Iron Workers District Council of Western New York and Vicinity

Welfare Fund

Summary Plan Description

Restated, Amended, & Effective July 1, 2020

Iron Workers District Council
of Western New York and Vicinity Welfare Fund

July 1, 2020

Dear Participant:

We are pleased to provide You with this booklet summarizing the Welfare Plan of the Iron Workers District Council of Western New York and Vicinity.

This booklet describes the main features of Your Plan. As You look through it, You will learn how You become a Plan participant, what Your benefits are, how they are paid and what procedures require precertification (e.g., imaging and surgical procedures often require precertification before a specified time period) as explained within this booklet.

To make all this information as clear as possible, this booklet was written in simple, straightforward language.

Please read this booklet carefully and show it to Your family. It is important that they are aware of Your Welfare benefits.

The Fund Office will be pleased to answer any questions You may have about Your Welfare Plan.

Sincerely,

THE BOARD OF TRUSTEES

IMPORTANT NOTICE

This document describes Your benefits. Do not rely on statements made by any individual(s). The only authorized information concerning Your benefits must be in writing from the Board of Trustees, who are acting within their official capacity. The Board of Trustees has not empowered anyone else to speak for them in regards to the Iron Workers District Council of Western New York and Vicinity's Welfare Plan. No employer, Union representative, supervisor, or shop steward is in a position to discuss Your rights under this Plan with authority. If You have any questions about any aspect of Your participation in the Plan, You should, for Your own permanent record, write to the Fund Office or the Board of Trustees. You will then receive a written response, which will provide You with a permanent reference.

The Trustees reserve the right to change or discontinue the types and amounts of benefits under this Plan and the eligibility rules. Written amendments are periodically made to the Plan and distributed to Participants. Please retain any amendments to this document for easy reference.

The nature and amount of Plan benefits are always subject to the actual terms of the Plan as it exists at the time the claim occurs.

If You or one of Your eligible dependents incurs an expense covered by this Plan, You or the provider of service must timely file a claim for such benefit coverage. Claims filed after the claim filing limitation period has elapsed will not be honored by the Fund Office unless it was not reasonably possible, as determined by the Trustees, to submit the claim before the deadline. Please see section called Internal Claims and Appeals Procedures for more information on the timely filing of claims.

Neither the Board of Trustees nor the Fund Office makes any commitment or guarantee that any amounts paid to or for the benefit of a Participant under this Plan will be excludable from the Participant's gross income for federal or state income tax purposes, or that any other federal or state tax treatment will apply to or be available to any Participant. It will be the obligation of each Participant to determine whether each payment under the Plan is excludable from the Participant's gross income for Federal and State income tax purposes, and to notify the Fund Office if the Participant has reason to believe that any such payment is not so excludable.

Iron Workers District Council of Western New York and Vicinity Welfare Plan

3445 Winton Place, Suite 238
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(585) 424-3510

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CONFIDENTIALITY OF PROTECTED HEALTH INFORMATION

A Federal law, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), requires that health plans protect the confidentiality of Your Protected Health Information ("PHI"). A summary of Your rights under HIPAA can be found in the Plan's privacy notice, which was distributed to You, in accordance with HIPAA, and which is available from the Plan's Privacy Official, Suzanne Ranelli.

This Plan, and the Plan Sponsor (the Plan Sponsor for HIPAA purposes is the Board of Trustees of the Iron Workers District Council of Western New York and Vicinity Welfare Fund), will not use or disclose Your PHI except as necessary for Treatment, Payment, Health Care Operations, and Plan administration, or as permitted or required by law.

"Payment" includes activities undertaken by the Plan to determine or fulfill its responsibility for Coverage and the provision of Plan Benefits that relate to an individual to whom health care is provided. The activities include, but are not limited to:

(a) determination of eligibility, Coverage and cost sharing amounts (for example, cost of a benefit, Plan maximums and co-payments as determined for a Participant's claim);
(b) coordination of benefits;
(c) adjudication of health benefit claims (including appeals and other Payment disputes);
(d) subrogation of health benefit claims;
(e) establishing contributions to the Plan, including, but not limited to, COBRA contributions;
(f) risk adjusting amounts due based on enrollee health status and demographic characteristics;
(g) billing, collection activities and related health care data processing;
(h) claims management and related health care data processing, including auditing Payments, investigating and resolving Payment disputes and responding to Participant inquiries about Payments;
(i) obtaining Payment under a contract for reinsurance (including stop-loss and excess of loss insurance);
(j) medical necessity reviews or reviews of appropriateness of care or justification of charges;
(k) utilization review, including pre-certification, preauthorization, concurrent review and retrospective review;
(l) disclosure to consumer reporting agencies related to reimbursement (the following PHI may be disclosed for Payment purposes: name and address, date of birth, Social Security number, Payment history, account number and name and address of the provider or health plan); and
(m) reimbursement to the Plan.

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

(a) quality assessment;
(b) population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting health care providers, and patients with information about treatment alternatives and related functions;
(c) rating Provider and Plan performance, including accreditation, certification, licensing or credentialing activities;

(d) underwriting, premium rating, and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing, or placing a contract for reinsurance of risk relating to claims for health care (including stop-loss insurance and excess loss insurance);
(e) conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;
(f) business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the Plan, including formulary development and administration, development or improvement of payment methods or coverage policies; and
(g) business management and general administrative activities of the Plan, including, but not limited to:
    i. management activities relating to the implementation of and compliance with HIPAA's administrative simplification requirements;
    ii. customer service, including the provision of data analyses for policy holders, Plan sponsors, or other customers;
    iii. resolution of internal grievances; and
    iv. due diligence regarding a merger with a potential successor in interest, if the potential successor in interest is a "covered entity" under HIPAA or, following completion of the merger, will become a covered entity.

Only the employees of the Iron Workers District Council of Western New York and Vicinity Welfare Fund who assist in the Plan's administration and the Board of Trustees of the Iron Workers Local District Council of Western New York and Vicinity Welfare Fund will have access to Your PHI. These individuals may only have access to use and disclose Your PHI for Plan administration functions. This Plan provides a complaint mechanism for resolving noncompliance matters. If these individuals do not comply with the above rules, they will be subject to disciplinary sanctions.

Note: Only employees have access to this information and those employees will use only the minimum necessary PHI.

By law, the Plan has required all of its business associates to also observe HIPAA's privacy rules.

The Plan will not, without Your authorization, use or disclose Your PHI for employment related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

HIPAA provides that this Plan may disclose Your PHI to the Plan Sponsor only upon receipt of a Certification by the Plan Sponsor that it agrees to the following: (a) not use or further disclose the information other than as permitted or required by the Plan documents or as required by law; (b) ensure that any agents, including a subcontractor, to whom it provides PHI received from this Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information; (c) not use or disclose the information for employment related actions and decisions unless authorized by You; (d) not use or disclosure the information in connection with any other benefit or employee benefit plan of the Plan Sponsor unless authorized by You; (e) report to this Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware;

(f) make PHI available to You in accordance with HIPAA's access requirements; (g) make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA; (h) make available the information required to provide an accounting of disclosures; (i) make its internal practices, books, and records relating to the use and disclosure of PHI received from this Plan available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining compliance by this Plan with HIPAA; (j) if feasible, return or destroy all PHI received from this Plan that the Plan Sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which the 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 (k) maintain adequate separation between the Plan and the Plan Sponsor. The Plan Sponsor has made such Certification to the Plan.

If a breach of your unsecured health information (PHI) occurs, the Plan will notify you.

Under HIPAA, You have certain rights with respect to Your PHI, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information. You also have the right to file a complaint with this Plan or with the Secretary of the U.S. Department of Health and Human Services if You believe Your rights under HIPAA have been violated.

This Plan's privacy notice provides a summary of Your rights under HIPAA's privacy rules. Please contact Suzanne Ranelli, the Fund's Privacy Official, at (585) 424-3510 or toll-free at (800) 288-0782 if: (a) You wish to obtain a copy of the notice; (b) You have questions about the privacy of Your health information; or (c) You wish to file a complaint under HIPAA.

In addition, the Plan Sponsor:

(a) has implemented administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information that it creates, receives, maintains or transmits on behalf of the Plan;
(b) has ensured that the adequate separation between the Plan and the Plan Sponsor, as required by HIPAA, with respect to electronic protected health information, is supported by reasonable and appropriate security measures;
(c) has ensured that any agent, including a subcontractor, to whom it provides electronic protected health information agrees to implement reasonable and appropriate security measures to protect the information;
(d) will report to Plan any security incident of which it becomes aware concerning electronic protected health information; and
(e) has appointed Suzanne Ranelli as the Fund's HIPAA Security Official.

INTRODUCTION

General

The Iron Workers District Council of Western New York and Vicinity Welfare Fund, hereafter referred to as the "Welfare Fund" or "Fund", established this health care and welfare benefits plan for eligible employees and their qualified dependents, as a result of collective bargaining agreements between various local unions of the International Association of Bridge, Structural and Ornamental Iron Workers AFL-CIO, and employers under contract with them. This booklet has been prepared to help You understand Your benefits. Please read it carefully. It will assist You in understanding Your benefits which are governed by this document.

Not all health care services ordered by a physician Health Care Practitioner will be covered or payable under the provisions of the Plan. Health services may be subject to review by a designated medical review firm for necessity and appropriateness before, during, or after the care is rendered. Please refer to the Managed Health Care section for specific information regarding precertification and other types of utilization review, any penalty areas, and preferred provider networks.

Benefit payments are governed by this Summary Plan Description, as determined by the Plan Administrator and/or its designee, and may be subject to, but not limited to the following controls:

- Confirmation of eligibility for coverage;
- Determination of medical necessity and appropriateness of the service;
- Compliance as a covered benefit under the Plan design;
- Determination of Allowed Charges;
- Coordination of benefits/third party recovery; and
- Termination provisions.

All provisions of the Plan are subject to such rules and regulations adopted by the Trustees and to the Trust Agreement that established and governs the Fund's operations. Plan Benefits for You and Your dependents are not guaranteed and may be changed or amended by the Trustees. The nature and amount of Plan Benefits are always subject to the actual terms of the Plan as it existed at the time the claim was incurred.

Purpose

The Plan is established under the Federal law, commonly known as ERISA, and with the exception of the life insurance and medical stop-loss insurance, is self-funded. The purpose of the Plan document is to describe the provisions of the Plan, which provides for payment of benefits for medical, dental, physical exam, hearing aid and optical charges, for death, accidental death or dismemberment and occupational and non-occupational disabilities charges, employee assistance program, and for certain wage replacement benefits. The Plan is maintained exclusively for the benefit of the participants and eligible dependents.

Plan Interpretation and Determinations
The Board of Trustees is responsible for interpreting this Plan and for making determinations under the Plan. In order to carry out this responsibility, the Trustees have exclusive authority and discretion to:

- determine whether an individual is eligible for any benefits under the Plan;
- determine the amount of benefits, if any, an individual is entitled to from the Plan;
- determine or find facts that are relevant to any claim for benefits from the Plan;
- interpret all of the Plan's provisions within this booklet;
- interpret the provisions of any Collective Bargaining Agreement or written Participation Agreement involving or impacting this Plan;
- interpret the provisions of the Trust Agreement governing the operation of this Plan;
- interpret all of the provisions of any other document or instrument involving or impacting this Plan; and,
- interpret all of the terms used in the Plan, this booklet and in all of the other previously mentioned agreements, documents, and instruments.

All such determinations and interpretations made by the Trustees, or their designee: will be final and binding upon any individual claiming benefits under the Plan and upon all Participants, all Employers, the Union, and any party who has executed any agreement with the Trustees or the Union; will be given deference in all courts of law, to the greatest extent allowed by applicable law; and will not be overturned or set aside by any court of law unless the court finds that the Trustees, or their designee, abused their discretion in making such determination or rendering such interpretation.

BENEFITS UNDER THIS PLAN WILL BE PAID ONLY IF THE TRUSTEES DECIDE IN THEIR DISCRETION THAT YOU ARE ENTITLED TO THEM.

Plan Amendment and Termination
The Trustees reserve the right to amend or discontinue: (1) the Plan; (2) the types and amounts of benefits under the Plan; (3) the eligibility rules for Participating Employers; and (4) the eligibility rules for You and Your dependents, even if extended eligibility has already been accumulated.

Plan benefits and eligibility rules for covered employees and dependents:

- Are not guaranteed or otherwise vested;
- May be changed or discontinued by the Board of Trustees;
- Are subject to the rules and regulations adopted by the Board of Trustees;
- Are subject to the Trust Agreement which establishes and governs the Fund's operations; and
- Are subject to the provisions of any group insurance policy purchased by the Trustees.

If the Plan terminates, the Trustees will apply the assets of the Fund to provide benefits or otherwise carry out the purposes of the Fund in an equitable manner until the entire remainder of the Fund has been dispersed.

If the Plan is changed or discontinued, it will not affect You or Your beneficiary's right to any insured benefit to which You have already become entitled.

Fund Administrator
The Welfare Fund is administered by a Board of Trustees composed of Employer Trustees and Union Trustees, as listed in the front of this booklet. The Board of Trustees is designated as the agent for service of legal process in accordance with the regulations of the Department of Labor. Under ERISA, the Trustees are required to act prudently and solely in the interest of participants and beneficiaries.

The employer identification number assigned by the Internal Revenue Service to the Board of Trustees is: 16-0776208.

The Department of Labor Plan Number is 501.

The day-to-day administration of the Plan is generally handled by the Fund Office, whose address and telephone numbers are listed in the front of this booklet and on the Quick Reference Chart in the next section.

Effective Date
The effective date for this Plan booklet is October 16, 2020. Unless otherwise specified or amended, Plan benefits apply for an entire Plan year.

Benefit Coverage
Medical/Hospital benefits are self-insured and administered by Excellus Blue Cross Blue Shield, 165 Court Street, Rochester, NY 14647.

Life Insurance is underwritten by Prudential Life Insurance of America, 80 Livingston Avenue, Roseland, NJ 07068.

Life Insurance under the Wage Replacement Account ("WRA") benefit is underwritten by Hartford Life Insurance Company, 200 Hopmeadow Street, Simsbury, CT 06089.

Prescription Drug Coverage is self-insured and administered by Express Scripts, P.O. Box 6773, St. Louis, MO 63166-6773.

Employee Assistance Program (EAP) Services are self-insured and administered by Workforce Development Institute, 96 South Swan Street, Albany, NY 12210.

The Welfare Fund self-insures and self-administers the following benefits:

- Accidental Death and Dismemberment Benefit;
- Supplementary Weekly Disability Benefit;
- Dental Benefit;
- Basic Physical Examination Benefit;
- Vision Benefit;
- Hearing Aid Benefit; and
- Wage Replacement Account Benefits.

Benchmark Plan
In accordance with the requirements of the Affordable Care Act (ACA), in order to determine which benefits are considered "essential health benefits (EHBs)", this Plan has selected Utah as its benchmark plan.

Employer Contributions
The Welfare Fund is maintained through collective bargaining agreements between Locals 9, 33, & 440 affiliated with the International Association of Bridge, Structural and Ornamental Iron Workers, AFL-CIO and the participating employers. Employer contributions support the Plan, with the contribution rate determined by the collective bargaining agreements. You may receive from the Fund Office, upon written request, a complete list of the employers and employee organizations sponsoring the Plan [such list is available for examination as well], and/or information as to whether a particular employer (or employee organization) is a sponsor of the Plan, and if the employer or employee organization is a Plan sponsor, the sponsor's address.

Note: Participants can request a copy of any CBAs that cover Plan coverage/contributions.

Income and Reserves
Income received by the Fund from contributing employers is held in a Trust Fund for the purpose of providing benefits to eligible employees and for defraying reasonable administrative expenses. The Fund's assets and reserves are held in custody and invested as directed by the Board of Trustees.
For the purpose of maintaining the Fund's fiscal records, the fiscal year ending date of the Plan is June 30th, and the Plan Year is July 1 – June 30.

QUICK REFERENCE CHART	
Information Needed	**Contact the following:**
Medical and Hospital benefits, PPO Network, Preauthorization and medical review	Excellus Blue Cross Blue Shield 165 Court Street Rochester, NY 14647 (800) 499-1275
Employee Assistance (EAP) services	Workforce Development Institute 96 South Swan Street Albany, NY 12210 (800) 252-4555 (800) 225-2527 www.theEAP.com
Medical and Prescription eligibility; Dental and Orthodontia claims, eligibility, benefits; Vision claims, eligibility, benefits; Medicare Part D Notice of Creditable Coverage; Wage Replacement Account claims, eligibility, benefits; Accidental Death and Dismemberment claims, eligibility, benefits and; Supplemental Disability claims, eligibility, benefits.	Iron Workers District Council of WNY 3445 Winton Place, Suite 238 Rochester, NY 14623-2950 (800) 288-0782 (585) 424-3510 Fax: (585) 424-3722
Prescription Drug Benefits Retail and Mail-Order Pharmacy	Express Scripts P.O. Box 66773 St. Louis, MO 63166-6773 Member Services: (866) 544-2926 Pharmacist Help Desk: (800) 235-4357 www.express-scripts.com Mail-Order Express Scripts, Inc. PO Box 52150 Phoenix, AZ 85072 Accredo Specialty Pharmacy (877) 222-7336 www.accredo.com

Information Needed	Contact the following:
Life Insurance	Prudential Life Insurance Company of America 80 Livingston Avenue Roseland, NJ 07068 (866) 439-9026
Wage Replacement Account Life and Accidental Death and Dismemberment Insurance	The Hartford Group Benefits Division, Customer Service P.O. Box 2999 Hartford, CT 06104-2999 (800) 523-2233

PLAN INFORMATION	
Plan Name, Address, and Phone Number:	Iron Workers District Council of Western New York & Vicinity Welfare Fund 3445 Winton Place, Suite 238 Rochester, NY 14623 (585) 424-3510 (800) 288-0782
Plan Sponsor's Federal I.R.S. Employer Identification Number:	16-0776208
Plan Number:	501
Claims Administrator's Name, Address and Phone Number:	Suzanne Ranelli Administrative Manager Iron Workers District Council of Western New York & Vicinity Welfare Fund 3445 Winton Place, Suite 238 Rochester, NY 14623 (585) 424-3510 (800) 288-0782
Plan Year Is:	July 1st through June 30th
Plan Administrator's Name, Business Address, Zip Code And Business Telephone Number:	Board of Trustees Iron Workers District Council of Western New York & Vicinity Welfare Fund 3445 Winton Place, Suite 238 Rochester, NY 14623 (585) 424-3510 (800) 288-0782

PLAN INFORMATION	
The Name, Address And Zip Code Of The Person Designated As Agent For The Service Of Legal Process Is:	Board of Trustees Iron Workers District Council of Western New York & Vicinity Welfare Fund 3445 Winton Place, Suite 238 Rochester, NY 14623 (585) 424-3510 (800) 288-0782 Legal process can also be served on any of the Trustees individually.
The Plan's Fiscal Year Ends On:	June 30th
The Plan Is Mainly Self-Funded With:	The contributions made by employers. Participants may also make contributions for COBRA coverage or for one of the self-pay options for coverage.

DEFINITIONS

The following terms define specific wording used in this Plan. These definitions should not be interpreted to extend coverage unless specifically provided for under the Schedule of Medical or Dental Benefits.

Accident
An unforeseen and unavoidable event resulting in an injury, which is not due to any fault of the covered person.

Allowable Expense/Allowed Charge/Allowed Amount
The maximum amount the Plan will pay for the services or supplies covered under this Plan, before any applicable Coinsurance, Copayment, and Deductible amounts are subtracted. The Allowed Expense for In-Network services and facilities is determined as follows:

The Allowable Expense for in-network Facilities or Providers will be the amount the Plan has negotiated with the in-network Facility or the Provider, or the amount approved by another Blue Cross and/or Blue Shield plan, or the in-network Facility or Provider's charge, if less. However, when the in-network Facility or Provider's charge is less than the amount the Plan has negotiated with the in-network Facility or Provider, your Coinsurance, Copayment or Deductible amount will be based on the in-network Facility or Provider's charge.

The Allowable Amount/Expense for out-of-network Facilities and Providers will be determined as follows:

(1) **Facilities in the Service Area.**
For Facilities in the Service Area, the Allowable Expense will be 65% of the Facility's charge.

(2) **Facilities outside the Service Area.**
For Facilities outside the Service Area, the Allowable Expense will be the Facility's charge or a BlueCross and/or BlueShield host plan's rate, if less.

(3) **For a Professional Provider or a Provider of Additional Health Services in the Service Area.**
For a Professional Provider or a Provider of Additional Health Services in the Service Area, the Allowable Expense will be 100% of the Centers for Medicare and Medicaid Services Provider ("CMMSP") fee schedule, as applicable to the provider type unadjusted for geographic locality, or the Professional Provider or Provider of Additional Health Services' charge, if less.

If there is no CMMSP amount as described above, the Allowable Expense will be 75% of the Professional Provider or Provider of Additional Health Services' charge.

(4) **For a Professional Provider or a Provider of Additional Health Services Outside the Service Area.**
For a Professional Provider or a Provider of Additional Health Services outside the Service Area, the Allowable Expense will be the Professional Provider's charge or Provider of Additional Health Services' charge or a BlueCross and/or BlueShield host plan's rate, if less.

(5) **Physician-Administered Pharmaceuticals.**
For Physician-administered pharmaceuticals, the Plan uses gap methodologies that are similar to the pricing methodology used by the Centers for Medicare and Medicaid Services, and produces fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by RJ Health Systems, Thomson Reuters (published in its Red Book), or the Plan based on an internally developed pharmaceutical pricing resource if the other methodologies have no pricing data available for a Physician-administered pharmaceutical or special circumstances support an upward adjustment to the other pricing methodology.

(6) **Air Ambulance Providers.**
For air ambulances providers inside or outside Excellus' Service Area, the Allowable Expense will be 100% of the Centers for Medicare and Medicaid Services Provider fee schedule, unadjusted for geographic locality, or the Provider's charge, if less.

The Allowable Expense is not based on UCR. The out-of-network Facility or Provider's actual charge may exceed the Allowable Expense. You may be requested to pay the difference between the Allowable Expense and the out-of-network Facility or Provider's charge. Contact the Claims Administrator at the number on your ID card or visit the Claims Administrator's website for information on your financial responsibility when you receive services from an out-of-network Facility or Provider.

The Plan reserves the right to negotiate a lower rate with an out-of-network Facility or Provider or to pay a Blue Cross and/or Blue Shield host plan's rate, if lower. Medicare based rates referenced in and applied under this section shall be updated no less than annually.

Please note that In-Network air ambulance services will be paid at their network rates.

Ambulance
A legally licensed company providing vehicles, helicopters or airplanes certified for acute emergency patient transportation.

Ambulatory Surgical Center
A distinct entity that operates exclusively for the purpose of furnishing outpatient surgical services to patients who do not require hospitalization and whose duration of care is unlikely to exceed 24 hours. The Ambulatory Surgical Center is either owned independently or operated by a hospital system. Those operated by a hospital must be an identifiable entity, physically, administratively, and financially independents of operations of the hospital.

Balance Bill/Billing
Balance Billing occurs when an Out-of-Network Facility or Provider bills You for the difference between the Allowable Expense and the Out-of-Network Facility's or Provider's charges. In-Network Facilities and Providers agree to accept the Plan's payment for covered services as payment in full and may not Balance Bill You for covered services.

Behavioral Health
For this Plan, this term refers to disorders, conditions and diseases as defined within the mental and behavioral disorders section of the International Classification of Diseases (ICD) manual or Diagnostic Statistical Manual of Mental Disorders (DSM), current edition.

Behavioral Health Treatment Facility
A licensed certified mental health or substance use facility that maintains a highly structured therapeutic level of care 24 hours a day, seven (7) days a week. Service must include the ability to evaluate and treat an acute psychiatric condition or provide detoxification services, which include evaluation, care, and treatment of substance abusing enrollees.

Benefit(s) Payment
The amount of money payable for a claim, after calculations of all deductible amounts, coinsurances, co-pays and Plan exclusions, maximums and limitations.

Benefit Maximums
Total Plan payments for each covered person are limited to certain maximum benefit amounts. A benefit maximum can apply to specific benefit categories or to all benefits. A benefit maximum amount also applies to a specific time period, such as annual or lifetime. Whenever the word lifetime appears in this Plan in reference to benefit maximums, it refers to the entire time You or Your dependents are covered by this Plan, regardless of any periods of ineligibility.

Calendar Year
The 12-month period beginning January 1st and ending December 31st. All annual deductibles and benefit maximums, unless otherwise indicated by the Plan, accumulate during the Calendar Year.

Chiropractor
A properly licensed person holding a degree of Doctor of Chiropractic (D.C.). Chiropractors detect and correct bymanual or mechanical means structural imbalance, distortion, or subluxations in the human body for the purpose of removing nerve interference and the effects thereof, where such interference is the result of or related to distortion, misalignment or subluxation of or in the vertebral column.

Claims Administrator
The third party administrative organization designated by the Plan Administrator to be responsible for processing claims and payment of benefits, administration, accounting, and other services contracted for by the Fund.

Coinsurance
Your share of the cost of a covered service, calculated as a percentage of the Allowed Amount for the service. Typically, the Deductible must be met before the Coinsurance is applied. You are wholly responsible for all non-covered expenses in addition to any Coinsurance. The percentages shown in the Schedule of Medical and Dental Benefits reflect the amount the Plan pays for each respective service.

Co-payment/Co-pay
The fixed dollar amount (for example, $10) You pay for covered health care. You are responsible for all non-covered expenses. The Co-pays are shown in the Schedule of Medical Benefits.

Corrective Appliance
Items which are Prosthetic or Orthotic and necessary for the restoration of function or replacement of body parts as follows:

Prosthetic - Items or equipment, with the exception of dental, which replace all or part of a body.

Orthotic - A device for supporting, restoring, or immobilizing a body part that is weakened, ineffective, deformed, or injured.

Cosmetic Surgery
A treatment, Surgery, or service performed which will preserve, change, enhance and improve a person's appearance (e.g. tummy tuck or rhinoplasty) and which does not affect the physiological function.

Covered Expenses
Expenses are for:

- Medical/hospital;
- dental & orthodontics;
- preventative services;
- hearing aid;
- optical charges;
- prescription drugs;
- life insurance
- accidental death or dismemberment;
- occupational and non-occupational disabilities claims; and
- for certain wage replacement benefits.

These are only covered to the extent that the expenses meet all of the following qualifications as determined by the Plan Administrator or its designee:

- they are Medically Necessary, as defined in this Definitions section;
- the charges for them are an Allowed Amount, as defined in this Definitions section;
- services or supplies are not excluded under this Plan
- the Lifetime Orthodontia benefit, if applicable, has not been reached, and
- they are for the diagnosis, treatment of an injury, or illness except where wellness/ preventive services are payable by the Plan as noted in the Schedule of Medical Benefits in this Plan.

Custodial Care
Care services which are provided to assist a person with activities of daily living such as, personal hygiene, walking, meal preparation, and housekeeping. Custodial Care can be safely performed by individuals who are not trained, licensed health care professionals. Services are deemed Custodial regardless of who recommends, orders, provides, directs the care, location for the care, and is not based upon the diagnosis or rehabilitation potential.

Deductible
A Deductible is the amount of covered expenses You must pay during each calendar year before the Plan will consider expenses for reimbursement. The individual Deductible applies separately to each covered person. The family Deductible applies collectively to all covered persons under the same contract. When two family members meet their individual Deductibles, the family Deductible is satisfied and no further Deductible will be applied for any covered family member during the remainder of that Calendar Year. The annual individual and family Deductible amounts are shown in the Schedule of Medical Benefits chapter.

Dentist
A person acting within the scope of his/her license, holding the degree of Doctor of Dental Surgery (D.D.S.), or Doctor of Dental Medicine (D.M.D.) and who is legally entitled to practice dentistry in all its branches under the laws of the state or jurisdiction where the services are rendered and is not a family member of the individual receiving the services.

Dependent
Eligible Dependents include the employee's lawful spouse as defined by applicable federal law and Dependent Children.

Dependent Child
For the purposes of this Plan, a Dependent Child is any of the following who are under the age of 26 (whether married or unmarried):

- Your natural born son or daughter (proof of relationship and age will be required);
- Your legally adopted child or a child placed for adoption with You, (proof of adoption or placement for adoption will be required); or
- a child named as an "alternate recipient" under a **Qualified Medical Child Support Order**. Notwithstanding any provision of this Plan to the contrary, benefits will be provided to any dependent child as required by any Qualified Medical Child Support Order ("QMCSO"), in accordance with §609(c) of ERISA. The Plan will notify the eligible employee if a QMCSO is received.

In addition to the Dependent Children defined above, the following individuals are eligible for coverage under the Plan:

- An unmarried Dependent Child (as defined above) age 26 or older who is Disabled with a Disability that existed prior to age 26 and who is eligible for tax-free health coverage as a "qualifying child" or "qualifying relative" under the applicable requirements of Internal Revenue Code Section 152(c) or 152(d), respectively. The Plan will require initial and periodic proof of disability.

With the exception of a Dependent Child who is permanently and totally Disabled, coverage will terminate at the end of the calendar month in which the individual attains the age of 26.

A spouse or child of a Dependent Child is not eligible for coverage under the Plan.

Disabled/Disability: The inability of a person to be self-sufficient as the result of a physically or mentally disabling injury, illness, or condition (Including, but not limited to intellectual disabilities, cerebral palsy, epilepsy or another neurological disorder, or psychosis), and the person is permanently and totally disabled in that they are unable to engage in any substantial gainful activity by reason of a medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months and the condition was diagnosed by a Physician, and accepted by the Plan Administrator or its designee, as a permanent and continuing condition. See also the definition of Totally Disabled.

Durable Medical Equipment
The rental or purchase of standard (non-customized) equipment which:

- Can withstand repeated use;
- Is primarily and customarily used to be medically useful; and
- Is not generally useful in the absence of injury or illness;
- Is ordered by a Health Care Practitioner;
- Is for primary use in the home; and
- Is neither disposable nor Non-durable.

The purchase or rental of non-standard DME, those with special features, must be medically necessary and must be authorized by the Plan or its designee.

Elective
Medically Necessary services/procedures which are made by the member or the doctor and can be scheduled/performed at varying times without jeopardizing the patient's life or causing serious impairment of body function. Elective surgery is different from Cosmetic Surgery.

Emergency
A medical or behavioral condition, the onset of which is sudden that manifests itself by symptoms of sufficient severity, including pain, that a prudent layperson, possessing an average knowledge of medicine and health could reasonably expect the absence of immediate medical attention to result in: 1. Placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition, placing the health of the person or others in serious jeopardy; or 2. Serious impairment to such person's bodily functions; or 3. Serious dysfunction of any bodily organ or part of such person; or 4. Serious disfigurement of such person
For more specific information, please refer to the Urgent Care Claims subsection in the Claims Procedure section.

Exclusions
Specific conditions, situations, and treatments for which the Plan, the Plan Administrator, or designee will not provide benefit payment. Services that are Excluded from the Plan are the responsibility of the member.

Experimental or Investigational Services
Treatment, procedures (including some organ transplant), drugs, biologicals products, or medical devices, which in the judgment of the Plan are experimental/investigational in nature, including, but not limited to:

- Those where there is insufficient information to determine if the services are of proven benefit for a particular diagnosis or for treatment of a particular condition;
- Those not generally recognized by the medical community. As reflected in published, peer reviewed, medical literature, as effective or appropriate for a particular diagnosis or for the treatment of a particular condition; or
- Those not of proven safety for a person with a particular diagnosis or a particular condition (i.e., that which is currently being evaluated in research studies to ascertain the safety and effectiveness of the treatment on the wellbeing of a person with the particular diagnosis or in the particular condition.)

The Plan Administrator or its designee has the sole discretion and authority to determine if a drug, device, medical treatment, procedure, or service is or should be classified as Experimental or Investigational.

Gene Therapy: Gene therapy typically involves replacing a gene that causes a medical problem with one that does not, adding genes to help the body fight or treat disease, or inactivating genes that cause medical problems. The Fund does not cover any charges related to gene therapy, whether or not those therapies have received approval from the U.S. Food and Drug Administration (FDA) or are considered experimental or investigational. Illustrative examples of gene therapy include Chimeric Antigen Receptor T-Cell (CAR-T) Therapies such as Kymriah and Yescarta, as well as Luxturna and Zolgensma, but new applications for gene therapies are submitted every year.

Health Care Practitioner/Health Care Provider
A Physician, physician assistant, psychiatrist, optometrist, nurse, nurse practitioner, midwife or other licensed healthcare professional who provides a health care service, who is legally entitled to practice under the laws of the state or jurisdiction where the services are rendered and is not a family member of the individual receiving the services.

Home Health Care
Intermittent Skilled Nursing Care, given in Your home for an illness or injury, provided by a licensed home health agency.

Home Health Agency
A public agency or private organization licensed, pursuant to federal or state laws, Home Health Agency which meets all of the following requirements:

- It must primarily provide Skilled Nursing Services and other therapeutic services under the supervision of physicians or registered Nurses;It must be run according to rules established by any state or local licensing agency;
- It must maintain clinical records on all patients;
- It must be licensed by the jurisdiction where it is located, if licensure is required, and run according to the laws of that jurisdiction which pertain to agencies providing Home Health Care; and
- Meets any additional requirements for providing a surety bond or escrow accounts as applicable by law.

Hospice
A facility or organization licensed and operating according to the law, which administers a program of palliative and supportive health care services providing physical, psychological, social and spiritual care for terminally ill persons assessed to have a life expectancy of six (6) months or less.

Hospital
A public or private facility, licensed and operating according to the law, which provides care and treatment by Physicians and Nurses on a 24-hour basis for an illness or injury through the medical, surgical, and diagnostic facilities on its premises. A Hospital also includes mental, neurological, or substance abuse treatment facilities which are licensed and operated according to the law. A Hospital does not include a facility or any part thereof which is a residential treatment facility or a place for rest, the aged, or convalescent care.

Illness
Any disease or sickness of the body or mind, as diagnosed by a Physician, and any congenital abnormalities (also referred to as birth defects) of an eligible newborn child. For the purposes of this Plan, a pregnancy of an eligible enrollee will be considered an illness.

Injury
Trauma or physical damage to a body part by an external force.

Injury to Sound and Natural Teeth: An injury to the teeth caused by an external object. Intrinsic force such as the force of chewing is not eligible (See also Sound & Natural Teeth).

Inpatient
Treatment in an approved and licensed facility during the period when charges are made for room and board.

Investigational
Same as Experimental, as defined above.

Lifetime
A maximum total that the Plan will ever pay (not per calendar year) for You or Your eligible Dependents claims.

Maintenance Care
Services and supplies primarily to maintain (support and/or preserve) a level of physical or mental function.

Medically Necessary
Health care services, supplies, or treatment that a physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing, or treating an illness, injury, disease, or its symptoms, and that are:

1. In accordance with generally accepted standards of medical practice;
2. Clinically appropriate, in terms of type, frequency, extent, site, and duration, and considered effective for the patient's illness, injury, or disease;
3. Not primarily for the convenience of the patient, Physician, or other health care provider; and
4. Not costlier than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the patient's illness, injury or disease.

"Generally acceptable standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community when available, Physician Specialty Society recommendation, the view of prudent Physicians practicing in relevant-clinical areas, and any other clinically relevant factors.

The fact that a Physician or health care practitioner may order, recommend, or approve a service, supply, or treatment does not in itself make it Medically Necessary. The Plan Administrator or its designee has the sole discretion and authority to determine if a service, supply, or treatment is Medically Necessary.

Medicare
Title XVIII (Health Insurance for the Aged and Disabled) of the United States Social Security Act, as amended.

Mental Disorder/Mental Illness
Conditions and diseases as classified by the Diagnostic and Statistical Manual of Mental Disorders, current edition.

Non-durable
Goods/supplies which cannot withstand repeated use and/or are considered disposable and limited to a one-person or one-time use, including but not limited to, incontinence pads, diapers, soap, etc.

Nurse
A person acting within the scope of his/her license and holding a degree/licensure of a Registered Nurse (R.N.), Licensed Vocational Nurse (L.V.N.) or Licensed Practical Nurse (L.P.N.).

Orthotic
See Corrective Appliance.

Out Of Pocket Maximum
An Out Of Pocket Maximum is the maximum amount of coinsurance and/or Co-pay payable for covered expenses that each eligible individual must pay during a Calendar Year. This amount includes the Deductible. When the Out Of Pocket maximum is reached by an individual, the Plan will pay 100% of eligible expenses for the remainder of the Calendar Year for that individual. The annual Out Of Pocket Maximum amount is shown in the Schedule of Medical Benefits.

Outpatient
Treatment either outside of a Hospital setting or at a Hospital when room and board charges are not incurred.

Pharmacist
A person licensed to prepare, compound, and dispense medication who is practicing within the scope of his or her license.

Physician
A person acting within the scope of his/her license and holding the degree of Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), or Doctor of Podiatry Medicine (D.P.M.), who is legally entitled to practice medicine in all its branches under the laws of the state or jurisdiction where the services are rendered, and who is not a family member.

Plan
The benefits, provisions, and exclusions described in this document.

Plan Administrator
The Plan Administrator is the Board of Trustees of the Welfare Fund, whose members are fiduciaries of the Plan. The Board of Trustees has all discretionary authority to interpret the provisions and control the operation and administration of the Plan within the limits of the law. All decisions made by the Plan Administrator are final and binding on all parties.

The Welfare Fund may choose to hire a consultant, Claims Administrator, or both to perform specified duties in relation to the Plan. The Plan Administrator also has the right to Amend, modify, or terminate the Plan at any time or in any manner.

Precertification
The process of reviewing the Medical Necessity, appropriateness, location, duration, cost efficiency, or a combination thereof with respect to a health care service before it is rendered. This review is performed by licensed health professionals.

Prosthetic
See Corrective Appliance.

Provider
Same as Health Care Practitioner, as defined above.

Qualified Medical Child Support Order
A support order of a state or administrative agency that usually results from a divorce or legal separation, complies with requirements of federal law, requires an Employee to provide health care coverage for a Dependent Child, and requires that benefits payable on account of that Dependent Child be paid directly to the health care provider who rendered the services or to the custodial parent of the Dependent Child.

Reconstructive Surgery
A procedure which is performed on an abnormal or absent structure of the body to correct damage caused by a congenital birth defect, developmental abnormalities, trauma, infection, disease or tumor or for breast reconstruction following a total or partial mastectomy.

Rehabilitation
Therapy services (physical, speech, or occupational therapy) include those providing significant measurable improvement to an individual who is restricted and unable to perform normal bodily functions as a result of illness, injury or surgery and requiring the skills of a professionally licensed therapist working under the direction of a qualified Physician.

- **Active Rehabilitation**
  Refers to an individual's participation in the therapy services toward attainment of specific functional goals.

- **Maintenance Rehabilitation**
  Refers to therapy of less intensity and frequency than rehabilitation therapy that is rendered after a patient has met functional goal(s) in anticipation of no continued improvement. However, this therapy is deemed reasonably necessary to maintain (support and/or preserve) the patient's functional level goal(s). Maintenance rehabilitation is also called Habilitation.

Second Opinion/Second Surgical Opinion (SSO)
A consultation or exam, or both, preferably with a board-certified Physician not affiliated with the primary attending Physician/surgeon for the purpose of evaluating the Medical Necessity and advisability of undergoing a surgical procedure or receiving a service.

Skilled Nursing Care
Services performed by a licensed health care professional which meet the following criteria:

- are ordered and provided under the direction of a physician;
- are intermittent and part-time (nursing service duration not to exceed 16 hours per day); and
- require the skills of technical or professional personnel (e.g., R.N., L.P.N.) in that the service is so inherently complex that it can be safely and effectively performed only by or under the supervision of this technical/professional individual.

Examples of Skilled Nursing Care include but are not limited to:

- initiation of intravenous therapy
- initial management of medical gases (e.g., oxygen)

Skilled Nursing Facility
A licensed institution (other than a Hospital, as defined) which meets all of the following requirements:

- it is eligible to qualify as a skilled nursing facility and as a provider of services under Medicare;
- it maintains on the premises all facilities necessary for medical care and treatment;
- it provides such services under the supervision of Physicians; and
- it provides nursing services by or under the supervision of a licensed registered Nurse, with one registered Nurse on duty at all times.

Sound and Natural Teeth
Natural teeth, not dentures, bridges, pontics or artificial teeth, which are free of active or chronic clinical decay, have at least 50% bony support, are functional in the arch, and have not been excessively weakened by previous dental procedures.

Specialized Health Care Facilities
Specialized Health Care Facilities, as the term relates to this Plan, include a licensed birthing center, ambulatory surgical facility, skilled nursing facility, or licensed hospice facility, as those terms are specifically defined herein.

Specialty Care Unit
A section, ward, or wing within a hospital which offers specialized care for the patient's needs. The unit usually provides constant observation, special supplies, equipment, and care provided by registered nurses or highly trained personnel. Examples include, but are not limited to Intensive Care Units (ICU), Cardiac Care Units (CCU), etc.

Spinal Manipulation
The detection and correction, by manual or mechanical means, of the interference with nerve transmissions and expressions resulting from distortion, misalignment, or dislocation of the spinal (vertebrae) column.

Substance Use Disorder
Disorders such as those related to, but not limited to, alcohol, tobacco, cannabis (marijuana), stimulants, hallucinogens, and opioids as defined by the Diagnostic and Statistical Manual of Mental Disorders, current edition.

Surgery
The treatment of injuries, diseases, and other disorders by manual incision or instrumental means. The Plan or its designee determines which procedures are allowed as separate codes and which are considered inclusive in the total service and which do not warrant separate payment.

Third Opinion
After obtaining a Second Opinion (see definition), a third consultation or exam, or both, preferably with a board-certified Physician not affiliated with the primary attending Physician/surgeon or the second opinion Physician/surgeon, for the purpose of evaluating the medical necessity and advisability of undergoing a surgical procedure or receiving a service.

Total Disability (Totally Disabled)
The inability to perform all the duties of the covered person's occupation as the result of a physical or mental illness or injury. For an unemployed covered person, total disability means the inability to perform the normal duties of a person of the same age and gender.

Visit
A personal interview between a Physician or Health Care Provider and the covered person. When applied to billing, medical records indicate that services provided meet coding according to the most current CPT code manual.

Well Baby/Child Care
Charges made by a Physician or Health Care Practitioner for care of a healthy newborn or child from birth up to age 19, not as a result of illness, accident or injury.

You, Your
When used in this document, these words refer to the Participant who is covered by the Plan. They do not refer to any Dependent(s) of the Participant.

ELIGIBILITY

Initial Eligibility
Employees working under the jurisdiction of participating local unions become eligible for benefits on the first day of the month immediately following the prior six (6) consecutive month period in which they have worked a minimum of 400 hours in "covered employment" (defined as work for which contributions are required to be made on your behalf to this Plan) with a contributing employer. These new employees will be covered under the Plan for a period of six months.

Apprentices of the Welfare Fund become eligible for benefits on the first day of the month immediately following the prior twelve consecutive month period in which they have worked a minimum of 400 hours in covered employment with a contributing employer.

Continuing Eligibility
After establishing initial eligibility, an employee who works a minimum of 200 hours during each three-month Work Period will be covered for the corresponding three-month Eligibility Period as shown on the chart below.

Work Period	**Eligibility Period**
January through March	June, July, August
April through June	September, October, November
July through September	December, January, February
October through December	March, April, May

However, if You do not work at least 200 hours in the January through March Work Period, You will be eligible for benefits for the June through August Eligibility Period if You worked at least 400 hours over the previous six-month October through March Work Period.

If You meet the eligibility requirements, You and Your eligible Dependents will be covered for:
- hospital;
- surgical;
- medical;
- dental & orthodontia;
- prescription drug;
- optical;
- preventative care;
- hearing benefits; and
- employee assistance programs ("EAP").

The Life Insurance, Accidental Death and Dismemberment Insurance and Supplemental Weekly Disability Benefit apply only to the eligible employee.
For eligibility for benefits under the Wage Replacement Account, please see the section of this Plan entitled Wage Replacement Account Benefits.

For purposes of determining both initial and continuing eligibility, if Your employer fails to make the required contributions to the Fund, You will still be given credit for the hours worked for which those contributions are required, provided those hours are reported to or verified by the Fund Office. However, if the delinquent contributions are eventually collected by the New York State Department of Labor and paid by the Department directly to You, then You must pay the entire amount You receive to the Fund within ninety (90) days after the Fund demands payment from You. If You do not remit the entire amount to the Fund within ninety (90) days after the Fund demands payment, the Fund has the authority and discretion to suspend Your eligibility for benefits (and that of Your dependents).

Termination of Eligibility
An employee who works less than 200 hours during any three-month Work Period, except as noted above, will lose coverage at the end of the Eligibility Period which corresponds to the Work Period in which he or she last worked 200 hours.

For example:
Mike has met the initial eligibility requirement and works 200 hours in the January through March 2018 Work Period. He and his Dependents are covered through August 31, 2018. He then fails to work 200 hours during the April through June Work Period and decides not to self-pay for coverage. He and his Dependents will lose eligibility as of August 31, 2018.

If the six-month period of initial eligibility coverage ends at the same time as the above-noted Eligibility Periods, the employee must meet the continuing eligibility requirements as noted above to continue coverage. If the six-month period of initial coverage ends in the middle of an Eligibility Period, the employee must have met the continuing eligibility requirement of 200 hours in the Work Period to continue coverage beyond the six-month period.

For example:
Tom began working in August 2018 and worked 400 hours by the end of October. He receives six-months of initial eligibility beginning November 1, 2018. This coverage continues for him and his Dependents through April 30, 2019. At that time, in order to continue coverage, he must have worked at least 200 hours in the October through December Work Period. If he only worked 90 hours during the October through December Work Period, he and his Dependents will lose coverage as of April 30. If he worked 200 hours during the October through December 2018 Work Period, he and his Dependents would have remained eligible through May 31, 2019.

If a covered employee works for an employer that fails to make the required contributions to the Fund, the employee will be granted credit for the purposes of determining eligibility, for all hours reported to and verified by the Fund Office.

Termination of Coverage for Cause, Including Fraud or Intentional Misrepresentation and Rescission of Coverage
As always, the Fund reserves the right to terminate coverage for You or Your Dependent(s) if You or Your Dependent(s) are otherwise determined to be ineligible for coverage. The coverage may be rescinded retroactively (as opposed to prospectively) to the extent the circumstances are warranted and the applicable law allows such cancellation.

Self-Payment (when short hours)
If You work at least 100 hours in a Work Period, but less than the 200 hours required for coverage, You can self-pay for the hours You are short to continue coverage for You and Your eligible Dependents. The self-payment rates are based upon the employer contribution rates for the current year. If You qualify for this option, You will be notified by mail the number of hours You lack in the current Work Period to maintain Your coverage. In addition, You will be advised of the amount You would owe should You choose to continue Your coverage. If You wish to apply for coverage under the Self-Payment Plan for hours which You are short, contact the Fund Office for details no later than ten calendar (10) days after the regular termination of Your coverage. If You believe that You have additional hours, which were not reported, please contact the Fund Office. You must be covered under the Plan for Your Dependent to be covered.

For Example:
If You worked 111 hours in a Work Period. You are able to self-pay the remaining 89 hours at the current employer contribution rate to meet the 200-hour requirement.

Active Self-Payment
If You lose eligibility due to working less than 200 hours in a Work Period and not being able to self-pay in a Work Period in which You worked at least 100 hours, You have the option of self-payment. The self-payment rates are calculated each year and are available from the Fund Office. Under this arrangement, the Plan provides for a maximum self-payment period of four (4) consecutive Work Periods. You must make a written statement to the Fund Office that You are available for work in the Iron Worker industry and not employed in any other type of work. An exception will apply in the case of an individual who is injured while working in the trade as an Iron Worker and is unable to continue work as an Iron Worker. If You choose the self-payment option, You are not eligible for COBRA at the end of the four (4) consecutive Work Periods. If You have exhausted the four (4) consecutive Work Periods under the self-payment option, You must establish initial eligibility by working 400 hours in a six (6) month period. You must be covered under the Plan for Your Dependent to be covered. If You would like to apply for coverage under the Self-payment option, contact the Fund Office for details no later than ten calendar (10) days after the regular termination of Your coverage. Payment for members who work less than 100 hours will not be automatically taken from the Supplemental Fund under the authorization for Automatic Purchase of Health Insurance. Please note if You have the option of choosing Self-Payment or COBRA, the Fund office will send you a COBRA eligibility letter; the selection of one of the options is the rejection of the other option.

For the first month of self-payment coverage requested, payment of monthly premium is due within the ten (10) calendar day notification period described above. For the months following payments are due on a monthly basis and must be made to the Fund Office on or before the first day of each month coverage is requested. There is a five (5) calendar day grace period for payment of the monthly premium. If payment is not received by the Fund Office within the time periods set forth above, You and Your dependents will not be eligible for coverage from Self-Payment and will not have any COBRA rights.

Reinstatement
A covered employee who loses his eligibility will be reinstated upon the earning of at least 200 hours of covered employment in a Work Period during the 12-month period that follows the date when his coverage terminated. If such an employee fails to meet the above 200-hour test, he must re-establish initial eligibility in order to become covered. A pensioner, whose pension has been suspended and who returns to work in covered employment, must re-establish initial eligibility in order to become insured under the Plan.

Extension of Coverage for Disabled Children
If a Dependent Child is physically or mentally Disabled on the date coverage would otherwise end, the child's eligibility will be extended for as long as the employee is covered by this Plan, the Disability continues, and the child continues to qualify for coverage in all aspects other than age. The Plan will require You to obtain a physician's statement certifying the child's physical or mental Disability from time to time. The proof should be sent to the Fund Office within 31 days after the child attains the limiting age and furnished thereafter, as required.

Qualified Medical Child Support Order or National Medical Support Order
If a Qualified Medical Child Support Order ("QMCSO") is issued for your child, that child will be eligible for coverage as required by the order. You must notify the Fund and elect coverage for that child, and yourself if you are not already enrolled, within 31 days of the Qualified Medical Child Support Order being issued.

According to federal law, a Qualified Medical Child Support Order is a judgment, decree or order (issued by a court or resulting from a state's administrative proceeding) that creates or recognizes the rights of a child, also called the "alternate recipient," to receive benefits under a group health plan, typically the non-custodial parent's plan. A QMCSO usually results from a divorce or legal separation and typically:

- Designates one parent to pay for a child's health plan coverage;
- Indicates the name and last known address of the parent required to pay for the coverage and the name and mailing address of each child covered by the QMCSO;
- Contains a reasonable description of the type of coverage to be provided under the designated parent's health care plan or the manner in which such type of coverage is to be determined;
- States the period for which the QMCSO applies; and
- Identifies each health care plan to which the QMCSO applies.

An order is not a QMCSO if it requires the Plan to provide any type or form of benefit or any benefit option that the Plan does not otherwise provide, or enroll an individual who is not otherwise eligible to be covered under the Plans. For a state administrative agency order to be a QMCSO, state statutory law must provide that such an order will have the force and effect of law, and the order must be issued through an administrative process established by state law. If a court or state administrative agency has issued an order with respect to health care coverage for any Dependent Child of the employee, the Plan Administrator or its designee will determine if that order is a QMCSO as defined by federal law. That determination will be binding on the employee, the other parent, the child, and any other party acting on behalf of the child. The Plan Administrator or its designee will notify the parents and each child if an order is determined to be a QMCSO, and if the employee is covered by the Plan, and advise them of the procedures to be followed to provide coverage of the Dependent Child(ren).

If the Plan has determined that an order is a valid QMCSO it will accept enrollment of the alternate recipient as of the earliest possible date following the date the Plan determined the order was valid, without regard to typical enrollment restrictions.

- If the employee is already enrolled in the Plan, the QMCSO may require the Plan to provide coverage for the employee's Dependent Child(ren). The Plan will accept a Special Enrollment of the alternate recipient specified by the QMCSO from either the employee or the custodial parent. Coverage of the alternate recipient will become effective as of the date specified on the QMCSO or if not specified, the first day of the month after the Special Enrollment request is received. Coverage will be subject to all terms and provisions of the Plan as permitted by applicable law.
- If the employee is not enrolled in the Plan when the QMCSO is received and if the QMCSO orders the employee to provide coverage for the alternate recipient, the Plan will accept a Special Enrollment of the employee and the alternate recipient specified by the QMCSO. Coverage of the employee and the alternate recipient will become effective as of the date specified on the QMCSO, or if not specified, the first day of the month after the Special Enrollment request is received. Coverage will be subject to all terms and provisions of the Plan, as permitted by applicable law.

Generally, coverage under the Plan terminates for an alternate recipient when the period of coverage required under the QMCSO ends or for the same reasons coverage terminates under the Plan for other Dependent children. When coverage terminates, alternate recipients may be eligible for COBRA Continuation Coverage. See also the COBRA chapter of this document. You and your Beneficiaries can obtain, without charge, a copy of the Plan's QMCSO procedures from the Administrative Manager.

Credit for Periods of Disability
An eligible employee who is absent from covered employment because of disability for which he is receiving Workers' Compensation, New York State disability benefits, or disability benefits payable under this Plan, will be allowed to continue accumulating credit toward eligibility on the basis of 20 hours per week for each week that he continues to receive such benefits up to a maximum of 26 weeks.

Extension of Benefits
Extension of benefits are available through the Self-Payment Plan, which is described earlier in this booklet and COBRA continuation coverage which is described later in this booklet.

Hospital and medical coverage will be extended for the Dependents of a deceased eligible employee for a period of up to six months following the month in which the employee died. Coverage for such spouse and Dependents will be extended for the time that the deceased member had left under "hours worked." Any extended benefits are subject to the limitations and provisions of the Plan.

ENROLLMENT

How to Enroll
The Fund Office will notify You when You become eligible for coverage under the Plan and send You an Enrollment form. You are automatically enrolled in the Welfare Plan, which includes Medical Benefits, Life & Accidental Death & Dismemberment Insurance, Supplemental Disability Benefits, and the Employee Assistance Program (EAP). In order to enroll Your eligible Dependents, You must complete the COB/Enrollment form. You may opt out of coverage provided by the Plan by completing the applicable section on the Enrollment form. In order to opt out, You must certify that You have other group health coverage that meets the minimum value requirements set forth under the Affordable Care Act. You also have the option to opt out of, or in to, the dental and optical Plans once per year. In order to opt out of dental and optical benefits, You must complete the appropriate waiver form and return it to the Fund Office with Your open enrollment materials. Please note, there is not an option to decline coverage for Life, Accidental Death & Dismemberment, Supplemental Disability, and Employee Assistance Program Benefits.

For Your eligible Dependents to receive coverage under the Plan, You need to enroll them within 30 days of the effective date of Your coverage, and provide the Fund Office with proof of dependent status. The Fund Office will accept a copy of any of the following documents as proof of dependent status:

- Spouse/Marriage: a copy of Your certified marriage certificate (You will also need to notify the Fund Office of other coverage for Your Spouse or family, if applicable).
- Child/Birth: a copy of Your child's certified birth certificate.
- Adoption or placement for adoption: a copy of a court order signed by a judge.
- Extension of Coverage for Disabled Child(ren): a current written statement from the child's physician, indicating the child's diagnoses that are the basis for the physician's assessment, that the child is incapable of self-support because of mental or physical incapacitation (as described in "Extension of Coverage for Disabled Children subsection) and proof that the child is an eligible Dependent.

Special Enrollment for Dependents
If You decline enrollment for Yourself or Your eligible Dependents because of other health insurance or group health plan coverage, You may be able to enroll Yourself or Your dependents in this Plan if You lose eligibility for that other coverage. However, You must request enrollment within 30 days after Your other coverage ends.

Coverage under this Plan for You is automatic upon Your eligibility. However, by law, the Plan must provide the following description of special enrollment rights to anyone who becomes eligible for coverage:

- You and Your Dependents may also enroll in this Plan if You (or Your Dependents) have coverage through Medicaid or a State Children's Health Insurance Program (CHIP) and You (or Your Dependents) lose eligibility for that coverage. However, You must request enrollment within 60 days after the Medicaid or CHIP coverage ends.
- You and Your Dependents may also enroll in this Plan if You (or Your Dependents) become eligible for a premium assistance program through Medicaid or CHIP. However, You must request enrollment within sixty (60) days after You (or Your Dependents) are determined to be eligible for such assistance.

If You acquire a Dependent by marriage, adoption or placement for adoption, You may enroll Yourself and Your Dependents. However, You must request enrollment within 30 days after the marriage, adoption, or placement for adoption and provide proof of dependency in order to enroll Your Dependent (e.g., marriage certificate).

To request special enrollment or obtain more information, contact the Fund Office.

Special Enrollment for Newborn Children
Additional time is available to request enrollment for a newborn child. If the Fund Office receives a complete enrollment form and the necessary documentation providing proof of dependency (a copy of the child's birth certificate) within 60 days of the birth of Your child, coverage will be effective from the date of birth.

If the Fund Office does not receive the necessary enrollment materials for a newborn child within 60 days of birth, coverage will not become effective until the beginning of the month following the month in which the Fund Office receives completed enrollment information and necessary proof dependency. If claims are submitted for Your newborn child before the enrollment process is complete, the claims will be denied and will need to be resubmitted once enrollment is complete, but will only be paid retroactive to the effective date of the coverage described above.

Start of Coverage for Dependents Following Enrollment
Coverage for Your Dependents cannot begin until the Fund Office receives a completed Enrollment form along with the necessary documentation (e.g., birth certificate, marriage certificate, or adoption papers). If You have Dependents, other than newborn children, and enroll them when You are first eligible for coverage, and it is within 30 days of Your Initial Eligibility, their coverage will be effective retroactive to the date You were first eligible. Newborn eligibility will be effective retroactive to the date of birth as described in the section above.

For newly added Dependents, other than newborn children, if the Fund Office receives a complete Enrollment form and the necessary documentation within 30 days of the date of the marriage, adoption, placement for adoption, or loss of other group coverage, coverage will be effective as follows:

- For adopted Dependent Child(ren): Adopted child(ren) are covered from the date that child is adopted or "placed for adoption" with You, whichever is earlier. "Placed for adoption" means the lawful placement of the child for legal adoption, and the assumption and retention, by a participant or beneficiary, of a legal obligation for total or partial support of the child in anticipation of adoption. A child who is placed for adoption with You within 30 days after the child was born will be covered from birth. However, if a child is placed for adoption with You, and if the adoption does not become final, coverage of that child will terminate as of the date You no longer have a legal obligation to support that child.
- For Your new Spouse: Your new spouse is covered retroactive to the date of Your marriage.
- Following loss of other group coverage: Your Dependent(s) will be covered retroactive to date of loss of other coverage provided that the Plan receives the enrollment information within 30 days of the loss of other coverage.

If You request enrollment within 60 days of the date of the Special Enrollment opportunity related to Medicaid or CHIP, generally coverage will become effective retroactive to the date of loss of coverage related to Medicaid or CHIP.

Start of Coverage Following Late Enrollment
If the Fund Office does not receive the necessary enrollment material for Your Dependents within 30 days, coverage will not become effective until the beginning of the month following the month in which the Fund Office receives Your completed Enrollment form and necessary proof. If You submit claims for Your Dependents before You enroll them, they will be denied and will need to be resubmitted once enrollment is complete, but will only be paid retroactive to the effective date of coverage.

Annual Open Enrollment
Each year, the Fund has an open enrollment period. During that time, You may make changes to Your current elections, as well as enroll or disenroll Dependents as described in this section. For those with family coverage, an Enrollment/COB form must be completed and returned to the Fund Office each year regardless of whether there have been any changes.

Note, if You or Your Dependents opt-out of coverage under this Plan, with the exception of the Special Enrollment rights described above, the individual that opted out must wait until the next open enrollment period to request coverage.

Please note that You are automatically covered for Life Insurance under the Welfare Plan, Accidental Death Insurance, Supplemental Disability, and the Employee Assistance Program as soon as You are eligible for benefits. There are no options to decline these benefits.

Coverage Options
Coverage for participants who are members of Local 9, Local 33, and Local 440 will be provided as follows:

BARGAINING GROUP I- BASIC COVERAGE

Local 9, 33, & 440- Coverage for members only: Supplemental Disability, Life Insurance, Accidental Death and Dismemberment Insurance and the Employee Assistance Program.

BARGAINING GROUP II (**SINGLE COVERAGE**) Local 9, 33, & 440- Coverage: **BASIC COVERAGE** (see Group I) and the following coverage for the member only:

- hospital;
- surgical;
- medical;
- dental & orthodontia;
- prescription drug;
- optical;
- preventative care; and
- hearing benefits.

BARGAINING GROUP III (**FAMILY COVERAGE**)

Local 9, 33, & 440- Coverage: **BASIC COVERAGE** plus Group II coverage for the member and his or her eligible Dependents.

Coverage for participants who have contributions made on their behalf to the Wage Replacement Account is detailed in the section entitled Wage Replacement Account Benefits.

CONTINUATION OF COVERAGE DURING CERTAIN ABSENCES

There are certain circumstances where You may be entitled to coverage during periods when You are absent from Covered Employment. This section describes how certain absences from Covered Employment will affect Your Fund coverage. If You have any questions about how an absence from Covered Employment affects Your coverage, please contact the Fund Office.

Qualified Military Service/Uniformed Services Employment and Reemployment Rights Act (USERRA)

If You are a participant who enters military service, You will be provided continuation and reinstatement rights in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), as amended from time to time.

What is USERRA? USERRA Continuation Coverage is a temporary continuation of coverage when it would otherwise end because the employee has been called to active duty in the uniformed services. USERRA protects employees who leave for and return from covered types of uniformed service in the United States armed forces, including the Army, Navy, Air Force, Marines, Coast Guard, National Guard, National Disaster Medical Service, the reserves of the armed forces, and the commissioned corps of the Public Health Service.

The Plan will offer You continuation coverage under USERRA only after You have notified the Plan in writing that You have been called to active duty in the uniformed services. You must notify the Plan as soon as possible, but no later than sixty (60) days after the date on which You will lose coverage due to the call to active duty, unless it is impossible or unreasonable to give such notice.
Your coverage under this Plan will terminate when You enter active duty in the uniformed services. Pursuant to USERRA:

- If You are on active military duty for less than thirty-one (31) days, You and Your eligible dependents can elect, free of charge, to continue to receive healthcare coverage for up to thirty (30) days, in accordance with USERRA.

- If You are on active military duty for more than thirty (30) days, USERRA permits You to elect to continue medical and dental coverage for You and Your eligible Dependents at Your own expense for up to twenty-four (24) months or until the day after the date You fail to apply for reemployment within the time period specified below, whichever is less. The cost of coverage is the same as that under the Plan's COBRA continuation coverage. If You elect USERRA continuation coverage, this Plan will coordinate with TRICARE.

Please note that USERRA is an alternative to COBRA, therefore either COBRA or USERRA coverage can be elected and the coverage will run simultaneously, not consecutively.

Duty to Notify the Plan: The Plan will offer the employee USERRA continuation coverage only after the Plan Administrator has been notified by the employee in writing that they have been called to active duty in the uniformed services. The employee must notify the Plan Administrator (contact information is on the Quick Reference Chart in the front of this document) as soon as possible but no later than 60 days after the date on which the employee will lose coverage due to the call to active duty, unless it is impossible or unreasonable to give such notice.

Paying for USERRA Coverage:
If You elect to continue Your coverage under USERRA, You can freeze Your earned eligibility to date and pay for Your coverage out of pocket or You can use the eligibility for coverage You have already earned. If You use up Your eligibility, You will then be permitted, at Your option, to continue coverage by paying Your premiums out of pocket. Upon returning to reemployment, You would then have to pay the cost of the coverage until You earn the hours necessary to sustain continued coverage in the Plan.

How USERRA and COBRA Coordinate:
When Your coverage under this Plan terminates because of Your reduction in hours due to Your military service, You and Your eligible dependents may also have COBRA rights. See the COBRA section of this document for details. In addition, Your Dependent(s) may be eligible for health coverage under TRICARE.

Your coverage will be reinstated in accordance with the requirements set forth by USERRA.

Contact the Fund Office to obtain a copy of the COBRA or USERRA election forms or if You have questions about coverage during a military service leave. Completed USERRA election forms must be submitted to the Plan in the same timeframes as is permitted under COBRA.

Family and Medical Leave Act (FMLA)
You are generally eligible for a leave under the Family Leave and Medical Act (FLMA) if You:

- Have worked for a covered employer for at least twelve (12) months;
- Have worked at least 1,250 hours over the previous twelve (12) months; and
- Work at a location where at least fifty (50) employees are employed by the employer within seventy-five (75) miles.

If You qualify, the FMLA allows You to take up to twelve (12) weeks, and in some cases, up to twenty-six (26) weeks as explained below, of unpaid leave during any twelve-month period for, among other things:

- The birth, adoption, or placement with You for adoption of a child;
- Providing Care for a spouse, child, or parent who is seriously ill; or
- Your own serious illness.

Qualified employees are entitled to a maximum of twelve (12) weeks of unpaid leave and can continue to maintain health care coverage for the duration of the leave. During the leave, contributions will be maintained by Your employer at the level of twenty (20) hours per week. Contact the Fund Office or Your employer regarding eligibility for this benefit.

The FMLA also allows You to take up to twenty-six (26) weeks of unpaid leave during any twelve-month period to provide care for a "covered service" member. A member who is a spouse, son, daughter, parent, or next of kin of a member of the Armed Forces, including a member of the National Guard or Reserves, may take leave up to twenty-six (26) weeks to care for a member of the Armed Forces who is undergoing medical treatment, recuperation, or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list, for a serious injury or illness. The injury or illness must have been incurred in the line of duty while on active duty, and it must be an injury or illness that may render the service member unfit to perform the duties of his/her office, grade, rank or rating.

Taking a leave under the FMLA is not a COBRA qualifying event. A qualifying event can occur after the FMLA period expires if You do not return to work. Then, the COBRA period is measured from the date of the qualifying event—in most cases, the last day of the FMLA leave.

New York Paid Family Leave

You are also entitled to continue your health coverage while on New York Paid Family Leave (PFL). During the PFL, you will maintain the coverage you were eligible for at the time you started PFL until the end of your leave, as long as your Employer properly grants the leave under New York PFL and makes the required notifications and contributions to the Fund Office on your behalf. For more information, please call the Fund office.

MANAGED HEALTH CARE/COST CONTAINMENT PROGRAM

The Welfare Fund desires to provide You and Your family with a health care benefit Plan that protects You financially from significant health care expenses and assures You quality care. While part of increasing health care costs results from new technology and important medical advances, another significant cause is the way health care services are used and delivered.

Some studies indicate that a high percentage of the cost for health care services may be unnecessary. For example, hospital stays can be longer than medically necessary. Some hospitalizations may be entirely avoidable, such as when surgery could be performed at an outpatient facility with equal quality and safety. Also, surgery is sometimes performed when other treatment could be more effective. All of these instances increase costs for You and the Welfare Fund.

Preauthorization Program
Excellus administers the medical management program. The preauthorization program, ensures that the treatments You receive are necessary, appropriate, and cost-effective. This helps You and the Fund save money by avoiding unnecessary healthcare. Preauthorization is completely automatic when You use an in-network provider, so You do not need to call to get a service preauthorized when You see an in-network provider. For out-of-network services You are obligated to obtain preauthorization.

To request preauthorization for certain out-of-network services, You or Your provider should call Excellus at (800) 499-1275.
For Behavior Health Preauthorization's, call (844) 694-6411. After receiving a request for preauthorization, Excellus will review the purpose for the proposed treatment and determine if benefits are available under the Plan and, where applicable, whether medical necessity exists.

To learn more about the preauthorization requirement or to obtain a complete list of services subject to the preauthorization requirement, visit Excellus at **www.excellusbcbs.com** or call (800) 499-1275.

Case Management
Any patient, doctor or health care practitioner can request case management services by calling the utilization review organization. In the majority of instances though, the utilization review firm will be actively searching for those cases that could benefit from case management services and will initiate these review services automatically with the patient.

Failure to Follow Required Review Procedures
When the required review procedures are followed, Your benefits will be unaffected, and You and the Plan can avoid expenses related to unnecessary health care. However, if preauthorization is not obtained, it may cause additional and unnecessary costs to You and the Welfare Fund.

Please refer to the Claims Procedures section of this Plan for more information.

SCHEDULE OF MEDICAL BENEFITS

The following table outlines covered medical expenses for the Plan and includes brief reference to applicable limitations, exclusions, and explanations. The Plan's medical coverage provides benefits for Medically Necessary eligible charges either on a network or out-of-network basis. Your out-of-pocket expenses differ depending on whether You use a network provider or an out-of-network provider, as described below and outlined in the schedule beginning on page 43. All expenses are subject to medical necessity and the applicable calendar year deductible, except where noted.

The Plan's Network
The Fund has contracted with Excellus to provide the network for the Plan. This network of physicians covers specialists ranging from internists and family doctors to various types of surgeons. A listing of Excellus network providers may be obtained, without charge, as a separate document. To obtain the most current list of provider locations, call Excellus at (800) 499-1275 or visit their website at **www.excellusbcbs.com**.

Medically Necessary
The Plan only provides coverage for services and supplies, which are considered Medically Necessary, appropriate and reasonable, as defined in this Plan.

Overview of Medical Plan Design

	Plan of Benefits			
	In-Network		**Out-of-Network**	
Deductible The amount You must pay each Calendar Year before the Plan pays benefits. ➢ Per Individual ➢ Per Family	 $400 $800		 $800 $1,600	
Hospital Admission Copay A fixed dollar amount You pay for each hospital admission. Note: When You are admitted to a Hospital as an inpatient, You may have to pay Coinsurance for health care services administered during Your stay in addition to the applicable Copay amount for Your admission.	$100		$200	
Coinsurance Your share of the cost of a covered service, calculated as a percent of the Allowed Charge after the Deductible is met.	*You Pay*:	*Plan Pays*:	*You Pay:*	*Plan Pays*:
➢ Hospital, Specialized Health Care; Facilities and Home Health Care;	20%	100%	30%	70%
➢ Office Visits, Urgent Care, Outpatient Rehabilitation Services and Durable Medical Equipment;	20%	80%	40%	60%
➢ Inpatient Health Care Practitioner Visits and Surgeons' Fees; or	20%	80%	40%	60%
➢ Diagnostic Tests and Imaging. **Note:** Out-of-network urgent care and emergency room services are subject to the same Coinsurance as in-network urgent care and emergency room services.	20%	80%	40%	60%
Out-of-Pocket Maximum* The most You have to pay for covered in-network health care services in a calendar year. ➢ Per Individual ➢ Per Family	 $3,000 $6,000		 No limit No limit	

*The Out-of-Pocket Maximum for individuals applies to everyone, including those enrolled in family coverage. This means that no person can be required to pay more in annual medical costs than the individual Out-of-Pocket Maximum, even though a family unit as a whole may be subject to a higher overall Out-of-Pocket Maximum.

Out-of-Pocket Expenses You Always Incur
Under the Plan, each year, You will be responsible for paying the following expenses out of Your own pocket:

- Any applicable Deductible up to the applicable Out-of-Pocket Maximum;
- Any applicable Coinsurance up to the applicable Out-of-Pocket Maximum;
- Any applicable Copayments up to the applicable Out-of-Pocket Maximum;
- All expenses for health care services or supplies that are above the Allowed Amount as defined by the Plan;
- Any penalties You have to pay because You failed to get prior authorization or otherwise comply with the Utilization Management Program described in the Managed Health Care/Cost Containment Program chapter of this SPD;
- Balance billing amounts;
- All expenses that are not eligible expenses as defined by the Plan; and
- All expenses for health care services or supplies that are excluded by the Plan.

Deductible

Each deductible applies once per Calendar Year, even though You may have several different injuries or illnesses. Separate Deductibles apply to individuals and families, except as indicated below:

Family Limit on Deductibles- if two family members each incur expenses in excess of the deductible in any Calendar Year, any covered health care expenses incurred by other covered persons in the same family unit will not be subject to the Deductible.

Lifetime and Annual Limits on Major Medical Benefits

This Plan has no lifetime or annual limits on essential health benefits.

Note: Unless otherwise stated, "Per year" refers to a Calendar Year.

Important Information about COVID-19/Coronavirus Benefits
The Fund is committed to ensuring the health and safety of its participants. As a result, your health plan now offers COVID-19 benefits for a limited time.

Effective March 18, 2020 and through the announced end date of the COVID-19 public health emergency declared by the Secretary of the Department of Health and Human Services, the Fund will now cover the following services either In-Network or Out-of-Network with no cost sharing (including deductibles, copayments and coinsurance) to you:

- Diagnostic tests that are approved or authorized as described below to detect the virus that causes COVID-19, including the administration of such tests, for the following types of tests:
  - Tests to detect the virus that are approved, cleared or authorized by certain sections (as required by law) of the Federal Food, Drug and Cosmetic Act (the "Drug Act")
  - Tests for which the developer has requested, or intends to request, emergency use authorization under the Drug Act (and where such authorization has not been denied or the request is not submitted within a reasonable timeframe)
  - Tests developed in and authorized by a State that has notified HHS of its intention to review tests to diagnose COVID-19
  - Tests determined appropriate by HHS
- Items and services furnished to individuals during provider office visits (whether in-person or via telehealth), urgent care visits, and emergency room visits that result in an order for, or the administration of, the test described above, but only to the extent such items or services relate to the furnishing or administration of the test or the evaluation of whether the person needs the test.

The Fund waives any preauthorization (or other medical management) requirements for diagnostic tests for the Coronavirus.

Additionally, effective for services received on or after March 18th, 2020 through September 7th, 2020, if you receive treatment for COVID-19, the Fund will cover all ***in-network*** services at 100% with *no cost-sharing by you*. This means the Fund will waive co-pays for inpatient admissions, observation care, skilled nursing, ambulance, home care or any claim for otherwise-covered service filed with a diagnosis of confirmed COVID-19. This does not include pharmacy services or out-of-network treatment. These services will be covered at 100% of the allowed amount in accordance with the plan terms.

SCHEDULE OF MEDICAL BENEFITS This chart lists what You will pay. See also the medical exclusion and definition chapters of this document.			
Benefit Description	**In-Network**	**Out-of-Network**	**Limits and Additional Information**
Office Visit/Telephonic Visit			
Primary Care	20% coinsurance; subject to deductible	40% coinsurance; subject to deductible	
Specialist	20% coinsurance; subject to deductible	40% coinsurance; subject to deductible	
Inpatient Facility			
Inpatient Hospital Services	$100 copayment; subject to deductible	$200 copayment and 30% coinsurance; subject to deductible	Deductible applies before copayment and coinsurance.
Mental Health Care Mental Health Residential Care	$100 copayment; subject to deductible	$200 copayment and 30% coinsurance; subject to deductible	Deductible applies before copayment and coinsurance.
Substance Use Detoxification Substance Use Rehabilitation Substance Use Residential Care	$100 copayment; subject to deductible	$200 copayment and 30% coinsurance; subject to deductible	Deductible applies before copayment and coinsurance.
Skilled Nursing Facility	$100 copayment; subject to deductible	$200 copayment and 30% coinsurance; subject to deductible	Deductible applies before copayment and coinsurance. Limited to 60 days per year, combined in and out of network.
Physical Rehabilitation	$100 copayment; subject to deductible	$200 copayment and 30% coinsurance; subject to deductible	Deductible applies before copayment and coinsurance. Limited to 60 days per year, combined in and out of network.
Maternity Care	$100 copayment; subject to deductible	$200 copayment and 30% coinsurance; subject to deductible	Deductible applies before copayment and coinsurance.

Prosthetic - Implanted Devices	$100 copayment; subject to deductible	$200 copayment and 30% coinsurance; subject to deductible	Deductible applies before copayment and coinsurance
Routine Newborn Nursery Care	Covered in full	$200 copayment and 30% coinsurance; subject to deductible	Deductible applies to out-of-network before copayment and coinsurance.
Observation Stay	Covered in full; subject to deductible	30% coinsurance; subject to deductible	
Inpatient Professional Services			
Inpatient Hospital Surgery	20% coinsurance; subject to deductible	40% coinsurance subject to deductible	
Anesthesia	20% coinsurance; subject to deductible	40% coinsurance; subject to deductible	Includes anesthesia rendered for Inpatient, Outpatient, Office Visit, and Maternity services. Anesthesia does not require a prior authorization.
In-Hospital Physician Visits and Consultation	20% coinsurance; subject to deductible	40% coinsurance; subject to deductible	
Outpatient Facility Services			
Surgicenters and freestanding Ambulatory Centers Surgical Care	Covered in full; subject to deductible	30% coinsurance; subject to deductible	
Colonoscopy Facility Diagnostic	Covered in full subject to deductible	30% coinsurance; subject to deductible	
Preadmission Pre-Operative Testing	Covered in full; subject to deductible	30% coinsurance; subject to deductible	

SCHEDULE OF MEDICAL BENEFITS This chart lists what You will pay. See also the medical exclusion and definition chapters of this document.			
Benefit Description	**In-Network**	**Out-of-Network**	**Limits and Additional Information**
Diagnostic X-Ray	20% coinsurance; subject to deductible	40% coinsurance; subject to deductible	Advanced Imaging Services include PET scans, MRI, nuclear medicine, and CAT scans.
Routine X-Ray	20% coinsurance; subject to deductible	40% coinsurance; subject to deductible	
Advanced Imaging Services	20% coinsurance; subject to deductible	40% coinsurance; subject to deductible	Advanced Imaging Services include PET scans, MRI, nuclear medicine, and CAT scans.
Mammography Facility Diagnostic	Covered in full	40% coinsurance; subject to deductible	
Diagnostic Laboratory and Pathology Routine Laboratory and Pathology	20% coinsurance; subject to deductible	40% coinsurance; subject to deductible	
Diagnostic Testing	20% coinsurance; subject to deductible	40% coinsurance; subject to deductible	
Radiation Therapy	20% coinsurance; subject to deductible	40% coinsurance; subject to deductible	
Chemotherapy	20% coinsurance; subject to deductible	40% coinsurance; subject to deductible	
Infusion Therapy	20% coinsurance; subject to deductible	40% coinsurance; subject to deductible	Included in the Home Care benefit and not covered as a separate benefit.
Dialysis	20% coinsurance; subject to deductible	40% coinsurance; subject to deductible	
Mental Health Care	20% coinsurance; subject to deductible	40% coinsurance; subject to deductible	Includes partial hospitalization.

Substance Abuse Care	20% coinsurance; subject to deductible	40% coinsurance; subject to deductible	Includes partial hospitalization.
Substance Use Family Counseling	20% coinsurance; subject to deductible	40% coinsurance; subject to deductible	
Autism Applied Behavior Analysis	Not Covered	Not Covered	
Pulmonary Rehabilitation	20% coinsurance; subject to deductible	40% coinsurance; subject to deductible	
Cardiac Rehabilitation	20% coinsurance; subject to deductible	40% coinsurance; subject to deductible	
Home Care			
Home Care	Covered in full; subject to deductible	30% coinsurance; subject to deductible	Limited to 40 visits per year, combined in and out of network.
Home Infusion Therapy	Covered in full; subject to deductible	30% coinsurance; subject to deductible	
Hospice Care			
Hospice Care (Inpatient and Outpatient)	Covered in full; subject to deductible	30% coinsurance; subject to deductible	Limited to 180 days per year, combined in and out of network and combined inpatient and outpatient.
Professional Services			
Outpatient Hospital and Ambulatory Surgery	20% coinsurance; subject to deductible	40% coinsurance; subject to deductible	
Office Surgery	20% coinsurance; subject to deductible	40% coinsurance; subject to deductible	
Colonoscopy Professional Diagnostic	20% coinsurance; subject to deductible	40% coinsurance; subject to deductible	

SCHEDULE OF MEDICAL BENEFITS This chart lists what You will pay. See also the medical exclusion and definition chapters of this document.			
Benefit Description	**In-Network**	**Out-of-Network**	**Limits and Additional Information**
Diagnostic X-Ray	20% coinsurance; subject to deductible	40% coinsurance; subject to deductible	Advanced Imaging Services includes PET scans, MRI, nuclear medicine, and CAT scans.
Routine X-Ray	20% coinsurance; subject to deductible	40% coinsurance; subject to deductible	
Advanced Imaging Services	20% coinsurance; subject to deductible	40% coinsurance; subject to deductible	Advanced Imaging Services include PET scans, MRI, nuclear medicine, and CAT scans.
Mammography Professional Services	Covered in full	40% coinsurance; subject to deductible	
Diagnostic Laboratory and Pathology Routine Laboratory and Pathology	20% coinsurance; subject to deductible	40% coinsurance; subject to deductible	
Diagnostic Testing	20% coinsurance; subject to deductible	40% coinsurance; subject to deductible	
Radiation Therapy	20% coinsurance; subject to deductible	40% coinsurance; subject to deductible	
Chemotherapy	20% coinsurance; subject to deductible	40% coinsurance; subject to deductible	
Infusion Therapy	Covered under Home Care benefit	Covered under Home Care benefit	Included in the Home Care benefit and not covered as a separate benefit.
Dialysis	20% coinsurance; subject to deductible	40% coinsurance; subject to deductible.	
Mental Health Care	20% coinsurance; subject to deductible.	40% coinsurance; subject to deductible.	

Substance Abuse Care	20% coinsurance; subject to deductible	40% coinsurance; subject to deductible	
Maternity Care	20% coinsurance; subject to deductible	40% coinsurance; subject to deductible	
Additional Surgical Opinion	20% coinsurance; subject to deductible	40% coinsurance; subject to deductible	
Second Medical Opinion for Cancer	20% coinsurance; subject to deductible	40% coinsurance; subject to deductible	
Pulmonary Rehabilitation	20% coinsurance; subject to deductible	40% coinsurance; subject to deductible	
Cardiac Rehabilitation	20% coinsurance; subject to deductible	40% coinsurance; subject to deductible	
Office Visits- Diagnostic	20% coinsurance; subject to deductible	40% coinsurance; subject to deductible	Covered for the diagnosis and treatment of injury, disease and medical conditions. All professional provider specialties are included. Office visits may include house calls.
Autism Applied Behavior Analysis	Not Covered	Not Covered	
TeleMedicine Program - MDLIVE	PCP/Specialist - $10 Copayment	Not Covered	Covers online internet consultations between the member and the providers who participate in our telemedicine program for medical conditions that are not an emergency condition.

SCHEDULE OF MEDICAL BENEFITS This chart lists what You will pay. See also the medical exclusion and definition chapters of this document.			
Benefit Description	**In-Network**	**Out-of-Network**	**Limits and Additional Information**
Chiropractic Care	50% coinsurance; subject to deductible	50% coinsurance; subject to deductible	Maximum benefit of $550 per person, combined in and out of network.
Allergy Testing	20% coinsurance; subject to deductible	40% coinsurance; subject to deductible	Allergy Testing includes injections and scratch and prick tests.
Allergy Treatment Including Serum	20% coinsurance; subject to deductible	40% coinsurance; subject to deductible	Includes desensitization treatments (injections & serums)
Eye Exams Diagnostic	20% coinsurance; subject to deductible	40% coinsurance; subject to deductible	
Hearing Evaluations Diagnostic	20% coinsurance; subject to deductible	40% coinsurance; subject to deductible	
Hearing Evaluation Routine	Covered in full up to Maximum benefit.	Covered in full up to Maximum benefit.	Maximum benefit of $1,000 per person every 3 years towards the cost of hearing aids and exam, combined in and out of network.
Hearing Aids	Covered in full up to Maximum benefit.	Covered in full up to Maximum benefit.	Maximum benefit of $1,000 per person every 3 calendar years towards the cost of hearing aids and exam, combined in and out of network.

Rehab and Habilitation - Outpatient Facility and Outpatient Professional Services			
Physical Rehabilitation	20% coinsurance; subject to deductible	40% coinsurance; subject to deductible	
Occupational Rehabilitation	20% coinsurance; subject to deductible	40% coinsurance; subject to deductible	
Speech Rehabilitation	20% coinsurance; subject to deductible	40% coinsurance; subject to deductible	
Preventive Services			
Adult Physical Examination	Covered in full	30% coinsurance; subject to deductible	
Adult Immunizations	Covered in full	30% coinsurance; subject to deductible	
Well Child Visits and Immunizations	Covered in full	30% coinsurance; subject to deductible	
Routine GYN Visit	Covered in full	30% coinsurance; subject to deductible	
Family Planning	Covered in full	40% coinsurance; subject to deductible	
Pre/Post-Natal Care	Covered in full	40% coinsurance; subject to deductible	
Mammography Screening Professional	Covered in full	40% coinsurance; subject to deductible	
Colonoscopy Screening Professional	Covered in full	40% coinsurance; subject to deductible	
Bone Density Screening Professional	Covered in full	40% coinsurance; subject to deductible	
Preventive Facility Services			
Cervical Cytology Preventative	Covered in full	30% coinsurance; subject to deductible	
Mammography Screening Facility	Covered in full	30% coinsurance; subject to deductible	
Colonoscopy Screening Facility	Covered in full	30% coinsurance; subject to deductible	
Bone Density Screening Facility	Covered in full	30% coinsurance; subject to deductible	
Preventive Professional Services			

SCHEDULE OF MEDICAL BENEFITS This chart lists what You will pay. See also the medical exclusion and definition chapters of this document.			
Benefit Description	**In-Network**	**Out-of-Network**	**Limits and Additional Information**
Prostate Cancer Screening	Covered in full	40% coinsurance; subject to deductible	
Mammography Screening Professional	Covered in full	40% coinsurance; subject to deductible	
Colonoscopy Screening Professional	Covered in full	40% coinsurance; subject to deductible	
Bone Density Screening Professional	Covered in full	40% coinsurance; subject to deductible	
Additional Benefits			
Autologous Blood Banking	Not Covered	Not Covered	
Treatment of Diabetes Insulin & Supplies	20% coinsurance; subject to deductible	40% coinsurance; subject to deductible	Limited to a 30-day supply for retail pharmacy or a 90-day supply for mail order pharmacy. More detail is available in the Prescription Drug section of the SPD.
Diabetic Equipment and Education	20% coinsurance; subject to deductible	40% coinsurance; subject to deductible	Non-durable diabetic supplies and insulin covered under Pharmacy Benefit administered by Express Scripts.
Durable Medical Equipment	20% coinsurance; subject to deductible	40% coinsurance; subject to deductible	Antiembolism and vascular support garments (e.g., Jobst) limited to two (2) per year.

Medical Supplies	20% coinsurance; subject to deductible	40% coinsurance; subject to deductible	
Mastectomy Prosthesis	20% coinsurance; subject to deductible	40% coinsurance; subject to deductible	
Orthotics	20% coinsurance; subject to deductible	40% coinsurance; subject to deductible	Orthotics (except for feet) subject to a $3,000 max per claim.
Foot Orthotics	20% coinsurance; subject to deductible	40% coinsurance; subject to deductible	Limited to a $1,000 annual maximum for all foot orthotics.
Prosthetic - External Benefit	20% coinsurance; subject to deductible	40% coinsurance; subject to deductible	Wigs not covered
Reproductive and Fertility Services	Not covered	Not covered	
Breast Pump Purchase or Rental	Covered in full	40% coinsurance; subject to deductible	1 Rental or Purchase per pregnancy
Acupuncture	Not Covered	Not covered	
Private Duty Nursing	Not covered	Not covered	
PUVA Treatment	20% coinsurance; subject to deductible	40% coinsurance; subject to deductible	
Biofeedback	Not Covered	Not covered	
Nutritional Therapy	Not Covered	Not covered	
Gene Therapy CAR-T Therapy	Not Covered	Not covered	Note: Only the drugs will be excluded. Routine services associated with treatment (such as lab testing) may be covered.
Diagnosis			
Temporomandibular Joint (TMJ)	Not Covered	Not Covered	
Nutritional Counseling	PCP/Specialist - Included Subject to Deductible	Included Subject to Deductible	
Inherited Metabolic Disorder - PKU	PCP/Specialist - Included Subject to Deductible	Included Subject to Deductible	

SCHEDULE OF MEDICAL BENEFITS This chart lists what You will pay. See also the medical exclusion and definition chapters of this document.			
Benefit Description	**In-Network**	**Out-of-Network**	**Limits and Additional Information**
Organ and Bone Marrow Transplants	PCP/Specialist - Included Subject to Deductible	Included Subject to Deductible	
Elective Sterilization	PCP/Specialist - Included Subject to Deductible	Included Subject to Deductible	
Accidental Dental	PCP/Specialist - Included Subject to Deductible	Included Subject to Deductible	Treatment for accidental injury to teeth or jaws must be received by a Dentist or Physician within twelve (12) months of injury.
Dental Oral Surgery	PCP/Specialist - Included Subject to Deductible	Included Subject to Deductible	Treatment for accidental injury to teeth or jaws must be received by a Dentist or Physician within twelve (12) months of injury.
Emergency Room Facility			
Facility Emergency Room Visit	Covered in full; subject to deductible	Covered in full; subject to in-network deductible	Emergency services are covered worldwide if provided by a hospital facility.
Emergency Room Professional			
Physician Emergency Room Visit	20% coinsurance; subject to deductible	20% coinsurance; subject to in-network deductible	Emergency services are covered worldwide if provided by a hospital facility.
Transportation			
Prehospital Emergency Transportation- Ground or Water	Covered in full; subject to deductible	Covered in full; subject to in-network deductible	Non-emergency transportation services are not covered.

Air Ambulance	Amount up to Plan Allowance; subject to deductible	100% of the Centers for Medicare and Medicaid Services Provider fee schedule, unadjusted for geographic locality, or the Provider's charge, if less	The Plan will pay Air Transportation only covered as medically necessary due to inaccessibility by ground transport and/or use of ground transport would be detrimental to the health status of the patient.
Urgent Care			
Urgent Care Center Facility Visit	Covered in full; subject to deductible	Covered in full; subject to in-network deductible	
Urgent Care Professional			
Physician Urgent Care Center Visit	20% coinsurance; subject to deductible	20% coinsurance; subject to in network deductible	
Physician Office Visit for Urgent Care	20% coinsurance; subject to deductible	20% coinsurance; subject to in network deductible	
Charges Related to a Mastectomy			
Your benefit Coverage includes charges incurred by You or Your beneficiary in connection with a mastectomy Covered by the Plan, in a manner determined in consultation with the attending Physician and You or Your beneficiary, for: (1) reconstruction of the breast on which the mastectomy has been performed; (2) surgery and reconstruction of the other breast to produce a symmetrical appearance; and (3) prostheses and Treatment of physical complications at all stages of the mastectomy, including lymphedemas, provided you/your beneficiary elect breast reconstruction in connection with such mastectomy.			
Mothers and Newborns			
In accordance with Federal law, the Plan may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn Child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, the Plan may not, under Federal law, require that a Provider obtain authorization from the Plan for prescribing a length of stay not in excess of 48 hours (or 96 hours).			

PREVENTIVE SERVICES

To the extent required by applicable law, this Plan covers a comprehensive range of preventive services that are recommended by physicians and other experts without cost-sharing (i.e., without charges such as copayments, coinsurance or deductibles) when the services are provided by an in-network provider. Specifically, the covered preventive services include the following categories of services:

1. Evidence-based preventive services: Preventive services with a "grade" of A or B by the U.S. Preventive Services Task Force, including, but not limited to, breast and colon cancer screenings, screening for vitamin deficiencies during pregnancy, screenings for diabetes, high cholesterol and high blood pressure, and tobacco cessation counseling.

2. Routine vaccines: Standard vaccines recommended by the Advisory Committee on Immunization Practices ranging from routine childhood immunizations to periodic tetanus shots for adults.

3. Preventive services for children recommended and developed by the Health Resources and Services Administration with the American Academy of Pediatrics, including, but not limited to, regular pediatrician visits, vision and hearing screening, developmental assessments, immunizations, and screening and counseling to address obesity and help children maintain a healthy weight.

4. Preventive services for women: These services have been identified by the independent Institute of Medicine and endorsed by the Health Resources and Services Administration. They include: (1) Breastfeeding support, supplies, and counseling; (2) screening and counseling for interpersonal and domestic violence; (3) screening for gestational diabetes; (4) DNA testing for high-risk strains of HPV; (5) counseling r egarding sexually transmitted infections, including HIV; (6) screening for HIV; (7) contraceptive methods and counseling; and (8) well woman visits.

The guidelines for preventive services covered by the Plan are regularly updated to reflect new scientific and medical advances. As new services are approved, the Plan will cover them with no cost-sharing for plan years beginning one year later. A list of the covered services is available at **https://www.healthcare.gov/what-are-my-preventive-care-benefits/.**

Sometimes preventive services are included with other services as part of an office visit. The Plan may impose cost-sharing to an office visit: (a) if the preventive service is billed separately (or is tracked as individual encounter data separately) from the office visit; or (b) if the recommended preventive service is not billed separately (or is not tracked as individual encounter data separately) from the office visit, the primary purpose of the office visit is something other than the delivery of the recommended preventive service. In such a case, the Plan may still impose a copayment, coinsurance or a deductible. The Plan may not impose cost sharing to an office visit if: (a) the preventive service is not billed separately (or is not tracked as individual encounter data separately) from the office visit; and (b) the primary purpose of the visit is the delivery of the recommended preventive service. The Plan may impose cost-sharing for these preventive services when provided by an out-of-network provider.

Participation in Clinical Trials

The Fund shall not cease coverage for any participant's or beneficiary's participation in a clinical trial or deny coverage for routine patient costs for items and services furnished in connection with a participant's or beneficiary's participation in a clinical trial, to the extent required by the regulations of the United States Department of Health and Human Services. The Trustees reserve the right to use reasonable medical management techniques to determine the frequency, method, treatment, or setting for an item or service to the extent not specified in the particular recommendation or guideline. For instance, if an item or service described above is billed separately (or is tracked as individual encounter data separately) from an office visit, then the Trustees reserve the right to impose cost-sharing requirements with respect to the office visit. If an item or service is not billed separately (or is not tracked as individual encounter data separately) from an office visit and the primary purpose of the office visit is not the delivery of such an item or service, then the Trustees reserve the right to impose cost-sharing requirements with respect to the office visit.

MEDICAL EXCLUSIONS/LIMITATIONS

The Plan will not provide benefits for the following services or expenses, regardless of medical necessity or recommendation from a physician or healthcare practitioner. These limitations and exclusions include, but are not limited to, the items below:

General

1. Expenses exceeding any Allowed Charges, as defined in this Plan.

2. Expenses which exceed any Plan benefit limitation or maximum allowable payment.

3. Expenses used to satisfy Plan Deductibles or which are applicable/eligible for consideration under any other Plan of the employer.

4. Expenses for services/supplies not prescribed or recommended by a Physician or health care provider.

5. Expenses for services/supplies for which there is no legal obligation to pay, that are free, or would not be made except for the availability of benefits under this Plan.

6. Expenses provided as a covered benefit under a program of the government, its subdivisions and agencies to which the individual is eligible including, but not limited to, active duty, armed forces, Medicare, Medicaid, TRICARE, etc., except as otherwise required by law.

7. Expenses for services/supplies/medications/devices which are Experimental or Investigational or mainly for research purposes (i.e.: clinical trials), as defined in this Plan.

8. Injury, illness, sickness, condition, or expenses resulting from war (or any act of war whether the war is declared or undeclared), riot, insurrection, rebellion, invasion or aggression.

9. Injury or illness resulting from or sustained as a result of commission or attempted commission of an illegal act, unless deemed as the result from a physical medical condition or a psychiatric disorder.

10. Charges related to an injury or illness covered by any state or federal Workers' Compensation, employer's liability, Occupational Disease law or similar law.

11. Treatment or services rendered outside the United States of America or Canada except for Injury or medical Emergency as defined by this Plan.

12. Expenses for preparing medical reports, bills or claim forms, mailing/shipping/handling expenses, fees if You or Your Dependents fail to keep an appointment, telephone calls, or photocopying fees.

13. Expenses for and related to travel (non-emergency transportation, lodging, meals and related expenses) of a physician, health care professional or covered person and family unless pre-approved by this Plan.

14. Charges for the professional or nonprofessional services performed by a person who ordinarily resides in Your household or is related (by blood or law) to the covered person, including but not limited to a spouse, parent, child, brother, sister-in-law, etc.

15. Personal comfort services or items including, but not limited to, guest meals, television, radio, telephone, beautician services, etc.

16. Complications arising from any non-covered surgery/service/procedure.

17. Expenses incurred before or after the date coverage is in effect.

18. Expenses related to the surgical correction of refractive errors and refractive keratoplasty procedures, including but not limited to, radial keratotomy (RK) and automated lamellar keratoplasty (ALK) or Lasik.

19. Vision therapy (orthoptics) and supplies.

20. Expenses related to the diagnosis and treatment of refractive errors including eye examinations, purchase, fitting and repair of eyeglasses or lenses and associated supplies, except as provided by the Optical/Vision Plan described in the Schedule of Medical Benefits.

21. Expenses for the purchase, servicing, fitting and repair of hearing aid devices including but not limited to hearing aids, cochlear implants, etc., except as provided under the Hearing Aid Benefit as described in the Schedule of Medical Benefits.

22. Medication which is non-FDA approved for the application for which it is prescribed, Experimental/Investigational or does not require a prescription (e.g. over the counter).

23. Vaccinations, immunizations, inoculations or preventive injections, except as related to the treatment of an injury or exposure such as anti-rabies, tetanus, anti-venom, immunoglobulin and as provided by Well Child Visits or the Basic Physical Exam Benefit under the Schedule of Medical Benefits, or except as required by applicable law.

24. Smoking cessation medication/devices except as payable under the Prescription benefit described in the Schedule of Medical Benefits, or except as required by applicable law.

25. Expenses related to the medical or surgical treatment of obesity including, but not limited to, gastric restrictive intestinal bypass and reversal procedures, adjustable gastric banding, weight loss programs, dietary instructions, nutritional supplements, and complications thereof. Except as provided in the Schedule of Medical Benefits, or except as required by applicable law.

26. Nutritional supplements including, but not limited to, home meals, foods, diets, vitamins, minerals, naturopathic or homeopathic services/substances.

27. Expenses incurred for health club, exercise or gymnasium membership or visits or home exercise equipment.

28. Expenses related to the diagnosis and treatment of infertility or fertility or complications thereof including, but not limited to, services, drugs and procedures or devices to achieve fertility, in-vitro fertilization, intrafallopian tube transfers, artificial insemination, embryo transfer, surrogate services, donor semen, adoption and reversal of sterilization (vasectomies/tubal ligations) procedures.

29. Medical, prescription, and surgical expenses related to transsexual sex reassignment surgery, or services in preparation for such procedures or complications thereof.

30. Nutritional Therapy

31. Expenses related to the medical or surgical treatment of sexual dysfunction or inadequacy, and complications thereof, except as provided under the Pharmacy Benefit.

32. Expenses related to insertion and maintenance of an artificial heart, organ or related devices (except kidney dialysis), and complications thereof.

33. Expenses related to non-human organ or tissue transplants or implants.

34. Expenses for education, job training and vocational rehabilitation.

35. Massage therapy, Rolfing therapy, aroma therapy, chelation therapy, and related services.

36. Hypnosis, hypnotherapy and biofeedback.

37. Expenses for rehabilitation services (e.g., physical, occupational, speech and inpatient rehabilitation confinement) for individuals not actively participating or able to participate in a purposeful manner with the therapy/rehabilitation services as determined by the Plan or its designee, including, but not limited to, coma stimulation programs and services.

38. Expenses for rehabilitation services which maintain therapy goals and do not provide significant continued functional improvement.

39. Speech therapy for functional or restorative purposes including, but not limited to, stuttering, stammering and conditions of psychoneurotic origin.

40. Expenses for injury to Sound and Natural Teeth except to restore to a functional level as a result of a traumatic injury.

41. Expenses for dental services and supplies including, but not limited to, orthodontics, general dentistry, extractions, ridge augmentation, dentures, etc., except as payable by this Plan's Dental Benefit.

42. Oral surgery except as related to acute injury, tumors, cysts, or abscess of the gum, cheek, lip, tongue, hard and soft palate. No payment for conditions related to impacted teeth, root canal, gingivectomy or other services except as covered under the Dental Benefits.

43. Non-durable or disposable supplies, except as provided in the Schedule of Medical Benefits.

44. Expenses for services and supplies not deemed Medically Necessary, which do not meet the definition of Corrective Appliances or the definition of Durable Medical Equipment and which exceed standard model fees including, but not limited to: mattresses, wigs, artificial hairpieces or implants, corrective dental, optical or hearing appliances, air conditioners, swimming pools, hot tubs/spas, air purifiers, vehicles, elevators, bicycles, exercise equipment etc., except as provided in the Schedule of Medical Benefits.

45. Reconstructive surgery or procedures except as covered in the Schedule of Medical Benefits.

46. Expenses in connection with cosmetic/plastic surgery services, drugs or treatments, as determined by the Plan or its designee, which are primarily intended to improve appearance without restoring body function.

47. Expenses related to Intellectual Disability, learning disorders, with or without hyperactivity, developmental disabilities, or vocational and transsexual transitional counseling.

48. Private duty nursing/health care personnel.

49. Expenses for homemaker, custodial, child/adult day care or personal care, except as provided under the Specialized Healthcare Facilities Benefit in the Schedule of Medical Benefits.

50. Expenses for a private room, unless medically necessary as determined by the Plan or its designee.

51. Expenses associated with Custodial (non-skilled) Care including: confinement in a sanitarium, extended care facility, residential treatment center (except for covered mental health and substance abuse services to the extent applicable), halfway house, group home, school infirmary or educational facility, or for environmental change.

52. Acupuncture or acupressure.

53. Facility charges if You leave a health care facility, against the medical advice of the attending Physician (discharged AMA), within seventy-two (72) hours of the admission.

54. Expenses related to physical examinations and testing necessary for employment, government, insurance, school, camp, recreation, sports or other third party requests.

55. Routine physical examinations or health checkups for a purpose other than for treatment or diagnosis of a specific illness, symptom, complaint or injury, except as provided under the Well Child or Basic Physical Exam Benefit in the Schedule of Medical Benefits.

56. Expenses for services of a medical student, intern or resident.

57. Charges for purchase, rental, repair, maintenance, construction or modification to a home, residence, business or vehicle.

58. Expenses related to education including, but not limited to, computers, software, printers, books, tutoring, visual/auditory/speech aides, etc.

59. Expenses associated with an attempt at suicide or from a self-inflicted injury or illness and complication thereof, unless deemed as the result of a physical or mental medical condition.

60. Expenses related to illness or injury as a result of a person operating a vehicle with a blood alcohol level which equals or exceeds the motor vehicle or state operation legal limit, unless deemed as the result from a physical or mental medical condition.

61. For injuries or illnesses arising from an automobile, motorcycle or related accident if personal injury protection coverage or no-fault benefits are recoverable under state law, other than as noted in the section entitled Coordination of Benefits (COB) – Non-Duplication of Benefits, General Provisions/Limitations, not obtaining or maintaining any state requirements for licensing and/or insurance.

62. Expenses for which some other third party is responsible.

63. **Gene Therapy:** Expenses related to any course of treatment involving (1) the replacement of a gene that causes an identified medical problem with a healthy gene that does not; (2) introducing genes to fight disease; or (3) inactivating genes that cause medical problems or function improperly.

SCHEDULE OF DENTAL BENEFITS

Dental benefits are treated as a stand-alone (or excepted) benefit under the Health Insurance Portability and Accountability Act (HIPAA) and the Affordable Care Act (ACA). Subject to the terms and conditions, including maximums listed in this SPD, the Plan covers expenses determined to be Medically Necessary, appropriate and reasonable for the diagnosis or treatment of an injury or illness and which meet standards accepted by the American Dental Association (ADA), as defined in this Plan.

The following schedule summarizes annual and lifetime benefit maximums:

Annual Out-of-Pocket Maximum for Your eligible Dependents under the age of 19.	$2,500
Annual Dental Services Maximum for You and Your eligible Dependents age 19 and older. (excluding Orthodontia)	$1,500
Annual Dental Services Maximum for Your eligible Dependents under the age of 19. (excluding Orthodontia)	Unlimited (Based upon Allowed Charges.)
Per person, per Lifetime Orthodontia Maximum Diagnosis and construction and insertion of orthodontic appliance, including all previous prophylactic appliances for tooth guidance.	$2,050
Maximum Active Orthodontia Benefit	$550 for the initial insertion of orthodontic appliance. 20 months; not to exceed $75 per month to a maximum of $1,500.

Note: The term LIFETIME refers to the entire period of time a covered person is a participant in this Plan, regardless of any periods of ineligibility.

Alternate Procedures
An alternate procedure is the most cost-effective treatment of a dental condition, which will provide a professionally acceptable result as determined by national standards of dental practice.

Consideration is given to the current clinical oral condition based upon the diagnostic material submitted by the dentist. This Plan will only reimburse You for the cost of an alternate procedure where applicable, even if You have received a more costly procedure. To avoid incurring higher out of pocket costs, see the Pretreatment Review Section below.

Pretreatment Review (Dental)
A proposed course of treatment estimated to be over $150 should be submitted by Your dentist for review prior to the actual performance of services. Evaluation of the course of treatment is subject to alternate procedures and does not guarantee payment of benefits when the actual services are performed.

Advance Claim Review
Advance Claim Review is intended to tell You, in advance, what Your expenses for a course of treatment are likely to be and to tell You and the dentist how much of these expenses will be covered by the Plan. A course of treatment is a planned program of one or more dental services or supplies provided for the treatment of a condition diagnosed by the attending dentist as a result of an oral examination. A course of treatment starts when the dentist first treats the dental condition involved.

Advance Claim Review is intended only for courses of treatment involving dental charges of $150 or more. Although services for emergency treatment, oral examinations (including prophylaxis) and dental X-rays are considered a part of a course of treatment, these services are not subject to the Advance Claim Review provision.

Advance claim review works this way:

Your dental office should submit to the Fund Office a description of the proposed services and supplies, and the estimated charges, for any course of treatment before it starts, along with the supporting information (for example, X-rays) required by the Fund Office, as described in the Limitations section.

The Fund Office will then determine the amount of benefits available and You and the dentist will be notified as soon as possible of the amount of estimated benefits payable under the Plan for that course of treatment.

If Advance Claim Review is not made, benefits will be determined as if Advance Claim Review had been made. However, see the Limitations section for the provisions that apply if the Fund is unable to verify any covered dental expenses.

Coverage Guidelines for Dental Charges
The incurred date for a dental charge is considered to be the date of service or the date the supply is furnished, except for the following:

- On the date of preparation of the tooth or teeth involved for fixed partial dentures, crowns, inlays or onlays.
- On the date the impression was taken for removable partial or complete dentures.
- On the date the tooth was opened for root canal therapy or endodontics.

Basic Dental Benefits
If You incur "covered dental expenses", as described on the following pages, the dental expense benefits pay 80% of such Allowed Charges. Not more than $1,500 of non-orthodontic covered dental expenses will be paid in any one Calendar Year for You and Your eligible dependents age 19 and older. The $1,500 maximum does not apply for eligible dependents under the age of 19. Once Your eligible dependent reaches the age of 19, they will be limited to the $1,500 benefit for the remainder of the Calendar Year in which they turn 19 and thereafter.

No more than $2,050 of Orthodontic expenses will be paid as a lifetime maximum for all eligible participants. The benefits payable are subject to the definitions, exclusions and limitations, and special provisions in this booklet.

Annual Out-of-Pocket Maximum (Eligible Dependents under the age of 19)
You will note that most covered dental expenses are payable at the rate of 80% and You are responsible for paying the remaining 20%. When 20% of such expenses incurred by an Eligible Dependent under the age of 19 in a calendar year equals $2,500 any benefits payable for such expenses incurred by the family member in the rest of that year will be payable at 100%, rather than 80%, subject to the benefit maximums noted in the Schedule of Dental Benefits.

SCHEDULE OF DENTAL BENEFITS

The following table summarizes covered dental expenses and includes brief reference to applicable limitations/exclusions and explanations. Covered dental expenses include the eligible charges by a licensed dentist and licensed dental hygienist. The Plan pays 80% of Allowed Charges. **The fact that a dentist has prescribed, approved, recommended or performed a service does not make it payable under this dental benefit.**

Benefit Description	Additional Limitations and Explanations	Plan Benefits Payable (Based on Allowed Charges)
Preventive Services • Oral examination. • Prophylaxis (cleaning of the teeth). • Examination in connection with emergency palliative treatment. • Examination for consultation purposes. • Bitewing x-rays. • Full mouth x-rays. • Topical application of sodium or stannous fluoride.	• Subject to the annual (for those ages 19 and older) and lifetime benefit maximums. • Oral examination limited to twice a Calendar Year, but no more than once every six (6) months. • Prophylaxis, scaling, cleaning and polishing limited to twice a Calendar Year, but no more than once every six (6) months. • Bitewing x-rays limited to once in a period of twelve (12) consecutive months. • Full mouth x-rays limited to once in a period of thirty-six (36) consecutive months. • Fluoride limited to family members under the age of 15 and limited to not more than twice per Calendar Year.	80%

Benefit Description	Additional Limitations and Explanations	Plan Benefits Payable (Based on Allowed Charges)
Basic Services • Dental x-rays as required for diagnosis of a specific dental condition. • Application of sealants on bicuspid and posterior teeth (molars). • Injection of necessary antibiotic drugs by the attending dentist. • Oral surgery. • Administration of local, general anesthesia or intravenous sedation in connection with oral surgery and other covered dental services. • Tooth extractions. • Amalgam, silicate, acrylic, synthetic porcelain and composite filling restoration for decayed/broken teeth. • Treatment of periodontal and other diseases of the gums and supporting structures of the mouth (gingival and/or alveolar bone). • Space maintainers. • Occlusal adjustment, only in connection with periosurgery. • Endodontic treatment, including root canal therapy. • Laboratory services including cultures, necessary for diagnosis/treatment of a specific dental condition. • Tooth implants, transplants, grafting and removal of implants/grafts.	• Subject to the annual (for Dependents ages 19 and older) and lifetime benefit maximums. • Application of sealants limited to permanent bicuspids and molars, once in a period of thirty-six (36) consecutive months, for children under the age of 19. • Oral surgery limited to removal of impacted teeth or as necessary for teeth covered partially or totally by bone, root canal treatment or gingivectomy. • Space maintainers for the premature loss of posterior primary teeth limited to children under the age of 15.	• 80%

Benefit Description	Additional Limitations and Explanations	Plan Benefits Payable (Based on Allowed Charges)
Major Services • Installation of crowns, bridges, or partials.	• Subject to the annual (for Dependents ages 19 and older) and lifetime benefit maximums.	• 80%
• Onlays and crowns, including porcelain for the front teeth only. • Repair or re-cementing of crowns, inlays, or onlays. • Initial installation of dentures. • Adjusting, relining or re-basing of removable dentures. • Replacement of an existing partial or full removable denture or fixed bridgework; the addition of teeth to an existing partial or removable denture; or bridgework to replace teeth which were extracted if satisfactory evidence is presented to the Plan that such change is required due to the reasons noted in the limitations and explanations section to the right. • Initial installation of fixed bridgework (including wing attachments, inlays and crowns as abutments) to replace natural teeth. Adjustments are payable for the six (6) month period following initial installation. • Precision or semi-precision attachments for prosthetic devices. • Gold restorations.	Installation of fixed bridgework must be completed within twelve (12) months of the extraction. For replacement of an existing partial or full removable denture: • The replacement or addition of teeth is necessary to replace one or more teeth extracted after the existing denture or bridgework was installed and the addition of teeth is completed within twelve (12) months of the extraction. • The existing denture or bridgework cannot be made serviceable and was installed at least five (5) years prior to the replacement date. • The existing denture is an immediate temporary denture replacing one or more natural teeth extracted while participating in the Plan. Replacement by a permanent denture is required. The replacement must take place within twelve (12) months from the placement of the temporary denture. • The replacement is due to accidental injury requiring oral surgery and the replacement takes place within 15 months of the accident.	

Benefit Description	Additional Limitations and Explanations	Plan Benefits Payable (Based on Allowed Charges)
Orthodontia Services • This orthodontia benefit is for non-surgical services utilized to correct malocclusion (alignment of the teeth and or jaws) which significantly interferes with their function. • Expenses related to orthodontia will be covered only when one or more of the conditions listed in the Limitations and Explanations section is present. • The initial installation of orthodontic appliances for an active course of orthodontia treatment. • Adjustment of active orthodontia appliances.	• Subject to the lifetime orthodontia benefit maximums. Coverage for orthodontia: • The existence of an extreme buccolingual version of the teeth, either unilateral or bilateral. (The teeth are pushed out toward the cheek or in toward the tongue on one or both sides.) • A protrusion of the upper teeth of more than 3 millimeters. • A protrusion or retrusive relation of the maxillary or mandibular arch. (The upper and lower teeth buck back.) • Payment for orthodontia benefits will not continue if treatment ceases for any reason. • Repair or replacement of orthodontia appliances not covered.	Limited to payment as follows: Diagnosis and construction and insertion of orthodontic appliance including all previous prophylactic appliances for tooth guidance: $550. Active orthodontia treatment: 20 months not to exceed $75 per month, up to a maximum of $1,500. Total amount payable per lifetime: $2,050.

Benefit Description	Additional Limitations and Explanations	Plan Benefits Payable (Based on Allowed Charges)
TMJ Syndrome • Non-surgical and surgical treatment of temporomandibular joint (TMJ) syndrome/dysfunction/disease.	• Limited to $250 per covered person, per year.	• $250 per person per year.

DENTAL EXCLUSIONS AND LIMITATIONS

The Plan will not provide benefits for the following services or expenses, regardless of medical necessity or recommendation from a dentist. These limitations and exclusions include, but are not limited to, the items below:

1. Expenses exceeding the Allowed Charges, as defined in this Plan.

2. Expenses for services and supplies not prescribed, recommended, or provided by a licensed Dentist or cleaning by a licensed dental hygienist.

3. Expenses for services and supplies for which there is no legal obligation to pay, are free, or would not be made except for the availability of benefits under this Plan.

4. Expenses for services, supplies and medication which are Experimental or Investigational, or mainly for research purposes, as defined in this Plan.

5. Injury or illness resulting from or sustained as a result of commission or attempted commission of an illegal act, unless deemed as the result from a physical or mental medical condition.

6. Injury, illness or expenses resulting from war (or any act of war whether the war is declared or undeclared), riot, insurrection, rebellion, invasion or aggression.

7. Charges related to an injury or illness covered by Worker's Compensation, occupational disease law or similar law.

8. Treatment or services rendered outside the United States of America, Canada, or Native American Sovereign territories except Accidental Injury or Dental Emergency as defined by this Plan.

9. Expenses for and related to travel (non-emergency transportation, lodging, meals and related expenses) of a dentist or physician, health care professional or covered person and family.

10. Expenses for preparing dental reports, bills or claim forms, mailing/shipping/handling expenses, fees for failing to keep an appointment, telephone calls or photocopying fees.

11. Charges for the professional or non-professional services performed by a person who ordinarily resides in Your household or is related (by blood or law) to the covered person to include, but not limited to, a spouse, parent, child, brother, sister-in-law, etc.

12. Expenses which are applicable or eligible for consideration under any other plan of the employer.

13. Complications arising from any non-covered surgery, service, or procedure.

14. Expenses provided as a covered benefit under a program of the government, its s ubdivisions and agencies to which the individual is eligible including, but not limited to, active duty, armed forces, Medicare, Medicaid, TRICARE, etc., except as otherwise required by law.

15. Expenses for cosmetic/plastic surgery services, drugs or treatments, as determined by the Plan or its designee, which will restore and/or improve bodily appearance without affecting body function. (i.e.: Teeth whitening)

16. Veneers or facings.

17. Expenses incurred before the date coverage is in effect or after the date of termination.

18. Expenses that exceed any Plan benefit limitation or maximum allowable payment.

19. Services rendered by anyone other than a covered dental care provider.

20. Any services received from a health maintenance organization if the individual is a participant in the health maintenance organization.

21. Training, educational instruction or materials, including but not limited to, dietary counseling, personal oral hygiene or dental plaque control.

22. Prescription drugs. (Prescription drugs are covered under the medical portion of this Plan.)

23. The replacement of a lost, stolen, or missing prosthetic device.

24. Duplicate prosthetic, dental and orthodontia appliances and devices.

25. Services and supplies for personalization or characterization of prosthetic devices.

26. Procedures and appliances including, but not limited to, items to increase vertical dimension, restore occlusion, stabilize tooth structure lost by wear/bruxism, splinting, and harmful habits, except as provided under the orthodontia benefit as outlined in the Schedule of Dental Benefits.

27. Athletic mouth guards and associated devices.

28. Myofunctional therapy.

29. Treatment, by any means, of jaw joint problems including temporomandibular joint dysfunction or disturbance syndrome and other craniomandibular disorders, or other conditions of the joint linking the jawbone and skull, and the muscles, nerves and other tissues related to that joint, except as provided by the Schedule of Dental Benefits.

30. Under certain circumstances the medical Plan will pay for the facility fees and anesthesia associated with Medically Necessary dental services covered by the dental Plan if the utilization review firm or claims administrator determines that hospitalization or outpatient surgery facility care is medically necessary to safeguard the health of the patient during the performance of dental services. No payment is extended toward the dentist or any assistant dental provider fees under this medical Plan.

31. Charges for prosthetic devices including bridges, crowns and fitting thereof, which were ordered while the individual was not covered under the Plan or which were ordered while the individual was covered under the Plan, but are finally installed or delivered more than 30 days after termination of coverage.

32. Anterior space maintainers.

33. Study model, molds or casts.

34. Gnathologic recordings for jaw movement/position.

35. In the event that an eligible person transfers from the care of one dentist to that of another dentist during the course of treatment, or if more than one dentist renders services for the same dental procedure, the Plan will not be liable for more than the amount it would have been liable had but one dentist rendered all the services during each course of treatment, nor will the Plan be liable for duplication of services.

36. Analgesia, sedation, hypnosis and related services provided for apprehension or anxiety.

37. Expenses associated with an attempt at suicide or from a self-inflicted injury or illness, and complication thereof, unless deemed as the result of a physical or mental medical condition.

38. Expenses related to illness or injury as a result of a person operating a vehicle with a blood alcohol level, which exceeds the motor vehicle or state operation legal limit, unless deemed as the result from a physical or mental medical condition.

39. Home use supplies, including but not limited to, toothpaste, toothbrush, water pick, fluoride, mouthwash, floss, etc.

40. Expenses related to injury of Sound and Natural Teeth. See the Schedule of Medical Benefits of this Plan for this coverage information.

41. Additional exclusions and limitations as per the Schedule of Dental Benefits section.

42. Expenses for which some other third party is responsible.

PRESCRIPTION DRUG BENEFIT

How the Plan Works

The Prescription Drug Benefit is self-insured and administered by Express Scripts. With the Prescription Drug Benefit, the amount You pay for prescription drugs is based on whether a prescribed drug is a generic, preferred brand, or non-preferred brand and whether You purchase the drug at a retail pharmacy or through Express Scripts' mail order program. All Coinsurance and copayment amounts are listed in the Schedule of Prescription Drug Benefits below.

When You fill a prescription at a retail pharmacy, You can receive up to the greater of a 30-day supply or 100 units of the prescribed drug. With the mail order program, You can save money because You pay for a two or two and a half-month supply but receive up to a 90-day (three-month) supply. Mail order is ideal for maintenance medication that You take on an ongoing basis for chronic conditions and illnesses.

Prescription Drug Formulary

The Plan uses the Express Scripts National Preferred Formulary for generic and brand name medications. The formulary is a list of commonly prescribed medications from which Your Physician or Health Care Practitioner may choose to prescribe. Medications selected for the formulary can safely and effectively treat most medical conditions while helping to keep costs down.

Not all prescription drugs are on the formulary. Non-formulary (or off-formulary drugs) are excluded (i.e., not covered) by the Plan. If You attempt to fill a prescription that is not on the National Preferred Formulary, the pharmacist will generally let You know and work with the prescribing physician or health care practitioner to find a comparable drug on the formulary to ensure coverage. If You fill a prescription for a non-formulary drug, You will pay the entire cost for the prescription.

Generic drugs are usually the lowest cost option available under the Plan. When You purchase generic drugs, You will pay a fixed Copayment amount for each prescription. Brand drugs will cost You more than generic drugs and are subject to Coinsurance with mandatory minimums and maximums. You will pay less for preferred brand drugs than non-preferred brand drugs because the Coinsurance minimum and maximums are lower for preferred brand drugs. Also, Your share of the cost of a drug depends on whether the drug is a specialty drug. In general, specialty drugs are used to treat a broad array of complex diseases that may require special handling, administration by infusion or injection, or specialized support. In addition, if You are prescribed a specialty drug, it can only be filled through the Accredo specialty pharmacy. Accredo is described in more detail below. All Coinsurance and Copayment amounts are listed in the Schedule of Prescription Drug Benefits below.

Please note that a drug's placement on National Preferred Formulary is subject to change. To find out whether a medication is on the formulary, or whether it is a preferred or non-preferred drug, call Express Scripts at the number listed in the Quick Reference Chart of Your SPD or on the back of Your ID card, or visit Express Scripts online at: **www.express-scripts.com**.

There may be exceptions for coverage of a non-formulary drug in certain circumstances. Use of drugs that are not on the formulary and thus not covered by the Plan must be approved through Express Scripts' exception process. The requests are evaluated on the basis of medical necessity, the individual's health and safety and the existence of other comparable alternatives. If You or Your physician would like to request an exception, Your physician must contact Express Scripts directly – the exception process must be initiated by Your physician.

	Retail (Greater of a 30-day supply or 100 units)	**Mail (90-day supply)**
NON-SPECIALTY PRESCRIPTION DRUGS		
Generic	$10 Copay	$20 Copay
Brand *Preferred*	20% Coinsurance ($20 Min/$40 Max)	20% Coinsurance ($50 Min/$100 Max)
Brand *Non-preferred*	20% Coinsurance ($40 Min/$80 Max)	20% Coinsurance ($100 Min/$200 Max)
SPECIALTY PRESCRIPTION DRUGS		
Generic	Not covered	20% Coinsurance ($300 Max per prescription)
Brand *Preferred*	Not covered	20% Coinsurance ($300 Max per prescription)
Brand *Non-preferred*	Not covered	20% Coinsurance ($400 Max per prescription)
Prescription Drug Out-of-Pocket Maximum		
Per Individual	$4,150	
Per Family	$8,300	

* The Out-of-Pocket Maximum for individuals applies to everyone, including those enrolled in family coverage. This means that no person can be required to pay more in annual prescription drug costs than the individual Out-of-Pocket Maximum, even though a family unit as a whole may be subject to the higher overall Out-of-Pocket Maximum.

Retail Pharmacy

Participating Pharmacies

Express Scripts has a national network of participating retail pharmacies, including most major chain pharmacies. To obtain a medication from a participating retail pharmacy, present Your prescription and Express Scripts identification card to a pharmacist. The pharmacist will fill Your prescription and charge You the applicable Coinsurance or Copayment amount. There are no claims forms to fill out unless You purchase medication at a non-participating pharmacy.

To find out whether a particular pharmacy participates in Express Scripts' network, to locate a participating pharmacy near You, or to obtain a list of participating pharmacies, contact Express Scripts at the number on the back of Your identification card or visit Express Scripts online at **www.express-scripts.com**.

Non-Participating Pharmacies
When You purchase a medication at a non-participating pharmacy, You may pay the full price at the pharmacy and then submit a prescription drug claim form and receipt to Express Scripts for reimbursement. Mail the completed claim form together with the receipt to the address on the form as soon as possible but no later than 12 months from the date of purchase. You'll be reimbursed the amount Express Scripts would have paid a participating pharmacy had You filled the prescription at the participating pharmacy, less the applicable Coinsurance or Copayment amount. This means You are responsible for the difference in cost between the non-participating pharmacy's charges and the participating pharmacy's charges.

Claim forms are available from Express Scripts at **www.express-scripts.com** or by calling the number on the back of Your identification card.

Mail-Order Program
If You take maintenance medications, You can save time and money by using the mail order program for Your medications. Maintenance medications are prescription drugs that You need to take regularly to treat a chronic condition or illness. Examples of the types of chronic conditions and illnesses treated with maintenance medication include:

- Asthma
- Diabetes
- Psychiatric disorders
- High blood pressure
- High cholesterol
- Ulcers

A maintenance medication can also be a drug that You take for three to six months and then discontinue. For example, an allergy medication that You take throughout the spring and summer could be considered a maintenance medication.

How to Use the Mail-Order Program
If You want to order prescription drugs through the mail order program follow these steps:

- Ask Your Physician or Health Care Practitioner to prescribe a 90-day supply of medication with up to three refills;
- If You need to begin taking the medication immediately, ask Your Physician or Health Care Practitioner for two prescriptions- one for a two-week supply, which You can fill right away at a retail pharmacy, and one for the mail order program; and
- Complete a Home Delivery Order Form and mail the form, the original mail order prescription (not a copy), and the applicable Copayment or Coinsurance amount to Express Scripts.

To obtain the Home Delivery Order Form or a pre-addressed Express Scripts envelope, or for help determining the applicable Copayment or Coinsurance amount, visit **www.express-scripts.com** or contact Express Scripts by calling the number on the back of Your identification card.

Note: Non-participating mail order pharmacies are not covered by the Plan. If You choose to fill a prescription through a non-participating mail order pharmacy, the Plan will not reimburse You for any of Your costs.

Patient Assurance Program (PAP)
The Patient Assurance Program aims to help You curb the costs for participating drugs and there is no cost to enroll. PAP is meant to cap member responsibility for participating drugs (such as insulin) at $25 for a 30-day prescription, $50 for a 60-day prescription and $75 for a 90-day prescription. In conjunction with Express Scripts' existing solutions, Express Scripts can provide members and plan sponsors improved outcomes and greater overall drug spend management. Please contact Express Scripts for more information.

Specialty Pharmacy
Specialty medications are used to treat a broad array of complex diseases that may require special handling, administration by infusion or injection, or specialized patient support. Accredo Specialty Pharmacy is the Plan's exclusive supplier of specialty medications.

If You try to fill your specialty prescription at a retail pharmacy, You will be directed to contact Accredo. In many cases, Accredo will automatically reach out to you to assist you with filling Your prescription so that it is covered by the Plan. If You need to contact Accredo, please call (800) 803-2523 or visit **www.accredo.com**.

Note: If You fill a prescription for a specialty drug, with a pharmacy other than Accredo, You will have to pay the entire cost for the prescription because no other specialty drug pharmacy is covered by the Plan.

When You fill a prescription for a specialty drug with Accredo, the pharmacy provides You with around the clock access to pharmacists and nurses who are trained in specialty medications, and coordination of home care and other health care services. Accredo also offers free scheduled delivery of medications (including to a Health Care Professional's office for administration), free supplies such as needles and syringes, and refill reminder calls. All You pay is the applicable Copayment or Coinsurance amount for up to a 90-day supply of specialty drugs as shown in the Schedule of Prescription Drug Benefits.

Generics Preferred
To help You keep Your costs down, every time You fill (or refill) a prescription for a brand name drug, the pharmacist will automatically check whether a generic equivalent is available and notify You if there is one. Generics are approved by the U.S. Food and Drug Administration (FDA) and are created to be the same as a brand name drugs in the form of dosage, safety, route of administration, quality, and performance. Generic drugs are created to be bioequivalent to the brand name drug.

When You purchase a brand drug that has a generic equivalent available, You pay the applicable Coinsurance plus the difference in cost between the generic equivalent and the brand drug. The additional cost applies even if Your Physician or Health Care Practitioner writes "dispense as written" or "DAW" on Your prescription for the brand drug. If the prescribing Physician or Health Care Practitioner believes it is Medically Necessary for You to take a brand named drug, when a generic equivalent is available, the prescriber can call Express Scripts to request Prior Authorization before You can obtain the prescription. Should such a request be approved, You will only have to pay the applicable Coinsurance for the brand drug. Any additional costs or penalties for using a brand name when a generic is available does not accumulate towards the Out-of-Pocket Maximum.

If You are prescribed a brand drug that has no generic equivalent, You will only have to pay the applicable Coinsurance for the brand drug.

Prior Authorization
Prior Authorization is required for certain prescription drugs (or the prescribed quantity of particular drugs). Prior Authorization helps promote appropriate utilization and enforcement of the Plan's guidelines for prescription drug coverage. At the time You fill a prescription the pharmacist is informed of any applicable Prior Authorization requirements through the pharmacy's computer system. When Prior Authorization is required, Express Scripts may contact Your provider for additional information to determine whether Prior Authorization should be granted. Your Health Care Practitioner is able to electronically submit the information required to receive Prior Authorization. For more information, have your Health Care Practitioner visit: **express-scripts.com/providers/physicians/**

Express Scripts will communicate the results of the decision to both You and Your Physician or Health Care Practitioner. If Prior Authorization is denied, You will receive written notification of the denial along with instructions for filing an appeal. You can learn more about how to file an appeal and what to expect from the Claims and Appeals Procedure section of the SPD.

Express Scripts maintains a list of prescription drugs that require Prior Authorization.

To find out if a specific drug requires Prior Authorization, visit Express Scripts online at **www.express-scripts.com** or call the number on the back of your identification card. You, Your provider, or Your pharmacist, may check with Express Scripts to verify Prior Authorization or other requirements.

The list of prescription drugs that require Prior Authorization is subject to change. Contact Express Scripts for the most up-to-date information on which drugs require Prior Authorization.

Gene Therapy
There is no coverage under this Plan for Gene Therapy prescription drugs (for example, Zolgensma).

Diabetic Supplies
The prescription drug benefit may cover the cost of diabetic supplies and equipment when prescribed by a Physician or other Health Care Practitioner.

INTERNAL CLAIMS AND APPEALS PROCEDURES

This section describes the procedures followed by the Iron Workers District Council of Western New York and Vicinity Welfare Fund in making internal claim decisions and reviewing appeals of denied claims. These procedures apply to claims for Medical/Hospital, Prescription Drug, Dental, Orthodontics, Optical, Hearing Aid, Employee Assistance Program (EAP), Life Insurance, Accidental Death and Dismemberment, Supplementary Disability, Wage Replacement Account Benefits (Supplemental Disability, Workers' Compensation, Unemployment and Vacation Benefits).

The Plan's internal claims and appeal procedures are designed to provide You with full, fair, and fast claim review and so that Plan provisions are applied consistently with respect to You and other similarly situated participants and dependents. In addition, the Plan must consult with a health care professional with appropriate training and experience when reviewing an adverse benefit determination that is based in whole or in part on a medical judgment (such as a determination that a service is not Medically Necessary or appropriate or is Experimental or Investigational).

General Information

Claims Administrators

Initial claims decisions are issued by the following companies/organizations:

Benefit Type and Claims Administrator	Types of Claims Processed
Medical/Hospital and Hearing Aid Benefits Excellus Blue Cross Blue Shield 165 Court Street Rochester, NY 14647 (800) 499-1275 www.excellusbcbs.com	• Pre-Service Claims; • Urgent Care Claims; • Concurrent Review; • Post-Service Claims.
Employee Assistance Program (EAP) Services Workforce Development Institute 96 South Swan Street Albany, NY 12210 (800) 252-4555 (800) 225-2527 www.theEAP.com	• EAP Service Claims

Benefit Type and Claims Administrator	Types of Claims Processed
Prescription Drug Benefits Express Scripts P.O. Box 66773 St. Louis, MO 63166-6773 Member Services: (800) 451-6245 Pharmacist Help Desk: (800) 235-4357 www.express-scripts.com	• Pre-Service Claims; • Urgent Care Claims; • Concurrent Review Claims; and • Post-Service Claims for prescriptions filled at Out-of-Network retail pharmacies.
Self-insured Health Benefits: Dental, Orthodontia, Optical, and Hearing Aid. **Self-insured Non-Heath Benefits: Accidental Death and Dismemberment, Supplemental Disability, and Wage Replacement Account** Iron Workers District Council of WNY Welfare Fund 3445 Winton Place, Suite 238 Rochester, NY 14623-2950 (800) 288-0782 (585) 424-3510	• Post-Service Claims • Accidental Death and Dismemberment Claims • Supplementary Disability Claims • Wage Replacement Account Claims
Life Insurance Benefits Prudential Life Insurance of America 80 Livingston Avenue Roseland, New Jersey 07068	• Life insurance Claims (You must obtain a life insurance claim form from the Fund Office or Prudential).
Wage Replacement Account Life and Accidental Death and Dismemberment Insurance Benefits The Hartford Group Benefits Division, Customer Service P.O. Box 2999 Hartford, CT 06104-2999 (800) 523-2233	• Life insurance Claims (You must obtain a life insurance claim form from the Fund Office or The Hartford).

Days Defined
For the purpose of the initial claims and appeal processes, "days" refers to calendar days, not business days.

I. Discretionary Authority of Plan Administrator and Designees

In carrying out their respective responsibilities under the Plan, the Plan Administrator, other Plan fiduciaries, Claims Administrators, and other individuals to whom responsibility for the administration of the Plan has been delegated, have discretionary authority to interpret the terms of the Plan and to interpret any facts relevant to the determination, and to determine eligibility and entitlement to Plan benefits in accordance with the terms of the Plan. Any interpretation or determination made under that discretionary authority will be given full force.

Adverse Benefit Determination

An adverse benefit determination, for the purpose of the internal claims and appeal process, means:

- A denial, reduction, or termination of, or a failure to provide or make payment in whole or in part for, a benefit (collectively, "denial"), including any denial based on (1) a determination of an individual's eligibility to participate in the Plan, (2) an application of utilization review, or (3) a determination that the item is Experimental, Investigational, or not Medically Necessary or appropriate;
- A rescission of coverage, whether or not there is an adverse effect on any particular health or disability benefit. An adverse benefit determination does not include rescissions of coverage with respect to life insurance and dismemberment insurance/death benefits.

All notices, to the extent required by applicable law, will be provided in a culturally and linguistically appropriate manner.

Definition of a Claim

A claim is a request for a Plan benefit made by You or Your covered Dependent (also referred to as "claimant") or Your authorized representative in accordance with the Plan's reasonable claims procedures.

Types of Claims

II. Health Benefit Claims

Health benefit claims can be filed for Medical/Hospital, Prescription Drug, Dental, Optical, Orthodontics, Hearing Aid, and Employee Assistance Program (EAP) Benefits.

There are four categories of health claims as described:

- ***Pre-Service Claims*** - A Pre-Service Claim is a claim for a benefit that requires approval of the benefit (in whole or in part) before health care is obtained. Under this Plan, prior approval is required for certain medical/hospital services and prescription drugs.

  Please note that while a Pretreatment Review/Advance Claim Review is suggested for a proposed course of dental treatment that is estimated to be over $150, there is no penalty for failure to obtain this review. If no Pretreatment Review/Advance Claim Review is obtained prior to services being rendered, the claim will be treated as if an Advance Claim Review was obtained. These Reviews are not considered pre-service claims.

- ***Urgent Care Claims*** – An Urgent Care Claim is any Pre-Service Claim for health care treatment that (i) could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or (ii) in the opinion of the claimant's attending health care provider with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. However, the Plan will not deny benefits for these procedures or services if it is not possible for the claimant to obtain the pre-approval, or the pre-approval process would jeopardize the claimant's life or health.

- ***Concurrent Claims*** - A Concurrent Claim is a claim that is reconsidered after an initial approval has been made and results in a reduced or terminated benefit. Also, a Concurrent Claim can pertain to a request for an extension of a previously approved treatment or service.

- ***Post-Service Claims*** - A Post-Service Claim is a request for benefits under the Plan that is not a Pre-Service Claim. Post-Service Claims are requests that involve only the payment or reimbursement of the cost of the care that has already been provided. A standard paper claim or electronic bill submitted for payment after services have been provided are examples of a Post-Service Claim. A claim regarding the rescission of coverage will be considered to be a Post-Service Claim.

Supplementary Disability Benefit Claims

A Supplemental Disability Claim is a request for benefits during a period of disability. Supplemental Disability Claims are filed after a participant suffers a disability and benefits are paid if the Claims Administrator determines that the participant has suffered a disability as defined by the terms of the Plan.

Life Insurance and Accidental Death and Dismemberment Insurance Claims

A request for Life Insurance and/or the Accidental Death Benefit may be completed by a designated Beneficiary following the death of a Participant. A claim for the Accidental Dismemberment Benefit may be completed by the Participant along with the proof of a bodily loss.

Wage Replacement Account Benefits (Supplemental Disability, Workers' Compensation, Unemployment and Vacation Benefits)

See the section entitled *Wage Replacement Account Benefits* for details on claims and appeals procedures for these benefits.

Claim Elements

An initial claim must include the following elements to trigger the Plan's internal claims process:

- Be written or electronically submitted (oral communication is acceptable only for Urgent Care Claims);
- Be received by the Plan Administrator or Claims Administrator (as applicable);
- Name a specific individual participant and his/her Social Security Number;
- Name a specific claimant and his/her date of birth;
- Name a specific medical condition or symptom;
- Provide a description and date of a specific treatment, service or product for which approval or payment is requested (must include an itemized detail of charges);
- Identify the provider's name, address, phone number, professional degree or license, and federal tax identification number (TIN); and
- When another plan is primary payer, include a copy of the other Plan's Explanation of Benefits (EOB) statement along with the submitted claim.

A request is *not* a claim if it is:

- Not made in accordance with the Plan's benefit claims filing procedures described in this section;
- Made by someone other than You, Your eligible dependent(s), or an Authorized Representative;
- Made by a person who will not identify himself or herself (anonymous);
- A casual inquiry about benefits such as verification of whether a service/item is a covered benefit or the estimated allowed cost for a service;
- A request for prior approval where prior approval is not required by the Plan;
- An eligibility inquiry that does not request benefits. However, if a benefit claim is denied on the grounds of lack of eligibility, it is treated as an adverse benefit determination and the individual will be notified of the decision and allowed to file an appeal;

- The presentation of a prescription to a retail pharmacy or mail order pharmacy that the pharmacy denies at the point of sale. After the denial by the pharmacy, You may file a claim with the Plan;

- A request for an eye exam, lenses, frames or contact lenses that is denied at the point of sale from the Plan's contracted in-network vision provider(s). After the denial by the vision service provider, You may file a claim with the Plan.

If You submit a claim that is not complete or lacks required supporting documents, the Plan Administrator or Claims Administrator, as applicable, will notify You about information which is necessary to complete the claim. This does not apply to simple inquiries about the Plan's provisions that are unrelated to any specific benefit claim or which relate to proposed or anticipated treatment or services that do not require prior approval.

Initial Claim Decision Timeframes

Claim Filing Deadline

Claims should be filed within twelve (12) months following the date charges were incurred. Failure to file claims within the time required will not invalidate or reduce any claim, if it was not reasonably possible to file the claim within such time. However, in that case, the claim must be submitted as soon as reasonably possible and in no event later than eighteen (18) months from the date the charges were incurred.

The time period for making a decision on an initial claim request starts as soon as the claim is received by the appropriate Claims Administrator, provided it is filed in accordance with the Plan's reasonable filing procedures. A claim may be filed by You, a covered Dependent, an authorized representative, or by a network provider. In the event a claim is filed by a provider, the provider will not automatically be considered to be Your authorized representative.

Health Care Claims – (And determinations conditioned on a finding of disability by the Plan)

The Plan will provide You, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the claim. Such evidence will be provided as soon as possible (and sufficiently in advance of the date on which notice of an adverse benefit determination on review is required to be provided) to give You a reasonable opportunity to respond prior to that date. Additionally, before the Plan issues an adverse benefit determination on review based on a new or additional rationale, You will be provided, free of charge, with the rationale. The rationale will be provided as soon as possible (and sufficiently in advance of the date on which notice of adverse benefit determination on review is required to be provided) to give You a reasonable opportunity to respond prior to that date.

- **Pre-Service Claims**

Claims for Pre-Service (that are not for Urgent Care) will be decided no later than fifteen (15) days after receipt by the appropriate Claims Administrator. You will be notified in writing (or electronically, as applicable) within the initial fifteen (15) day period whether the claim was approved or denied (in whole or in part).

The time for deciding the claim may be extended by up to fifteen (15) days due to circumstances beyond the Claims Administrator's control (e.g., inability of a medical reviewer to meet a deadline); provided You are given written (or electronic, as applicable) notification before the expiration of the initial fifteen (15) day determination period.
If You improperly file a Pre-Service Claim, the Claims Administrator will notify You in writing (or electronically, as applicable) as soon as possible, but in no event later than five (5) days after receiving the claim. The notice will describe the proper procedures for filing a Pre-Service Claim. Thereafter, You must re-file a claim to begin the Pre-Service Claim determination process.
If a claim cannot be processed due to insufficient information, the Claims Administrator will notify You in writing (or electronically, as applicable) about what specific information is needed before the expiration of the initial fifteen (15) day determination period. Thereafter, You will have 45 days following Your receipt of the notice to supply the additional information. If You do not provide the information during the 45-day period, the claim will be denied (i.e., an adverse benefit determination). During the period in which You are permitted to supply additional information, the normal period for making a decision is suspended. The claim decision deadline is suspended until the earlier of 45 days or the date the Claims Administrator receives Your response to the request for information. The Claims Administrator then has fifteen (15) days to make a decision and notify You in writing (or electronically, as applicable).

- **Urgent Care Claims**

In the case of an Urgent Care Claim, if a health care professional with knowledge of Your medical condition determines that a claim constitutes an Urgent Care Claim, the health care professional will be considered by the Plan to be Your authorized representative bypassing the need for completion of the Plan's written authorized representative form.
The appropriate Claims Administrator will decide claims for Urgent Care as soon as possible, but in no event later than 72 hours after receipt of the claim. The Claims Administrator will orally communicate its decision by telephone to You and Your health care professional. The determination will also be confirmed in writing (or electronically, as applicable) no later than three (3) days after the oral notification.
If you improperly file an Urgent Care Claim, the Claims Administrator will notify You and Your health care professional as soon as possible, but in no event later than 24 hours after receiving the claim. The written (or electronic, as applicable) notice will describe the proper procedures for filing an Urgent Care Claim. Thereafter, You must re-file a claim to begin the Urgent Care Claim determination process.
If a claim cannot be processed due to insufficient information, the Claims Administrator will provide You and Your health care professional with a written (or electronic, as applicable) notification about what specific information is needed as soon as possible and no later than 24 hours after receipt of the claim. Thereafter, You will have not less than 48 hours following receipt of the notice to supply the additional information. If You do not provide the information during the period, the claim will be denied (i.e., an adverse benefit determination). Written (or electronic, as applicable) notice of the decision will be provided to You and Your health care professional no later than 48 hours after the Claims Administrator receives the specific information or the end or the period given for You to provide this information, whichever is earlier.

- **Concurrent Claims**

If a decision is made to reduce or terminate an approved course of treatment, you will be provided with a written (or electronic, as applicable) notification of the termination or reduction sufficiently in advance of the reduction or termination to allow You to request an appeal and obtain a determination of that adverse benefit determination before the benefit is reduced or terminated.

A Concurrent Claim that is an Urgent Care Claim will be processed according to the Plan's internal appeals procedures and timeframes described above under the Urgent Care Claim section.

A Concurrent Claim that is not an Urgent Care Claim, will be processed according to the Plan's internal appeals procedures and timeframes applicable to the Pre-Service or Post-Service Claim, as applicable, provisions described above in this section.

If the Concurrent Care Claim is approved, You will be notified orally followed by written (or electronic, as applicable) notice provided no later than three (3) calendar days after the oral notice.

If the Concurrent Care Claim is denied, in whole or in part, You will be notified orally with written (or electronic, as appropriate) notice.

Post-Service Claims (Claims for Post-Service treatments or services will be decided no later than 30 days after receipt by the appropriate Claims Administrator. You will be notified in writing (or electronically, as applicable) within the 30-day initial determination period if the claim is denied (in whole or in part).

The time for deciding the claim may be extended by fifteen (15) days due to circumstances beyond the Claim Administrator's control (e.g., inability of a medical reviewer to meet a deadline); provided You are given written (or electronic, as applicable) notification before the expiration of the initial 30-day determination period.

If a claim cannot be processed due to insufficient information, the Claim Administrator will notify You in writing (or electronically, as applicable) about what information is needed before the expiration of the initial 30-day determination period. Thereafter, You will have 45 days after Your receipt of the notice to supply the additional information. If You do not provide the information during the 45-day period, the claim will be denied (i.e., an adverse benefit determination). During the period in which You are permitted to supply additional information, the normal period for making a decision on the claim is suspended. The claim decision deadline is suspended until the earlier of 45 days or until the date the Claims Administrator receives Your written response to the request for information. The Claims Administrator then has fifteen (15) days to make a decision and notify You in writing (or electronically, as applicable).

Supplemental Disability Claims – Decision Timeframes

Claims for Supplemental Disability benefits will be decided no later than 45 days after receipt by the Fund Office. You will be notified in writing (or electronically, as applicable) within the 45-day initial determination period if the claim is denied (in whole or in part).

The time for deciding the claim may be extended by 30 days due to circumstances beyond the Claim Administrator's control; provided You are given written (or electronic, as applicable) notification before the expiration of the initial 45-day determination period. A decision will be made within 30 days of the date You are notified of the delay. The period for making a decision may be delayed an additional 30 days due to matters beyond the control of the Plan, provided You are notified of the additional delay, before the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date by which the decision should be rendered.

If a claim cannot be processed due to insufficient information, You will be notified in writing (or electronically, as applicable) about what information is needed before the expiration of the initial 45-day determination period. Thereafter, You will have 45 days after Your receipt of the notice to supply the additional information. If You do not provide the information during the 45-day period, the claim will be denied (i.e., an adverse benefit determination). During the period in which You are permitted to supply additional information, the normal period for making a decision on the claim is suspended. The claim decision deadline is suspended until the earlier of 45 days or until the date Your written response to the request for information is received. The Plan then has 30 days to make a decision and notify You in writing (or electronically, as applicable).

Life Insurance and Accidental Death and Dismemberment Claims – Decision Timeframe

Generally, You will receive written (or electronic, as applicable) notice of a decision on Your initial claim within 90 days of receipt of Your claim by the Claims Administrator. If additional time or information is required to make a determination on Your claim, for reasons beyond the control of the Claims Administrator, You will be notified in writing (or electronically, as applicable) within the initial 90-day determination period. The 90-day period may be extended up to an additional 90 days.

Initial Determination of Benefit Claims

Notice of Adverse Benefit Determination

If the Claims Administrator denies Your initial claim, in whole or in part, You will be given a notice about the denial (known as a "notice of adverse benefit determination"). The notice of adverse benefit determination will be given to You in writing (or electronically, as applicable) within the timeframe required to make a decision on a particular type of claim. The notice of adverse determination must:

- Identify the claim involved (and for health benefit claims will include the date of service, health care provider, claim amount if applicable, denial code and its corresponding meaning);
- Give the specific reason(s) for the denial (and for health benefit claims, will include a statement that the claimant has the right to request the applicable diagnosis and treatment code and their corresponding meanings; however, such a request is not considered to be a request for an internal appeal or external review for health benefit claims);
- If the denial is based on a Plan standard that was used in denying the claim, a description of such standard;
- Reference the specific Plan provision(s) on which the denial is based;
- Describe any additional material or information needed to perfect the claim and an explanation of why such added information is necessary;
- Provide an explanation of the Plan's internal appeal and external review (for health benefit claims) processes along with time limits and information about how to initiate an appeal and an external review for health benefit claims;
- Contain a statement that you have the right to bring civil action under ERISA section 502(a) following an appeal;
- If the denial was based on an internal rule, guideline, protocol or similar criteria, either the rule, etc., or a statement of such rule, guideline, protocol or similar criteria that was relied upon will be provided to You free-of-charge upon request;
- If the denial was based on Medical Necessity, Experimental treatment, or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the Plan's terms to Your medical circumstances; or a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided to You free-of-charge upon request;
- For Urgent Care claims, the notice will describe the expedited internal appeal and external review processes applicable to Urgent Care Claims. In addition, the required determination may be provided orally and followed with written (or electronic, as applicable) notification; and
- With respect to health benefit claims, provide information about the availability of, and contact information for, any applicable ombudsman established under the Public Health Services Act to assist You with the Plan's internal claims and appeal processes as well as with the external review process for health benefit claims.
- With respect to claims conditioned upon a finding of disability by the Plan, the notice will also include:

- a discussion of the Plan's initial claim discussion, including the basis for disagreeing with: (i) any disability determination by the Social Security Administration (SSA); (ii) the views of a treating physician, or health care professional or vocational expert evaluating the claimant, to the extent the Plan does not follow such views as presented by the claimant; or (iii) the views of medical professionals or vocational experts whose advice was obtained on behalf of the Plan, regardless of whether or not the advice was relied upon by the Plan in making an adverse benefit determination;

- Either the specific internal rules, guidelines, protocols, standards, or other similar criteria of the Plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist; and

- A statement that You are entitled to receive, upon request and free of charge, reasonable access to copies of all documents, records, and other information relevant to the claim.

Notice of Approval of Pre-Service and Urgent Care Claims

If a Pre-Service claim is approved, You will receive written (or electronic, as applicable) notice within fifteen (15) days of the appropriate Claims Administrator's receipt of the claim. Notice of Approval of an Urgent Care Claim will be provided in writing (or electronically, as applicable) to You and Your health care professional within the applicable timeframe after the Claims Administrator's receipt of the claim.

Internal Appeal Request Deadline

- ***Health Care Claims*** **(Applicable to Medical/Hospital, Prescription Drug, Dental, Optical, Hearing Aid and Employee Assistance Program (EAP) Benefits)**

If an initial health care claim is denied (in whole or in part) and You disagree with the Claims Administrator's decision, You or Your authorized representative may request an internal appeal. You have 180 calendar days following receipt of a notice of adverse benefit determination to submit a written request for an internal appeal. The Plan will not accept appeals filed after this 180-day period. Under limited circumstances, explained below in the section on External Review, You may bypass the Plan's internal claims and/or appeal processes and file a request for an external review.

- ***Supplemental Disability Claims***

If an initial Supplemental Disability Claim is denied and You disagree with the Claims Administrator's decision, You or Your authorized representative may request an internal appeal. You have 180 calendar days following Your receipt of an initial notice of adverse benefit determination to submit a written request for an internal appeal. The Plan will not accept appeals filed after this 180-day period.

- ***Life Insurance and Accidental Death and Dismemberment Claims***

Any appeal must be made in accordance with the terms of the applicable insurance policy. To request a copy of the policy, please contact the Fund Office. Generally, if an initial life insurance or accidental death and dismemberment Claim is denied and You disagree with the Claims Administrator's decision, You or Your authorized representative may request an appeal. You have 60 calendar days following Your receipt of an initial notice of adverse benefit determination to submit a written request for an appeal. The Plan will not accept appeal requests filed after this 60-day period. To the extent there is a conflict between this SPD and the terms of the applicable insurance policy, the insurance policy controls.

Internal Appeals Process

III. Appeal Procedures

To file an internal appeal of a self-insured benefit, You must submit a written statement to the appropriate party as described below within **180 days** of the adverse benefit determination:

Appeals for Medical/Hospital Benefits

The Plan maintains a two-level Appeal Process for Medical/Hospital benefits, except it maintains a one-level Appeal Process for Urgent Care Medical/Hospital benefits. First level appeals for Medical/Hospital Benefits should be submitted to Excellus at the address found in the Quick Reference Chart.

Second Level appeals should be submitted to the Board of Trustees at the address found in the Quick Reference Chart.

Appeal requests involving Urgent Care Claims may be made orally by calling the telephone numbers provided in the Quick Reference Chart or the number found on Your ID card.

Appeals for Prescription Drug Benefits

The Plan maintains a one level Appeal Process for Prescription Drug benefits. Appeals for prescription drug benefits should be submitted to Express Scripts at the address found in the Quick Reference Chart.

Appeal requests involving Urgent Care Claims may be made orally by calling Excellus or ESI at the telephone number listed on the Quick Reference Chart or the one found on Your ID card.

Appeals for all other self-insured benefits (Supplemental Disability, Dental, Orthodontia, Optical, and Hearing Aid Benefits)

The Plan maintains a one-level Appeals Process for these Benefit Claims. Appeals should be submitted to the Board of Trustees at the address found in the Quick Reference Chart.

Your request for an internal appeal must include the specific reasons why You believe the initial claim denial was improper. You may submit any document that You feel is appropriate to the internal appeal determination, as well as submitting any written issues and comments.

As a part of its internal appeals process, the Plan will:

- Provide You with the opportunity to submit to the Plan written comments, documents, records, and other information relating to Your initial claim for benefits;

- Provide You with the opportunity, upon request and without charge, reasonable access to and copies of all documents, records, and other information relevant to Your initial claim for benefits;

- Provide You with a full and fair review that takes into account all comments, documents, records, and other information submitted by You, without regard to whether such information was submitted or considered in the initial claim determination;

- Provide You with a review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate fiduciary of the Plan who is neither the individual who made the initial adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;

- In deciding an appeal of any adverse benefit determination regarding a health benefit claim that is based in whole or in part on a medical judgment, including whether a particular treatment, drug or other item is Experimental, Investigational, or Medically Necessary or appropriate, the fiduciary will consult with a health care professional who has appropriate experience in the field of medicine involved in the medical judgment, who is neither an individual who was consulted in connection with the initial adverse benefit determination that is the subject of the appeal nor the subordinate of any such individual; and will provide, upon request, the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with an adverse benefit determination without regard to whether the advice was relied upon in making the benefit determination.

Appeal Determination Timeframes

- ***Health Care Claims***

    - ***Pre-Service Claims for Prescription Drug Benefits.*** You will be notified of the benefit determination on review within a reasonable period of time appropriate to the medical circumstances, but no later than 30 days from the date Your written request for an appeal is received by ESI.

    - ***Pre-Service Claims for Medical/Hospital Benefits.*** Under the Plan's two-level appeals process, Excellus will notify You of its first-level determination no later than 15 days after receipt of the appeal. If the first-level review results in an adverse benefit determination, You may request a second level of review by the Board of Trustees. You will have 180 days from the date You received the first-level determination to request a second-level appeal review by sending a written request to the Board of Trustees. You will be notified of the second-level appeal determination no later than 15 days after the Plan receives Your request for a second-level appeal review.

- ***Urgent Care Claims for Medical/Hospital and Prescription Drug Benefits.*** You will be notified of the determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but no later than 72 hours after the appropriate Claim Administrator's receipt of Your (oral or written) request for appeal. A claim involving Urgent Care is any claim with respect to which the application of the time periods for making non-urgent care could seriously jeopardize Your ability to regain maximum function or, in the opinion of a physician with knowledge of Your medical condition, would subject You to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. The Plan will defer to determination of Your attending provider regarding whether the claim involves urgent care.

- ***Concurrent Claims for Medical/Hospital and Prescription Drug Benefits.*** You may request an internal appeal of a Concurrent Claim by submitting the request orally (for an Urgent Care Claim) or in writing to the appropriate Claims Administrator. You will be notified of the determination of Your internal appeal as soon as possible before the benefit is reduced or treatment is terminated.

- ***Post-Service Claims for Prescription Drugs.*** You will be notified of the benefit determination on review within a reasonable period of time appropriate to the medical circumstances, but no later than 60 days from the date Your written request for an appeal is received by ESI. No extension of the Plan's internal appeal review timeframe is permitted.

- ***Post-Service Claims for Medical/Hospital Benefit Claims.*** Under the Plan's two-level appeals process, Excellus will notify You of its first-level determination no later than 30 days after receipt of the appeal. If the first-level review results in an adverse benefit determination, You may request a second level of review by the Board of Trustees. You will have 180 days from the date You received the first-level determination to request a second-level appeal review by sending a written request to the Board of Trustees. You will be notified of the second-level appeal determination no later than 30 days after the Plan receives Your request for a second-level appeal review. No extension of the Plan's internal appeal review timeframes is permitted.

- ***Post-Service Claims for all other self-insured benefits (Dental, Optical, Employee Assistance Program (EAP) and Supplemental Disability Benefits.)*** The Plan will make an appeal determination no later than the date of the Board of Trustees' meeting immediately following the Plan's receipt of Your written request for an internal appeal, unless the request for an internal appeal review is filed within 30 calendar days preceding the date of such meeting. In such case, an appeal determination will be made no later than the date of the second meeting following the Plan's receipt of Your written request for an appeal. If special circumstances (such as the need to hold a hearing) require a further extension of time for processing, an appeal determination will be rendered no later than the third meeting following the Plan's receipt of Your written request for review. If such an extension is necessary, the Plan will provide You with a written (or electronic, as applicable) notice of extension describing the special circumstances and date the appeal determination will be made. The Board of Trustees will notify You in writing (or electronically, as applicable) of the benefit determination no later than five calendar days after the benefit determination is made.

- ***Life Insurance and Accidental Death and Dismemberment Benefit Claims***

A written (or electronic, as applicable) notice regarding a determination of Your appeal will be sent to You in accordance with the applicable insurance policy; generally, within 60 days from the date Your written request for an appeal is received by the Plan.

Notice of Adverse Benefit Determination Upon Appeal

Any notice of denial of Your appeal will include the following, to the extent applicable to your claim:

- Information sufficient to identify the claim involved (including the date of service, the health care provider, and the claim amount);
- The specific reasons for the adverse benefit determination upon appeal, including (i) the denial code (if any) applicable to a health benefit claim and its corresponding meaning, (ii) a description of the Plan's standard (if any) that was used in denying the claim, and (iii) a discussion of the decision;
- Reference the specific Plan provisions on which the denial is based;
- A statement describing the availability, upon request, of the diagnosis code (if applicable) and the treatment code (if applicable) and their corresponding meanings;
- A statement that You are entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the claim;
- A statement that You have the right to bring civil action under ERISA Section 502(a) following the appeal;
- An explanation of the external review process, along with any time limits and information about how to initiate a request for an external review regarding a denied internal appeal of a health benefit claim;
- If the denial was based on an internal rule, guideline, protocol, or similar criterion, either the rule, etc., or a statement will be provided that such rule, guideline, protocol, standard or criteria will be provided free of charge, upon request;
- If the denial of a health benefit or disability claim was based on either the medical judgment (Medical Necessity, Experimental, or Investigational), or a statement that the Plan will provide an explanation, free of charge, upon request, of the scientific or clinical judgment for the denial, applying the Plan's terms to Your medical circumstances;
- If applicable, a statement describing voluntary appeal procedures for prescription drug claims; and
- With respect to a health benefit claim, disclosure of the availability of, and contact information for, any applicable ombudsman established under the Public Health Services Act to assist You with internal claims and appeals and external review processes.

- A statement that the claimant 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 claimant's claim for benefits;

- With respect to a claim conditioned on a finding of disability by the Plan, the notice will also include:

    - The basis for disagreeing with, or not following (i) any disability determination by the Social Security Administration (SSA); (ii) the views of a treating health care professional or vocational expert evaluating the claimant, to the extent the Plan does not follow such views as presented by the claimant; or (iii) the views of medical professionals or vocational experts whose advice was obtained on behalf of the Plan, regardless of whether or not the advice was relied upon by the Plan in making an adverse benefit determination;

    - Either the specific internal rules, guidelines, protocols, standards, or other similar criteria of the Plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist; and

    - Any contractual limitations period for filing a civil action and the calendar date deadline for doing so.

Note, to the extent the Plan violates any applicable claims and appeals procedures, a participant may request a written explanation of the violation from the Plan. The Plan will respond within ten days.

Voluntary Appeal for ESI Prescription Drug Claims

The Plan offers an additional voluntary appeal level for Prescription Drug claims administered by Express Scripts after the standard appeals process is completed. Therefore, if You are dissatisfied with the outcome of Your standard appeal, You may file a voluntary second-level appeal with the Board of Trustees within 90 calendar days from the date on the notice of the letter denying Your first appeal.

You should also submit written comments, documents, medical records, and other information relating to the claim for benefits. In administering the voluntary appeal, the Plan will obtain a written report summarizing the facts underlying the claim and prior denials from ESI.

Decisions on voluntary appeals will be made at the next regularly-scheduled meeting of the Board of Trustees following receipt of Your request for review. However, if Your request for review is received within 30 days of the next regularly-scheduled meeting, Your request for review will be considered at the second regularly scheduled meeting following receipt of Your request. In special circumstances, a delay until the third regularly-scheduled meeting following receipt of Your request for review may be necessary. You will be advised in writing in advance if this extension will be necessary. Once a decision on review of Your claim has been reached, You will be notified of the decision as soon as possible, but no later than 5 days after the decision has been reached.

This second level of appeal is completely voluntary; it is not required by the Plan and is only available if You (or Your representative) request it. Regarding voluntary appeals:

- The Plan will not assert a failure to exhaust administrative remedies because You or Your authorized representative elect not to pursue a claim through the voluntary level of appeal;
- Where You or Your authorized representative choose to pursue a claim in court after completing the voluntary appeal, the Plan agrees that any statute of limitations (or other defense based on timeliness) applicable to your claim in court will be tolled (suspended) during the period of the voluntary appeals process;
- The voluntary level of appeal is available only after You (or Your representative) have pursued the appropriate mandatory appeals process required by the Plan;
- Upon Your request, the Plan will provide You (or Your representative) with sufficient information to make an informed judgment about whether to submit a claim through the voluntary appeal process, including a statement that the specific information regarding the process for selecting a decision-maker and any circumstances may affect the impartiality of the decision-maker.

The Plan will not impose fees or costs on You (or Your representative) if you or your authorized representative chooses to invoke the optional appeals process. Note that this voluntary level of appeal has no effect on the claimant's right to any other benefits under the Plan.

External Appeals Procedures

You have the right to file for external review of an adverse benefit determination within 4 months after receipt of the notice of the adverse benefit determination denying your appeal. For purposes of external review eligibility, an *adverse benefit determination* is a determination that an admission, availability of care, continued stay, or other health care service that is a covered benefit has been reviewed and, based upon the information provided, it is determined that the treatment is experimental or investigational or does not meet the Plan's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness, and the requested service or payment for the service is therefore denied, reduced, or terminated. A rescission of coverage is an adverse benefit determination.

Any request for external review must be in writing and submitted to the Fund Office, within four months after receipt of the notice of the adverse benefit determination denying your appeal.

Within 5 business days following the date of receipt of the request, the Trustees, or their designee, must provide a preliminary review determining: if you were covered under the Plan at the time the service was requested or provided, that the determination does not relate to eligibility, that you have exhausted the internal appeals process (unless deemed exhaustion applies), and you have provided all paperwork necessary to complete the External Review and you are eligible for External Review. Within one business day after completion of the preliminary review, the Trustees will issue to you a notification in writing.

If the request is complete but not eligible for External Review, such notification will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)). If the request is not complete, such notification will describe the information or materials needed to make the request complete and the Trustees must allow you to perfect the request for External Review within the four month filing period or within the 48 hour period following receipt of the notification, whichever is later.

Upon application and approval of the request for external review, the Fund Office will assign an independent review organization ("IRO").

The external review will be made by an IRO with health care professionals that have no conflict of interest with respect to the benefit determination. Except for approved expedited external reviews (described below) this external review is available once you have exhausted the internal appeal process.

The assigned IRO will timely notify you in writing of the request's eligibility and acceptance for External Review, and will provide an opportunity for you to submit in writing within 10 business days following the date of receipt, information that the IRO may consider when conducting the External Review. The IRO may also review additional records, including, but not limited to, your medical records and the terms of the Plan.

The assigned IRO must provide written notice of the Final External Review Decision within 45 days after the IRO receives the request for the External Review. The IRO must deliver notice of the Final External Review Decision to you and the Plan.

Note, you may make a request for an expedited external review at the time you receive:

An adverse benefit determination if the adverse benefit determination involves a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have filed a request for an expedited internal appeal; or a final internal adverse benefit determination, if you have a medical condition where the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or if the final internal adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but have not been discharged from the facility.

Upon a determination that a request is eligible for expedited External Review, the Trustees will assign an IRO. The IRO shall render a decision as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited External Review. If the IRO's decision is not in writing, within 48 hours after the date of providing that decision, the assigned IRO must provide written confirmation of the decision to you and the Plan.

SCHEDULE OF INSURANCE BENEFITS

The following schedule summarizes the various types and maximums of insurance benefits available to You or Your beneficiary while You are eligible under the Plan. Please note that the following insurance benefits do not include any other benefits that You may be eligible for under the Wage Replacement Account, detailed in the section entitled "Wage Replacement Account Benefits".

Life Insurance Fully-Insured by: Prudential Life Insurance Company of America	$25,000
Accidental Death and Dismemberment (AD&D) Self-Funded and Administered by the Fund Office	$25,000 (Principal Sum)
Supplemental Disability Self-Funded and Administered by the Fund Office	$200 per week less FICA. Maximum of 26 weeks (or 20 weeks if eligible for IMPACT Program benefit.) within a 52-week cycle, during any one period of disability.

Naming a Beneficiary

When You become eligible for Life Insurance and AD&D benefits, You'll be asked to name a person or persons who will receive the benefit if You should die. Your beneficiary may be any person or persons You name at the time of enrollment. You may change Your beneficiary at any time by writing, calling or visiting the Fund Office to request the appropriate forms. The last written beneficiary designation, which has been properly completed, signed by You and received by the Fund Office, will determine who is eligible to receive these benefits after Your death.

If You name more than one beneficiary, You should indicate how Your benefits should be divided. The initial designation or change of designation will take effect on the date You provide the beneficiary designation form to the Fund Office.

It's important that You name a beneficiary. If You do not name a beneficiary, or if Your beneficiary is not living at the time of Your death, Your benefit will be paid to Your survivors as follows:

- Spouse or spousal equivalent, or if none;
- Children, in equal shares, or if none;
- Parent(s), in equal shares, or if none;
- Brothers and sisters, in equal shares, or if none; and lastly
- Your Estate.

LIFE INSURANCE BENEFITS

The Life Insurance described in this booklet, which is underwritten by Prudential Insurance Company of America (Prudential), is provided under Prudential's Group Contract Number G-00286-NY. All provisions of this benefit are subject to the Contract and Certificate of Group Insurance issued by Prudential. If there are any discrepancies between this booklet and the Certificate or Contract, the Prudential Certificate or Contract will govern. Call the Fund Office to determine Eligibility.

The amount of life insurance, as shown in the Schedule of Insurance Benefits, is payable in the event of Your death from any cause at any time or place while You are insured. Payment will be made in a lump sum or in installments to the beneficiary designated by You. Your beneficiary may be changed whenever You wish.

A death benefit is payable under Prudential Section B if You die:

(1) within 31 days after You cease to be a Covered Person or within 31 days after the date Your amount of Employee Term Life Insurance under this Coverage is reduced; and

(2) while entitled to convert all or part of Your Employee Term Life Insurance under this Coverage to an individual contract; and

(3) before You make satisfactory application for the individual contract.

Conversion Privilege

This life insurance will cease upon termination of eligibility for benefits from the Fund. By applying within thirty-one (31) days following termination of eligibility and paying the first premium to Prudential, You may convert Your group life insurance to an individual life insurance policy. This individual policy will be issued without medical examination at the insurance company's regular rates. Please see the booklet provided by Prudential for more information or contact Prudential for conversion privilege options.

Extended Benefit During Disability

If You become totally disabled, as defined by Prudential under this policy, while You are covered under the Fund's benefits, are under age sixty (60) when You become disabled and are not working in any job for wage or profit and are able to continue to show evidence of continued disability, You may qualify to have Your life insurance benefit continue through a series of annual extensions. These extensions end at age sixty-five (65), and to be eligible You must satisfy Prudential's initial and continuing requirements to prove total disability. The amount of this death benefit is the same as if You were covered normally. Please see the booklet provided by Prudential for more information or contact Prudential for the requirements to extend life insurance during total disability.

Option to Accelerate Payment of Death Benefit

If You become terminally ill (12 months or less life expectancy) while You are covered under the Fund's benefits, You may be eligible for an accelerated benefit. After applying in writing and satisfying Prudential's requirements You may receive, prior to Your death, a payment of between 25% to 80% of Your death benefit. The remainder of the benefit will be paid to Your beneficiary upon Your death. Please see the booklet provided by Prudential for more information or contact Prudential for the requirements to receive accelerated payment of death benefits.

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

The Accidental Death and Dismemberment Insurance, which is provided by the Plan, provides for Your loss, while insured, of life, limbs, or the entire or irrecoverable loss of sight, including losses resulting from occupational, accidental bodily injuries. Benefits are payable only if the loss results directly from bodily injuries sustained solely through accidental means and occurs within ninety (90) days after the date of the accident causing the loss.

Accidental Death and Dismemberment Schedule of Benefits	
Type of Loss	**Amount Payable**
Loss of Life (payable to Your beneficiary)	$25,000
Loss of (payable to You): Both hands; Both feet; Sight in both eyes; One hand and one foot; One hand and sight in one eye; or One foot and sight in one eye.	$25,000
Loss of (payable to You): One hand; One foot; or Sight in one eye.	$12,500

The full principal sum of $25,000 or one-half of the principal sum of $12,500 will be paid in the event of certain losses, as shown in the table above. In no case will more than the full principal sum be paid for all losses resulting from one accident. Since this is coverage for losses due to Accidents, no benefits are paid on account of a loss caused or contributed to by bodily or mental infirmity, ptomaines, bacterial infection, disease, medical or surgical treatment not made necessary by an injury covered under the Plan, war or act of war, suicide or any intentionally self-inflicted injury. The injury causing the loss must occur while You are eligible for benefits.

In cases of accidental death, the death certificate should be submitted to the Fund Office. Payment will be made to Your beneficiary upon certification that Your death was accidental. For all other losses, proof of loss must be submitted to the Fund Office. Payment will be made to You upon certification that the loss was accidental. Call the Fund Office to determine Eligibility.

SUPPLEMENTAL DISABILITY BENEFITS

Weekly Disability Benefits

The Plan pays You a weekly benefit for disability absences during which You are prevented from working as a result of a non-occupational or occupational accidental injury, illness, or disease. For the purpose of this benefit, "disability" or "disabled" means the inability of a covered employee to perform the duties of his or her job with a Covered Employer as a result of non-occupational illness or injury. You must submit proof of Your disability from a Physician. If Your disability is verified by a Chiropractor, You must also show proof that You are receiving New York State Disability benefits. Call the Fund Office to determine Eligibility. You are not eligible for disability benefits to care for an injured or ill family member.

The Plan coordinates Weekly Non-Occupational Disability Benefit with the Off-the-Job Accident Program provided by the Ironworker Management Progressive Action Cooperative Trust ("IMPACT Program"). The IMPACT Program benefit, which is described under a separate heading below, is provided and administered separately from this Plan.

If You are eligible for both the IMPACT Program benefit and Weekly Non-Occupational Disability Benefits under this Plan, Your benefit from this Plan will commence on the fiftieth (50th) day of disability and is payable for a maximum of 20 weeks within a 52-week cycle, during any one period of disability. The disability absence must commence while coverage under the Plan is in force. The amount of Your weekly benefit is shown in the Schedule of Insurance Benefits.

If You are not eligible for the IMPACT Program benefit, but are eligible for Weekly Non-Occupational Disability Benefits under this Plan, Your benefit will commence on the eighth (8th) day of disability and is payable for a maximum of 26 weeks in a 52-week cycle, during any one period of disability. The Disability absence must commence while coverage under the Plan is in force. The amount of Your weekly benefit is shown in the Schedule of Insurance Benefits.

IMPACT Off-the-Job Accident Program

IMPACT has developed an Off-the-Job Accident Program to assist You with a short-term disability caused by an off-the-job accident. This program is provided and administered separately from this Plan. The amount of the benefit is the lesser of (1) $800.00 or (2) 66.67% of weekly earnings. The program requires a one-week waiting period. Your benefit will commence on the eighth (8th) day of disability and is payable for a maximum of 6 weeks.

Your eligibility for the IMPACT Program benefit is based on eligibility for benefits under the Iron Workers District Council of Western New York and Vicinity Welfare Fund. The IMPACT Program benefit is subject to the terms, conditions, exclusions, and other rules that govern the program. For more information on the IMPACT Program, please visit **http://www.impact-net.org/programs/off-the-job-accident/** or contact the administrator at:

Welfare & Pension Administrative Service, Inc.
P.O. Box 34687
Seattle, WA 98124-1687
(800) 331-6158

If Your most recent disability is related or due to the same cause(s) as Your prior disability for which You have received benefit payments, the Fund will treat Your current disability as part of the prior claim. The limit of 26 weeks will still apply and You would not have to complete the waiting period again. If the most recent disability is due to an unrelated injury or illness, and You have returned to active duty for one (1) day, it would be a new disability claim and You would be subjected to all the Plan provisions of a new claim.

It is not necessary to be confined to Your home to collect benefits, but benefits are only payable for:

- Those days on which You are under the care of a legally-qualified Physician. A period of care will be considered to have started when You have been seen and treated personally by the Physician.
- Are receiving treatment from a physician on a regular basis that is appropriate for your disability, as determined by the Plan Administrator or designee.

Those days on which You are not performing work for compensation or profit regardless of it being under covered or non-covered work.

Claims should be reported promptly to the Fund Office (and must be reported no later than one (1) year following the inception of the disability). Claim forms are available from the Fund Office. After the form is completed by You and Your Physician, return the form to the Fund Office for certification of processing.

Please note that the Plan reserves the right to have a physician examine You (at the Plan's expense) as often as is reasonable while a claim for benefits is pending or payable.

Duration of Benefit Payment

Supplemental Disability Benefits are payable on a weekly basis until the earliest occurrence of one or more of the following:

- The date You return to active work;
- The date You no longer have a qualified disability;
- The date Your Welfare coverage ends;
- The date You fail to comply with any applicable Fund policy or the failure to provide medical information to re-certify the disability;
- The date You are offered to return to work with restrictions, are offered the opportunity to return to work, but refuse;
- The date You retire from active employment;
- The date You have received the maximum 26 weeks that is payable under the Plan;
- The date You perform services for an employer (Including self-employment) other than union covered employment;
- The date You die; and
- The date the Plan is terminated or the date the Plan amends to eliminate the Supplemental Disability Benefit.

Credit for Periods of Disability

An eligible employee who is absent from covered employment because of a disability for which he is receiving Workers' Compensation, New York State disability benefits, disability benefits under the IMPACT Program, or disability benefits payable under this Plan, will be allowed to continue accumulating credit toward eligibility on the basis of 20 hours per week for each week that he continues to receive such benefits up to a maximum of 26 weeks.

EMPLOYEE ASSISTANCE PROGRAM (EAP) BENEFITS

This Plan offers you an Employee Assistance Program (EAP) Benefit so You can get the help You need. You can call the EAP 24 hours a day, 7 days a week to reach a professional counselor. You can call one of the toll-free numbers: 1-800-252-4555 or 1-800-225-2527, or log on to the web at **www.theEAP.com** to access other benefits.

Counseling Benefits:

You can contact a counselor regarding complex issues such as:

- Alcohol and substance abuse;
- Relationship and family issues;
- Depression, stress, or anxiety;
- Grief or loss of a loved one;
- Eating disorders; or
- Workplace difficulties.

Work/Life Benefits:

Assistance for personal, family, financial, and legal issues is available. You may be able to find solutions for problems including:

- Debt restructuring;
- Legal problems related to employment;
- Childcare or eldercare;
- Financial information;
- Real estate and tenant/landlord concerns; and
- Interpersonal skills with family and coworkers.

Information Resource Benefits:

You have access to various self-help tools and informative articles that cover a variety of problems You might face. You can log onto the website to access the following information:

- Behavioral health: information covering issues ranging from alcohol abuse to personal stress;
- Financial: articles, tools and information to help with various financial questions; and
- Legal information: information on topics ranging from adoption to wills.

Lifestyle Benefits:

Your lifestyle benefits include discounts and plans to help enhance Your quality of life. Check the website for special nutrition plans, smoking cessation, weight loss, and retirement planning benefits.

Personal Development and Training Benefits

You can balance Your work, life and career with the help of the Personal Development and Training Benefits. Visit **www.theEAP.com** website for tutorials and worksheets.

Wellness Benefits

The EAP wellness benefit allows You to accrue information and resources to improve Your family's overall wellness including stress reduction, fitness, and diet.

WAGE REPLACEMENT ACCOUNT BENEFITS

Eligibility

You may be eligible for this benefit if You have performed work for which contributions are required to be made to the Wage Replacement Account ("WRA") by Your employer. For initial WRA eligibility for the life insurance, Your WRA balance must be at least $400.00. Thereafter, You must maintain an account balance of at least $150.00 in order to receive WRA benefits. Effective January 16, 2014, the account balance may go below $150.00 if necessary to cover the Plan's life insurance premiums.

This minimum account balance requirement will be waived under the following circumstances: (1) as of the 60th day prior to your retirement – defined as the date You permanently cease to be Actively at Work – but this exception will not apply unless and until You file a completed pension application with the Iron Workers District Council of Western New York and Vicinity Pension Fund setting forth a permissible pension starting date.; (2) upon You becoming permanently and totally disabled; or (3) upon the termination of Your membership with the Union. If Your account does not contain sufficient monies to cover a requested benefit, the benefit will be paid based upon the available balance in Your account.

For purposes of circumstance (2) above, You will be considered "permanently and totally disabled" if You no longer perform iron work, You have exhausted supplemental disability or workers compensation benefits under the WRA, and You either (a) obtain a certification from a physician that You can no longer perform iron work due to disability or (b) provide a Social Security disability award letter.

Note: If You are a pensioner of the Iron Workers District Council of Western New York and Vicinity Pension Fund, You are not eligible for WRA benefits.

Benefits

All of the following benefits are subject to Your having a satisfactory account balance to receive the benefit and maintain the minimum balance. Please note, with the exception of the WRA life insurance benefit, these benefits are taxable.

1. **Supplemental Disability (Non-Occupational) Benefit** –You will be entitled to a disability benefit for each week You are so disabled that You cannot work at Your usual employment and earn no money as follows:

   Weekly Gross Benefit: $500

You must present satisfactory proof that You are entitled and continue to be entitled to State Disability Benefits for each week You seek the disability benefit. You must apply for supplemental benefits within twelve (12) months of the period of disability for which You are seeking benefits. Assuming you are otherwise eligible for this Supplemental Disability (Non-Occupational) Benefit, you will also receive this benefit for your first week of disability (the waiting week). The protocol regarding payment of Your benefit will be determined by the Fund Administrator.

2. **Supplemental Workers' Compensation Benefit** – You will be entitled to a weekly workers' compensation benefit for each week You cannot work due to an illness or injury entitling You to State Workers' Compensation Benefits as follows:

Weekly Gross Benefit:	$400

You must present satisfactory proof that You are entitled and continue to be entitled to State Workers' Compensation Benefits. You must apply for supplemental benefits within twelve (12) months of the illness or injury entitling You to benefits. Assuming you are otherwise eligible for this Supplemental Workers' Compensation Benefit, you will also receive this benefit for your first week of illness or injury (the waiting week). The protocol regarding payment of Your benefit will be determined by the Fund Administrator.

3. **Supplemental Unemployment Benefit** – You will be entitled to a weekly supplemental unemployment benefit if You satisfy the following conditions: (1) You must be involuntarily laid off by a signatory employer having a collective bargaining agreement requiring contributions to this Plan; (2) You must provide satisfactory proof that You are eligible and continue to be eligible for State unemployment benefits (or would be eligible to receive such benefits had You not already received such benefits for the maximum duration under State Law); and (3) Your Business Manager must certify that You are on the out of work list, are available for work, and have not refused employment when it has been offered.

For the first week of unemployment (Waiting week) You will receive a benefit as follows:

Weekly Gross Benefit:	$800

Thereafter, the maximum benefit for each week that You are on unemployment is as follows:

Weekly Gross Benefit:	$400

You must apply for supplemental benefits within twelve (12) months of the period of unemployment for which You are seeking benefits. The protocol regarding payment of Your benefit will be determined by the Fund Administrator.

4. **Vacation Benefit** – If You want to take a vacation, You will be eligible to draw monies from Your account for each week or day of vacation that You take as follows:

Under Age 50:	$300 daily gross benefit; $1,500 weekly gross benefit for a maximum of 2 weeks or 10 days per calendar year.
Age 50 or Older:	$900 daily gross benefit; $4,500 weekly gross benefit for a maximum of 6 weeks or 30 days per calendar year.

If You work during any day or week for which You make a vacation withdrawal, You must return the withdrawn amount for that day or week to the Fund Office to be returned to Your account. You will also be denied a Vacation Benefit for six (6) months from the date the money is returned.

You may request that vacation benefits are paid up to one (1) month in advance of the actual vacation week; however, You must apply for vacation benefits within twelve (12) months of the day or week for which the vacation benefits are paid. The protocol regarding payment of Your benefit will be determined by the Fund Administrator.

Life Insurance and Accidental Death and Dismemberment (AD&D) Benefit – The Life Insurance described in this booklet, which is underwritten by Hartford Life Insurance Company, is provided under Hartford's Group Contract Number GL-872745. All provisions of this benefit are subject to the Contract and Certificate of Group Insurance issued by Hartford. If there are any discrepancies between this booklet and the Certificate or Contract, the Hartford Certificate or Contract will govern. The Fund will purchase life and AD&D insurance through Your WRA by automatically withdrawing the premium from Your WRA on an annual basis. The life insurance benefit is $25,000 and the principal AD&D benefit is an additional amount of $25,000. Please review the certificate carefully as it contains important information about choosing a beneficiary, filing a claim, explanation of and payment of Your benefits, conversion rights, accelerated death benefits and appealing a denied claim.

To be eligible for the Life Insurance Benefit:

1) You must be a participating member of the Ironworkers District Council of Western New York Locals (Locals 9, 33 and 440);
2) You must have worked at least 200 work hours in the last plan year (July 1 – June 30);
3) You must be Actively at Work or available for work;
4) Your account balance must be sufficient to cover the life insurance premium, which will be paid annually; and

Waiting Period: The period prior to the Plan Anniversary date or Open Enrollment dates (September 1) after which You become an Active Member.

Termination: Coverage ends on the earliest of the following:
1) the date the Policy terminates;
2) the Policy Anniversary date or Annual Open Enrollment date following the date You cease to be eligible for the WRA;
3) Your account balance is insufficient to cover the life insurance premium. (If You lose coverage because of an insufficient account balance, coverage may be reinstated during subsequent enrollment periods if the balance rises to the required level and You work a minimum of 200 hours during the last plan year (July 1st – June 30th).

Reduction in Coverage Due to Age
Hartford will reduce the Life Insurance Benefit and Principal Sum for You by 35% on the Policy Anniversary Date following the date You attain age 65 and 50% when You attain age 70.

Option to Accelerate Payment of Death Benefit
If You become terminally ill (12 months or less life expectancy) while You are covered under the Fund's benefits, You may be eligible for an accelerated benefit. After applying in writing and satisfying Hartford's requirements You may receive, prior to Your death, a payment of between 25% to 80% of Your death benefit. The remainder of the benefit will be paid to Your beneficiary upon Your death. Please see the booklet provided by Hartford for more information or contact Hartford for the requirements to receive accelerated payment of death benefits.

See Hartford's Certificate of Coverage for a list of Exclusions.

Definitions

Administrative Fees
An administrative fee of $3.00 will be deducted from Your account for each check issued by the Fund in payment of WRA benefits to You.

Forfeiture
Monies held in Your account will be forfeited upon Your death or retirement. *However, claims for WRA benefits accrued before your retirement (that is, the date you permanently ceased to be Actively at Work) may be submitted up to 60 days after your retirement and, assuming you are otherwise eligible for such benefits, will be paid if there was a sufficient balance in your account prior to your retirement.*

How to File a Claim for Wage Replacement Account Benefits
A claim for Wage Replacement Benefits depends on the type of claim for which You are seeking benefits. For Supplemental Disability, Worker's Compensation, Unemployment, or Vacation benefits, simply contact the Fund Office and provide the necessary information, evidence or proof in order to receive the benefit. The Fund Office will make a decision no more than ninety (90) days after receipt of Your properly-filed claim. If the Fund Office requires an extension of time due to matters beyond its control, it will notify You of the reason for the delay and when the decision will be made. This notification will occur before the expiration of the 90-day period. A decision will be made within ninety (90) days of the time the Fund Office notifies You of the delay. If an extension is needed because additional information is needed from You, the extension notice will specify the information needed. Until You supply this additional information, the normal period for making a decision on the claim will be suspended.

For Life Insurance and Accidental Death and Dismemberment claims, please refer to Your Certificate of Insurance You received from the insurer.

Notice of Decision

1. If the period of time is extended due to failure to submit sufficient information, You will be notified of the need for additional information in the Notice of Extension and granted at least forty-five (45) days to provide additional information. The Plan will then make a claim determination within a reasonable period but no later than thirty (30) days from earlier of the date the Plan receives the additional information or the date by which the additional information must be provided.

    - Proof of entitlement to benefits must be provided to the Plan no later than twelve (12) months after the beginning of the period for which WRA supplemental disability or workers compensation benefits are payable. If You do not provide satisfactory proof within the time specified, You can still claim full benefits if You can show that proof was furnished as soon as reasonably possible.

2. Benefits begin when the claim for benefits has been determined to meet the requirements set forth herein. If the claim for benefits is approved, You will be notified in writing and benefit payments will begin.

3. If the claim for WRA benefits is wholly or partially denied, a notice of this initial denial will be provided to You in writing. This notice of initial denial will:

    - give specific reason(s) for the denial;
    - reference the specific Plan provision(s) on which the denial is based;
    - describe any additional information needed to perfect the claim and an explanation of why such added information is necessary;
    - provide an explanation of the Plan's appeal procedure, along with time limits;
    - contain a statement that You have the right to bring civil action under ERISA section 502(a) following an adverse appeal;
    - if the denial was based on an internal rule, guideline, protocol, or similar criterion, either the rule, etc., or a statement will be provided that such rule, guideline, protocol, or criteria will be provided free of charge to You, upon request; and
    - if the denial was based on a medical judgment (i.e., medical necessity, experimental, or investigational), the denial will state that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge to You, upon request.

Appeal of WRA Claims

If the claim is denied and You disagree with that decision, You or Your authorized representative may appeal. You have 180 days following receipt of an initial denial to appeal. The Plan will not accept appeals filed after this 180-calendar day period.

- Appeals of Supplemental Disability, Supplemental Worker's Compensation, Supplemental Unemployment and Vacation claims must be made in writing to the Board of Trustees. You will be provided with:

- upon request and without charge, reasonable access to and copies of all relevant documents, records and other information relevant to Your claim for benefits;

- the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;

- a full and fair review that takes into account all comments, documents, records, and other information submitted by You, without regard to whether such information was submitted or considered in the initial benefit determination;

- a review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;

- in deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including whether a particular treatment, drug, or other item is Experimental, Investigational, not Medically Necessary, or not appropriate, the appropriate named fiduciary will consult with a health care professional who has appropriate experience in the field of medicine involved in the medical judgment who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal nor the subordinate of any such individual; and

- upon request, the Plan will identify medical or vocational experts whose advice was obtained on behalf of the Plan in connection with an adverse benefit determination.

For Life Insurance and Accidental Death and Dismemberment appeals, please refer to Your Certificate of Insurance You received from the insurer.

Timing and Notice of Determination on Review

1. The Board will make a benefit determination on review no later than the date of the meeting of the committee or board that immediately follows the Plan's receipt of a request for review, unless the request for review is filed within thirty (30) calendar days preceding the date of such meeting. In such case, a benefit determination may be made no later than the date of the second meeting following the Plan's receipt of the request for review. If special circumstances require a further extension of time for processing, a benefit determination will be rendered no later than the third meeting of the Board following the Plan's receipt of the request for review. If such an extension is necessary the Plan will provide to You a Notice of Extension describing the special circumstances and date the benefit determination will be made.

2. The Plan Administrator will notify You of the benefit determination no later than five (5) days after the benefit determination is made. If Your appeal is denied, the notice of the denial on review will:

   - give specific reason(s) for the adverse decision;
   - reference the specific Plan provision(s) on which the denial is based;
   - contain a statement that You are entitled to receive, upon request, free access to and copies of documents relevant to Your claim;
   - note that You have the right to bring civil action under ERISA section 502(a) following the appeal;
   - if the denial was based on an internal rule, guideline, protocol, or similar criterion, a statement will be provided that such rule, guideline, protocol, or criteria will be provided free of charge to You, upon request; and
   - if the denial was based on a medical judgment (i.e., medical necessity, experimental, or investigational), the denial will state that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge to You, upon request.

Recovery of Excess Payments
In the event that a participant or a third party is paid benefits from the Plan in an improper amount or otherwise receives Plan assets not in compliance with the Plan (hereinafter referred to as "overpayments" or "mistaken payments"), the Plan has the right to start paying the correct benefit amount. In addition, the Plan has the right to recover any overpayment or mistaken payment made to You or to a third party. The claimant, third party, or other individual or entity receiving the overpayment or mistaken payment must pay back the overpayment or mistaken payment to the Plan with interest at 9% per annum. Such a recovery may be made by reducing other benefit payments made to or on behalf of You or Your spouse or eligible dependents, by commencing a legal action or by such other methods as the Trustees, in their discretion, determine to be appropriate. The claimant, third party, or other individual or entity will reimburse the Plan for attorneys' fees and paralegal fees, court costs, disbursements, and any expenses incurred by the Plan in attempting to collect and in collecting the overpayment or mistaken payment of benefits. The determination as to these matters is solely made by the Trustees.

Disclaimer of Liability
The Plan has no control over any diagnosis, treatment, care or lack thereof or other services delivered to You by a provider and disclaims liability for any loss or injury caused to You or Your Dependents by any provider by reason of negligence, failure to provide treatment or conduct otherwise deemed harmful to You or Your covered dependents.

Release of Records/Information
The Plan may, without the consent of or notice to any person, release to or obtain from any organization or person, information or records needed to implement Plan provisions. When You request benefits, You must furnish all the information required to implement Plan provisions. The Plan reserves the right to reject or suspend a claim based on lack of information and/or records. Any such release will be subject to HIPAA privacy/security rules.

Changes to be Reported
It is important that the Welfare Fund Office be notified whenever a change in any of the following occurs:

Home Address — Advise the Fund Office promptly so their records will be up-to-date if they have to contact You about any matter concerning Your benefits.

Beneficiary Designation — Contact the Fund Office to obtain the necessary form in the event You wish to change Your beneficiary for Your life insurance and Accidental Death and Dismemberment Insurance.

Family Composition — Give prompt written notice to the Fund Office about any change in Your family status, such as marriage or divorce, legal separation, birth or adoption or placement for adoption of a child, or the death of any dependent. The following may be used to document the change You are reporting: birth certificates, adoption papers, divorce decrees, legal separation agreements, and marriage certificates. (This list is illustrative, not exhaustive).

Physical Exam and Autopsy

The Plan, at its own expense, may require the person (whose illness, injury, disease or pregnancy is the basis of a claim) to be examined by a Physician chosen by the Plan. The Plan may require such an exam as often as is reasonable while a claim is pending. In case of death, the Plan may require an autopsy when the law does not forbid it.

COORDINATION OF BENEFITS (COB) – NON-DUPLICATION OF BENEFITS

This Plan contains a provision coordinating it with other similar group health plans under which a person may be covered such that the total benefits paid will not exceed the charges.

General Provision/Limitations

- When You or Your Dependents are covered under more than one group health plan, the combined benefits payable by this Plan and all other group health plans will not exceed 100% of the eligible expense incurred by the individual.
- The Plan assuming primary payer status will determine benefits first without regard to benefits provided under any other group health plan.
- Any individual, non-group insurance plan (the cost of which is entirely paid by the beneficiary) is specifically excluded from this coordination of benefits provision.
- The term "group health plan" includes the Federal programs of Medicare, Medicaid and Tricare (CHAMPUS). The regulations governing these programs take precedence over the order of determination of this Plan.
- When this group health plan is the secondary payer, it will reimburse, subject to all Plan provisions, the balance of remaining eligible expenses, not to exceed the normal Plan liability.
- If You are covered or eligible for benefits under any automobile or motor vehicle insurance, such as no fault, uninsured or underinsured coverage, personal injury protection (PIP), medical payments (Med-Pay) coverage, or other motor vehicle insurance, and You incur injuries related to a motor vehicle accident, the motor vehicle insurance is the primary payer for all charges related to that accident up to the policy's limit of liability. If Your no-fault or personal injury protection (PIP) policy has a limit of liability of at least $50,000, the Plan will pay, subject to the Plan terms, for related charges once that limit of liability has been reached. You must present proof of exhaustion of coverage which the Trustees in their sole discretion deem sufficient. Evidence or proof of exhaustion includes, but is not limited to, a written statement from each insurer for which coverage was or could have been provided that all benefits are exhausted, no further coverage is available, and no further benefits will be provided. The Trustees may deny coverage under this Plan until You have exhausted all legal remedies against the primary insurance.

Rules Guiding Payments

If a person is eligible for benefits under this Plan and another plan or plans, which also have a coordination of benefits provision, the following rules establish the order in which the various plans will pay, so that no more than 100% of eligible charges incurred are paid:

- If the person who received care is covered as an active employee under one coverage, and as a dependent under another, the coverage through employment pays first.
- If the person who received care is covered as an active employee under one coverage and as an inactive employee under another, the coverage through active employment pays first.
- If a person is an active employee under one or more coverage, the coverage which has covered the person for the longer period of time will pay first.
- If a person is covered by a state's Medicaid program, the coverage under the group health plan will be considered primary.

For a Dependent Child with parents not legally separated or divorced when this plan and another plan cover the same child as a dependent of different persons, called parents, the following rules apply:

- The benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year; but
- If both parents have the same birthday, the benefits of the plan which covered one parent longer are determined before those of the plan which covered the other parent for a shorter period of time; however,
- If the other plan does not have the rule described above, but instead has a rule based upon the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of the benefits.

When all plans covering a person as a Dependent Child of divorced or legally separated parents contain a coordination of benefits provision, the order of payment will be:

- The plan covering the Dependent Child of the natural parent designated by a court or state agency order to be responsible for the child's health care expenses will be considered primary; or
- In the absence of a court or state agency order specifying otherwise, the plan covering the Dependent Child of the natural parent having legal custody of the child will be considered primary; or
- Joint Custody: If the specific terms of a court decree state that the parents are to share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child will follow the order of benefit determination rules outlined in the steps for a dependent child with parents not separated or divorced (see above).

When none of the above applies, the coverage a covered person has had for the longest continuous period of time pays first.

If a covered person under this Plan is also covered under a health maintenance organization, this Plan will not provide benefits for any non-health maintenance organization treatment which would have been covered by the health maintenance organization if treatment had been obtained from the health maintenance organization.

Any group health plan that does not contain a coordination of benefits provision will be considered primary.

Right to Make Payments to Other Organizations
Whenever payments that should have been made by this Plan have been made by any other plan(s), this Plan has the right to pay the other plan(s) any amount necessary to satisfy the terms of this coordination of benefits provision. Amounts paid will be considered benefits paid under this Plan and, to the extent of such payment, the Plan will be fully released from any liability regarding the person for whom payment was made.

COORDINATION WITH MEDICARE

Entitlement to Medicare Coverage: Generally, anyone age 65 or older is entitled to Medicare coverage. Anyone under age 65 who is entitled to Social Security Disability Income benefits is also entitled to Medicare coverage after a waiting period.

Medicare Participants Who Are Actively Working May Retain or Cancel Coverage Under This Plan: If an eligible individual under this Plan becomes covered by Medicare Part A, B or D while actively working, whether because of end-stage renal disease (ESRD), disability or age, that individual may either retain or cancel coverage under this Plan. If the eligible individual under this Plan is covered by both this Plan and by Medicare, as long as the eligible employee remains actively employed, that employee's medical expense coverage will continue to provide the same benefits and contributions for that coverage will remain the same. In that case, this Plan pays first and Medicare pays second.

If an eligible individual under this Plan is covered by Medicare and an employee cancels coverage under this Plan, coverage of their Spouse and Dependent Child(ren) will terminate, but they may be entitled to COBRA Continuation Coverage. See the COBRA chapter for further information about COBRA Continuation Coverage.

If any of the eligible employee's Dependents are covered by Medicare and the employee **cancels** that Dependent's coverage under this Plan, that Dependent will **not** be entitled to COBRA Continuation Coverage. The choice of retaining or canceling coverage under this Plan of a Medicare participant is the responsibility of the employee. Neither this Plan nor the employee's employer will provide any consideration, incentive or benefits to encourage cancellation of coverage under this Plan.

Coverage Under Medicare and This Plan When Totally Disabled: If an eligible individual under this Plan who is actively working becomes Totally Disabled and entitled to Medicare because of that Disability, the eligible employee will no longer be considered to remain actively employed. As a result, once entitled to Medicare because of that disability, Medicare pays first and this Plan pays second to the extent consistent with applicable law.

Coverage Under Medicare and This Plan for End-Stage Renal Disease: If, while actively employed, an eligible individual under this Plan becomes entitled to Medicare because of end-stage renal disease (ESRD), this Plan pays first and Medicare pays second for 30 months starting the earlier of the month in which Medicare ESRD coverage begins; or the first month in which the individual receives a kidney transplant. Then, starting with the 31st month after the start of Medicare coverage, Medicare pays first and this Plan pays second.

Coverage Under Medicare When Participant is Retired: If You are retired and receiving benefits through the Plan's Medicare Supplemental Plan, Medicare benefits will be primary to any benefits received from the Fund. There is a separate booklet which describes coverage available to retirees. Please refer to that booklet for specific information on how the Medicare Supplemental Plan coordinates with Medicare for retired participants.

Information About Medicare Part D Prescription Drug Plans for People with Medicare: Prescription drug coverage is available to everyone with Medicare through private Medicare prescription drugs plans (often referred to as Medicare Part D). All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. For more information about this Plan's prescription drug coverage and Your options for Medicare prescription drug coverage, refer to separate materials provided by the Plan that explain how this Plan's prescription drug coverage compares to Medicare prescription drug coverage.

COORDINATION WITH OTHER GOVERNMENT PROGRAMS

Medicaid	If both this Plan and Medicaid cover a Covered Individual, this Plan pays first and Medicaid pays second.
TRICARE (Military Health Plan)	If both this Plan and the TRICARE military health plan cover an eligible individual, this Plan pays first and TRICARE pays second.
Veterans Affairs Facility Services	If an eligible individual receives services in a U.S. Department of Veterans Affairs Hospital or facility on account of a military service-related illness or injury, benefits are not payable by the Plan to the extent allowed by applicable law. If an eligible individual receives services in a U.S. Department of Veterans Affairs hospital or facility on account of any other condition that is not a military service-related illness or injury, benefits are payable by the Plan in accordance with regular Plan guidelines.
Other Coverage Provided by State or Federal Law	If You are covered by both this Plan and any other coverage provided by any other state or Federal law, the coverage provided by any other state or Federal law pays first and this Plan pays second.
Workers' Compensation	Injuries and diseases covered under any workers' compensation program are excluded from coverage under this Plan.

SUBROGATION PROVISION

Note: This provision applies to all employees (and pensioners) and their covered spouses and Dependents, with respect to all of the benefits provided under this Plan. For the purposes of this provision, the terms "You" and "Your" refer to all employees, pensioners and eligible spouses and Dependents.

General
Occasionally, a third party may be liable for Your medical expenses. This may occur when a third party is responsible for causing Your illness or injury or is otherwise responsible for Your medical bills. The Trustees, in their discretion, may determine to not provide benefits under the Plan for you if a third party may be responsible for the payment of benefits, until a determination is made by the proper and final decision-maker regarding the third party's responsibility to you.
The rules in this section govern how this Plan pays benefits in such situations.

These rules have two purposes. First, the rules ensure that Your benefits will be paid promptly. Often, where there is a question of third-party liability, many months pass before the third party actually pays. These rules permit the Plan to pay Your covered expenses until Your dispute with the third party is resolved.

Second, the rules protect this Plan from bearing the full expense in situations where a third party is liable. Under these rules, once it is determined that a third party is liable in any way for the injuries giving rise to these expenses, this Plan must be reimbursed for the relevant benefits it has advanced to You out of any recovery that You receive that is in any way related to the event which caused You to incur the medical expenses.

Rights of Subrogation and Reimbursement
If You incur covered expenses for which a third party may be liable, You are required to advise the Plan of that fact. By law, the Plan automatically acquires any and all rights to which You may have against the third party.

In addition to its subrogation rights, the Plan has the right to be reimbursed for payments made on Your behalf under these circumstances. The Plan must be reimbursed under any settlement, judgment, or other payment that You obtain from the liable third party, before any other expenses, including attorneys' fees, are taken out of the payment regardless of how you or the court characterize the nature of the recovery. In enforcing the Plan's rights to subrogation and reimbursement, the Trustees are not limited by any determination of the trier of fact as to the causal relationship between the injuries giving rise to these expenses and the liability of the third party if evidence exists which, in the opinion of the Trustees, supports causation.

The Plan must be paid in full without regard to whether you have received compensation for all of your damages and without regard to whether you have been "made whole". The Plan's rights to subrogation and reimbursement will not be affected, reduced or eliminated by the make-whole doctrine, comparative fault or the common fund doctrine. The Plan has no responsibility to contribute to the payment of your attorneys' fees and costs with respect to any aspect of your representation including the third party action itself, the reimbursement action or any other matter.

The Trustees may, in their sole discretion, require the execution of this Plan's lien forms by You (or Your authorized representative if You are a minor or cannot sign) before this Plan pays You any benefits related to such expenses. If the Trustees have required execution of the Plan's lien forms, no benefits will be provided unless You and Your attorney (if any) sign the form. You must also notify the Plan before You retain another attorney or an additional attorney since that attorney must also execute the form. The Plan's Subrogation Agreement must be signed by You and Your attorneys and received at the Fund Office on the earlier of either (1) one year from the date of your accident; or (2) thirty (30) days after the date of the letter from the Fund Office forwarding the Agreement to be signed. No Benefits will be paid by the Plan for the expenses related to that accident if the Agreement is not signed. **IN NO EVENT WILL THE FAILURE OF THE TRUSTEES TO REQUIRE EXECUTION OF THE LIEN FORMS DIMINISH OR BE CONSIDERED A WAIVER OF THE PLAN'S RIGHTS OF SUBROGATION AND REIMBURSEMENT.**

At the Plan's request, you must complete a form(s) which includes, but is not limited to, the following information:

1. The details of your accident or injury;

2. The name and the address of the person you claim caused the accident or injury as well as the name and address of that person's insurance company and attorney; and

3. The name and address of your attorney.

You must also:

1. Sign the Plan's lien forms;

2. Have your attorney sign the lien forms and return it to the Fund Office before any benefits are paid;

3. Provide the Fund Office with quarterly reports regarding the status of your third party claim or action including, but not limited to, motions, depositions, pretrial conferences, trial dates, settlement conferences, etc.; and

4. Promptly respond to any inquiries from the Plan regarding the status of the third party claim or action including, but not limited to, motions, depositions, pretrial conferences, trial dates, settlement conferences, etc.

Your duty to provide this information to the Plan is a continuing one.

Right of Future Subrogation and Reimbursement
In addition to satisfaction of the existing lien from any recovery received by the participant, spouse, or Dependent, the Plan is also entitled to a future credit for future related expenses equal to the net recovery by the participant, spouse, or Dependent. "Net recovery" shall be defined as the amount of Your total recovery and/or judgment less payment in full of the amount of the Plan's lien, less payment of Your attorneys' fees and costs related to the third party action. As such, the participant, spouse and/or dependent must spend the net recovery on related Plan expenses until the amount of said net recovery is exhausted. It is only at that point that the participant's, spouse's or Dependent's further related Plan benefits will again be the responsibility of the Plan pursuant to the terms of the Plan. The Plan will not resume payment of medical and related benefits until such time as You have provided the Plan with proof that You have utilized the net proceeds of the recovery and/or judgment to pay for medical and related expenses arising out of or related to the injuries which were the subject of the third party settlement or action. The Plan Office will determine the net monies available for a future credit.

Assignment of Claim
You may not assign any rights or causes of action that You may have against any third-party tortfeasor without the express written consent of the Plan.

The Trustees, in their sole discretion, may require You to assign Your entire claim against a third party to this Plan. If this Plan recovers from the third party any amount in excess of the benefits paid to You, plus the expenses, including attorneys' fees and costs, incurred in making the recovery, then the excess will be paid to You.

Failure to Disclose or Cooperate
You will be personally liable to the Plan for reimbursement owed to the Plan and the Plan will discontinue Your benefits if any of the following occurs:

1. You fail to tell the Plan that You have a claim against a third party;

2. You fail to assign Your claim against the third party to this Plan when required to do so;

3. You fail to cooperate with the Plan's efforts to recover the full amount of benefits paid by the Plan;

4. You fail to require any attorney You subsequently retain to sign the Plan's lien forms;

5. You and/or Your attorney fail to reimburse the Plan;

6. You fail to provide the Plan with medical or other authorization to obtain necessary information; or

7. You or Your attorneys fail to file written quarterly reports regarding your case with the Fund Office.

This Plan may offset the amount You owe from any future claims submitted by You as well as by Your dependents and beneficiaries and/or will discontinue benefits to You, Your dependents and beneficiaries, or, if necessary, take legal action against You and You will be personally liable to this Plan for the Plan's attorney's fees and costs incurred in recovering that amount. The Board of Trustees has the sole discretion to determine whether You and Your attorney have cooperated with the Plan's efforts to recover the entire amount of its lien. The reimbursement owed to the Plan may also, in the Trustees' discretion, be considered an overpayment or mistaken payment and must be repaid as provided in the section of this Plan dealing with overpayments and mistaken payments.

COBRA CONTINUATION COVERAGE

The Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") allows You and Your eligible dependents to elect to continue health coverage on a self-pay basis under the Plan, under certain circumstances, if coverage would otherwise stop. Your COBRA rights are subject to change. Coverage will be provided as required by law. If the law changes, Your rights will change accordingly.

Under COBRA, You and Your Dependents may continue the same health coverage that You/they were enrolled in right before the COBRA-Qualifying Event except for Life insurance, Accidental Death and Dismemberment, Supplemental Disability, Employee Assistance Program and Wage Replacement benefits. These benefits are not available under COBRA Continuation Coverage.

Definition of Terms Used Under the COBRA Section

Each Qualified Beneficiary **has an independent right to elect COBRA** Continuation Coverage when a Qualifying Event occurs, **and** as a result of that Qualifying Event, that person's health care coverage ends, either as of the date of the Qualifying Event or as of some later date. A parent or legal guardian may elect COBRA for a minor child. A Qualified Beneficiary also has the same rights and enrollment opportunities under the Plan as other covered individuals including Special Enrollment.

1. **"Qualified Beneficiary"**: Under the law, a Qualified Beneficiary is any Employee or the Spouse or eligible Dependent Child of an employee who was covered by the Plan when a Qualifying Event occurs, and who is therefore entitled to elect COBRA Continuation Coverage. A child who becomes a Dependent Child by birth, adoption or placement for adoption with the covered employee during a period of COBRA Continuation Coverage is also a Qualified Beneficiary.
    - A child of the covered employee who is receiving benefits under the Plan because of a Qualified Medical Child Support Order (QMCSO), during the employee's period of employment, is entitled to the same rights under COBRA as an eligible dependent child.
    - A person who becomes the new spouse of an existing COBRA participant during a period of COBRA Continuation Coverage is not a Qualified Beneficiary.
2. **"Qualifying Event"**: Qualifying Events are those described below under the sub-section "Providing Notice of Qualifying Events." Qualified Beneficiaries are entitled to COBRA Continuation Coverage when Qualifying Events (which are specified in the law) occur, **and**, as a result of the Qualifying Event, coverage of that Qualified Beneficiary ends. **A Qualifying Event triggers the opportunity to elect COBRA when the covered individual LOSES health care coverage under this Plan.** If a covered individual has a qualifying event but does not lose his or her health care coverage under this Plan, (*e. g.* employee continues working even though entitled to Medicare) then COBRA will not be offered.

Qualifying Events for You

For individuals covered by the Plan as employees, COBRA continuation coverage may be elected upon loss of coverage under the Plan due to voluntary or involuntary termination of employment (except for gross misconduct) or because the employee no longer meets the eligibility requirements of the Plan due to a reduction in hours worked, including a strike, walkout or layoff.

Qualifying Events for Your Spouse
Your spouse may elect COBRA continuation coverage upon the occurrence of (1) Your death; (2) Your spouse's loss of coverage under the Plan due to voluntary or involuntary termination of Your employment (except for gross misconduct), or because You no longer meet the eligibility requirements of the Plan due to a reduction in hours worked including a strike, walkout, or layoff; (3) divorce or judicial order of legal separation; or (4) Your enrollment in Part A or Part B of Medicare.

Qualifying Events for Your Dependent Child
Your Dependent Children can elect COBRA continuation coverage upon the occurrence of: (1) Your death; (2) Your Dependent Child's loss of coverage under the Plan due to termination of Your employment (for reasons other than gross misconduct) or because You no longer meet the eligibility requirements of the Plan due to a reduction in hours worked including a strike, walkout, or layoff; (3) divorce or judicial order of legal separation of the child's parents; (4) Your enrollment in Part A or Part B of Medicare; or (5) the child ceases to qualify as an "eligible dependent."

If, while You are receiving COBRA continuation coverage, You have a newborn child or a child is placed with You for adoption, the child may be added to Your coverage. You must, however, notify the Fund Office immediately of such a change.

Eligibility for COBRA Coverage due to a Qualifying Event
The following chart lists the COBRA Qualifying Events, who can be a Qualified Beneficiary and the maximum period of COBRA coverage based on that Qualifying Event. The maximum period of COBRA Continuation Coverage is generally either 18 months or 36 months, depending on which Qualifying Event occurred, measured from the date of the loss of Plan coverage. The 18-month period of COBRA Continuation Coverage may be extended for up to 11 months under certain circumstances (as described in below). The maximum period of COBRA coverage may be cut short for the reasons described in the section on "Early Termination of COBRA Continuation Coverage" that appears later in this section.

If You lose coverage a "qualifying event":	These individuals would be eligible for COBRA coverage:	For up to:
Your coverage terminates*	You and Your covered spouse and children	18 months**
Your working hours are reduced	You and Your covered spouse and children	18 months**
You die	Your covered spouse and children	36 months
You divorce or legally separate	Your covered spouse and children	36 months
Your Dependent Child no longer qualifies as an eligible Dependent	Your child	36 months
You become entitled to Medicare	Your covered spouse and children	36 months

* For any reason other than gross misconduct.

** **Coverage continues for 29 months.** If Your employment ends due to Your termination of employment or reduction in hours, and at that time, or within 60 days of the event, You or one of Your eligible dependents is totally disabled (as determined by the Social Security Administration), coverage may continue for an additional 11 months, for a total of 29 months. To continue coverage for an additional 11 months, You must notify the Fund Office of Your determination of Total Disability by the Social Security Administration. The self-payment for the additional 11 months will be 150% of the self-payment for the first 18 months.

Duration of COBRA
If the election is due to Your (the participant's) death, divorce, judicial order of legal separation, Your eligibility for and enrollment in, or entitlement to, Part A or Part B of Medicare (and You voluntarily drop Fund coverage due to the Medicare entitlement), a child's loss of status as an eligible dependent or the occurrence of a second qualifying event, COBRA continuation coverage can continue for up to 36 months.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months).

Extension of COBRA Continuation Coverage because of a Second Qualifying Event that Occurs During an 18-Month COBRA Continuation Period
If during an 18-month period of COBRA Continuation Coverage resulting from loss of coverage because of Your termination of employment or reduction in hours, You die, become divorced or legally separated, become entitled to Medicare, or if a covered child ceases to be a Dependent Child under the Plan, the maximum COBRA Continuation period for the affected Spouse and/or child is extended to 36 months from the date of Your termination of employment or reduction in hours (or the date You first became entitled to Medicare, if that is earlier, as described below).

This extended period of COBRA Continuation Coverage is not available to anyone who became Your Spouse after the termination of employment or reduction in hours. However, this extended period of COBRA Continuation Coverage is available to any child(ren) born to, adopted by or placed for adoption with You (the covered employee) during the 18-month period of COBRA Continuation Coverage.

Disability
An 11-month extension of coverage may be available if any of the qualified beneficiaries is determined by the Social Security Administration (SSA) to be disabled. To be entitled to this extension, the disability has to have started at some time before the 60th day of COBRA continuation of coverage and must last at least until the end of the initial 18-month period of continuation coverage. You must provide a copy of the Social Security Administration Determination along with Your notice. To receive this extension, notice of such disability must be provided to the Fund Office within the first 18 months of the COBRA continuation coverage, and within 60 days after the later of: (1) when you received the Social Security Administration disability determination; or (2) when your COBRA continuation coverage began.

If the qualified beneficiary is determined by the SSA to no longer be disabled, You must notify the Plan of that fact within 30 days after the SSA's determination.

Notifications to the Fund Office
Your employer has the obligation to notify the Fund Office of Your death or Your enrollment in Part A or Part B of Medicare. The Trustees have determined that because employees frequently work for more than one employer making contributions to the Plan and because of the difficulty which this causes employers in providing this notice, employment will be deemed to have terminated and/or the number of hours worked will be deemed to have been reduced when Your regular group health care coverage terminates.

You have the responsibility to inform the Administrative Manager of a divorce, legal separation, a child's loss of status as an eligible dependent, the birth or adoption of a dependent, or of a determination by the Social Security Administration that a qualified beneficiary is disabled. **This notice must be given in writing within sixty (60) days after the occurrence of the qualifying event or the date coverage would be lost because of the event, whichever is later. You must also provide supporting documentation with the written notice such as a copy of the divorce paperwork.** Failure to give notice to the Administrative Manager within the time limits may result in Your ineligibility for COBRA continuation coverage.

In addition to giving notice of certain qualifying events, You have the responsibility to inform the Fund in the event that the Social Security Administration has determined You or one of Your qualified beneficiaries to no longer be disabled. This notification must be made within thirty (30) days of the date of the final determination by the Social Security Administration that the qualified beneficiary is no longer disabled.

Notification of COBRA Rights
After the Administrative Manager receives notice of the occurrence of one of the above qualifying events, the Administrative Manager will notify each eligible individual whether he or she has the right to elect COBRA continuation coverage and will send the materials necessary to make the proper election. In general, the Administrative Manager will notify eligible individuals of their COBRA rights within 14 days after receiving notice of the occurrence of one of the qualifying events described above or after it has determined that Your regular group health care coverage has terminated.

Election of COBRA Coverage
The employee, spouse, and dependent children each have independent election rights. Covered employees may elect COBRA continuation coverage on behalf of their spouses and parents may elect COBRA continuation coverage on behalf of their children. Each individual will have 60 days from the date he or she would lose coverage because of one of the qualifying events described above or the date on which he or she is advised of the right to elect continuation coverage, whichever date is later, to inform the Administrative Manager that he or she wants COBRA continuation coverage. If no election of COBRA continuation coverage is made, the individual's group health coverage will terminate. You will not have another opportunity to elect continuation coverage. However, You may change Your election within the 60-day period described above as long as the completed COBRA Election Form, if mailed, is postmarked no later than the due date. If the election is hand delivered, the date of delivery must be on or before the due date. If You change Your mind after first rejecting COBRA continuation coverage, Your COBRA continuation coverage will begin on the date the completed Election Form is postmarked, if mailed. If the Election Form is hand delivered, Your COBRA continuation coverage will begin on the date of delivery.

Benefits Provided Under COBRA Coverage
The benefits an eligible individual is allowed to elect to receive will include all benefits the individual was entitled to before the occurrence of the event making the individual eligible for COBRA continuation coverage. However, no life insurance, disability or accidental death and dismemberment benefits or other non-health benefits will be included.

Consequences of Failing to Elect or Waive COBRA Continuation Coverage
In considering whether to elect continuation coverage, You should take into account that a failure to continue Your group health coverage could affect Your future rights under federal law. You should take into account that You have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which You are otherwise eligible (such as a plan sponsored by Your spouse's employer) within 30 days after Your group health coverage ends because of the qualifying event listed above. You will also have the same special enrollment right at the end of continuation coverage if You get continuation coverage for the maximum time available to You.

Other Health Coverage Alternatives to COBRA
Note that You may also have other health coverage alternatives to COBRA available to you that can be purchased through the Health Insurance Marketplace, the Marketplace helps people without health coverage find and enroll in a health plan, see Your state Health Insurance Marketplace or visit **www.healthcare.gov** for more information.
Also, in the Marketplace you could be eligible for a tax credit that lowers Your monthly premiums for Marketplace-purchased coverage. Being eligible for COBRA does not limit Your eligibility for coverage for a tax credit. Also, You may qualify for a special enrollment opportunity for another group health plan for which You are eligible (such as a spouse's plan), if You request enrollment in that other plan within 30 days of losing coverage under this Plan, even if that other plan generally does not accept late enrollees.

Termination of COBRA Coverage (How Long Coverage Lasts)
If the election is due to termination of Your employment or a reduction in hours worked, COBRA continuation coverage will end 18 months after Your other coverage ended. However, if You, Your spouse, or one of Your dependent children is determined by the Social Security Administration to be disabled on the day regular coverage terminates or within 60 days thereafter, the disabled person can receive a total of 29 months of COBRA continuation coverage. If You are the disabled person, Your spouse and Your dependent children also qualify for 29 months of this coverage. For all other situations, such coverage is available for 36 months. COBRA continuation coverage will end at an earlier time for any of the following reasons:

- The first day of the time period for which the individual does not pay the COBRA premiums within the required time period.
- The date on which the Plan is terminated.
- The date, after the date of the COBRA election, on which the individual first becomes covered by another group health plan.
- The date, after the date of the COBRA election, on which the individual first becomes entitled to Medicare (usually age 65).
- When active employee coverage would be terminated for cause (for example, You submit fraudulent claims to the Fund).

If any of these events occur, the Fund Office will send You a Notice of Termination of Coverage, explaining the reason the COBRA coverage terminated early, the date coverage terminated, and any rights the employee, spouse or dependent child may have under the Plan to elect alternate coverage.

Cost of COBRA Coverage
Each month, any individual electing COBRA continuation coverage will be required to make a payment to the Fund Office to continue COBRA continuation coverage. The monthly premium will be based on the average cost that the Plan incurs annually per participant plus a two percent administrative charge. The extra 11 months of COBRA continuation coverage available to disabled participants are at a monthly charge based on one and one-half times the average annual per participant cost incurred by the Plan.

The amount You, Your spouse and or Your eligible dependent(s) must pay for COBRA coverage will be paid monthly. The Fund Office will notify You of the cost of the coverage at the time You receive Your notice of entitlement, and of the monthly premium amount changes. The cost of COBRA Coverage may be subject to future increases during the period it remains in effect.

There will be an initial grace period of 45 days to pay the first amount due starting with the date COBRA coverage was elected. If this payment is not made when due, COBRA coverage will not take effect. After that, payments are due on the first day of each month. There will then be a grace period of 30 days to make these monthly payments. If payment of the amount due is not made by the end of this grace period, Your COBRA coverage will terminate.

Whom to Contact if You Have Questions or to Give Notice of Changes in Your Circumstances (Very Important Information)
If You have any questions about Your COBRA rights, please contact the Fund Office at:

Iron Workers District Council of Western New York and Vicinity
Welfare Fund
3445 Winton Place, Suite 238
Rochester, New York 14623-2950

Additional Information about COBRA Coverage
COBRA continuation coverage is described in greater detail in a letter sent out by the Fund Office to each participant when the participant becomes eligible to participate in the Fund or when COBRA first became applicable to the Fund, if later. If You have any questions concerning COBRA continuation coverage, You should contact the Administrative Manager.

For more information about Your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA) and other laws affecting group health plans, contact the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in Your area or visit the EBSA website at **www.dol.gov/ebsa**. (Addresses and telephone number of Regional and District EBSA Offices are available through EBSA's website).

STATEMENT OF ERISA RIGHTS

As a participant in the Welfare Fund, You are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants are entitled to:

Receive Information About Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as work sites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements and copies of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage
Continue health care coverage for Yourself, spouse or dependent children if there is loss of coverage under the Plan as a result of a qualifying event. You or Your dependents may have to pay for such coverage. Review this summary Plan description and the documents governing the Plan on the rules governing Your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries
In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit Plan. The people who operate Your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of You and other Plan participants and beneficiaries. No one, including Your employer, Your union, or any other person, may fire You or otherwise discriminate against You in any way to prevent You from obtaining Welfare Fund benefits or exercising Your rights under ERISA.

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

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

Assistance with Your Questions
If You have any questions about Your Plan, You should contact the Plan Administrator. If You have any questions about this statement or about Your rights under ERISA, You should contact the nearest Area Office of the Employee Benefits Security Administration, U.S. Department of Labor at the Boston Regional Office, JFK Federal Building, Room 3575, Boston, MA 02203, telephone (617) 565-9600, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administrations, U.S. Department of Labor 200 Constitution Avenue, N.W., Washington, DC 20210. You may also obtain certain publications about Your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Miscellaneous Provisions

The Trustees' Decision is Final and Binding
The Trustees' (or their designee's) final decision with respect to their review of your appeal will be final and binding upon you because the Trustees have exclusive authority and discretion to determine all questions of eligibility and entitlement under the Plan. Any legal action against this Plan must be started within 180 days from the date the adverse benefit determination denying your appeal, or External Review Decision, if you are eligible and pursue External Review, is deposited in the mail to your last known address. Please note that filing a lawsuit without exhausting the Fund's appeals procedures could limit your right to appeal or cause you to lose benefits to which you would otherwise be entitled. Notwithstanding anything to the contrary herein, you may not assign, convey, or in any way transfer your right to bring a lawsuit against the Plan, or its Trustees, to anyone else.

Venue
Venue of any legal action, including, but not limited to, any challenge to an appeal denial, in connection with this Plan shall lie exclusively in the Federal District Court in Monroe County, New York and all legal actions against this Plan and its Trustees may only be brought in the Federal District Court in Monroe County, New York.

Facility Of Payment
If the Plan Board or its designee determines that You cannot submit a claim or prove that You or Your eligible Dependent paid any or all of the charges for health care services that are covered by the Plan because You are incompetent, incapacitated, or in a coma, the Plan may, at its discretion, pay Plan Benefits directly to the Health Care Provider(s) who provided the health care services or supplies, or to any other individual who is providing for Your care and support. Any such payment of Plan Benefits will completely discharge the Plan's obligations to the extent of that payment. Neither the Plan, Board, nor any other designee of the Board, will be required to see to the application of the money so paid.