

Laborers Local No. 754 Welfare Fund

SUMMARY PLAN DESCRIPTION

Effective: May 1, 2024

LABORERS LOCAL NO. 754 WELFARE FUND

BOARD OF TRUSTEES
(Plan Administrator)

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CERTIFIED PUBLIC ACCOUNTANT

MSPC Certified Public Accountants

PLAN CONSULTANT

O'Sullivan Associates

IMPORTANT NOTICE

Nothing in this booklet is meant to interpret or extend or change in any way the provisions expressed in the plan or insurance policies that may be purchased by the Trustees. The Trustees reserve the right to amend, modify, or discontinue all or part of this plan whenever, in their judgment, conditions so warrant. This booklet describes the plan as it exists on May 1, 2024.

CAUTION

This booklet and the Plan Managers are authorized sources of plan information for you. The Trustees of the plan **have not empowered anyone else** to speak for them with regard to the health plan. No Employer, Union Representative, Supervisor or Shop Steward is authorized to interpret your rights under this plan.

COMMUNICATIONS

If you have a question about any aspect of your participation in the plan, you should, for your own permanent record, write to the Plan Managers or Trustees. You will then receive a written reply, which will provide you with a permanent reference.

PLAN CHANGE OR BENEFIT TERMINATION

The Trustees reserve the right to change or discontinue the types and amounts of benefits under the plan and the eligibility rules for extended or accumulated eligibility, even if extended eligibility has already been accumulated.

Benefits provided by the plan:

- are not guaranteed;
- are not intended or considered to be deferred income;
- are not vested upon retirement;
- are contingent upon the right of the Trustees to make modification or terminate such benefits;
- are subject to the rules and regulations adopted by the Trustees; and
- may be modified or discontinued and such modification or termination right is not contingent on financial necessity.

The benefits and eligibility rules applicable to participants and their dependents have been established by the Trustees as part of an overall benefit program for participants. The right to amend or modify the eligibility rules and plan of benefits for participants and dependents is reserved by the Board of Trustees. The continuance of benefits for participants and their dependents and the eligibility rules relating to qualification therefore are subject to modification and revision by the Board of Trustees in accordance with their responsibilities and authority.

In accordance with the rules and regulations of the plan and the Trust Agreement, no employee or participant has a vested interest in the benefits provided for participants and their dependents. In addition to the right to terminate benefits of participants and/or their dependents at any time, in the event of termination of the health plan the Trustees also reserve the right to terminate the program of benefits for participants and there shall not be any vested right by any participant or dependent or beneficiary nor contractual rights after the disposition of all plan assets and the termination of the plan. Participants and their dependents shall have no priority with respect to the disposition of plan assets in connection with the termination of this plan.

The plan gives the Trustees full discretion and authority to make the final decision regarding all areas of plan interpretation and administration including:

1. eligibility for benefits;
2. the level of benefits provided;
3. interpretation of plan language (including this summary plan description); and
4. administrative procedures.

SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this Plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward you or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. If the event was a marriage, the coverage is required to be effective no later than the first day of the first calendar month beginning after the date the completed request for enrollment is received by the Plan. In the case of birth, adoption, or placement for adoption, coverage is required to be effective no later than the date of the event.

To request special enrollment or obtain more information, contact: The Fund Office, LABORERS LOCAL NO. 754 WELFARE FUND, 215 Old Nyack Turnpike, Chestnut Ridge, NY

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ESTABLISHMENT OF THE PLAN

Grandfathered Plan Status

Board of Trustees Laborers Local No. 754 Welfare Fund believes this Plan is a “grandfathered health plan” under the Patient Protection and Affordable Care Act (the “Affordable Care Act”). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when the law was enacted. Being a grandfathered health plan means your Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans; for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act; for example, the elimination of lifetime dollar limits on Essential Health Benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status, can be directed to the Plan Administrator at, 215 Old Nyack Turnpike, Chestnut Ridge, NY 10977 or at (845) 425-0210. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

Purpose of the Plan

The Plan Sponsor has established the Plan for your benefit and for the benefit of your eligible Dependents, on the terms and conditions described herein. The Plan Sponsor’s purpose in establishing the Plan and each Participating Employer’s purpose of adopting the Plan is to help to protect you and your family by offsetting some of the financial problems that may arise from an Injury or Illness. To accomplish this purpose, the Plan Sponsor and each Participating Employer must attempt to control health care costs through effective plan design and the Plan Administrator must abide by the terms of the Plan to allow the Plan Sponsor to allocate the resources available to help those individuals participating in the Plan to manage their healthcare costs.

The Plan is not a contract of employment between you and your Employer or any Participating Employer and does not give you the right to be retained in the service of your Employer.

The purpose of this Plan is to set forth the terms and provisions of the Plan that provide for the payment or reimbursement of all or a portion of certain health care expenses. This Plan is maintained by the Plan Administrator and may be inspected at any time during normal working hours by you or your eligible Dependents.

This Plan is maintained pursuant to one or more collective bargaining agreements. A copy of any applicable collective bargaining agreement, as well as a list of Participating Employers, may be obtained, upon request and free of charge, by contacting the Plan Administrator during normal business hours.

GENERAL OVERVIEW OF THE PLAN

The Plan Administrator has entered into an agreement with Aetna Choice[®] POS II (the “Network”). This Network offers you health care services at discounted rates. Using a Network provider will normally result in a lower cost to the Plan as well as a lower cost to you. This Plan is an Exclusive Provider Organization (EPO). There is no requirement for anyone to seek care from a provider who participates in the Network. The choice of provider is entirely up to you. However, you and your Dependents must seek care within the Network for expenses to be considered by the Plan. Expenses incurred outside the Network will be denied, except as specified below.

Non-Participating Provider Exceptions

Unless otherwise described herein, covered services rendered by a Non-Participating Provider are paid at the Participating Provider level, subject to the Usual and Customary provision of the Plan when a:

- (1) Covered Person has no choice of a Participating Provider.
- (2) Covered Person has a Medical Emergency requiring immediate care.
- (3) Covered Person receives services by a Non-Participating Provider who is under agreement with a Network facility.
- (4) Covered Person receives a COVID-19 vaccine.

NOTE: In the case of a Surprise Bill for covered services from a Non-Participating Provider who is under agreement with a Network facility and the Covered Person had no control of the Non-Participating Providers participation in their care or when a Covered Person seeks Emergency Services for an Emergency Medical Condition from a Non-Participating Provider, the cost share will be based on the median contract rate.

Not all Physicians based in Network Hospitals or medical facilities are Participating Providers. It is important when you enter a Hospital or medical facility that you request that ALL Physician services be performed by Participating Providers. By doing this, you will always receive the greater Participating Provider level of benefits.

A current list of Participating Providers is available, without charge, through the Third Party Administrator at www.meritain.com. If you do not have access to a computer at your home, you may contact your Employer or the Network at the phone number on the Employee identification card to obtain a paper copy of the Participating Providers available.

You have a free choice of any provider and you, together with your provider, are ultimately responsible for determining the appropriate course of medical treatment, regardless of whether the Plan will pay for all or a portion of the cost of such care. Participating Providers are independent contractors; neither the Plan nor the Plan Administrator makes any warranty as to the quality of care that may be rendered by any Participating Provider.

Transitional Care

Certain Covered Expenses may be paid at the applicable Participating Provider benefit level if the Covered Person is currently under a treatment plan by a Physician or other health care provider or facility that was a member of this Plan’s previous Network but who is not a member of this Plan’s current Network. In order to ensure continuity of care for certain medical conditions already under treatment, the Participating Provider benefit level may continue for 180 days for conditions approved as transitional care. Examples of medical conditions appropriate for consideration for transitional care include, but are not limited to:

- (1) Cancer if under active treatment with chemotherapy and/or radiation therapy.
- (2) Organ transplant patients if under active treatment (seeing a Physician on a regular basis, on a transplant waiting list, ready at any time for transplant).
- (3) If the Covered Person is Inpatient in a Hospital on the effective date.
- (4) Post acute Injury or Surgery within the past 3 months.

- (5) Pregnancy in the second or third trimester and up to 8 weeks postpartum.
- (6) Behavioral Health – any previous treatment.

You or your Dependent must call the Third Party Administrator prior to the effective date or within 4 weeks after the effective date to see if you or your dependents are eligible for this benefit.

Routine procedures, treatment for stable chronic conditions, minor Illnesses and elective Surgical procedures will not be covered by transitional level benefits.

Costs

You must pay for a certain portion of the cost of Covered Expenses under the Plan, including (as applicable) any Copay, Deductible and Coinsurance percentage that is not paid by the Plan, up to the Out-of-Pocket Maximum set by the Plan.

Coinsurance

Coinsurance is the percentage of eligible expenses the Plan and the Covered Person are required to pay. The amount of Coinsurance a Covered Person is required to pay is the difference from what the Plan pays as shown in the Medical Schedule of Benefits.

Continuity of Care (Keeping the provider you go to now)

You may have to find a new provider when:

- (1) The Plan's Network changes and the provider you have now is not in the new Network; or
- (2) You are already enrolled in the Plan and your provider stops participating in the Plan's Network.

However, in some cases, you may be able to keep going to your current provider to complete a treatment or to have treatment that was already scheduled. This is called continuity of care. If you are pregnant and have entered your second trimester, this will include the time required for postpartum care directly related to the delivery. Routine procedures, minor Illnesses and elective Surgical Procedures generally are not covered under this provision.

Contact the phone number on the back of your identification card to obtain further information on how to submit a request for continuity of care. If your request is approved to keep going to your current provider, you will be informed how long you can continue to see the provider. Reimbursement for approved continuity of care will be at the applicable Participating Provider benefit level subject to the Usual and Customary provision of the Plan.

Copay

A Copay is the portion of the medical expense that is your responsibility, as shown in the Medical Schedule of Benefits. A Copay is applied for each occurrence of such covered medical service and is not applied toward satisfaction of the Deductible, Coinsurance or Out-of-Pocket Maximum.

Deductible

A Deductible is the total amount of eligible expenses as shown in the Schedule of Benefits, which must be Incurred by you during any Calendar Year before Covered Expenses are payable under the Plan. The family Deductible maximum, as shown in the Schedule of Benefits, is the maximum amount which must be Incurred by the covered family members during a Calendar Year. However, each individual in a family is not required to contribute more than one individual Deductible amount to a family Deductible.

Out-of-Pocket Maximum

An Out-of-Pocket Maximum is the maximum amount you and/or all of your family members will pay for eligible expenses Incurred during a Calendar Year before the percentage payable under the Plan increases to 100%.

The single Out-of-Pocket Maximum applies to a Covered Person with single coverage. When a Covered Person

reaches his/her Out-of-Pocket Maximum, the Plan will pay 100% of additional eligible expenses for that individual during the remainder of that Calendar Year.

The family Out-of-Pocket Maximum applies collectively to all Covered Persons in the same family. The family Out-of-Pocket Maximum, if applicable, is the maximum amount that must be satisfied by covered family members during a Calendar Year. The entire family Out-of-Pocket Maximum must be satisfied; however each individual in a family is not required to contribute more than the single Out-of-Pocket amount to the family Out-of-Pocket Maximum before the Plan will pay 100% of covered expenses for any Covered Person in the family during the remainder of that Calendar Year.

Your Out-of-Pocket Maximum may be higher for Non-Participating Providers than for Participating Providers. Please note, however, that not all Covered Expenses are eligible to accumulate toward your Out-of-Pocket Maximum. The types of expenses, which are not eligible to accumulate toward your Out-of-Pocket Maximum, (“non-accumulating expenses”) include:

- (1) Copays, including Prescription Drug Copays
- (2) Deductibles
- (3) Charges this Plan does not cover

Reimbursement for these non-accumulating expenses will continue at the percentage payable shown in the Medical Schedule of Benefits, subject to the Plan maximums.

The Plan will not reimburse any expense that is not a Covered Expense. In addition, you must pay any expenses to which you have agreed that are in excess of the Usual and Customary Charges for Non-Participating Providers. This could result in you having to pay a significant portion of your claim. None of these amounts will accumulate toward your Out-of-Pocket Maximum.

Once you have paid the Out-of-Pocket Maximum for eligible expenses Incurred during a Calendar Year, the Plan will reimburse additional eligible expenses Incurred during that year at 100%.

If you have any questions about whether an expense is a Covered Expense or whether it is eligible for accumulation toward your Out-of-Pocket Maximum, please contact your Plan Administrator for assistance.

Non-Essential Health Benefits

Essential Health Benefit has the meaning found in section 1302(b) of the Patient Protection and Affordable Care Act and as may be further defined by the Secretary of the United States Department of Health and Human Services. Essential Health Benefits includes the following general categories and the items and services covered within such categories: ambulatory patient services; Emergency Services; hospitalization; maternity and newborn care; mental health and substance use disorder services (including behavioral health treatment); Prescription Drugs; rehabilitative and habilitative services and devices; laboratory service; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

The Plan considers the following items or services to be non-Essential Health Benefits:

- (1) Vision hardware for Covered Persons age 19 and over.

MEDICAL MANAGEMENT PROGRAM

Medical Management is a program designed to help ensure that you and your eligible Dependents receive necessary and appropriate healthcare while avoiding unnecessary expenses. This program is not designed to be the practice of medicine or to be a substitute for the medical judgment of the attending Physician or other healthcare provider. The Medical Management Program Administrator contact information for this Plan is identified on the Employee identification card and also on the General Plan Information page of this Plan.

Precertification

Before you or your eligible Dependents are admitted to a medical facility or receive items or services from the list below, the Medical Management Program Administrator will, based on clinical information from the provider or facility, certify the care according to the Medical Management Program Administrator's policies, procedures and guidelines. Once an Inpatient setting has been precertified, working directly with your Physician, the Medical Management Program Administrator will identify and approve the most appropriate and cost-effective setting for the treatment as it progresses. The Medical Management Program Administrator will also assist and coordinate the initial implementation of any services you will need post hospitalization (called discharge planning) with the attending Physician and the facility. This could include registering you for specialized programs or case management when appropriate.

Your provider may precertify your treatment for you; however, you should verify prior to incurring Covered Expenses that your provider has obtained precertification. If your treatment is not precertified by you or your provider within the time periods described below a retrospective review may be performed. A retrospective review (as directed by the Plan) will determine if the services were Medically Necessary and would have been approved had the required phone call been made, provided the Covered Expenses meets all other Plan provisions and requirements. However, any charges not deemed Medically Necessary will be denied.

Case Management

Depending on the level of care needed, the case manager will coordinate and implement the case management program by providing guidance and information on available resources and suggesting the most appropriate treatment plan. All parties involved (e.g., the Plan, attending Physician, and patient) must all agree to the alternate individually tailored treatment plan. Each treatment plan is specific to that patient and should not be seen as appropriate or recommended for any other patient, even one with the same diagnosis. Case management is a voluntary service. There are no reductions of benefits or penalties if you or your eligible Dependents choose not to participate.

Important Timeframes to Know

You, your Physician, the Facility or someone acting on your behalf, should call the Medical Management Program Administrator (at the number listed on your Employee identification card or the General Plan Information page of this Plan) within the following time frames for a:

Non-emergency admission	48 hours <u>before</u> the scheduled admission
Non-emergency services	48 hours <u>before</u> you are scheduled to receive the services
Emergency admission	Within 48 hours or if later, the next business day <u>after</u> you are admitted

If the attending Physician feels that it is Medically Necessary for a patient to receive services for a greater length of time than initially precertified, the attending Physician or the medical facility should request the additional service or days as soon as reasonably possible, but no later than the final authorized day.

List of Items and/or Services that Require Precertification

The below items and/or services, if Covered Expenses under the Plan, should be precertified before any medical services are provided. To determine whether a benefit is covered or excluded, please review the Eligible Medical Expenses and/or General Exclusions and Limitations sections of your Plan.

All Inpatient Admissions:

- Acute
- Long-Term Acute Care
- Rehabilitation Facility
- Mental Disorder / Substance Use Disorder
- Residential Treatment Facility
- Transplant
- Skilled Nursing Facility

Diagnostic Services (Outpatient and Physician):

- CT for non-orthopedic
- MRI for non-orthopedic
- PET
- Capsule endoscopy
- Genetic testing, including BRCA
- Sleep study

Surgery (including in a Physician's office):

- Breast and bone marrow biopsy
- Thyroidectomy, partial or complete
- Open prostatectomy
- Oophorectomy, unilateral and bilateral
- Back Surgeries and hardware related to Surgery
- Osteochondral Allograft, knee
- Hysterectomy (including prophylactic)
- Autologous chondrocyte implantation, Carticel
- Transplant (excluding cornea)
- Balloon sinuplasty
- Sleep apnea related Surgeries, limited to:
 - Radiofrequency ablation (Coblation, Somnoplasty)
 - Uvulopalatopharyngoplasty (UPPP), including laser-assisted procedures

Continuing Care Services (Outpatient and Physician):

- Chemotherapy (including oral)
- Radiation therapy
- Oncology and transplant related injections, infusions and treatments (e.g., CAR-T, endocrine and immunotherapy), excluding supportive drugs (e.g., antiemetic and antihistamine)
- Hyperbaric oxygen
- Home health care
- Durable Medical Equipment, limited to electric/motorized scooters or wheelchairs and pneumatic compression devices
- Gene therapy

Monthly High Cost Drugs that are \$2,000 or more and are:

- Injectables
- Infusion therapies
- Gene therapy drugs

Important Notes:

- ❖ Precertification is recommended if a procedure could be considered Experimental and/or Investigational or potentially Cosmetic in nature (such as, but not limited to: abdominoplasty, cervicoplasty, liposuction/lipectomy, mammoplasty (augmentation and reduction - includes removal of implant), Morbid Obesity procedures, septoplasty, etc.).
- ❖ Precertification is NOT REQUIRED for a maternity delivery admission, unless the stay extends past 48 hours for vaginal delivery or 96 hours for a cesarean section. A Hospital stay begins at the time of delivery or for deliveries outside the Hospital, the time the newborn or mother is admitted to a Hospital following birth, in connection with childbirth. If a newborn remains hospitalized beyond the time frames specified, the confinement should be precertified with the Medical Management Program.
- ❖ High Cost Drugs are drugs that are covered under the medical benefits section of the Plan. This requirement does not apply to drugs covered under the Prescription Drug Card Program.

Recommended List of Items and/or Services for Prenotification

The below items and/or services, if Covered Expenses under the Plan, should be prenotified before any medical services are provided. To determine whether a benefit is covered or excluded, please review the Eligible Medical Expenses and/or General Exclusions and Limitations sections of this document.

- Biopsies (excluding skin)
- Vascular Access Devices for the infusion of chemotherapy (including, but not limited to, PICC and Central Lines)
- Creation and revision of Arteriovenous Fistula (AV Fistula) or Vessel to Vessel Cannula for dialysis
- Dialysis

Prenotification is used to inform the Medical Management program of upcoming services. It is a data-entry process and does not require judgment or interpretation for Medical Necessity. Prenotification is set in motion by a telephone call from you, the patient, or a representative acting on your behalf or on behalf of the patient. There are no reductions of benefits or penalties if prenotification is not performed.

Precertification Does Not Guarantee Payment

Precertification of the above benefits ensures the service being rendered is Medically Necessary and appropriate. All benefits/payments are subject to the patient's eligibility for benefits under the Plan. For benefit payment, services rendered must be considered a Covered Expense and are subject to all other provisions of the Plan.

To File a Complaint or Request an Appeal to a Non-Certification

If it is determined that the item and/or services are not Medically Necessary, the notification you receive will explain why. Verbal appeal requests and information regarding the appeal process should be directed to the Medical Management Program Administrator as identified on the General Plan Information page of this Plan.

High Cost Drug Management Program

The primary objective of the High Cost Drug Management program is to provide assistance when you or your eligible Dependents have been prescribed a high cost drug that exceeds \$2,000 per month and is covered under the medical benefits section of the Plan.

The High Cost Drug Management program helps coordinate the most effective way to reduce expenses associated with the high cost drug. Specially trained case managers will make recommendations based on the terms of the Plan to ensure the medication is being obtained through the most cost effective method.

If you or your eligible Dependents are not currently utilizing the most cost effective method, the case manager will make a recommendation on how to obtain the medication from the most cost efficient Participating Provider. The program includes 1-on-1 coaching based on the terms of the Plan, support and education to improve adherence and avoid complications.

There are no reductions of benefits or penalties if the Covered Person and family choose not to participate or to comply with recommendations or suggestion provided by case managers.

Disease Management

Meritain Health Disease Management is aimed at reducing the health risks of Covered Persons with chronic conditions at high risk levels by utilizing evidence-based guidelines to identify and positively impact the health of participants.

Meritain Health Disease Management participation is limited to Covered Persons enrolled in the Plan. Disease Management candidates are identified through self-referral and by using predictive modeling that is based on medical and prescription claims data. On-site biometric screenings and online health risk assessments may also be used. Examples of medical conditions that could benefit from Disease Management are:

- (1) Asthma (pediatric and adult);
- (2) Chronic kidney disease;
- (3) Chronic Obstructive Pulmonary Disease (COPD);
- (4) Chronic pain (from osteoarthritis, rheumatoid arthritis or low-back pain);

- (5) Congestive Heart Failure (CHF);
- (6) Coronary Artery Disease (CAD);
- (7) Diabetes (pediatric and adult);
- (8) Hyperlipidemia (high cholesterol);
- (9) Hypertension (high blood pressure).

Participants in the Meritain Health Disease Management program are assigned a dedicated nurse coach who:

- (1) Helps members set healthcare targets and goals;
- (2) Motivates members and elevates their self-confidence in managing chronic disease;
- (3) Educates members on warning signs and symptoms and what to do if they occur;
- (4) Provides educational resources specific to the interaction and needs of members;
- (5) Identifies ways for members to stay healthy.

A Covered Person may contact the Meritain Health Disease Management 24 hour Nurse Line 7 days a week at (888) 610-0089 to discuss current illnesses, health issues, treatments, lifestyle choices and self-care strategies.

EMPLOYEE ASSISTANCE PROGRAM

Your Plan Sponsor or Participating Employer recognizes the need to provide a resource for those personal and family stresses that affect everyone at one time or another. The Lower Hudson Valley Employee Assistance Program ("EAP") is a confidential way for individuals, couples and families to obtain professional help to reduce the impact of everyday stresses. EAP services include referrals for such problems as mental or nervous disorders, family and marital problems, emotional stress, depression and anxiety, substance abuse, parent/child conflict and family budgeting.

This program is maintained separately and independently from this Plan. Your personal information will be kept strictly confidential by the Program Administrator.

You may contact the EAP Administrator identified on the General Plan Information page for additional information.

MEDICAL SCHEDULE OF BENEFITS

BENEFIT DESCRIPTION	PARTICIPATING PROVIDERS ONLY
LIFETIME MAXIMUM BENEFIT	Unlimited
CALENDAR YEAR MAXIMUM BENEFIT	Unlimited
CALENDAR YEAR DEDUCTIBLE	
Single	\$500
Family	\$1,000
CALENDAR YEAR OUT-OF-POCKET MAXIMUM (excludes Deductible)	
Single	\$3,000
Family	\$6,000
MEDICAL BENEFITS	
Allergy Injections	80% after Deductible
Allergy Testing	\$25 Copay then 100% (Deductible waived)
Ambulance Services	
Emergency Medical Condition	80% after Deductible
Non-Emergency Medical Condition	Not Covered
Ambulatory Surgical Center	80% after Deductible
Cardiac Rehab (Outpatient)	80% after Deductible
Maximum Benefit	36 sessions in a 12-week period
Chiropractic Care/Spinal Manipulation	\$25 Copay then 100% (Deductible waived)
Contraceptive Medication and Devices (not obtainable at a Pharmacy) – includes office visits	80% after Deductible
NOTE: This benefit applies to services that are not considered Preventive Services.	
Dental (Accidental Injury)	80% after Deductible
Diagnostic Testing, X-Ray and Lab Services (Outpatient)*	80% after Deductible
*If rendered as part of a Physician office visit and billed by the Physician, benefits are covered subject to the applicable Physician's office visit cost sharing.	
Durable Medical Equipment (DME)	80% after Deductible
Emergency Services – Emergency Medical Condition	80% (Deductible waived)
Emergency Room – Non-Emergency Medical Condition	Not Covered
eviCore – Embarc Program	100% (Deductible waived)
NOTE: Gene therapy drugs include but are not limited to, Luxturna, Zyntegro, Zolgensma, and Skysona and must be purchased through the eviCore - Embarc Program to be eligible for coverage under the Plan. Any facility charges or administrative costs associated with these drugs will be paid under the regular plan benefits.	

BENEFIT DESCRIPTION	PARTICIPATING PROVIDERS ONLY
Hinge Health Program	There is no cost to the member for this program
Home Health Care	80% after Deductible
Calendar Year Maximum Benefit	120 visits (3 visits per day maximum)
Hospice Care	
Inpatient	80% after Deductible
Inpatient Lifetime Maximum Benefit	30 days
Outpatient	80% after Deductible
Hospital Expenses or Long-Term Acute Care Facility/Hospital (facility charges)	
Inpatient	80% after Deductible
Room and Board Allowance	*Semi-Private Room Rate
Intensive Care Unit	ICU/CCU Room Rate
Miscellaneous Service and Supplies	80% after Deductible
Outpatient	80% after Deductible
* A private room will be considered eligible when Medically Necessary. Charges made by a Hospital having only single or private rooms will be considered at the least expensive rate for a single or private room.	
Maternity (Professional Fees)*	
Preventive Prenatal and Breastfeeding Support (other than lactation consultations)	100% (Deductible waived)
Lactation Consultations	100% (Deductible waived)
All Other Prenatal and Postnatal Care	100% (Deductible waived)
Delivery	80% after Deductible
* See Preventive Services under Eligible Medical Expenses for limitations.	
Mental Disorders and Substance Use Disorders*	
Inpatient	100% (Deductible waived)
Outpatient	\$25 Copay then 100% (Deductible waived)
Telemedicine	\$25 Copay then 100% (Deductible waived)
* Mental Disorder and Substance Use Disorder benefits will be administered by Lower Hudson Valley EAP. Lower Hudson Valley EAP will not require any precertification beyond that which may be required by the Claims Administrator for a particular service.	
NOTE: Emergency care (ambulance and emergency room) will be paid the same as the benefits for ambulance services and emergency room listed above in the Medical Schedule of Benefits, however, the Participating Provider level of benefits will always apply regardless of the provider utilized.	
MinuteClinic	100%; (Deductible waived)
Outpatient Therapies (e.g., physical, speech, occupational)	\$25 Copay then 100% (Deductible waived)
Combined Calendar Year Maximum Benefit	60 visits
Physician's Services	
Inpatient/Outpatient Services	80% after Deductible
Office Visits	\$25 Copay* then 100% (Deductible waived)
Physician Office Surgery	\$25 Copay* then 100% (Deductible waived)
Telemedicine	\$25 Copay* then 100% (Deductible waived)
Teledoc	100% (Deductible waived)

BENEFIT DESCRIPTION	PARTICIPATING PROVIDERS ONLY
*Copay applies per visit regardless of what services are rendered.	
Preventive Services and Routine Care	
Preventive Services (includes the office visit and any other eligible item received at the same time as the preventive service, whether billed at the same time or separately)	100% (Deductible waived)
Routine Care (includes any routine care item or service not otherwise covered under the preventive service provision above)	
Routine Care (age 22 and over) - including immunizations	100% (Deductible waived)
Maximum Benefit	1 exam every 12 months
Well Child Care (up to age 22) - including immunizations	100% (Deductible waived)
Age and frequency limitations: 7 visits up to age 12 months; 3 visits from age 13 months - 24 months; 3 visits from age 25 months - 36 months; 1 visit per 12 month period from 3 years - 22 years	
Routine Gynecological Exam - including routine tests and related lab fees	100% (Deductible waived)
Routine Mammogram (age 40 and over)	100% (Deductible waived)
Routine Digital Rectal Exam / Prostate-specific Antigen Test (PSA) (age 40 and over)	100% (Deductible waived)
Routine Colorectal Cancer Screening (age 50 and over)	100% (Deductible waived)
Routine Hearing Examination	\$25 Copay then 100% (Deductible waived)
Maximum Benefit	1 exam every 24 months
Private Duty Nursing	
Calendar Year Maximum Benefit	80% after Deductible 70 eight hour shifts
Prosthetics	
80% after Deductible	
Pulmonary Therapy (Outpatient)	
Maximum Benefit	80% after Deductible 36 hours or a 6-week period
Skilled Nursing Facility and Rehabilitation Facility	
Combined Calendar Year Maximum Benefit	80% after Deductible 60 days
Transplants	
80% after Deductible (Aetna IOE program)* Not Covered (All Other Network Providers)	
* Please refer to the Aetna Institute of Excellence (IOE) Program section of this Plan for a more detailed description of this benefit, including transportation and lodging maximums.	
Urgent Care Facility	
Medical Emergency Services	80% (Deductible waived)
Non-Medical Emergency Services	80% after Deductible

BENEFIT DESCRIPTION	PARTICIPATING PROVIDERS ONLY
Vision Care	
Routine Eye Examination	\$25 Copay then 100% (Deductible waived)
Maximum Benefit	1 exam every 24 months
Glasses or Contact Lenses	100% (Deductible waived)
Glasses or Contact Lenses (age 19 and over)	1 pair every 24 months up to \$100 maximum
Glasses (up to age to 19)	1 pair every 12 months
Vision Therapy/Orthoptic Training (treatment of convergence insufficiency only)	100% (Deductible waived)
Lifetime Maximum Benefit	12 vision therapy visits or sessions
Walk-In Clinic	\$25 Copay then 100% (Deductible waived)
Wig (see Eligible Medical Expenses)	80% after Deductible
All Other Eligible Medical Expenses	80% after Deductible

PRESCRIPTION DRUG SCHEDULE OF BENEFITS

BENEFIT DESCRIPTION	PARTICIPATING PHARMACY	NON-PARTICIPATING PHARMACY
Retail Pharmacy: 30-day supply		
Generic Drug	\$25 Copay, then 100%	\$25 Copay then 40%
Brand Name Drug	\$35 Copay, then 100%	\$35 Copay then 40%
Preventive Drug (Prescription Drugs classified as a Preventive Drug by HHS)	\$0 Copay (100% paid)	\$0 Copay then 40%
Mail Order Pharmacy: 90-day supply		
Generic Drug	\$50 Copay, then 100%	N/A
Brand Name Drug	\$70 Copay, then 100%	N/A
Preventive Drug (Prescription Drugs classified as a Preventive Drug by HHS)	\$0 Copay (100% paid)	N/A

* The Covered Person must use the mail order program for maintenance medications or the Covered Person will pay the entire cost if the Covered Person continues to obtain maintenance medication through a retail pharmacy.

Dispense as Written

The Plan requires pharmacies dispense Generic Drugs when available unless the Physician specifically prescribes a Brand Name drug and marks the script "Dispense as Written" (DAW). Should a Covered Person choose a Brand Name Drug rather than the Generic equivalent when the Physician allowed a Generic Drug to be dispensed, the Covered Person will also be responsible for the cost difference between the Generic and Brand Name Drug. The cost difference is not covered by the Plan and will not accumulate toward your Out-of-Pocket Maximum.

Specialty Pharmacy Program

Specialty drugs are high cost drugs used to treat chronic diseases, including, but not limited to: HIV/Aids, Rheumatoid Arthritis, Cancer, Hepatitis, Hemophilia, Multiple Sclerosis, Infertility and Growth Hormone Deficiency. Specialty drugs must be obtained directly from the specialty pharmacy program after 3 refills at a retail pharmacy. For additional information, please contact the Prescription Drug Card Program Manager.

Specialty drugs are usually injectable medications that require refrigeration, special handling, additional safety protocols and timely delivery. Mail order prescriptions may be filled by Accredo, our dedicated specialty pharmacy.

Preventive Drug means items which have been identified by the U.S. Department of Health and Human Services (HHS) as a preventive service. You may view the guidelines established by HHS by visiting the following website:

<https://www.healthcare.gov/what-are-my-preventive-care-benefits>

For a paper copy, please contact the Plan Administrator.

ELIGIBILITY FOR PARTICIPATION

Active Employee Eligibility

- (1) A full-time active Employee employed by an employer who has a collective bargaining agreement with Laborers Local 754 requiring the Employer to contribute to the Welfare Fund on behalf of Employees covered under this Plan.
- (2) Eligible to participate in the Plan according to the Rules of Eligibility established by the Board of Trustees.

Initial benefit coverage for an active Employee will start at his effective date as determined by the Rules of Eligibility, except that if the active Employee is absent from active work on account of Injury or Illness at his initial effective date or on the date he would be entitled to additional or increased benefits, such benefit coverage will begin when he returns to, or becomes available for return to, contributed employment. **For this purpose, absence from work due to any health factor (such as being absent from work on sick leave) is treated as being actively at work for purposes of health coverage.**

You are not eligible to participate in the Plan if you are a part-time, temporary, leased Employee, an independent contractor or a person performing services pursuant to a contract under which you are designated an independent contractor (regardless of whether you might later be deemed a common law employee by a court or governmental agency).

The Remittance System

In accordance with the terms of the Collective Bargaining Agreement which a Plan Sponsor or Participating Employer has with Laborers Local Union No. 754, each Plan Sponsor or Participating Employer is required to pay contributions to provide benefits under this Welfare Fund. The method of contribution payment is through a "Remittance System" whereby the Plan Sponsor or Participating Employer pays for benefits on a monthly basis using a Monthly Remittance Report. When the Plan Sponsor or Participating Employer submits a remittance report to the Fund Office, each Employee will receive a "Voucher" indicating the number of hours and the payroll period reported. The rate of contributions are set forth in the Collective Bargaining Agreement.

(1) Employer Responsibility

Each Plan Sponsor or Participating Employer must complete a monthly "Remittance Report" and pay benefits no later than the 10th day of the following month (for example April 2024 Remittance is due by May 10, 2024).

(2) Employee Responsibility

It is the Employee's responsibility to review the monthly voucher received. If the Employee does not receive a monthly voucher or the hours are not accurate, he/she must contact the Fund Office at which time the Fund Office will request copies of check stubs from the Employee and contact the contractor.

All hours are credited in the Plan Year earned regardless of when the hours are remitted by the Employer. There is no carry over of hours from one Plan Year to another. Benefits are determined by when the hours are earned.

Credit for hours will not be given, if it can be determined that the Employee did not earn said hours by working for a Participating Employer to the Welfare Fund.

Rules of Eligibility

(1) Initial and Subsequent Eligibility

Initial and Subsequent Eligibility is based on your hours accrued via the "Remittance System" during the Eligibility Periods. A minimum of 500 accrued hours is necessary for 6 months of **Employee only** coverage. A minimum of **600** accrued hours is necessary for 6 months of **Family** coverage. Insurance Periods are as follows:

- (a) **April Eligibility Period:** 500 HOURS worked November through April provides **Employee only** coverage from August 1st through January 31st. **600** HOURS worked November through April provides **Family** coverage from August 1st through January 31st.

(b) **October Eligibility Period:** 500 HOURS worked May through October provides **Employee Only** coverage from February 1st through July 31st. **600 HOURS** worked May through October provides **Family** coverage from February 1st through July 31st.

(2) Any Employee who earns **800** hours or more in the Eligibility Period that immediately precedes an Insurance Period will receive coverage for that Insurance Period, even if the Employee is not actively at work* as stated above. Additionally, the requirement to be actively at work as stated above does not apply to an Employee who is not, or ceases to be, actively at work during an Insurance Period due to the Employee's disability, as evidenced by a verified Disability or Workers' Compensation claim.

* **"Actively at work" is solely determined by Laborers Local Union No. 754.**

(3) **"Bank" Hours Carry-Over Provision**

If an eligible active Employee reports more than **800 HOURS** in any Eligibility Period, the reported hours in excess of **800** may be carried over and "Banked" for use in succeeding insurance periods.

This "bank" provision is subject to the following conditions:

- (a) Only reported contributory hours can be banked. No disability or Worker's Compensation hours will be used.
- (b) Maximum hours which may be banked at any time is 800.
- (c) Banked Hours may be used only if the Employee is registered with Laborers Local 754 as being ready, willing, able and actively at work in contributory employment at the start of the Insurance Period in which such Banked Hours are to be utilized. **Note: If you are receiving a pension from the Laborers Local 754 Pension Fund you will no longer be able to use "bank" hours for continued eligibility.**

(4) **Employees Previously Covered Under Another Collective Bargaining Agreement**

If an Employee performs work covered under a collective bargaining agreement that requires contributions to this Welfare Fund, and the Employee does not work the minimum number of hours necessary to obtain this Welfare Fund coverage for any Insurance Period, on a one-time basis the Employee will nonetheless be eligible for a 500 hour loan for single coverage and 600 hour loan for family coverage for that Insurance Period, provided that the Employee meets the following criteria:

- (a) The Employee has not been covered under this Welfare Fund in any previous Insurance Period;
- (b) Within the last 6 months prior to the beginning of the Insurance Period, the Employee was covered under a group health plan established or maintained under a collective bargaining agreement to which another local union of the Laborers' International Union of North America was a signatory;
- (c) The Employee will lose or is expected to lose eligibility for such other coverage, exclusive of rights to "continuation coverage" under COBRA or a comparable state law, before the beginning of the Insurance Period that follows the Insurance Period described herein; and
- (d) The Employee provides proof acceptable to the Board of Trustees that the Employee has worked at least 1,200 hours in the jurisdiction of the New York Laborers' District Council (Eastern) during the past 2 years immediately preceding the Insurance Period for which the Employee will be loaned Bank Hours pursuant to this Paragraph (4).

An Employee who meets the above criteria will receive a loan of 500 hours for single coverage and 600 hours for family coverage from the Welfare Fund pursuant to a Loan Agreement to be executed by the Employee and returned to the Welfare Fund prior to the beginning of the Insurance Period. If such Employee fails to work at least 500 or 600 hours respectively in Covered Employment within 6 months from the date such Employee becomes enrolled in the Welfare Fund, the Board of Trustees has the right to call the loan and request reimbursement from the Employee. Further, no additional Bank Hours will be credited to such an Employee until after the Employee has worked 500 or 600 hours, depending on whether the Employee elects single coverage or family coverage under the Loan Agreement, in Covered Employment.

All Employees' eligibility for subsequent Insurance Periods will be based on hours worked in subsequent Eligibility Periods, as provided under this Plan.

(5) Newly Organized Contractor - Initial Eligibility Contract Option

On an once-in-a-lifetime basis, if you work in Covered Employment for the first time, you have the option to enter into a contract with the Welfare Fund for a loan of 500 "Bank Hours" to establish coverage in the Welfare Fund the first of the month following Board of Trustees approval. This option is only available to individuals that begin work in Covered Employment in the jurisdiction of Laborers Local No. 754 for the first time or have not been a member of Laborers Local No. 754 for at least 3 years.

The following requirements must be satisfied in order to qualify for this loan of "Bank Hours" from the Welfare Fund to establish initial eligibility:

- (a) The new Employee must provide evidence that he/she maintained health insurance coverage for the month preceding the request for coverage in the Laborers Local No. 754 Welfare Fund through another employer group health plan. There can be no lapse in coverage between prior insurance coverage and commencement of eligibility for coverage in this Plan;
- (b) The new Employee must enter into a contract with the Welfare Fund to repay the hours extended to qualify for coverage under the Welfare Fund. The value of the loan is equal to 500 hours multiplied by the hourly contribution rate to the Welfare Fund as set forth in the Collective Bargaining Agreement with Laborers Local No. 754 at the time the new Employee terminates work in Covered Employment;
- (c) A new Employee must apply to the Board of Trustees and request coverage under this provision within 30 days of the date he/she began work in Covered Employment;
- (d) The loan will be paid off with the first 500 hours worked in Covered Employment under the Collective Bargaining Agreement;
- (e) If the new Employee fails to work at least 500 hours in Covered Employment after signing the contractual Loan Agreement within 6 months from entering into the agreement ("Eligibility Period"), the Board of Trustees has the right to call the loan and request reimbursement of all claims paid by the Welfare Fund less contributions received on the new Employee's behalf for work in Covered Employment;
- (f) A new Employee who is laid off or otherwise leaves Covered Employment before working 500 hours during the eligibility period is required to notify the Fund Office immediately. In addition, a contractor employing a member under an arrangement of this nature should also be instructed to notify the Fund Office immediately when a member with an outstanding loan ceases work for that contractor.
- (g) If the new Employee leaves work in Covered Employment or otherwise loses coverage in the Welfare Fund, the Welfare Fund will terminate the Employee's eligibility for coverage on the last day of the calendar month in which the Employee ceases working in Covered Employment. These Covered Persons will be offered COBRA self-payments beginning the first of the month after the month in which their eligibility terminated.
- (h) An Employee who elects for COBRA self-payments under this scenario would be considered to have his loan "suspended." Once an Employee making COBRA self-payments returns to work in Covered Employment, his/her eligibility would be reinstated the first of the calendar month following the date he/she resumed work. The loan arrangement would resume and operate in the same manner prior to the Employee ceasing to work in Covered Employment.
- (i) If the Employee does not elect to make COBRA self-payments, the Loan Agreement would be terminated and coverage would cease the last day of the calendar month the Employee worked in Covered Employment. The Employee is personally liable for reimbursing the Welfare Fund the cost of benefits extended as a loan of 500 "bank hours," less contributions received on the new Employee's behalf for work in Covered Employment, within 30 days.

- (j) In the event a new Employee that gets laid off or otherwise terminates before the loan has been paid back, the contractor must notify the Union and the Welfare Fund.

All new Employees that request a loan to establish initial eligibility enter into a formal contract that is subject to approval by the Board of Trustees. Loan agreement forms are available by contacting the Fund Office.

WAIVING INSURANCE COVERAGE

The Trustees have adopted an amendment to the Welfare Plan providing a policy for determining eligibility when a dependent's employer offers a financial incentive for such dependent to waive insurance coverage. In the above noted case, the Welfare Fund WILL REFUSE TO ACCEPT PRIMARY LIABILITY for such dependent, and will treat such dependent as if they continued to be insured through their employer, and only pay claims on a secondary basis.

TEMPORARY DISABILITY CREDIT

If a currently eligible Active Employee become temporarily and totally disabled, as evidenced by a verified Disability or Workers' Compensation claim, and the Active Employee had accumulated at least four consecutive Insurance Periods of eligibility prior to date of disability, then the disabled Active Employee may be granted Disability Credit at a rate of 8 hours for each regular work day of verified disability or Workers' Compensation claim.

Disability Credit will be granted up to an aggregate of 1,040 hours (130 regular work days) within any four consecutive "Insurance Periods." Disability Credit hours may not be used for "Bank Hours" purposes. Further, any bank hours accumulated by the insured, prior to the date of disability must be used before Disability Credit will be granted. To be eligible for Credit under this provision, the Employee must submit a copy of his Disability Claim Benefit Statement or Workers' Compensation decision to the Fund Office. Documents submitted must show effective date of disability starting and ending dates, for which benefits were paid to Employee.

MILITARY SERVICE

If an Employee was eligible on the date he left for required military service and registers with the Fund within 60 days after his military discharge, and becomes available for employment, his Welfare Fund insurance eligibility will be immediately reinstated. His Welfare Fund eligibility will be continued for the number of months of continued eligibility he would have been entitled to upon leaving for the required military service, or to the end of the current insurance period, whichever is greater.

EMPLOYMENT OUTSIDE THE JURISDICTION OF FUND

An Active Employee shall be considered to be in covered employment while so employed outside of the jurisdiction of this Fund, provided:

(a) his employer makes, on his behalf, contributions to a Laborers' Welfare Fund having jurisdiction in the area of his then employment; and (b) he is not obtaining, or is not entitled to obtain, any benefits from such other Laborers' Welfare Fund. Credit for such employment outside of the jurisdiction of this Fund shall be granted on the number of hours and contributions being transferred from such other Laborers' Welfare Fund.

General Provisions Relating to Eligibility Rules

- (1) All questions with respect to eligibility shall be determined by the Trustees, whose decision shall be final.
- (2) The Rules for Eligibility are subject to change by the vote of the Trustees, including any temporary waiver or modification which the Trustees may determine to be in the best interest of the Welfare Fund and eligible Employees and their Dependents.

- (3) "Covered Employment" shall mean employment in the jurisdiction of Laborers Local No. 754 by a Plan Sponsor or Participating Employer who is obligated to make contributions to this Welfare Fund. Covered Employment shall also be deemed to include full time Employees of Laborers Local No. 754.

Dependent Eligibility

Your Dependents are eligible for participation in this Plan provided he/she is:

- (1) Your Spouse.

If your Spouse is employed full-time and eligible for medical coverage under a plan sponsored by his/her employer, your Spouse must enroll for at least single coverage under the medical plan provided by his/her employer in order for your Spouse to be eligible for medical coverage under this Plan. For purposes of this Plan, "provided" is defined as the employer providing some portion of the contribution toward plan participation. Coverage under this Plan will be secondary to any medical coverage provided by the employer of your Spouse.

- (2) Your Child until the end of the month in which he/she attains age 26.

- (3) A child for whom you are required to provide health coverage due to a Qualified Medical Child Support Order (QMCSO). Procedures for determining a QMCSO may be obtained from the Plan Administrator at no cost.

The below terms have the following meanings:

"Spouse" means any person who is lawfully married to you under any state law, including persons of the same sex who were legally married in a state that recognizes such marriages, but who may reside in a state that does not recognize same sex marriages. Specifically excluded from this definition is a spouse by reason of common law marriage, whether or not permitted in your State. The Plan Administrator may require documentation proving a legal marital relationship.

"Child" means your natural born child, stepchild, legally adopted child (or a child placed with you in anticipation of adoption), Eligible Foster Child or a child for whom you are the Legal Guardian. Coverage for an Eligible Foster Child or a child for whom you are the Legal Guardian will remain in effect until such child no longer meets the age requirements of an eligible Dependent under the terms of the Plan, regardless of whether or not such child has attained age 18 (or any other applicable age of emancipation of minors).

"Child placed with you in anticipation of adoption" means a child that you intend to adopt, whether or not the adoption has become final, who has not attained the age of 18 as of the date of such placement for adoption. The term "placed" means the assumption and retention by you of a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child must be available for adoption and the legal process must have commenced.

"Eligible Foster Child" shall mean an individual who is placed with you by an authorized placement agency.

"Legal Guardian" means a person recognized by a court of law as having the duty of taking care of the person and managing the property and rights of an individual that is placed with such person by judgment, decree or other order of any court of competent jurisdiction.

Effective Date of Dependent Coverage

Employees are required to submit Proof of Dependents before such Dependent is considered eligible for benefits. An active Employee, who fails to submit the required Proof of Dependents will be initially enrolled as a single individual. Coverage for Dependents will begin on the FIRST DAY OF THE MONTH FOLLOWING RECEIPT OF REQUIRED PROOF OF DEPENDENTS BY THE FUND OFFICE.

THE PROOF OF DEPENDENT RULE ALSO APPLIES TO CHILDREN BORN WHILE YOU ARE ON ACTIVE COVERAGE. You must inform the Fund Office when a child is born and submit copy of child's birth certificate, listing the Employee as parent of such child. If you notify the Fund Office and provide copy of the birth certificate within the 30 days after child's birth, - OR - within 30 days of issue date of birth certificate, such child's coverage will be effective on his/her date of birth. Notification and submission of required proof after 30 days will result in the child's coverage being effective the first day of the month after receipt of documents.

Below is a list of required documents, which must be submitted to the Fund Office for Dependents' coverage:

(1) Required Proof of Dependents

- (a) Employees with Dependent Spouses - A copy of Certificate of Marriage must be submitted to the Fund Office.
- (b) Employees with Dependent Children - A copy of Birth Certificate for each Dependent child must be submitted to the Fund Office. The Birth Certificate must list the Employee as parent of such child. In the event that you are not in possession of a Birth Certificate, a copy of a Court Order naming you as Guardian, must be submitted.
- (c) Employees With Dependent Stepchildren - A copy of the Certificate of Marriage of the Employee and his or her Spouse (biological parent) and a copy of the Birth Certificate showing the Dependent stepchild as the biological child of the Employee's Spouse.

Benefit coverage for both Employee and Dependents will exclude payment of expenses Incurred before the Covered Person's effective date of eligibility.

Opt Out

Upon written request to the Fund, a participant may elect to opt out of dependent coverage with respect to the participant's spouse or any children then covered by the Fund. The effective date of the opt-out will be the date that the Fund receives a participant's written request for an opt-out, on a form provided to the participant by the Fund.

When you and your Spouse are both Covered Employees

When both you and your Spouse are covered Employees, each of you must choose coverage as either an Employee or as a Dependent. You may not be covered under this Plan as both an Employee and a Dependent. However, if a husband and wife are both covered as covered Employees under this Plan, benefits will be provided for both persons and their eligible Dependent Children on the same coordinated basis as if 2 separate plans were involved.

Court Ordered Coverage for a Child

Federal law requires the Plan, under certain circumstances, to provide coverage for your children. The details of these requirements are summarized below.

The Plan Administrator shall enroll for immediate coverage under this Plan any Child, who is the subject of a "qualified medical child support order" ("QMCSO"). If you are ordered to provide such coverage for a Child and you are not enrolled in the Plan at the time the Plan Administrator receives a QMCSO, the Plan Administrator shall also enroll you for immediate coverage under this Plan if you are eligible for coverage. Coverage under the Plan will be effective as of the later of the date specified in the order or the date the Plan Administrator determines that the order is a QMCSO.

A QMCSO is defined as a child support decree or order issued by a court (or a state administrative agency that has the force and effect of law under applicable state law) that obligates you to support or provide health care coverage to your child and includes certain information concerning such coverage. The Plan Administrator will determine whether any child support order it receives constitutes a QMCSO. Except for QMCSO's, no child is eligible for Plan coverage, even if you are required to provide coverage for that child under the terms of a separation agreement or court order, unless the child is an eligible Child under this Plan. Procedures for determining a QMCSO may be obtained, free of charge, by contacting the Plan Administrator.

Employee is not in possession of Court Order - A SIGNED, NOTARIZED AFFIDAVIT must be completed by the Employee and stating that such Employee is legally responsible for all medical expenses Incurred by such stepchild, and there are no other benefits due from Child's Natural Parent. The signed, notarized affidavit must be submitted, together with copy of Birth Certificate for such stepchild. Birth Certificate must list parent's name.

Newborn Coverage

If a newborn child Incurs charges because of Injury, Illness, congenital defects or abnormalities or premature birth, benefit coverage begins from birth provided the Employee notifies the Fund Office and submits required documentation as outlined above.

The Fund covers pregnancy-related costs of dependent children of Fund participants, in accordance with the terms of the Plan. However, as a self-insured plan, the Fund does not cover newborns of dependent children upon the newborn's birth.

Retiree Eligibility

- (1) Former active Laborers who are eligible to participate in the Plan according to the Rules of Eligibility established by the Board of Trustees.
- (2) Normal and Disability Retirees shall be eligible for coverage under the Welfare Fund if the Retiree meets each of the following requirements:
 - (a) He/she is eligible for a Normal or Disability retirement benefit from the Laborers Local Union No. 754 Pension Fund;
 - (b) He/she was continuously eligible for active Employee coverage under this Welfare Fund in each of the last 5 years immediately prior to retirement;
 - (c) He/she was eligible for active Employee coverage at date of retirement.
- (3) Early Retirees: If an Employee starts receiving an Early Pension under the Local Union No. 754 Pension Fund, he/she will remain covered if:
 - (a) At his/her early pension date, he/she was continuously eligible for active Employee coverage under the Welfare Fund in each of the last 5 years;
 - (b) 5 years immediately prior to retirement, and
 - (c) He/she was eligible for Employee coverage at his/her early retirement date.

However, in the event that an Employee has 30 years service with Local No.754 Laborers Union, pursuant to the Rules and Regulations of the Local Union #754 Pension Fund and elects to receive an early pension in accordance with the Early Pension Provision of such plan, his coverage through this Welfare Fund will remain in effect at Retiree level.

All Retirees will be required to make the following self-payments to continue coverage under the Laborers Local 754 Welfare Fund:

Class	Monthly Self-Payment Amount
Retiree Not Eligible for Medicare	\$350
Retiree Spouse Not Eligible for Medicare	\$350
Retiree Eligible for Medicare	\$125
Retiree Spouse Eligible for Medicare	\$180
Retiree Dependent	\$350

In all of the cases outlined above, costs to be paid by Retirees will be deducted from their monthly pension payment. The Trustees reserve the right to change the monthly self-payment amounts as they deem necessary. Please be advised if you terminate from Retiree Self-Pay coverage for any reason, you will not be eligible for COBRA continuation coverage.

Open Enrollment Period*

You and your Dependents may enroll for coverage during the Plan's open enrollment period, designated by the Plan Sponsor and communicated to you prior to such open enrollment period. During this time you will be permitted to make changes to any existing benefit elections. Benefit elections made during the open enrollment period will become effective the following year unless you or your Dependent experiences a Special Enrollment Event.

***Note: Please refer to Rules of Eligibility.**

Late Enrollment*

If you did not enroll during your original 30-day eligibility period and have now decided to apply for coverage, you may do so by making written application to the Plan Administrator. Likewise, if you declined to enroll any of your eligible Dependents during the original enrollment period, you may apply for coverage for them at a later date by completing all election and enrollment forms and submitting them to your Human Resources Department. In these circumstances, you and/or your eligible Dependents will be considered Late Enrollees.

***Note: Please refer to the Rules of Eligibility.**

Special Enrollment Event

A special enrollment event occurs when you or your Dependents suffer a loss of other health care coverage, when you become eligible for a state premium assistance subsidy or acquire a new Dependent as a result of marriage, birth, adoption or placement for adoption. In these circumstances, you and/or your eligible Dependents will be considered Special Enrollees.

Each special enrollment event is more fully described below:

- (1) **Loss of Other Coverage (other than under Medicaid or SCHIP).** If you declined enrollment for yourself or your Dependents (including your Spouse) because you or your Dependents had other health coverage (including coverage under a group health plan sponsored by a governmental or educational institution, a medical care program of the Indian Health Service or of a tribal organization), you may enroll for coverage for yourself and/or your Dependents under this Plan if the other health coverage is lost as a result of one of the following provided, however, you submitted a written statement to your Human Resources Department when you and/or your Dependents were initially eligible stating that other health coverage was the reason for declining enrollment under this Plan:
 - (a) The other health coverage was under COBRA and the maximum continuation period available under COBRA has been exhausted;
 - (b) Loss of eligibility under the other health coverage for reasons other than non-payment of the required contribution or premium, making a fraudulent claim or intentional misrepresentation of a material fact in connection with the other plan; or
 - (c) Employer contributions cease for the other health coverage.

If you are already enrolled in a benefit option available under the Plan and your Dependent lost his/her other health coverage, you may enroll in a different benefit option available under the Plan due to the special enrollment event of your Dependent.

You must submit the appropriate election and enrollment forms to your Human Resources Department within 30 days after the date the other health coverage was lost. Coverage under the Plan will become effective on the first day of the month following the date you submit the appropriate election and enrollment forms to your Human Resources Department.

- (2) **Loss of Coverage under Medicaid or SCHIP or Eligibility for a State Premium Assistance Subsidy.** If you or your Dependents did not enroll in the Plan when initially eligible because you and/or your Dependents were covered under Medicaid or a State sponsored Children's Health Insurance Program (SCHIP) and your coverage terminates because you or your Dependents are no longer eligible for Medicaid or SCHIP or you or your Dependents become eligible for a State premium assistance subsidy under Medicaid or SCHIP, you may enroll for coverage under this Plan for yourself and your Dependents after Medicaid or SCHIP coverage terminates or

after you or your Dependents' eligibility for a State assistance subsidy under Medicaid or SCHIP is determined.

You must submit the appropriate election and enrollment forms to your Human Resources Department within 60 days after coverage under Medicaid or SCHIP terminates or within 60 days after eligibility for a State premium assistance subsidy under Medicaid or SCHIP is determined. Coverage under the Plan will become effective on the first day of the month following the date you submit the appropriate election and enrollment forms to your Human Resources Department.

TERMINATION OF COVERAGE

Termination of Employee Coverage

Coverage under the Plan will terminate on the earliest of the following dates:

- (1) The date the Plan terminates, in whole or in part.
- (2) The date you report to active military service, unless coverage is continued through the Uniformed Services Employment and Reemployment Rights Act (USERRA) as explained below.
- (3) The end of the month in which you cease to be eligible for coverage under the Plan according to the Rules of Eligibility.
- (4) The end of the month in which you terminate employment or cease to be included in an eligible class of Employees.
- (5) The date you (or any person seeking coverage on your behalf) performs an act, practice or omission that constitutes fraud.
- (6) The date you (or any person seeking coverage on your behalf) makes an intentional misrepresentation of a material fact.

Termination of Dependent Coverage

Coverage under the Plan will terminate on the earliest of the following dates:

- (1) The date the Plan terminates, in whole or in part.
- (2) The date the Plan discontinues coverage for Dependents.
- (3) The date your Dependent becomes covered as an Employee under the Plan.
- (4) The date coverage terminates for the Employee.
- (5) The date the Dependent Spouse reports to active military service.
- (6) The end of the month in which a Dependent ceases to be a Dependent as defined by the Plan.
- (7) The date your Dependent (or any person seeking coverage on behalf of your Dependent) performs an act, practice or omission that constitutes fraud.
- (8) The date your Dependent (or any person seeking coverage on behalf of your Dependent) makes an intentional misrepresentation of a material fact.

NOTE: Upon written request to the Welfare Fund, an Employee may elect to opt out of Dependent coverage with respect to the Employee's Spouse or any Dependent Children then covered by the Welfare Fund. The effective date of the opt-out will be the date that the Welfare Fund receives an Employee's written request for an opt-out, on a form provided to the Employee by the Welfare Fund.

Termination of Retiree Coverage

Coverage under the Plan will terminate for you and any Dependents on the earliest of the following dates:

- (1) The end of the month in which you attain age 65;
- (2) The date the Plan terminates or no longer provides Retiree coverage;
- (3) The date you or any eligible Dependent become eligible for Medicare. Coverage will terminate only for the Medicare eligible person;
- (4) The end of the month in which a Dependent no longer satisfies the eligibility requirements as a Dependent under the terms of the Plan;
- (5) The end of the month of a Retiree's death;
- (6) The date you or your Dependent (or any person seeking coverage on behalf of you or your Dependent) performs an act, practice or omission that constitutes fraud;
- (7) The date you or your Dependent (or any person seeking coverage on behalf of you or your Dependent) makes an intentional misrepresentation of a material fact.

Continuation of Plan Coverage - Temporary Disability Credit

If an eligible active Employee becomes temporarily and totally disabled, as evidenced by a verified Disability or Workers' Compensation claim, and the active Employee had accumulated at least 4 consecutive Insurance Periods of eligibility prior to date of disability, then the disabled active Employee may be granted Disability Credit at a rate of 8 hours for each regular work day of verified disability or Workers' Compensation claim.

Disability Credit will be granted up to an aggregate of 1,040 hours (130 regular work days) within any 4 consecutive "Insurance Periods." Disability Credit hours may not be used for "Bank Hours" purposes. Further, any Bank Hours accumulated by the Employee, prior to the date of disability must be used before Disability Credit will be granted. To be eligible for credit under this provision, the Employee must submit a copy of his Disability Claim Benefit Statement or Workers' Compensation decision to the Fund Office. Documents submitted must show effective date of disability starting and ending dates, for which benefits are paid to the Employee.

Coverage under this provision will continue in accordance with the same terms and conditions of an active Employee. If a COBRA qualifying event occurs, any period of continued coverage under this section will not reduce the maximum time for which you may elect to continue coverage under COBRA. Please refer to the COBRA Continuation Coverage section of the Plan.

Retroactive Termination of Coverage

Except in cases where you and/or your covered Dependents fail to pay any required contribution to the cost of coverage, the Plan will not retroactively terminate coverage under the Plan unless you and/or your covered Dependents (or a person seeking coverage on behalf of you and/or your covered Dependents) performs an act, practice or omission that constitutes fraud with respect to the Plan or unless the individual makes an intentional misrepresentation of material fact. In such cases, the Plan will provide at least 30 days advance written notice to you or your covered Dependent who is affected before coverage will be retroactively terminated. As provided above, coverage may be retroactively terminated in cases where required employee contributions have not been paid by the applicable deadline. In those cases, no advance written notice is required.

Continuation of Coverage under the Family and Medical Leave Act (FMLA)

The Plan shall at all times comply with the Family and Medical Leave Act of 1993 (FMLA), as amended and as promulgated in regulations issued by the Department of Labor.

During any leave taken under the FMLA, you may maintain coverage under the Plan on the same conditions as coverage would have been provided if you had been continuously employed during the leave period. Failure to make required payments within 30 days of the due date established by your Employer the Plan Sponsor or Participating Employer will result in the termination of coverage for you and/or your eligible Dependents.

If you fail to return to work after the FMLA leave, the Employer may have the right to recover its contributions toward the cost of coverage during the FMLA leave.

If coverage under the Plan terminates during the FMLA leave, coverage will be reinstated for you and your covered Dependents if you return to work at the end of the FMLA leave.

The Plan shall at all times comply with the Family and Medical Leave Act of 1993 (FMLA), as amended and as promulgated in regulations issued by the Department of Labor.

During any leave taken under the FMLA, you may maintain coverage under the Plan on the same conditions as coverage would have been provided if you had been continuously employed during the leave period. Failure to make required payments within 30 days of the due date established by your Employer the Plan Sponsor or Participating Employer will result in your termination of coverage.

If you fail to return to work after the FMLA leave, the Employer may have the right to recover its contributions toward the cost of coverage during the FMLA leave.

If coverage under the Plan terminates during the FMLA leave, your coverage will be reinstated if you return to work at the end of the FMLA leave.

Continuation of Coverage under State Family and Medical Leave Laws

To the extent this Plan is required to comply with a State family and medical leave law that is more generous than the FMLA, continuation of coverage under this Plan will be provided in accordance with such State family and medical leave law, as well as under FMLA.

Military Service Reinstatement

If an Employee was eligible on the date he/she left for required military service and registers with the Welfare Fund within 60 days after his/her military discharge, and becomes available for employment, his eligibility under the Fund will be immediately reinstated. His/her eligibility will be continued for the number of months of continued eligibility he/she would have been entitled to upon leaving for the required military service, or to the end of the current Insurance Period, whichever is greater.

Continuation of Coverage under USERRA

You may elect to continue Plan coverage under the Uniformed Services Employment and Reemployment Rights Act (USERRA) if you are absent from work due to military service in the Uniformed Services (as defined under USERRA). You may elect to continue coverage for yourself and any of your Dependents that were covered under the Plan at the time of your leave. Your eligible Dependents do not have an independent right to elect coverage under USERRA; therefore unless you elect to continue coverage on their behalf, your eligible Dependents will not be permitted to continue coverage under USERRA separately.

To elect coverage under USERRA, you must submit your election to continue coverage under USERRA, on a form prescribed by the Plan Administrator to your Human Resources Department within 60 days after the date of your leave. Coverage under the Plan will become effective as of the date of your leave and will continue for the lesser of (a) 24 months (beginning on the date your absence begins); or (b) the period of time beginning on the date your absence begins and ending on the day after the date you return to employment with the Plan Sponsor or Participating Employer or fail to apply for or return to employment with the Employer within the time limit applicable under USERRA.

If your leave is 31 days or more, you will be required to pay up to 102% of the full contribution under the Plan. If your leave is 30 days or less, you will not be required to pay more than the amount (if any) you would have paid had you remained an active Employee of the Employer. The Plan Sponsor or your Participating Employer will notify you of the procedures for making payments under this Plan.

Continuation coverage provided under USERRA counts towards the maximum coverage period under COBRA continuation coverage.

An Employee returning from USERRA-covered military leave who participated in the Plan immediately before going on USERRA leave has the right to resume coverage under the Plan upon return from USERRA leave, as long as the Employee resumes employment within the time limit that applies under USERRA. No waiting period will apply to an Employee returning from USERRA leave (within the applicable time period) unless the waiting period would have applied to the Employee if the Employee had remained continuously employed during the period of military leave.

BASIC LIFE INSURANCE ELIGIBLE ACTIVE EMPLOYEES

When and to Whom Benefits are Available

\$10,000.00 will be paid to the beneficiary listed on your Beneficiary Form in the event of your death from any cause while this insurance is in effect. You may change your beneficiary or the method of payment at any time. Beneficiary

You may name anyone you wish as beneficiary to whom the insurance will be paid, and you may change the beneficiary at any time by completing the proper form. The change will be effective when the Fund receives the completed form at the Fund Office. Forms for this purpose are available at the Fund Office.

Extended Benefits If You Become Totally Disabled

If, while insured and before attaining age 60, you become totally disabled so that you are unable to work, and you remain so disabled until your death, the amount for which you were last insured will be paid to your beneficiary. In order for you to be protected under the extended benefit provision, proof of your initial and continued total disability must be submitted to The Union Labor Life Insurance Company.

What Happens to Your Life Insurance When Your Fund Coverage Terminates

Within thirty-one days of termination of coverage you may convert your Life Insurance coverage to an individual Life Policy by making application and paying the proper premium within thirty-one days. No medical examination will be required. If you die within the thirty-one day period and have not converted your coverage, The Union Labor Life insurance Company will pay \$10,000.00 to your beneficiary.

BASIC LIFE INSURANCE ELIGIBLE RETIRED EMPLOYEES

When and to Whom Benefits are Available

\$1,000.00 will be paid to the beneficiary listed on your Beneficiary Form in the event of your death from any cause while this insurance is in effect.

Beneficiary

You may name anyone you wish as beneficiary to whom the insurance will be paid, and you may change the beneficiary at any time by completing the proper form. The change will be effective when the Fund receives the completed form at the Fund Office. Forms for this purpose are available at the Fund Office.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT FOR ELIGIBLE ACTIVE EMPLOYEES (24 HOUR COVERAGE)

The Benefits for Loss Of:

LIFE	\$10,000.00
BOTH HANDS OR BOTH FEET OR SIGHT OF BOTH EYES	\$10,000.00
ONE HAND AND ONE FOOT	\$10,000.00
ONE HAND AND SIGHT OF ONE EYE	\$10,000.00
ONE FOOT AND SIGHT OF ONE EYE	\$10,000.00
ONE HAND OR ONE FOOT	\$5,000.00
SIGHT OF ONE EYE	\$5,000.00
THUMB AND INDEX FINGER OF SAME HAND	\$2,500.00

Loss of hand or foot means that the limb is severed at or above the wrist or ankle joint. Loss of sight means total and irrecoverable loss of sight. Loss of thumb and index finger means severance of two or more phalanges of both the

thumb and the index finger.

Only one of the amounts is payable for loss resulting from one accident.

The benefit for loss of life is payable to your beneficiary. The benefit for any other loss is payable to you.

You may change your beneficiary at any time by filing a written request with the Welfare Fund Office on the insurance Company's form.

WORKPLACE ACCIDENTAL DEATH BENEFIT

In addition to any other benefit payable under the Policy, the Company will pay a Workplace Accidental Death Benefit as shown on the Schedule if the Person suffers a Covered Loss as a result of a Workplace Injury.

Workplace Injury means (1) a bodily injury caused by an accident that occurs while the Person is at his or her workplace and performing his regularly scheduled union work or serving in an official capacity for his or her local, state, or national labor organization; or (2) an Injury that occurs while the Person is:

(1) Traveling from his or her residence to his or her workplace to begin performing his or her regularly scheduled union work or service in an official capacity for his or her local, state, or national labor organization; or

(2) Traveling from his workplace to his residence after having performed his regularly scheduled union work or service in an official capacity for his local, state, or national labor organization.

The Workplace Injury must be the direct cause of a Covered Loss and must be independent of all other causes.

REPATRIATION BENEFIT

In addition to any other benefit payable under the Policy, the Company will pay a Repatriation Benefit of up to \$5,000, but not to exceed the Principal Sum, for the preparation and transportation of the Person's body to a mortuary if:

1. The Person dies as a result of an accident for which an Accidental Death & Dismemberment benefit is payable; and
2. The Person's death occurs at least 75 miles away from his or her principal place of residence.

SEAT BELT BENEFIT

In addition to any other benefit payable under the Policy, the Company will pay a Seat Belt Benefit if:

1. The Person dies as a result of an automobile accident for which an Accidental Death & Dismemberment benefit is payable; and
2. The seat belt was in actual use and properly fastened, as certified in the official police report, at the time of the accident; and
3. The Person was driving an automobile who was neither:
 - a) Intoxicated or under the influence of any narcotic unless administered or consumed on the advice of a physician; nor
 - b) an unlicensed driver.

Coverage will be provided for a Person if the Person is a passenger in an automobile driven by an individual who is intoxicated or under the influence of any narcotic unless administered or consumed on the advice of a physician.

The amount of the Seat Belt benefit is:

1. 10% of the Principal Sum; or
2. \$1,000 if an official police report certifying that the seat belt is properly fastened cannot be submitted with the claim.

AIR BAG BENEFIT

In addition to any other benefit payable under the Policy, the Company will pay an Air Bag Benefit if the Person dies in an accident payable under the Accidental Death and Dismemberment benefit while the Person is positioned in a seat protected by a properly functioning, original, factory installed Supplemental Restraint System that inflates on impact (airbag). The additional amount payable under this Benefit is 5% of the Principal Sum up to \$5,000.

No benefits are payable for any loss caused directly or indirectly, wholly or partly, by:

- (a) bodily or mental illness or disease of any kind; ptomaines or bacterial infection (except infections caused by pyogenic organisms which occur with and through an accidental cut or wound);
- (b) intentional self-destruction or self-inflicted injury;
- (c) intentional participation in a riot or in the committing of a felony;
- (d) war or an act of war; or service in any military, naval or air force of any country while such country is engaged in war; or police duty as a member of any military, naval or air organization;
- (e) travel or flight in or on any species of noncommercial aircraft;
- (f) carbon monoxide poisoning; or
- (g) allergic reactions.

PAID UP LIFE BENEFIT

The Welfare Fund provides an additional \$1,000.00 death benefit on behalf of participants who have worked at least 800 hours in covered employment in at least 15 different plan years. This death benefit is paid to the participant's designated beneficiary. Since 2003, the Welfare Fund has paid this benefit directly. Death benefits earned by participants prior to 2003 are insured under a contract with CNA.

ELIGIBLE MEDICAL EXPENSES

Eligible expenses shall be the charges actually made for services provided to the Covered Person and will be considered eligible only if the expenses are:

- (1) Routine care or preventive services provided such services are ordered and performed by a Physician and not otherwise excluded under the Plan; or
- (2) Due to Illness or Injury provided such services are ordered and performed by a Physician, Medically Necessary and not otherwise excluded under the Plan.

Reimbursement for eligible expenses will be made directly to the provider of the service, unless a receipt showing payment is submitted. All eligible expenses Incurred at a Participating Provider will be reimbursed to the provider.

- (1) **Acupuncture:** Services by a licensed Doctor of Medicine, Doctor of Osteopathic Medicine or Acupuncturist, only as a form of anesthesia in connection with a covered Surgical Procedure.
- (2) **Allergy Services:** Allergy testing, serum and injections. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

Expenses for specific non-standard allergy services and supplies will not be considered eligible, including but not limited to, skin titration (Rinkel method), cytotoxicity testing (Bryan's Test) treatment of non-specific candida sensitivity, and urine autoinjections.

- (3) **Ambulance Service:** Professional ground, water or air ambulance service to transport the Covered Person:
 - (a) To the nearest Hospital equipped to treat the specific Illness or Injury in an emergency situation; or
 - (b) To another Hospital in the area when the first Hospital did not have services required and/or facilities to treat the Covered Person; or
 - (c) To and from a Hospital during a period of Hospital confinement to another facility for special services which are not available at the first Hospital; or
 - (d) From the Hospital to the patient's home or to a Skilled Nursing Facility, Rehabilitation Facility or any other type of convalescent facility nearest to the patient's home when there is documentation the patient required ambulance transportation.

Ambulance services for a non-Medical Emergency will not be considered eligible.

Professional ground, water or air ambulance charges for convenience are not covered. Air and water ambulance is covered only when terrain, distance or condition warrants.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

- (4) **Ambulatory Surgery Center:** Services and supplies provided by an Ambulatory Surgery Center. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.
- (5) **Anesthetics:** Anesthetics and their professional administration. Anesthesia rendered by the operating Physician or Certified Registered Nurse Anesthetist (C.R.N.A.) will not be considered eligible.
- (6) **Attention Deficit Disorder:** Testing and treatment for Attention Deficit Disorder (ADD/ADHD).
- (7) **Autism:** Diagnosis, care and treatment of autism and autistic spectrum disorders.
- (8) **Blood and Blood Derivatives:** Blood, blood plasma or blood components not donated or replaced.

Expenses related to blood, blood plasma, synthetic blood, blood products or substitutes, including but not limited to, the provision of blood, other than blood derived clotting factors, will not be considered eligible. Any related

services including processing, storage or replacement costs, and the services of blood donors, apheresis or plasmapheresis are not covered.

- (9) **Cardiac Rehabilitation:** Cardiac rehabilitation services which are rendered: (a) under the supervision of a Physician; and (b) in connection with a myocardial infarction, coronary occlusion or coronary bypass Surgery or any other medical condition if medically appropriate; and (c) initiated within 12 weeks after other treatment for the medical condition ends; and (d) in a medical care facility.

Expenses in connection with Phase III cardiac rehabilitation, including, but not limited to occupational therapy or work hardening programs will not be considered eligible. Phase III is defined as the general maintenance level of treatment, with no further medical improvements being made and exercise therapy that no longer requires the supervision of medical professionals.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

- (10) **Chemotherapy:** Services and supplies related to chemotherapy.
- (11) **Chiropractic Care/Spinal Manipulation:** Skeletal adjustments, manipulation or other treatment in connection with the correction by manual or mechanical means of structural imbalance or subluxation in the human body, including x-rays. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.
- (12) **Circumcision:** Services and supplies related to circumcision. Circumcision performed while Hospital confined following birth will be considered as part of the mother's expenses.
- (13) **Cognitive Therapy:** Cognitive therapy rendered by a qualified Physician or a licensed therapist under the recommendation of a Physician, associated with physical rehabilitation when the cognitive deficits have been acquired as a result of neurologic impairment due to trauma, stroke, or encephalopathy and when the therapy is part of a treatment plan intended to restore previous cognitive function.
- (14) **Contraceptives:** Contraceptive procedures and medications other than those considered preventive services, including, but not limited to: orals, patches, injections, diaphragms, intrauterine devices (IUD), implants and any related office visit. Some contraceptives may be available under the Prescription Drug Card Program. The Plan does not cover contraceptive supplies or devices available without a Physician's prescription or contraceptives provided over-the-counter (unless the expense qualifies as a preventive service).
- (15) **Cosmetic Procedures/Reconstructive Surgery:** Cosmetic procedures or Reconstructive Surgery will be considered eligible only under the following circumstances:
- (a) For the correction of a Congenital Anomaly for a Dependent Child.
 - (b) Any other Medically Necessary Surgery related to an Illness or Injury provided that the Surgery occurs no more than 24 months after the original Injury.
 - (c) Surgery to correct the result of the Injury that occurred during a covered Surgical Procedure provided that the reconstructive surgery occurs no more than 24 months after the original Injury.
 - (d) Charges for reconstructive breast Surgery following a mastectomy will be eligible as follows:
 - (i) Reconstruction of the breast on which the mastectomy has been performed;
 - (ii) Surgery and reconstruction of the other breast to produce symmetrical appearance; and
 - (iii) Coverage for prostheses and physical complications of all stages of mastectomy, including lymphedemas.

The manner in which breast reconstruction is performed will be determined in consultation with the attending Physician and the Covered Person.

- (16) **Dental Care:** Dental services and x-rays rendered by Dentist or dental surgeon, if Medically Necessary, for:

- (a) Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth.
- (b) Emergency repair due to Injury to sound natural teeth, within one year of the Accident, including the replacement of sound natural teeth.
- (c) Surgery needed to correct accidental Injuries to the jaws, cheeks, lips, tongue, floor and roof of the mouth.
- (d) Excision of benign bony growths of the jaw and hard palate.
- (e) External incision and drainage of cellulitis.
- (f) Incision of sensory sinuses, salivary glands or ducts.
- (g) Removal of impacted teeth.

If crowns, dentures, bridges, or in-mouth appliances are installed due to Injury, Covered Expenses only include charges for:

- (a) The first denture or fixed bridgework to replace lost teeth;
- (b) The first crown needed to repair each damaged tooth; and
- (c) An in-mouth appliance used in the first course of orthodontic treatment after the Injury.

General anesthesia and Hospital expenses are covered for eligible dental care services that would require the service be performed in a Hospital to monitor the patient due to a serious underlying medical condition, such as heart condition, blood disorder, etc. or is necessary due to accidental Injury to sound natural teeth.

Dental Benefits Through Cigna

The Welfare Fund offers a dental benefit to Employees and their eligible Dependents through a contract with Cigna. Cigna offers a Dental PPO. Please refer to the Cigna materials provided with this Plan about the Dental Benefits.

- (17) **Diabetic Education:** The following diabetic education and self-management programs: diabetes outpatient self-management training and education, including medical nutrition therapy that is provided by a certified, registered or licensed healthcare professional working in a program consistent with the national standards of diabetes self-management education as established by the American Diabetes Association. Coverage is provided for individuals with diabetes.
- (18) **Diabetic Supplies:** All Physician-prescribed medically appropriate and necessary equipment and supplies used in the management and treatment of diabetes that are not covered under the Prescription Drug Card Program.
- (19) **Diagnostic Testing, X-ray and Laboratory Services:** Diagnostic testing, x-ray and laboratory services, including services of a professional radiologist or pathologist. Dental x-rays are not eligible expenses, except as specified under Dental Care. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.
- (20) **Durable Medical Equipment:** The rental of oxygen, wheelchairs, walkers, special Hospital beds, iron lungs and other Durable Medical Equipment subject to the following:
 - (a) The equipment must be prescribed by a Physician and Medically Necessary; and
 - (b) The equipment will be provided on a rental basis; however such equipment may be purchased at the Plan's option. Any amount paid to rent the equipment will be applied towards the purchase price. In no case will the rental cost of Durable Medical Equipment exceed the purchase price of the item (oxygen equipment is not limited to the purchase price); and
 - (c) Benefits will be limited to standard models as determined by the Plan; and
 - (d) The Plan will pay benefits for only one of the following unless Medically Necessary due to growth of the

Covered Person or if changes to the Covered Person's medical condition requires a different product, as determined by the Plan: a manual wheelchair, motorized wheelchair or motorized scooter; and

- (e) If the equipment is purchased, benefits will be payable for subsequent repairs, excluding batteries, necessary to restore the equipment to a serviceable condition. If such equipment cannot be restored to a serviceable condition, replacement will be considered eligible subject to prior approval by the Plan. In all cases, repairs or replacement due to abuse or misuse, as determined by the Plan, are not covered; and
- (f) Expenses for the rental or purchase of any type of air conditioner, air purifier or any other device or appliance will not be considered eligible.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(21) **Emergency Services/Emergency Room:** When you experience an Emergency Medical Condition, coverage for Emergency Services will continue until your condition is Stabilized and:

- (a) Your attending Physician determines that you are medically able to travel or to be transported, by non-medical or non-emergency medical transportation, to another provider if you need more care; and
- (b) You are in a condition to be able to receive from the Non-Participating Provider delivering services the notice and consent criteria with respect to the services; and
- (c) Your Non-Participating Provider delivering the services meets the notice and consent criteria with respect to the services.

If you go to an emergency room for what is not an Emergency Medical Condition, the Plan may not cover your expenses. See the Medical Schedule of Benefits and the General Exclusions and Limitations for specific Plan details. If your Physician decides you need to stay in the Hospital (emergency admission) or receive follow-up care, these are not Emergency Services. Different benefits and requirements apply.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(21) **Genetic Testing:** Diagnostic testing of Genetic Information and counseling when Medically Necessary. Genetic testing is covered in addition to and to the extent it is not otherwise included for coverage under the preventive services section of the Plan.

(22) **Gene Therapy Drugs (through eviCore – Embarc Program only):** Gene therapy drugs include but are not limited to, Luxturna, Zynteglo, Zolgensma, and Skysona and must be received through the eviCore - Embarc Program to be eligible for coverage under the Plan. Covered services include the cost for the gene therapy product, however, any medical, surgical, and Hospital services directly related to the administration of the gene therapy product will be paid under the regular plan benefits.

(23) **Hemodialysis/Peritoneal Dialysis:** Treatment of a kidney disorder by hemodialysis or peritoneal dialysis as an Inpatient in a Hospital or other facility or for expenses in an outpatient facility or in the Covered Person's home, including the training of one attendant to perform kidney dialysis at home. The attendant may be a family member. When home care replaces Inpatient or outpatient dialysis treatments, the Plan will pay for rental of dialysis equipment and expendable medical supplies for use in the Covered Person's home as shown under the Durable Medical Equipment benefit. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(24) **Home Health Care:** Services provided by a Home Health Care Agency to a Covered Person in the home. The following are considered eligible home health care services:

- (a) Home nursing care;
- (b) Services of a home health aide or licensed practical nurse (L.P.N.), under the supervision of a registered nurse (R. N.);

- (c) Visits provided by a medical social worker (MSW);
- (d) Psychological counseling by a licensed provider, up to one hour per visit;
- (e) Physical, occupational, speech, or respiratory therapy if provided by the Home Health Care Agency;
- (f) Medical supplies, drugs and medications prescribed by a Physician;
- (g) Laboratory services; and
- (h) Nutritional counseling by a licensed dietician.

For the purpose of determining the benefits for home health care available to a Covered Person, each visit by a member of a Home Health Care Agency shall be considered as one home health care visit and each 4 hours of home health aide services shall be considered as one home health care visit.

In no event will the services of a Close Relative, Custodial Care, transportation services, housekeeping services and meals, etc., be considered an eligible expense.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

- (25) **Hospice Care:** Hospice care on either an inpatient or outpatient basis for a terminally ill person rendered under a Hospice treatment plan. The Hospice treatment plan must certify that the person is terminally ill with a life expectancy of 6 months or less.

Covered services include:

- (a) Room and board charges by the Hospice.
- (b) Other Medically Necessary services and supplies.
- (c) Part-time or intermittent nursing care by or under the supervision of a registered nurse (R.N.).
- (d) Part-time or intermittent home health care services furnished in the patient's home by a Home Health Care Agency for the following:
 - (i) health aide services consisting primarily of caring for the patient (excluding housekeeping, meals, etc.); and
 - (ii) physical, occupational and speech therapy.
- (e) Counseling services by a licensed social worker or a licensed pastoral counselor for the patient's immediate family.
- (f) Nutritional counseling by a licensed dietician.
- (g) Psychological counseling.
- (h) Bereavement counseling services by a licensed social worker or a licensed pastoral counselor for the patient's immediate family within 6 months after the patient's death. For the purposes of bereavement counseling, the term "Patient's Immediate Family" means the patient's spouse, parents of a Dependent Child and/or Dependent children who are covered under the Plan.

In no event will the services of a Close Relative, funeral arrangements, financial or legal counseling, housekeeping services and meals, etc., be considered an eligible expense.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

- (26) **Hospital Services or Long-Term Acute Care Facility/Hospital:**

(a) Inpatient

Room and board, including all regular daily services in a Hospital or Long-Term Acute Care Facility/Hospital. Care provided in an Intensive Care Unit (including cardiac care (CCU) and burn units).

Miscellaneous services and supplies, including any additional Medically Necessary nursing services furnished while being treated on an Inpatient basis.

(b) Outpatient

Services and supplies furnished while being treated on an outpatient basis.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(27) **Infertility Testing:** Diagnosis, testing and treatment of the underlying medical cause of infertility (the inability to conceive), as well as ovulation induction and artificial insemination. However, benefits do not include other impregnation procedures, such as but not limited to invitro fertilization, GIFT (Gamete Intrafallopian Transfer) and ZIFT (Zygote Intrafallopian Transfer).

(28) **Infusion Therapy:** Services, supplies and equipment necessary for infusion therapy rendered at a freestanding outpatient facility, outpatient department of a Hospital, a Physician's office or in the Covered Person's home. Expenses for infusion therapy include:

- (a) The pharmaceutical when administered in connection with infusion therapy;
- (b) Professional services;
- (c) Total parenteral nutrition (TPN);
- (d) Chemotherapy;
- (e) Drug therapy (includes antibiotic and antivirals);
- (f) Pain management (narcotics); and
- (g) Hydration therapy (includes fluids, electrolytes and other additives).

Charges Incurred for infusion therapy will not include:

- (a) Enteral nutrition;
- (b) Blood transfusions and blood products;
- (c) Dialysis; and
- (d) Insulin.

Benefits payable for infusion therapy will not count toward the Home Health Care maximum benefits.

(29) **Lenses:** Initial pair of eyeglasses, contact lenses or an intraocular lens following a Medically Necessary Surgical Procedure to the eye or for aphakic patients. Soft lenses or sclera shells intended for use as corneal bandages.

(30) **Maternity:** Expenses Incurred by all Covered Persons for:

- (a) Pregnancy.
- (b) Preventive prenatal and breastfeeding support as identified under the preventive services section below.
- (c) Services provided by a Birthing Center.

- (d) Amniocentesis testing when Medically Necessary.
- (e) Up to 2 ultrasounds per pregnancy (more than 2 only when it is determined to be Medically Necessary).
- (f) Elective induced abortions.

Hospital stays in connection with childbirth for either the mother or newborn may not be limited to less than 48 hours following a vaginal delivery or 96 hours following a cesarean section. These requirements can only be waived by the attending Physician in consultation with the mother. The Covered Person or provider is not required to precertify the maternity admission, unless the stay extends past the applicable 48 or 96 hour stay. A Hospital stay begins at the time of delivery or for deliveries outside the Hospital, the time the newborn or mother is admitted to a Hospital following birth, in connection with childbirth.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

- (31) **Medical and Surgical Supplies:** Casts, splints, braces, crutches, ostomy supplies, urinary catheters and external urinary collective devices, orthotics (excluding foot orthotics), dressings and other Medically Necessary supplies ordered by a Physician.
- (32) **Mental Disorders:** Covered charges for care, supplies and treatment of a Mental Disorder. Mental Disorder benefits will be administered by Lower Hudson Valley EAP. Lower Hudson Valley EAP will not require any precertification beyond that which may be required by the Claims Administrator for a particular service. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.
- (33) **MinuteClinic:** Walk-in clinic health services provided at a MinuteClinic for:
 - (a) Scheduled and unscheduled visits for minor illnesses and injuries;
 - (b) Routine vaccinations and immunizations administered within the scope of the clinic's license; and
 - (c) Screening and monitoring services.

Expenses for health examinations needed to go to a school, camp, or sporting event, or to join in a sport or other recreational activity will not be covered under the MinuteClinic benefit but may be payable under other provisions of the Plan.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

- (34) **Morbid Obesity:** Charges for the care and treatment of Morbid Obesity (including surgical treatment), if Medically Necessary.
- (35) **Nutritional Counseling:** Services related to nutritional counseling for medical and mental health conditions (e.g., eating disorders such as bulimia and anorexia, diabetes mellitus, gastro-intestinal disorders, chronic obstructive pulmonary disease), in which dietary adjustment has a therapeutic role, when furnished by a provider (e.g., licensed nutritionist, registered dietician, or other qualified licensed health professionals such as nurses who are trained in nutrition) recognized under the Plan. Medically necessary nutritional counseling is covered in addition to and to the extent it is not otherwise included for coverage under the preventive services section of the Plan.
- (36) **Nutritional Supplements:** Physician-prescribed nutritional supplements or other enteral supplementation necessary to sustain life, including rental or purchase of equipment used to administer nutritional supplements or other enteral supplementation. Special dietary treatment for phenylketonuria (PKU) when prescribed by a Physician.

Specialized supplements delivered enterally via a tube directly into the stomach or intestines will not be considered eligible. Over-the-counter nutritional supplements or infant formulas will also be excluded even if prescribed by a Physician.

- (37) **Occupational Therapy:** Rehabilitative occupational therapy rendered by a qualified Physician or a licensed

occupational therapist under the recommendation of a Physician. Expenses for Maintenance Therapy or therapy primarily for recreational or social interaction will not be considered eligible. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

- (38) **Off-Label Drug Use:** Expenses related to Off-Label Drug Use (the use of a drug for a purpose other than that for which it was approved by the FDA) will be eligible for coverage when all of the following criteria have been satisfied:
- (a) The named drug is not specifically excluded under the General Exclusions and Limitations section of the Plan; and
 - (b) The named drug has been approved by the FDA; and
 - (c) The Off-Label Drug Use is appropriate and generally accepted by the medical community for the condition being treated; and
 - (d) If the drug is used for the treatment of cancer, The American Hospital Formulary Service Drug Information or NCCN Drugs and Biologics Compendium recognize it as an appropriate treatment for that form of cancer.
- (39) **Outpatient Pre-Admission Testing:** Outpatient pre-admission testing performed within 14 days of a scheduled Inpatient hospitalization or Surgery. If the testing indicates that Surgery should not be performed because of your physical condition, the Plan will pay for the tests, however Surgery will not be considered eligible.
- (40) **Physical Therapy:** Physical therapy rendered by a qualified Physician or a licensed physical therapist under the recommendation of a Physician. This includes Medically Necessary aquatic therapy (hydrotherapy or pool therapy) for musculoskeletal conditions when provided by a physical therapist or other recognized, licensed provider. Eligible expenses include the professional charges for physical therapy modalities administered in a pool, which require direct one-on-one patient contact. Charges for aquatic exercise programs or separate charges for use of a pool are not covered. Maintenance Therapy will not be considered eligible. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.
- (41) **Physician Services:** Services of a Physician for medical care or Surgery.
- (a) Services performed in a Physician's office on the same day for the same or related diagnosis. Services include, but are not limited to: examinations, supplies, injections, allergy shots, x-ray and laboratory tests (including the reading or processing of the tests), cast application and minor Surgery. If more than one Physician is seen in the same clinic on the same day, only one Copay will apply.
 - (b) Diagnostic x-ray and laboratory services which are ordered on the same day as the office visit, but performed or read at a later date and/or at another facility will be considered as part of the office visit.
 - (c) For multiple or bilateral surgeries performed during the same operative session which are not incidental or not part of some other procedure and which add significant time or complexity (all as determined by the Plan) to the complete procedure, the charge considered will be: (i) 100% for the primary procedure; (ii) 50% for the secondary procedure, including any bilateral procedure; and (iii) 25% for each additional covered procedure. This applies to all Surgical Procedures, except as determined by the Plan.
 - (d) For surgical assistance by an Assistant Surgeon, the charge will be 20% of the Usual and Customary Charge for the corresponding Surgery.
 - (e) Teladoc: Teladoc provides 24/7/365 access to a national network of U.S. board-certified Physicians who can resolve many of your medical issues. Teladoc services involve the delivery of clinical medicine via real-time telecommunications such as telephone, the Internet, or other communication networks or devices that do not involve direct patient contact.

For any questions with respect to Teladoc, please contact the Plan Administrator. Coverage under this benefit does not include consults from your regular Physician; it only includes coverage for consults to the extent the Physician who is consulted participates in the Teladoc program. To learn more about Teladoc,

see the Teladoc contact information under General Plan Information section of the Plan.

Teladoc benefits include:

- 24/7/365 access to a Physician online or by phone.
- Fast treatment.
- Talk to a Teladoc Physician from anywhere: at home, work, or while traveling.
- Save money by avoiding expensive urgent care or emergency room visits.

Call Teladoc:

- When you need care now.
- If you're considering the emergency room or urgent care center for non-emergency issues.
- On vacation, on a business trip, or away from home.
- For short-term prescription refills.

Teladoc providers treat conditions such as:

Cold and flu
Bronchitis
Respiratory infection
Sinus problems
Allergies
Urinary tract infection
Pediatric care
Poison ivy
Pink eye
Ear infections

- (f) Telemedicine: Services related to the delivery of clinical medicine via real-time telecommunications such as telephone, the Internet, or other communication networks or devices that do not involve direct patient contact.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits

- (42) **Podiatry:** Treatment for the following foot conditions: (a) bunions, when an open cutting operation is performed; (b) non-routine treatment of corns or calluses; (c) toenails when at least part of the nail root is removed; (d) any Medically Necessary Surgical Procedure required for a foot condition. In addition, orthopedic shoes when an integral part of a leg brace will also be covered.

- (43) **Preventive Services and Routine Care:** The following preventive services and routine care are paid as shown in the Medical Schedule of Benefits:

(a) Preventive Services

(i) Evidence-Based Preventive Services

Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (the "Task Force") with respect to the individual involved, except that with respect to breast cancer screening, mammography and prevention of breast cancer, the recommendations of the Task Force issued in 2002 will be considered the current recommendations until further guidance is issued by the Task Force or the Health Resources and Services Administration.

(ii) Routine Vaccines

Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved.

(iii) Prevention for Children

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

(iv) Prevention for Women

With respect to women, such additional preventive care and screenings, not otherwise addressed by the Task Force, as provided for in comprehensive guidelines supported by the Health Resources and Services Administration and published on August 1, 2011 (or any applicable subsequent guidelines or guidance requiring any additional women's preventive services). Those guidelines generally include the following:

- (A) Well-woman visits. Well-woman preventive care visits annually for adult women to obtain the recommended preventive services that are age and developmentally appropriate, including preconception and prenatal care. The inclusion of a well-woman visit is not meant to limit the coverage for any other preventive service described elsewhere in the Plan that might be administered as part of the well-woman visit.

Coverage for prenatal care is limited to pregnancy-related Physician office visits including the initial and subsequent history and physical exams of the pregnant woman. In the event a provider bills a "maternity global rate", the portion of the claim that will be considered for prenatal visits and therefore, preventive care, is 40% of the "maternity global rate". As a result, 60% of the "maternity global rate" will be considered for delivery and postnatal care and the normal cost-sharing provisions would apply. Items not considered preventive (and therefore subject to normal cost-sharing provisions) include inpatient admissions, high risk specialist units, ultrasounds, amniocentesis, fetal stress tests, delivery including anesthesia and certain pregnancy diagnostic lab tests.

- (B) Screening for gestational diabetes. A maximum of 5 screenings for gestational diabetes shall be covered in pregnant women.
- (C) Human papillomavirus (HPV) testing. High-risk HPV DNA testing in women with normal cytology results. Screening is limited to women age 30 or older and is limited to 1 screening every 3 Calendar Years.
- (D) Counseling annually for sexually transmitted infections (including for the human immunodeficiency virus (HIV)) and screening annually for HIV for all sexually active women. Limited to 2 counseling sessions per Calendar Year.
- (E) Screening and counseling annually for interpersonal and domestic violence.
- (F) Contraceptive methods and counseling, as prescribed by your Physician. All FDA approved contraceptive methods (see Preventive Drugs section below), sterilization procedures and patient education and counseling for women with reproductive capacity. Contraceptive counseling is limited to 2 visits per 12-month period.

For purposes of the above, the sterilization procedures to be considered preventive include sterilization implant (Essure) and surgical sterilization (Sterilization) either abdominally, vaginally or laparoscopically. Eligible charges for a sterilization procedure and all ancillary services will be covered when sterilization is the primary purpose of the services provided and/or if it is performed as a standalone procedure and billed as such. However, complications arising following a sterilization procedure are not covered as preventive services. Covered Expenses do not include charges for a sterilization procedure to the extent the procedure was not billed separately by the provider or because it was not the primary purpose of the procedure. To the extent sterilization is part of another procedure and/or is not a separate line on the bill, the sterilization procedure is not a Covered Expense.

- (G) Breastfeeding support, supplies and counseling in conjunction with each birth, including the following:
- (1) Comprehensive lactation support and counseling by a trained provider during pregnancy and/or in the postnatal period (60 days from baby's date of birth). Lactation consultation is limited to 6 cumulative visits per 12-month period.
 - (2) Breastfeeding equipment will be covered, subject to the following:
 - (i) Rental of a Hospital grade electric pump while the baby is Hospital confined; and
 - (ii) Purchase of a standard (non-Hospital grade) electric breast pump or manual breast pump if requested during pregnancy or during the duration of breastfeeding, provided the Covered Person has not received either a standard electric breast pump or a manual breast pump within the last 3 Calendar Years and provided the Covered Person remains continuously enrolled in the Plan.
 - (3) For women using a breast pump from a prior pregnancy, one new set of breast pump supplies will be covered at 100% with each subsequent pregnancy for initiation or continuation of breastfeeding.

For a detailed listing of women's preventive services, please visit the U.S. Department of Health and Human Services website at: <http://www.hrsa.gov/womensguidelines>. For a paper copy, please contact the Plan Administrator. To the extent the above does not cover any preventive service required to be covered under the guidelines published by the Health Resources and Services Administration on August 1, 2011 (or any applicable subsequent guidelines or guidance requiring any additional women's preventive services), the above shall be deemed to be amended to cover such preventive services to the extent required by such guidelines.

- (v) Preventive Drugs means items which have been identified by the U.S. Department of Health and Human Services (HHS) as a preventive service. You may view the guidelines established by HHS by visiting the following website:

<https://www.healthcare.gov/what-are-my-preventive-care-benefits>

For a paper copy, please contact the Plan Administrator.

For a detailed listing of preventive services, please visit the U.S. Department of Health and Human Services website at: <https://www.healthcare.gov/what-are-my-preventive-care-benefits>. For a paper copy, please contact the Plan Administrator. To the extent the above does not cover any preventive service required to be covered by the U.S. Department of Health and Human Services (HHS) the above shall be deemed to be amended to cover such preventive service to the extent required by the HHS.

(b) Routine Care

Routine care including, but not limited to, the office visit, lab tests, x-rays, routine testing, vaccinations or immunizations (including flu vaccines), well child care (up to age 22), gynecological exams, pap smears, mammograms (age 40 and over), colon exams (age 50 and over), PSA testing (age 40 and over) and hearing exams.

Routine hearing exams must be rendered by a Physician certified as an Otolaryngologist or Otologist or a licensed Audiologist under the recommendation of an Otolaryngologist or Otologist.

If a diagnosis is indicated after a routine exam, the exam will still be payable under the routine care benefit, however, all charges related to the diagnosis (except the initial exam) will be payable as any other illness.

The above routine care items are covered in addition to and to the extent they are not otherwise included

for coverage under the Preventive Services section of the Plan.

- (44) **Private Duty Nursing:** Private duty nursing care by a licensed nurse (R.N., L.P.N. or L.V.N.). Covered charges for this service will be included to the following extent:
- (a) Inpatient Nursing Care. Charges are covered only when care is Medically Necessary and not Custodial in nature and the Hospital's Intensive Care Unit is filled or the Hospital has no Intensive Care Unit. Inpatient Private Duty Nursing must be supported by a certification from the attending Physician.
 - (b) Outpatient Nursing Care. Charges are covered only when care is Medically Necessary and not Custodial in nature. Charges covered for outpatient nursing care billed by a Home Health Care Agency are shown under Home Health Care Services and Supplies. Outpatient private duty nursing care not billed by a Home Health Care Agency must be supported by a certification and a treatment plan from the attending Physician.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

- (45) **Prosthetic Devices:** Prosthetic devices when necessary due to an Illness or Injury, including but not limited to, artificial limbs, eyes, speech generating device, cardiac pacemaker and pacemaker defibrillators, and an external breast prosthesis (including the first bra after a mastectomy). This benefit includes any necessary repairs to restore the prosthesis to a serviceable condition. If such prosthesis cannot be restored to a serviceable condition, replacement will be considered eligible, subject to prior approval by the Plan. In all cases, repairs or replacement due to abuse or misuse, as determined by the Plan, are not covered. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.
- (46) **Pulmonary Therapy:** Pulmonary therapy under the recommendation of a Physician. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.
- (47) **Qualified Clinical Trial Expenses:** Healthcare services for the treatment of cancer for a Covered Person enrolled in a Qualified Clinical Trial that are consistent with the Usual and Customary standard of care for someone with the Covered Person's diagnosis, are consistent with the study protocol for the clinical trial and would be covered if the Covered Person did not participate in the Qualified Clinical Trial.

Notwithstanding the above, Qualified Clinical Trial expenses do not include any of the following:

- (a) An FDA approved drug or device shall be considered a Qualified Clinical Trial Expense only to the extent that the drug or device is not paid for by the manufacturer, the distributor or the provider of the drug or device; or
 - (b) Non-healthcare services that a Covered Person may be required to receive as a result of being enrolled in the Qualified Clinical Trial; or
 - (c) Costs associated with managing the research associated with the Qualified Clinical Trial; or
 - (d) Costs that would not be covered for non-Experimental and/or Investigational treatments; or
 - (e) Any item, service or cost that is reimbursed or otherwise furnished by the sponsor of the Qualified Clinical Trial; or
 - (f) The costs of services, which are not provided as part of the Qualified Clinical Trials' stated protocol or other similarly intended guidelines.
- (48) **Radiation Therapy:** Radium and radioactive isotope therapy treatment.
- (49) **Reconstructive Surgery:** See Cosmetic Procedures/Reconstructive Surgery.
- (50) **Rehabilitation Facility:** Inpatient care in a Rehabilitation Facility provided such confinement: (a) is under the recommendation and general supervision of a Physician; (b) is for the purpose of receiving medical care necessary for convalescence from the conditions causing or contributing to the precedent Hospital or Skilled Nursing Facility confinement; and (c) is not for Custodial Care.

See the Skilled Nursing Facility benefit for services and supplies provided for confinements in a Skilled Nursing Facility.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

- (51) **Routine Newborn Care:** Routine newborn care including Hospital nursery expenses and routine pediatric care while confined following birth will be considered as part of the mother's expense.

If the newborn is ill, suffers an Injury or requires care other than routine care, benefits will be provided on the same basis as any other eligible expense.

- (52) **Second Surgical Opinion:** Voluntary second surgical opinions for elective, non-emergency Surgery when recommended for a Covered Person.

Benefits for the second opinion will be payable only if the opinion is given by a specialist who: (a) is certified in the field related to the proposed Surgery; and (b) is not affiliated in any way with the Physician recommending the Surgery.

If the second opinion conflicts with the first opinion, the Covered Person may obtain a third opinion, although this is not required.

- (53) **Skilled Nursing Facility:** Skilled nursing care in a Skilled Nursing Facility provided such confinement: (a) is under the recommendation and general supervision of a Physician; (b) is for the purpose of receiving medical care necessary for convalescence from the conditions causing or contributing to the precedent Hospital or Rehabilitation Facility confinement; and (c) is not for Custodial Care.

See the Rehabilitation Facility benefit for services and supplies provided for confinements in a Rehabilitation Facility.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

- (54) **Sleep Disorders:** Sleep disorder treatment that is Medically Necessary.

- (55) **Speech Therapy:** Restorative or rehabilitative speech therapy rendered by a qualified Physician or a licensed speech therapist under the recommendation of a Physician, necessary because of loss or impairment due to an Illness, Injury or Surgery or therapy to correct a Congenital Anomaly. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

- (56) **Sterilization:** Elective sterilization procedures (this does not include reversal of sterilization). Elective sterilization procedures are covered in addition to and to the extent they are not otherwise included for coverage under the preventive services section of the Plan.

- (57) **Substance Use Disorders:** Charges for care, supplies and treatment of a Substance Use Disorder. Substance Use Disorder benefits will be administered by Lower Hudson Valley EAP. Lower Hudson Valley EAP will not require any precertification beyond that which may be required by the Claims Administrator for a particular service. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

- (58) **Temporomandibular Joint Dysfunction (TMJ):** Surgical and non-surgical treatment of Temporomandibular Joint Dysfunction (TMJ).

The treatment of jaw joint disorders (TMJ) includes conditions of structures linking the jawbone and skull and complex muscles, nerves and other tissues related to the temporomandibular joint. Treatment shall include, but is not limited to: exams; x-rays; injections; oral surgery; anesthetics; physical therapy; and any appliance that is attached to or rests on the teeth. Orthodontia treatment will not be considered eligible.

- (59) **Transplants (other than those received through the Aetna IOE Program):** Services and supplies in connection with Medically Necessary non-Experimental and/or non-Investigational transplant procedures.

(a) If both the donor and the recipient are covered under this Plan, eligible expenses Incurred by each person

will be treated separately for each person.

- (b) If the recipient is covered under this Plan and the donor is not covered, eligible expenses Incurred by the donor will be considered eligible if not covered by the donor's plan.
- (c) If the donor is covered under this Plan and the recipient is not covered, eligible expenses Incurred by the donor will not be covered.
- (d) The Usual and Customary fee of securing an organ from the designated live donor, a cadaver or tissue bank, including the surgeon's fees, anesthesiology, radiology and pathology fees for the removal of the organ and a Hospital's charge for storage or transportation of the organ.

See the Aetna Institute of Excellence (IOE) Program section of the Plan with respect to coverage for transplants received through the Aetna IOE Program.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

Exclusions:

- (a) Non-human and artificial organ transplants.
 - (b) The purchase price of any of bone marrow, organ, tissue or any similar items which are sold rather than donated.
 - (c) Transplants which are not medically recognized and are Experimental and/or Investigational in nature.
 - (d) Lodging expenses, including meals.
 - (e) Expenses related to the Covered Person's transportation.
- (60) **Urgent Care Facility:** Services and supplies provided by an Urgent Care Facility. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.
- (61) **Vision Care:** Routine eye exams (including refractions and glaucoma testing), office visit and the purchase of prescription lenses and frames or prescription contact lenses in lieu of glasses. In addition, services for vision therapy and orthoptic training if Medically Necessary will be covered for the treatment of convergence insufficiency. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.
- (62) **Walk-In Clinic:** Services and supplies provided by a walk-in clinic. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.
- (63) **Wigs:** Purchase of a scalp hair prosthesis when necessitated by hair loss due to chemotherapy or radiation. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

AETNA INSTITUTE OF EXCELLENCE (IOE) PROGRAM

The Institute of Excellence (IOE) is a facility that contracted with Aetna to furnish particular services and supplies to you in connection with one or more highly specialized medical procedures. The maximum charge made by the IOE for such services and supplies will be the amount agreed to between Aetna and the IOE.

Transplant Expenses

Once it has been determined that you or one of your eligible Dependents may require an organ transplant, you or your Physician should call the Medical Management Program Administrator to discuss coordination of your transplant care. Aetna will coordinate all transplant services. In addition, you must follow any precertification requirements. Organ means solid organ; stem cell; bone marrow and tissue.

Benefits may vary if an IOE facility or a non-IOE facility is used. In addition, some expenses listed below are payable only within the IOE network. The IOE facility must be specifically approved and designated by Aetna to perform the procedure you require. A transplant will be covered at the Participating Provider level only if performed in a facility that has been designated as an IOE facility or that is an Aetna Participating Provider facility that has a single case rate agreement between an Aetna Participating Provider and Aetna for the type of transplant in question. Any treatment or service related to transplants that are provided by a facility that is not specified as an IOE network facility or that is not an Aetna Participating Provider facility that has a single case rate agreement between an Aetna Participating Provider and Aetna, even if the facility is considered a Participating Provider for other types of services, will not be covered. Please read each section below carefully.

Covered Transplant Expenses

Covered transplant expenses include the following:

- (1) Charges for activating the donor search process with national registries.
- (2) Compatibility testing of prospective organ donors that are immediate family members. For purposes of this section an "immediate" family member is defined as a first-degree biological relative. These are your biological parent, sibling or child.
- (3) Inpatient and outpatient expenses directly related to a transplant.
- (4) Charges made by a Physician or a transplant team.
- (5) Charges made by a Hospital, outpatient facility or Physician for the medical and surgical expenses of a live donor, but only to the extent not covered by another plan or program.
- (6) Related supplies and services provided by the IOE facility during the transplant process. These services and supplies may include: physical, speech and occupational therapy; bio-medicals and immunosuppressants; home health care expenses and home infusion services.

Covered transplant services are typically Incurred during the 4 phases of transplant care described below. Expenses Incurred for one transplant during these 4 phases of care will be considered one transplant occurrence.

A transplant occurrence is considered to begin at the point of evaluation for a transplant and end either: (1) 180 days from the date of the transplant; or (2) upon the date the patient is discharged from the Hospital or outpatient facility for the admission or visits related to the transplant, whichever is later.

The 4 phases of one transplant occurrence and a summary of covered transplant expense during each phase are as follows:

- (1) Pre-transplant evaluation/screening. Pre-transplant evaluation screening includes all transplant-related professional and technical components required for assessment, evaluation and acceptance into a transplant facility's transplant program.
- (2) Pre-transplant candidacy screening. Pre-transplant candidacy screening includes Human Leukocyte Antigen (HLA) typing/compatibility testing of prospective organ donors that are immediate family members.

- (3) Transplant event. A transplant event includes Inpatient and outpatient services for all covered transplant- related health services and supplies provided to you and a donor during the one or more surgical procedures or medical therapies for a transplant; prescription drugs provided during your Inpatient stay or outpatient visits, including bio-medical and immunosuppressant drugs; physical, speech or occupational therapy provided during your Inpatient stay or outpatient visits; cadaveric and live donor procurement.
- (4) Follow-up care. Follow-up care includes all covered transplant expenses; home health care services; home infusion services and transplant-related outpatient services rendered within 180 days from the date of the transplant event.

One Transplant Occurrence

The following are considered one transplant occurrence:

- (1) Heart.
- (2) Lung.
- (3) Heart/Lung.
- (4) Simultaneous Pancreas Kidney (SPK).
- (5) Pancreas.
- (6) Kidney.
- (7) Liver.
- (8) Intestine.
- (9) Bone marrow/stem cell transplant.
- (10) Multiple organs replaced during one transplant surgery.
- (11) Tandem transplants (stem cell).
- (12) Sequential transplants.
- (13) Re-transplant of same organ type within 180 days of first transplant.
- (14) Any other single organ transplant, unless otherwise excluded under the Plan.

More Than One Transplant Occurrence

The following are considered more than one transplant occurrence:

- (1) Autologous blood/bone marrow transplant followed by allogeneic blood/bone marrow transplant (when not part of a tandem transplant).
- (2) Allogeneic blood/bone marrow transplant followed by an autologous blood/bone marrow transplant (when not part of a tandem transplant).
- (3) Re-transplant after 180 days of the first transplant.
- (4) Pancreas transplant following a kidney transplant.
- (5) Atransplant necessitated by an additional organ failure during the original transplant surgery/process.
- (6) More than one transplant when not performed as part of a planned tandem or sequential transplant (i.e. a liver transplant with subsequent heart transplant).

Limitations

Transplant coverage does not include charges for the following:

- (1) Outpatient drugs, including bio-medicals and immunosuppressants not expressly related to an outpatient transplant occurrence.
- (2) Services and supplies furnished to a donor when recipient is not a Covered Person.
- (3) Home infusion therapy after the transplant occurrence.
- (4) Harvesting or storage of organs without the expectation of immediate transplant for an existing illness.
- (5) Harvesting and/or storage of bone marrow, tissue or stem cells without the expectation of transplantation within 12 months for an existing illness.
- (6) Cornea (corneal graft with amniotic membrane) or cartilage (autologous chondrocyte or autologous osteochondral mosaicplasty) transplants, unless otherwise authorized by the Plan.

Travel and Lodging Expenses

Travel and lodging expenses will be covered under the Plan subject to the conditions described below.

- (1) Distance requirement. The IOE facility must be more than 100 miles away from the patient's residence.
- (2) Travel allowances. Travel is reimbursed between the patient's home and the facility for round trip (air, train or bus) transportation costs (coach class only). If traveling by auto to the facility, mileage, parking and toll cost will be reimbursed per IRS guidelines.
- (3) Lodging allowances. Reimbursement of expenses incurred by the patient and any companion for hotel lodging away from home is reimbursed at a rate of \$50 per night per person, to a maximum of \$100 per night.
- (4) Overall maximum. Travel and lodging reimbursement is limited to \$10,000 for any one transplant or procedure type, including tandem transplants. This is a combined maximum for the patient, companion and donor.
- (5) Companions. One companion is permitted per adult and 2 parents or guardians are permitted per Child.

HINGE HEALTH PROGRAM

The Hinge Health Digital Musculoskeletal (MSK) Clinic includes Prevention, Chronic, Acute, and Surgical programs. The program includes both an embedded Expert Medical Opinion service focused on elective MSK procedures as well as Enso, a groundbreaking wearable technology for pain management that is both non-addictive and non-invasive. You and your covered Dependents who meet participation criteria as established by Hinge Health have access to the following programs:

Prevention Program: This software only program (no sensors, coaching, or tablet) is designed to increase education regarding key strengthening and stretching activities around injury prevention. All Covered Persons have access to the Prevention Program; participation criteria does not apply.

Chronic Program: Personalized exercise therapy sessions guided by wearable motion-sensors, unlimited 1:1 access to personal health coach via email, text, phone, personalized educational content, and cognitive behavioral support. The Chronic Program pathways include: knee, neck, low back, hip, and shoulder.

Women's Pelvic Health (part of the Chronic program): Supports women at all stages of life, including pregnancy, postpartum, and menopause, when pelvic disorders are most common.

Acute Program: Live virtual sessions with a dedicated licensed physical therapist along with software guided rehabilitation and individual education. A user may only obtain 6 virtual physical therapy (PT) sessions per

episode through Hinge Health prior to needing an in-person PT visit with their Physician or a qualified provider in physical therapy. The medical Plan of benefits will apply to the Covered Person's in-person PT visit. Once the in-person PT visit occurs and a plan of care is submitted, a Covered Person may receive an additional 6 virtual physical therapy sessions per episode before the process repeats.

Surgery Program: Provides Covered Persons with a dedicated physical therapist, a dedicated health coach, sensor- guided exercise therapy, and covers both pre- and post-surgical rehabilitation for the most common MSK surgeries. The Surgery Program is designed as a continuation of the Chronic Program but Covered Persons can enroll in the Surgery Program directly.

Expert Medical Opinion (EMO): EMO service focused on elective musculoskeletal procedures. EMO services are available to all Covered Persons; participation criteria does not apply.

For additional information about the Hinge Health Program, please visit the Hinge Health website at: www.hingehealth.com or call (855) 902-2777.

INPATIENT & OUTPATIENT SUBSTANCE ABUSE BENEFITS

The inpatient and outpatient Substance Abuse benefits are contracted directly with Lower Hudson Valley Employee Assistance Program for the EAP. The EAP will coordinate care with the fund's health benefits provider.

Members must contact Mike Popp Program Director of the EAP at telephone (914) 245-6300 for these services.

Patient must complete treatment in order to receive coverage. For example, if patient voluntarily discontinues treatment before completion, Fund will not provide any coverage and patient will be responsible for the entire cost.

ALTERNATE BENEFITS

In addition to the benefits specified, the Plan may elect to offer benefits for services furnished by any provider pursuant to a Plan-approved alternate treatment plan, in which case those charges Incurred for services provided to a Covered Person under an alternate treatment plan to its end, will be more cost effective than those charges to be Incurred for services to be provided under the current treatment plan to its end.

The Plan shall provide such alternate benefits at its sole discretion and only when and for so long as it determines that alternate treatment plan is Medically Necessary and cost effective. If the Plan elects to provide alternate treatment plan benefits for a Covered Person in one instance, it shall not be obligated to provide the same or similar benefits for such Covered Person in any other instance or for other Covered Persons under this Plan in any other instance, nor shall it be construed as a waiver of the Plan Administrator's rights to administer this Plan thereafter in strict accordance with its express terms.

GENERAL EXCLUSIONS AND LIMITATIONS

No payment will be eligible under any portion of this Plan for expenses Incurred by a Covered Person for the expenses or circumstances listed below. If an expense is paid that is found to be excluded or limited as shown below, the Plan has the right to collect that amount from the payee, the Covered Person or from future benefits and any such payment does not waive the written exclusions, limitations or other terms of the Plan.

- (1) **Acupuncture:** Expenses for acupuncture and acupressure will not be considered eligible, except as specified under Eligible Medical Expenses.
- (2) **Administrative Services:** Expenses for completion of claim forms and shipping and handling will not be considered eligible.
- (3) **Adoption:** Expenses related to adoption will not be considered eligible.
- (4) **After Termination Date:** Expenses which are Incurred after the termination date of your coverage under the Plan will not be considered eligible.
- (5) **Alternative Therapies:** Expenses related to any of the following therapies or treatments will not be considered eligible:
 - (a) Aromatherapy;
 - (b) Biofeedback and bioenergetic therapy;
 - (c) Carbon dioxide therapy;
 - (d) Chelation therapy (except for heavy metal poisoning);
 - (e) Computer-aided tomography (CAT) scanning of the entire body;
 - (f) Gastric irrigation;
 - (g) Hair analysis;
 - (h) Hyperbaric therapy, except for the treatment of decompression or to promote health of wounds;
 - (i) Hypnosis, and hypnotherapy, except when performed by a Physician as a form of anesthesia in connection with covered Surgery;
 - (j) Lovaas therapy;
 - (k) Massage therapy;
 - (l) Megavitamin therapy;
 - (m) Primal therapy;
 - (n) Psychodrama;
 - (o) Purging;
 - (p) Rolfing;
 - (q) Sensory or auditory integration therapy;
 - (r) Sleep therapy; and
 - (s) Thermograms and thermography.

- (6) **Cardiac Rehabilitation:** Expenses in connection with Phase III cardiac rehabilitation, including, but not limited to occupational therapy or work hardening programs will not be considered eligible. Phase III is defined as the general maintenance level of treatment, with no further medical improvements being made and exercise therapy that no longer requires the supervision of medical professionals.
- (7) **Close Relative:** Expenses for services, care or supplies provided by a person who normally resides in the Covered Person's home or by a Close Relative will not be considered eligible.
- (8) **Complications:** Expenses for care, services or treatment required as a result of complications from a treatment or procedure not covered under the Plan will not be considered eligible.
- (9) **Convenience Items:** Expenses for personal hygiene and convenience items will not be considered eligible, including: telephone, television, internet, barber or beauty service or other guest services; housekeeping, cooking cleaning, shopping, monitoring, security or other home services; and travel, transportation, or living expenses, rest cures, recreational or diversional therapy.
- (10) **Cosmetic Procedures:** Except as specified under Eligible Medical Expenses, expenses for Cosmetic and reconstructive procedures will not be considered eligible, including, but not limited to:
- (a) Face lifts, body lifts, tummy tucks, liposuctions, removal of excess skin, removal or reduction of non-malignant moles, blemishes, varicose veins, cosmetic eyelid surgery and other Surgical Procedures;
 - (b) Procedures to remove healthy cartilage or bone from the nose (even if the surgery may enhance breathing) or other part of the body;
 - (c) Chemical peels, dermabrasion, laser or light treatments, bleaching, creams, ointments or other treatments or supplies to alter the appearance or texture of the skin;
 - (d) Insertion or removal of any implant that alters the appearance of the body (such as breast or chin implants); except removal of an implant will be covered when Medically Necessary;
 - (e) Removal of tattoos (except for tattoos applied to assist in covered medical treatments, such as markers for radiation therapy); and
 - (f) Repair of piercings and other voluntary body modifications, including removal of injected or implanted substances or devices;
 - (g) Surgery to correct gynecomastia;
 - (h) Breast augmentation; and
 - (i) Otoplasty.
- (11) **Counseling:** Expenses for religious, marital, family, career, social adjustment, pastoral, financial or relationship counseling will not be considered eligible, except as specified under Eligible Medical Expenses.
- (12) **Court Ordered Services:** Expenses related to court ordered services will not be considered eligible, including those required as a condition of parole or release.
- (13) **Custodial Care:** Expenses for Custodial Care will not be considered eligible.
- (14) **Dental Care:** Expenses Incurred in connection with dental care, treatment, x-rays, general anesthesia or Hospital expenses will not be considered eligible, except as specified under Eligible Medical Expenses, including but not limited to:
- (a) Services of Dentists, oral surgeons, dental hygienists, and orthodontists including Apicoectomy (dental root resection), root canal treatment, soft tissue impactions, treatment of periodontal disease, Alveolectomy, augmentation and vestibuloplasty and fluoride and other substances to protect, clean or alter the appearance of teeth;

- (b) Dental implants, false teeth, prosthetic restoration of dental implants, plates, dentures, braces, mouth guards, and other devices to protect, replace or reposition teeth; and
 - (c) Non-surgical treatments to alter bite or the alignment or operation of the jaw, including treatment of malocclusion or devices to alter bite or alignment.
- (15) **Developmental Delays:** Expenses in connection with the treatment of developmental delays, including, but not limited to speech therapy, occupational therapy, physical therapy and any related diagnostic testing will not be considered eligible. This exclusion will not apply to expenses related to the diagnosis, testing and treatment of autism, ADD or ADHD and to expenses covered as a preventive service under the Eligible Medical Expense section of the Plan.
- (16) **Disposable Supplies:** Expenses for any outpatient disposable supply or device will not be considered eligible, including sheaths, bags, elastic garments, support hose, bandages, bedpans, syringes, blood or urine testing supplies, and other home test kits, splints, neck braces, compresses, and other devices not intended for reuse by another patient.
- (17) **Emergency Room, if not for a Medical Emergency:** Emergency room expenses for treatment of a condition that is not considered a Medical Emergency will not be considered eligible.
- (18) **Exercise Programs:** Expenses for exercise programs for treatment of any condition will not be considered eligible, except for Physician-supervised cardiac rehabilitation and occupational or physical therapy covered by the Plan.
- (19) **Experimental and/or Investigational:** Expenses for treatment, procedures, devices, drugs or medicines which are determined to be Experimental and/or Investigational will not be considered eligible, except for Off- Label Drug Use or when such expenses are considered Qualified Clinical Trial Expenses.
- (20) **Facility:** Expenses for care, services or supplies provided in the following facilities will not be considered eligible:
- (a) Rest homes;
 - (b) Assisted living facilities;
 - (c) Similar institutions serving as an individual's primary residence or providing primarily custodial or rest care;
 - (d) Health resorts;
 - (e) Spas, sanitariums; or
 - (f) Infirmaries at schools, colleges, or camps.
- (21) **Foot Care:** Expenses for routine foot care, treatment of weak, unstable or flat feet will not be considered eligible, unless for metabolic or peripheral vascular disease or foot care to minimize the risk of infection for Covered Persons with diabetes.
- (22) **Foot Orthotics:** Expenses for foot only orthotics, orthopedic shoes (except those that are an integral part of a leg brace), arch supports or for the exam, prescription or fitting thereof will not be considered eligible.
- (23) **Gambling Addiction:** Expenses for services related to gambling addiction will not be considered eligible.
- (24) **Governmental Agency:** Expenses for services and supplies which are provided by any governmental agency for which the Covered Person is not liable for payment will not be considered eligible. In the case of a state-sponsored medical assistance program, benefits payable under this Plan will be primary. Benefits payable under this Plan will also be primary for any Covered Person eligible under TRICARE (the government sponsored program for military dependents).

- (25) **Growth/Height:** Expenses for any treatment, device, drug, service or supply (including Surgical Procedures, devices to stimulate growth and growth hormones), solely to increase or decrease height or alter the rate of growth will not be considered eligible.
- (26) **Hair Loss:** Expenses for hair loss or hair transplants will not be considered eligible, except as specified under Eligible Medical Expenses.
- (27) **Hearing Aids:** Expenses for hearing aids (including the fitting thereof) and supplies will not be considered eligible.
- (28) **Home and Mobility:** Except as specified under Eligible Medical Expenses, expenses related to any addition or alteration to a home, workplace or other environment, or vehicle and any related equipment or device will not be considered eligible, such as:
- (a) Purchase or rental of exercise equipment, air purifiers, central or unit air conditioners, water purifiers, waterbeds and swimming pools;
 - (b) Exercise and training devices, whirlpools, portable whirlpool pumps, sauna baths, or massage devices;
 - (c) Equipment or supplies to aid sleeping or sitting, including non-hospital electric and air beds, water beds, pillows, sheets, blankets, warming or cooling devices, bed tables and reclining chairs;
 - (d) Equipment installed in your home, workplace or other environment, including stair-glides, elevators, wheelchair ramps, or equipment to alter air quality, humidity or temperature;
 - (e) Other additions or alterations to your home, workplace or other environment, including room additions, changes in cabinets, countertops, doorways, lighting, wiring, furniture, communication aids, wireless alert systems, or home monitoring;
 - (f) Services and supplies furnished mainly to provide a surrounding free from exposure that can worsen your Illness or Injury;
 - (g) Removal from your home, worksite or other environment of carpeting, hypo-allergenic pillows, mattresses, paint, mold, asbestos, fiberglass, dust, pet dander, pests or other potential sources of allergies or illness; and
 - (h) Transportation devices, including stair-climbing wheelchairs, personal transporters, bicycles, automobiles, vans or trucks, or alterations to any vehicle or transportation device.
- (29) **Home Births:** Expenses for any services and supplies related to births occurring in the home or in a place not licensed to perform deliveries will not be considered eligible.
- (30) **Homeopathic Treatment:** Expenses for naturopathic and homeopathic treatments, services and supplies will not be considered eligible.
- (31) **Illegal Occupation/Felony:** Expenses for or in connection with an Injury or Illness arising out of an illegal occupation or commission of a felony will not be considered eligible. This exclusion will not apply to Injuries and/or Illnesses sustained due to a medical condition (physical or mental) or due to an act of domestic violence.
- (32) **Infertility:** Expenses for artificial procedures for the promotion of conception (e.g., invitro fertilization, GIFT (Gamete Intrafallopian Transfer), and ZIFT (Zygote Intrafallopian Transfer) will not be considered eligible. This exclusion does not apply to treatment of infertility as specified under Eligible Medical Expenses.

Nothing in this section is intended to exclude coverage for any infertility counseling or treatment required to be covered (if any) as a preventive service under the guidelines published by the Health Resources and Services Administration on August 1, 2011 (or any applicable subsequent guidelines).

- (33) **Immunizations:** Expenses for immunizations related to work will not be considered eligible.

- (34) **LEAP Program:** Expenses related to the LEAP, TEACCH, Denver and Rutgers programs will not be considered eligible.
- (35) **Maintenance Therapy:** Expenses for Maintenance Therapy of any type when the individual has reached the maximum level of improvement will not be considered eligible.
- (36) **Medically Necessary:** Expenses which are determined not to be Medically Necessary will not be considered eligible.
- (37) **Missed Appointments:** Expenses for missed appointments will not be considered eligible.
- (38) **No Legal Obligation:** Expenses for services provided for which the Covered Person has no legal obligation to pay will not be considered eligible. This exclusion will not apply to eligible expenses that may be covered by state Medicaid coverage where federal law requires this Employer's plan to be primary.
- (39) **Non-Covered Procedures:** Expenses for services related to a non-covered Surgery or procedure will not be considered eligible regardless of when the Surgery or procedure was performed.
- (40) **Not Performed Under the Direction of a Physician:** Expenses for services and supplies which are not prescribed or performed by or under the direction of a Physician will not be considered eligible.
- (41) **Not Recommended by a Physician:** Expenses by a Hospital or covered residential treatment center if hospitalization is not recommended or approved by a legally qualified Physician will not be considered eligible.
- (42) **Nursing and Home Health Aid Services:** Expenses related to nursing and home health aid services provided outside the home (such as in conjunction with school, vacation, work or recreational activities) will not be considered eligible.
- (43) **Nutritional Supplements:** Expenses for nutritional supplements or other enteral supplementation will not be considered eligible, except as specified under Eligible Medical Expenses. This includes specialized supplements delivered enterally via a tube directly into the stomach or intestines. Over-the-counter nutritional supplements or infant formulas will not be considered eligible even if prescribed by a Physician.
- (44) **Obesity:** Expenses for surgical and non-surgical care and treatment of obesity including weight loss or dietary control, whether or not it is in any case a part of a treatment plan for another Illness, will not be considered eligible, except as otherwise covered as a preventive service under the Eligible Medical Expenses section of the Plan or covered under the Prescription Benefit.
- (45) **Occupational Therapy:** Expenses for occupational therapy primarily for recreational or social interaction will not be considered eligible.
- (46) **Operated by the Government:** Expenses for treatment at a facility owned or operated by the government will not be considered eligible, unless the Covered Person is legally obligated to pay. This does not apply to Covered Expenses rendered by a Hospital owned or operated by the United States Veteran's Administration when services are provided to a Covered Person for a non-service related Illness or Injury.
- (47) **Outside the United States (U.S.):** Expenses for non-emergency services or supplies if the Covered Person leaves the U.S. or the U.S. Territories for the express purpose of receiving medical treatment will not be considered eligible. This exclusion also includes prescription medication or supplies if:
 - (a) Such prescription medication or supplies are unavailable or illegal in the U.S. or the U.S. Territories; or
 - (b) The purchase of such prescription medication or supplies outside the U.S. or the U.S. Territories is considered illegal.

- (48) **Over-the-Counter (OTC) Medication:** Expenses for any over-the-counter medication will not be considered eligible. Expenses for drugs and medicines not requiring a prescription by a licensed Physician and not dispensed by a licensed pharmacist will not be considered eligible, except as otherwise covered as a preventive service under the Eligible Medical Expenses section of the Plan.
- (49) **Plan Maximums:** Expenses for charges in excess of Plan maximums will not be considered eligible.
- (50) **Prior to Effective Date:** Expenses which are Incurred prior to the effective date of your coverage under the Plan will not be considered eligible.
- (51) **Radioactive Contamination:** Expenses Incurred as the result of radioactive contamination or the hazardous properties of nuclear material will not be considered eligible.
- (52) **Recreational and Educational Therapy:** Expenses for recreational and educational services; learning disabilities; behavior modification services; vocational testing or training; any form of non-medical self-care or self-help training, including any related diagnostic testing; music therapy; health club memberships; will not be considered eligible. Diabetic education is considered eligible as specified under Eligible Medical Expenses. This exclusion will not apply to expenses related to the diagnosis, testing and treatment of autism, ADD or ADHD.
- (53) **Refractive Errors:** Expenses for radial keratotomy, Lasik Surgery or any Surgical Procedure to correct refractive errors of the eye will not be considered eligible.
- (54) **Required by Law:** In any case where an individual is required by law to maintain insurance coverage (or to maintain any other security or reserve amount in lieu of insurance coverage), expenses of a Covered Person that would be paid by such insurance coverage are not eligible expenses, regardless of whether the individual is in fact covered under such coverage. For purposes of any required automobile, motorcycle or other vehicle coverage, otherwise eligible expenses below the minimum required coverage or the actual coverage elected, whichever is higher, will be excluded from coverage under this Plan.
- (55) **Resident/Intern:** Expenses related to services of a resident physician or intern rendered in that capacity will not be considered eligible.
- (56) **Riot/Revolt:** Expenses resulting from a Covered Person's participation in a riot or revolt will not be considered eligible. This exclusion will not apply to Injuries and/or Illnesses sustained due to a medical condition (physical or mental) or domestic violence.
- (57) **Services Not Permitted Under Applicable State or Local Laws:** Some state or local laws restrict the scope of health care services that a provider may render. In such cases, the Plan will not cover such health care services.
- (58) **Sex Transformation:** Expenses in connection with sex transformation will not be considered eligible.
- (59) **Sexual Dysfunction/Impotence:** Expenses for services, supplies or drugs related to sexual dysfunction/impotence not related to organic disease will not be considered eligible. Expenses for sex therapy will not be considered eligible.
- (60) **Smoking Cessation:** Expenses for smoking cessation programs, including smoking deterrents will not be considered eligible, unless otherwise covered as a preventive service under the Eligible Medical Expenses section of the Plan.
- (61) **Stand-by Physician:** Expenses for technical medical assistance or stand-by Physician services will not be considered eligible.
- (62) **Sterilization:** Expenses for the reversal of elective sterilization will not be considered eligible.
- (63) **Strength and Endurance:** Expenses related to services, devices and supplies to enhance strength, physical condition, endurance or physical performance will not be considered eligible, including:
- (a) Exercise equipment, memberships in health or fitness clubs, training, advice, or coaching;

- (b) Drugs or preparations to enhance strength, performance, or endurance; and
 - (c) Treatments, services and supplies to treat Illnesses, Injuries or disabilities related to the use of performance enhancing drugs or preparations.
- (64) **Surrogate:** Expenses relating to a surrogate pregnancy of any person who is not covered under this Plan, including but not limited to pre-pregnancy, conception, pre-natal, childbirth and post-natal expenses, will not be considered eligible.
- (65) **Third Party Exams:** Expenses related to any health examinations will not be considered eligible if required:
- (a) By a third party, including examinations and treatments required to obtain or maintain employment, or which an employer is required to provide under a labor agreement;
 - (b) By a law of a government;
 - (c) For securing insurance, school admissions or professional or other licenses;
 - (d) To travel;
 - (e) To attend a school, camp, or sporting event or participate in a sport or other recreational activity; and
 - (f) Any special medical reports not directly related to treatment except when provided as part of a covered service.
- (66) **Travel:** Expenses for travel will not be considered eligible, except as specified under Eligible Medical Expenses.
- (67) **Usual and Customary Charge:** Expenses in excess of the Usual and Customary Charge will not be considered eligible.
- (68) **Wage or Profit:** Expenses for or in connection with any Injury or Illness which arises out of or in the course of any occupation for wage or profit (including self-employment) will not be considered eligible.
- (69) **War:** Expenses for the treatment of Illness or Injury resulting from a war or any act of war or terrorism, whether declared or undeclared, civil war, hostilities or invasion, or while in the armed forces of any country or international organization will not be considered eligible.
- (70) **Weekend Admissions:** Expenses for care and treatment billed by a Hospital for non-Medical Emergency admissions on a Friday, Saturday or Sunday will not be considered eligible, unless Surgery is scheduled within 24 hours.
- (71) **Wilderness Programs:** Expenses related to wilderness treatment program will not be considered eligible (whether or not the program is part of a licensed residential treatment facility, or otherwise licensed institution), educational services, schooling, or any such related or similar program, including therapeutic program within a school setting.
- (72) **Workers' Compensation:** Expenses for or in connection with any Injury or Illness which arises out of or in the course of any occupation for which the Covered Person would be entitled to compensation under any Workers' Compensation Law or occupational disease law or similar legislation will not be considered eligible.

Expenses for Injuries or Illness which were eligible for payment under Workers' Compensation or similar law and have reached the maximum reimbursement paid under Workers' Compensation or similar law will not be eligible for payment under this Plan.

PREScription DRUG CARD PROGRAM

Eligible expenses include Prescription Drugs and medicines prescribed in writing by a Physician and dispensed by a licensed pharmacist, which are deemed necessary for treatment of an Illness or Injury including but not limited to: insulin; hypodermic needles or syringes, but only when dispensed upon a written prescription of a licensed Physician; diabetic supplies; oral infertility medication; and oral contraceptives, contraceptive shots and contraceptive patches (regardless of intended use). Please note Prescription Drugs are subject to the cost-sharing provisions described in the Prescription Drug Schedule of Benefits unless the Prescription Drug qualifies as a Preventive Drug (as described below).

When your prescription is filled at a retail pharmacy, the maximum amount or quantity of Prescription Drugs covered per Copay is a 30-day supply. Maintenance drugs of more than a 30-day supply may be purchased through the mail order program. The Covered Person must use the mail order program for maintenance medications or the Covered Person will pay the entire cost if the Covered Person continues to obtain maintenance medication through a retail pharmacy.

When using the mail order program, the maximum amount or quantity of Prescription Drugs covered per Copay is a 90-day supply.

Expenses for injectables that are not covered under the Prescription Drug Card Program and are Medically Necessary for the treatment of a covered Illness or Injury will be payable under this Plan subject to any applicable major medical Deductibles and Coinsurance as well as any coverage limitations and exclusions applicable to the major medical component of the Plan. Please refer to the Eligible Medical Expenses and the General Limitations and Exclusions section of the Plan.

NOTE: Coverage, limitations and exclusions for Prescription Drugs will be determined through the Prescription Drug Card Program elected by the Plan Sponsor and will not be subject to any limitations and exclusions under the major medical component of the Plan (except for injectables that are not covered under the Prescription Drug Card Program). For a complete listing of Prescription Drugs available under the Prescription Drug Card Program, as well as any exclusions or limitations that may apply, please contact the Prescription Drug Card Program Manager identified in the General Plan Information section of this Plan.

Dispense as Written

The Plan requires pharmacies dispense Generic Drugs when available unless the Physician specifically prescribes a Brand Name drug and marks the script "Dispense as Written" (DAW). Should a Covered Person choose a Brand Name Drug rather than the Generic equivalent when the Physician allowed a Generic Drug to be dispensed, the Covered Person will also be responsible for the cost difference between the Generic and Brand Name Drug. The cost difference is not covered by the Plan and will not accumulate toward your Out-of-Pocket Maximum.

Specialty Pharmacy Program

Specialty drugs are high cost drugs used to treat chronic diseases, including, but not limited to: HIV/Aids, Rheumatoid Arthritis, Cancer, Hepatitis, Hemophilia, Multiple Sclerosis, Infertility and Growth Hormone Deficiency. Specialty drugs must be obtained directly from the specialty pharmacy program after 3 refills at a retail pharmacy. For additional information, please contact the Prescription Drug Card Program Manager.

Specialty drugs are usually injectable medications that require refrigeration, special handling, additional safety protocols and timely delivery. Mail order prescriptions may be filled by Accredo, our dedicated specialty pharmacy.

Brand Name Drug: Means a trade name medication.

Generic Drug: A Prescription Drug which has the equivalency of the Brand Name Drug with the same use and metabolic disintegration. This Plan will consider as a Generic Drug any Food and Drug Administration approved generic pharmaceutical dispensed according to the professional standards of a licensed pharmacist and clearly designated by the pharmacist as being generic.

Prescription Drug: Any of the following: (a) a Food and Drug Administration-approved drug or medicine, which, under federal law, is required to bear the legend, "Caution: federal law prohibits dispensing without prescription"; (b) injectable insulin; or (c) hypodermic needles or syringes, but only when dispensed upon a written prescription of a licensed Physician. Such drug must be Medically Necessary in the treatment of an Illness or Injury.

Preventive Drug means items which have been identified by the U.S. Department of Health and Human Services (HHS) as a preventive service. You may view the guidelines established by HHS by visiting the following website:

<https://www.healthcare.gov/what-are-my-preventive-care-benefits>

For a paper copy, please contact the Plan Administrator.

SaveOnSP Program: The SaveOnSP Program moves selected specialty medications which have co-payment coupons or other financial assistance to a separate co-payment tier to take into account the full value of the available coupon or assistance. Your actual out-of-pocket costs for your specialty medications under this program will never exceed the cost-sharing amounts that would otherwise be applicable to these drugs under the Plan. Under this program, any manufacturer dollars applied will not count towards your deductible or your annual out-of-pocket maximum. Any out-of-pocket costs that you actually incur (not manufacturer dollars) will be applied toward your deductible and out-of-pocket maximum.

The SaveOnSP Program is subject to all applicable terms and coverage exclusions described in this Summary Plan Description. For more information about which prescription drugs are included in the SaveOnSP Program, **call 1 (800) 683-1074 or go online to www.SaveOnSP.com**

NON-MEDICARE ELIGIBLE RETIREES

RETIREE LEVEL BENEFITS

Retiree level benefits included Hospitalization, surgical-medical and major medical through Meritain. (it is the same as the active benefit). Prescription drugs are covered through Express Scripts (also the same as the active benefit.) Vision Care is \$100 every 2 years (same as active benefit) and is paid by National Vision Administrators (NVA). The is also a \$1,000 life insurance benefit for the member only through Union Labor Life Insurance Company (Ullico).

MEDICARE ELIGIBLE RETIREES

MEDICARE SUPPLEMENTAL BENEFITS PROVIDED BY THE HARTFORD

Medicare eligible retirees and Medicare eligible spouses will receive Medicare supplemental coverage through a group policy insured by The Hartford. These Medicare supplemental benefits are provided by The Hartford under a contract between the Welfare Fund and Labor First, LLC. These benefits supplement Medicare Part A (Hospital Services) and Part B (Physician Services). Please refer to The Hartford schedule of benefits enclosed with this Summary Plan Description for a detailed description of these Medicare supplemental benefits.

Note: Retirees/Dependents Eligible for Medicare Benefits DO NOT INCLUDE Prescription Drug Plan Benefit. YOU MUST SIGN UP FOR MEDICARE PART D.

LOWER HUDSON VALLEY EMPLOYEE ASSISTANCE PROGRAM

Medicare eligible retirees and Medicare eligible spouses will continue to be eligible for inpatient mental health services and inpatient alcohol/drug abuse services through Lower Hudson Valley EAP. Additional information about

the benefits provided through the Lower Hudson Valley EAP is enclosed with this Summary Plan Description.

AETNA VISION PREFERRED

Medicare eligible retirees, their spouses and dependents are eligible for vision benefits administered by Aetna, under a separate schedule of benefits called "Aetna Vision Preferred," The Aetna Vision Preferred schedule provides both in-network and out-of-network benefits. The Aetna Vision Preferred schedule will be provided to all Medicare eligible retirees and upon written request.

DENTAL BENEFIT THROUGH CIGNA

The Fund offers a Dental Benefit to active participants and their eligible dependents through a contract with Cigna. Cigna offers a Dental PPO. Please refer to the Cigna materials provided with this Summary Plan Description for details about the Dental Benefit.

VISION BENEFIT THROUGH NVA

The Fund offers a Vision Benefit to active participants and their eligible dependents through a contract with National Vision Administrators (NVA). Please refer to the NVA materials provided with this Summary Plan Description for details about the Vision Benefit.

COBRA CONTINUATION COVERAGE

The right to COBRA Continuation Coverage was created by a federal law known as the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA"). COBRA Continuation Coverage can become available to you and/or your eligible Dependents when your coverage under the Plan ends because of a life event known as a "qualifying event".

Qualified Beneficiary

In general, you, your Spouse and any Dependent Child covered under the Plan on the day before a qualifying event that causes you to lose coverage under the Plan is considered a "qualified beneficiary".

In addition, any Dependent Child who is born to or placed for adoption with you during a period of COBRA continuation coverage is considered a "qualified beneficiary".

If the qualifying event is a bankruptcy proceeding under Title 11 of the U.S. Code with respect to the Plan Sponsor or Participating Employer, a covered Retiree and his/her covered Spouse, surviving Spouse or Dependent Child of such Retiree will also be considered qualified beneficiaries provided the bankruptcy results in the loss of their coverage under the Plan.

Each qualified beneficiary (including a child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage) is offered the opportunity to make an independent election to receive COBRA continuation coverage.

Qualifying Event

If you are a covered Employee, you, your Spouse and/or Dependent Child will become a qualified beneficiary if you lose your coverage under the Plan because of either one of the following qualifying events:

- (1) Your hours of employment are reduced or
- (2) Your employment ends for any reason other than your gross misconduct.

You, your Spouse and/or Dependent Child may elect to continue coverage under the Plan for up to a maximum period of 18 months provided you elect to enroll in COBRA within 60 days following the later of (a) the date coverage under

the Plan would end due to the qualifying event; or (b) the date you are given notice of your rights to elect COBRA Continuation Coverage.

You, your Spouse and Dependent Child have an independent right to elect COBRA Continuation Coverage. You and/or your Spouse may elect coverage on behalf of either one of you and parents may elect coverage on behalf of their Dependent Child.

If you are the Spouse and/or Dependent Child of a covered Employee, you will also become a qualified beneficiary if you lose your coverage under the Plan because of any of the following qualifying events:

- (1) Your spouse/parent-Employee dies;
- (2) Your spouse/parent-Employee becomes entitled to Medicare benefits (under Part A, Part B or both); or
- (3) You/your parents become divorced or legally separated.

Your Spouse and/or Dependent Child may elect to continue coverage under the Plan for up to a maximum period of 36 months provided such Spouse and/or Dependent Child provide notice of the qualifying event to the Human Resources Department and elect to enroll in COBRA within 60 days following the later of (a) the date coverage under the Plan would end due to the qualifying event; or (b) the date they are given notice of their rights to elect COBRA Continuation Coverage and their obligation to provide such notice. Please see the section below entitled "Notice Requirement" for the requirements of such notice.

If you are a Dependent Child of a covered Employee, you will also become a qualified beneficiary if you lose coverage under the Plan because you cease to be eligible for coverage under the Plan as a Dependent Child. You may elect to continue coverage under the Plan for up to a maximum period of 36 months provided you provide notice of the qualifying event to the Human Resources Department and elect to enroll in COBRA within 60 days following the later of; (a) the date coverage under the Plan would end due to the qualifying event; or (b) the date you are given notice of your rights to elect COBRA Continuation Coverage and your obligation to provide such notice. Please see the section below entitled "Notice Requirement" for the requirements of such notice.

Extension of 18-Month Continuation Coverage Period

If you, your Spouse or Dependent Child is determined to be disabled by the Social Security Act (SSA); you and all other qualified beneficiaries may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 61st day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. To qualify for this extension in coverage, notification must be given to your Human Resources Department on a date that is both within 60 days after the later of (a) the date of the SSA determination; (b) the date coverage under the Plan would end due to the qualifying event; or (c) the date you are given notice of your obligation to provide such notice and before the end of the initial 18-month period of coverage. If you are later determined not disabled by SSA, you must notify your Human Resources Department within 30 days following the later of (a) the date of the SSA determination; or (b) the date you are given notice of your obligation to provide such notice. Please see the section below entitled "Notice Requirement" for the requirements of such notice.

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, your Spouse and any Dependent Child in your family may be entitled to receive up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months. To qualify for this extension in coverage, notification must be given to your Human Resources Department within 60 days after the later of (a) the date coverage under the Plan would end due to the qualifying event or (b) the date you are given notice of your obligation to provide such notice. Please see the section below entitled "Notice Requirement" for the requirements of such notice.

Notice Requirement

The notice must be postmarked (if mailed) or received by your Human Resources Department (if hand delivered), by the deadline set forth above. If the notice is late, the opportunity to elect or extend COBRA continuation coverage is lost and if you are electing COBRA continuation coverage, your coverage under the Plan will terminate on the last date for which you are eligible under the terms of the Plan or if you are eligible for an extension of COBRA continuation coverage, such coverage will end on the last day of the initial 18-month COBRA continuation coverage period.

For qualifying events such as divorce or legal separation of the Employee and Spouse or a Dependent Child's loss of eligibility under the Plan, the notice must contain the following information:

- (1) Name and address of the covered Employee or former employee;
- (2) Name and address of your Spouse, former Spouse and any Dependent Children;
- (3) Description of the qualifying event; and
- (4) Date of the qualifying event.

In addition to the information above, if you, your Spouse or any Dependent Child is determined by SSA to be disabled within 60 days after your COBRA continuation coverage begins, the notice must also contain the following information:

- (1) Name of person deemed disabled;
- (2) Date of disability determination; and
- (3) Copy of SSA determination letter.

If you cannot provide a copy of the decree of divorce or the SSA's determination by the deadline for providing the notice, complete and provide the notice, as instructed, by the deadline and submit the copy of the decree of divorce or the SSA's determination within 30 days after the deadline. The notice will be timely if you do so. However, no COBRA continuation coverage or extension of such coverage, will be available until the copy of the decree of divorce or the SSA's determination is provided.

If the notice does not contain all of the required information, the Human Resources Department may request additional information. If the individual fails to provide such information within the time period specified in the request, the notice may be rejected.

In addition to accepting a letter with the information described above, the Plan Administrator, in its discretion, may develop and make available a form, which may then be completed to provide the required notice. If such a form is available, a covered Employee or a covered Spouse may obtain a copy by requesting it from the Plan Administrator at the address provided in this notice.

Notice must be sent to the Human Resources Department at:

Board of Trustees Laborers Local No. 754 Welfare Fund
215 Old Nyack Turnpike
Chestnut Ridge, NY 10977

Termination of COBRA Continuation Coverage

COBRA continuation coverage automatically ends 18, 29 or 36 months (whichever is applicable) after the date of the qualifying event; however coverage may end before the end of the maximum period on the earliest of the following events:

- (1) The date the Plan Sponsor ceases to provide any group health plan coverage;
- (2) The date on which the qualified beneficiary fails to pay the required contribution;
- (3) The date that the qualified beneficiary first becomes, after the date of election, covered under any other group health plan (as an Employee or otherwise) or entitled to either Medicare Part A or Part B (whichever comes first);
or
- (4) The first day of the month that begins more than 30 days after the date of the SSA's determination that the qualified beneficiary is no longer disabled, but in no event before the end of the maximum coverage period that applied without taking into consideration the disability extension.

Payment for COBRA Continuation Coverage

Once COBRA continuation coverage is elected, you must pay for the cost of the initial period of coverage within 45 days. Payments then are due on the first day of each month to continue coverage for that month. If a payment is not received within 30 days of the due date, COBRA continuation coverage will be canceled and will not be reinstated. The amount you are required to pay for COBRA continuation coverage is 102% of the actual cost of coverage you elect, unless you qualify for the 11-month period of extended coverage due to disability (as specified above). In the event of disability, you will be required to pay 150% of the actual cost of coverage you elect for the 11-month extension period.

Additional Information

Additional information about the Plan and COBRA continuation coverage is available from the Plan Administrator, who is identified on the General Plan Information page of this Plan.

Current Addresses

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members.

CLAIM PROCEDURES

NOTE: These provisions do not apply to employee assistance program benefits, unless otherwise specified below.

You will receive an Employee identification card which will contain important information, including claim filing directions and contact information. The Employee identification card will show your Participating Provider Network and the Medical Management Administrator.

At the time you receive treatment, show the Employee identification card to your provider of service. In most cases, your provider will file your claim for you. You may file the claim yourself by submitting the required information to:

Meritain Health, Inc.
P.O. Box 853921
Richardson, TX 75085-3921
(800) 925-2272

Most claims under the Plan will be "post service claims." A "post service claim" is a claim for a benefit under the Plan after the services have been rendered. Post service claims must include the following information in order to be considered filed with the Plan:

- (1) The date of service;
- (2) The name, address, telephone number and tax identification number of the provider of the services or supplies;
- (3) The place where the services were rendered;
- (4) The diagnosis and procedure codes;
- (5) The amount of charges (including Network repricing information);
- (6) The name of the Plan;
- (7) The name of the covered Employee; and
- (8) The name of the patient.

A call from a provider who wants to know if an individual is covered under the Plan or if a certain procedure or treatment is a Covered Expense before the treatment is rendered, is not a "claim" since an actual written claim for benefits is not being filed with the Plan. Likewise, presentation of a prescription to a pharmacy does not constitute a claim.

Timely Filing

All claims must be filed with the Third Party Administrator within 12 months following the date services were Incurred. Claims filed after this time period will be denied.

Procedures for all Claims

The Plan's claim procedures are intended to reflect the Department of Labor's claims procedures regulations and should be interpreted accordingly. In the event of any conflict between this Plan and those Regulations, those Regulations will control. In addition, any changes in those Regulations shall be deemed to amend this Plan automatically, effective as of the date of those changes.

To receive benefits under the Plan, the claimant (i.e. you and your covered Dependents) must follow the procedures outlined in this section. There are 4 different types of claims: (1) Urgent Care Claims; (2) Concurrent Care Claims; (3) Pre-Service Claims; and (4) Post-Service Claims. The procedures for each type of claim are more fully described below:

- (1) **Urgent Care Claims.** If your claim is considered an urgent care claim, the Plan Administrator will notify you of the Plan's benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than 72 hours after the Plan receives the claim, unless you fail to provide sufficient information to determine whether or to what extent, benefits are covered or payable under the Plan. If you fail to provide sufficient information for the Plan to decide your claim, the Plan Administrator will notify you as soon as possible, but not later than 24 hours after the Plan receives the claim, of the specific information necessary to complete the claim. The notification may be oral unless written notification is requested by you. You will be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. The Plan Administrator will notify you of the Plan's determination as soon as possible, but in no case later than 48 hours after the earlier of (1) the Plan's receipt of the specified additional information or (2) the end of the period afforded the claimant to provide the specified additional information.

A claim for benefits is considered an urgent care claim if the application of the time periods for making non-urgent care determinations could seriously jeopardize your life or health or your ability to regain maximum function or, in the opinion of a Physician with knowledge of your medical condition, would subject you to severe pain that could not be adequately managed without the care or treatment which is the subject of the claim.

- (2) **Concurrent Care Claims.** If the Plan has approved an ongoing course of health care treatment to be provided over a period of time or number of treatments, any reduction or termination by the Plan of the previously approved course of treatment (other than by Plan amendment or termination) before the approved time period or number of treatments constitutes an adverse determination. In such a case, the Plan Administrator will notify you of the adverse determination at a time sufficiently in advance of the reduction or termination to allow you, the claimant, to appeal and obtain a determination on review of that adverse determination before reduction or termination of the benefit.

Any request by you to extend a previously approved course of urgent care treatment beyond the approved period of time or number of treatments shall be decided as soon as possible, taking into account the medical exigencies and the Plan Administrator will notify you of the benefit determination, whether adverse or not, within 24 hours after the Plan receives the claim provided that any such claim is made to the Plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.

- (3) **Pre-Service Claims.** For a pre-service claim, the Plan Administrator will notify you of the Plan's benefit determination (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after the Plan receives the claim. If, due to matters beyond the control of the Plan, the Plan Administrator needs additional time to process a claim, the Plan Administrator may extend the time to notify you of the Plan's benefit determination for up to 15 days provided that the Plan Administrator notifies you within 15 days after the Plan receives the claim, of those special circumstances and of when the Plan Administrator expects to make its decision. However, if such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension must specifically describe the required information and you will be afforded at least 45 days from receipt of the notice within which to provide the specified information.

A claim for benefits is considered a pre-service claim if the claim requires approval, in part or in whole, in advance

of obtaining the health care in question.

- (4) **Post-Service Claims.** For a post-service claim, the Plan Administrator will notify you of the Plan's adverse determination within a reasonable period of time, but not later than 30 days after receipt of the claim. If, due to special circumstances, the Plan Administrator needs additional time to process a claim, the Plan Administrator may extend the time for notifying you of the Plan's benefit determination on a one-time basis for up to 15 days provided that the Plan Administrator notifies you within 30 days after the Plan receives the claim, of those special circumstances and of the date by which the reviewer expects to make a decision. However, if such a decision is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information and you will be afforded at least 45 days from receipt of the notice within which to provide the specified information.

A claim for benefits is considered a post-service claim if it is a request for payment for services or other benefits that you have already received (or any other claim for health benefits that is not a pre-service claim or an urgent care claim).

Manner and Content of Notice of Initial Adverse Determination

If the Plan Administrator denies a claim, it must provide to you in writing or by electronic communication:

- (1) An explanation of the specific reasons for the denial;
- (2) A reference to the Plan provision or insurance contract provision upon which the denial is based;
- (3) A description of any additional information or material that you must provide in order to perfect the claim;
- (4) An explanation of why the additional material or information is necessary;
- (5) Notice that you have the right to request a review of the claim denial and information on the steps to be taken if you wish to request a review of the claim denial along with the time limits applicable to a request for review;
- (6) A statement describing your right to request a second level appeal or, if applicable, to bring an action under ERISA Section 502(a);
- (7) A copy of any rule, guideline, protocol or other similar criterion relied upon in making the adverse determination (or a statement that the same will be provided upon your request and without charge); and
- (8) If the adverse determination is based on the Plan's Medical Necessity, Experimental treatment or similar exclusion or limit, either: (a) an explanation of the scientific or clinical judgment applying the exclusion or limit to your medical circumstances or (b) a statement that the same will be provided upon your request and without charge.

For an adverse determination concerning an urgent care claim, the information described in this Section may be provided to you orally within the permitted time frame provided that a written or electronic notification in accordance with this section is furnished to you no later than 3 days after the oral notification.

Internal Review of Initially Denied Claims

If you submit a claim for Plan benefits and it is initially denied under the procedures described above, you may request a review of that denial under the procedures described below.

You have 180 days after you receive notice of an initial adverse determination within which to request a review of the adverse determination. For a request for a second level appeal, you have 60 days after you receive notice of an adverse determination at the first level of appeal to request a second level appeal of the adverse determination.

If you request a review of an adverse determination within the applicable time period, the review will meet the following requirements:

- (1) The Plan will provide a review that does not afford deference to the adverse determination that is being appealed and that is conducted by an appropriate named fiduciary of the Plan who did not make the adverse determination that is the subject of the appeal and who is not a subordinate of the individual who made that adverse

determination.

- (2) The appropriate named fiduciary of the Plan will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment before making a decision on review of any adverse determination based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug or other item is Experimental and/or Investigational or not Medically Necessary or appropriate. The professional engaged for purposes of a consultation in the preceding sentence will be an individual who is neither an individual who was consulted in connection with the adverse determination that is the subject of the appeal, nor a subordinate of any such individual.
- (3) The Plan will identify any medical or vocational experts whose advice is obtained on behalf of the Plan in connection with the Plan's review of an adverse determination, without regard to whether the advice is relied upon in making the adverse determination on review.
- (4) For a requested review of an adverse determination involving an urgent care claim, the review process will meet the expedited deadlines described below. Your request for such an expedited review may be submitted orally or in writing and all necessary information, including the Plan's determination on review, will be transmitted between the Plan and you by telephone, facsimile or other available similarly expeditious method.
- (5) The reviewer will afford you an opportunity to review and receive, without charge, all relevant documents, information and records relating to the claim and to submit issues and comments relating to the claim in writing to the Plan. The reviewer will take into account all comments, documents, records and other information submitted by the claimant relating to the claim regardless of whether the information was submitted or considered in the initial benefit determination.

All requests for review of initially denied claims and denied EAP claims (including all relevant information) must be submitted to the following address:

Meritain Health, Inc.
Appeals Department
P.O. Box 660908
Dallas, TX 75266-090

Deadline for Internal Review of Initially Denied Claims

- (1) **Urgent Care Claims.** The Plan provides for 2 levels of appeal for urgent care claims. For each level of appeal, the reviewer will notify you of the Plan's determination on review as soon as possible, taking into account the medical exigencies, but not later than 36 hours after the Plan receives your request for review of the initial adverse determination (or of the first-level appeal adverse determination).
- (2) **Pre-Service Claims.** The Plan provides for 2 levels of appeal for a pre-service claim. At each level of appeal, the reviewer will notify you of the Plan's determination on review within a reasonable period of time appropriate to the medical circumstances, but in no event later than 15 days after the Plan receives your request for review of the initial adverse determination (or of the first-level appeal adverse determination).
- (3) **Post-Service Claims.** The Plan provides for 2 levels of appeal for a post-service claim. At each level of appeal, the reviewer will notify you of the Plan's determination on review within a reasonable period of time appropriate to the medical circumstances, but in no event later than 30 days after the Plan receives your request for review of the initial adverse determination (or of the first-level appeal adverse determination).

Manner and Content of Notice of Decision on Internal Review of Initially Denied Claims

Upon completion of its review of an initial adverse determination (or a first-level appeal adverse determination), the reviewer will give you, in writing or by electronic notification, a notice of its benefit determination. For an adverse determination, the notice will include:

- (1) A description of the Plan's decision;
- (2) The specific reasons for the decision;
- (3) The relevant Plan provisions or insurance contract provisions on which its decision is based;

- (4) A statement that you are entitled to receive, upon request and without charge, reasonable access to and copies of, all documents, records and other information in the Plan's files which is relevant to your claim for benefits;
- (5) A statement describing your right to request a second level appeal) or, if applicable, to bring an action under ERISA Section 502(a);
- (6) If an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination on review, a statement that a copy of the rule, guideline, protocol or other similar criterion will be provided without charge to you upon request;
- (7) If the adverse determination on review is based on a Medical Necessity, Experimental treatment or similar exclusion or limit, either: (a) an explanation of the scientific or clinical judgment on which the determination was based, applying the terms of the Plan to the claimant's medical circumstances or (b) a statement that such an explanation will be provided without charge upon request; and
- (8) The following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and, if your benefit is an insured benefit, your State insurance regulatory agency."

Voluntary Appeal

Decision on the review of a denied claim will be made by the Participating Employer on any question involving the terms of an insurance contract and by the Board of Trustees on any other question. However, for any claims involving benefits provided by the Plan, after 2 levels of appeal, if the denial is upheld in the second level of appeal, then the Plan will inform the Covered Person and beneficiary of their right to appeal to the Board of Trustees for final review. If the request for review involves a claim for benefits that are provided directly by the Welfare Fund, the Board of Trustees shall make a decision at its next regularly scheduled meeting. However, if the request is received less than 30 days before a meeting the decision may be made at the second meeting following receipt of the request. If special circumstances require an extension of time for processing, a decision may be made at the third meeting following the date the request for a review is made. The decision of the Board of Trustees shall be in writing and shall include the specific reason(s) for the decision and specific references to plan provisions on which the decision is based. If you request a review of a denied claim you will be notified of the approximate date you can expect to receive a decision.

In some cases, you may also be able to ask for an external review if you are not satisfied with the Welfare Fund's review process. Please review the additional materials enclosed with this Plan regarding external reviews.

Calculation of Time Periods

For purposes of the time periods described in the Plan's claim procedures, the period of time during which a benefit determination is required to be made begins at the time a claim (or a request for review of a denied claim) is filed in accordance with the Plan procedures without regard to whether all the information necessary to make a decision accompanies the request. If a period of time is extended due to your failure to submit all information necessary for a claim for non-urgent care benefits, the period for making the determination is "frozen" from the date the notification requesting the additional information is sent to you until the date you respond or, if earlier, until 45 days from the date you receive (or were reasonably expected to receive) the notice requesting additional information.

Adverse Determination

For purposes of the Plan's claim procedures, an "adverse determination" is a denial, reduction or termination of or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination or failure to provide or make payment that is based on a determination of an individual's eligibility to participate in the Plan and including a denial, reduction or termination of or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be Experimental and/or Investigational or not Medically Necessary or appropriate. Adverse determination also includes any rescission of coverage, whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at the time of rescission.

Plan's Failure to Follow Procedures

If the Plan fails to follow the claim procedures described above, you will be deemed to have exhausted the Plan internal claim procedures and you will be entitled to pursue any available remedy under State or Federal law on the

basis that the Plan has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim.

Statute of Limitations for Plan Claims

Please note that no legal action may be commenced or maintained to recover benefits under the Plan more than 3 years after the final review/appeal decision by the Plan Administrator has been rendered (or deemed rendered).

Appointment of Authorized Representative

A Covered Person is permitted to appoint an authorized representative to act on his/her behalf with respect to a benefit claim or appeal of a denial. An assignment of benefits by a Covered Person to a provider will not constitute appointment of that provider as an authorized representative. To appoint such a representative, the Covered Person must complete a form which can be obtained from the Plan Administrator or the Third Party Administrator. However, in connection with a claim involving urgent care, the Plan will permit a health care professional with knowledge of the Covered Person's medical condition to act as the Covered Person's authorized representative without completion of this form. In the event a Covered Person designates an authorized representative, all future communications from the Plan will be with the representative, rather than the Covered Person, unless the Covered Person directs the Plan Administrator, in writing, to the contrary.

Physical Examinations

The Plan reserves the right to have a Physician of its own choosing examine any Covered Person whose Illness or Injury is the basis of a claim. All such examinations will be at the expense of the Plan. This right may be exercised when and as often as the Plan Administrator may reasonably require during the pendency of a claim. The Covered Person must comply with this requirement as a necessary condition to coverage.

External Review of Adverse Benefit Determinations

If you have exhausted the Plan's internal appeal process for claims specifically related to compliance with federal protections for Surprise Billing and associated cost-sharing, you may request an external review of the Plan's final adverse determination.

The Plan will provide for an external review process in accordance with federal law.

- (1) You have **4** months following the date you receive notice of the Plan's final internal adverse determination specifically related to Surprise Billing and associated cost-sharing, within which to request an external review. The request for an external review must be submitted to the following address:

Meritain Health Inc.
Appeals Department
P.O. Box 41980
Plymouth, MN 55441-0970

- (2) Within 5 business days following the date the Plan receives your external review request the Plan will complete a preliminary review. The Plan will notify you in writing within one business day after it completes the preliminary review whether the claim is eligible for the external review process:
 - (a) If the request is complete, but the claim is not eligible for external review, the notice will describe the reasons it is not eligible and will provide contact information for the Employee Benefits Security Administration.
 - (b) If the request is not complete, the notice will describe information or materials needed to make the request complete. If the request is not complete and additional information or materials are needed to complete the preliminary review, you will have until the later of (i) 48 hours following the date of receipt of the notification or (ii) the end of the 4-month deadline described in (1) above to provide the necessary additional information or materials.
- (3) Following the Plan's preliminary review, if the request is eligible for external review, the Plan will assign an independent review organization (IRO) (as soon as administratively feasible) to make a determination on the request for external review. Within 5 business days following assignment of the IRO, the Plan will forward to the IRO all information and materials relevant to the final internal adverse determination.

- (4) The assigned IRO will notify you in writing (within a reasonable period of time) of the request's eligibility and acceptance for external review. The notice will include a statement regarding your right to submit any additional information, within 10 business days from the date of receipt of the notice, for the IRO to consider as part of the external review process. Any such additional information received by the IRO will be forwarded on and shared with the Plan. The Plan, based upon any new information received, may reconsider its final internal adverse determination. Reconsideration by the Plan will not delay the external review process. If the Plan does not reconsider its final internal adverse benefits determination, the IRO will continue to proceed with the external review process.
- (5) Within 45 days after the IRO receives the external review request from the Plan, the IRO must provide written notice of its external review determination to you and the Plan. The IRO's notice is required to contain the following:
 - (a) A general description of the reason for the request for external review, including information sufficient to identify the claim, the diagnosis code and treatment code and the corresponding meaning for each and the reason for the previous denial;
 - (b) The date the IRO received the assignment to conduct the external review and the date of the IRO decision;
 - (c) References to the evidence or documentation, including the specific coverage provisions and evidence based standards, considered in reaching its decision;
 - (d) A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;
 - (e) A statement that the determination is binding except to the extent that other remedies may be available under state or federal law to either the group health plan or to you;
 - (f) A statement that judicial review may be available to you; and
 - (g) Current contact information, including telephone number, for any applicable office of health insurance consumer assistance or ombudsman established under the Public Health Service Act Section 2793.

Effect of External Review Determination

A determination on external review is binding on the Plan and the claimant, except to the extent that other remedies are available under applicable state or federal law. However, a decision by the external reviewer does not preclude the Plan from making payment or providing benefits on a claim at any time, including after a decision that denies the claim. When an external review decision requires the Plan to provide benefits or payment on a claim, the Plan will provide benefits or payment pursuant to the decision without unreasonable delay regardless of whether the Plan intends to seek judicial review of the decision, unless and until there is a judicial decision that provides otherwise.

COORDINATION OF BENEFITS

Benefits Subject to This Provision

This provision applies to all benefits provided under any section of this Plan.

Excess Insurance

If at the time of Injury, Illness, disease or disability there is available or potentially available, any coverage (including, but not limited to, coverage resulting from a judgment at law or settlements), the benefits under the Plan shall apply only as an excess over such other sources of coverage.

The Plan's benefits will be excess to, whenever possible:

- (1) Any primary payer besides the Plan;
- (2) Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
- (3) Any policy of insurance from any insurance company or guarantor of a third-party;
- (4) Workers' Compensation or other liability insurance company; or
- (5) Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments and school insurance coverage.

Vehicle Limitation

When medical payments are available (or, under applicable law should be available) under any vehicle insurance, the Plan shall pay excess benefits only, without reimbursement for vehicle plan and/or policy deductibles. This Plan shall always be considered secondary to such plans and/or policies. This applies to all forms of medical payments under vehicle plans and/or policies regardless of its name, title or classification. If medical payments would have been available under a vehicle insurance policy if minimum legally required levels of coverage had been in effect, but the minimum level of coverage was not in effect, the Plan shall pay excess benefits only, determined as if the minimum legally required level of coverage had been in effect at the applicable time.

Allowable Expenses

"Allowable expenses" shall mean any Medically Necessary, Usual and Customary item of expense, at least a portion of which is covered under this Plan. When some Other Plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered in the amount that would be payable in accordance with the terms of the Plan shall be deemed to be the benefit.

In the case of HMO (Health Maintenance Organization) plans, this Plan will not consider any charges in excess of what an HMO provider has agreed to accept as payment in full. Further, when an HMO is primary and the Covered Person does not use an HMO provider, this Plan will not consider as allowable expenses any charge that would have been covered by the HMO had the Covered Person used the services of an HMO provider.

Other Plan

"Other Plan" means any of the following plans, other than this Plan, providing benefits or services for medical or dental care or treatment:

- (1) Group, blanket or franchise insurance coverage;
- (2) Any group Hospital service prepayment, group medical or dental service prepayment, group practice or other group prepayment coverage;
- (3) Any coverage under labor-management trustee plans, union welfare plans, employer organization plans, school insurance or employee benefit organization plans;
- (4) Coverage under Medicare and any other governmental program that the Covered Person is liable for payment, except state-sponsored medical assistance programs and TRICARE, in which case this Plan pays primary;

- (5) Coverage under any Health Maintenance Organization (HMO); or
- (6) Any mandatory automobile insurance (such as no-fault) providing benefits under a medical expense reimbursement provision for health care services because of Injuries arising out of a motor vehicle accident and any other medical and liability benefits received under any automobile policy.

Application to Benefit Determinations

The plan that pays first according to the rules in the section entitled "Order of Benefit Determination" will pay as if there were no other plan involved. When this Plan is secondary, this Plan will always pay either its benefits in full or a reduced amount which, when added to the benefits payable by the other plan or plans, will not exceed 100% of allowable expenses. When there is a conflict in the order of benefit determination, this Plan will never pay more than 50% of allowable expenses.

Order of Benefit Determination

For the purposes of the section entitled "Application to Benefit Determinations," the rules establishing the order of benefit determination are listed below. The Plan will consider these rules in the order in which they are listed and will apply the first rule that satisfies the circumstances of the claim:

- (1) A plan without a coordinating provision will always be the primary plan;
- (2) The plan covering the person directly rather than as an employee's dependent is primary and the other plans are secondary.
- (3) Active/laid-off employees or retirees: The plan which covers a person as an active employee (or as that employee's dependent) determines its benefits before the Plan which covers a person as a laid-off or retired employee (or as that employee's dependent). If the Plan which covers that person has not adopted this rule and if, as a result, the Plans do not agree on the order of benefits, this rule will not apply.
- (4) Dependent children of parents not separated or divorced or unmarried parents living together: The plan covering the parent whose birthday falls earlier in the year pays first. The plan covering the parent whose birthday falls later in the year pays second. However, if the other plan does not have this rule but instead has a rule based upon the gender of the parent and if as a result the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.
- (5) Dependent children of separated or divorced parents or unmarried parents not living together: When parents are separated or divorced or unmarried and not living together, neither the male/female nor the birthday rules apply. Instead:
 - (a) The plan of the parent with custody pays first;
 - (b) The plan of the spouse of the parent with custody (the step-parent) pays next;
 - (c) The plan of the parent without custody pays next; and
 - (d) The plan of the spouse of the non-custodial parent pays last.

Notwithstanding the above provisions, if there is a court decree that would otherwise establish financial responsibility for the child's health care expenses, the benefits of the plan that covers the child as a dependent of the parent with such financial responsibility shall be determined before the benefits of any other plan that covers the child as a dependent child.

- (6) If a person whose coverage is provided under a right of continuation pursuant to state or federal law (e.g., COBRA) is also covered under another plan, the plan covering the person as an employee, member, subscriber or retiree (or as that person's dependent) is primary and the continuation coverage is secondary. If the other plan does not have this rule and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

When the rules above do not establish an order of benefit determination, the benefits of a plan which has covered the person on whose expenses claim is based for the longer period of time shall be determined before the benefits of a plan which has covered such person the shorter period of time.

Right to Receive and Release Necessary Information

For the purpose of determining the applicability of and implementing the terms of this coordination of benefits provision or any provision of similar purpose of any other plan, this Plan may, without notice to any person, release to or obtain from any insurance company or other organization or individual, any information with respect to any person, which the Plan deems to be necessary for such purposes. Any person claiming benefits under this Plan is deemed to consent to the release and receipt of such information and agrees to furnish to the Plan such information as may be necessary to implement this provision.

Facility of Payment

Whenever payments which should have been made under this Plan in accordance with this provision have been made under any other Plans, the Plan Administrator may, in its sole discretion, pay any organizations making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of this provision and amounts so paid shall be deemed to be benefits paid under this Plan and, to the extent of such payments, this Plan shall be fully discharged from liability.

Right of Recovery

Whenever payments have been made by this Plan with respect to allowable expenses in a total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this provision, the Plan shall have the right to recover such payments, to the extent of such excess, in accordance with the Recovery of Payments provision of this Plan.

Recovery of Payments

Occasionally, benefits are paid more than once, are paid based upon improper billing or a misstatement in a proof of loss or enrollment information, are not paid according to the Plan's terms, conditions, limitations or exclusions or should otherwise not have been paid by the Plan. This Plan may also inadvertently pay benefits that are later found to be greater than the maximum allowable charge. In this case, this Plan may recover the amount of the overpayment from the person or entity to which it was paid, primary payers or from the party on whose behalf the charge(s) were paid. Whenever the Plan pays benefits exceeding the amount of benefits payable under the terms of the Plan, the Plan Administrator has the right to recover any such erroneous payment.

A Covered Person, provider, another benefit plan, insurer or any other person or entity who receives a payment exceeding the amount of benefits payable under the terms of the Plan or on whose behalf such payment was made, shall return or refund the amount of such erroneous payment to the Plan within 30 days of discovery or demand. The Plan Administrator shall have discretion in deciding whether to obtain payment for the expense for which the erroneous payment was made or to which it was applied.

The person or entity receiving an erroneous payment may not apply such payment to another expense. The Plan Administrator shall have the sole discretion to choose who will repay the Plan for an erroneous payment and whether such payment shall be reimbursed in a lump sum. When a Covered Person or other entity does not comply with the provisions of this section, the Plan Administrator shall have the authority, in its sole discretion, to deny payment of any claims for benefits by the Covered Person and to deny or reduce future benefits payable (including payment of future benefits for any other Injury or Illness) under the Plan by the amount due as reimbursement to the Plan. The Plan Administrator may also, in its sole discretion, deny or reduce future benefits (including future benefits for any other Injury or Illness) under any other group benefits plan maintained by the Plan Sponsor. The reductions will equal the amount of the required reimbursement.

Providers and any other person or entity accepting payment from the Plan or to whom a right to benefits has been assigned, in consideration of services rendered, payments and/or rights, agree to be bound by the terms of this Plan and agree to submit claims for reimbursement in strict accordance with their State's health care practice acts, most recent edition of the ICD or CPT standards, Medicare guidelines, HCPCS standards or other standards approved by the Plan Administrator or insurer. Any payments made on claims for reimbursement not in accordance with the above provisions shall be repaid to the Plan within 30 days of discovery or demand or incur prejudgment interest of 1.5% per month. If the Plan must bring an action against a Covered Person, provider or other person or entity to

enforce the provisions of this section, then that Covered Person, provider or other person or entity agrees to pay the Plan's attorneys' fees and costs, regardless of the action's outcome.

Further, a Covered Person and/or their dependents, beneficiaries, estate, heirs, guardian, personal representative or assigns ("Plan Participants") shall assign or be deemed to have assigned to the Plan their right to recover said payments made by the Plan, from any other party and/or recovery for which the Plan Participant(s) are entitled, for or in relation to facility-acquired condition(s), provider error(s) or damages arising from another party's act or omission for which the Plan has not already been reimbursed.

The Plan reserves the right to deduct from any benefits properly payable under this Plan the amount of any payment which has been made:

- (1) In error;
- (2) Pursuant to a misstatement contained in a proof of loss or a fraudulent act;
- (3) Pursuant to a misstatement made to obtain coverage under this Plan within 2 years after the date such coverage commences;
- (4) With respect to an ineligible person;
- (5) In anticipation of obtaining a recovery if a Covered Person fails to comply with the Plan's Subrogation, Third Party Recovery and Reimbursement provisions; or
- (6) Pursuant to a claim for which benefits are recoverable under any policy or act of law providing for coverage for occupational Injury or disease to the extent that such benefits are recovered. This provision (6) shall not be deemed to require the Plan to pay benefits under this Plan in any such instance.

The deduction may be made against any claim for benefits under this Plan by a Covered Person if such payment is made with respect to the Covered Person.

If the Plan seeks to recoup funds from a provider, due to a claim being made in error, a claim being fraudulent on the part of the provider and/or the claim that is the result of the provider's misstatement, said provider shall, as part of its assignment to benefits from the Plan, abstain from billing the Covered Person for any outstanding amount(s).

Medicaid Coverage

You or your Dependent's eligibility for any state Medicaid benefits will not be taken into account in determining or making any payments for benefits to or on behalf of you or your Dependent. Any such benefit payments will be subject to the state's right to reimbursement for benefits it has paid on behalf of such person, as required by the state Medicaid program; and the Plan will honor any subrogation rights the state may have with respect to benefits which are payable under the Plan.

Coordination of Benefits with Medicaid

In all cases, benefits available through a state or federal Medicaid program will be secondary or subsequent to the benefits of this Plan.

Coordination of Benefits with Medicare

When Medicare is the primary payor, the Plan will base its payment upon benefits allowable by Medicare. If you or your Dependent(s) are enrolled in the Plan due to Retiree coverage, and you and/or your Dependent(s) did not elect coverage under Medicare Parts A and/or B when eligible, the Plan will be secondary and coordinate with benefits that would have been provided by Medicare.

When you, your Spouse or Dependents (as applicable) are eligible for or entitled to Medicare and covered by the Plan, the Plan at all times will be operated in accordance with any applicable Medicare secondary payer and non-discrimination rules. These rules include, where applicable, but are not necessarily limited to, rules concerning individuals with end stage renal disease, rules concerning active employees age 65 or over and rules concerning working disabled individuals (as discussed below).

When Medicare is the primary payor, the Plan will pay secondary to the extent the benefit is a Covered Expense

under the Plan (meaning that the Plan will base its payment upon benefits allowable by Medicare).

In accordance with federal law, the following rules apply in determining whether Medicare or Plan coverage is primary health care coverage:

- (1) **The Working Aged Rule:** Medicare benefits are secondary to benefits payable under the Plan for individuals entitled to Medicare due to being age 65 or over and who have Plan coverage as a result of his/her current employment status (or the current employment status of a Spouse). When you or your Spouse become eligible for Medicare due to the attainment of age 65, you or your Spouse may still be eligible for benefits provided under the Plan based on your current employment status.

If, as a result, you have or your Spouse has primary coverage under the Plan, the Plan will pay the portion of your incurred expenses that are normally covered by the Plan. All or part of the remaining amount, if any, may be paid by Medicare if the expenses are covered expenses under Medicare and the portion of the expenses covered by Medicare exceeds the portion covered by the Plan. If the expenses are not covered by the Plan but are Medicare-covered expenses, then Medicare will process its payment of the expenses as if you do not have Plan coverage.

- (2) **The Working Disabled Rule:** Medicare benefits are secondary to benefits payable under the Plan for covered individuals under age 65 entitled to Medicare on the basis of disability (other than end-stage renal disease) and who are covered under the Plan as a result of current employment status with an employer. That is, if you or your dependents are covered by the Plan based on your current employment status, Medicare benefits are secondary for you or your covered Dependents entitled to Medicare on the basis of disability (other than end-stage renal disease). In this case the Plan is primary.

- (3) **End-Stage Renal Disease Rule:** Medicare benefits are secondary to benefits payable under the Plan for covered individuals eligible for or entitled to Medicare benefits on the basis of end-stage renal disease ("ESRD"), for a period not to exceed 30 months generally beginning the first day of the month of eligibility or entitlement to Medicare due to ESRD. (Special rules apply if you were entitled to Medicare based on age or disability prior to becoming eligible for Medicare due to ESRD.) Because an ESRD patient can have up to a 3- month wait to obtain Medicare coverage, the Plan's primary payment responsibility may vary up to 3 months. If the basis of your entitlement to Medicare changes from ESRD to age or disability, the Plan's primary payment responsibility may terminate on the month before the month in which the change is effective and the rules set forth above, if applicable, will apply. Your Human Resources Department can provide you with more detailed information on how this rule works.

Medicare and COBRA

For most COBRA beneficiaries (e.g., the working aged or disabled Medicare beneficiaries), Medicare rules state that Medicare will be primary to COBRA continuation coverage and this would apply to this Plan's Continuation of Benefits (COBRA) coverage. For an ESRD-related Medicare beneficiary, COBRA continuation coverage (if elected) is generally primary to Medicare during the 30-month coordination period.

Coordination of Benefits with TRICARE

The Plan at all times will be operated in accordance with any applicable TRICARE secondary payer and non-discrimination rules issued by the Department of Defense.

SUBROGATION, THIRD-PARTY RECOVERY AND REIMBURSEMENT

Payment Condition

- (1) The Plan, in its sole discretion, may elect to conditionally advance payment of medical benefits in those situations where an Injury, Illness, disease or disability is caused in whole or in part by or results from the acts or omissions of you and/or your Dependents, plan beneficiaries and/or their Dependents, beneficiaries, estate, heirs, guardian, personal representative or assigns (collectively referred to hereinafter in this section as "Covered Person") or a third party, where other insurance is available, including but not limited to no-fault, uninsured motorist, underinsured motorist and medical payment provisions (collectively "coverage").
- (2) The Covered Person, his/her attorney and/or Legal Guardian of a minor or incapacitated individual agrees that acceptance of the Plan's conditional payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain 100% of the Plan's conditional payment of benefits or the full extent of payment from anyone or combination of first and third party sources in trust, without disruption except for reimbursement to the Plan or the Plan's assignee. By accepting benefits the Covered Person agrees the Plan shall have an equitable lien on any funds received by the Covered Person and/or their attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The Covered Person agrees to include the Plan's name as a co-payee on any and all settlement drafts.
- (3) In the event a Covered Person settles, recovers or is reimbursed by any coverage, the Covered Person agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the Covered Person. If the Covered Person fails to reimburse the Plan out of any judgment or settlement received, the Covered Person will be responsible for any and all expenses (fees and costs) associated with the Plan's attempt to recover such money.
- (4) If there is more than one party responsible for charges paid by the Plan or may be responsible for charges paid by the Plan, the Plan will not be required to select a particular party from whom reimbursement is due. Furthermore, unallocated settlement funds meant to compensate multiple injured parties of which the Covered Person(s) is/are only one or a few, that unallocated settlement fund is considered designated as an "identifiable" fund from which the Plan may elect to seek reimbursement, at its discretion.

Subrogation

- (1) As a condition to participating in and receiving benefits under this Plan, the Covered Person agrees to assign to the Plan the right to subrogate any and all claims, causes of action or rights that may arise against any person, corporation and/or entity and to any coverage to which the Covered Person is entitled, regardless of how classified or characterized, at the Plan's discretion.
- (2) If a Covered Person receives or becomes entitled to receive benefits, an automatic equitable subrogation lien attaches in favor of the Plan to any claim, which any Covered Person may have against any coverage and/or party causing the Illness or Injury to the extent of such conditional payment by the Plan plus reasonable costs of collection.
- (3) The Plan may, at its discretion, in its own name or in the name of the Covered Person, commence a proceeding or pursue a claim against any party or coverage for the recovery of all damages to the full extent of the value of any such benefits or conditional payments advanced by the Plan.
- (4) The Covered Person authorizes the Plan to pursue, sue, compromise and/or settle any such claims in the Covered Persons and/or the Plan's name and agrees to fully cooperate with the Plan in the prosecution of any such claims if the Covered Person fails to file a claim or pursue damages against.
 - (a) The responsible party, its insurer or any other source on behalf of that party;
 - (b) Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
 - (c) Any policy of insurance from any insurance company or guarantor of a third party;

- (d) Workers' Compensation or other liability insurance company; or
- (e) Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments and school insurance coverage.

The Covered Person assigns all rights to the Plan or its assignee to pursue a claim and the recovery of all expenses from any and all sources listed above.

Right of Reimbursement

- (1) The Plan shall be entitled to recover 100% of the benefits paid, without deduction for attorneys' fees and costs or application of the common fund doctrine, make whole doctrine or any other similar legal theory, without regard to whether the Covered Person is fully compensated by his/her recovery from all sources. The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines and laws of any State prohibiting assignment of rights which interferes with or compromises in any way the Plan's equitable subrogation lien. The obligation exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability or other expenses. If the Covered Persons' recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved.
- (2) No court costs, experts' fees, attorneys' fees, filing fees or other costs or expenses of litigation may be deducted from the Plan's recovery without the prior, expressed written consent of the Plan.
- (3) The Plan's right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of the Covered Person, whether under the doctrines of causation, comparative fault or contributory negligence or other similar doctrine in law. Accordingly, any lien reduction statutes, which attempt to apply such laws and reduce a subrogating Plan's recovery will not be applicable to the Plan and will not reduce the Plan's reimbursement rights.
- (4) These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgment of these rights is required by the Plan and signed by the Covered Person.
- (5) This provision shall not limit any other remedies of the Plan provided by law. These rights of subrogation and reimbursement shall apply without regard to the location of the event that led to or caused the applicable Illness, Injury, disease or disability.

Excess Insurance

If at the time of Injury, Illness, disease or disability, there is available or potentially available any coverage (including but not limited to coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of coverage, except as provided for under the Plan's "Coordination of Benefits" section. The Plan's benefits shall be excess to:

- (1) The responsible party, its insurer or any other source on behalf of that party;
- (2) Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
- (3) Any policy of insurance from any insurance company or guarantor of a third party;
- (4) Workers' Compensation or other liability insurance company; or
- (5) Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments and school insurance coverage.

Separation of Funds

Benefits paid by the Plan, funds recovered by the Covered Person and funds held in trust over which the Plan has an equitable lien exist separately from the property and estate of the Covered Person, such that the death of the Covered Person or filing of bankruptcy by the Covered Person, will not affect the Plan's equitable lien, the funds over which the Plan has a lien or the Plan's right to subrogation and reimbursement.

Wrongful Death

In the event that the Covered Person dies as a result of his/her Injuries and a wrongful death or survivor claim is asserted against a third party or any coverage, the Plan's subrogation and reimbursement rights shall still apply.

Obligations

- (1) It is the Covered Person's obligation at all times, both prior to and after payment of medical benefits by the Plan:
 - (a) To cooperate with the Plan or any representatives of the Plan, in protecting its rights, including discovery, attending depositions and/or cooperating in trial to preserve the Plan's rights;
 - (b) To provide the Plan with pertinent information regarding the Illness, disease, disability or Injury, including Accident reports, settlement information and any other requested additional information;
 - (c) To take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights;
 - (d) To do nothing to prejudice the Plan's rights of subrogation and reimbursement;
 - (e) To promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received; and
 - (f) To not settle or release, without the prior consent of the Plan, any claim to the extent that the Plan beneficiary may have against any responsible party or coverage.
- (2) If the Covered Person and/or his/her attorney fails to reimburse the Plan for all benefits paid or to be paid, as a result of said Injury or condition, out of any proceeds, judgment or settlement received, the Covered Person will be responsible for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Covered Person.
- (3) The Plan's rights to reimbursement and/or subrogation are in no way dependent upon the Covered Persons' cooperation or adherence to these terms.

Offset

Failure by the Covered Person and/or his/her attorney to comply with any of these requirements may, at the Plan's discretion, result in a forfeiture of payment by the Plan of medical benefits and any funds or payments due under this Plan may be withheld until the Covered Person satisfies his/her obligation.

Minor Status

- (1) In the event the Covered Person is a minor as that term is defined by applicable law, the minor's parents or court-appointed guardian shall cooperate in any and all actions by the Plan to seek and obtain requisite court approval to bind the minor and his/her estate insofar as these subrogation and reimbursement provisions are concerned.
- (2) If the minor's parents or court-appointed guardian fail to take such action, the Plan shall have no obligation to advance payment of medical benefits on behalf of the minor. Any court costs or legal fees associated with obtaining such approval shall be paid by the minor's parents or court-appointed guardian.

Language Interpretation

The Plan Sponsor retains sole, full and final discretionary authority to construe and interpret the language of this provision, to determine all questions of fact and law arising under this provision and to administer the Plan's subrogation and reimbursement rights. The Plan Sponsor may amend the Plan at any time without notice, subject to the terms and conditions of any relevant collective bargaining agreement.

Severability

In the event that any section of this provision is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining sections of this provision and Plan. The section shall be fully severable. The Plan shall be construed and enforced as if such invalid or illegal sections had never been inserted in the Plan.

Notwithstanding anything contained herein to the contrary, to the extent this Plan is not governed by ERISA, the Plan's right to subrogation and reimbursement may be subject to applicable State subrogation laws.

DEFINITIONS

In this section you will find the definitions for the capitalized words found throughout this Plan. There may be additional words or terms that have a meaning that pertains to a specific section and those definitions will be found in that section provided, however, any such capitalized word shall have such meaning when used in any other section. These definitions are not an indication that charges for particular care, supplies or services are eligible for payment under the Plan. Please refer to the appropriate sections of this Plan for that information.

Accident means a non-occupational sudden and unforeseen event, definite as to time and place or a deliberate act resulting in unforeseen consequences.

Ambulatory Surgical Center means a free-standing surgical center, which is not part of a Hospital and which: (1) has an organized medical staff of Physicians; (2) has permanent facilities that are equipped and operated primarily for the purpose of performing surgical procedures; (3) has continuous Physician's services and registered graduate nursing (R.N.) services whenever a patient is in the facility; (4) is licensed by the jurisdiction in which it is located; and (5) does not provide for overnight accommodations.

Assistant Surgeon means a Physician who actively assists the Physician in charge of a case in performing a Surgical Procedure. Depending on the type of Surgery to be performed, an operating surgeon may have 1 or 2 Assistant Surgeons. The technical aspects of the Surgery involved dictate the need for an Assistant Surgeon.

Birthing Center means a place licensed as such by an agency of the state. If the state does not have any licensing requirements, it must meet all of the following tests: (1) is primarily engaged in providing birthing services for low risk pregnancies; (2) is operated under the supervision of a Physician; (3) has at least one registered nurse (R.N.) certified as a nurse midwife in attendance at all times; (4) has a written agreement with a licensed ambulance for that service to provide immediate transportation of the Covered Person to a Hospital as defined herein if an emergency arises; and (5) has a written agreement with a Hospital located in the immediate geographical area of the Birthing Center to provide emergency admission of the Covered Person.

Calendar Year means January 1 – December 31.

Close Relative means a Covered Person's spouse, parent (including step-parents), sibling, child, grandparent or in-law.

COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985, as may be amended from time to time.

Coinurance has the same meaning as set forth in the section of this Plan entitled "General Overview of the Plan".

Concurrent Review means the Medical Management Program Administrator will review all Inpatient admissions for a patient's length of stay. The review is based on clinical information received by the Medical Management Program Administrator from the provider or facility.

Congenital Anomaly means a physical developmental defect that is present at birth.

Copay has the same meaning as set forth in the section of this Plan entitled "General Overview of the Plan".

Cosmetic means any procedure which is primarily directed at improving an individual's appearance and does not meaningfully promote the proper function of the body or prevent or treat illness or disease.

Covered Expense means:

- (1) An item or service listed in the Plan as an eligible medical expense for which the Plan provides coverage.
- (2) For prescription drug expenses, any prescription drugs or medicines eligible for coverage under the Prescription Drug Card Program.
- (3) For EAP expenses, an item or service listed in the contract or other materials issued by the EAP Administrator.

Covered Person means, individually, a covered Employee or Retiree and each of his/her Dependents who are covered under the Plan.

Custodial Care means care or confinement provided primarily for the maintenance of the Covered Person, essentially designed to assist the Covered Person, whether or not totally disabled, in the activities of daily living, which could be rendered at home or by persons without professional skills or training. This care is not reasonably expected to improve the underlying medical condition, even though it may relieve symptoms or pain. Such care includes, but is not limited to, bathing, dressing, feeding, preparation of special diets, assistance in walking or getting in and out of bed, supervision over medication which can normally be self-administered and all domestic activities.

Dentist means an individual who is duly licensed to practice dentistry or to perform oral Surgery in the state where the service is performed and is operating within the scope of such license. A Physician will be considered a Dentist when performing any covered dental services allowed within such license.

Dependent is a Covered Person, other than the Employee or Retiree, who is covered by the Plan pursuant to the terms and conditions set forth in the "Eligibility for Participation" section of the Plan.

Durable Medical Equipment means equipment that:

- (1) Can withstand repeated use;
- (2) Is primarily and customarily used to serve a medical purpose;
- (3) Generally is not useful to a person in the absence of an Illness or Injury; and
- (4) Is appropriate for use in the home.

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

- (1) Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- (2) Serious impairment to bodily functions; or
- (3) Serious dysfunction of any bodily organ or part.

Emergency Services means treatment given in a Hospital's emergency room for an Emergency Medical Condition. This includes evaluation of, and treatment to Stabilize an Emergency Medical Condition.

Employee is anyone hired by an Employer who is covered by a collective bargaining agreement or a participation agreement executed by his or her Employer requiring contributions to the Fund..

Employer means any Employer signatory to a collective bargaining agreement with Laborers Local No. 754 or a participation agreement with the Plan Sponsor that obligates such Employer to make contributions to the Fund.

ERISA means the Employee Retirement Income Security Act of 1974, as may be amended from time to time.

Experimental and/or Investigational means services, supplies, care and treatment which do not constitute accepted and appropriate medical practice considering the facts and circumstances of the case and by the generally accepted standards of a reasonably substantial, qualified, responsible, relevant segment of the appropriate medical community or government oversight agencies at the time services were rendered, as determined by the Plan Administrator as set forth below.

The Plan Administrator must make an independent evaluation of the Experimental or non-Experimental standings of specific technologies. The Plan Administrator shall be guided by a reasonable interpretation of Plan provisions. The decisions shall be made in good faith and rendered following a detailed factual background investigation of the claim and the proposed treatment. The decision of the Plan Administrator will be final and binding on the Plan. In addition

to the above, the Plan Administrator will be guided by the following principles to determine whether a proposed treatment is deemed to be Experimental and/or Investigational:

- (1) If the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA) and approval for marketing has not been given at the time the drug or device is furnished, then it is deemed to be Experimental and/or Investigational; or
- (2) If the drug, device, medical treatment or procedure or the patient informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function or if federal law requires such review or approval, then it is deemed to be Experimental and/or Investigational; or
- (3) If Reliable Evidence shows that the drug, device, medical treatment or procedure is the subject of on-going Phase I or Phase II clinical trials or is the subject of the research, Experimental, study, Investigational or other arm of on-going Phase III clinical trials or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis, then it is deemed to be Experimental and/or Investigational; or
- (4) If Reliable Evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis, then it is deemed to be Experimental and/or Investigational.

Reliable Evidence shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, service, medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure.

Drugs are considered Experimental if they are not commercially available for purchase and/or they are not approved by the FDA for general use.

Expenses for drugs, devices, services, medical treatments or procedures related to an Experimental and/or Investigational treatment (related services) and complications from an Experimental and/or Investigational treatment and their related services are excluded from coverage, even if such complications and related services would be covered in the absence of the Experimental and/or Investigational treatment.

Final determination of Experimental and/or Investigational, Medical Necessity and/or whether a proposed drug, device, medical treatment or procedure is covered under the Plan will be made by and in the sole discretion of the Plan Administrator.

FMLA means the Family and Medical Leave Act of 1993, as may be amended from time to time.

Foster Child is defined in the "Eligibility for Participation" section of the Plan.

Genetic Information means information about genes, gene products and inherited characteristics that may derive from the individual or a family member. This includes information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories and direct analysis of genes or chromosomes. Genetic Information will not be taken into account for purposes of (1) determining eligibility for benefits under the Plan (including initial enrollment and continued eligibility) and (2) establishing contribution or premium accounts for coverage under the Plan.

HIPAA means the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as may be amended from time to time.

Home Health Care Agency means a public or private agency or organization that specializes in providing medical care and treatment in the home. Such a provider must meet all of the following conditions, it: (1) is duly licensed, if such licensing is required, by the appropriate licensing authority to provide skilled nursing services and other therapeutic services; (2) qualifies as a Home Health Care Agency under Medicare; (3) meets the standards of the area-wide healthcare planning agency; (4) provides skilled nursing services and other services on a visiting basis in the patient's home; (5) is responsible for administering a home health care program; and (6) supervises the delivery

of a home health care program where the services are prescribed and approved in writing by the patient's attending Physician.

Hospice means an agency that provides counseling and incidental medical services and may provide room and board to terminally ill individuals and which meets all of the following requirements: (1) has obtained any required state or governmental Certificate of Need approval; (2) provides 24-hour-a-day, 7 days-a-week service; (3) is under the direct supervision of a duly qualified Physician; (4) has a nurse coordinator who is a registered nurse (R.N.) with 4 years of full-time clinical experience, at least 2 of which involved caring for terminally ill patients; (5) has a social- service coordinator who is licensed in the jurisdiction in which it is located; (6) is an agency that has as its primary purpose the provision of hospice services; (7) has a full-time administrator; (8) maintains written records of services provided to the patient; (9) the employees are bonded and it provides malpractice and malplacement insurance; (10) is established and operated in accordance with the applicable laws in the jurisdiction in which it is located and, where licensing is required, has been licensed and approved by the regulatory authority having responsibility for licensing under the law; (11) provides nursing care by a registered nurse (R.N.), a licensed practical nurse (L.P.N.), a licensed physical therapist, certified occupational therapist, American Speech Language and Hearing Association certified speech therapist or a certified respiratory therapist; and (12) provides a home health aide acting under the direct supervision of one of the above persons while performing services specifically ordered by a Physician.

Hospital means a facility which: (1) is licensed as a Hospital where licensing is required; (2) is open at all times; (3) is operated mainly to diagnose and treat illnesses or injuries on an inpatient basis; (4) has a staff of one or more Physicians on call at all times; (5) has 24-hour-a-day nursing services by registered nurses (R.N.'s); and (6) has organized facilities for major Surgery.

However, an institution specializing in the care and treatment of Mental Disorders or Substance Use Disorders which would qualify as a Hospital, except that it lacks organized facilities on its premises for major Surgery, shall be deemed a Hospital.

In no event shall "Hospital" include an institution which is primarily a rest home, a nursing home, a clinic, a Skilled Nursing Facility, a convalescent home or a similar institution.

Illness means a non-occupational bodily disorder, disease, physical sickness, pregnancy (including childbirth and miscarriage), Mental Disorder or Substance Use Disorder.

Incurred means the date the service is rendered or the supply is obtained. With respect to a course of treatment or procedure which includes several steps or phases of treatment, expenses are Incurred for the various steps or phases as the services related to each step are rendered and not when services relating to the initial step or phase are rendered. More specifically, Covered Expenses for the entire procedure or course of treatment are not Incurred upon commencement of the first stage of the procedure or course of treatment.

Injury means physical damage to the body, caused by an external force and which is due directly and independently of all other causes, to an Accident.

Inpatient means any person who, while confined to a Hospital, is assigned to a bed in any department of the Hospital other than its outpatient department and for whom a charge for room and board is made by the Hospital.

Intensive Care Unit means a separate, clearly designated service area, which is maintained within a Hospital solely for the care and treatment of patients who are critically ill. This also includes what is referred to as a "coronary care unit" or an "acute care unit." It has: (1) facilities for special nursing care not available in regular rooms and wards of the Hospital; (2) special life saving equipment which is immediately available at all times; (3) at least 2 beds for the accommodation of the critically ill; and (4) at least one registered nurse (R.N.) in continuous and constant attendance 24 hours a day.

Late Enrollee is an eligible Employee or eligible Dependent that does not elect coverage under this Plan during their original 30-day eligibility period. A Special Enrollee is not considered a Late Enrollee.

Legal Guardian is defined in the "Eligibility for Participation" section of the Plan.

Lifetime Maximum means the maximum benefit payable during an individual's lifetime while covered under this Plan. Benefits are available only when an individual is eligible for coverage under this Plan. The Plan may provide for a

Lifetime Maximum benefit for specific types of medical treatment. Any Lifetime Maximum will be shown in the applicable Schedule of Benefits or the applicable covered expenses section of the Plan.

Long-Term Acute Care Facility/Hospital (LTACH) means a facility that provides specialized acute care for medically complex patients who are critically ill; have multi-system complications and/or failures and require hospitalization in a facility offering specialized treatment programs and aggressive clinical and therapeutic intervention on a 24-hour-a-day, 7 days a week basis. The severity of the LTACH patient's condition requires a Hospital stay that provides: (1) interactive Physician direction with daily on-site assessment; (2) significant ancillary services as dictated by complex, acute medical needs - such as full service and laboratory, radiology, respiratory care services, etc.; (3) a patient-centered outcome-focused, interdisciplinary approach requiring a Physician-directed professional team that includes intensive case management to move the patient efficiently through the continuum of care; (4) clinically competent care providers with advanced assessment and intervention skills; and (5) education for the patient and family to manage their present and future healthcare needs.

Maintenance Therapy means medical and non-medical health-related services that do not seek to cure or that are provided during periods when the medical condition of the patient is not changing or does not require continued administration by medical personnel.

Medical Emergency means medical services and supplies provided after the sudden onset of a medical condition (Injury or Illness) manifesting itself by acute symptoms, including intense pain, which are severe enough that the lack of immediate medical attention could reasonably be expected to result in any of the following: (1) the patient's health would be placed in serious jeopardy; (2) bodily function would be seriously impaired; or (3) there would be serious dysfunction of a bodily organ or part.

Medically Necessary/Medical Necessity means treatment is generally accepted by medical professionals in the United States as proven, effective and appropriate for the condition based on recognized standards of the health care specialty involved.

- (1) "Proven" means the care is not considered Experimental and/or Investigational, meets a particular standard of care accepted by the medical community and is approved by the Food and Drug Administration (FDA) for general use.
- (2) "Effective" means the treatments beneficial effects can be expected to outweigh any harmful effects. Effective care is treatment proven to have a positive effect on your health, while addressing particular problems caused by disease, Injury, Illness or a clinical condition.
- (3) "Appropriate" means the treatment's timing and setting are proper and cost effective.

Medical treatments which are not proven, effective and appropriate are not covered by the Plan.

All criteria must be satisfied. When a Physician recommends or approves certain care it does not mean that care is Medically Necessary.

Medicare means the program of health care for the aged established by Title XVIII of the Social Security Act of 1965, as amended.

Mental Disorder means any disease or condition, regardless of whether the cause is organic, that is classified as a Mental Disorder in the current edition of the International Classification of Diseases published by the U.S. Department of Health and Human Services.

Morbid Obesity is defined as (1) a body mass index (BMI) of 40 or greater or (2) a BMI of 35 or greater in conjunction with a severe co-morbidity, such as obesity hypoventilation, sleep apnea, diabetes, hypertension, cardiomyopathy or musculoskeletal dysfunction.

Non-Participating Provider means a health care practitioner or health care facility that has not contracted directly with the Plan or an entity contracting on behalf of the Plan to provide health care services to Plan enrollees.

Participating Provider means a health care practitioner or health care facility that has contracted directly with the Plan or an entity contracting on behalf of the Plan to provide health care services to Plan enrollees.

Physician means a legally licensed Physician who is acting within the scope of their license and any other licensed practitioner required to be recognized for benefit payment purposes under the laws of the state in which they practice and who is acting within the scope of their license. The definition of Physician includes, but is not limited to: Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Chiropractor, Licensed Consulting Psychologist, Licensed Psychologist, Licensed Clinical Social Worker, Occupational Therapist, Optometrist, Ophthalmologist, Physical Therapist, Podiatrist, Registered Nurse (R.N.), Licensed Practical Nurse (L.P.N.), Nurse Practitioner, Physician's Assistant, Speech Therapist, Speech Pathologist and Licensed Midwife (if covered by the Plan). An employee of a Physician who provides services under the direction and supervision of such Physician will also be deemed to be an eligible provider under the Plan.

Plan means the Laborers Local No. 754 Welfare Fund.

Plan Administrator means the Plan Sponsor. The Plan Sponsor may delegate fiduciary and other responsibilities to the Plan Administrator.

Plan Sponsor means Board of Trustees Laborers Local No. 754 Welfare Fund or any successor thereto.

Plan Year means the period from July 1 - June 30 each year.

Prescription Drug means any of the following: (a) a Food and Drug Administration-approved drug or medicine, which, under federal law, is required to bear the legend, "Caution: federal law prohibits dispensing without prescription," (b) injectable insulin; or (c) hypodermic needles or syringes, but only when dispensed upon a written prescription of a licensed Physician. Such drug must be Medically Necessary in the treatment of an Illness or Injury.

Primary Care Physician means a licensed Physician practicing in one of the following fields: (1) family practice; (2) general practice; (3) internal medicine; (4) obstetrics and gynecology; or (5) pediatrics.

Qualified Clinical Trial is defined as a clinical trial that meets all the following conditions:

- (1) The clinical trial is intended to treat cancer in a Covered Person who has been so diagnosed; and
- (2) The clinical trial has been peer reviewed and is approved by at least one of the following:
 - (a) One of the United States National Institutes of Health;
 - (b) A cooperative group or center of the National Institutes of Health;
 - (c) A qualified non-governmental research entity identified in guidelines issued by the National Institutes of Health for center support grants;
 - (d) The United States Food and Drug Administration pursuant to an Investigational new drug exemption;
 - (e) The United States Departments of Defense or Veterans Affairs;
 - (f) Or, with respect to Phase II, III and IV clinical trials only, a "qualified institutional review board." A "qualified institutional review board" shall mean a committee of Physicians, statisticians, researchers, community advocates and others that ensures a clinical trial is ethical and that the rights of the trial participants are protected; and
- (3) The facility and personnel conducting the clinical trial are capable of doing so by virtue of their experience and training and treat a sufficient volume of patients to maintain that expertise as determined by the Plan Administrator; and
- (4) The Covered Person meets the patient selection criteria enunciated in the study protocol for participation in the clinical trial; and
- (5) The Covered Person has provided informed consent for participation in the clinical trial in a manner that is

consistent with current legal and ethical standards; and

- (6) The available clinical or pre-clinical data provide a reasonable expectation that the Covered Person's participation in the clinical trial will provide a medical benefit that is commensurate with the risks of participation in the clinical trial; and
- (7) The clinical trial does not unjustifiably duplicate existing studies; and
- (8) The clinical trial must have a therapeutic intent and must, to some extent, assess the effect of the intervention on the Covered Person.

Reconstructive Surgery means Surgery that is incidental to an Injury, Illness or Congenital Anomaly when the primary purpose is to improve physiological functioning of the involved part of the body. The fact that physical appearance may change or improve as a result of Reconstructive Surgery does not classify such Surgery as Cosmetic when a physical impairment exists and the Surgery restores or improves function. Additionally, the fact that a Covered Person may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Illness or Congenital Anomaly does not classify Surgery to relieve such consequences or behavior as Reconstructive Surgery.

Rehabilitation Facility means a facility must meet all of the following requirements: (1) must be for the treatment of acute Injury or Illness; (2) is licensed as an acute Rehabilitation Facility; (3) the care is under the direct supervision of a Physician; (4) services are Medically Necessary; (5) services are specific to an active written treatment plan; (6) the patient's condition requires skilled nursing care and interventions which cannot be achieved or managed at a lower level of care; (7) nursing services are available 24 hours a day; and (8) the confinement is not for Custodial Care or maintenance care.

Retiree is defined in the "Eligibility for Participation" section of the Plan.

Security Standards mean the final rule implementing HIPAA's Security Standards for the Protection of Electronic PHI, as amended.

Semi-Private Room means a Hospital room shared by 2 or more patients.

Skilled Nursing Facility is a facility that meets all of the following requirements:

- (1) It is licensed to provide professional nursing services on an inpatient basis to persons convalescing from Injury or Illness. The service must be rendered by a registered nurse (R.N.) or by a licensed practical nurse (L.P.N.) under the direction of a registered nurse. Services to help restore patients to self-care in essential daily living activities must be provided.
- (2) Its services are provided for compensation and under the full-time supervision of a Physician.
- (3) It provides 24 hour per day nursing services by licensed nurses, under the direction of a full-time registered nurse.
- (4) It maintains a complete medical record on each patient.
- (5) It has an effective utilization review plan.
- (6) It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, developmentally disabled, Custodial or educational care or care of Mental Disorders.
- (7) It is approved and licensed by Medicare.

This term also applies to charges incurred in a facility referring to itself as an extended care facility, convalescent nursing home, rehabilitation hospital, long-term acute care facility or any other similar nomenclature.

Special Enrollee is an eligible Employee or eligible Dependent that does not elect coverage under this Plan during their original 30-day eligibility period and who later enrolls in the Plan due to a Special Enrollment Event.

Specialist means a licensed Physician that provides services to a Covered Person within the range of their

specialty (e.g. cardiologist, neurologist, etc.).

Spouse is defined in the "Eligibility for Participation" section of the Plan.

Stabilize means with respect to an Emergency Medical Condition, to provide such medical treatment for the condition as may be necessary to assure, within reasonable medical probability that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility; or with respect to an Emergency Medical Condition of a pregnant woman who is having contractions and (1) there is inadequate time to effect a safe transfer to another Hospital before delivery or (2) transfer may pose a threat to the health or safety of the woman or her unborn child to deliver (including the placenta

Substance Use Disorder means any disease or condition that is classified as a Substance Use Disorder in the current edition of the International Classification of Diseases published by the U.S. Department of Health and Human Services.

Surgery or Surgical Procedure means any of the following:

- (1) The incision, excision, debridement or cauterization of any organ or part of the body and the suturing of a wound;
- (2) The manipulative reduction of a fracture or dislocation or the manipulation of a joint including application of cast or traction;
- (3) The removal by endoscopic means of a stone or other foreign object from any part of the body or the diagnostic examination by endoscopic means of any part of the body;
- (4) The induction of artificial pneumothorax and the injection of sclerosing solutions;
- (5) Arthrodesis, paracentesis, arthrocentesis and all injections into the joints or bursa;
- (6) Obstetrical delivery and dilation and curettage; or
- (7) Biopsy.

Surprise Bill/Surprise Billing happens when people unknowingly get care from providers that are outside of their health Plan's Network and can happen for both emergency and non-emergency care.

Third Party Administrator means Meritain Health, Inc., P.O. Box 27267, Minneapolis, MN 55427-0267.

Urgent Care Facility means a facility which is engaged primarily in providing minor emergency and episodic medical care to a Covered Person. A board-certified Physician, a registered nurse and a registered x-ray technician must be in attendance at all times that the facility is open. The facility must include x-ray and laboratory equipment and a life support system. For the purpose of this Plan, a facility meeting these requirements will be considered to be an Urgent Care Facility, by whatever actual name it may be called; however, an after-hours clinic shall be excluded from the terms of this definition.

USERRA means the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), as may be amended from time to time.

Usual and Customary Charge (U&C) means, with respect to Non-Participating Providers, charges made for medical or dental services or supplies essential to the care of the individual will be subject to a Usual and Customary determination. Subject to the rest of this definition, the Usual and Customary Charge means the lesser of the charge by other providers in the same geographic area or billed charges for the same or comparable service or supply. From time to time, the Plan may enter into an agreement with a Non- Participating Provider (directly or indirectly through a third party) which sets the rate the Plan will pay for a service or supply. In these cases the Usual and Customary Charge will be the rate established in such agreement with the Non-Participating Provider.

The Plan may reduce the Usual and Customary Charge by applying reimbursement policies administered by the Plan's Third Party Administrator. These reimbursement policies address the appropriate billing of services, taking

into account factors that are relevant to the cost of the service such as:

- (1) The duration and complexity of a service;
- (2) Whether multiple procedures are billed at the same time, but no additional overhead is required;
- (3) Whether an Assistant Surgeon is involved and necessary for the service;
- (4) follow up care is included;
- (5) Whether there are any other characteristics that may modify or make a particular service unique; and
- (6) When a charge includes more than one claim line, whether any services described by a claim line are part of or incidental to the primary service provided.

The reimbursement policies utilized are based on review of the policies developed for Medicare; the generally accepted standards of medical and dental practice, which are based on credible scientific evidence published in peer-reviewed literature generally recognized by the relevant medical or dental community or which are otherwise consistent with Physician or dental specialty society recommendations; and the views of Physicians and Dentists practicing in the relevant clinical areas.

The Usual and Customary Charge for covered services will be based on the median contract rate when a Covered Person had no control over the services performed by a Non-Participating provider who is under agreement with a Network facility or when the Covered Person seeks Emergency Services for an Emergency Medical Condition from a Non-Participating Provider.

PLAN ADMINISTRATION

Delegation of Responsibility

The Plan Sponsor is a named fiduciary of the Plan with full discretionary authority for the control and management of the operation and administration of the Plan. The Plan Sponsor may delegate fiduciary and other responsibilities to any individual or entity. Any person to whom any responsibility is delegated may serve in more than one fiduciary capacity with respect to the Plan and may be a participant in the Plan.

Authority to Make Decisions

The Plan is administered by the Plan Administrator in accordance with ERISA. The Plan Administrator has retained the services of the Third Party Administrator to provide certain claims processing and other ministerial services. An individual or entity may be appointed by the Plan Sponsor to be Plan Administrator and serve at the convenience of the Plan Sponsor. If the Plan Administrator resigns, dies, is otherwise unable to perform, is dissolved or is removed from the position, the Plan Sponsor will appoint a new Plan Administrator as soon as reasonably possible.

The Plan Administrator will administer this Plan in accordance with its terms and establish its policies, interpretations, practices and procedures. It is the express intent of this Plan that the Plan Administrator will have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits (including the determination of what services, supplies, care and treatments are Experimental and/or Investigational), to decide disputes which may arise relative to you and/or your Dependent's rights and to decide questions of Plan interpretation and those of fact and law relating to the Plan. The decisions of the Plan Administrator as to the facts related to any claim for benefits and the meaning and intent of any provision of the Plan or its application to any claim, shall receive the maximum deference provided by law and will be final and binding on all interested parties. Benefits under this Plan will be paid only if the Plan Administrator decides, in its discretion, that you and/or your Dependent (as applicable) are entitled to them.

The duties of the Plan Administrator include the following:

- (1) To administer the Plan in accordance with its terms;
- (2) To determine all questions of eligibility, status and coverage under the Plan;
- (3) To interpret the Plan, including the authority to construe possible ambiguities, inconsistencies, omissions and disputed terms;
- (4) To make factual findings;
- (5) To decide disputes which may arise relative to a Covered Person's rights;
- (6) To prescribe procedures for filing a claim for benefits, to review claim denials and appeals relating to them and to uphold or reverse such denials; or, alternatively, to appoint a qualified administrator to carry out these functions on the Plan Administrator's behalf;
- (7) To keep and maintain the Plan documents and all other records pertaining to the Plan;
- (8) To appoint and supervise a Third Party Administrator to pay claims;
- (9) To perform all necessary reporting as required by Federal or State law;
- (10) To establish and communicate procedures to determine whether a child support order or decree is a QMCSO;
- (11) To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate; and
- (12) To perform each and every function necessary for or related to the Plan's administration.

Amendment or Termination of Plan

The Plan Sponsor expects to maintain this Plan indefinitely; however, the Plan Sponsor may, in its sole discretion, at any time, amend, suspend or terminate the Plan in whole or in part, subject to the terms and conditions of any relevant collective bargaining agreements.

Any such amendment, suspension or termination shall be taken and enacted in accordance with applicable federal and state law and any applicable governing documents.

If the Plan is terminated, the rights of Covered Persons are limited to expenses Incurred before termination. All amendments to this Plan shall become effective as of a date established by the Plan Sponsor.

MISCELLANEOUS INFORMATION

Assignment of Benefits

No benefit under the Plan shall be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge and any attempt to do so shall be void. No benefit under the Plan shall in any manner be liable for or subject to the debts, contracts, liabilities, engagements or torts of any person.

Notwithstanding the foregoing, the Plan will honor any Qualified Medical Child Support Order ("QMCSO") which provides for coverage under the Plan for an alternate recipient, in the manner described in ERISA Section 609(a) and in the Plan's QMCSO procedures.

Clerical Error

Clerical errors made on the records of the Plan and delays in making entries on such records shall not invalidate coverage nor cause coverage to be in force or to continue in force. Rather, the effective dates of coverage shall be determined solely in accordance with the provisions of this Plan regardless of whether any contributions with respect to you and/or your Dependents have been made or have failed to be made because of such errors or delays. Upon discovery of any such error or delay, an equitable adjustment of any such contributions will be made.

Conformity with Applicable Laws

This Plan shall be deemed automatically to be amended to conform as required by any applicable law, regulation or the order or judgment of a court of competent jurisdiction governing provisions of this Plan, including, but not limited to, stated maximums, exclusions or limitations. In the event that any law, regulation or the order or judgment of a court of competent jurisdiction causes the Plan Administrator to pay claims that are otherwise limited or excluded under this Plan, such payments will be considered as being in accordance with the terms of Plan. It is intended that the Plan will conform to the requirements of any applicable federal or state law.

Cost of the Plan

The Plan Sponsor is responsible for funding the Plan and will do so as required by law. To the extent permitted by law, the Plan Sponsor is free to determine the manner and means of funding the Plan, including, but not limited to, payment of Plan expenses from the Trust. The amount of contribution (if any) for your coverage or coverage for your Dependents will be determined from time to time by the Plan Sponsor, in its sole discretion.

Interpretation of this Document

The use of masculine pronouns in this Plan shall apply to persons of both sexes unless the context clearly indicates otherwise. The headings used in this Plan are used for convenience of reference only. You and your Dependents are advised not to rely on any provision because of the heading.

The use of the words, "you" and "your" throughout this Plan applies to eligible or covered Employees and, where appropriate in context, their covered Dependents.

Minimum Essential Coverage

Refer to the Employer's Summary of Benefits and Coverage (SBC) for determination as to whether the Plan provides "minimum essential coverage" within the meaning of Code Section 5000A(f) and any accompanying regulations or guidance and whether it provides "minimum value" within the meaning of Code Section 36B(c)(2)(C)(ii) and any accompanying regulations or guidance (e.g. the Plan provides at least 60% actuarial value).

No Contract of Employment

This Plan and any amendments constitute the terms and provisions of coverage under this Plan. The Plan shall not be deemed to constitute a contract of any type between the Employer and any person or to be consideration for or an inducement or condition of, the employment of any Employee. Nothing in this Plan shall be deemed to give any Employee the right to be retained in the service of the Plan Sponsor or Participating Employer or to interfere with the right of the Plan Sponsor or Participating Employer to discharge any Employee at any time.

Release of Information

For the purpose of determining the applicability of and implementing the terms of these benefits, the Plan Administrator may, without the consent of or notice to any person, release or obtain any information necessary to determine the acceptability of any applicant or person covered for benefits under this Plan. In so acting, the Plan

Administrator shall be free from any liability that may arise with regard to such action; however, the Plan Administrator at all times will comply with the applicable privacy standards. Any Covered Person claiming benefits under this Plan shall furnish to the Plan Administrator such information as may be necessary to implement this provision.

Workers' Compensation

This Plan excludes coverage for any Injury or Illness that is eligible for coverage under any Workers' Compensation policy or law regardless of the date of onset of such Injury or Illness. However, if benefits are paid by the Plan and it is later determined that you received or are eligible to receive Workers' Compensation coverage for the same Injury or Illness, the Plan is entitled to full recovery for the benefits it has paid. This exclusion applies to past and future expenses for the Injury or Illness regardless of the amount or terms of any settlement you receive from Workers' Compensation. The Plan will exercise its right to recover against you. The Plan reserves its right to exercise its rights under this section and the section entitled "Recovery of Payment" even though:

- (1) The Workers' Compensation benefits are in dispute or are made by means of settlement or compromise;
- (2) No final determination is made that the Injury or Illness was sustained in the course of or resulted from your employment;
- (3) The amount of Workers' Compensation benefits due specifically to health care expense is not agreed upon or defined by you or the Workers' Compensation carrier; or
- (4) The health care expense is specifically excluded from the Workers' Compensation settlement or compromise.

You are required to notify the Plan Administrator immediately when you file a claim for coverage under Workers' Compensation if a claim for the same Injury or Illness is or has been filed with this Plan. Failure to do so or to reimburse the Plan for any expenses it has paid for which coverage is available through Workers' Compensation, will be considered a fraudulent claim and you will be subject to any and all remedies available to the Plan for recovery and disciplinary action.

THE WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998 (WHCRA)

Surgical procedures shall include reconstructive breast surgery, following a mastectomy on one or both breasts, as follows: surgery to restore and achieve symmetry between the two breasts, cost of breast prosthesis, outpatient chemotherapy following surgical procedures in connection with the treatment of breast cancer. These benefits will be provided to the same extent as for any other sickness under the your Plan.

STATEMENT OF ERISA RIGHTS

As a Covered Person in the Plan, you and your Dependents are entitled to certain rights and protections under ERISA. ERISA provides that you and your eligible Dependents are entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, all documents governing the Plan, including insurance contracts (if any) and copies of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts (if any) and copies of the latest annual report (Form 5500 Series). The Plan Administrator may make a reasonable charge for the copies.

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

Continue Group Health Plan Coverage

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

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order, a medical child support order or a national medical support notice, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a Federal court. The court will decide who would pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

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

HIPAA PRIVACY PRACTICES

The following is a description of certain rules that apply to the Plan Sponsor regarding uses and disclosures of your health information.

Disclosure of Summary Health Information to the Plan Sponsor

In accordance with HIPAA's standards for privacy of individually identifiable health information (the "privacy standards"), the Plan may disclose summary health information to the Plan Sponsor, if the Plan Sponsor requests the summary health information for the purpose of:

- (1) Obtaining premium bids from health plans for providing health insurance coverage under this Plan; or
- (2) Modifying, amending or terminating the Plan.

"Summary health information" is information, which may include individually identifiable health information, that summarizes the claims history, claims expenses or the type of claims experienced by individuals in the Plan, but that excludes all identifiers that must be removed for the information to be de-identified, except that it may contain geographic information to the extent that it is aggregated by 5-digit zip code.

Disclosure of Protected Health Information ("PHI") to the Plan Sponsor for Plan Administration Purposes

Except as described under "Disclosure of Summary Health Information to the Plan Sponsor" above or under "Disclosure of Certain Enrollment Information to the Plan Sponsor" below or under the terms of an applicable individual authorization, the Plan may disclose PHI to the Plan Sponsor and may permit the disclosure of PHI by a health insurance issuer or HMO with respect to the Plan to the Plan Sponsor only if the Plan Sponsor requires the PHI to administer the Plan. The Plan Sponsor by formally adopting this Plan certifies that it agrees to:

- (1) Not use or further disclose PHI other than as permitted or required by the Plan or as required by law;
- (2) Ensure that any agents, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;
- (3) Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor;
- (4) Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor becomes aware;
- (5) Make available PHI in accordance with section 164.524 of the privacy standards;
- (6) Make available PHI for amendment and incorporate any amendments to PHI in accordance with section 164.526 of the privacy standards;
- (7) Make available the information required to provide an accounting of disclosures in accordance with section 164.528 of the privacy standards;
- (8) Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the U.S. Department of Health and Human Services ("HHS"), for purposes of determining compliance by the Plan with part 164, subpart E, of the privacy standards;
- (9) If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible; and

(10) Ensure that adequate separation between the Plan and the Plan Sponsor, as required in section 164.504(f)(2)(iii) of the privacy standards, is established as follows:

- (a) The Plan Sponsor shall only allow certain named employees or classes of employees or other persons under control of the Plan Sponsor who have been designated to carry out plan administration functions, access to PHI. The Plan Sponsor will maintain a list of those persons and that list is incorporated into this document by this reference. The access to and use of PHI by any such individuals shall be restricted to plan administration functions that the Plan Sponsor performs for the Plan.
- (b) In the event any of the individuals described in (a) above do not comply with the provisions of the Plan relating to use and disclosure of PHI, the Plan Administrator shall impose reasonable sanctions as necessary, in its discretion. Such sanctions shall be imposed progressively (for example, an oral warning, a written warning, time off without pay and termination), if appropriate and shall be imposed so that they are commensurate with the severity of the violation.

“Plan administration” activities are limited to activities that would meet the definition of payment or health care operations, but do not include functions to modify, amend or terminate the Plan or solicit bids from prospective issuers. “Plan administration” functions include quality assurance, claims processing, auditing, monitoring and management of carve-out plans, such as vision and dental. It does not include any employment-related functions or functions in connection with any other benefit or benefit plans.

The Plan shall disclose PHI to the Plan Sponsor only upon receipt of a certification by the Plan Sponsor that:

- (1) The Plan has been amended to incorporate the above provisions; and
- (2) The Plan Sponsor agrees to comply with such provisions.

Disclosure of Enrollment Information to the Plan Sponsor

Pursuant to section 164.504(f)(1)(iii) of the privacy standards, the Plan may disclose to the Plan Sponsor information on whether an individual is participating in the Plan or is enrolled in or has disenrolled from a health insurance issuer or health maintenance organization offered under the Plan.

Disclosure of PHI to Obtain Stop-loss or Excess Loss Coverage; Disclosures of Genetic Information

Except as otherwise provided below, the Plan Sponsor hereby authorizes and directs the Plan, through the Plan Administrator or the Third Party Administrator, to disclose PHI to stop-loss carriers, excess loss carriers or managing general underwriters (“MGUs”) for underwriting and other purposes in order to obtain and maintain stop-loss or excess loss coverage related to benefit claims under the Plan. Such disclosures shall be made in accordance with the privacy standards.

The Plan will not use or disclose genetic information, including information about genetic testing and family medical history, for underwriting purposes. The Plan may use or disclose PHI for underwriting purposes, assuming the use or disclosure is otherwise permitted under the privacy standards and other applicable law, but any PHI that is used or disclosed for underwriting purposes will not include genetic information.

“Underwriting purposes” is defined for this purpose under federal law and generally includes any Plan rules relating to (1) eligibility for benefits under the Plan (including changes in deductibles or other cost-sharing requirements in return for activities such as completing a health risk assessment or participating in a wellness program); (2) the computation of premium or contribution amounts under the Plan (including discounts or payments or differences in premiums based on activities such as completing a health risk assessment or participating in a wellness program); and (3) other activities related to the creation, renewal, or replacement of a contract for health insurance or health benefits. However, “underwriting purposes” does not include rules relating to the determination of whether a particular expense or claim is medically appropriate.

HIPAA SECURITY PRACTICES

Disclosure of Electronic Protected Health Information (“Electronic PHI”) to the Plan Sponsor for Plan Administration Functions

In accordance with HIPAA’s standards for security (the “security standards”), to enable the Plan Sponsor to receive and use Electronic PHI for Plan administration functions (as defined in 45 CFR § 164.504(a)), the Plan Sponsor agrees to:

- (1) Implement and maintain administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the Electronic PHI that it creates, receives, maintains or transmits on behalf of the Plan.
- (2) Ensure that adequate separation between the Plan and the Plan Sponsor, as required in 45 CFR § 164.504(f)(2)(iii), is supported by reasonable and appropriate Security Measures.
- (3) Ensure that any agent, including any business associate or subcontractor, to whom the Plan Sponsor provides Electronic PHI created, received, maintained or transmitted on behalf of the Plan, agrees to implement reasonable and appropriate Security Measures to protect the Electronic PHI.
- (4) Report to the Plan any Security Incident of which it becomes aware.
- (5) The Plan Sponsor will promptly report to the Plan any breach of unsecured Protected Health Information of which it becomes aware in a manner that will facilitate the Plan’s compliance with the breach reporting requirements of the HITECH Act, based on regulations or other applicable guidance issued by the Department of Health and Human Services.

Any terms not otherwise defined in this section shall have the meanings set forth in the security standards.

FUTURE OF THE PLAN AND PLAN TERMINATION

This Summary Plan Description includes information concerning the circumstances which may result in disqualification, ineligibility, or denial, loss, forfeiture, or suspension of benefits that a participant or beneficiary might otherwise reasonably expect the plan to provide. This plan description booklet details the eligibility rules, qualification rules, benefits, limitations and exclusions from coverage.

It is anticipated that the Plan will remain in effect indefinitely. However, the right to amend or modify the Plan is reserved by the Board of Trustees, in accordance with the Declaration of Trust. In addition, the continuance of the Plan is subject to the maintenance of Collective Bargaining Agreements which provide for Employer contributions to the Fund. If it ever becomes necessary to terminate the Plan at some future date, the Trust Agreement provides that assets then held by the Trustees must be used exclusively on behalf of Plan Participants and to defray the cost of reasonable administration and termination expenses. In no event will any of the assets revert to any Employer or to the Union. In the event of termination of the Plan, the Trust Funds are to be used exclusively to continue the payment of benefits provided for in the Plan to eligible Employees, their dependents, beneficiaries, or their estates, to defray reasonable administration and termination expenses and to otherwise effectuate the purpose of the Trust Fund. Upon the necessity for termination, the Trustees would establish a plan to be applied to the balance of assets in the Trust Fund so that the assets would be applied solely for these purposes. Upon final liquidation of the Plan, participants and beneficiaries would have no further rights or vested interest in the Welfare Plan.

MODIFICATION OF BENEFITS AND ELIGIBILITY RULES FOR RETIRED EMPLOYEES AND THEIR DEPENDENTS

This Summary Plan Description include information concerning the benefits provided by the Trustees to Retired Employees and their dependents and the circumstances which may result in disqualification, ineligibility, or denial, loss, forfeiture or suspension of benefits that a Retired Employee or dependent might otherwise reasonably expect the Plan to provide.

The benefits and eligibility rules applicable to Retired Employees and their dependents have been established by the Trustees as part of an overall benefit program. The right to amend or modify the eligibility rules and plan of benefits for Retired Employees and dependents is reserved by the Board of Trustees, in accordance with the Declaration of Trust. The continuance of benefits for Retired Employees and their dependents and the eligibility relating to a qualification therefore are subject to modification and revision by the Board of Trustees in accordance with their responsibilities and authorities contained in the Declaration of Trust.

In accordance with the rules and regulations and the Trust Agreement, no person has a vested interest in the benefits provided for Retired Employees and the dependents. In the event of termination of the Plan, as stated above, the Trustees reserve the right to terminate the program

of benefits for Retired Employees and there shall not be any vested right by any Retired Employee or dependent or beneficiary nor contractual rights after the disposition of all Plan assets and the termination of the Plan. Retired Employees and their dependents shall not have any priority with respect to the disposition of assets in connection with the termination of this Welfare Plan.

FAMILY AND MEDICAL LEAVE ACT

Under the Family and Medical Leave Act, you may be eligible for up to 12 weeks of unpaid leave for any of the following reasons:

- to care for your newly born or adopted child;
- to care for your spouse, child or parent who has a serious health care problem; or
- if you have a serious health problem which prevents you from performing your job.

In order for you be eligible for such leave, your employer must have been obligated to make contributions to the Plan on your behalf for at least 1,250 hours in the preceding 12 month- period. You must also have worked for that employer for at least 12 months immediately preceding the date your leave will commence.

However, not all employers are covered by the Family and Medical Leave Act. To be subject to the Act, an employer must have at least 50 employees for each working day for each of 20 work weeks in the current or preceding calendar year. Additionally, you must:

- work at a location where the employer has at least 50 employees; or
- work within 75 miles of one or more work sites where the employer has 50 or more employees.

Your employer must notify the Fund Office that you are on leave for one of the purposes described in the Act, must continue to include you on its monthly remittance reports to the Plan, and must continue to make contributions on your behalf. The number of hours to be reported and for which contributions are to be made shall be those hours that would have been reported but for your exercising your right under the Act to a leave of absence.

While you are on leave, you (and your eligible dependents, if any) will continue to participate in the Plan just as if your employment had not stopped, unless your employer fails to make the required contributions for you.

Your eligibility for continued benefits under the Family and Medical Leave Act will be terminated upon the occurrence of any of the following events:

- your employer fails for any reason to make the required contributions to the Plan on your behalf while you are on leave;
- you exhaust the 12 weeks of leave which you are entitled to under the act; or
- you or your employer notifies the Fund Office that you do not intend to return to the employer's employment. (NOTE: If you do not return to work for your employer at the end of your leave, you may be responsible for repaying the employer contributions made for you during the leave).

LABORERS LOCAL NO. 754 WELFARE FUND TRAINING FUND BENEFIT

Training Benefits – Journeymen

The Fund will provide training for its members through a partnership with the Laborers International Union of North America Local 17. Local 754 members are free to choose from over 100 courses offered at Local 17 at no cost to the participant.

Class schedules can be found on the Union website (www.local754.com). They are also posted in the Union office. Members choosing to participate in a class can sign up by contacting the Union office.

Training Benefits – Apprentices

As mandated by the New York State Department of Labor, apprentices must complete 309 hours of core curriculum training and 150 hours of additional required training. All expenses associated with Apprentice Training are covered by the Fund. Please note that members are not permitted to attend a class without signing up before it due to limited space.

Class schedules can be found on the Union website (www.local754.com). They are also posted in the Union Office. Members choosing to participate in a class can sign up by contacting the Union Office.

Entry Level Driver Training:

Entry Level drivers who are seeking who are seeking a Class A or B commercial driver's license ("CDL") for the first time, upgrading to a Class A or B CDL, or obtaining a passenger, school bus or a hazardous material endorsement for the first time, are required to complete Entry Level Driver Training.

Entry-level driver applicants must successfully complete both a mandatory theory (knowledge) course and a behind-the-wheel training course as part of the Entry Level Driver Training. All courses must be conducted by a training provider listed on the Training Provider Registry ("TPR"), which can be found on the Federal Motor Carrier Safety Administration website (<https://tpr.fmcsa.dot.gov/>).

The Fund will cover the cost of the theory course. However, Local 754 members will be responsible for paying the cost of the behind-the-wheel training course.

CDL Physical Exam & Licensing:

When a member chooses to participate in a CDL physical exam, the Fund will reimburse the participant directly via check for the exam and license costs.

Laborers Local 754 Welfare Fund Paid Sick Leave Benefits

The Fund provides a Paid Sick Leave Benefit to each participant at the end of each calendar year, based on contributions for this benefit made to the Welfare Fund by a participant's employer under an applicable collective bargaining agreement.

Paid Sick Leave Benefit payments are made by the Welfare Fund as checks to participants. Around the first week of December, the Fund sends a first check to participants that includes contributions made on the participant's behalf through approximately November 30th of that calendar year. A second check is then sent to participants by around the 15th of December for any Paid Sick Leave Benefit contributions received by the Fund on behalf of the participant between December 1st and December 15th.

Laborers Local No. 754 Welfare Fund Stamp Savings Benefit

The Fund provides a Stamp Savings Benefit to each participant at the end of each calendar year, based on contributions for this benefit made to the Welfare Fund by a participant's employer under an applicable collective bargaining agreement.

Stamp Savings Benefit payments are made by the Welfare Fund as checks to participants. Around the first week of December, the Fund sends a first check to participants that includes contributions made on the participant's behalf through approximately November 30th of that calendar year. A second check is then sent to participants by around the 15th of December for any Stamp Savings Benefit contributions received by the Fund on behalf of the participant between December 1st and December 15th.

Stamp Savings Benefit Withdrawals

The Fund will allow one withdrawal of a Participant's Stamp Savings Benefit during any 12-month period from contributions made on the Participant's behalf provided that the Participant provides written proof according to the following:

- (1) Educational expenses, including tuition and/or room and board, but not books and other supplies for the Participant's dependent children at a high school, accredited college or university. Hardship withdrawals for this purpose can only be used for expenses incurred during the semester, year or period immediately prior to or current to the application.
- (2) For the purchase or construction of a house, or coop or condominium apartment, as the Participant's primary residence.
- (3) Funeral expenses for the Participant's spouse, dependent child, dependent grandchild or children, or the Participant's parent or Participant's spouse's parent.
- (4) Expenses in excess of \$1,000 resulting from an illness or accident which have not been reimbursed by benefits payable from the Laborers Local No. 754 Welfare Fund, any public or private plan or program including, but not limited to Social Security, workers compensation, Medicaid, or any employer, union, employer-union welfare plan or program.
- (5) Expenses related to the prevention of foreclosure, tax lien or eviction proceedings threatening the loss of a home, cooperative, condominium or apartment which is the Participant's principal residence.
- (6) Expenses related to the repair of a participant's primary residence due to damage from fire, flood, hurricane, or other catastrophic event.

- (7) Expenses associated with an apartment rental as well as automobile purchase or repair in the amount of \$1,000 or more.

Supplemental Unemployment Fund Benefit

The Fund provides a Supplemental Unemployment Benefit to eligible members. Dependents are not eligible for this benefit. A claim form will be available yearly during the winter season. Provisions are as follows:

- Participant has not refused work more than four (4) times.
- Participant must currently be eligible for Welfare Benefits.
- Claims may be filed weekly or in bulk but no later than May 31st.
- 1st Payment will be issued in January.
- Proof of unemployment must be provided at time of application.

For more information contact the Fund Office.

A FINAL WORD

This description is intended to provide you with an easy-to-understand explanation of your Plan. Every effort has been made to make this explanation as complete and accurate as possible. If any conflict should arise between this explanation and the Plan, or if any provision is not covered, or only partially covered, the terms of the actual Plan or other applicable documents, as the case may be, will govern in all cases.

GENERAL PLAN INFORMATION

Name of Plan:	Laborers Local No. 754 Welfare Fund
Plan Sponsor: (Named Fiduciary)	Board of Trustees Laborers Local No. 754 Welfare Fund 215 Old Nyack Turnpike Chestnut Ridge, NY 10977 (845) 425-0210
Plan Administrator:	Board of Trustees Laborers Local No. 754 Welfare Fund 215 Old Nyack Turnpike Chestnut Ridge, NY 10977 (845) 425-0210
Plan Sponsor EIN:	13-1895923
Plan Year:	July 1 - June 30
Plan Number:	501
Meritain Health, Inc. Group Number:	15566
Plan Type:	Multi-Employer Plan providing medical and prescription drug benefits. This Plan is maintained pursuant to one or more collective bargaining agreements. For a copy of such agreement, please contact the Plan Administrator.
Plan Funding:	All benefits are paid through a trust that has been established by the Plan Sponsor for the exclusive benefit of its Employees and their eligible Dependents and the Employees and eligible Dependents of Participating Employers.
Contributions:	The cost of coverage under the Plan is funded solely by contributions from the Plan Sponsor and each Participating Employer.
Third Party Administrator:	Meritain Health, Inc. P.O. Box 27267 Minneapolis, MN 55427-0267 (800) 925-2272
Medical Management Program Administrator:	Meritain Health Medical Management 7400 West Campus Road, F-510 New Albany, OH 43054-8725 (800) 242-1199
Prescription Drug Card Program Administrator:	Express Scripts P.O. Box 14711 Lexington, KY 40512 (866) 544-2926 www.express-scripts.com

**Telemedicine Program
Administrator**

Teledoc, Inc.
1945 Lakepointe Dr
Lewisville, TX 75057
(800) 835-2362
www.teledoc.com

Dental Benefit

Cigna Health and Life Insurance Company
P.O. Box 188037
Chattanooga, TN 37422-8037
1-800-244-6224
www.cigna.com

Vision Benefit

National Vision Administrators
P.O. Box 2187
Clifton, NJ 07015
(800)-672-7723
www.e-nva.com

**Employee Assistance Program
(EAP) Administrator:**

Lower Hudson Valley Employee Assistant Program
3505 Hill Blvd., Suite A
Yorktown Heights, NY
10598
1(800) EAP-2799
www.lowerhudsonvalleyeap.com

Participating Employer(s):

A list of Participating Employers is available upon request and free of charge by contacting the Plan Administrator.

**Agent for Service of Legal
Process:**

Ms. Vincenza Quinlan
Board of Trustees Laborers Local No. 754 Welfare Fund
215 Old Nyack Turnpike
Chestnut Ridge, NY 10977
(845) 425-0210

Employer Trustee(s):

John T. Cooney, Jr.
Construction Industry Council of
Westchester & the Hudson Valley
620 Old White Plains Road
Tarrytown, NY 10591
(914) 631-6070

Alan Seidman
Construction Contractors Association
330 Meadow Avenue
Newburgh, NY 12550
(845) 562-4280

Union Trustee(s)

Stephen J. Reich
Laborers Local Union No. 754
215 Old Nyack Turnpike
Chestnut Ridge, NY 10977
(845)425-5073

Kenneth T. Lewis
Laborers Local Union No. 754
215 Old Nyack Turnpike
Chestnut Ridge, NY 10977
(845) 425-5073

The Plan is a legal entity. Legal notice may be filed with and legal process served upon, the Plan Administrator or Plan Trustee.