INTERNATIONAL UNION OF OPERATING ENGINEERS, LOCAL 399 HEALTH AND WELFARE PLAN OF BENEFITS

RESTATED AND EFFECTIVE FEBRUARY 1, 2025

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ARTICLE 1 – DEFINITIONS

Words and phrases appearing in this Plan shall have the respective meanings set forth in this Article, unless the context clearly indicates to the contrary.

Section 1.01. Alternate Recipient

Any child of a Participant who is recognized under a medical child support order or National Medical Support Notice as having a right to enrollment under a group health plan with respect to such Participant.

Section 1.02. Allowable Charge

The maximum covered charge for a service rendered or supply furnished by a health care provider that will be considered for payment.

A. For in-network providers, the Allowable Charge is the contracted fee.

B. For out-of-network providers, the Allowable Charge is the Reasonable Charge.

C. If this Plan is secondary to Medicare, the Allowable Charge means only that amount which is an allowable charge under Medicare's benefit rules.

Section 1.03. Ambulatory Surgical Center

A specialized facility operated under the supervision of a licensed physician and established and equipped to operate, and operates, in accordance with applicable laws in the area it is located. In order to be covered, the facility must be licensed under applicable law. The facility must provide at least one operating room, at least one recovery room and be equipped to perform diagnostic testing. Personnel must include licensed physicians (surgeon and anesthesiologist), registered nurse and other personnel equipped to handle emergencies. The Center must maintain a written agreement with at least one area hospital to immediately accept patients who develop complications or require post-operative confinement. Ambulatory Surgical Centers that are not in the PPO Network are excluded under this Plan.

Section 1.04. Ancillary Services

Emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether provided by a Physician or non-Physician practitioner; items and services provided by assistant surgeons, hospitalists, and intensivists; diagnostic services, including radiology and laboratory services;

and items and services provided if there is no PPO Provider who can furnish such item or service at PPO facility.

Section 1.05. Calendar Year

The period of twelve months starting on January 1 and ending on December 31 of each year.

Section 1.06. Cardiac Rehabilitation

A comprehensive exercise, education and behavioral modification program designed to improve the physical and emotional condition of patients with heart disease.

Section 1.07. Chiropractic Care

Diagnostic and Therapeutic services that are customarily provided by a chiropractor, including but not limited to spinal manipulations and adjustments.

Section 1.08. Claims Administrator

The firm(s) or corporation(s) that, pursuant to a contractual agreement with the Board of Trustees, provide(s) claims processing services, handles coordination of benefits, and provides services in connection with subrogation, utilization management and complaint resolution assistance.

Section 1.09. Coinsurance

The percentage a Participant pays for covered services after the Deductible or co-payment (if applicable) has been applied.

Section 1.10. Contributions

Payments made by an Employer to the Trust Fund pursuant to a collective bargaining agreement or other written agreement between the Employer and the Union.

Section 1.11. Cosmetic

Those procedures or services that affect appearance only, or which are performed for a purely superficial benefit, or which are preformed to improve the self-esteem of a person rather than to enhance the function or usefulness of a part of the body. The fact that the patient may suffer psychological or behavioral consequences absent the treatment or procedure does not make it non-cosmetic or covered by the Plan.

Section 1.12. Cosmetic Surgery

An elective surgical procedure that is performed for a Cosmetic reason, including but not limited to a face lift, breast enlargement or liposuction.

Section 1.13. Covered Employment

Services performed as an employee of an Employer for which Contributions are made to the Trust Fund.

Section 1.14. Covered Expense

A. With respect to all Plan benefits:

   1. A Covered Expense will not exceed the Reasonable Charge, as determined by the Fund Administrator; and

   2. An expense must also be allowable and not excluded from coverage under the benefit provisions of the Plan in order to be considered a Covered Expense.

B. With respect to the Major Medical Benefit, the charges for reasonably necessary services and supplies for the diagnosis or care of a Participant's Illness or Injury. To be reasonably necessary, the service or supply must be ordered by a Physician and must be recognized throughout the health care profession as the customary treatment for the Illness or Injury.

Section 1.15. Covered Under the Plan

When an individual is eligible to receive the benefits provided under this Plan that are applicable to his eligibility status as an Eligible Employee or Eligible Dependent.

Section 1.16. Custodial Care

The type of care which takes place at that time when a Participant is not under a specific Therapeutic program that has a reasonable expectancy of effecting improvement in the Participant's condition within a reasonable period of time and which does not require the technical skills or professional training of medical and/or nursing personnel in order to be safely and effectively performed.

Section 1.17. Deductible

The amount of covered charges incurred by a Participant which must be paid by the Participant before Plan benefits are payable.

Section 1.18. Dependent; Eligible Dependent

Any or all of the following individuals:

A. The Eligible Employee's lawful spouse (husband or wife), as documented by a valid marriage certificate; and

B. The Eligible Employee's natural or legally adopted children (or children who have been placed in the Employee's home for the purpose of adoption) under age 26 as documented by birth certificates or legal adoption orders.

C. A stepchild of an Eligible Employee who is under age 26 as documented by a birth certificate. A "stepchild" means a child of the Employee's spouse who was born to or legally adopted by the spouse prior to the spouse's marriage to the Employee.

D. A child under age 26 who is an Eligible Employee's alternative recipient in a divorce decree or under a Qualified Medical Child Support Order (QMCSO).

E. A child age 26 or over with a permanent mental or physical handicap that began prior to age 26 and that renders the child incapable of self-support. (The Employee must present written proof to the Fund Office that the Child meets these conditions when requested, but not more than once a year.) This handicapped adult dependent must be mainly dependent on the Eligible Employee for care and support and unable to engage in regular employment.

Section 1.19. Durable Medical Equipment

Equipment which:

A. Can withstand repeated use;

B. Is primarily and customarily used for medical purposes;

C. Is generally not useful to a person in the absence of illness or injury; and

D. Is appropriate for use in the home.

Durable Medical Equipment does not include equipment used for the purpose of altering air quality or temperature, providing a safe surrounding, or for exercise or training.

Section 1.20. Eligible Employee

An Employee who satisfies the conditions for eligibility under Article VI.

Section 1.21. Emergency

An accident or a sudden, unexpected medical condition that, without immediate medical attention, could result in death, impairment of bodily functions, or other serious medical consequences.

Section 1.22. Emergency Medical Condition

A bodily injury or sickness, including a mental health condition or substance use disorder, manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention would result in 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, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

Section 1.23. Emergency Services

Emergency Services with respect to an Emergency Medical Condition means:

A. A medical screening examination that is within the capability of the emergency department of a hospital or of an independent freestanding emergency department, as applicable, including Ancillary Services routinely available to the emergency department to evaluate such emergency medical condition; and

B. Medical examination and treatment that are within the capabilities of the staff and facilities available at such hospital or independent freestanding emergency department, as applicable, to Stabilize the patient (regardless of the department of the hospital in which such further examination or treatment is furnished); and

C. Unless the covered individual's consent to Out-of-Network Provider services is provided to the Plan by the provider or facility, items and services for which benefits are provided by the Plan that are furnished by an Out-of-Network Provider or Out-of-Network Provider emergency facility after the covered individual is Stabilized and as part of outpatient observation or an inpatient or outpatient stay with respect to the Emergency Medical Condition which gave rise to the initial Emergency Services.

Section 1.24. Employee

An individual who is actively employed by an Employer and on whose behalf the Employer is required to submit Contributions to this Fund under the terms of a collective bargaining agreement with the Union or a participation agreement with the Fund.

Section 1.25. Employer

A. Any person, firm, association, partnership or corporation which enters into a collective bargaining agreement with the Union or a participation agreement with the Fund requiring Contributions to be made to the Fund on behalf of the Employees employed by such person, firm, association, partnership or corporation; or

B. The Union and the Trust Fund for the purpose only of making Contributions to the Fund on behalf of their full-time Employees.

Section 1.26. Experimental, Investigational or Unproven

Medical, surgical, diagnostic, psychiatric, substance abuse or other health care technologies, supplies, treatments, diagnostic procedures, drug therapies or devices that are determined by the Fund (at the time it makes a determination regarding coverage in a particular case) to be:

A. Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service, or the American Medical Association Drug Evaluations as appropriate for the proposed use;

B. Subject to review and approval by an Institutional Review Board for the proposed use;

C. The subject of an ongoing clinical trial that meets the definition of a Phase I, II, or III clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight; or

D. Not demonstrated through prevailing peer-reviewed medical literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed.

The Fund reserves the right to make final judgment regarding coverage of Experimental, Investigational or Unproven procedures and treatments.

Section 1.27. Fund

The International Union of Operating Engineers, Local 399 Health and Welfare Trust Fund, established to receive and invest Contributions of the contributing Employers and from which benefits are paid.

Section 1.28. Fund Administrator

The person to whom the Trustees have delegated certain responsibilities for the Plan's day-to-day operations. (The business office of the Fund Administrator is referred to herein as the "Fund Office.")

Section 1.29. Home Health Care

A. Home Health Care is a program of continued medical care and treatment rendered by a licensed Home Health Care Agency team at home in lieu of a Hospital confinement or a stay in a Skilled Nursing Facility. Also, it must be for the care or treatment of sick or injured persons and must be ordered in writing by the eligible person's Physician; the Physician must certify, in writing, that without Home Health Care, confinement in a Hospital or Skilled Nursing Facility would be required.

B. Pre-certification by the Review Organization is required before benefits will be payable for Home Health Care.

C. Home Health Care does not include:

1. Full-time nursing care at home;

2. Private duty nursing;

3. Meals delivered to the home; or

4. Homemaker services.

Section 1.30. Home Health Care Agency

Home Health Care Agency means a public or private agency that:

A. Specializes in giving nursing or Therapeutic services in the home;

B. Is licensed or certified as a home health care agency; and

C. Operates within the scope of its license.

Section 1.31. Hospice Agency

A public or private agency, specializing in care for the terminally ill and their families, that is licensed and operates within the scope of its license.

Section 1.32. Hospital

An institution that:

A. Holds a license as a hospital (if required in the state in which it is located);

B. Is engaged primarily in providing medical care and treatment to sick and injured persons on an inpatient basis at the patients' expense; and

C. Is:

1. Accredited as a hospital by the Joint Commission;

2. A recipient of National Integrated Accreditation for Healthcare Organizations (NIAHO) accreditation through Det Norske Veritas Healthcare, Inc. (DNVHC); or

3. An approved provider with the Centers for Medicare and Medicaid Services (CMS).

Section 1.33. Illness

For the purpose of benefit payments under this Plan, an Illness is:

A. A condition not caused by the person's occupation wherein the body's organs do not function normally;

B. When a temporary ailment not caused by the person's occupation reduces the body's ability to function normally; or

C. Pregnancy.

Section 1.34. Infertility

The inability to conceive or the inability to sustain a successful pregnancy, excluding the inability to conceive due to a prior voluntary sterilization procedure.

Section 1.35. Injury

Bodily harm resulting from a non-occupational accident. "Accident," as used in the foregoing, means an undesirable or unfortunate happening, unintentionally caused, resulting in harm.

Section 1.36. Licensed Substance Abuse Professional

Any of the following who are credentialed, licensed by the state, and acting within the scope of his license:

A. A psychiatrist (MD);

B. A psychologist (PhD, PsyD);

C. A licensed clinical social worker (LCSW or equivalent);

D. A certified addictions counselor (CAC); or

E. A licensed clinical professional counselor (LCPC or equivalent).

Section 1.37. Licensed Medical Professional

Any of the following who are licensed by the state and acting within the scope of his license:

A. A podiatrist (DPM);

B. An optometrist (OD) when treating an acute medical (sudden onset) condition;

C. A chiropractor (DC) acting within the scope of his license;

D. A nurse practitioner (NP) acting under the direction of a medical physician;

E. A physician assistant (PA) acting under the direction of a medical physician;

F. A certified registered nurse anesthetist (CRNA) acting under the direction of a medical physician;

G. A certified nurse-midwife or certified midwife who is accredited by the American College of Nurse-Midwives and working under the supervision of an obstetrician; or

H. An oral and maxillofacial surgeon (OMD) when treating a medical condition.

Section 1.38. Licensed Mental Health Professional

Any of the following who are credentialed, licensed by the state, and acting within the scope of his license:

A. A psychiatrist (M.D.);

B. A clinical psychologist (Ph.D., Psy.D.);

C. A licensed clinical social worker (LCSW or equivalent);

D. A licensed clinical professional counselor (LCPC or equivalent); or

E. A licensed clinical marriage and family therapist (LMFT or equivalent).

Section 1.39. Licensed Surgeon

Any of the following who is licensed by the state to practice surgery and who is acting within the scope of his license:

A. A medical physician (MD or DO);

B. A podiatrist (DPM); or

C. An oral and maxillofacial surgeon (OMD).

Section 1.40. Medically Necessary

Those health services which are determined by the Trustees, based on the opinion of a qualified medical professional, to be medically appropriate according to the standards of good medical practice and that are:

A. Necessary to meet the basic health needs of the Participant;

B. Rendered in the most cost-efficient manner to meet the Participant's essential health needs and in the type of setting appropriate for the delivery of health services. (When more than one alternative is available that can meet the Participant's health needs, Medically Necessary shall mean the most cost-effective that can be provided.);

C. Consistent in type, frequency, and duration of treatment with scientifically based guidelines of national medical research and health care coverage organizations and government agencies that are accepted by the Trustees;

D. Consistent with the symptoms or diagnosis and treatment of the Participant's condition;

E. Required for reasons other than the comfort or convenience of the Participant, the physician or hospital; and

F. Not Experimental, Investigational or Unproven.

The fact that the patient's physician or health care professional deems a service to be medically necessary is not binding on the Trustees.

Section 1.41. Mental or Nervous Disorder

A condition which is described and coded in the mental health section of the current edition of the Diagnostic and Statistical Manual of Mental Disorders, except for conditions specifically excluded by the Plan, including but not limited to developmental delays, learning or developmental disabilities or disorders, or attention deficit disorders (such as ADD and ADHD).

Section 1.42. No Surprises Act

The federal No Surprises Act (Public Law 116-260, Division BB).

Section 1.43. No Surprises Act Services

No Surprises Act Services includes the following services, to the extent covered under the Plan:

A. Out-of-Network Provider services to treat an Emergency Medical Condition;

B. Out-of-Network Provider air ambulance services;

C. Ancillary services as defined under the No Surprises Act and its implementing regulations (including anesthesiology, pathology, radiology, neonatology and diagnostic services) when performed by Out-of-Network Providers at PPO facilities; and

D. Other services to treat a condition that is not an Emergency or Emergency Medical Condition performed by an Out-of-Network provider at PPO health care facilities with respect to which the provider does not comply with the notice and consent requirements under the No Surprises Act and its implementing regulations.

Section 1.44. Participant

An Eligible Employee or Eligible Dependent who is covered under the Plan according to the eligibility rules as set forth in Article VI or Article I, Section 1.18 as applicable.

Section 1.45. Participating Provider; PPO Provider

A facility, medical group or health care professional that has a written agreement with the Plan's PPO Network to provide services to participants, with economic incentives for using designated providers of health care services. When used herein, the term "PPO Provider" shall mean only a provider that is covered under the terms of the Plan and that has an in-force agreement with the PPO Network on the date the Participant receives the services and supplies. A provider that is not a PPO Provider is referred to herein as a "Out-of-Network Provider."

Section 1.46. Physician

A qualified doctor, physician or surgeon, who is a Doctor of Medicine (MD) or a Doctor of Osteopathy (DO) and who is licensed to practice medicine and surgery in all of its branches.

Section 1.47. Plan

The International Union of Operating Engineers Local 399 Health and Welfare Plan, the health and welfare plan of benefits provided by the International Union of Operating Engineers, Local 399 Health and Welfare Trust Fund, i.e., the plan set forth herein, as amended from time to time.

Section 1.48. PPO Network

A network of doctors, hospitals and dentists that has agreed to accept a discounted fee for their services from the Plan.

Section 1.49. Preferred Provider Organization (PPO)

A. A group or network of Hospitals, Physicians and Health Care Providers under contract with the Plan to provide health care services and supplies at agreed-upon discounted rates.

B. The Plan may also contract with preferred provider organizations for its dental and vision benefit programs.

Section 1.50. Qualifying Payment Amount

The median contracted rate on January 31, 2019, as adjusted, for the same or similar item or service that is provided by a provider in the same or similar specialty and provided in a geographic region in which the item or service is furnished, increased for inflation.

Section 1.51. Reasonable Charge

An amount established by the Plan, in its sole discretion, to be a fair and appropriate charge for the services provided. In determining Reasonable Charges, the Plan considers the actual charges of providers for identical or similar services and items provided in the same or similar general locality. Reasonable Charges for PPO Providers refers to the amount the provider agrees to charge the Plan for services to covered participants.

Section 1.52. Residential Treatment Facility

An institution or that part of any institution that operates to provide medical care and rehabilitation for individuals with Mental or Nervous Disorders or Chemical Dependency/Substance Abuse, that meets all of the following criteria:

A. It is licensed as an intermediate-care inpatient behavioral health treatment facility pursuant to state law.

B. It is either part of the Plan's PPO network or it is considered a duly accredited psychiatric residential treatment facility by the Centers for Medicare and Medicaid Services (CMS).

C. It is not, other than incidentally, an institution providing Custodial Care.

D. Every patient must be under the supervision of a Physician, and a Physician is available at all times to furnish necessary medical care in case of emergency.

Group homes and halfway houses are not considered Residential Treatment Facilities and are excluded under this Plan.

Section 1.53. Review Organization

A professional provider of health care review and certification services with whom the Trustees have entered into a contract for the purpose of administering the Plan's utilization review programs.

Section 1.54. Skilled Nursing Facility

A facility, which is operating legally to provide room and board for sick or injured persons under the supervision of a registered nurse or a Physician, and along with the services of nurses at all hours, meets all of the following tests:

A. It is licensed as a skilled nursing facility pursuant to state law;

B. It has available at all times the services of a Physician who is on the staff of a Hospital;

C. It keeps a daily medical record for each patient;

D. It is not primarily a place for rest or Custodial Care, a place for the aged, a place for alcoholics or drug addicts, or a hotel; and

E. It is either part of the Plan's PPO network or it is considered a duly accredited skilled nursing facility by the Centers for Medicare and Medicaid Services (CMS).

Section 1.55. Stabilize(d)

With respect to an Emergency Medical Condition, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility.

Section 1.56. Substance Abuse

Alcoholism, alcohol abuse, drug addiction, drug abuse, or any other type of addiction to, abuse of, or dependency on any type of drug or chemical, except nicotine.

Section 1.57. Therapeutic

Treatment of, for, or contributing to the cure, or to halt the progression, of disease or impaired physical function.

Section 1.58. Trust Agreement

The Agreement and Declaration of Trust creating the International Union of Operating Engineers Local 399 Health & Welfare Trust, as amended, supplemented and restated, and all amendments and modifications hereto, thereafter made.

Section 1.59. Trustees

The persons selected under the Trust Agreement to administer the Plan and the Fund, together with their successors, sometimes collectively referred to as the "Board of Trustees" or the "Board."

Section 1.60. Union

The International Union of Operating Engineers Local 399, and any other union whose collective bargaining agreement requires Contributions to the Fund.

ARTICLE II – GENERAL PLAN PROVISIONS

Section 2.01. Administration

The Trustees shall have all rights, duties and powers necessary or appropriate for the administration of the Plan. In particular, the Trustees shall have and shall exercise complete discretionary authority to construe, interpret and apply all of the terms of the Plan, including all matters relating to eligibility for benefits, amount, time or form of payment, and any disputed or allegedly doubtful terms. The Trustees may employ or retain the services of one or more individuals to carry out the day-to-day administration of the Plan on behalf of the Trustees, of whom the chief executive is the Fund Administrator.

Section 2.02. Alternative Benefit

Notwithstanding any provisions of the Plan to the contrary, the Fund Administrator of the Plan or the Board of Trustees, in its sole discretion, may make exceptions to the coverage and limitations set forth in this Plan in a particular case where:

A. The exception permits a Participant to receive coverage for services that are not covered but have the expected medical or Therapeutic benefits of covered services; and

B. The expected cost to the Plan of the alternative treatment permitted by this exception is less than the expected cost to the Plan if the Participant were to obtain services that are covered by the Plan.

Section 2.03. Altered/Forged Claims

If a Participant or Eligible Dependent knowingly misrepresents or falsifies any information or matter in connection with a claim for benefits, the Trustees may deny all or part of the benefits otherwise due.

Section 2.04. Enrollment Requirements

A. Enrollment Form for a Newly Hired Employee

A newly hired Employee must obtain and complete a Plan Enrollment Form and provide the Fund Office with original marriage and birth certificates and other requested documentation for his dependents. Identification cards and Plan reference information will be issued to the Employee after the Enrollment Form and related documentation has been received.

B. Enrollment Form for Adding a Dependent(s)

If an Employee acquires a new dependent through marriage, birth or adoption, the dependent shall generally be eligible for coverage immediately on the date of such marriage, birth or adoption. However, the Employee must complete and submit a new Enrollment Form or an Enrollment Change Form within 90 days from the date the new dependent(s) would be eligible for enrollment. Documentation (marriage, birth certificate, etc.) will be required. If the Employee does not complete and submit the required documentation within this 90-day period, coverage will begin on the first day of the month after the Fund Office receives the required documentation (such as the marriage certificate, birth certificate, etc.).

C. Special Enrollment Due to Loss of Other Group Coverage

1. An Employee may decline coverage for one or more dependents if the dependent is covered under another group health plan, including Medicare, Medicaid or a State Children's Health Insurance Program (SCHIP) or health insurance. In such case, that dependent may be enrolled in this Plan at a later date when the other coverage ends due to:

   a. Loss of eligibility for the coverage (not including a loss of eligibility due to failure to pay premiums);

   b. An employer ceasing to make Contributions for that coverage; or

   c. The maximum coverage period under COBRA being exhausted.

2. To exercise this special enrollment right, the Employee must request to enroll his dependent within 90 days after the loss of coverage or the employer's cessation of Contributions for such coverage (or within 90 days in the case of the loss of coverage under Medicaid or SCHIP). There is no special enrollment right if the other coverage ceases due to an individual's failure to pay premiums or for cause such as filing fraudulent claims. Coverage for a Dependent who is enrolled under this special enrollment provision will begin on the first day of the month after the Fund Office receives the enrollment request, the completed Enrollment Form and documentation (such as the marriage certificate, birth certificate, etc.)

3. These special enrollment rights will also apply to a dependent for whom coverage was declined due to other coverage and who later becomes eligible for a premium assistance subsidy for Medicaid or SCHIP.

4. Only a dependent who meets the Plan's definition of an Eligible Dependent is eligible for special enrollment and coverage under the Plan.

Section 2.05. Examinations

The Trustees shall have the right and opportunity:

A. To employ a physician of their choice to examine the person whose Injury or Illness is the basis of a claim hereunder when and so often as they may reasonably require during pendency of the claim;

B. To examine any and all hospital or medical records relating to a claim under this Plan; and

C. To request an autopsy in case of death, provided an autopsy is not forbidden by law.

Section 2.06. Free Choice of Physician

A Participant shall have free choice of any legally qualified Physician, and the Physician-patient relationship shall be maintained and in no way interfered with.

Section 2.07. Funding

A. All Employers shall make Contributions as required under their collective bargaining agreements with the Union, as well as any and all Contributions otherwise required by law.

B. All Contributions made under the Plan shall be held in trust in the Fund until disbursed for payment of benefits (including payment of premiums on insurance to provide benefits) or administrative expenses.

C. The Trustees may, in their discretion, use assets of the Plan to purchase insurance to provide any benefit under the Plan. In addition, the Trustees may, in their discretion, use assets of the Plan to purchase "excess" or "stop-loss" insurance, provided that such "excess" or "stop-loss" insurance is no more than a financial device of the Plan intended to protect the Plan assets against large losses, meaning that the Trustees (or the Plan) are the named insured, in the event of an insurable event reimbursement under such insurance flows directly from the insurer to the Plan, and no Participant has any rights of any kind under such "excess" or "stop-loss" coverage.

D. Except to the extent insured, all benefits under the Plan shall be paid from the assets of the Plan held in the Fund. Neither the Union nor any contributing Employer nor any Trustee shall have any liability for payment of benefits under the Plan.

E. All benefits under this Plan are conditioned upon the sufficiency of the assets of the Plan to provide them. No benefit under this Plan is due if the assets of Plan are insufficient to provide it.

Section 2.08. Gender and Number

Any reference to the masculine gender in this document shall be deemed also to apply to the feminine gender and vice versa, unless the context requires otherwise. Any reference to the singular may also apply to the plural and vice versa, unless the context requires otherwise, or the result would be unreasonable.

Section 2.09. Governing Law

This Plan is created and accepted in the State of Illinois. All questions pertaining to the validity, construction or interpretation of the Trust Agreement, the Plan, and of the acts and transactions of the Trustees or of any matter affecting the Plan or Fund shall be determined under Federal law where applicable Federal law exists; where no applicable Federal law exists, the laws of the State of Illinois shall apply without giving effect to its conflict of law rules.

Section 2.10. Legal Proceedings

A. The Plan is maintained for the exclusive benefit of the Plan's Participants. All rights and benefits granted to them are legally enforceable.

B. No action at law or in equity or otherwise may be brought on any claim or other matter whatsoever against the Plan, the Fund Administrator, the Trustees, or any of them, until all of the proper claim filing procedures and claim review procedures mandated by ERISA as set forth in Article V shall have been followed and exhausted. No legal action can be brought with respect to a claim or other matter whatsoever against the Plan after six months from the date of decision on appeal.

Section 2.11. Maternity Hospitalizations

A Participant on whose behalf maternity benefits are payable by the Plan shall be entitled to at least 48 hours of inpatient Hospital care for a normal delivery and at least 96 hours of inpatient Hospital care for a Caesarean section. The Plan will provide benefits for the Covered Medical Expenses incurred by such individual during these time periods, subject to all applicable Deductibles, co-payment percentages and maximum benefits set forth on the Schedule of Benefits.

Section 2.12. Payment of Benefits

A. Benefits payable for any loss shall be paid upon timely receipt by the Trustees or their duly appointed representatives, of written proof of loss covering the occurrence, character and extent of the event for which claim is made.

B. Benefits for Out-of-Network Providers are payable to the Eligible Employee whose Injury or Illness, or whose Dependent's Injury or Illness, is the basis of claim under this Plan, unless benefits are assigned according to the provisions of Section 2.12-C below.

C. The provisions governing assignments shall be:

1. No assignment of any present or future right, interest, or benefit under this Plan shall bind the Trustees without their written consent thereto.

2. The Trustees may, at their option, accept validly executed assignments of benefits made by an Eligible Employee or the spouse of the Employee when such assignments are executed in favor of a provider providing medical services or supplies that are covered by the Plan, in which case benefits may be paid to the assignee instead of to the Employee.

3. No assignment of benefits shall assign more than the assignor's right to payment of benefits and shall not be deemed to assign any other right or interest that the assignor has under the Plan, including, but not limited to, the right to seek review of a benefit denial.

D. If any individual is, in the opinion of the Trustees, legally incapable of giving a valid receipt for any payment due and no guardian has been appointed for such individual, the Trustees may, at their option, make such payment to the person who, in their opinion, has assumed the care and principal support of such individual. If the individual dies before all amounts due and payable have been paid, the Trustees may, at their option, make such payment to the executor, administrator or personal representative of the individual's estate, to his surviving spouse, parent, child or children, or to any other person who, in the Trustees' opinion, is equitably entitled thereto.

E. Unless specifically stated otherwise, for the purpose of determining the satisfaction of any Deductible amounts and the amount of benefit payments, a charge for any service, supply or treatment shall be considered to have been incurred on the date on which the service or treatment was rendered or on which the supply was provided.

F. Benefits shall be payable by the Plan up to but not to exceed any maximum benefit or other benefit limitation specified on the Schedule of Benefits. For each Participant, whether or not there has been an interruption in the continuity of his eligibility, the maximum amount of benefits available during any specified period of time shall be equal to the amount by which the maximum benefit specified for that period of time exceeds the sum of the benefits previously paid or provided on his account during that period of time.

G. Benefits shall be payable only for expenses incurred by persons who are Covered Under the Plan at the time the expenses are incurred.

H. Benefits shall be payable for expenses incurred by a Participant only if the expenses are incurred within any applicable time limitations specified on the Schedule of Benefits or in any other applicable provision of this Plan.

I. Benefits shall be payable only for expenses which are specified as Covered Expenses or which are specified as payable in any other applicable provision of this Plan, subject to any applicable limitations or exclusions governing such expenses.

J. Benefits shall be payable only for expenses which are actually incurred.

K. The self-funded (self-insured) benefits payable under this Plan are limited to the Fund assets available for such purposes.

L. Any payments made by the Trustees in accordance with these provisions will fully discharge the liability of the Trustees to the extent of such payment.

M. Other provisions governing the payment of benefits and/or the limiting or exclusion of benefits are specifically set forth in other Articles of this Plan.

Section 2.13. Plan Amendment

The Trustees may amend this Plan at any time and in such manner as they may deem advisable and consistent with the terms of the Trust Agreement.

Section 2.14. Plan Discontinuation or Termination

A. This Plan may be terminated under certain circumstances, e.g., if future collective bargaining agreements do not require employer Contributions to the Fund, if the Plan or Fund is merged into another plan or fund, or if the Trustees determine, for any reason, to terminate the Plan.

B. If the Plan is terminated, benefits for covered charges incurred before the termination date fixed by the Trustees shall be paid on behalf of its Participants as long as the Fund's assets are more than the Fund's liabilities.

C. Full benefits may not be paid if the Fund's liabilities are more than its assets, and benefit payments shall be limited to the funds available in the Trust Fund for such purposes. The Trustees shall not be liable for the adequacy or inadequacy of such funds.

D. If there are any excess assets remaining after the payment of all Fund liabilities, those excess assets shall be used for purposes determined by the Trustees in accordance with the provisions of the Trust Agreement.

Section 2.15. Plan Identification Numbers

A. The Employer Identification Number (EIN) assigned to the Fund is 36-6198426.

B. The Plan Number (PN) assigned to this Plan is 501.

Section 2.16. Plan Year

The Fund's financial records are kept on a twelve-month fiscal year basis, beginning June 1 of each year and ending May 31 of the next year.

Section 2.17. Precedence of Plan Provisions Over a Summary

If any provision of this document is summarized in a Summary Plan Description or Summary of Material Modifications or other notice to Plan Participants and there is a discrepancy between the actual provision contained in this document and the summary, the provision as contained in this document shall take precedence.

Section 2.18. Prohibition on Rescission

The Plan cannot rescind coverage except in the case of fraud or an intentional misrepresentation of a material fact. A rescission is a cancellation or discontinuance of coverage initiated by the Plan that has retroactive effect, unless it is attributable to a failure to pay timely required premiums or contributions towards the cost of coverage. The Plan must provide 30 calendar days advance notice to a covered person before coverage may be rescinded.

Section 2.19. Right to Receive and Release Necessary Information

A. The Trustees have the right to obtain or provide any information needed to process claims and to coordinate benefit payments with other plans. This information may be obtained from or provided to any insurance company, organization, or person without notice to the Participant and without the Participant's consent. Any such uses and disclosures that involve protected health information will comply with the provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

B. A Participant making application for benefits shall be required by the Trustees to authorize any provider, employer, government agency or any other person, corporation or organization having information which may be required for a proper determination of the claim by the Trustees to release such information to the Trustees. The Participant must provide the appropriate authorizations to accomplish this purpose.

Section 2.20. Right of Recovery (Offset)

In the event any payment is made by the Plan to or on behalf of a person who is not entitled to such payment or to the full amount of such payment, the Trustees shall have the right to take such action as they deem appropriate to recover such payment, including but not limited to the right to reduce future payments due to or on behalf of such person or his eligible family members by the amount of any erroneous payment. This right of offset shall not limit the rights of the Plan to recover such erroneous payments in any other manner.

Section 2.21. Severability Clause

A. Should any provision contained in the Plan or any amendment thereto be deemed or held to be unlawful, such illegality shall apply only to the provision in question and shall not apply to any other provisions of the Plan, unless such illegality shall make impossible or impracticable the functioning of such Plan.

B. If any provision of this Plan is contrary to any law to which it is subject, such provision is hereby amended to conform to such law.

Section 2.22. Subrogation and Constructive Trust of Plan Assets

A. Subrogation applies whenever a Participant has a right to recover payment from a third party (including his own insurance carrier). Subrogation does not apply to work-related conditions which are not covered by the Plan in any circumstance.

B. The Plan is not obligated to pay benefits or claims in those circumstances where a third party is liable for the injury giving rise to the claim for benefits. The Plan may withhold payment of benefits payable in connection with accidental Injuries when any party other than the Participant or this Plan may be liable for expenses, until such liability is legally determined.

C. The Plan, in its sole discretion, may make payment of benefits before a finding of liability is made, subject to the agreement of the Participant (including a minor) and his counsel, if any, to hold any proceeds of litigation, settlement or judgment in trust for the Plan and to acknowledge that the proceeds are a Plan asset. Payment may be conditioned upon receipt of a Subrogation and Constructive Trust Agreement signed by the Participant (or, if the Participant is minor, the legally responsible party) and his legal representative. In the event of any payment for services under this Plan, the Plan shall, to the extent of such payment, be subrogated to all the rights of recovery of the Participant and shall be entitled to immediate payment of amounts due before any distribution to or on behalf of the Participant. The Participant will be required to reimburse this Plan for any and all benefits paid under this Plan out of any monies recovered as the result of judgment, settlement or any other cause.

D. Upon receipt by the Participant or the legal representative, the monies recovered shall become an asset of this Plan. The Participant and the legal representative shall hold the monies recovered as a result of judgment, settlement or any other cause in trust for this Plan. The Plan is entitled to payment in full of 100% of the benefits paid, whether or not the Participant is made whole. No reductions or deductions are allowed for litigation costs, court costs, or attorneys' fees (i.e., the Common Fund Doctrine, Make Whole Doctrine, and/or any other state law affecting these rights are preempted by this Plan provision under ERISA).

E. The Trustees may, in their sole discretion, compromise the amount due under this provision when, in their judgment, the compromise is more likely to result in a higher recovery for the Plan than if no compromise were made.

F. The Participant must take such action, furnish such information and assistance, and execute and deliver all necessary instruments as the Plan may require to facilitate the enforcement of its rights. If the Participant fails to cooperate with the Plan in the enforcement of its rights, the Plan may suspend payment of all benefits subject to subrogation, enforce its right to restitution of amounts paid and to equitable enforcement of the Plan, and seek such other legal or equitable relief to which it is entitled. In addition, if the Participant fails to cooperate with the Plan in the enforcement of its rights, the Plan may offset all present and future payments due the Participant under the Plan against amounts paid pursuant to the Agreement.

G. This Plan has the right to recover against any proceeds from other sources received in connection with the accident or Injury, including, but not limited to, an uninsured or underinsured policy of insurance that applies to the Participant. It does not pay for nor is responsible for the Participant's attorney's fees. Attorney's fees are to be paid solely by the Participant. If a covered person takes no action to recover any money from any source, the Trustees may initiate a direct action for recovery of benefits paid. If the Trustees take such action, they will be allowed to retain the amount of benefits paid as well as attorney's fees and costs incurred from any settlement or judgment award by the court or paid by a third party in satisfaction of the claim.

Section 2.23. Time Limitation

If any time limitation of the Plan, with respect to giving notice of claim or furnishing proof of claim or loss or the bringing of an action at law or in equity, is less than that permitted by any law to which this Plan is subject, such limitation is hereby extended to agree with the minimum period permitted by such law.

Section 2.24. Trustee Interpretation and Authority; Decisions by the Trustees

A. The Plan shall be administered by the Trustees in accordance with the provisions of the Trust Agreement.

B. The Trustees have sole authority to make final determinations regarding any application for benefits and to interpret the Plan, the Plan documents, and any other regulations, procedures or administrative rules adopted by the Trustees. If a decision of the Trustees is challenged in court, it is the intention of the parties that such decision is to be upheld unless it is determined to be arbitrary or capricious.

C. Benefits under this Plan will be paid only when the Board of Trustees or persons delegated by them decide, in their sole discretion, that the employee or beneficiary is entitled to benefits.

D. All questions or controversies of whatsoever character arising in any manner or between any parties or persons in connection with this Plan or the Fund or its operation, whether as to any claim for benefits, as to the construction of the language of this Plan or any rules and

regulations adopted by the Trustees, or as to any writing, decision, instrument or account in connection with the operation of the Plan or otherwise, shall be submitted to the Trustees or their Fund Administrator for decision. Decisions of the Trustees or their Fund Administrator in such matters are final and binding on all persons dealing with the Plan or the Fund or claiming any benefits from the Plan, unless appealed on a timely basis.

E. The Trustees have the authority to amend the eligibility rules or other provisions of the Plan. The Trustees may increase, decrease, change or eliminate benefits or other provisions of the Plan at any time as they may determine to be in the best interests of Plan Participants and beneficiaries and as may in their discretion be proper or necessary for the sound and efficient administration of the Trust Fund and have sole authority to terminate the Plan at any time, provided that any such change or termination is not inconsistent with applicable law or with the provisions of the Plan or the Trust Agreement.

Section 2.25. Use and Disclosure of Protected Health Information Pursuant to HIPAA

A. The Fund will use and disclose protected health information (individually identifiable health information, regardless of the form in which it is kept) only to the extent of and in accordance with the uses and disclosures permitted or required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and Department of Health and Human Service Regulations Regarding Privacy of Individually Identifiable Health Information. The Fund will not disclose protected health information to the Plan Sponsor, Board of Trustees of the International Union of Operating Engineers Local 399 Health and Welfare Trust or permit a health insurance issuer or HMO to disclose protected health information unless this disclosure complies with HIPAA and Department of Health and Human Service Regulations Regarding Privacy of Individually Identifiable Health Information.

B. The Fund may disclose to the Board of Trustees "summary health information" (information which summarizes claims history, claims expenses, or types of claims experienced by individuals for whom the Trustees provide coverage under the Fund and from which aspects permitting identification, other than a five-digit zip code, have been eliminated) and this information may be used by the Board of Trustees to obtain premium bids from health plans for providing health insurance coverage under the Fund or for the Board of Trustees to modify, amend or terminate this Plan.

C. The Fund may disclose to the Board of Trustees protected health information concerning whether a person participates in the Fund or have enrolled or disenrolled from a health insurance issuer or HMO, in the event the Fund were to ever have such options.

D. The Fund may disclose protected health information to the Board of Trustees pursuant to a written authorization supplied by the participant or beneficiary which complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and Department of

Health and Human Service Regulations Regarding Privacy of Individually Identifiable Health Information.

E. Except for the disclosures set forth in Sections 2.25-B. through D above, in order for the Fund to disclose protected health information to the Board of Trustees or to permit the disclosure of such information to the Board of Trustees by a health insurance issuer or HMO with respect to the Fund, for any purposes including the administration of the Fund, the Fund must ensure that the Plan documents restrict uses and disclosure of protected health information consistent with the requirements of the Department of Health and Human Service Regulations Regarding Privacy of Individually Identifiable Health Information. These restrictions are set forth in this Section.

F. In order for the Fund to disclose protected health information to the Board of Trustees other than as set forth in Sections 2.25-B. through D above, the Board of Trustees must certify that the Plan has been amended to incorporate the provisions set forth in this Section 2.25-F and that the Board of Trustees agrees to each of the items set forth in this Section 2.25-F. Specifically, the Board of Trustees agrees that it will:

1. Not use or further disclose protected health information other than as permitted or required by the Plan or as required by law;

2. Ensure that any agents, including a subcontractor, to whom the Board of Trustees provides protected health information received from the Fund agree to the same restrictions and conditions that apply to the Board of Trustees with respect to the protected health information;

3. Not use or disclose the information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Board of Trustees;

4. Report to the Fund any use or disclosure of the protected health information that is inconsistent with the uses or disclosure provided for of which it becomes aware;

5. Make available protected health information as required by the Department of Health and Human Service Regulations Regarding Privacy of Individually Identifiable Health Information;

6. Make available protected health information for amendment and incorporate any amendments to protected health information in accordance with Department of Health and Human Service Regulations Regarding Privacy of Individually Identifiable Health Information;

7. Make its internal practices, books, and records relating to the use and disclosure of protected health information received from the Fund available to the Secretary of Health and Human Services for purposes of determining compliance by the Fund with Subpart E of the Department of Health and Human Service Regulations Regarding Privacy of Individually Identifiable Health Information; and

8. If feasible, return or destroy all protected health information received from the Fund that the Board of Trustees still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible and provide for the separation of the Fund and Board of Trustees and protections set forth in Section 2.25-G.

G. The Board of Trustees shall ensure that adequate separation exists between the Fund and the Board of Trustees. In order to ensure this separation:

1. Access to protected health information provided from the Fund to the Board of Trustees shall be restricted to the members of the Board of Trustees who are involved in matters relating to payment, health care operations or other matters pertaining to the Fund in the ordinary course of business;

2. Access by the Trustees to protected health information provided from the Fund to the Board of Trustees shall be restricted to the plan administration functions that the Board of Trustees provide for the Fund; and

3. The Board of Trustees shall provide an effective mechanism for resolving any issues of noncompliance by Trustees with the provisions of this Section.

H. The Fund may not disclose protected health information to the Board of Trustees nor permit a health insurance issuer or HMO to disclose protected health information to the Board of Trustees as otherwise permitted under the Department of Health and Human Service Regulations Regarding Privacy of Individually Identifiable Health Information unless a statement required by Section 164.520 (1) (iii)(C) of these Regulations is included in the Notice of Privacy Practices promulgated under Section 164.520.

I. The Fund may not disclose protected health information to the Board of Trustees for the purpose of employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Board of Trustees.

Section 2.26. Workers' Compensation Not Affected

This Plan is not in lieu of and does not affect any requirement for coverage under any workers' compensation law, employer's liability law, occupational diseases law or similar law. Benefits which would otherwise be payable under the provisions of such laws shall not be paid by the Plan merely because a Participant fails or neglects to file a claim for benefits under the provisions of such laws.

ARTICLE III – GENERAL PLAN LIMITATIONS AND EXCLUSIONS

Section 3.01. Expenses Not Payable

All Plan benefits are subject to the following exclusions, conditions and limitations. The interpretation and application of these exclusions will be at the sole discretion of the Trustees. This is not an all-inclusive listing of the Plan's limitations and excluded procedures, services and supplies. It is only representative of the types of charges which are not payable by the Plan and of the types of situations in which incurred charges are not payable. These exclusions and limitations are in addition to the exclusions and limitations listed in the various Articles of this Plan that describe the specific Plan benefits. Benefits are not payable for:

A. Services by a **provider** who is not licensed by the appropriate state agencies; any services or treatment by a professional acting outside the scope of said license; any facility that does not meet the definition of a Hospital; or charges by providers not specifically identified as covered by the Plan for the services being performed.

B. Services that are **not Medically Necessary** for the diagnosis or treatment of an **Illness or Injury**, and/or any services provided when the patient has no current symptoms, except for those services and supplies covered under the Dental Benefit or the Vision Benefit.

C. Any charge, or portion of any charge, which exceeds that amount determined to be a **Reasonable Charge** for the service rendered or the supply provided.

D. **LASIK** surgery, radial keratotomy or other types of eye surgery done for the purpose of correcting visual acuity.

E. **Vision therapy** or orthoptics.

F. Drugs, medical devices, procedures and research treatments performed for the purpose of clinical trials, or that are **Experimental, Investigational or Unproven**, or that are not generally considered acceptable as an appropriate means of treatment by the medical profession, or that have not been approved by the FDA for a specific condition or disease.

G. Care and treatment of an injury or sickness that is **occupational** and arises from work for wage or profit, including self-employment, for which benefits are compensable or for which settlement has been made by a worker's compensation carrier.

H. Expenses in connection with any disease or injury caused by an **act of war**, whether declared or undeclared; or treatment of military service-connected disabilities for which the patient is eligible for treatment at government expense.

I. Injury or sickness caused by or contributed to by engaging in an **illegal act** by committing or attempting to commit any crime, criminal act, assault, or other unlawful behavior, or by participating in a riot or public disturbance.

J. Any charges from a provider for only being available to a patient or only preparing to provide services to a patient, but no services to diagnose or treat a patient were directly provided (sometimes referred to as "**stand-by services**").

K. **A service or supply that is free of charge** from the American Cancer Society or another organization.

L. Charges for claims received by the Claims Administrator **more than 15 months after the services were rendered**.

M. Treatment for covered services by a provider **when the provider is related** by birth or marriage to the patient or resides in the patient's home.

N. **Travel and accommodations**, whether or not prescribed by a physician, except as defined as a covered expense.

O. Charges or portion of charges **over the Plan's maximum** benefit amounts.

P. Charges for which there is **no legal obligation to pay** or for which the Employee would not have been charged had there been no coverage.

Q. Charges for **infection control or medical waste disposal, failure to keep a scheduled visit, completion of claim forms, fees for phone calls, handling, service fees or late fees**.

R. **Gene therapy.**

ARTICLE IV – COORDINATION OF BENEFITS

Section 4.01. Benefits Subject to this Article

The provisions of this Article shall apply to all of the medical, dental and vision benefits provided under This Plan. The provisions of this Article shall not apply to the Prescription Drug Program, Disability Income Benefit, or to the insurance benefits.

Section 4.02. Definitions Applicable to this Article

A. The term "Plan," as used in this Article, means any Plan providing benefits or services for or by reason of medical, dental or vision care or treatment which benefits or services are provided by:

1. Group or blanket insurance coverage, group Blue Cross and group Blue Shield, or other group prepayment coverage, coverage under a labor-management trusteed plan, union welfare plan, employer organization plan, or employee benefit organization plan, including any federal or state or other governmental plans or law;

2. Coverage under any Plan largely tax-supported or otherwise provided for by or through action of any government; or

3. Medicare. For the purposes of this Article, the definition of Medicare shall include both Part A and Part B of Medicare, whether or not the Participant is enrolled for both Parts.

The term "Plan" shall be construed separately with respect to each policy, contract, or other arrangement for benefits or services and separately with respect to that portion of any policy, contract or other arrangement which reserves the right to take the benefits or services of other plans into consideration in determining its benefits and that portion which does not.

B. The term "This Plan," as used in this Article, means that portion of this Plan which provides the benefits subject to the provisions of this Article.

C. The order of benefit determination rules determine whether This Plan is a "primary Plan" or "secondary Plan" when compared to another Plan covering the person on whose behalf a claim is made. When This Plan is primary, its benefits are determined before those of any other Plan without consideration of any other Plan's benefits. When This Plan is secondary, its benefits are determined after those of another Plan and may reduce its benefits payable so that payments from all Plans do not exceed 100% of the total Allowable Expenses.

D. The term "Claim Determination Period," as used in this Article, means a period of one year commencing with a January 1, or if less, the period within a Calendar Year during which the claimant is covered by This Plan and another Plan.

E. The term "Allowable Expense," as used in this Article, means any Medically Necessary item, up to the Reasonable Charge, at least a portion of which is covered under at least one of the Plans covering the person with respect to whom claim is made.

1. When a Plan provides benefits in the form of furnishing services or supplies rather than cash payments, the reasonable cash value of each service or supply furnished shall be deemed to be both an Allowable Expense and a benefit paid.

2. The Trustees shall not be required to determine the existence of any Plan or the amount of benefits payable under any Plan except This Plan, and the payment of benefits under This Plan shall be payable under any and all other Plans only to the extent that the Trustees are furnished with information relative to such other Plans by the Employer, Participant, or any insurance company or other organization or person.

3. If a Plan has procedures which must be followed by a Plan participant in order to obtain maximum reimbursement under that Plan, benefits shall be coordinated as if those rules or procedures had been followed even if they were not, e.g., if the Plan requires an individual to use certain providers, assesses a utilization review penalty for non-compliance or requires the individual to follow other procedures, expenses represented by that penalty, in dollars or other reduction in benefits, shall not be considered "Allowable Expenses" under this Article.

4. If This Plan is secondary to a Plan that determines its benefits on the basis of negotiated fees, any amounts in excess of such negotiated fees are not "Allowable Expenses." When This Plan is secondary to another Plan that has a negotiated fee agreement with the same facility, the Allowable Expense with respect to the health care facility claim shall be the primary Plan's negotiated fee, unless no benefits are payable by the primary Plan, or the amount of This Plan's payment exceeds the amount This Plan would have paid in absence of the other coverage. In such case, the Allowable Expense will be This Plan's negotiated fee amount, and This Plan's payment shall be what it would have paid in absence of the other coverage. When This Plan is secondary to another Plan that has a negotiated fee agreement with the same provider, other than a health care facility, the Allowable Expense with respect to that provider's claim shall be This Plan's negotiated fee, except that This Plan's payment shall not exceed what it would have paid as the secondary Plan had the primary Plan's negotiated fee amount been the Allowable Expense.

F. The term "Dependent" as used in this Article means, with respect to This Plan, any individual included within the definition of "Dependent" as specified in Article I, and with respect to any other Plans, any individual who qualifies for benefits under such Plan as the dependent of an individual covered by such other Plan.

Section 4.03. Effect on Benefits

A. When This Plan is secondary in accordance with Section 4.04 below, it may reduce its benefits during a Claim Determination Period so that the total benefits paid or provided by all Plans for claims incurred during the Claim Determination Period are not more than 100 percent of the total Allowable Expenses incurred during that period. Benefits payable under another Plan include the benefits that would have been payable had claim been duly made.

B. Any benefit savings resulting from coordination of medical benefits in a Claim Determination Period will be held in the Participant's benefit credit account for payment of Allowable Expenses on the person's future medical claims incurred in that Claim Determination Period.

C. Benefits payable under another Plan include the benefits that would have been payable had claim been duly made therefor.

Section 4.04. Order of Benefit Determination

The rules establishing the order of benefit determination are:

A. The primary Plan pays or provides its benefits as if the secondary Plan or Plans did not exist.

B. A Plan that does not contain a coordination of benefits provision is always primary.

C. A Plan may consider the benefits paid or provided by another Plan in determining its benefits only when it is secondary to that other Plan.

D. If a husband and wife are both covered under This Plan as Employees and Dependents (of each other), benefits will be coordinated as if there are two separate plans, applying the order of benefit rules in this Section 4.04.

E. The first of the following rules that describes which Plan is primary is the applicable rule that will be used to establish the order of benefit determination:

1. Non-Dependent or Dependent

The benefits of a Plan which covers the person on whose expenses claim is based other than as a dependent shall be primary and shall determine its benefits before the benefits of a Plan which covers such person as a dependent, unless the person on whose behalf claim is based is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent.

2. Claims for Dependent Children

With respect to establishing the order of benefit determination on claims for Dependent children, the following rules apply:

a. *Birthday Rule*

(1) The benefits of the Plan which covered the child on whose expenses claim is based as a Dependent of a person whose date of birth, excluding year of birth, occurs first in a Calendar Year shall be the primary plan, if:

(a) The parents are married;

(b) The parents are not separated (whether or not they were ever married to each other); or

(c) A court decree awards joint custody of the child without specifying that one parent has the responsibility to provide health care coverage.

(2) If the birthday rule applies and if both parents have the same month and day of birth, the Plan that has covered either of the parents longer is the primary Plan.

(3) If the birthday rule would apply except that the other Plan does not use the birthday rule, then the other Plan is primary to This Plan.

b. In the case of a child whose parents are divorced or separated, if the terms of a Qualified Medical Child Support Order or other court order states that one of the parents is responsible for the child's health care expenses or health care coverage, then the responsible parent's plan is primary.

c. If the parents are not married and not living together, or are separated or divorced and no court decree allocates responsibility for the child's health care expenses or health care coverage, or if a court decree states that the custodial parent is responsible for the child's health care expenses or health care coverage, the order of benefits for all possible Plans is:

(1) The Plan of the custodial parent;

(2) The Plan of the spouse of the custodial parent;

(3) The Plan of the noncustodial parent; and

(4) The Plan of the spouse of the noncustodial parent.

d. If the child has employer-sponsored coverage as well as coverage through a parent, the Non-Dependent/Dependent rule (No. 1 above) will apply.

e. If the child is covered as a Dependent under his or her spouse's plan and as a Dependent under his or her parent's plan, then the spouse's plan shall be primary and the parent's plan shall be secondary.

3. Active or Inactive Employee

The Plan that covers a person as an employee is primary for claims filed on behalf of the employee and his dependents over a Plan that covers the person as other than an employee.

4. COBRA Coverage

If a person whose coverage is provided under a right of continuation coverage provided by federal or state law is also covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree (or a dependent of such person) is primary, and the continuation coverage is secondary.

Exception: If the Plan covering the person as an employee, member, subscriber or retiree (or a Dependent of such person) is primary, as determined above, and if such Plan has a pre-existing condition limitation or exclusion, the Plan providing continuation coverage will be primary with respect to the Allowable Expenses incurred as a result of treatment for the preexisting condition.

5. Length of Coverage

If none of the above rules apply, the Plan that covered the person for the longer period of time shall be the primary.

Section 4.05. Right to Receive and Release Necessary Information

For the purposes of determining the applicability of and implementing the terms of this Article of This Plan or any provision of similar purpose of any other Plan, the Trustees may, without the consent of or notice to any person, release to or obtain from any insurance company or other organization or person any information, with respect to any person, which the Trustees deem to be necessary for such purposes. Any person claiming benefits under This Plan shall furnish to the Trustees such information as may be necessary to implement the provisions of this Article.

Section 4.06. Facility of Benefit Payment

Whenever payments which should have been made under This Plan in accordance with this Article have been made under any other Plans, the Trustees shall have the right, exercisable alone and in their sole discretion, to pay over to any organization making such payments any amounts they shall determine to be warranted in order to satisfy the intent of this Article, and amounts so paid shall be deemed to be benefits paid under This Plan, and to the extent of such payments, the Trustees shall be fully discharged from liability under This Plan.

Section 4.07. Right of Recovery

Whenever payments have been made by the Trustees 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 Article, the Trustees shall have the right to recover such payments, to the extent of such excess, from one or more of the following, as the Trustees shall determine: any persons to or for or with respect to whom such payments were made, any insurance companies, or any other organizations.

Section 4.08. Coordination with Medicare

All medical benefits provided under This Plan are subject to this provision.

A. Definitions

1. "Medicare" as used herein means benefits provided under the Health Insurance for the Aged Program under Title XVIII of the Social Security Act as such Act was amended by the Social Security Amendments of 1965 (Public Law 89-97) and as such Program is currently constituted and as it may later be amended.

2. "Allowable Expenses" as used herein means any necessary, Reasonable Charge at least a portion of which is covered under Medicare or This Plan.

B. Provisions

1. Active Eligible Employees Age 65 or Older

If an Eligible Employee who is age 65 or over and eligible to participate in Medicare continues to work as an Employee for a Contributing Employer and such Employee continues to maintain his eligibility for benefits under This Plan as an Employee, unless This Plan is legally permitted to pay its benefits after Medicare pays its benefits, This Plan will be the primary Plan and Medicare will be the secondary Plan with respect to such Eligible Employee's Allowable Expenses provided that the expenses are considered by Medicare to be Allowable Expenses by Medicare, provided the Employee is not entitled and could not upon application become entitled to Medicare as an End Stage Renal Disease beneficiary, and provided the Employee has not rejected This Plan and elected Medicare as his health care coverage.

2. Age 65 or Over Eligible Dependent Spouses of Employees

If an Eligible Employee has a Dependent spouse who is age 65 or older and eligible to participate in Medicare, unless This Plan is legally permitted to pay its benefits after Medicare pays its benefits, This Plan will be the primary Plan with respect to such Dependent spouse's Allowable Expenses and Medicare will be the secondary Plan with respect to such Dependent spouse's Allowable Expenses, provided the spouse is not entitled

and could not upon application become entitled to Medicare as an End Stage Renal Disease beneficiary, and provided such spouse has not rejected This Plan and elected Medicare as her health care coverage.

3. Disabled Persons Under Age 65

Benefits shall be payable under This Plan without regard to an Eligible Employee's or Eligible Dependent's entitlement or potential entitlement to Medicare due to total disability, unless This Plan is legally permitted to pay its benefits as a secondary Plan after Medicare pays its benefits, if the Employee is under age 65 and Covered Under the Plan due to active employment.

4. End Stage Renal Disease Beneficiaries

Benefits shall be payable under the Plan without regard to an Eligible Employee's or Eligible Dependent's entitlement to Medicare, unless This Plan is legally permitted to pay its benefits as a secondary Plan after Medicare pays its benefits, if such Employee or Dependent is entitled to Medicare as an End Stage Renal Disease beneficiary and not more than 30 months have elapsed since the earliest of the following months:

a. The month in which the Employee or Dependent began a regular course of renal dialysis;

b. The month in which the Employee or Dependent received a kidney transplant;

c. The month in which the Employee or Dependent was admitted to the hospital in anticipation of a kidney transplant that was performed within the next two months; or

d. The second month before the month the kidney transplant was performed, if performed more than two months after admission.

C. All Medicare-Eligible Persons Deemed Enrolled

If a Participant is eligible to participate in Medicare Part A and to enroll in Medicare Part B, This Plan will coordinate its benefits with Medicare Part A and Medicare Part B with respect to claims filed by or on behalf of such individual whether or not such individual has enrolled for both Parts. This Plan will only pay benefits equal to the benefits it would have paid if the Participant enrolled in both Medicare Part A and Medicare Part B when first eligible to do so.

Section 4.09. Coordination with Sub-Plans

If This Plan is secondary on a Participant's claim under its order of benefit determination rules, but the primary Plan has a rule allowing it to pay less than its normal benefits when there is secondary coverage, without regard to whether the lesser benefits are payable under the terms of a sub-plan or wrap-around provision, then such individual will be deemed covered under This Plan's sub-plan. The maximum payable by This Plan for all claims incurred by an individual

covered under the sub-plan is $1,000 per Calendar Year, or, if less, the amount payable after application of This Plan's coordination of benefits rules.

A. If the primary Plan has a no-loss provision, and if the sum of the primary Plan's sub-plan benefits, plus This Plan's sub-plan benefits, plus any additional benefits payable by the primary Plan's regular benefit plan under its no-loss provision, is less than the sum of the benefits otherwise payable under This Plan's regular benefit plan, then This Plan's regular benefit plan will pay the difference.

B. If the primary Plan pays its normal benefits for the individual's claim, that is, the benefits it would have paid if the individual was not also Covered Under the Plan, then the individual will be deemed covered under This Plan's regular benefit plan, and This Plan will coordinate its regular benefits as the secondary payer to the other Plan.

ARTICLE V – CLAIMS

Section 5.01. Definitions Applicable to this Article

A. A "claim" is a request for a Plan benefit or benefits, made by a Participant (or the Participant's Authorized Representative) that complies with the Plan's procedure for making benefit claims, including a request for benefit reimbursement for services rendered, for pre-certification or approval of a Plan benefit, or for a utilization review determination in accordance with the terms of the Plan. A request for confirmation of Plan coverage is not a claim if the expense has not yet been incurred unless the Plan conditions payment on the receipt of prior approval. A general inquiry about eligibility or coverage when no expense has been incurred is not a claim, nor is presenting a prescription to a pharmacy.

B. A claim is "post-service" if the Participant has already received the treatment or supply for which payment is now being requested.

C. A "disability claim" is a claim for Disability Income Benefits, including a retroactive termination of a Disability Income Benefit.

D. A "pre-service claim" is a request for preauthorization of a type of treatment or supply that requires approval in advance of obtaining medical care in order for benefits to be paid.

E. An "urgent care claim" is a pre-service claim where the application of the time periods for making non-urgent care determinations could seriously jeopardize the patient's life, health, or ability to regain maximum functions, or that could subject the patient to severe pain that cannot be adequately managed without the proposed treatment.

F. The "Review Committee" is the full Board of Trustees or a committee designated by the Trustees for the purpose of reviewing claim appeals.

G. An "authorized representative" is a person designated by a Participant to act on behalf of the Participant. Except in the case of an urgent care claim, such designations must be in writing. The Fund shall have final authority to determine if an individual qualifies as an authorized representative.

   1. Unless the claimant's authorization states otherwise, all notices regarding his claim will be sent to his authorized representative and not to the claimant.

   2. A routine assignment of benefits so that the Plan will pay the provider directly is not a designation of the provider as the claimant's authorized representative.

Section 5.02. General Rules Pertaining to Claim Filing

A. In order for the Plan to pay benefits, a claim must be filed with the office designated by the Trustees for handling claims in accordance with the written procedures given to all Eligible Employees (hereafter "Fund Office"). A claim can be filed by the claimant, an Eligible family member of the claimant, or by the claimant's authorized representative.

B. A claim is considered to have been filed on the date it is received at the correct Plan Office, even if the claim is incomplete. Claims are received during regular business hours, Monday through Friday.

C. Claims must be filed within 15 months of the date the claim is incurred.

Section 5.03. Claim Processing Time Limits

A. If all information needed to process the claim is provided to the Fund Office, the claim will be processed within the following time limits:

1. Within 30 days for a post-service claim;
2. Within 45 days for a disability claim;
3. Within 15 days for a pre-service claim;
4. Within 72 hours for an urgent care claim; or
5. Within 90 days for a Life Insurance Benefit or Accidental Death and Dismemberment Benefit claim.

B. In addition, any request to extend a course of treatment beyond the period of time or number of treatments previously approved (called a "concurrent care" claim) will be decided as soon as possible, taking into account the medical circumstances, and the Participant will be notified of the Plan's decision within 24 hours after receipt of the request, provided that any such request is made at least 24 hours prior to the expiration of the prescribed period of time or number of treatments. Otherwise, the urgent care claim time periods will apply.

C. If a Participant sends a claim to the Fund Office that cannot be processed because information is missing, the Participant will receive a notice stating the reason(s) the claim cannot be completed and what additional information is needed. It is the Participant's responsibility to send any missing information to the Fund Office to complete a claim. Notice about an incomplete claim will be sent to the Participant, the provider, or the individual's Physician:

1. Within 30 days for a post-service claim;
2. Within 45 days for disability claims;
3. Within 15 days for a pre-service claim;

4. Within 24 hours for an urgent care claim; or

5. Within 90 days for a Life Insurance Benefit or Accidental Death and Dismemberment Benefit claim.

D. It is the Participant's responsibility to see that the missing information is provided to the Fund Office. The normal claim processing period will be extended by the time it takes for the Participant to provide the information to the Fund Office. Once the Fund Office has received the information from the Participant, the time limits will again begin running. If the Participant does not provide the missing information within 48 hours for an urgent care claim or 45 days for any other claim (except for Life Insurance Benefit and Accidental Death and Dismemberment Benefit claims), the Fund Office will make a decision on his claim without such information.

E. The time limits described in this Section 5.03 may be extended if the Fund Office determines that an extension is necessary due to matters beyond the control of the Plan. The Participant will be notified prior to the expiration of the normal approval/denial time period if an extension is needed. If an extension is needed, it will not last more than:

1. 15 days for post-service claims.

2. 30 days for disability claims (a second 30-day extension may be needed in special circumstances).

3. 15 days for pre-service claims.

4. 90 days for a Life Insurance Benefit or Accidental Death and Dismemberment Benefit claim.

F. The Participant may have an authorized representative act on his behalf, although the Trustees may verify that the representative has been so authorized. However, in connection with an urgent care claim, the Plan will recognize a health care professional with knowledge of the Participant's medical condition as the Participant's representative.

Section 5.04. Claim Denials

A. If all or part of a Participant's claim is denied after the Fund Office has received a completed claim form and all other necessary information from him, he will be sent a written notice giving him the reasons for the denial.

B. The notice will provide:

1. Reference to the Plan provisions on which the denial was based and a description of the Plan's Claim Appeal Procedures.

2. A description of any additional material or information necessary for the Participant to perfect the claim, and the reason such information is necessary, if applicable.

3. A description of the applicable time limits for following the procedures, including a statement of the Participant's right to bring a civil action under section 502(a) of ERISA.

4. The specific internal rule, guideline, protocol or similar criterion upon which the Plan relied to make the decision (if applicable).

5. If the decision was based on Medical Necessity or if the treatment was deemed Experimental and Investigative, either an explanation of the scientific or clinical judgment for the determination or a statement that such explanation will be provided free of charge upon request.

6. With respect to a denial of a disability claim, the notice, which will be provided in a culturally and linguistically appropriate manner to the extent required under applicable law, shall include:

    a. A statement regarding the rights of the claimant and an authorized representative.

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

        (1) The views presented by the claimant to the Plan of health care professionals treating the claimant and vocational professionals who evaluated the claimant;

        (2) The views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and

        (3) A disability determination regarding the claimant presented by the claimant to the Plan made by the Social Security Administration.

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

    d. The decision will include either the specific internal rules, guidelines, protocols, standards or other similar criteria that the Plan relied upon in making an adverse benefit determination or, alternately, a statement that such rules, guidelines, protocols, standards or other similar criteria do not exist.

Section 5.05. Claim Appeal Procedures

A. A Participant may request the Review Committee to review a claim after a denial of benefits.

1. For urgent care claims, the Participant may orally request that the Review Committee review the decision by contacting the Fund Office. The request may also be submitted in writing.

2. For concurrent care claims for which the Fund Office has terminated or reduced a previously approved period of treatment, the Participant will have the right to appeal that termination or reduction. The Participant will be given advance notice of the termination or reduction and allowed to appeal the determination before the termination or reduction. However, this rule allowing the treatment to continue pending an appeal does not apply if the Participant's benefits have terminated because he lost eligibility under the Plan, or if the termination or reduction is the result of a Plan amendment.

3. For review of all other claims, the Participant should request a claim review form from the Fund Office. When the Participant receives the form, he should fill it in completely, attach any additional information that may help a favorable decision to be made, and return the completed form within 180 days after the date the denial was mailed to him, except with respect to Life Insurance Benefit and Accidental Death and Dismemberment Benefit claims. The Participant must file a request for an appeal of the denial of a Life Insurance Benefit or Accidental Death and Dismemberment Benefit claim within 60 days after the date the denial was mailed to him.

B. The Participant may designate an authorized representative who can file his request for review and otherwise act for him. The Participant and/or his representative may review materials in the Plan's files that are related to his claim. The Participant and/or his representative may also submit written issues and comments to support the request for review. The Participant may also make a written request for a personal appearance by himself and/or his representative at a hearing before the Review Committee. Any such personal appearance will be made at the sole expense of the Participant.

C. The Review Committee will conduct a full and fair review of all of the material and information submitted with the claim, the action taken by the Fund Office, the additional information provided by the Participant and the reasons the individual thinks the claim should be paid.

D. The review will:

1. Be conducted by an appropriate named fiduciary who is neither the party who made the initial adverse determination, nor the subordinate of such party;

2. Not afford deference to the initial adverse benefit determination;

3. Take into account all comments, documents, records and other information submitted by the claimant, without regard to whether such information was previously submitted or relied upon in the initial determination; and

4. With respect to a review of any determination based on a medical judgment, the Review Committee will consult with a health care professional with appropriate training and experience in the field of medicine involved in the medical judgment. Such health care professional will be "independent," which means the person consulted will be an individual different from, and not subordinate to, any individual who was consulted in connection with the initial decision.

E. With respect to an appeal of a disability claim, the claimant shall be provided, free of charge, with any new or additional evidence considered, relied upon, or generated by the Review Committee in connection with the claim, and any new or additional rationale for the adverse determination. This evidence will be provided as soon as possible before issuing an adverse benefit determination on review, and sufficiently in advance of the required date for providing an adverse benefit determination on review to provide the claimant with a reasonable opportunity to respond prior to that date.

Section 5.06. Notification Following Review

A. With respect to an urgent care claim, the Participant will be notified of the Review Committee's decision about his appeal as soon as possible, taking into account the medical circumstances, but not later than 72 hours after receipt of the Participant's request for review. In the case of pre-service claims, the Participant will be notified no later than 30 days after receipt of his request for review.

B. With respect to all other claims, a review and determination will be made within 60 days of the Plan's receipt of the request for review.

C. After a decision has been made on a disability or post-service claim, the Participant will be informed in writing of the Review Committee's decision, normally within five calendar days of the review.

D. The written notification of the Review Committee's decision of the appeal will contain:

1. The reason(s) for the decision and specific references to the particular Plan provisions upon which the decision was based;

2. A statement explaining that the Participant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claim;

3. A statement describing any voluntary appeal procedures offered by the Plan and the Participant's right to obtain the information about such procedures;

4. A statement of the Participant's right to bring an action under section 502(a) of ERISA; and

5. If applicable, the Participant will be informed of the specific internal rule, guideline, protocol or similar criterion relied upon to make the decision. If the decision was based on a medical judgment, the individual will receive an explanation of that determination or a statement that such explanation will be provided free of charge upon request.

6. With respect to denial of a disability claim following review, the notice, which will be provided in a culturally and linguistically appropriate manner to the extent required under applicable law, shall include:

   a. A statement regarding the rights of the claimant and an authorized representative.

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

      (1) The views presented by the claimant to the Plan of health care professionals treating the claimant and vocational professionals who evaluated the claimant;

      (2) The views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and

      (3) A disability determination regarding the claimant presented by the claimant to the Plan made by the Social Security Administration.

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

   d. The decision will include either the specific internal rules, guidelines, protocols, standards or other similar criteria that the Plan relied upon in making an adverse benefit determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria do not exist.

Section 5.07. External Review Procedures

A. External Review Filing Deadline

If your health care claim involving compliance with cost-sharing and surprise billing protections was denied under the internal appeals procedures, resulting in an adverse benefit determination, you have the right to file a request for an external review by an independent

review organization with the Fund Office within four months of the date of the internal appeal decision.

However, you do not have a right to request external review if your health care claim did not involve compliance with cost-sharing and surprise billing protections.

B. External Review Process

The external review process works as follows:

1. Request for External Review

Within five days of the Plan's receipt of the request for external review, the Plan must determine whether:

a. You are or were covered under the Plan at the time of service or requested service;

b. The adverse benefit determination does not relate to your failure to meet the Plan's eligibility requirements;

c. You exhausted or are deemed to have exhausted the Plan's internal appeal process as outlined in Section 5.05; and

d. You have provided all information and forms required to process an external review.

2. Determination of Eligibility for External Review

Within one business day after the completion of this review, the Fund must notify you (or your authorized representative) whether the request is complete and is eligible for review. If the request is not complete, the Fund must provide notice of what information or materials are needed and allow you to perfect the request within the four-month filing period or 48 hours following receipt of the notification, whichever is later. If the request is not eligible for external review, the notice must include the reason(s) for ineligibility and contact information for the Employee Benefits Security Administration.

3. Referral to an Independent Review Organization (IRO)

If your request is eligible for review, the Fund will utilize an unbiased method to assign the external review to one of its three IROs. The timeline for completion of the external review is as follows:

a. The IRO will timely notify you of receipt of assignment of the external review and such notice will inform you that you may provide additional information within ten business

days following receipt of the notice. The IRO is not required, but may, accept and consider additional information submitted after ten business days.

b. The Fund must provide the claim file, and any information considered in making the adverse benefit determination within five business days after the date of assignment to the IRO. Failure by the Fund to submit the information to the IRO may result in an immediate reversal of the adverse benefit determination. The IRO must send notice of such to you and the Fund within one business day.

c. The IRO must forward any additional information received from you to the Fund within one day of receipt and the Fund may reconsider and reverse its decision, terminating the external review. The Fund must provide notice within one business day of such a decision to you and the IRO.

d. The IRO will review all information received de novo and may not be bound by any decisions or conclusions reached during the Fund's internal claims and appeals process. In addition to all information provided, the IRO may consider the following information, if the IRO deems it appropriate:

(1) The claimant's medical records;

(2) The attending health care professional's recommendation;

(3) Reports from appropriate health care professionals and other documents submitted by the Plan, claimant or treating provider;

(4) The terms of the Plan;

(5) Appropriate practice guidelines, which must include all evidence-based standards and may include any other practice guidelines developed by the federal government, national or professional medical societies, boards and associations;

(6) Any applicable clinical review criteria developed and used by the Plan, unless the criteria is inconsistent with the terms of the Plan or applicable law; and

(7) The opinion of the IRO's clinical reviewer or reviewers after considering the information described in this notice to the extent the information or documents are available and the clinical reviewer or reviewers consider it appropriate.

4. Request for an Expedited External Review

You may make a request for an expedited external review if the adverse benefit determination involves a medical condition for which the timeframe for completion of an expedited internal appeal or standard external review as described above would seriously jeopardize the life or health of the claimant or would jeopardize the ability to regain maximum

function or if the final adverse benefit determination concerns an admission, availability of care, continued stay or health care item or service for which the claimant received emergency services, but has not been discharged from a facility.

An expedited external review will occur in accordance with the procedures stated above for a standard external review, except that each step must be performed in the most expeditious method and the IRO must provide the claimant of its decision as expeditiously as the circumstances require, but no more than 72 hours after the IRO receives the request for an expedited external review. If the decision is not communicated in writing, the notice must provide written confirmation to you and the Plan within 48 hours after notice is provided.

C. Timing of Notice of Decision on External Review

The assigned IRO must provide written notice of the final external review to the claimant and the Plan within 45 days after the IRO first receives the request for review.

D. Content of Notice of Decision on External Review

The IRO will provide you and the Fund with a written decision. The notice of the decision will contain all of the following:

1. A general description of the reason for the request for external review including sufficient information to identify the claim involved, including the date of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning and the reason for the previous denial.

2. The date the IRO received the assignment and the date of the IRO decision.

3. Reference to the evidence or documentation, including the specific coverage provisions and evidence-based standards that were relied on in making its decision.

4. A discussion of the principal reason(s) for the IRO's decision, including the rationale for the decision and any evidence-based standards that were relied on in making its decision.

5. 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 Plan or the claimant.

6. A statement that judicial review may be available to the claimant.

7. Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsmen established under Section 2793 of the Public Health Service Act.

Section 5.08. Enforcement of Rights

If the Plan fails to make timely decisions or otherwise fails to comply with the applicable federal regulations, the Employee may file suit in court to enforce his rights.

ARTICLE VI – ELIGIBILITY

Section 6.01. General

Employees shall become eligible for benefits if they perform covered work and sufficient Contributions are made to the Fund on their behalf in accordance with the following provisions of this Article. In certain instances, eligibility may be based on self-contributions as specified in this Article.

Section 6.02. Initial Eligibility

A. Effective Date of Employee Benefits

An Employee will become initially eligible for Plan benefits on the first day of the calendar month following the calendar month during which he begins Covered Employment.

B. Effective Date of Dependent Benefits

1. A person who is a Dependent of an Employee will become eligible for Plan benefits on the date the Employee's benefits start.

2. A person who becomes a Dependent of an Employee while the Employee is already Covered Under the Plan will generally become effective on the date on which the person becomes the Employee's Dependent.

Section 6.03. Continuing Eligibility

A. After an Employee becomes initially eligible for Plan benefits, he will remain eligible until the last day of the calendar month during which he is no longer working for the Employer who is making Contributions to the Fund on his behalf.

B. A Dependent will remain eligible for benefits as long as he or she satisfies the Plan's definition of a Dependent, provided that the Employee's benefits remain in effect.

Section 6.04. Medical Leaves

A. Family and Medical Leave Act (FMLA)

If an Employee is entitled to take an unpaid leave of absence that qualifies under the Family and Medical Leave Act of 1993 (FMLA), and if his Employer is required to maintain his eligibility during the leave period by making Contributions to the Fund, the Employee's eligibility will continue in the usual manner, subject to the Fund's receipt of the appropriate Contributions from the Employer. All disputes concerning the eligibility of the Employee are between

the Employee and his Employer. Benefits will be suspended pending resolution of the dispute. The Trustees will have no direct role in resolving such dispute.

B. Other Medical Leaves

If an Employee takes a medical leave of absence for an injury or illness from an Employer who is making Contributions to the Fund on the Employee's behalf, the Employer may be required to extend the Employee's coverage for a period of time in accordance with the Employer's collective bargaining agreement. When the Employer's obligation has ended, the Employee may be eligible for COBRA coverage.

Section 6.05. Military Leave

A. If an Eligible Employee leaves Covered Employment with an Employer to enter active service in the uniformed services (as defined by the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)) of the United States for 31 days or more, and as a result the Employee and his Dependents lose Plan coverage, the Employee or Dependent will be entitled to make self-payments for continued Plan coverage for up to 24 months, regardless of any coverage provided by the military or government. The payment amounts, rules and provisions for continued coverage during military leave are the same as those for COBRA coverage and will run concurrently with the Employee's or Dependent's COBRA coverage period.

B. Following discharge from such service, the Employee may be eligible to apply for reemployment with his former Employer in accord with USERRA. Such reemployment includes the right to elect reinstatement in any then existing health coverage provided by the Employer.

C. In the event of a conflict between this provision and USERRA, the provisions of USERRA shall apply.

Section 6.06. COBRA Continuation Coverage

A. COBRA Coverage Provisions of the Consolidated Omnibus Budget Reconciliation Act (COBRA)

In accordance with Federal law (Public Law 99-272, Title X), if a qualifying event occurs, each qualified beneficiary (other than a qualified beneficiary for whom the qualifying event will not result in any immediate or deferred loss of coverage) shall be offered an opportunity to elect to make self-payments to the Fund to continue to receive the health Plan coverage that he or she received immediately before the qualifying event. This continued coverage is "COBRA coverage," and the rules governing such coverage are specified in the following provisions of this Section.

B. Qualified Beneficiary

1. A qualified beneficiary is any individual who, on the day before a qualifying event, is Covered Under the Plan by virtue of being on that day either:

   a. The Eligible Employee;

   b. The spouse of the Eligible Employee; or

   c. The Dependent child of the Eligible Employee.

2. An Eligible Employee can be a qualified beneficiary only in connection with a qualifying event that consists of the termination of the Employee's employment or reduction in the Employee's hours.

3. An individual is not a qualified beneficiary if, on the day before the qualifying event, the individual is Covered Under the Plan solely by reason of another individual's election of COBRA coverage and is not already a qualified beneficiary by reason of a prior qualifying event, provided, however, that if a child is born to an Eligible Employee, adopted by an Eligible Employee, or placed for adoption with an Eligible Employee after an 18-month COBRA coverage period begins for such Employee and any Dependents, the child will be deemed a qualified beneficiary.

C. Qualifying Event

1. A "qualifying event" is any of the following events which, under the terms of the Plan, causes an Eligible Employee, or the spouse or a Dependent child of the Eligible Employee, to lose coverage under the Plan (for this purpose, to "lose coverage" means to cease to be covered under the same terms and conditions as in effect immediately before the qualifying event):

   a. A reduction in the Eligible Employee's hours;

   b. The termination of the Eligible Employee's employment for reasons other than gross misconduct;

   c. With respect to a Dependent spouse, divorce from the Employee;

   d. A Dependent child ceasing to meet the Plan's definition of a Dependent and thereby losing Dependent status; or

   e. The death of the Eligible Employee.

2. It is the responsibility of the Employee, the spouse, or the child, as applicable, to notify the Plan of the date of a divorce or of the date a child loses Dependent status. If notice is not provided within 60 days of the occurrence of such an event, or within 60 days after Plan coverage would terminate for the affected Dependent(s), whichever date is later, the

Dependent(s) who would lose coverage due to such a qualifying event will not be entitled to elect COBRA coverage.

D. Maximum Coverage Period

1. COBRA coverage that has been elected by a qualified beneficiary will extend for a period beginning on the date that Plan coverage would otherwise terminate for the individual(s) affected by the election and ending on the applicable date set forth below:

   a. 18 months after the date coverage would otherwise terminate for the qualified beneficiary if the qualifying event giving rise to COBRA coverage election rights is an Employee's termination of employment or reduction in hours, provided however that if a qualified beneficiary (Employee or Dependent) is disabled, as determined by the Social Security Administration for the purpose of receiving Social Security disability benefits, as of the date of the Employee's termination of employment or reduction in hours or becomes so disabled at any time during the first 60 days of an 18-month COBRA coverage period, the 18-month period may be extended for up to an additional eleven (11) months for a total maximum coverage period of 29 months for that qualified beneficiary as well as for all individuals who are qualified beneficiaries due to the Employee's reduction in hours or termination of employment, provided that the Fund Office is notified by the Employee or disabled qualified beneficiary:

      (1) Within 60 days of the date of the disability determination by the Social Security Administration and before termination of the original 18-month continuation period; and

      (2) Within 30 days after the Social Security Administration makes a final determination that the previously disabled qualified beneficiary is no longer disabled for Social Security disability benefits purposes.

   b. 36 months after the date coverage would otherwise terminate due to any other qualifying event.

   c. If an Eligible Employee is entitled to Medicare as of the date of the Employee's termination of employment or reduction in hours, COBRA coverage for the Employee's Dependents will terminate 36 months from the date of the Employee's Medicare entitlement or, if longer, 18 months from the Employee's termination of employment or reduction in hours.

2. In the case of a qualifying event that gives rise to an 18-month maximum coverage period and is followed, within that 18-month period, by a second qualifying event (e.g., the Employee's death or divorce, or a child's loss of Dependent status), the original 18-month period will be expanded to 36 months, but only for those individuals who were qualified beneficiaries under the Plan as of the first qualifying event and who were Covered Under the Plan at the time of the second qualifying event. If the Fund Office is not notified

within 60 days, the qualified beneficiary will not be entitled to extend COBRA coverage beyond the original 18-month period.

3. No qualifying event(s) can give rise to a maximum coverage period that ends more than 36 months after the date that coverage would otherwise terminate due to the first qualifying event.

E. Termination of COBRA Coverage

COBRA coverage under this Plan will normally terminate at the end of the last month of the applicable maximum coverage period (specified above) to which the individual was entitled and for which proper and timely self-payments were made. However, COBRA coverage will be terminated prior to the end of the applicable maximum coverage period on the first to occur of any of the following dates:

1. The first day of any month for which a correct and timely COBRA self-payment is not made to the Fund by or on behalf of the covered person;

2. The date upon which the Fund ceases to maintain any group health plan (including successor plans);

3. The date after the date of the election of COBRA coverage upon which the individual becomes entitled to Medicare benefits;

4. The first date after the date of the election upon which the individual is covered (i.e., actually covered, rather than merely eligible to be covered) under another group health plan that is not maintained by the Fund, provided, however, that this provision shall not apply if a person becomes covered under another group health plan that limits or excludes benefits for a medical condition of such person that is deemed to be a pre-existing condition by the other group health plan. When the other plan's pre-existing condition limitation or exclusion no longer applies to the individual, his COBRA coverage under this Plan will terminate; or

5. If the covered person has been receiving extended COBRA coverage for up to an additional 11 months due to his or another family member's disability, on the date on which the Social Security Administration determines that he or the family member whose disability gave rise to the 11-month extension is no longer disabled.

F. COBRA Coverage Benefits

The Plan benefits provided for an Employee and/or for Dependents affected by an election of COBRA coverage will be the same medical (including prescription drug), dental and vision benefits for which the Employee and/or Dependents were eligible on the day before the occurrence of the qualifying event and will be the same as any such benefits provided to Eligible Employees and Dependents to whom a qualifying event has not occurred. COBRA coverage

does not include Disability Income Benefits or Life Insurance or Accidental Death and Dismemberment Insurance benefits.

G. Monthly Self-Payment Amount for COBRA Coverage

The monthly self-payment amount will be determined by the Trustees in accordance with the law governing such determination. The self-payment amount is subject to change, but not more often than once during the Plan's fiscal year unless there is a substantial change in the benefit plan.

H. Provisions Governing Election of COBRA Coverage

1. When the Fund Office is notified that a qualifying event has occurred, an election notice and an election form will be sent to the qualified beneficiary(ies) affected by the qualifying event. The election notice will inform the affected individuals of their right to elect COBRA coverage and of the self-payment amount required if COBRA coverage is elected.

2. If COBRA coverage is desired, the qualified beneficiary electing the coverage must fill in and return the election form to the Fund Office within 60 days after the date the election notice is mailed by the Fund Office to the qualified beneficiary(ies) or within 60 days after Plan coverage would otherwise terminate for the qualified beneficiary(ies), whichever date is later.

3. An election of COBRA coverage is considered to be made on the date that the completed election form is mailed (postmarked) or personally delivered to the Fund Office.

4. If the completed election form is not mailed or personally delivered to the Fund Office within the applicable period of time specified above, COBRA coverage will be considered to have been declined with respect to all qualified beneficiaries affected by the qualifying event.

5. Each qualified beneficiary must be offered the opportunity to make an independent election to receive COBRA coverage. However, if a qualified beneficiary who is either an Eligible Employee or the Dependent spouse of the Employee makes an election to provide any other qualified beneficiary with COBRA coverage, the election will be binding on the other spouse.

6. If the Employee does not elect COBRA coverage on behalf of his Dependents who are entitled to COBRA coverage, his Dependents are entitled to make a separate and independent election of COBRA coverage for up to 18 months within the time period in which the Employee could have elected the coverage on their behalf.

7. An election on behalf of a minor child may be made by the child's parent or legal guardian.

8. COBRA coverage may be elected for any individual who, as of the individual's election date, is already entitled to Medicare, provided however, that if an individual becomes

entitled to Medicare after the date of the election of COBRA coverage, COBRA coverage will terminate.

9. COBRA coverage may be elected for any individual who, as of the individual's election date, is already covered under another group health care plan, provided however, that if an individual becomes covered, after the date of the election of COBRA coverage, under another group health plan, COBRA coverage will terminate unless the individual has a pre-existing medical condition that would cause benefits to be excluded or limited under the other group health care plan, in which case this exclusion will not apply.

I. Provisions Governing Self-Payments and Due Dates

1. Self-payments may be made in person at the Fund Office or may be mailed to the Fund Office.

2. Self-payments must be made monthly.

3. An individual making an election of COBRA coverage will have 45 days after the date of the election to make his initial payment for COBRA coverage provided between the date his coverage terminated and the date the payment is made.

4. Each subsequent monthly self-payment is due on or before the first day of each month. However, a self-payment will be considered to have been made on a timely basis if the payment is received by the Plan within 30 days of the due date.

5. If a self-payment is not received by the Fund Office within the time limits specified above, COBRA coverage will be terminated for all affected individuals, retroactive to the first day of the month for which a timely self-payment was not made. The overdue payment may not be made up nor may coverage be reinstated by the making of further payments.

Section 6.07. Extension of Eligibility for Survivors

In an Employee dies while Covered Under the Plan, coverage for the Employee's Eligible Dependents will be extended for 90 days and will terminate at the end of the calendar month during which the 90th day occurs. This extension of benefits does not apply to spouses and Dependents who have other group coverage or eligibility for Medicare at the time of the Employee's death.

The Eligible Dependents will be eligible to elect 36 months of COBRA coverage following the expiration of this 90-day extension in accordance with, and subject to, the provisions of Section 6.06.

Section 6.08. Expulsion From the Plan

A. A Participant may be expelled from the Plan if the Participant:

1. Accepts a benefit payment knowing that he is not entitled to it, whether because he attempted to defraud the Plan or because the payment was issued in error;

2. Provides incorrect information to the Fund Office or provider of medical services in order to receive benefits to which he is not entitled; or

3. Falsifies information on an Enrollment Form or any other documentation requested by the Fund Office.

B. If it is determined that a Participant may be subject to expulsion, the Fund Office will advise the party by letter of its findings.

Section 6.09. Termination of Eligibility

A. Termination of Employee Benefits

An Employee will cease to be eligible for benefit coverage under the Plan on the earliest of the following dates unless he is entitled to COBRA coverage and a correct and on-time COBRA coverage election and self-payment is made by or on behalf of the Employee:

1. The end of the last day of the month during which the Employee worked for the Employer and for which the Employer made the required Contributions to the Plan, or if later, the end of the last day of the month for which the Employer made the required Contributions to the Plan in accordance with the Employer's Collective Bargaining Agreement with the Union;

2. The date the Employee is expelled from the Plan;

3. The date the Trustees terminate the benefits provided by this Plan or amend the Plan so that the Employee is no longer eligible to participate in the Plan;

4. If the Employee is making COBRA coverage self-payments, at the end of the last day of the applicable maximum coverage period to which he was entitled and for which correct and on-time self-payments have been made or, on the date of occurrence of any of the events stated in Section 6.06-E, whichever occurs first; or

5. The date of the Employee's death.

B. Termination of Dependent Benefits

A Dependent will cease to be eligible for benefits from this Plan on the earliest of the following dates unless the Dependent is entitled to COBRA coverage and a correct and on-time COBRA coverage election and self-payment is made by or on behalf of the Dependent:

1. The date the Employee ceases to be Covered Under the Plan;

2. In the case of the Employee's death, at the end of the calendar month during which the 90th day following the date of death occurs;

3. For the Employee's spouse, the last day of the month during which her divorce from the Employee occurs;

4. For a child who ceases to meet this Plan's definition of a Dependent, on the last day of the month in which the loss of Dependent status occurs;

5. The date the Dependent is expelled from the Plan;

6. The date the Trustees terminate Plan or terminate benefits for Dependents; or

7. For the Employee's spouse, the date the spouse enters the armed forces of any country on a full-time basis.

C. Time of Termination

If an Employee or Dependent loses eligibility in accordance with the provisions set forth in this Article, the person's benefits will terminate at midnight on the specified date.

ARTICLE VII – SCHEDULE OF BENEFITS

Section 7.01. Major Medical Benefits

Calendar Year Deductible:

Individual Deductible applicable to each person separately $300

Family Deductible (aggregate per family) $1,200

Emergency room co-pay – Participant co-payment for each incidence of emergency room treatment (waived if admitted) $100

Plan payment percentage of Covered Medical Expenses:

Charges by PPO Providers 90%

Charges by Out-of-Network Providers* 70%

*Out-of-Network charges for No Surprises Act Services will be paid at 90% of the lesser of the amount billed or the QPA.

Out-of-pocket maximum per person, applies to charges by PPO Providers only $5,000

Prescription drug copays and cost-sharing for Out-of-Network Providers do not apply to the PPO out-of-pocket maximum and will not be paid at 100% once the person's out-of-pocket maximum has been met, unless required by the No Surprises Act. Calendar Year Deductibles do apply to the out-of-pocket maximum.

Special Benefits and Limitations:

Acupuncture – Maximum benefit per Calendar Year $1,000

Ambulance – Charges by PPO Providers and Non-PPO Providers 90%

Chiropractic Care – Maximum benefit per Calendar Year $1,000

Diagnostic Testing for COVID-19 (Excluding over-the counter-tests, which are not covered)

Charges by PPO Providers 90%

Charges by Out-of-Network Providers 70%

Genetic Testing – Maximum benefit per lifetime $10,000**

**Maximum limits do not apply to BCRA tests.

COVID-19 Vaccine

Charges by PPO Providers..... 90%

Charges by Out-of-Network Providers..... 70%

Hearing Aids – Maximum benefit per ear, every third Calendar Year ……..$2,000

Section 7.02. Prescription Drug Program

No Deductible applies to the Prescription Drug Program.

Patient co-pay for drugs purchased at a participating retail pharmacy:

Generics..... 30%

Brands 40%

Patient co-pay for drugs purchased at the mail-order pharmacy..... 30%

Patient co-pay for covered vaccines at a participating retail pharmacy ……..……10%

Patient co-pay for covered vaccines at a non-participating retail pharmacy ……...30%

Patient co-pay when a brand name drug is chosen over an available generic ……..……..difference in cost between the brand and generic plus 50%

Patient co-pay for the 4th and any subsequent fill of a drug at a retail pharmacy when the drug can be purchased through the mail-order pharmacy..... 50%

Section 7.03. Dental Benefits

Maximum benefit payable per Calendar Year per person $1,500

Lifetime maximum benefit for orthodontia (orthodontia benefits provided for Dependent children only)..... $2,000

Calendar Year Deductible per person (does not apply to Type I services) ……$50

Plan payment percentage for Covered Dental Expenses:

Preventive (Type I):

When provided by a PPO Dentist..... 100%

When provided by an Out-of-Network Dentist..... 50%

Restorative (Type II) and Replacement (Type III)..... 50%

Orthodontia (Dependent children only)..... 50%

Section 7.04. Vision Benefits

A. Vision PPO Providers

Vision exam (one every Calendar Year) …..covered in full after $10 co-pay

Prescription eyeglass lenses (one pair per Calendar Year) limited to single vision and lined bifocal/trifocal .....covered in full after $50 co-pay

Frames (one per Calendar Year) ……..covered in full up to a $200 retail value plus 20% of excess cost

Contact Lenses (per Calendar Year) in lieu of eyeglass lenses covered in full up to contracted allowance…… covered in full up to a $200 retail value plus 20% of excess cost

B. Out-of-Network Vision Providers

Maximum benefit per Calendar Year per person for vision exam, frame, spectacle lenses and/or contact lenses $150

Section 7.05. Life, Dismemberment and Disability Benefits

The following benefits are payable for Eligible Employees only.

A. Life Insurance Benefit

Benefit amount $10,000

B. Accidental Death and Dismemberment Benefit

Benefit amount for accidental death.....$10,000

Benefit amount for loss of limbs.....$10,000

Benefit amount for loss of one hand, one foot or sight of one eye $5,000

C. Disability Income Benefit

Amount of weekly benefit, based on a 5-day week.....$250

Maximum period that benefits are payable per disability .....26 weeks

Waiting period ..... 14 days

ARTICLE VIII – DISABILITY INCOME BENEFIT

Section 8.01. Eligibility for Benefits

The benefits described in this Article are payable for Eligible Employees whose coverage is not being maintained through COBRA coverage self-payments.

Section 8.02. Payment of Benefits

A. If an Eligible Employee becomes totally disabled while Covered Under the Plan and submits written proof of such disability, the Plan shall pay to the Employee for the period of such disability a weekly indemnity in the amount specified on the Schedule of Benefits, such payments to be subject to all applicable provisions of this Article.

B. "Totally disabled" means unable to work as an operating engineer or other occupation for which the Employee is suited by education, training or experience due to a non-occupational Illness or Injury, and under the care of a Physician.

Section 8.03. Indemnity Limits

Benefits shall be payable under this Article in accordance with the following indemnity limits:

A. Weekly benefits shall be computed on the basis of a five-day work week.

B. Benefits shall be payable for up to but not to exceed the maximum indemnity period of 26 weeks during one Period of Disability.

C. The Fund shall deduct from each weekly benefit any taxes which are required by law.

Section 8.04. Commencement of Benefits

Benefits shall commence on the 14th day of total disability.

Section 8.05. Successive Periods of Disability

A. Two or more periods of disability due to the same or related causes will be considered one period of disability unless the Employee returns to full-time work for a continuous period of at least five days between the periods of disability.

B. Periods of disability due to unrelated causes will be considered one period of disability unless the periods of disability are separated by one day of active full-time work.

Section 8.06. Exclusions and Limitations

No Disability Income Benefits will be paid for:

A. Any disability which results from an Illness or Injury for which the Employee is not under the direct care of a Physician;

B. Any period of disability after benefits for the maximum number of weeks specified on the Schedule of Benefits have been paid;

C. Any period after the Employee retirees or for which the Employee is eligible to receive a pension benefit or Social Security retirement or disability benefits;

D. Any disability caused by an occupational illness or injury; or

E. Any disability caused by an act of war.

ARTICLE IX – MAJOR MEDICAL BENEFIT

Section 9.01. Payment of Benefits

A. If during a Calendar Year, a Participant incurs Covered Medical Expenses in excess of the individual's Calendar Year Deductible, and, if applicable, in excess of any emergency room co-pays, the Plan shall pay on behalf of that Participant for the remainder of that Calendar Year, subject to the provisions and limitations set forth, an amount derived by multiplying the amount of such Covered Medical Expenses for such category of expenses by the applicable co-payment percentage specified on the Schedule of Benefits, provided that not more than any applicable maximum benefit specified on the Schedule of Benefits shall be paid as a result of all such charges incurred by that Participant.

B. If, during a Calendar Year, the Participants who are members of the same family incur Covered Medical Expenses after satisfaction of the family Deductible, and, if applicable, in excess of any emergency room co-pays, the Plan shall pay, on behalf of the Participants in that family for the remainder of that Calendar Year, subject to the provisions and limitations set forth, an amount derived by multiplying the amount of such Covered Medical Expenses for such category of expenses by the applicable co-payment percentage specified on the Schedule of Benefits, provided that not more than any applicable maximum benefit specified on the Schedule of Benefits shall be paid as a result of any such charges incurred by any Participants in that family.

C. Payment of benefits will be governed by any and all applicable provisions to which such payment is subject, including but not limited to the following provisions of this Article.

D. The Eligible Employee will be responsible for paying, on behalf of himself and his Eligible Dependents, the amount of incurred Covered Medical Expenses used to satisfy any applicable Deductibles, co-pays and Coinsurance not paid by the Plan, any expenses not considered Covered Medical Expenses, and any amounts considered not to be Reasonable Charges.

Section 9.02. PPO Network

A. General Information

The Fund has entered into an agreement with a Preferred Provider Organization (PPO). Participants may choose health care services provided by PPO Providers, and the Plan will generally pay a higher percentage when PPO Providers are used.

B. Continuing Care

If a Participant is a continuing care patient, and the contract with the Participant's PPO Provider or facility terminates, or the Plan changed benefits because the provider or facility left the PPO

network, then the Participant may qualify for transitional care from the provider or facility for up to ninety (90) days at PPO network cost sharing. A Participant is considered a "continuing care patient" if he or she is receiving treatment for a serious and complex condition, is undergoing a course of institutional or inpatient care, is scheduled for non-elective surgery, is pregnant and undergoing a course of treatment for pregnancy or is determined to be terminally ill and receiving treatment for such illness. This provision does not apply to contracts with PPO Providers or facilities that terminate for-cause (provider fails to meet quality standards or commits fraud).

Section 9.03. Calendar Year Deductibles

A. Individual Deductible

If, during a Calendar Year, a Participant incurs Covered Medical Expenses in the amount of the individual Calendar Year Deductible specified on the Schedule of Benefits, that Participant shall be considered to have satisfied his individual Deductible for that Calendar Year.

B. Family Deductible

Once four or more Participants in one family incur Covered Medical Expenses aggregating the amount of the family Deductible specified on the Schedule of Benefits during a Calendar Year, the family Deductible shall be considered to be satisfied for that Calendar Year and no further individual Deductibles shall be required to be satisfied by any member of that family during the remainder of that Calendar Year.

C. General Provisions Governing Deductibles

1. The Eligible Employee shall be responsible for paying the amount of incurred Covered Medical Expenses used to satisfy any Deductibles.

2. Only those charges considered to be Covered Medical Expenses may be used to satisfy any Deductible.

3. If a Participant suffers from a condition for which Covered Medical Expenses are incurred in two or more Calendar Years, the individual's applicable Deductibles must be satisfied by that individual for each Calendar Year.

Section 9.04. Emergency Room Co-Pay

A. If a Participant incurs Covered Medical Expenses in any Hospital emergency room (by whatever name such room is called, including but not limited to an urgent care room, an immediate care room, a convenient care room, etc. when the services are billed by a Hospital), the amount of the emergency room co-pay specified on the Schedule of Benefits will be deducted from such Covered Medical Expenses before the Plan will pay its applicable benefits.

B. The emergency room co-pay will be waived if the patient is admitted to the Hospital as an inpatient as a direct result of the emergency room visit.

C. Amounts paid out-of-pocket for emergency room co-pays will apply to the Participant's out-of-pocket maximum.

Section 9.05. Plan Co-Payment Percentages; Out-of-Pocket Maximum

A. Plan Co-Payment Percentages

1. The co-payment/payment percentages payable by the Plan for Covered Medical Expenses incurred for various types of treatment, types of conditions and categories of expenses are specified on the Schedule of Benefits.

2. After a Participant's individual or family Calendar Year Deductible has satisfied for that Calendar Year, the Plan will pay on behalf of the Participant the applicable co-payment/payment percentage specified on the Schedule of Benefits with respect to Covered Medical Expenses incurred by that individual during the remainder of that Calendar Year that are in excess of the Deductible.

B. Out-of-Pocket Maximum

1. Subject to the provisions of this Section 9.05-B and any other applicable Plan provisions, including exclusions, limitations and maximum benefits, after a Participant's Coinsurance for Covered Medical Expenses incurred from PPO Providers and for the Participant's Calendar Year Deductible aggregate the amount of the out-of-pocket maximum shown on the Schedule of Benefits, the Plan will pay 100% of most of the Covered Medical Expenses incurred by that individual for PPO Covered Medical Expenses during the remainder of that Calendar Year.

2. Amounts not counted towards the out-of-pocket maximum are amounts paid out of pocket for any of the following:

   a. Expenses for services by Out-of-Network Providers;

   b. Expenses not considered Covered Medical Expenses;

   d. Expenses incurred after a maximum benefit or limitation has been reached for a particular type of treatment; or

   e. Prescription drug co-payments.

3. The Plan will not pay 100% for the following even after a Participant's out-of-pocket maximum has been reached:

   a. Expenses for services by Out-of-Network Providers, except for No Suprises Act Services;

b. Prescription drug co-payments.

Section 9.06. Maximum Benefits

A. There are separate maximum benefits for specific types of care or treatment specified on the Schedule of Benefits.

B. Once the total Major Medical Benefit payments made by the Plan on behalf of a Participant aggregate the amount of the applicable maximum benefit for a type of care or treatment subject to a maximum benefit limitation, the Participant shall not be entitled to any further payments under the Major Medical Benefit for charges incurred during the time period to which the maximum applies.

Section 9.07. Pre-Certification Review Program

A. The Trustees have entered into a contract with a professional Review Organization for pre-certification review of the following types of treatment.

1. All hospital admissions including pre-scheduled 23-hour or overnight observation in a hospital;
2. Surgical or other outpatient procedures performed in a hospital, PPO Ambulatory Surgical Center or surgical suite in a clinic;
3. Skilled Nursing Facility confinements;
4. Physical and occupational therapy for Dependent children under the age of 12, unless therapy immediately followed a related surgical procedure;
5. Physical and occupational therapy following related surgical procedures that exceeds 24 therapies;
6. Physical and occupational therapy ages 13 and up that exceeds 12 therapies per medical condition that is non-surgical related;
7. Speech therapy;
8. Intravenous (IV) therapy or injectable drugs administered in a physician's office;
9. Home Health Care services;
10. Hospice services;
11. Durable Medical Equipment;
12. Prosthetics;
13. Foot orthotics in excess of one pair every three Calendar Years;

14. Sleep studies;

15. Insulin pumps;

16. CPAP equipment (purchase only);

17. BRCA1 and BRCA2 genetic screenings;

18. Genetic testing services that are (a) necessary to diagnose an existing medical condition; or (b) in connection with an actual treatment plan for a diagnosed illness; and

19. Applied behavioral analysis therapy ("ABA Therapy").

B. Prior to incurring any of the services or supplies listed in Section 9.07-A above, the Review Organization must be contacted to initiate a review of the Medical Necessity and appropriateness of the services or supplies.

C. In the case of an Emergency hospital admission, the Review Organization must be contacted within two working days.

D. The Participant, or someone acting on his behalf, or his medical care provider, may initiate the contact with the Review Organization, however, it is ultimately the responsibility of the Employee to see that the contact is made on his own behalf or on behalf of his Dependent.

Section 9.08. Covered Medical Expenses

Except as otherwise provided in this Article and in Article 3, and subject to the Plan's pre-certification requirements, Covered Medical Expenses under the Major Medical Benefit are the actual Medically Necessary Reasonable Charges incurred for the following, when rendered for the purpose of diagnosing or treating a non-occupational Illness or Injury.

A. **Hospital** expenses as follows:

1. Hospital room and board charges up to the standard daily rate for a semi-private room;

2. Charges for specialty care units (e.g., intensive care, cardiac care unit) up to the standard daily rate for such unit;

3. Surgical room and related supplies;

4. Skilled nursing services;

5. Physical rehabilitation services;

6. Emergency room charges; and

7. Other services and supplies furnished by the Hospital.

B. **Ambulatory Surgical Center** services if the facility is in the PPO Network and the services have been pre-certified by the Review Organization. No Surprises Act Services performed by an Out-of-Network provider at a PPO Network ambulatory surgical center are covered.

C. **Outpatient medical facility** services if the facility is licensed and providing treatment or care that would be covered when provided by a Hospital.

D. **Emergency Services with respect to an Emergency Medical Condition**; and **urgent care** for treatment of an Illness or Injury that cannot be treated in a Physician's office.

E. **Physicians'** professional medical and surgical services as follows:

1. Hospital, office and home visits;
2. Emergency room services; and
3. Surgery performed by a Licensed Surgeon.

F. Services by **Licensed Medical Professionals** provided the services would have been covered had they been performed by a Physician.

G. Benefits for **Chiropractic Care** are subject to the Calendar Year maximum benefit for Chiropractic Care shown on the Schedule of Benefits.

H. Benefits for **Acupuncture Care** are subject to the Calendar Year maximum benefit for Acupuncture shown on the Schedule of Benefits.

I. **Pregnancy**, childbirth and well newborn care for the Dependent child of the Eligible Employee as follows:

1. Inpatient Hospital or licensed birthing center charges for childbirth and newborn care;
2. Charges by an obstetrician (Physician) for pre-natal, delivery and post-natal services;
3. Newborn exam in the Hospital by a pediatrician exam in the hospital;
4. Newborn circumcision; and
5. Services of a licensed nurse midwife who is providing services under the direction of a Physician.

J. **Anesthetics** and their administration.

K. **Radiology and pathology** testing and interpretation.

L. **Diagnostic testing** performed to diagnose existing symptoms or to evaluate the status of an existing medical condition.

M. **Radiation therapy**.

N. **Chemotherapy**.

O. **Hemodialysis**.

P. **Cardiac rehabilitation** program operating under the direct supervision of a Physician and following a cardiac episode (sometimes referred to as "Phase II Cardiac Rehab").

Q. Treatment for **Mental or Nervous Disorders** on an inpatient or outpatient basis in a Hospital or Residential Treatment Facility, including outpatient psychological testing, outpatient medical management by a Physician, and outpatient counseling by a Licensed Mental Health Professional, including individual, group and family counseling.

R. Treatment for **Chemical Dependency/Substance Abuse** on an inpatient or outpatient basis, including intensive outpatient (IOP) or partial hospitalization (PHP) treatment, and outpatient counseling by a Licensed Chemical Dependency/Substance Abuse Professional, including individual, group and family counseling.

S. **Physical therapy** to restore useful physical functions that were lost or impaired by Illness or Injury, when ordered by a Physician and provided by a licensed physical therapist (PT). Coverage is limited to the initial evaluation and subsequent Therapeutic exercise program.

T. **Occupational therapy** to restore useful physical functions that were lost or impaired by Illness or Injury, when ordered by a Physician and provided by a licensed occupational therapist (OT). Coverage is limited to the initial evaluation and subsequent Therapeutic exercise program.

U. **Speech therapy** to restore speech that was lost or impaired as a result of an Illness or Injury when ordered by a Physician and provided by a licensed speech therapist. Speech therapy must be pre-certified by the Review Organization.

V. **Home Health Care** services provided by a Home Health Care Agency, when prescribed by a Physician and provided in lieu of an inpatient admission. The Home Health Care must be Therapeutic and curative in nature and limited to a person who is homebound.

W. **Injectable drugs** administered in a Physician's office that are approved by the U.S. Food and Drug Administration (FDA) for the diagnosis being treated.

X. **Preventive care** as follows:

1. For adults:

    a. One mammogram per Calendar Year for asymptomatic women aged 40 or older;

b. Periodic gynecological exams by a physician and the related testing, such as a Pap test and HPV screening, for non-symptomatic women in accordance with the American Gynecological (ACOG) guidelines;

c. One prostate-specific antigen (PSA) test and the related Physician's exam per Calendar Year for asymptomatic men aged 45 or older;

d. Colorectal cancer screening as follows:

(1) Fecal occult blood testing for persons aged 45 or older, up to one test every three Calendar Years;

(2) Colonoscopy or sigmoidoscopy up to one test every three Calendar Years:

(a) For persons aged 45 or older; or

(b) For persons under age 45 who are classified as high risk for colorectal cancer due to a first-degree family member having a history of colorectal cancer, as pre-certified by the Review Organization.

e. One adult physical and standard testing per Calendar Year when performed by a PPO Provider;

f. Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control (CDC) when provided by a PPO Provider; and

g. BRCA1 and BRCA2 genetic screenings for female Eligible Employees and Dependent spouses with specific family histories that can increase their risk for breast cancer. Whether or not a covered person has a family history that increases her risk will be determined in accordance with the U.S. Preventive Services Task Force (USPSTF) recommendations. For example, the USPSTF considers two first-degree relatives with breast cancer, one of whom received the diagnosis at age 50 years or younger; or a combination of three or more first- or second-degree relatives with breast cancer regardless of age at diagnosis to be patterns indicating that a woman is at increased risk of developing cancer. The Plan will also cover one genetic counseling visit with a suitably trained health care provider for women who meet the USPSTF criteria for BRCA testing; and interventions such as intensive screening procedures (e.g., MRI scanning of the breasts), prophylactic surgery or chemoprevention for female Eligible Employees and Dependent spouses whose BRCA screening results indicate a deleterious mutation. These services must be pre-certified by the Review Organization.

2. For children through age 18, but only when PPO Providers are used:

a. Well-child examinations by a Physician;

b. Immunizations prescribed by the Physician; and

c. Tuberculin skin test (PPD).

Y. **Ambulance** services, including medical transport from the patient's home, the scene of an Injury or from an originating Hospital to the nearest Hospital quipped to provide appropriate treatment.

Z. **Oxygen** and the rental of equipment for its administration.

AA. **Durable Medical Equipment**, including:

1. Rental or purchase of equipment such as wheelchairs, hospital beds, walkers and crutches and the equipment used for the administration of oxygen;

2. Repairs, adjustments or replacement of Durable Medical Equipment when due to normal growth or normal wear and tear; and

3. Supplies used in connection with covered equipment.

BB. **Medical supplies** prescribed by a Physician for treatment of an acute Illness or Injury, including medical and surgical dressings, casts, trusses, braces and colostomy supplies.

CC. **Prosthetic devices** including fitting, repair and replacement of a natural limb or eye.

DD. Custom-molded **foot orthotics**, up to one pair every three Calendar Years. Additional orthotics will only be covered if pre-certified as Medically Necessary by the Review Organization.

EE. **Diabetes self-management** services and supplies to include training and education and purchase of glucose monitor. (Insulin, syringes and needles, and test strips are covered under the Prescription Drug Program.)

FF. **Allergy injections**.

GG. **Blood and plasma** and its administration.

HH. **Sterilization** procedures.

II. **Hospice** care by a Hospice Agency.

JJ. **Skilled Nursing Facility** confinements that are recommended and supervised by a Physician, and pre-certified to be Medically Necessary by the Review Organization.

KK. Surgical r**epair of oral/facial structures** by an oral and maxillary surgeon (OMD).

LL. **Annual screenings** for lung cancer with low dose computed tomography (CT) for adults based on age and health requirements as provided under the USPSTF guidance. The Plan will only cover lung CT screening performed by a PPO Provider or a provider in the Plan's preferred imaging network.

MM. **Sleep studies**.

NN. **CPAP equipment**.

OO. **Insulin pumps**.

PP. **Telemedicine services.**

QQ. **Nutritional counseling** sessions by a registered dietician immediately following a diabetes diagnosis or Mental or Nervous Disorder. The Plan will provide coverage for up to two nutritional counseling sessions per person.

RR. **Genetic Testing** services up to the maximums set forth in the Schedule of Benefits, subject to the following:

1. The testing is (a) necessary to diagnose an existing medical condition; or (b) in connection with an actual treatment plan for a diagnosed illness. These services must be pre-certified by the Review Organization; OR

2. The tests are performed prenatally within the Level A recommendations established by the American College of Obstetrics and Gynecology (ACOG):

    a. First or second trimester screening tests for fetal aneuploidy disorders (e.g., Down Syndrome), or specific inherited disorders such as cystic fibrosis and sickle cell disease; and

    b. Follow-up diagnostic tests for the same conditions if an initial screening indicates a likelihood of a genetic defect.

Prenatal tests may be performed and billed as a "panel" that screens for several diseases at once. When a covered test is included in a panel of tests that includes other non-covered tests, only the reasonable and customary amount (or the negotiated amount if the lab is in-network) for the covered test will be allowed.

The Plan excludes screening and testing of the following: (a) of family members; (b) by multiple methods for the same disorder(s); (c) multigene panels for diseases such as cancer; (d) tests to determine the child's gender or hereditary predispositions (predictive tests); and (e) home testing kits.

SS. **Hearing aids** up to the maximums set forth in the Schedule of Benefits. Covered services may include the hearing test, consultation, initial fitting and follow-up appointments for adjustments.

TT. **Cochlear implants**.

UU. **COVID-19 Vaccine.**

VV. **Care when traveling outside the United States.**

WW. **Autism treatment**, including applied behavioral analysis therapy.

Section 9.09. Exclusions and Limitations

No Major Medical Benefits shall be payable under this Article for any expense, treatment, care or condition excluded in Article III, or any of the following:

A. Ambulatory Surgical Center charges **when the facility is not in the PPO Network**.

B. **Immunizations,** except when listed in this Article as preventive care or a Covered Medical Expense.

C. Treatment of **obesity**, including obesity related surgery unless specifically pre-certified by the Review Organization. The Plan will cover obesity surgery if the covered person:

1. Has a body mass index (BMI) of 45 or greater and is 100 pounds or more over the medically desirable weight;

2. Has a documented history of unsuccessful Physician-directed weight loss programs; and

3. Has co-morbidities such as diabetes, heart disease or hypertension that are severe enough to be life threatening.

D. **Marriage counseling**.

E. **Dental services** covered under the Plan's Dental Benefit, including oral surgical procedures involving orthodontia, removal of impacted teeth, periodontal disease, implantation or preparing the mouth for the fitting of or continued use of dentures.

F. **Vision services** covered under the Plan's Vision Benefit.

G. **Cosmetic Surgery** unless:

1. It is to repair the results of an accidental Injury that occurred 90 days prior to the surgery.

2. It is for repair of a congenital disease or anomaly that resulted from trauma, infection or other disease of the involved portion of the body; or

3. It is for reconstructive surgery incidental to or following surgery for any covered Illness.

H. **Infertility treatment**, including but not limited to artificial insemination, in-vitro fertilization, embryo transfer, uterine embryo lavage, gamete intrafallopian tube transfer, zygote intrafallopian tube transfer and low tubal ovum transfer; immunotherapy for treatment of Infertility; sperm harvesting and sperm freezing (cryopreservation); and surrogacy.

I. **Reversal of a sterilization procedure**.

J. **Inpatient hospitalization** expenses for procedures or services that can be performed on an outpatient basis.

K. **Elective hospital admissions on Friday or Saturday** unless surgery is performed within 24 hours of admission.

L. **Court-ordered treatment** or confinement unless determined by the Plan to be Medically Necessary treatment for a covered condition.

M. **Personal convenience items** during hospitalization or confinement in other facilities (such as a skilled nursing facility) such as take-home supplies, guest expenses, television rental and telephone charges.

N. **Elective private room** charges that exceed the hospital's highest semi-private room rate.

O. **Custodial Care** whether provided in a Hospital or other facility such as a nursing home.

P. Any service or supply **not specifically listed in this Article** as covered, unless the service or supply was specifically pre-authorized by the Review Organization.

Q. **Shoes,** including orthopedic shoes, Therapeutic shoes, and shoes for diabetics.

R. **Rental** charges in excess of the purchase price.

S. **Modifications** to the structure of the home or vehicle.

T. **Installation** of equipment.

U. **Repairs** and/or replacement to equipment that result from misuse or abuse.

V. **Physical or occupational therapy** that is provided for any reason other than to restore loss or impairment of activity or to treat neurological and congenital conditions.

W. Physical or occupational therapy by a provider who is not a licensed physical or occupational therapist, including but not limited to an **athletic trainer, massage therapist**.

X. **Speech therapy** that is provided for any reason other than to restore loss of speech due to illness or injury or hearing loss.

Y. Services or supplies to diagnose, treat or accommodate a **developmental delay, learning or developmental disability or disorder, or ADD (attention deficit disorder).**

Z. Charges for **ambulance** services when the participant does not require medical attention or services during the transport.

AA. Items that could be used for **purposes other than medical care**, including but not limited to air conditioners, air purification units and humidifiers, swimming pools, hot tubs or Jacuzzi, or physical fitness equipment.

BB. **Wilderness therapy.**

CC. **Alternative, complementary or other non-standard treatments, therapies or services**. For example, the Plan does not cover acupressure, aversion therapy, exercise, hair analysis, herbal treatments, holistic treatment, homeopathy, hypnosis, meditation, mind-body stress management, naprapathy, naturopathy, relaxation therapy, soft-tissue manipulative therapy, or yoga.

DD. With respect to **Durable Medical Equipment**:

1. Deluxe items, upgrades, customizations or add-ons, even if prescribed by a doctor. Only standard equipment is covered. The participant will be responsible for the cost difference between a standard item and the deluxe, upgraded, enhanced or customized model.

2. Backup or duplicative items, or items specifically designed for outdoor use, sports or travel.

EE. **Fitness expenses**, including, but not limited to, health club memberships, workout or exercise equipment, personal fitness trainers, spas or saunas, or swimming pools, even if recommended by a doctor.

FF. **Genetic testing** or expenses, except as specifically provided for under the Major Medical Benefit.

GG. Services by a **naprapath**.

HH. **Naturopathic** or homeopathic services and substances.

II. **Nutritional supplements** or vitamins.

JJ. **Stop smoking** products.

KK. **Weight loss** drugs or products.

LL. **Hair-loss** related items whether or not prescribed by a physician. Exception: The Plan will cover the purchase of one wig following chemotherapy or radiation treatment.

MM. Items used solely for **convenience**, comfort or personal hygiene.

NN. **Blood pressure instruments, elastic bandages or stockings**.

OO. Procedures, including surgical procedures, supplies and other services directed toward **sexual reassignment**.

PP. Services performed for **educational** or training purposes.

Section 9.10. No Suprises Act

To the extent required by law, the Fund will comply with the No Surprises Act and the regulations promulgated thereunder. The No Surprises Act generally protects Participants from "balance billing" for Out-of-Network Provider emergency services, Out-of-Network Provider air ambulance services, and certain non-emergency services performed by an Out-of-Network Provider or facility.

A. Emergency Services

If a Participant has an Emergency Medical Condition and receives Emergency Services from an Out-of-Network Provider or facility, the most the provider or facility may bill the Participant is the Plan's PPO cost-sharing amount (such as copayments and coinsurance). A Participant cannot be balance billed for these Emergency Services. This includes services a Participant may get after he or she is in stable condition, unless the Participant provides written consent and gives up his or her protections not to be balanced billed for these post-stabilization services.

B. Non-Emergency Services from an Out-of-Network Provider at PPO Facility

If a Participant receives services from a PPO Hospital or ambulatory surgical center, certain providers may be considered Out-of-Network Providers. Under the No Surprises Act, the most these providers may bill the Participant is the Plan's PPO cost-sharing amount (such as copayments and coinsurance). This applies to emergency medicine, anesthesia, pathology, laboratory, neonatology, assistant surgeon, hospitalist or intensivists services. These providers cannot balance bill the Participant and may not ask him or her to give up their protections not to be balance billed.

If a Participant receives other services at these PPO facilities, the Out-of-Network Providers cannot balance bill him or her, unless they provide written consent and give up their protections. A Participant is never required to give up their protections from balance billing.

C. Out-of-Network Provider Air Ambulance Services

If a Participant receives air ambulance services from an Out-of-Network Provider, the most the provider may bill him or her is the Plan's PPO cost-sharing amount (such as copayments and coinsurance). A Participant cannot be balance billed for these services.

D. Complaint Process

If a Participant believes he or she has been wrongly billed, or otherwise have a complaint under the No Surprises Act, they may contact the Fund Office, or the No Surprises Help Desk at 1-800-985-3059.

To the extent required by law, the Fund will comply with the No Surprises Act and the regulations promulgated thereunder. The No Surprises Act generally protects Participants from "balance billing" for Out-of-Network Provider emergency services, Out-of-Ne

To the extent required by law, the Fund will comply with the No Surprises Act and the regulations promulgated thereunder. The No Surprises Act generally protects Participants from "balance billing" for Out-of-Network Provider emergency services, Out-of-Ne

ARTICLE X – PRESCRIPTION DRUG PROGRAM

Section 10.01. Eligibility

Eligible Employees and Eligible Dependents are eligible for benefits under the Plan's Prescription Drug Program.

Section 10.02. General Provisions

A. The Prescription Drug Program consists of two subsidiary programs: the retail program for short-term prescription drugs and the mail-order program for long-term prescription drugs. The Trustees have entered into a contract with pharmacy benefits manager to administer both programs.

B. The Prescription Drug Program is completely separate from the Major Medical Benefit. Any co-pay amounts paid by or on behalf of a Participant as his share of the cost of Covered Prescription Drugs do not apply to the Major Medical Benefit Deductibles, nor do amounts paid out-of-pocket apply to the Major Medical Benefit out-of-pocket maximum.

C. The Participant s co-pay amounts for Covered Prescription Drugs are specified on the applicable Schedule of Benefits.

Section 10.03. Retail Program

A. The prescription benefit manager has agreements with certain retail pharmacies ("participating pharmacies") to provide prescription drugs to Participants at negotiated prices. When a Participant presents his prescription drug card to a participating pharmacy, the pharmacy will provide Covered Prescription Drugs to the Participant in accordance with the following provisions.

B. A Participant may use the retail program to purchase short-term or acute drugs, which are drugs taken for a short time due to an acute Injury or Illness.

C. The Participant may purchase the amount of the medication prescribed by his Physician, up to a 30-day supply for each single purchase.

D. For each prescription or refill, the Participant must pay directly to the participating pharmacy the co-pay amount specified on the Schedule of Benefits. The Plan will pay the remaining cost.

E. The Participant will pay the higher co-pay shown on the Schedule of Benefits for every prescription refill at a retail participating pharmacy after the original and two refills.

F. The Participant will also pay the higher co-pay shown on the Schedule of Benefits if a generic equivalent of his brand name drug is available, but the Participant declines the generic substitution and asks for the brand name drug.

G. Benefits are provided only for drugs purchased at participating pharmacies. Drugs purchased at non-participating pharmacies should be submitted to the pharmacy benefits manager who may reimburse the individual for a portion of the cost according to the contract between the pharmacy benefits manager and the Trustees.

Section 10.04. Mail-Order Program

The mail-order program provides long-term (maintenance) Covered Prescription Drugs to Participants at negotiated prices, subject to the following provisions.

A. The Participant will pay directly to the mail-order pharmacy the amount of the co-pay specified on the Schedule of Benefits. The Plan will pay the remaining cost.

B. The mail-order program will provide the Participant with the quantity of medication prescribed by the individual's Physician up to a 90-day supply for each single purchase.

C. Participants will be provided with order forms, and other materials and information regarding the procedures to follow for obtaining Covered Prescription Drugs through the mail-order program.

Section 10.05. Covered Prescription Drugs

Generally, Covered Prescription Drugs are the Medically Necessary drugs and medicines prescribed for the treatment of non-occupational Illnesses and Injuries that are identified by a prescription number and can only be legally dispensed by a registered licensed pharmacist according to the written prescription of a Physician.

Disposable insulin pumps, continuous glucose monitors, and any immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control (CDC) when provided by a registered licensed pharmacist are a Covered Medical Expense delivered through the prescription benefit manager.

Section 10.06. Specialty Drugs

A. Drugs considered "specialty drugs" by the prescription benefit manager are only provided under the Plan's Prescription Drug Program in 30-day supplies or less and must be purchased through the prescription benefit manager's dedicated specialty pharmacy.

B. Oral oncology drugs (chemotherapy taken in pill form) used for a specific condition or purpose approved by the FDA are a Covered Medical Expense delivered through the prescription benefit manager's dedicated specialty pharmacy.

Section 10.07. Prior Authorization on Certain Drugs in the Pharmacy Benefit Managers Program

Prior authorization by the prescription benefit manager is required for many specialty drugs, all compound drugs, and other drugs specified by the prescription benefit manager.

Section 10.08. Exclusions and Limitations

Covered Prescription Drugs under either the retail program or the mail-order program do not include any of the following:

A. Drugs or medications that may be obtained without a Physician's written prescription (over-the-counter); or that are not legally dispensed by a registered pharmacist according to the written prescription of a Physician. This exclusion does not apply to any immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control (CDC) when provided by a registered licensed pharmacist;

B. Fertility enhancing drugs;

C. Cosmetic drugs;

D. Drugs to promote weight loss;

E. Stop-smoking products, including those requiring a prescription;

F. Drugs that treat impotency, or any drugs or products used for sexual enhancement, e.g., Viagra;

G. Vitamins; mineral or nutrient supplements;

H. Charges for the administration or injection of any drug;

I. Drugs labeled "caution—limited by federal law to investigational use";

J. Drugs that are Experimental, Investigational or Unproven even though a charge is made to the individual;

K. Drugs used for a purpose not approved by the U.S. Food and Drug Administration (FDA);

L. Medication that is to be taken by or administered to an individual, in whole or in part, while he or she is a patient in a hospital, rest home, sanitarium, extended care facility, convalescent

hospital, nursing home or similar institution which operates on its premises, or allows to be operated on its premises, a facility for dispensing pharmaceuticals;

M. Gene therapy drugs;

N. Charges for prescriptions filled at Wal-Mart or Sam's Club; or

O. Any drug or medication which is excluded under the Plan as set forth in Article III, or any drug or medication utilized in connection with any type of treatment excluded under the Plan as set forth in Article III.

Section 10.09. Effect of Contract with Prescription Benefit Manager

To the extent that the prescription drug benefits described on the Schedule of Benefits and explained in this Article are provided through a contract between the Trustees and a prescription benefit management organization, the provisions of any such contract shall govern if there is a discrepancy between the provisions of such contract and the provisions contained in this Plan.

ARTICLE XI – DENTAL BENEFIT

Section 11.01. Eligibility

Eligible Employees and Eligible Dependents are eligible for benefits under the Plan's Dental Benefit.

Section 11.02. Dental PPO Network and Claims Administrator

A. The Plan's Dental Benefit is administered by a dental PPO organization. This organization processes dental claims and provides access to network dentists.

B. Plan participants can use any licensed dentist they choose. They do not have to enroll or select a particular dentist. However, the benefits the Plan pays may vary depending on whether the dentist participates in the dental PPO network.

Section 11.03. Calendar Year Dental Deductible

A Deductible in the amount specified on the Schedule of Benefits, applies to all Type II and Type III dental expenses before the Plan will start paying the applicable co-payment percentage for Covered Dental Expenses. The Eligible Employee is responsible for paying amounts not paid by the Plan for charges incurred by the Employee and his Eligible Dependents.

Section 11.04. Maximum Benefits

A. Dental Benefits Calendar Year Maximum Benefits

1. The maximum amount of dental benefits payable on behalf of a Participant for all charges incurred in a Calendar Year is set forth on the Schedule of Benefits. Once the Plan has paid Dental Benefits for dental services incurred by the Participant during a Calendar Year, no further Dental Benefits will be payable on his behalf for dental expenses incurred during that Calendar Year.

2. Dental Benefits paid for the removal of fully impacted teeth do not apply to the person's Calendar Year maximum under the Dental Benefit.

B. Orthodontia Benefits Lifetime Maximum Benefits

The maximum amount of orthodontia benefits payable on behalf of an Eligible Dependent child for all orthodontia charges incurred in his lifetime is set forth on the Schedule of Benefits. Once the Plan has paid orthodontia benefits for services incurred by such individual during his lifetime, no further orthodontia will be payable on his behalf for orthodontia expenses.

Section 11.05. Payment of Benefits

A. If a Participant incurs Covered Dental Expenses as specified in Section 11.06 below, the Plan will pay an amount derived by multiplying the Covered Expense by the applicable Plan payment/co-payment percentage specified on the Schedule of Benefits, up to but not to exceed the applicable Maximum Benefit.

B. Payments made by the Plan that apply to a Dependent child's orthodontia benefits lifetime maximum benefit do not apply to his Dental Benefits Calendar Year maximum benefit.

C. Dental expenses are considered incurred on the date the service is performed or the supply is received. However:

1. Charges for crowns and other restorations requiring lab fabrication are considered incurred on the date the tooth is prepared;

2. Charges for prosthetic devices, such as a full or partial denture or bridgework, are considered incurred when the impression for the appliance is taken and any abutment teeth prepared; and

3. Charges for root canal therapy are considered incurred when the tooth is opened.

Section 11.06. Covered Dental Expenses

A. Charges incurred for dental care will be considered Covered Dental Expenses only if the services and supplies for which the charges are incurred are provided by a licensed dentist acting within the scope of his license or, with respect to cleaning and scaling of teeth, are provided by a licensed dental hygienist working under the supervision and direction of a dentist.

B. Only the amount of a charge which is considered a usual and customary charge will be considered a Covered Dental Expense. The usual and customary charges for PPO dentists are determined by the dental PPO organization. A usual and customary charge with respect to an out-of-network dentist is determined by comparing the charge with the charge made by other dentists in the locality concerned for services and supplies customarily used for treatment of a particular dental condition.

C. Covered Dental Expenses include the following services and supplies which are necessary for the treatment of a dental condition:

1. Preventive Care (Type I)

a. Routine oral examinations, limited to two per Calendar Year;

b. Routine prophylaxis, limited to two per Calendar Year;

c. For Dependent children under age 19 only, topical application of fluoride solutions;

d. Emergency (palliative) treatment of pain;

e. Dental x-rays when professionally indicated, including full-mouth x-rays once every 36 months;

f. Space maintainers; and

g. Sealants for Dependent children under age 19 only.

2. Restorative (Type II) and Replacement (Type III)

a. Fillings, including amalgams, resins and composites;

b. Extractions, including extractions of simple, partially or fully impacted teeth, and extractions performed in the course of orthodontia treatment (benefits paid for orthodontia-related extractions do not apply to the person's orthodontia benefits lifetime maximum);

c. Endodontic treatment;

d. Periodontic treatment, including osseous surgery and periodontal prophylaxis;

e. General anesthesia;

f. Consultations and examinations by a specialist;

g. Repair of existing dental implants or prosthodontics;

h. Recementing of crowns or bridges;

i. Occlusal adjustments;

j. Night guards for bruxism;

k. Crowns in the presence of disease when teeth cannot be restored with another filling material;

l. Bridges;

m. Partial and complete dentures; and

n. Dental implants.

3. Orthodontia (Dependent Children Up to Age 19 Only)

a. All necessary procedures relating to the proper alignment of teeth, including an initial consult by the orthodontist;

b. The initial payment, limited to no more than 25% of the charge for the entire orthodontia course of treatment; and

c. Subsequent payments, which will be reimbursed at the Plan's payment level in equal intervals, upon receipt of a claim, until the Plan's maximum orthodontia benefit has been paid, or the child is no longer an Eligible Dependent, or coverage terminates for some other reason.

D. The dental PPO organization will determine the extent to which a service or supply is covered based on the following criteria:

1. The service or supply is necessary and customarily employed nationwide to treat the dental condition; and

2. The service or supply is appropriate and meets professional standards of quality; and

Section 11.07. Exclusions and Limitations

No payment will be made under the Dental Benefit for:

A. Services performed for Cosmetic purposes, including the whitening or bleaching of teeth, or services whose purpose is to improve, alter, or enhance appearance;

B. Services or supplies which are covered under the Major Medical Benefit;

C. Education or training, including but not limited to supplies or charges for personal oral hygiene or dental plaque control, dietary or nutritional counseling, or infection control;

D. Replacement of lost, stolen or discarded appliances;

E. Personalization of dentures;

F. Duplication of dentures; or

G. Any service or supply which is excluded under the Plan as set forth in Article III.

ARTICLE XII – VISION BENEFIT

Section 12.01. Eligibility

Eligible Employees and Eligible Dependents are eligible for benefits under the Plan's Vision Benefit.

Section 12.02. Vision PPO Network and Claims Administrator

A. The Plan's Vision Benefit is administered by a vision PPO organization. This organization processes vision claims and provides access to network vision providers.

B. Plan participants can use any licensed vision provider they choose. They do not have to enroll or select a particular provider. However, the benefits the Plan pays will usually be higher when the provider participates in the vision PPO network.

Section 12.03. Payment of Vision Benefits

A. If a Participant incurs Covered Vision Expenses, benefits will be payable up to the maximum benefit allowable for a particular service or supply during the time period set forth on the Schedule of Benefits, subject to the provisions and limitations stated in this Article.

B. If the Participant receives services from a vision PPO Provider and is required to pay a co-pay or percentage of the cost for a Covered Vision Expense, the co-pay and/or patient percentage should be paid directly to the provider.

C. To be considered a Covered Vision Expense, the charge for a service or supply must be provided by an optometrist or an ophthalmologist who is legally qualified and licensed to practice his trade or profession by the appropriate governmental authority and who is performing services within the scope of his specialty.

D. If a Participant uses an Out-of-Network Provider:

1. He must pay the provider in full and submit a claim to the vision PPO administrator for reimbursement up to the Plan's maximum benefit for Out-of-Network Providers as set forth on the Schedule of Benefits.

2. The Plan's out-of-network vision benefit can be applied toward the cost of an exam, lenses, frame and contact lenses, but cannot duplicate the Plan's benefit(s) for vision PPO Providers.

Section 12.04. Covered Vision Expenses

Covered Vision Expenses include the Reasonable Charges made for the following:

A. Examination - A complete visual analysis once per Calendar Year, including case history and refraction, and the prescription of eyeglasses where indicated. Benefits are payable only when eye refraction is performed.

B. Lenses - Up to two eyeglass lenses per Calendar Year.

C. Frame - One frame per Calendar Year.

D. Contact Lenses - One pair per Calendar Year if contact lenses are selected in lieu of an eyeglass frame and lenses. Only one allowance, up to the maximum benefit specified on the Schedule of Benefits, will be paid per Calendar Year regardless of the number of sets of lenses purchased. The contact lens allowance also applies to the providers fee for the contact lens exam and lens fitting.

Section 12.05. Exclusions and Limitations

No benefits are payable under the Vision Benefit for:

A. Vision treatment which started, or supplies ordered while an individual was not Covered Under the Plan;

B. Services or supplies for which benefits are payable under the Major Medical Benefit;

C. Medical or surgical treatment;

D. Duplicate or spare eyeglasses, lenses or frames;

E. Two pair of glasses in lieu of bifocals;

F. Replacement of lost, stolen or broken lenses and/or frames;

G. Special procedures, such as orthoptics or vision training;

H. Special supplies, such as subnormal vision aids;

I. For any professional services or materials connected with aniseikonic lenses, multifocal plastic lenses, coated lenses, no-line bifocals (blended type), non-prescription lenses, or sunglasses, plain or prescription (tinted lenses with a tint higher than #2 are considered sunglasses);

J. Any eye examination required by:

   1. An employer as a condition of employment that the employer is required to provide under the terms of a labor agreement; or

   2. A government body;

K. More than one visual analysis during a Calendar Year, or for more than two lenses during a Calendar Year, or for more than one frame during a Calendar Year;

L. Charges in excess of any maximum benefit stated on the Schedule of Benefits;

M. Charges for services or supplies from Wal-Mart or Sam's Club; or

N. Any service or supply which is excluded under the Plan as set forth in Article III.

ARTICLE XIII – INSURANCE BENEFITS

Section 13.01. Life Insurance

A. Life insurance is provided through a group insurance contract between the Board of Trustees and an insurance carrier, and all benefits payable are governed by the policy provided by the insurance carrier to the Trustees.

B. Life insurance is provided only for active Eligible Employees who are eligible for such insurance in accordance with the terms and eligibility provisions of the policy. Life insurance is not provided for Dependents, or Employees whose coverage is being continued under the COBRA coverage provisions of the Plan.

C. The amount of the Life insurance provided for active Eligible Employees is specified on the Schedule of Benefits.

Section 13.02. Accidental Death and Dismemberment Insurance

A. Accidental death and dismemberment insurance coverage is currently provided through a group insurance contract between the Board of Trustees and an insurance carrier and is governed by the policy provided by the insurance carrier to the Trustees.

B. Accidental death and dismemberment insurance is provided only for active Eligible Employees who are eligible for such insurance in accordance with the terms and eligibility provisions of the policy. Accidental death and dismemberment insurance is not provided for Dependents, or Employees whose coverage is being continued under the COBRA coverage provisions of the Plan.

C. The full amount of accidental death and dismemberment insurance provided for active Eligible Employees is specified on the Schedule of Benefits.