office, 7130 Columbia Gateway Drive, Suite A, Columbia, MD 21044

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PARTICIPATING LOCAL UNIONS

Metropolitan Area of Philadelphia/Baltimore/Washington Laborers' District Council, Local Unions 11, 572, 710 and 202R

International Union of Painters and Allied Trades District Council No. 51

MEMBER WEBSITE

For more information about your Construction Workers' Trust Fund benefits, including important notices to members, visit the member website at:

www.ourbenefitoffice.com/ConstructionWorkersTrustFund/Benefits.

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ABOUT THIS BOOKLET

This Booklet explains your benefits under the Construction Workers' Trust Fund (CWTF or Fund) - what benefits you have, how to claim them, and how you may lose them. This Booklet No. 21 replaces all prior Booklets. Please read this Booklet carefully so you know how your Fund can help you in times of need.

This Booklet contains a summary of the benefits provided as of January 1, 2023. The Fund's Health and Welfare Plan (the "Plan") sets forth the official rules for receiving benefits from the Fund. The provisions of the Plan, the Trust Agreement, any insurance policies and the rules adopted by the Trustees will control if there is a conflict between them and this Booklet. A copy of the Plan document is available for inspection at the Fund Office, and will be provided to any member who requests one in writing. A reasonable payment may be required to cover copying costs.

The Trustees of the CWTF have the discretionary authority to interpret the terms of the Plan and any insurance policies and other documents related to the Plan, and to resolve all questions and determine all facts relating to eligibility for benefits from the Fund. All decisions made by the Trustees are final and binding upon all persons. The Trustees have the right to amend any provision of the Plan with or without notice at any time, including retroactively, in the best interest of the Fund and its members. An amendment is effective even if it is not described in this Booklet.

If you want more information or have a question, please call the Fund Office at 410-884-1406.

Coverage for benefits is based on your employer's contributions to the Fund for your work under a collective bargaining or participation agreement in the Fund's jurisdiction and on self-payments that you can make in certain cases. If you work outside the Fund's jurisdiction, employer contributions for your work may be transferred to the Fund by reciprocal agreements, but only if you submit the proper authorization for transfer. Contact the Fund Office for more information.

NETWORK PROVIDERS

All members of the Fund have access to health care providers that belong to the local CareFirst Network. Certain members of the Fund whose address of record is outside the CareFirst Network service area also have access to health care providers that belong to the national BlueCross BlueShield "FlexLink" Network.

You have access to both the local CareFirst Network and the national FlexLink Network if the front of your CWTF ID card has a small suitcase in the bottom right corner with "PPO" written in the suitcase. If you do not find "PPO" written in a small suitcase on your ID card, you only have access to the local CareFirst Network.

Most (but not all) health care providers in Maryland, D.C. and the Northern Virginia suburbs belong to the CareFirst Network. Most (but not all) health care providers in the United States belong to the FlexLink Network.

You do not have to use health care providers that belong to the Networks. However, Network providers charge reduced fees for their services, so using providers that belong to the Network that covers you can result in substantial savings. **If you use a health care provider that does not belong to the Network that covers you, the provider's charges will be higher and you have to pay the difference between what a Network provider would charge and what the non-Network provider charges you. Special rules apply to certain charges by out-of-Network providers that may limit the amount you have to pay – see "Special Rules for Certain Out-of-Network Providers" later in this Booklet.**

If your doctor refers you to another health care provider, you should request that you be referred to a Network provider. You should have received information from the Fund Office about how to use the Network that covers you and how to determine if your provider belongs to your Network. If you have any questions, call the Fund Office. Instructions for how to use the CareFirst website to determine if a provider belongs to your Network are on the last page of this Booklet.

NOTE – Unless expressly provided for in this Booklet, the Fund does not cover medical services by persons other than physicians. Physicians are licensed M.D.s, osteopaths and podiatrists. Just because a provider belongs to the Network does not mean their services are covered by the Fund – make sure they are a physician or one of the kinds of non-physicians that this Booklet says are covered.

TELEMEDICINE BENEFITS

The Fund gives you access to telemedicine visits through the Teladoc® program. Teladoc provides 24/7 telephone access to board-certified Medical Doctors licensed to practice medicine who can consult, diagnose and prescribe medication for many common conditions.

Each Teladoc consultation is provided to you and your covered family members at no cost to you. However, if you are given a prescription, you will still have to pay the normal copay when you pick up the prescription.

To set up your Teladoc access account, either call 1-800-835-2362, download the Teladoc app on your smartphone, or visit the Teladoc website on your personal computer.

Call the Fund Office at 410-884-1406 for a Teladoc handout with more information about the telemedicine service and setting up your account, or if you have any questions about this service.

SUMMARY OF BENEFITS

Here is a brief summary of the benefits provided by the Fund. The benefit explanations later in this Booklet provide specific benefit limits and other important information. “Allowed Benefit” means the maximum amount taken into account by the Plan, as explained later in this Booklet under Medical Benefits.

Life Insurance (Employee Only)	\$15,000
AD&D Insurance (Employee Only)	\$15,000
Disability (Employee Only)	\$60 per day \$80 per day while hospitalized
Annual Deductible	
Laborers	\$200 per person/\$600 per family
Glaziers	\$100 per person/\$300 per family
Coinsurance – Fund pays	80%
And you pay	20%, up to
Annual coinsurance Out-of-Pocket limit	\$1,000 per person – Laborers \$ 300 per person – Glaziers
Then Fund pays	100% of Allowed Benefit
Hospital Benefits	80%
Physician/Surgical Benefits	80%
Prescription Drugs	
	\$10 copay generic
	\$25 copay brand preferred
	\$50 copay brand not preferred
Specialty medications may be subject to 30% coinsurance unless obtained thru PrudentRx	
Dental Care	\$1,500 max per person per year
Orthodontia	\$1,000 max per person per lifetime
Eye Care	\$150 per person per year

GENERAL EXCLUSIONS

(Also see limits listed in each benefit explanation)

The Fund does not cover:

- job-related illness or injury (from your regular job, a part-time job, or while moonlighting)
- illness or injury covered by Workers Compensation
- injuries you receive while involved in a criminal act, evading arrest, misconduct, altercation with spouse, parents, children, siblings or anyone who lives with you, riot, mercenary activity, or military service
- injuries received in an airplane (unless it is a scheduled flight on a regular airline)
- self-inflicted injuries, suicide or attempted suicide, unless caused by a mental or nervous condition
- cosmetic treatment, unless due to accidental injury
- the removal of prostheses, implants or appliances the insertion of which was not medically necessary or which was otherwise excluded from coverage
- charges incurred in a government hospital or for treatment by a physician or dentist employed by the government, or when you are eligible for benefits from a federal or state agency or program, except as required by law
- expenses that would not be charged if you had no coverage by the Fund, charges that cannot legally be collected from you, and charges that you are not required to pay
- reversal of a sterilization
- artificial insemination, in-vitro fertilization or any other fertility enhancing procedure, including any related office visits or diagnostic services
- charges in excess of the Allowed Benefit
- treatments, medical devices or drugs which are not medically necessary
- experimental treatments, medical devices or drugs
- charges when the physician, resident staff of the hospital or intern billed under the hospital's tax identification number
- custodial care
- charges for completing claim forms
- treatment for sexual dysfunction that is not related to organic disease (unless specifically covered under the prescription drug benefit)
- charges for items of convenience, medical records or reports, mailing charges or broken or missed appointments
- weight loss programs
- hearing aids

Your claim must be filed on time for it to be covered. Claims must be filed within one year after the treatment is received or the expense is incurred, or the claim will not be covered.

If you (or your dependent) are asked to go to a physician for an examination related to a claim and do not do so, you (or your dependent) can lose coverage for the claim in question.

If benefits that you (or your dependent) are not entitled to are paid by the Fund, you will be required to repay those benefits. If you do not repay them, you (or your dependent) may lose Fund coverage.

If a claim arises out of violence, you may be required to provide a copy of the police report and other information to the Fund Office at your own expense, before your claim can be processed.

FALSE OR FRAUDULENT CLAIMS

If you make a false or fraudulent claim for benefits, the claim will be denied and you (and your dependents) may lose coverage for all benefits under the Fund. In addition, making a false or fraudulent claim is a federal offense, and the Fund may bring legal action against you.

HOW TO CLAIM YOUR BENEFITS

CareFirst and FlexLink Network providers will file benefit claims for you. You do not need to file a claim form with the Fund Office if you use a Network provider.

If you use an out-of-Network provider, they might file your benefit claim for you. It is your responsibility to find out if they file the claim for you. **If they don't file the claim for you, you must file the claim yourself.** You must also file your own claim to receive disability or AD&D benefits, and your survivors must file a claim to receive Life Insurance benefits. To file a claim:

1. Get a claim form from the Fund Office at 7130 Columbia Gateway Drive, Suite A, Columbia, MD 21044. You can also call 410-884-1406 or go online at www.cardayassociates.com.
2. Fill out your part of the form, and then have the rest completed by the provider.
3. Attach all receipts and bills to your claim form.
4. Mail or bring all information to the Fund Office.
5. You must file your claim with the Fund Office **no later than one year** after you receive treatment or incur an expense. If you do not file your claim within one year the Fund will **not** pay benefits.

All claims must show your name and Social Security number. If the claim is for a family member, show their name and relationship to you (spouse or child). You may be asked for a birth or marriage certificate or other evidence of the relationship.

If you have a question or concern regarding a claim that has been filed, please do not call the Fund Office until at least one week after the claim was filed. Too many phone calls can slow up payment.

If your claim is denied, you may appeal the denial to the Trustees. Rules for making an appeal are set forth later in this Booklet.

WHEN YOU ARE COVERED

To be covered for Fund benefits, you must meet the eligibility requirements based on hours you work for which employer contributions are made to the Fund. If your employer does not make sufficient contributions on your behalf to the Fund, you generally will not get Fund coverage.

Regular Eligibility Rule

The Regular Eligibility Rule for Fund coverage is based on employer contributions for work during eligibility quarters. The eligibility quarters are January-March, April-June, July-September and October-December. If at least 300 hours are contributed by your employer for your work during an eligibility quarter, then in the next following coverage quarter you will have Fund coverage. If you don't have at least 300 hours of contributions for one eligibility quarter, but you do have at least 550 hours for two consecutive eligibility quarters, that will also satisfy the coverage requirement. In that case, you will be covered in the coverage quarter which follows the second of the two consecutive eligibility quarters. The following chart shows how the Regular Eligibility Rule works:

<u>300 hours during eligibility quarter</u>	<u>or 550 hours during two eligibility quarters</u>	<u>to be covered during coverage quarter</u>
Jan. 1 to March 31	Oct. 1 to March 31	June 1 to Aug. 31
April 1 to June 30	Jan. 1 to June 30	Sept. 1 to Nov. 30
July 1 to Sept. 30	April 1 to Sept. 30	Dec. 1 to Feb. 28
Oct. 1 to Dec. 31	July 1 to Dec. 31	March 1 to May 31

A winter rule can help you if you don't have enough hours of contributions for the winter (January-March) eligibility quarter to be covered during the June-August coverage quarter. You can still be covered during the June-August coverage quarter if you have 1,200 or more hours for the past calendar year (January 1-December 31), including 400 hours for the past July-September eligibility quarter and 100 hours for the past October-December eligibility quarter.

Special Initial Eligibility Rule

The Special Initial Eligibility Rule helps you get Fund coverage for the first time more quickly.

- If at least 130 hours are contributed by your employer for your work in a calendar month, you will have Fund coverage during the second following calendar month.
- If at least 230 hours are contributed by your employer for your work in two consecutive calendar months, you will have Fund coverage during the second and third following calendar months.

You can only use the Special Initial Eligibility Rule until the first time you become covered under the Regular Eligibility Rule. Once you become covered under the Regular Eligibility Rule, you cannot use the Special Initial Eligibility Rule again.

Other Coverage Provisions

If your employer makes monthly contributions for your work rather than paying on an hourly basis, different Fund coverage rules may apply. Generally, if you or your employer makes monthly contributions, your Fund coverage will stop at the end of the month in which your employment ends.

Non-collectively bargained employees are subject to special coverage rules. Check with the Fund Office if you work as a non-collectively bargained office/clerical, administrative, supervisory, or union office employee.

If you die after you become covered, your dependents can continue their Fund coverage by making self-payments for COBRA Coverage as explained below. If COBRA Coverage is elected, your dependents will not have to pay for it for the first 12 months following your death.

The NPL Plan document contains the complete eligibility rules of the Fund. If you have any questions, please contact the Fund Office.

CONTINUED COVERAGE VIA COBRA SELF-PAYMENT

The Fund's self-payment rules comply with a federal law called "COBRA". The COBRA self-payment rules are summarized as follows.

CATEGORY I – Active Employees

If you lose Fund coverage because you don't work enough hours or because you terminate employment with an employer that makes monthly contributions, the Fund Office will notify you of your right to make self-payments to continue Fund coverage – we call this "COBRA Coverage". You cannot make self-payments to have COBRA Coverage if you lost your job due to "gross misconduct".

Dependent spouses and children can also make self-payments to have COBRA Coverage if they lose Fund coverage because of your death, a divorce or legal separation, or because your child no longer qualifies as a dependent. **In order for dependents to be able to make self-payments for COBRA Coverage after a divorce, legal separation, or no longer qualifying as a dependent, you or the dependent must notify the Fund Office in writing within 60 days after the event.** After receiving that notice, the Fund Office will then notify affected persons of their COBRA Coverage self-payment rights. **If notice of these events is not given to the Fund Office in writing within 60 days after the event occurs, then COBRA Coverage is not available.**

Dependent children include children born to you, adopted by you, or placed with you for adoption while you have COBRA Coverage. For such a child to have COBRA Coverage, you must notify the Fund Office in writing within 30 days after the event. If notice is given on time, the newborn or adopted child will have COBRA Coverage starting as of the date of the birth, adoption, or placement for adoption.

The self-payment rates for COBRA Coverage are determined by the Fund's actuary and updated periodically. Call the Fund Office for the current COBRA rates. If you worked some hours, but not enough to get Fund coverage, the employer contributions for your work are used to reduce the amount of the COBRA self-payment that you must make to have COBRA Coverage. (The minimum self-payment is \$25.00 per month.) If a dependent makes a separate election of COBRA Coverage, he or she gets no credit for employer contributions for your work.

COBRA Coverage includes all the regular benefits provided by the Fund, including life insurance, but does not include Disability or AD&D Benefits.

Length of COBRA Coverage

Following are the maximum time periods for which you or a dependent can normally have COBRA Coverage. The right to COBRA Coverage may end sooner as explained below under "End of COBRA Coverage".

(1) If you lose Fund coverage because you don't have enough hours of employer contributions, or because you terminate employment with an employer that makes monthly contributions, you and your dependents may generally have COBRA Coverage for 18 months after Fund coverage is lost. You and your dependents can have COBRA Coverage for up to 24 months if you don't have enough hours or you terminate employment because you are called up for military duty that is covered by the Uniformed Services Employment and Reemployment Rights Act ("USERRA").

(2) If you lose Fund coverage because you retire after reaching age 60, and you have been covered by the Fund for at least 18 out of the 20 coverage quarters before you lost Fund coverage, then you can have COBRA Coverage until you reach age 65.

(3) (a) If you lose Fund coverage after retiring under the "60 and 30" normal retirement or the "55 and 25" unreduced early retirement rules of the Laborers' District Council Pension Plan (or under a comparable provision of another pension plan sponsored by your employer) and you have been covered by the Fund for at least 36 out of the 40 coverage quarters before you lost Fund coverage, then you can have COBRA Coverage until you reach age 65.

(b) If you meet the requirements of part (a) and you are married and on COBRA Coverage when you reach age 65, your spouse can have COBRA Coverage until the earlier of (i) the 10th anniversary of when you began COBRA Coverage or (ii) when your spouse reaches age 65.

(c) If you meet the requirements of part (a) and you are married and on COBRA Coverage and you die or become entitled to Medicare due to disability before you reach age 65, your spouse can have COBRA Coverage until the earlier of (i) the 10th anniversary of when you began COBRA Coverage or (ii) when your spouse reaches age 65. This extended COBRA Coverage for your spouse also applies if you die before retiring, but you would have met the requirements of part (a) if you had retired before your death.

(4) If you elect COBRA Coverage and you or any of your covered dependents are disabled for Social Security purposes at any time during the first 60 days of COBRA Coverage, you may be allowed to have COBRA Coverage for up to 29 months (instead of 18 months) from the date you lost Fund coverage. **To be eligible for the extension to 29 months, you or any of your covered dependents must notify the Fund Office in writing within 60 days after Social Security issues its determination of disability and before the regular 18 months of COBRA Coverage is over.** The Fund Office will then tell you if the extension to 29 months applies. **There can be no extension unless notice of the Social Security disability determination is given to the Fund Office in writing within 60 days after the determination is issued and before the regular 18 months of COBRA Coverage is over.**

(5) If you die while on Fund coverage, your dependents can have COBRA Coverage for up to 36 months after your death, and the first 12 months of COBRA Coverage are free. If you die while on COBRA Coverage, your dependents can have COBRA Coverage for up to 36 months after when your COBRA Coverage began, but they will have to pay the normal COBRA rate for all months. (Note the special rules in paragraph (3)(c) above that might let your spouse have even longer COBRA Coverage.)

(6) If you and your spouse get divorced or legally separated, or if your child no longer qualifies as a dependent, your ex-spouse or dependent child can have COBRA Coverage for up to 36 months.

Special COBRA Coverage for Certain Retirees

If you meet the requirements of either paragraph (2) or (3) above, and you have health insurance coverage available through your spouse's employer, you can defer your election of COBRA Coverage. When your spouse's health insurance ends, you may elect COBRA Coverage from the Fund and may continue it until age 65 as described in paragraphs (2) and (3) above. You must both: (a) maintain your coverage under your spouse's health insurance continuously from when your Fund coverage ends until you elect to start COBRA Coverage, and (b) elect COBRA Coverage within 30 days after your spouse's health insurance coverage ends. Unless you meet both of these requirements, you will not be allowed to elect deferred COBRA Coverage from the Fund.

NOTE: If you defer COBRA Coverage from the Fund, you will have to self-pay to keep your life insurance benefits in effect during the period you are covered under your spouse's coverage. If you later elect COBRA Coverage from the Fund, your life insurance benefits will be provided as part of your regular COBRA Coverage until you reach age 65.

End Of COBRA Coverage

In all cases, you and/or your dependents' COBRA Coverage will end sooner than the times set forth above if any of the following things happen:

- (1) You and/or your dependents do not elect COBRA Coverage and make your first COBRA self-payment by the deadline set forth in the COBRA materials sent by the Fund Office.
- (2) You and/or your dependents fail to make any subsequent COBRA self-payment by the last day of the month for which the self-payment is due.
- (3) You and/or your dependents do not comply with the other requirements for self-payments which are explained in the COBRA materials sent by the Fund Office.
- (4) After COBRA Coverage is elected, you and/or your dependents become covered under another group health plan .
- (5) After COBRA Coverage is elected, you and/or your dependents become entitled to Medicare. Note – you become *eligible* for Medicare when you turn age 65. You do not become *entitled* to Medicare until you turn age 65 and actually apply for Social Security or Medicare. If (i) you become entitled to Medicare before age 65 due to disability, and (ii) your spouse continues COBRA coverage as described in paragraph (3)(c) above under **Length of COBRA Coverage**, then (iii) your COBRA coverage will continue until you reach age 65, but only on a secondary basis to the benefits provided by Medicare.

CATEGORY II -- Retired Employee Entitled to Medicare With Spouse Not Entitled to Medicare.

If you lose your COBRA Coverage because you become entitled to Medicare (and you are not covered by the special Medicare disability rules described in paragraph (5) under **End of COBRA Coverage** above), and your spouse is not entitled to Medicare, your spouse can have COBRA Coverage by making their own COBRA self-payments. Your spouse can have COBRA Coverage for up to 18 months after your COBRA Coverage began. (Note – if you are described in paragraph (3)(b) under **Length of COBRA Coverage** above, your spouse may be able to have COBRA Coverage for more than 18 months.) However, if any of the events described above under **End of COBRA Coverage** occurs for your spouse , then they will lose their COBRA Coverage.

If your spouse continues COBRA Coverage under this Category II, that will also continue your life insurance benefit. Except for the life insurance benefit, COBRA Coverage for your spouse under this Category II will not provide you with any other benefits.

CATEGORY III – Life Insurance if Retired Employee and Spouse Are Both Entitled to Medicare.

If both you and your spouse lose your COBRA Coverage because both of you become entitled to Medicare, you can make life insurance self-payments to continue your life insurance coverage. Except for the Retiree Benefits and your right to continue life insurance coverage, the Fund does not provide any benefits to any retiree entitled to Medicare.

The life insurance self-payment rate is \$45.00 per month for \$15,000 of life insurance coverage. However, if you are eligible for Retiree Benefits as described later in this Booklet, the first \$10,000 of life insurance coverage is free. If eligible for Retiree Benefits, you would only have to pay \$15.00 per month to increase your life insurance benefit from \$10,000 to \$15,000. Either way, once you have made life insurance self-payments for 20 years, your life insurance is fully paid up and you no longer have to make any more life insurance self-payments.

This Booklet only contains a summary of the COBRA Coverage rules. You will be supplied more detailed information about COBRA Coverage when you lose Fund coverage, provided you give written notice to the Fund Office when required to do so as explained above. Call the Fund Office if you have any questions regarding COBRA Coverage. More information about COBRA is set forth at the end of this Booklet in the **“Important Notice About Your Continuation Coverage Rights Under COBRA.”**

Coverage While Disabled

If you become totally disabled for at least six weeks in an eligibility quarter, for purposes of the Regular Eligibility Rule you may be credited with up to 300 hours worked for that quarter. To receive that credit, you must have worked at least 1,000 hours in the four eligibility quarters before you became disabled and you must have been covered for benefits at the time you became disabled. If you remain disabled after that first eligibility quarter, you may be granted a second quarter of coverage. If you are still disabled after the second eligibility quarter, you can apply for two additional quarters of coverage by submitting a written request for continued coverage to the Fund Office.

To qualify for this coverage while disabled, you must send the Fund Office satisfactory proof that you cannot work because of the disability. This proof can be a letter from your doctor. If you are receiving Workers Compensation benefits, this proof must be a letter from the Workers Compensation carrier stating that you are receiving total disability benefits.

RECIPROCITY

If you work outside the jurisdiction of the Construction Workers’ Trust Fund and you want the health insurance contributions made by your employer in the area where you are working to come back to the CWTF, you should contact the Fund Office and ask whether the CWTF has a reciprocal agreement with the fund in the area where you are working. If there is a reciprocal agreement, you can sign an authorization form instructing the fund where you are working to transfer your health insurance contributions back to the CWTF.

In order to have your contributions transferred, you must sign the reciprocity authorization form and file it with the fund where you are working. You must file a separate reciprocity authorization form for each outside fund in which you work.

Until the reciprocity authorization form is filed with the fund office of the outside fund, the employer contributions for your work in the outside fund’s jurisdiction will not be transferred back to the CWTF.

Some employers have a special arrangement with outside funds whereby the employer contributions for your work are made directly back to the CWTF, without you having to file a reciprocity authorization form. If you work outside the CWTF's jurisdiction, you must check with your employer to see if it has a special arrangement with the outside fund or not.

If you have any questions regarding reciprocity arrangements, you should contact the CWTF Fund Office.

DEPENDENT COVERAGE FOR YOUR FAMILY MEMBERS

In General

When you meet the requirements for your own Fund coverage, your eligible dependent spouse and children will also be covered for most benefits. In general, the dependents who are covered are your legally married spouse and your children (natural or legally adopted) who are under age 26.

Exclusions

Your spouse is not covered for benefits if you are divorced, legally separated, have signed a separation agreement, or have abandoned your spouse. Your spouse is also not covered if you have not lived together for 12 months and during that time you were living with someone else.

Only eligible spouses and your children can be covered. Grandchildren, nieces, nephews, etc. cannot be covered unless you legally adopt them as your own children.

Special dependent children rules

Stepchildren

Stepchildren (natural or adopted children of your legally married spouse, but who are not your natural or adopted children) are only covered if they live with you and you are financially responsible for them.

Newborn babies

Before any claims on the newborn baby will be paid, you must provide proof of birth and update your benefit enrollment form for the baby. To continue coverage of the baby for longer than 90 days following birth, you must submit a birth certificate.

Special rule for disabled children over age 25

Normally, your children lose coverage at their 26th birthday. However, your child over age 25 can be covered if he or she lives with you and has a mental or physical disability which prevents your child from working. The disability must have started before your child's 26th birthday. You must submit proof of the disability satisfactory to the Administrator.

Adopted children

Once a legal adoption is finalized, your adopted child will be covered under the same rules that apply to natural children. A child placed in your custody under a court order pending adoption can also be covered before the adoption is finalized if you have a legal obligation for support of the child in anticipation of adoption of the child.

“Common law” spouse

If you prove that you have been living with someone of the **opposite sex** as husband and wife and have been telling the public that you are husband and wife for one year or more and that person has been listed as your spouse on your enrollment form on file at the Fund Office for at least six full months, then he or she will be covered as your “common law” dependent spouse. Only one person at a time can be covered as your dependent spouse.

Changing your enrollment form

If you remove a dependent spouse or child’s name from your enrollment form on file at the Fund Office, that spouse or child will immediately lose coverage for benefits. To get such that spouse or child covered again, **you must put their name back on your enrollment form and after doing so you must wait for six months before they are covered again.**

REMEMBER: YOU MUST HAVE A CURRENT ENROLLMENT FORM ON FILE IN THE FUND OFFICE LISTING ALL YOUR DEPENDENTS AND YOUR LIFE INSURANCE BENEFICIARY.

Qualified Medical Child Support Orders

If you get divorced or separated or you have fathered a child out of wedlock, a court may issue a Qualified Medical Child Support Order (“QMCSO”) that requires the Fund to provide coverage for a child of yours who does not otherwise meet the requirements for dependent coverage. If the Fund receives a QMCSO that requires coverage for a child of yours, you will receive special information about what you must do. The Fund has procedures which govern the processing of QMCSOs.

LIFE INSURANCE (Employees Only)

The Fund provides a \$15,000 Life Insurance benefit for covered employees in case of death from any cause.

Refer to the rules explained earlier in this Booklet for how to maintain your Life Insurance benefit while you are on COBRA Coverage and after COBRA Coverage ends.

ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE (Employees Only)

In addition to your Life Insurance benefit, the Fund provides an additional \$15,000 of Accidental Death and Dismemberment (AD&D) benefits, if you die within 90 days after, and as a direct result of, a non-job related accident. Your beneficiary will receive the AD&D benefits.

If you lose a limb or your sight within 90 days after, and as a direct result of, a non-job related accident, AD&D benefits will be paid to you. You will receive the full \$15,000 of AD&D benefits if you lose either:

- two hands or feet
- sight of two eyes
- one hand and one foot
- one limb (hand or foot) and sight of one eye

You will receive \$7,500 of AD&D benefits if you only lose one hand or one foot or the sight of one eye.

AD&D benefits will not be paid if your loss or death results from any of the causes listed under **General Exclusions**.

When Life and AD&D Insurance Benefits Are Paid

The beneficiary named on your enrollment form will receive your Life Insurance and AD&D benefits after proof of your death is received by the Fund Office. Your beneficiary must apply for Life Insurance and AD&D benefits within one year after your death or benefits will not be paid.

Your beneficiary is the person you name on your enrollment form to get your benefits when you die. You may name anyone you want to be your beneficiary, but you must have his or her name on your enrollment form on file in the Fund Office. If you don't have a validly named beneficiary, your benefits will be paid to the first living person (or persons) on this list: (1) your spouse, (2) your children and (3) your estate. If any beneficiary is under 18, the benefit will be held by the Fund until the beneficiary is 18 or the Fund receives a court order to pay the benefit earlier.

If your spouse dies while you are covered for benefits, you will receive up to \$1,000 for the funeral expenses you can prove you paid.

Life Insurance While Disabled

If you become totally and permanently disabled while covered for Life Insurance, you may be able to continue that coverage directly from the insurance company that underwrites the Fund's Life Insurance benefit. If you become disabled, contact the Fund Office as soon as possible to find out about your rights to continue your Life Insurance. There are time limits for when you have to apply to the insurance company, so do not delay.

DISABILITY BENEFITS (Employees Only)

The Fund pays benefits while you are disabled due to a non-job related accidental injury or illness. Your disability must begin while you have Fund coverage. Disability Benefits start being paid from the first day of disability caused by an accident (provided you are treated by a physician within 72 hours after the accident). Disability Benefits start being paid from the eighth day of disability caused by an illness. However, if you are hospitalized for an illness for at least three days, then Disability Benefits will start being paid from the first day you are hospitalized.

Disability Benefits are \$80 per day while you are hospitalized and \$60 per day while you are not hospitalized. Certain taxes must be withheld from your Benefits. You may receive Disability Benefits for up to 13 weeks during a 12 consecutive month period.

REMEMBER: If you are injured on any job (including while moonlighting), you are not eligible for Disability Benefits from the Fund. Workers Compensation benefits may be available. If you are hurt in a job related accident, it would be fraudulent to make a claim for Disability Benefits from the Fund. See the severe penalties for fraud set forth above.

How To Receive Disability Benefits

Disability Benefits are only paid while you are in the hospital or under the care of a physician who is a licensed M.D., osteopath, or a podiatrist. A dentist or any other kind of health care practitioner cannot certify your disability. Your physician must fill out the correct form to prove that you are totally disabled. Total disability for this purpose means you can't perform the duties of your job for a certain amount of time because of a physical or mental problem. Disability Benefits are payable for mental conditions and alcohol/drug rehabilitation only while you are hospitalized and only for a maximum of 30 days in your lifetime.

Disability Benefits are paid from the date of your first physician visit to your last physician visit, including from your first to last day in the hospital. If you see your physician one time only, Disability Benefits are not payable. You must see your physician at least two times to receive Disability Benefits. In addition, if your physician states on the disability form that you are able to return to work within 14 days after the final visit, Benefits will be paid until the time your physician says you can return to work.

You must visit your physician and submit a completed disability claim form to the Fund Office at least once every 21 days. The disability claim form must be properly filled out and delivered to the Fund Office, or postmarked if mailed, within 14 days after each time you visit your physician. If the disability claim form is for a visit that was more than 21 days from the date for which Disability Benefits were last paid, benefits will be limited to 21 days. However, if your physician states on the disability claim form that your disability is severe enough that it is not medically necessary to see you within the next 21 days to be sure you are still disabled (for example, if you broke your leg), then you don't have to visit your physician for another 42 days.

After you have received Disability Benefits for 13 weeks, you may be eligible for another 13 weeks of Disability Benefits if (1) you must stay in the hospital or (2) your physician fills out the proper forms to say that after 13 weeks, you are totally disabled. For this purpose, totally disabled means you can't perform the duties of your job for at least 12 more months because of your physical condition.

If your disability is due to a non-job related accident for which a third party may be liable (such as a car accident), the Fund will advance Disability Benefits to you, provided you sign a subrogation agreement. The subrogation agreement states that if you recover money from the third party, you will reimburse the Fund for the money it advanced to you for the Disability Benefits.

Disability Benefit Limits

1. You cannot receive Disability Benefits for more than 52 weeks during any six year period.
2. If you are disabled twice from the same condition, with less than two weeks in between, it will count as one single disability with no waiting period for benefit payments.
3. You cannot receive Disability Benefits if you keep working at any job or continue to be paid for any job, if you are eligible for unemployment compensation or Workers Compensation benefits, or if you are receiving Social Security benefits or benefits from any pension fund.
4. Disability Benefits are not paid for illness or injury that results from any of the causes listed under **General Exclusions**.

MEDICAL BENEFITS

Medical Benefits pays for your covered health care expenses as follows:

You must first pay a \$200 annual deductible. After the deductible, **Medical Benefits** pays 80% of your first \$5,000 of covered expenses per calendar year, and 100% of your covered expenses above \$5,000 per calendar year. You pay the other 20% of your first \$5,000 of covered expenses per calendar year, but none of your covered expenses above \$5,000 per calendar year. In other words, after paying the \$200 deductible, you only have to pay a maximum of \$1,000 per year – that is 20% of your first \$5,000 of expenses. This is called an “Out-of-Pocket Maximum”. The Out-of-Pocket Maximum applies separately to you and each member of your family. In no event will the total Out-of-Pocket Maximum paid by all members of your family together exceed \$6,900 per year.

Annual Deductibles. Each covered person must pay the first \$200 in covered health care expenses each calendar year before **Medical Benefits** starts to pay. However, you will not have to pay more than \$600 in deductibles for your whole family in any one year. Also, any amounts you pay towards your annual deductible in October, November and December of a year are also counted towards the next year’s deductible.

If you are a Glazier, the two paragraphs above are read to substitute \$100 for \$200, \$1,500 for \$5,000, \$300 for \$1,000 and \$300 for \$600.

Allowed Benefit. You are responsible for all charges by out-of-Network providers that exceed the Allowed Benefit. Charges above the Allowed Benefit are not taken into account for any purpose under the Plan. For any service or supply, the Allowed Benefit is the lesser of (1) the provider’s actual charge or (2) the amount the Plan would have paid a Network provider for the same service or supply as determined by the Administrator in its discretion. If the Administrator cannot determine the amount that the Plan would have paid a Network provider, then in lieu thereof 150% of the amount that would be allowed by Medicare will be used.

Medical Benefits does not pay for:

- dental care, except for accidental injuries to natural teeth
- prescription drugs
- glasses, contact lenses, hearing aids or exams for their fitting

The above items are covered under the **Optical, Prescription Drug and Dental Benefits** sections described later in this Booklet.

EXAMPLES OF HOW MEDICAL BENEFITS WORKS

EXAMPLE - You are hospitalized five days for surgery.

	<u>Charges Incurred*</u>	<u>Covered Expenses</u>	<u>Not Covered</u>
Room and board for 5 days at \$750 per day	\$ 3,750	\$3,750	\$-0-
Hospital Misc. charges	\$ 4,100	4,100	-0-
Physician's charges	250	200	50
Surgeon's Charges	1,600	1,600	-0-
Outpatient Expenses			
Home health care (4 visits)	200	160	40
X-rays	<u>150</u>	<u>150</u>	-0-
Total Charges	\$10,050		
Total Covered Expenses		\$9,960	
Less Annual Deductible		<u>- 200</u>	
Charges Recognized by Medical Benefits		\$9,760	
(80% of \$5,000 plus 100% of 4,760)		<u>\$8,760</u>	
Difference that you pay		\$1,000	(Out-of-Pocket Maximum)

* "Charges Incurred" assume the charges for each item do not exceed the Allowed Benefit. Charges in excess of the Allowed Benefit are not covered by the Fund.

HOSPITAL BENEFITS

Room and Board

If you or your dependents are hospitalized, the Fund covers the hospital's charges for semi-private room and board under **Medical Benefits**. Charges for intensive care are covered at up to two times the semi-private room rate.

If the patient is transferred to a skilled nursing or rehabilitation facility directly from a hospital stay, the Fund covers the stay at the skilled nursing or rehabilitation facility as if it were a hospital stay.

No more than 60 days of inpatient hospital and skilled nursing or rehabilitation facility charges are covered during any consecutive 365 day period.

Hospital admissions for substance use disorder and mental health treatment are covered under the **Mental Health and Substance Use Disorder Benefit**.

Preauthorization Requirement

Before you or your dependents are admitted to the hospital, be certain that the hospital admission has been preauthorized by the Fund's managed care provider. The hospital should take care of this,

but you are responsible if the hospital does not get preauthorization. **THE FUND DOES NOT COVER HOSPITAL STAYS THAT ARE NOT PREAUTHORIZED.** Hospital stays will not be preauthorized unless it is medically necessary to be treated on an inpatient basis. Contact the Fund Office if you need more information about preauthorization.

Outpatient Treatment

Facility charges of a hospital or surgical center for outpatient treatment are covered under the **Medical Benefits** payment rules.

Miscellaneous Charges

Certain inpatient and outpatient hospital charges, such as anesthesia, emergency department facility charges (if covered as explained below), operating room charges, medications, lab fees and supplies are covered under the **Medical Benefits** payment rules. Certain charges for hospice or nursing home care, non-elective abortion and sterilization are also covered under the **Medical Benefits** payment rules.

The Fund does not cover:

- custodial care (except for hospice care in certain cases of terminal illness)
- special nurses, telephone, TV, charges for completing claim forms, etc.
- treatment related to any of the causes listed under **General Exclusions**

EMERGENCY DEPARTMENT TREATMENT

Facility charges of a hospital emergency department can be covered under **Medical Benefits**. In order for emergency department facility charges to be covered, the patient must have an ***emergency medical condition***, which is a medical condition (including a mental health condition or substance use disorder) that has symptoms of such severity (including severe pain) that a prudent person with average knowledge of health and medicine could reasonably believe that failure to receive immediate medical attention would:

- place the patient's health (including the unborn child of a pregnant woman) in serious jeopardy, or
- result in serious impairment to the patient's bodily functions, or
- result in serious dysfunction of a bodily organ or part.

Facility charges of a hospital emergency department for treatment of a condition that does not qualify as an ***emergency medical condition*** will **not** be covered. Charges of the emergency department physician (M.D., osteopath or podiatrist) for treatment of an ***emergency medical condition*** are covered under the **Physicians Visit Benefits** (see below).

In no event will the Fund pay more than the Recognized Amount for Emergency Services. "Recognized Amount" means the charges for out-of-Network emergency treatment that are recognized by the Fund in accordance with regulations issued under ERISA Section 716.

"Emergency Services" mean:

- treatment to stabilize an ***emergency medical condition***, whether provided in the emergency department or in any other department of a hospital;
- an appropriate medical screening examination within the capability of the emergency department, including ancillary services routinely available in the emergency department, to evaluate whether an ***emergency medical condition*** exists, and
- additional services and supplies furnished in any department of a hospital after the patient is stabilized and as part of outpatient observation, or an inpatient or outpatient stay, in connection with the visit for which the initial services were provided.

You are not legally responsible for out-of-Network Emergency Services charges that exceed the Recognized Amount, and the out-of-Network provider cannot "balance bill" for those charges. The Fund does not cover balance billing for out-of-Network Emergency Services.

SURGICAL BENEFITS

The Fund covers charges for surgery performed by a physician (M.D., osteopath or podiatrist) under the **Medical Benefits** payment rules.

Charges for anesthesia needed for covered surgery are paid under the **Medical Benefits** payment rules. Anesthesia is only covered for dental care when medically necessary for the provision of dental treatment that is covered by the Fund's Dental Benefits.

PHYSICIANS VISIT BENEFITS

Non-surgical physician visit charges are covered under the **Medical Benefits** payment rules.

This benefit covers physician visits in the office, the hospital or the emergency department.

Only visits to licensed physicians (M.D., osteopath or podiatrist) are covered.

Physicians visit benefits are not payable for post-operative surgeon's visits. Charges for those visits are covered by payment of the Surgical Benefit.

MATERNITY BENEFITS

The Fund provides maternity benefits to cover expenses of an employee or dependent spouse for pregnancy, childbirth, medically necessary (non-elective) abortion or miscarriage. Benefits are provided only if the mother is covered on the date of delivery. The Fund does not cover any expenses related to pregnancy, childbirth, abortion or miscarriage for dependent children, except for preventive care services. The Fund does not cover expenses related to artificial insemination, in-vitro fertilization or any other fertility enhancing treatment.

Hospital charges related to pregnancy, childbirth or miscarriage are covered under **Hospital Benefits** described above.

The physician's charges (which include all charges for pre-natal, delivery, and post-natal care) are covered under **Surgical Benefits** described above.

The Fund does not restrict any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a caesarean section. A provider is not required to obtain preauthorization from the Fund or its managed care provider for prescribing a length of stay within these limits. However, this does not prohibit the mother's or newborn's attending physician, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours after a normal delivery or 96 hours after a caesarean section.

Midwife Services

Some expectant mothers deliver their babies at a licensed birthing center, or at home attended by a nurse-midwife. These facilities specialize in child birth in a home-like environment with limited medical attention. A nurse-midwife must be a licensed specialist in non-complicated childbirth. The Fund considers a nurse-midwife to be a physician when the nurse-midwife is practicing within the scope of their license, and will cover the nurse-midwife's charges on the same terms as those charges would be covered if they were provided by a physician.

Doula care is not covered.

Sterilization

Charges for sterilization for male or female employees and spouses are covered as **Preventive Care Services** as described later in this Booklet.

Charges for sterilization for a dependent child are not covered.

Abortions

Charges for **elective** abortions for an employee or dependent spouse are covered under the Medical Benefits payment rules, up to \$50 for the physician and \$100 for the hospital.

For **medically necessary** (non-elective) abortions for an employee or dependent spouse, hospital charges are covered under **Hospital Benefits** and the physician's charges are covered under **Surgical Benefits**.

Charges for any kind of abortion (elective or medically necessary) for a dependent child are not covered.

MENTAL HEALTH AND SUBSTANCE USE DISORDER BENEFITS

Under the Fund's **Mental Health and Substance Use Disorder Benefits (MHSUD)**, you and your eligible dependents are provided a variety of mental health and substance abuse (drug/alcohol) treatment benefits. Mental health and substance use disorder treatment is referred to in this Booklet as "MHSUD Treatment".

The Fund covers expenses for inpatient hospitalization for covered MHSUD Treatment under **Medical Benefits** on the same terms as apply under **Hospital Benefits**. Admission to a licensed residential treatment program is considered to be an inpatient hospitalization. Partial hospitalization days and intensive outpatient care are considered to be outpatient treatment.

While you are hospitalized for MHSUD Treatment the Fund pays a disability benefit of \$80 per day (less taxes) for a maximum of 30 days in your lifetime. Disability benefits are also payable while you are admitted to a residence (whether or not licensed) that provides housing for individuals who have mental or substance use related disorders. No MHSUD disability benefits are provided while you are not hospitalized or admitted, or for your dependents.

The Fund covers expenses for individual or group counseling provided by a psychiatrist, psychologist or licensed psychiatric social worker under **Medical Benefits** on the same terms as apply under **Physician Benefits**.

EQUIPMENT AND APPLIANCES

Medical Benefits covers the rental or purchase of certain equipment and appliances needed because of an injury or illness covered by the Fund. The Administrator determines whether any equipment or appliance is covered on a case by case basis.

This benefit covers orthopedic and prosthetic equipment and appliances. This benefit also covers non-orthopedic and non-prosthetic medical equipment which is needed in order to be discharged from a hospital or skilled nursing/rehabilitation facility or to avoid a hospital or skilled nursing/rehabilitation facility admission.

Orthopedic and prosthetic equipment and appliances are only covered if prescribed by a physician.

Hearing aids and related supplies or exams for their fitting are not covered.

Wheelchair Benefit

Medical Benefits covers up to \$1,000 of the cost of a wheelchair that is recommended by a physician and needed due to an illness or injury that is covered by the Fund.

HOSPICE AND NURSING HOME BENEFITS

Certain charges of a hospice or nursing home are covered if you or a dependent have a terminal illness and need professional care, but do not need to stay in the hospital. The hospice care concept is based on the belief that for certain terminal illnesses, it is better for the patient to be in an

institution with a home like setting or to be at home. The hospice care concept revolves around easing pain and providing counseling to the patient and to family members.

Covered inpatient hospice or nursing home charges are combined with and paid under **Hospital Benefits** as though they were charges of a skilled nursing or rehabilitation facility. No more than 60 days of inpatient hospice or nursing home charges are covered in a consecutive 365 day period, counted together with covered hospital or skilled nursing or rehabilitation facility inpatient days in the same period.

Covered outpatient hospice benefits are paid under the **Home Health Care** benefits described below.

For more information regarding hospice care or nursing home benefits, call the Fund Office.

HOME HEALTH CARE

Medical Benefits also covers **Home Health Care** expenses, up to 100 visits during any 365 consecutive day period, but only for professional home health care visits that are necessary to avoid or shorten an inpatient hospital or skilled nursing/rehabilitation facility stay and that are rendered according to a treatment plan written by a physician and agency personnel. This benefit also covers home hospice care in the case of a terminal illness. Equipment, supplies and injectable drugs used in providing the home health care are also covered if they are necessary to avoid or shorten hospital or skilled nursing/rehabilitation facility stays. For more information concerning Home Health Care benefits contact the Fund Office.

OTHER FUND BENEFITS

The Fund also covers the following items:

Diagnostic Tests and Lab Fees

Medical Benefits covers charges for X-rays, diagnostic lab tests and their interpretations and other similar services.

Preventive Care Services

Medical Benefits covers charges for the following Preventive Care Services:

- Evidence based services that have in effect a rating of A or B in the current recommendation of the United States Preventive Services Task Force for the individual involved.
- Immunizations for routine use in children, adolescents and adults that have in effect recommendations from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention for the individual involved.

- For infants, children, and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration.
- Evidence-informed preventive care and screenings for women provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

Preventive Care Services are provided without application of deductibles and coinsurance. For more information on Preventive Care Services, contact the Fund Office.

Ambulance Transportation

Medical Benefits covers charges for medically necessary ambulance transportation needed:

- for treatment of an ***emergency medical condition*** as defined under **Emergency Department Treatment** earlier in this Booklet;
- to transport a patient from a hospital to a skilled nursing or rehabilitation facility for which charges are covered by the Fund, or
- as preauthorized by the Fund's managed care provider.

Air ambulance is only covered if it is medically necessary to be transported by air and not by ground. It is not medically necessary to be transported by air if a facility that can provide the necessary medical care can be safely accessed by ground transportation. Except for an ***emergency medical condition***, air ambulance transportation must be preauthorized by the Fund's managed care provider or it is not covered.

Except for ambulance transportation that is covered as described above, charges for any other transportation are not covered.

In no event will the Plan pay more than the Allowed Benefit for ground ambulance transportation, or more than the Qualifying Payment Amount for air ambulance transportation. "Qualifying Payment Amount" means the charges for out-of-Network air ambulance transportation that are recognized by the Fund in accordance with regulations issued under ERISA Section 717.

You are not legally responsible for out-of-Network air ambulance transportation charges that exceed the Qualifying Payment Amount, and the out-of-Network provider cannot "balance bill" for those charges. The Plan does not cover balance billing for out-of-Network air ambulance transportation charges.

Physical Therapy

Medical Benefits covers inpatient physical therapy while confined to a hospital because of an injury or illness for which **Hospital Benefits** are payable.

Medical Benefits covers outpatient physical therapy recommended by a physician and performed by a licensed therapist, up to 40 visits during any calendar year. Non-surgical casting intended to

avoid an otherwise necessary surgery is covered up to 50% of the Allowed Benefit for the avoided surgical procedure.

Medical Benefits covers chiropractic treatment by a licensed chiropractor on the same terms and limits as outpatient physical therapy, except there is no requirement that the chiropractic treatment be recommended by a physician.

Acupuncture

Medical Benefits covers acupuncture treatment recommended by a physician and performed by a licensed acupuncturist, up to six months per course of treatment and a maximum payment of \$700 per course of treatment.

Mastectomies

Medical Benefits covers charges for persons electing breast reconstruction in connection with a mastectomy. These include:

- Reconstruction of the breast on which the mastectomy was performed,
- Surgery and reconstruction of the other breast to provide a symmetrical appearance, and
- Prostheses and physical complications for all stages of a mastectomy, including lymphedemas (swelling associated with the removal of lymph nodes).

The manner of coverage is determined in consultation with the attending physician and patient. Normal deductibles and coinsurance will apply.

Asbestosis

The Fund will pay up to \$90 for initial asbestosis screening tests for employees with at least 15 years of employment covered by the Fund, provided the employee signs a subrogation form agreeing to reimburse the Fund if the employee recovers under Workers Compensation or from a third party for the condition. This benefit is payable only once each five years. The Fund will not pay for further tests or for treatment related to asbestosis if the condition was either occupationally caused or the responsibility of a third party.

Organ Transplants

All transplants must be preauthorized by the managed care provider. The transplant must be performed at a facility in the State of Maryland, unless it is demonstrated in advance to the satisfaction of the managed care provider that it is medically necessary for the transplant to be performed at a facility outside of the State of Maryland. If the transplant is performed at a facility outside the State of Maryland, charges for the transplant, together with all other charges covered by the Fund related to the condition or illness which necessitated the transplant, in excess of \$100,000 are not covered. If the cost of a transplant exceeds that limit, you are responsible for the difference.

The Fund covers non-experimental transplants only of the human heart, kidney, lung, heart/lung, bone marrow, liver, pancreas and cornea. Transplants that are experimental are not covered. Coverage is contingent upon continuing to meet the criteria for the managed care provider's transplant approval until the date of the transplant.

The following transplant services are not covered by the Fund:

- The transplant of an organ which is synthetic, artificial, or obtained from other than a human body.
- Expenses of an organ donor, except when the recipient is covered by the Fund and receives the organ in a covered organ transplant. When coordinating with the donor's health plan, the Fund will be secondary. If an organ is sold (i.e., not donated), the donor's expenses are not covered.
- Transplants performed outside of the United States.

If you or a member of your family may need an organ transplant, contact the Fund Office as soon as possible to discuss the benefits the Fund provides for the transplant.

RETIREE BENEFITS (Employees Only)

If you retire after reaching age 60, or under the "55 and 25" rule of the Laborers' District Council Pension Plan, you are covered for Retiree Benefits if you:

- were covered by the Construction Workers' Trust Fund during at least part of each of the 10 years before your retirement, and
- are not eligible for benefits from another group health plan

Only you can be covered for Retiree Benefits (not your spouse or dependent children).

Retiree Benefits are as follows:

- a life insurance benefit of \$10,000.
- if you are entitled to Medicare benefits, the Fund will reimburse you for the initial Medicare Part A deductible and Part B premiums and deductible you pay each year. You must obtain Part B coverage in order to be reimbursed for the Part B premiums and deductible. The maximum annual reimbursement per retiree of Part A deductible and Part B premiums and deductible combined will not exceed \$1,000. You must apply for reimbursement within 12 months after the end of the year in which you paid the deductibles or premiums in order to be reimbursed.

Before you reach age 65, you may be able to continue your health and life insurance coverage from the Fund under COBRA Coverage as explained earlier in this Booklet. Once you reach age 65, you

may be able to buy an additional \$5,000 of life insurance coverage (on top of the \$10,000 retiree life insurance benefit) by making the Category III life insurance self-payments described under COBRA Coverage.

Retiree Benefits are provided on a year to year basis only. The Trustees of the Fund reserve the right to change or cancel future Retiree Benefits at the end of any year. You will be notified of any change or cancellation of benefits.

If your pre-retirement coverage by the Fund was as a non-collectively bargained office/clerical, administrative or supervisory employee, and if your employer stops contributing for coverage for its non-collectively bargained active employees, then your Retiree Benefits will end as well.

If your pre-retirement coverage by the Fund was by your employer making monthly contributions (instead of hourly contributions), and if your employer stops contributing on its active employees, then your Retiree Benefits will end as well.

OPTICAL BENEFITS

The Fund covers up to \$150 per person per calendar year for eye examinations, glasses or contact lenses as set forth below. You may use the eye care provider of your choice, or ask the Fund Office for information on eye care providers who offer special discounts to persons covered by the Fund. You must use the Fund's claim form, which you can get from the Fund Office, in order to receive benefit payments.

Eye exam	\$ 30
Single vision glasses	\$ 75
Bifocals, trifocals, contact lenses	\$120

The Fund will also pay up to \$500 per eye per lifetime for laser vision correction surgery.

Charges exceeding the above eye care benefits are not covered under **Medical Benefits**.

PRESCRIPTION DRUG BENEFITS

Copays and coinsurance

Your prescription drug benefits under the Fund are administered by the pharmacy benefit manager, currently CVS Caremark. You will receive a prescription drug card to use while you are covered by the Fund. Present the card to a participating pharmacy along with your prescription. You pay only a \$10 copay for each prescription or refill of a generic drug (up to 34 day supply). You pay a \$25 copay for each prescription or refill of a preferred brand name drug (up to 34 day supply). You pay a \$50 copay for each prescription or refill of a non-preferred brand name drug (up to 34 day supply). The Fund pays the rest. Special rules apply to prescriptions for maintenance drugs, as explained below.

You pay 30% “coinsurance” of the charge for each prescription or refill of specialty medications on the PrudentRx Program Drug List. These are high cost drugs prescribed to treat complex medical conditions, and are usually (but not always) administered by injection or infusion. However, the 30% coinsurance is waived – and you pay no coinsurance – if you obtain the specialty medication through the PrudentRx Solution Program described below.

Annual Out of Pocket limit

The sum of all copays and coinsurance paid by you and all of your covered family members combined will not exceed an “out of pocket” limit of \$10,500 per calendar year (limit subject to increase for inflation). If you do not obtain a specialty medication on the PrudentRx Program Drug List through the PrudentRx Solution Program, and therefore you must pay 30% coinsurance, that coinsurance does not count against the out of pocket limit unless the specialty medication qualifies as an "essential health benefit" under the Affordable Care Act.

Preauthorization, Specialty Medications and Injectable Drugs

The Fund does not cover certain brand name drugs, and does not cover any specialty medications and injectable drugs, unless preauthorized by the Fund’s pharmacy benefit manager, currently CVS Caremark. To find out if preauthorization is required for any medication or drug, and to request preauthorization, your physician should call CVS Caremark at 800-552-8159.

You must use the CVS Caremark Specialty Pharmacy to fill your specialty medication prescriptions. Specialty medications filled through other pharmacies will not be covered.

If CVS Caremark denies your request for preauthorization for any medication or drug, you can make a first level appeal to CVS Caremark in accordance with the directions included on the denial letter. If CVS Caremark denies your first level appeal, you may appeal to the Fund’s Board of Trustees in accordance with the appeal rules for pre-service claims set forth below in this Booklet.

Maintenance Drugs

A prescription or refill is normally only covered for up to a 34-day supply, and you must pay a separate copay for each prescription or refill. If a prescription or refill is for greater than a 34-day supply (only covered for maintenance drugs), then a separate copay must be paid for each additional 34-day supply.

Through CVS Caremark’s Maintenance Choice Program, only two copays must be paid for each 90 day supply, regardless of whether the drugs are obtained from a retail pharmacy or by mail.

After you start taking a maintenance drug, you will be required to obtain the drug through the Maintenance Choice Program. You may fill your first and second 34-day prescriptions at a retail pharmacy, but thereafter your prescription will not be covered unless it is obtained through the Maintenance Choice Program. Under Maintenance Choice, you can fill your prescription at a CVS pharmacy or through the CVS Caremark mail order program.

Exclusions

Prescription Drug Benefits do not cover:

- over-the-counter drugs
- blood or blood plasma
- drugs obtained or administered in a hospital or other facility, whether part of inpatient or outpatient treatment
- medical devices (other than lancets, syringes, test strips or other supplies or devices prescribed for the treatment of diabetes)
- medications and drugs that require preauthorization, unless preauthorized by the Fund's pharmacy benefit manager
- cosmetic prescriptions, such as drugs for weight loss or hair restoration
- fertility drugs
- anti-smoking drugs
- any drug excluded by resolution of the Trustees

The Fund will cover contraceptive drugs and devices that are required to be covered under federal regulations under **Preventive Care Services**, as described earlier in this Booklet. Otherwise, contraceptive drugs and devices are not covered.

The Fund covers up to six doses per month of drugs for treatment of erectile dysfunction, but only when prescribed for a male employee with demonstrated impotency, and when such drug is otherwise covered under the Fund.

Generic Drug Requirement

Generic drugs are pharmaceutical equivalents of certain brand name drugs. If there is a generic equivalent to a brand name drug, the Fund will only pay for the generic drug. However, the Fund will pay for the brand name drug if your physician requires that you use the brand name drug for a valid medical reason acceptable to the pharmacy benefit manager.

If you purchase a brand name drug and there is a generic equivalent, the Fund will only cover the cost of the generic drug. You must pay the generic drug copay plus the difference in price between the cost of the generic drug and the brand name drug. This rule applies even if the pharmacy says it is out of stock of the generic equivalent.

Step Therapy

Step Therapy is a special program that applies if you are taking certain targeted high cost drugs. Step Therapy moves you along a well planned path, with your doctor approving your drugs each step of the way.

- The first step usually lets you begin treatment with generic drugs (if available) that have the lowest copay.

- If your path requires brand name drugs, then the program usually moves you along to the brand name drugs step which has a higher copay than the generic.
- When you submit a prescription that is not for a first-step drug, your pharmacist should contact your doctor. **Your prescription will not be changed to a first-step drug unless your doctor approves the change first.**
- If you have already tried the first-step drug, or your doctor decides you need a different drug for medical reasons, then your doctor can call CVS Caremark to request authorization to move you to a second-step drug. CVS Caremark will determine if a second-step drug is covered. If it is, then you would be moved to the second-step drug and you would have to pay the higher copay. If the second-step drug cannot be covered, you may have to pay the full price for the drug.

Non-participating pharmacies

Most pharmacies participate with CVS Caremark and will accept your prescription drug card. However, if you need to purchase drugs from a non-participating pharmacy, you must first pay for the prescription yourself. Then fill out a drug reimbursement form which you can get from the Fund Office and send the completed form to the address on the form. If the drug you purchased is covered, you will be reimbursed for the average wholesale price of the prescription, minus the copay.

Medicare Part D

If you are age 65 or over, you are eligible for Medicare coverage, which includes the Medicare prescription drug benefit known as “Medicare Part D”. The Fund’s prescription drug benefit is, on average for all participants, expected to pay as much in benefits as the standard Medicare Part D prescription drug coverage pays. This means the Fund’s prescription drug benefit constitutes “Creditable Coverage” for Medicare purposes, so you can keep your Fund benefit and not pay extra Medicare premiums if you later decide to enroll in Medicare Part D prescription drug coverage.

PrudentRx Solution Program for Specialty Medications

The PrudentRx Solution Program helps you enroll in drug manufacturer copay/coinsurance assistance programs for specialty medications on the Program Drug List. If you enroll in the PrudentRx Solution Program, you pay no coinsurance and no copay for specialty medications on the Program Drug List. The Program Drug List is updated from time to time.

As explained above, specialty medications are not covered at all unless the prescription is filled through the CVS Caremark Specialty Pharmacy.

Copay/coinsurance assistance is a process by which drug manufacturers cover most or all of a patient's copay/coinsurance requirement for certain specialty medications. The PrudentRx Solution Program will help you obtain copay/coinsurance assistance from drug manufacturers for the specialty medication you take.

When you fill a specialty medication prescription through the CVS Caremark Specialty Pharmacy, you will be contacted by PrudentRx, which will help you enroll in any available manufacturer copay/coinsurance assistance programs. **If you do not enroll through the PrudentRx Solution Program, or if you drop out of or do not comply with the Solution Program or manufacturer rules, you must pay 30% coinsurance (instead of a copay) for your specialty medication.**

Copay/coinsurance assistance from a drug manufacturer does not count toward your calendar year out of pocket limit on copays/coinsurance.

Specialty medications that are not on the PrudentRx Program Drug List are subject to the brand name drug copays explained above.

If you have any questions, PrudentRx can be reached at 800-578-4403.

DENTAL BENEFITS

The Fund covers dental expenses of up to \$1,500 per person per calendar year.

The Fund utilizes a network of participating dentists through CIGNA. Although you do not have to use dentists participating in the CIGNA network, participating dentists charged reduced fees for their services. Therefore, using participating dentists can result in savings for you and the Fund. Participating dentists cannot charge more than their contracted fee with CIGNA. The contracted fee is usually less than the dentist's regular fee. You will usually pay more if you use a non-participating dentist. Charges in excess of the CIGNA contracted fee are not taken into account for any purpose.

The following diagnostic and preventive treatments are covered at 100% of the contracted fee (up to the \$1,500 limit):

- oral exam (two per calendar year)
- cleanings (two per calendar year)
- bitewing X-rays (once per 12 month period)
- full mouth X-rays (once per 36 month period)
- fluoride treatment
- space maintainers (under age 15 only)

The following restorative, surgical and prosthetic treatments are covered at 70% of the contracted fee (up to the \$1,500 limit):

- fillings
- anesthesia
- crowns
- endodontics
- bridges
- dentures

- extractions
- oral surgery
- periodontal services

Dental benefits are NOT payable for charges:

- above the contracted fee
- above \$1,500 per person per calendar year
- for treatment excluded under **General Exclusions** or by any other limitation in this Booklet
- for prosthetic devices and their fitting which were ordered while you were not covered
- for dentures, bridges and crowns delivered more than 60 days after your coverage ends
- for orthodontic treatment (braces and straightening of teeth) or bite correction, except as described below under Orthodontia Care
- for lost or stolen appliances (bridgework and dentures)
- for professional fees to someone who is not a licensed dentist or hygienist
- for replacements of covered dentures or bridgework more than once every five years
- for engraving of dentures or cosmetic work

Orthodontia Care

Your dental care benefits also include coverage of 50% of the cost of orthodontia treatment, up to a lifetime maximum of \$1,000 per person. Benefits paid for orthodontia treatment do not count against the \$1,500 per person per year limit on dental care benefits. Charges for replacement or repair of orthodontic appliances are not covered.

Charges for dental care, including orthodontia, are not covered under **Medical Benefits**.

OTHER PLAN INFORMATION

Experimental Treatment And Medical Necessity

The Fund does not cover any experimental treatments, medical devices or drugs. A treatment, medical device, drug or drug usage is considered experimental if:

- the Trustees or Administrator determine, after considering the opinion of the Fund's medical consultant, any information submitted by the claimant, and any other information they deem appropriate, that it is being studied for safety, efficiency or effectiveness and/or it has not been endorsed for general use within the medical community by government oversight agencies or other appropriate medical specialty societies;
- it is labeled as being for experimental or investigative purposes (or words to that effect);
- the provider describes it in a patient informed consent document or in any other manner as being experimental or investigative in nature (or words to that effect); or
- it cannot be lawfully marketed for the use at issue without approval of the U.S. Food and Drug Administration and it has not been so approved for marketing at the time it is furnished.

Notwithstanding the exclusion of coverage for experimental treatment, but only to the extent necessary to comply with Public Health Service Act Section 2709, coverage is not excluded for, nor are limits or additional conditions imposed on coverage of, routine patient costs for treatment furnished in connection with participation by a qualified individual in an approved clinical trial. The complete rules for this exception are set forth in the legal Plan document, and can be obtained by contacting the Fund Office.

The Fund does not cover any treatments, medical devices, drugs or drug usages that are not medically necessary. A treatment, medical device, drug or drug usage is not medically necessary if the Trustees or Administrator determine, after considering the opinion of the Fund's medical consultant, any information submitted by the claimant, and any other information they deem appropriate, that it is not:

- provided for the diagnosis or direct treatment of an injury or illness;
- appropriate and consistent with the symptoms and diagnosis of the patient's injury or illness;
- provided in accord with generally accepted medical practice on a national basis; and

- the most appropriate supply or level of service which can be provided on a cost effective basis (including but not limited to inpatient versus outpatient treatment and surgical versus non-surgical treatment).

COORDINATION OF BENEFITS

If you or your dependents have any other health plan coverage for any benefit provided by the Fund, all benefit payments will be coordinated with that other coverage. (Coordination does not apply to Life Insurance, AD&D and Disability benefits.) Sometimes this Fund will pay first (meaning this Fund pays “primary”) and sometimes the other coverage will pay first (meaning this Fund pays “secondary”). In any case, the total amount of benefits you receive from all sources will not exceed the total of your actual expenses.

Coordination is based on all benefits the other health plan coverage could have paid had you or your dependents properly applied for them and followed all the rules of the other coverage. If you or your dependents fail to properly apply for all the benefits the other coverage could have paid, or fail to follow all the rules of the other coverage, the secondary benefits paid by this Fund will assume you received all the benefits the other coverage could have paid.

This Fund always pays secondary to individual health insurance policies. An employer health plan that covers a spouse as an employee is always primary for the spouse’s claims. Primary responsibility for claims of children who are covered by health plans of both parents will be paid by the plan of the parent whose birthday is earlier in the calendar year.

There are other coordination of benefits rules contained in the Plan document which are too numerous to list here. If you have any questions about the coordination of benefits rules, contact the Fund Office.

SUBROGATION AND REIMBURSEMENT

If you have an injury, illness or other condition that is covered by the Fund's Medical benefits and for which a third party might be liable, then you must comply with these reimbursement and subrogation provisions as a condition of receiving benefits from the Fund. Failure to comply is grounds for denial of the claim, and can require you to repay any benefits previously received and pay for costs incurred by the Fund. Any reference to "you" or "your" in this section refers to both you and any of your dependents who are covered by the Fund, and includes your or your dependent's legal representative, guardian, estate or heirs.

The Fund’s reimbursement and subrogation rights extend to all insurance coverage available to you due to an injury, illness or condition for which the Fund has paid or may pay benefits, including but not limited to liability coverage, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, medical payments coverage, workers compensation coverage, no fault automobile coverage or any first party insurance coverage. The Fund is always secondary to automobile no-fault coverage, personal injury protection coverage, or medical payments coverage.

Any third party contracted by the Fund to enforce these reimbursement and subrogation provisions has the authority and discretion to interpret these provisions and to make any findings of fact necessary to enforce the Fund's rights.

You are obligated to cooperate with the Fund and its agents in order to protect the Fund's reimbursement and subrogation rights. Cooperation means providing the Fund or its agents with any relevant information requested, signing and delivering any documents as the Fund or its agents request, obtaining the written consent of the Fund or its agents before releasing any party from liability, taking actions as the Fund or its agents request to assist the Fund in making a full recovery, and taking no action that may prejudice the Fund's rights. The Fund may withhold payment of any benefits for a claim described in this Section unless you or your attorney first sign a subrogation and reimbursement agreement, which entitles the Fund to recover the amount of benefits paid in connection with the claim.

You or your legal representative must provide written notice to the Fund as soon as practicable, but in no event more than 30 days, after notice is given by or on behalf of you to any party against whom you intend to pursue a claim.

If you enter into litigation or settlement negotiations regarding the obligations of other parties, you must not prejudice the Fund's reimbursement and subrogation rights. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full cost of all benefits provided by the Fund. The Fund has the right to withhold or offset future benefits payments up to the amount of any settlement, judgment, or recovery you obtain, regardless of whether the settlement, judgment or recovery is designated to cover future medical benefits or expenses.

You may not assign any rights you may have to recover medical expenses from any person or entity to your minor child or children without the prior express written consent of the Fund.

You must reimburse the Fund for all attorneys' fees the Fund incurs in successful attempts to recover amounts the Fund is entitled to under this Section, where such fees were incurred by the Fund due to your failure to comply with their obligations under this Section. The Fund has the right to choose the jurisdiction and venue of any dispute involving the Fund's rights under this Section.

Reimbursement.

The Fund's reimbursement rights apply when you receive, or in the future may receive, any amounts by settlement, verdict or otherwise, including from an insurance carrier, for an injury, illness or other condition that is covered by the Fund's benefits (a "Recovery"). If you receive a Recovery, the Fund may subtract the amount of the Recovery from the benefits it would otherwise pay for treatment of the injury, illness or other condition. If there is a possible future Recovery, the Fund may delay paying benefits until the Recovery is received, and then subtract the amount of the Recovery.

You must not disburse, or agree to the disbursement of, any portion of a Recovery until the Fund's rights under this Section have been satisfied.

If the Fund has already paid benefits to you or on your behalf for treatment of an injury, illness or other condition, you must reimburse the Fund from any Recovery received for the amount of benefits paid by the Fund. Reimbursement must be made on a first dollar basis regardless of whether you are fully compensated by the Recovery. The Fund does not waive its reimbursement rights where your Recovery is not sufficient to fully compensate for your damages. The Fund's right to reimbursement is not affected or reduced by the "make whole doctrine", the "common fund doctrine" or any other defenses or doctrines.

The Fund is not required to contribute to the fees and costs of your personal injury attorney. The Fund's reimbursement rights apply to all settlements and judgments in your favor, no matter how characterized or designated. The Fund is entitled to reimbursement regardless of whether any liability for payment is admitted, and regardless of whether the settlement or judgment identifies the benefits the Fund provided or purports to allocate any portion of such settlement or judgment to payment of expenses other than medical expenses. The Fund is entitled to recover from any and all settlements or judgments, even those designated as pain and suffering, non-economic damages or general damages only. The Fund's claim will not be reduced due to your own negligence.

In order to secure the Fund's reimbursement rights, you, to the full extent of the Fund's claim for reimbursement: (a) grant the Fund a first priority lien against the proceeds of any Recovery received and against any party who is in possession of funds that may ultimately be used for your Recovery; (b) assign to the Fund any benefits you may have under any insurance policy or other coverage and (c) must hold in constructive trust as a fiduciary for the Fund the proceeds of any Recovery received. Failure to hold such proceeds in trust will be deemed a breach of your fiduciary duties to the Fund. By paying, or being obligated to pay, any claims to you or on your behalf, the Fund automatically has the lien and other rights described in this Section.

Subrogation.

The Fund's subrogation rights apply when another party (including an insurance carrier) is or may be liable for your injury, illness or other condition, and the Fund has already paid, or may in the future pay, benefits for treatment of the injury, illness or other condition.

Subrogation means the right of the Fund to pursue a responsible party for expenses paid, or that may in the future be paid, by the Fund resulting from an accident or injury. The Fund has the right to recover from any source of recovery available to you, and you assign to the Fund any rights of recovery you may have.

The Fund is subrogated to all of your rights against any party (including an insurance carrier) that is or may be liable for your injury, illness or other condition or for paying for treatment of the injury, illness or other condition. The Fund is subrogated to the extent of the amount of the benefits it pays to you or on your behalf. The Fund may assert its subrogation right independently of you, without your consent, and whether or not you decide to pursue a claim.

The Fund is not required to pay you part of any recovery the Fund may obtain, even if the Fund files suit in your name.

The Fund's Rights.

The Fund has the right to conduct an investigation regarding your injury, illness or condition to identify potential sources of recovery. The Fund may notify all parties and their agents of the Fund's lien under this Section. Agents include, but are not limited to, insurance companies and attorneys.

The Fund has the right under federal and state law, including under the HIPAA privacy regulations, to share your personal health information in exercising the Fund's subrogation and reimbursement rights.

The Fund's legal costs in reimbursement and subrogation matters will be borne by the Fund. However, if you take any action to prevent the Fund from enforcing its reimbursement or subrogation rights, you must reimburse the Fund for any legal expenses that the Fund or its agents incur in enforcing the Fund's rights.

The Fund is only responsible for those legal costs to which it agrees in writing, and will not otherwise bear your legal costs. Your legal costs will be borne by you and not by the Fund.

Workers Compensation Recovery.

If the Fund pays benefits related to an incident, and determines you received or may receive workers compensation benefits for the incident, the Fund has the rights of recovery set forth in this Section. The Fund can exercise its rights of recovery against you.

The Fund's recovery rights apply notwithstanding the fact that:

- The workers compensation benefits are in dispute or are made by means of settlement or compromise;
- No final determination is made that bodily injury or illness was sustained in the course of or resulted from your employment;
- The amount of workers compensation benefits due to the medical or health care received is not agreed upon or defined by you or the workers compensation carrier; or
- The medical or health care benefits are specifically excluded from the workers compensation settlement or compromise.

You must notify the Fund of any workers compensation claim you make, and are bound by the Fund's rights of reimbursement and subrogation set forth in this Section.

PROHIBITION ON ASSIGNMENT OF BENEFITS

No benefit payment, or claim of a right to or cause of action for a benefit payment under the Fund, may be transferred or assigned to another person or entity, and no attempted transfer or assignment will be recognized by the Fund. The Fund may make direct payment of benefits to providers in accordance with arrangements between the Fund and the providers. However, such a payment does not make the provider an assignee, does not constitute acceptance by the Fund of an attempt to assign a benefit payment or claim of right to or cause of action for a benefit payment, and in no way confers upon the provider any rights that a participant has under the Fund or ERISA.

CLAIMS AND APPEALS RULES

Following is a summary of the Fund's rules for filing claims and appealing claim denials. The complete Claims and Appeals rules are set forth in the Plan document, and are available free of charge from the Fund Office.

The Fund's claims and appeal rules do not apply unless you have a claim. A "claim" is either (1) a request for coverage of treatment you have already received or (2) a request for preauthorization of coverage for treatment you want to receive. You also have a "claim" if your pharmacy refuses to fill a prescription based on information received from the Fund Office or the Fund's pharmacy benefit manager. A decision by your doctor that you do not need treatment is not a claim covered by the rules. The Fund's managed care provider (currently, American Health Holdings, Inc.), handles all requests for preauthorization of hospital admissions and other treatment requiring preauthorization. The Fund's pharmacy benefits manager (currently, CVS Caremark) handles all requests for preauthorization of prescription drugs and specialty medications.

Urgent Care Claims, Pre-Service Claims and Post-Service Claims

The filing requirements and the claims and appeal rules differ depending on whether you have an "Urgent Care Claim," a "Pre-Service Claim" or a "Post-Service Claim". There are special rules if a preauthorized hospital admission is reduced, or if you want to extend a preauthorized hospital admission. Any treatment that requires preauthorization as described in this Booklet (such as a hospital admission) is a Pre-Service Claim. Some Pre-Service Claims can be Urgent Care Claims. Treatment that doesn't require preauthorization is handled under the Post-Service Claims rules. Claims for disability benefits are also handled under the Post-Service Claims rules.

Treatment is for Urgent Care if following the time limits for deciding Pre-Service Claims:

- could seriously jeopardize the life or health of the patient or the ability of the patient to regain maximum function, or
- in the opinion of the patient's doctor, would subject the patient to severe pain that cannot be adequately managed without the treatment requested.

In general, whether treatment is for Urgent Care is determined by the Fund Office. However, if the patient's doctor determines that the treatment is for Urgent Care, it will be handled as an Urgent Care Claim.

A treatment that does not need to be preauthorized is a "Post-Service Claim".

Filing a Claim

For preauthorization of a hospital admission (either a regular hospital admission or for mental health or substance use disorder treatment), the hospital or facility should contact American Health Holdings **at the number shown on your CWTF member card**. Other Pre-Service Claims should be filed with the Fund Office the same way you file a Post-Service Claim.

To file a Post-Service Claim, you or your provider must submit a claim as explained earlier in this Booklet. If your pharmacy refuses to fill a prescription, call the Fund Office for information about how to pursue getting your prescription filled. To avoid delay in handling your claim, answer all questions completely and accurately.

Reducing or Extending a Preauthorized Hospital Admission

After American Health Holdings preauthorizes a hospital admission, it may in rare cases later determine that the number of days should be reduced. If that happens, American Health Holdings will notify you in advance and give you time to file an appeal before the reduction takes effect. If American Health Holdings preauthorizes a hospital admission, and you or your doctor want more days preauthorized, you or your doctor must request additional days from American Health Holdings.

Authorized Representative

An authorized representative may file a claim or appeal a denial of benefits for you. To name an authorized representative, you must use a Designation of Authorized Representative form which you can get from the Fund Office. You do not need to use a Designation of Authorized Representative form for your doctor to file or appeal an Urgent Care Claim.

Claims and Appeals Rules

If your claim for benefits is denied in whole or in part, you must follow these rules and exhaust your appeal rights before you may file suit in court. Once your claim has been filed and the Fund Office has all of the necessary information, your claim will be processed and you will be notified of the decision.

NOTE: All requests for preauthorization of a hospital admission or a transplant must be made to American Health Holdings, not to the Fund Office. If preauthorization of a hospital admission or a transplant is denied in whole or in part and you or your provider wants to appeal the denial, you must do so in accordance with American Health Holdings Appeals Procedures. If

preauthorization is still denied in whole or in part after you go thru American Health Holdings Appeals Procedures, then you can appeal to the Fund's Trustees as explained below.

The following rules for filing claims with the Fund Office apply **only** to claims **other than** requests for preauthorization of hospital admissions or transplants.

Urgent Care Claims

If an Urgent Care Claim is improperly filed, the Fund Office will notify you within 24 hours. You can request a written copy of an oral notice. Unless additional information is needed, you will be notified of an Urgent Care Claim decision within 72 hours after the claim is properly filed.

Pre-Service Claims

If a Pre-Service Claim is improperly filed, the Fund Office will notify you within five days. You can request a written copy of an oral notice. Unless additional information is needed, you will be notified of a Pre-Service Claim decision within 15 days after the claim is properly filed. If there are matters beyond the Fund Office's control, the time limit may be extended up to 15 more days. If there is an extension, you will be told why and when a decision is expected.

Post-Service Claims

Unless additional information is needed, if a Post-Service Claim for medical benefits is denied, you will be notified within 30 days after the claim is properly filed. For a disability claim, you will be notified within 45 days. If there are matters beyond the Fund Office's control, the time limit may be extended up to 15 more days (up to two 30 day extensions for disability benefits). If there is an extension, you will be told why and when a decision is expected.

If Additional Information is Needed

Pre-Service and Post-Service Claims

If the Fund Office needs more information to decide a Pre-Service or Post Service Claim, you will be told what information is needed and you will have 45 days to supply it. The time limit for the Fund Office to decide your claim is suspended until you supply the requested information. If you do not supply the information within 45 days, your claim will be processed without the additional information and reasonable presumptions may be drawn from your failure to provide the information.

Urgent Care Claims

If the Fund Office needs more information to decide an Urgent Care Claim, you will be told what information is needed and how long you have to supply it (you will have at least 48 hours). The time limit for the Fund Office to decide your Urgent Care Claim is suspended until you supply the requested information.

You will be notified of the Fund Office's decision on your Urgent Care Claim within 72 hours after you supply the requested information (or after the time to supply the requested information expires). If you don't supply the information on time, your claim will be processed without the additional information and reasonable presumptions may be drawn from your failure to provide the information.

If Your Claim is Denied

You will be notified in writing if your claim is denied in whole or in part. The notice will tell you why the claim was denied and the Plan provisions on which the denial is based. It will also describe any additional information that could change the decision and how you can Appeal to the Trustees.

The notice will tell you if an internal rule or guideline was relied on to deny your claim, or if your claim was denied because the treatment is not medically necessary or is experimental. For an Urgent Care Claim, the notice will explain the expedited Appeal process.

If you think the Fund Office made a mistake in denying your claim, or if you are otherwise dissatisfied with a claim decision, you may Appeal to the Trustees. You may also Appeal to the Trustees if after you go thru the American Health Holdings Appeals Procedures you still think American Health Holdings made a mistake.

Your Appeal must be filed within 180 days after you are notified that your claim has been denied. **If you do not file an Appeal within that time limit, you lose all rights to appeal and you cannot sue in court.**

Except for an appeal of a denial of an Urgent Care Claim, your Appeal must be in writing. You may hand deliver it to the Fund Office or send it by mail.

An Appeal of a denial of an Urgent Care Claim may be oral or in writing. You or your doctor should supply all information for an Urgent Care Claim Appeal by hand delivery to the Fund Office, by telephone to 410-844-1406 or by fax to 410-997-3657.

All Appeals will be submitted to the Board of Trustees or to a subcommittee of the Trustees. You may submit written comments and any other information relating to your claim. The Trustees will consider everything you submit. Upon written request, you will be provided with reasonable access to and free copies of all Plan documents, records and other information relevant to your Appeal.

If the denial of your claim involved a medical judgment (such as whether a treatment is experimental or medically necessary), the Trustees will consult with a health care professional with training and experience in the field of medicine involved. If medical or vocational experts were consulted when your claim was denied, they will be identified upon your request.

When Your Appeal Will Be Decided

The time when your Appeal will be decided depends on whether it involves an Urgent Care Claim, a Pre-Service Claim, a Post-Service Claim, or a reduction of, or denial of a request to extend, a preauthorized hospital admission.

- Urgent Care Claim – You will be notified of the decision within 72 hours after your Appeal is filed.
- Pre-Service Claim – You will be notified of the decision within 30 days after your Appeal is filed.
- Post-Service Claim – The Trustees will decide your Appeal at their next regular meeting after your Appeal is filed. If your Appeal is filed less than 30 days before the next regular meeting, the Trustees might not be able to decide your Appeal until the second regular meeting after it is filed. If more time is needed to decide your Appeal, the Trustees can wait until their third regular meeting to decide. If an extension is needed, you will be told why and when a decision is expected. You will be notified of the Trustees' decision on your Appeal within five days after it is decided.
- Reduction of, or request to extend, a preauthorized hospital admission – You will be notified of the decision within 30 days after your Appeal is filed.

You will be sent a written notice of the Trustees' decision. If your Appeal is denied, the notice will tell you why and the specific Plan provisions on which the denial is based. The notice will tell you if an internal rule or guideline was relied on to deny your Appeal, or if your Appeal was denied because the treatment is not medically necessary or is experimental.

If you disagree with the Trustees' decision on your Appeal, you may bring a civil action against the Fund under ERISA Section 502.

The Trustees may not make any decisions regarding hiring, compensation, termination, promotion or other similar matters regarding the retention of any individual based on the likelihood that the individual will support the Trustees' denial.

External Review

The Trustees have implemented an external review program as required under federal law. If you do not agree with the Trustees' decision on your appeal, you may request an external review of the Trustees' decision. The external review will be conducted by an independent review organization ("IRO") retained by the Trustees. If you wish to appeal to an IRO, contact the Fund Office for more information.

PROTECTED HEALTH INFORMATION

The Fund may create or obtain information that relates to your physical or mental health condition, treatment or payment for your health care. When this information is individually

identifiable to you, it is called “Protected Health Information (PHI)”. The Fund may disclose PHI to the Trustees, and the Trustees may use or disclose PHI obtained from the Fund, only for Fund administration purposes, as set forth in the Fund’s Health and Welfare Plan document.

The Fund has a Notice of Privacy Practices which describes how your PHI may be used and disclosed and how you can get access to your PHI. You may request a copy of the Notice from the Fund Office at any time.

The Fund has also implemented safeguards that protect the confidentiality, integrity and availability of PHI which is transmitted or maintained by electronic media.

SPECIAL RULES FOR CERTAIN OUT OF NETWORK PROVIDERS

Special rules apply to coverage of charges for treatment furnished by out-of-Network providers if you receive non-emergency services by an out-of-Network provider during or in connection with a visit to a facility that participates with the Fund's provider Network. For these special rules, "facility" means a hospital (including the outpatient department) or an ambulatory surgical center.

When these special rules apply, charges by the out-of-Network provider are covered under the Fund as though you received treatment from a Network provider. This means:

- Your 20% coinsurance share of the charges will be based on the **recognized amount**, not the amount charged by the out-of-Network provider.
- Except as described below, you are not legally responsible for out-of-Network provider charges that exceed the **recognized amount**, and the out-of-Network provider cannot "balance bill" you for those charges.

Recognized amount means the median in Network rate recognized by the Fund in accordance with regulations issued under ERISA Section 716.

Notice and Consent Exception

Charges for certain non-emergency services furnished by out-of-Network providers during or in connection with a visit to a Network provider facility are exempt from the prohibition on balance billing set forth above, but only if the provider gives you (or your authorized representative) advance written notice that you will be responsible for charges that exceed the **recognized amount**, and you (or your authorized representative) consent to be responsible for the charges.

The following items and services are **not** eligible for the notice and consent exception, and therefore remain subject to the prohibition on balance billing described above:

- ancillary services, meaning items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether provided by a physician or non-physician practitioner;

- items and services provided by assistant surgeons, hospitalists, and intensivists;
- diagnostic services, including radiology and laboratory services;
- items and services provided by an out-of-Network provider if there is no Network provider who can furnish the item or service at the in Network facility;
- items or services furnished as a result of unforeseen, urgent medical needs that arise at the time an item or service is furnished, regardless of whether the out-of-Network provider satisfied the notice and consent requirements.

The notice and consent requirements are regulated by federal law and enforced by the United States Department of Health and Human Services. The Fund is not involved in the notice and consent process. The Fund does not cover balance billing by an out-of-Network provider under any circumstances.

CONTINUITY OF CARE

If you are a continuing care patient (defined below) who is being treated by a Network provider or as an inpatient in a Network facility, and the provider or facility leaves the Network and becomes an out-of-Network provider, the following continuity of care provisions will apply to you. These provisions do not apply if the provider or facility leaves the Network due to failure to meet applicable quality standards or for fraud.

You will be notified that the provider or facility is leaving the Network, and of your right to notify the Administrator that you need continuing transitional care. If you notify the Administrator that you need continuing transitional care, you will be given the opportunity to elect continuing transitional care from the provider or in the facility. If you make the continuing transitional care election, your treatment by that provider or in that facility as a continuing care patient will be covered by the Fund as though the provider or facility had not left the Network. This continuing transitional care will last until 90 days after the notice that the provider or facility is leaving the Network was sent to you, or until you are no longer a continuing care patient of that provider or in that facility, whichever comes first.

A continuing care patient is someone who, in connection with treatment by a Network provider, or while an inpatient in a Network facility, is:

- undergoing a course of treatment for a serious and complex condition
- undergoing a course of institutional or inpatient care
- scheduled to undergo nonelective surgery, including receipt of postoperative care
- pregnant and undergoing a course of treatment for the pregnancy, or
- determined to be terminally ill (meaning a life expectancy of six months or less) and is receiving treatment for such illness

Serious and complex condition means:

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

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

YOUR LEGAL RIGHTS

As a participant covered by the Construction Workers' Trust Fund, you have certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all participants are entitled to:

- Examine, without charge, at the Fund Office all Plan documents, including insurance contracts, collective bargaining agreements and copies of all documents filed by the Fund with the U.S. Department of Labor, such as detailed annual reports and plan descriptions.
- Obtain copies of all Plan documents and other Fund information upon written request to the Fund Office. The Fund may make a reasonable charge for these copies.
- Receive a summary of the Fund's annual financial report. The Fund is required by law to furnish each participant with a copy of this summary annual report.

In addition to creating certain rights for Fund participants, ERISA imposes duties upon the people who are responsible for the operation of the Fund. The people who operate your Fund, called "fiduciaries" of the Fund, have a duty to do so prudently and in the interest of you and other Fund 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 for the purpose of preventing you from obtaining a benefit or exercising your rights under ERISA. If your claim for a benefit is denied in whole or in part you must receive a written explanation of the reason for the denial. You have the right to have the Trustees review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Trustees' decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court. If Fund fiduciaries misuse the Fund 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 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. If you have any questions about your Fund, you should contact the Fund Office. 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, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

THE TRUSTEES HAVE THE DISCRETIONARY AUTHORITY TO DETERMINE ELIGIBILITY FOR BENEFITS AND TO DETERMINE ALL FACTS RELEVANT TO ELIGIBILITY FOR BENEFITS. THE TRUSTEES HAVE THE DISCRETIONARY AUTHORITY TO INTERPRET ANY PROVISION OF THE FUND'S TRUST AGREEMENT, THE HEALTH AND WELFARE PLAN DOCUMENT, THE INSURANCE POLICIES AND THE REGULATIONS ADOPTED BY THE TRUSTEES. THE TRUSTEES MAY CHANGE OR END ANY FUND BENEFIT OR PROVISION, AT ANY TIME, IN THE BEST INTEREST OF THE FUND AND ITS BENEFICIARIES.

THIS SUMMARY PLAN DESCRIPTION BOOKLET IS ONLY A SUMMARY. BENEFITS ARE CONTROLLED BY THE TERMS OF THE FUND'S TRUST AGREEMENT, THE HEALTH AND WELFARE PLAN DOCUMENT, THE INSURANCE POLICIES, AND REGULATIONS ADOPTED BY THE TRUSTEES. IN CASE OF A DIFFERENCE IN WORDING BETWEEN THIS SUMMARY PLAN DESCRIPTION BOOKLET AND SUCH ITEMS, THE TRUST AGREEMENT, PLAN DOCUMENT, INSURANCE POLICIES AND/OR THE REGULATIONS WILL PREVAIL.

IMPORTANT NOTICE ABOUT YOUR CONTINUATION COVERAGE RIGHTS UNDER COBRA

This Notice contains important information about your right to COBRA Coverage, which is a temporary extension of coverage under the Plan. The right to COBRA Coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA may be available to you and to other members of your family who are covered under the Plan when you would otherwise lose your Regular Coverage. This Notice generally explains COBRA Coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it. This Notice gives only a summary of your COBRA Coverage rights. **For more information about your rights and obligations under the Plan and under federal law, refer to the discussion of COBRA Coverage earlier in this Booklet.**

COBRA Coverage

COBRA Coverage is a continuation of Plan coverage when Regular Coverage would otherwise end because of a life event known as a “qualifying event.” Specific qualifying events are described later in this Notice. COBRA Coverage is available to each person who is a “qualified beneficiary.” A qualified beneficiary is someone who will lose Regular Coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses and their dependent children may be qualified beneficiaries. Under the Plan, qualified beneficiaries who elect COBRA Coverage must pay a premium for COBRA Coverage.

If you are an employee, you will become a qualified beneficiary if you will lose your Regular Coverage under the Plan because either one of the following qualifying events happens:

- (1) Your hours of employment for which contributions are received are insufficient to continue your Regular Coverage under the Plan; or
- (2) If your employer makes monthly contributions for your Regular Coverage, your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your Regular Coverage under the Plan because any of the following qualifying events happens:

- (1) Your spouse dies;
- (2) Your spouse’s hours of employment for which contributions are received are insufficient to continue your Regular Coverage under the Plan;
- (3) If your spouse’s employer makes monthly contributions for their Regular Coverage, your spouse’s employment ends for any reason other than their gross misconduct;
- (4) Your spouse becomes enrolled in Medicare (Part A, Part B, or both); or
- (5) You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose Regular Coverage under the Plan because any of the following qualifying events happens:

- (1) The parent-employee dies;

- (2) The parent-employee's hours of employment for which contributions are received are insufficient to continue Regular Coverage under the Plan;
- (3) If the parent-employee's employer makes monthly contributions for their Regular Coverage, the parent-employee's employment ends for any reason other than their gross misconduct;
- (4) The parent-employee becomes enrolled in Medicare (Part A, Part B, or both);
- (5) The parents become divorced or legally separated; or
- (6) The child stops being eligible for Regular Coverage under the Plan as a "dependent child".

The Plan will offer COBRA Coverage to qualified beneficiaries only after the Fund Office has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or insufficient hours of employment, death of the employee, or enrollment of the employee in Medicare (Part A, Part B, or both), you do not have to notify the Fund Office.

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for Regular Coverage as a dependent child), you or a family member must notify the Fund Office in writing within 60 days after the qualifying event occurs. The notice must be sent to: Construction Workers' Trust Fund, 7130 Columbia Gateway Drive, Suite A, Columbia, MD 21044. If the notice is not properly sent within 60 days after the qualifying event occurs, no COBRA Coverage will be available.

Once the Fund Office receives notice that a qualifying event has occurred, COBRA Coverage will be offered to each of the qualified beneficiaries. For each qualified beneficiary who elects COBRA Coverage, the Coverage will begin on the date that Regular Coverage would otherwise have been lost. If COBRA Coverage is not properly elected, Plan coverage for the qualified beneficiaries will permanently end.

COBRA Coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, enrollment of the employee in Medicare (Part A, Part B, or both), your divorce or legal separation or a dependent child losing eligibility as a dependent child, COBRA Coverage can last for up to 36 months. (Note – a qualifying event means a loss of Regular Coverage. If an employee loses COBRA Coverage because of Medicare enrollment, that is not a qualifying event.)

When the qualifying event is the end of employment or insufficient hours of contributions, COBRA Coverage can last for up to 18 months. You and your dependents can have COBRA Coverage for up to 24 months if you don't have enough hours or you end employment because you are called up for military duty that is covered by the Uniformed Services Employment and Reemployment Rights Act (commonly known as "USERRA"). There are two ways in which this 18 (or 24) month period of COBRA Coverage can be extended.

Disability extension

If you or anyone in your family who is covered under the Plan is determined by the Social Security Administration to be disabled at any time during the first 60 days of COBRA Coverage and the Fund Office is notified in a timely fashion, you and your entire family (who were covered under the

Plan) can receive up to an additional 11 months of COBRA Coverage, for a total maximum of 29 months. **In order to receive these 11 additional months of COBRA Coverage, you or a family member must notify the Fund Office in writing of the Social Security Administration's determination within 60 days after the later of the date of the determination or the date Regular Coverage is lost, and before the end of the 18-month period of COBRA Coverage. This notice must be sent to: Construction Workers' Trust Fund, 7130 Columbia Gateway Drive, Suite A, Columbia, MD 21044 .** If the Social Security Administration determines that you or your family member is no longer disabled, then the additional 11 months of COBRA Coverage no longer applies and you must notify the Fund Office in writing within 30 days after receipt of the Social Security determination.

Second qualifying event extension

If your family experiences another qualifying event while receiving COBRA Coverage, your spouse and dependent children can receive additional months of COBRA continuation coverage, up to a maximum of 36 months (measured from when COBRA coverage first began). This extension is available to the spouse and dependent children if the employee dies, gets divorced or legally separated. The extension is also available to a dependent child when that child is no longer eligible under the Plan as a dependent child. **In all of these cases, you or a family member must notify the Fund Office in writing of the second qualifying event within 60 days of the second qualifying event. This notice must be sent to: Construction Workers' Trust Fund, 7130 Columbia Gateway Drive, Suite A, Columbia, MD 21044. If this notice is not given on time, your spouse or children will not receive additional months of COBRA continuation coverage.**

Termination of COBRA

COBRA Coverage will end before the end of the 18, 24, 29 or 36 month periods described above if any of the following happen:

- ◆ A covered individual becomes covered under another group medical plan after COBRA Coverage is elected (unless a pre-existing condition limitation would prevent the individual from receiving benefits from the new plan for a particular illness or injury);
- ◆ A covered individual enrolls in Medicare after COBRA Coverage is elected;
- ◆ The required premium for COBRA Coverage is not received on time;
- ◆ You make a false or fraudulent claim for benefits of the type that would cause someone to lose Regular Coverage; or
- ◆ The CWTF stops providing group medical coverage for all active employees.

If You Have Questions

If you have questions about your COBRA Coverage, you should contact the Fund Office, 410-884-1406, or you may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

Keep Your Plan Informed of Address Changes

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

Instructions for Finding Providers that Belong to Your Network

As explained near the front of this Booklet, there are two different preferred provider Networks for CWTF members. To find a provider that belongs to your Network, use the steps set forth below. You may also call CareFirst at 800-235-5160 for help.

The steps below are in effect when this Booklet is published. CareFirst may update its website from time to time, so the steps to find a provider may change.

As explained near the front of this Booklet, you are covered by the FlexLink Network if the front of your CWTF ID card has a small suitcase in the bottom right corner with “PPO” written in the suitcase. You are covered by the CareFirst Network if “PPO” is not written in a small suitcase on your ID card.

To Find FlexLink Network providers:

- A. Go to www.carefirst.com
- B. Click on “Providers & Facilities” in the black strip at the top of the page
- C. Under “Find A Doctor”, click on “Find a Doctor or Health Care Facility”
- D. Click on the blue “Search Now” box in the middle of the page
- E. Click on the “Continue as Guest” box in the middle of the page
- F. At the top of the page, under “Network” change the option to “BluePreferred” (unless “BluePreferred” already appears)
- G. At the top right of the page, under “City, state or zip” enter the city, state or zip code of the provider or facility you are looking for. Or, click on the arrow to “Use Current Location”.
- H. Type the name of the provider or specialty in the search box with the magnifying glass. Or, click on one of the “Common Searches” to browse by provider type.

To Find CareFirst Network providers:

- A. Go to www.carefirst.com
- B. Click on “Providers & Facilities” in the black strip at the top of the page
- C. Under “Find A Doctor”, click on “Find a Doctor or Health Care Facility”
- D. Click on the blue “Search Now” box in the middle of the page
- E. Do not log in. Instead, click on the “CareFirst – Network Leasing” box at the bottom left of the page
- F. At the top right of the page, under “City, state or zip” enter the city, state or zip code of the provider or facility you are looking for. Or, click on the arrow to “Use Current Location”.
- G. Type the name of the provider or specialty in the search box with the magnifying glass. Or, click on one of the “Common Searches” to browse by provider type.