KENTUCKY LABORERS DISTRICT COUNCIL HEALTH AND WELFARE FUND

PLAN DOCUMENT

RESTATED NOVEMBER 1, 2021

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PREAMBLE

WHEREAS, the Board of Trustees of the Kentucky Laborers District Council Health and Welfare Fund, pursuant to the authority delegated to them by the provisions of the Agreement and Declaration of Trust, have unanimously determined to provide a written plan for payment of authorized benefits from the Trust Fund, and

WHEREAS, the Trustees deem it necessary to restate the eligibility rules and regulations and plans of benefits, effective **January 1, 2016.**

WHEREAS, the Trustees have unanimously determined to provide the following benefits for eligible Employees and their dependents;

NOW, THEREFORE, be it resolved that pursuant to the authority of the Agreement and Declaration of Trust that the Plan is hereby restated as follows:

ARTICLE I – DEFINITIONS

Section 1.1 - Accident
The term "Accident" shall mean any unexpected or unavoidable act that causes an injury to a Participant. An injury can be anything from a cut to a broken bone or other injury to the Participant.

Section 1.2 - Actively at Work
The term "Actively at Work" shall mean an Employee who is employed or unemployed but able and available for work and physically and mentally capable of performing each of the main duties of his regular job on a full-time basis. If an Employee is Actively at Work on his last regular working day, then he shall be deemed to be Actively at Work on each day of paid vacation or regular non-working day on which he is not disabled.

Section 1.3 - Administrative Manager
The term "Administrative Manager" shall mean any person, firm or corporation duly designated by the Trustees pursuant to the Trust Agreement to perform any and all necessary and proper duties of managing the Fund.

Section 1.4 - Alternate Recipient
The term "Alternate Recipient" shall mean any person who is recognized under a Qualified Medical Child Support Order as having a right to enrollment under this Plan.

Section 1.5 - Board of Trustees and Board
The terms "Board of Trustees" and "Board" shall mean persons designated as Trustees pursuant to the Trust Agreement. The Trustees shall hold all property, income and assets of the Trust for the sole purposes as defined in the Trust Agreement. The Trustees shall have the sole authority to administer and manage the Fund and any decision made by them shall be final and binding on all eligible Employees and eligible Dependents, except as otherwise provided herein or in the Trust Agreement.

Section 1.6 - Chemical Dependency Unit
The term "Chemical Dependency Unit (CDU)" shall mean a licensed facility which has a structured Inpatient program providing medical, social, diagnostic and treatment services to persons who suffer from an illness related to the misuse or abuse of alcohol and other drugs. A Chemical Dependency Unit must have adequate professionally accredited personnel and staff to meet the needs of patients on a twenty-four (24) hour basis.

Section 1.7 - Collective Bargaining Agreement
The term "Collective Bargaining Agreement" shall mean any agreement entered into between the Employers and the Union and any extensions, renewals, or amendments thereto providing for payments by an Employer to the Fund.

Section 1.8 - Contributions
The term "Contributions" shall mean contributions required to be made by Employers on behalf of their Employees. Contributions by an Employee shall not be permitted except as hereinafter provided.

Section 1.9 - Covered Employment
The term "Covered Employment" shall mean employment for which an Employer is obligated to contribute to the Plan.

Section 1.10 - Date Claim Incurred
The term "Date Claim Incurred" shall mean the date medical services are rendered by a physician or other medical provider.

Section 1.11 - Eligible Active Participant
The term "Eligible Active Participant" shall mean an Employee who satisfies the eligibility rules of the Plan and is receiving benefits under the Plan.

Section 1.12 - Eligible Dependent
The term "Eligible Dependent" shall mean:

A. The lawful spouse of an Eligible Active Participant. Spouse includes any individual(s) who are lawfully married under any state law, including individuals married to a person of the same sex who were legally married in a state that recognizes such marriages, but who are domiciled in a state that does not recognize such marriages. Marriage will include a same-sex marriage that is legally recognized as a marriage under any state law.

B. Each child of an Eligible Active Participant from the date he or she first becomes a child of the Employee to the end of the month in which such child attains age 26.

C. An unmarried child who is incapable of self-sustaining employment by reason of mental retardation or physical handicap, provided:
   1. Such incapacity began before the end of the month such child attains age 26;
   2. Such child is chiefly dependent upon the Eligible Active Participant for financial support and maintenance; and
   3. Proof of such incapacity is submitted to the Trustees within 31 days of the date such Dependent's eligibility would

otherwise terminate. The Fund may require proof of continuing incapacity from time to time.

D. For purposes of this definition of Eligible Dependent, the term "child" shall include natural and legally adopted children, children placed in the Eligible Active Participant's home for adoption, foster children and step children. The term "placed for adoption" means the assumption and retention by the Eligible Active Participant of a legal obligation for total or partial support of such child in anticipation of adoption of such child.

Notwithstanding any provision herein to the contrary, any person named an "Alternate Recipient" in a court order shall qualify for coverage as an eligible Dependent, provided the court order constitutes a Qualified Medical Child Support Order and is in accordance with the written procedures adopted by the Trustees relating to such orders.

Once an Eligible Dependent reaches 19 years of age, he or she must complete the appropriate adult dependent enrollment forms with the Fund Office. If the enrollment forms are not completed and submitted to the Fund Office, coverage of the Eligible Dependent may be delayed or denied.

Participants may make a one-time election to cease coverage under the Plan for any Eligible Dependents at any time during the Plan Year by completing the appropriate disenrollment forms with the Fund Office. Both the Participant and Eligible Dependent must complete and submit the requisite disenrollment forms(s) to the Fund Office in order for the cessation of coverage to be effective. Cessation of coverage for your Dependent will be effective on the first day following the month the Fund Office receives the aforementioned documents. Once the Eligible Dependent has been disenrolled from the Plan, the Eligible Dependent's coverage cannot be reinstated unless the Special Enrollment rules under HIPAA apply.

Section 1.13 - Eligible Retired Participant

The term "Eligible Retired Participant" shall mean a former Eligible Active Participant or a spouse of a former Eligible Active Participant who satisfies the eligibility rules of the Plan's Retiree Program.

Section 1.14 - Employee

The term "Employee" shall mean a person represented in collective bargaining by the Union and working for a contributing Employer.

The term "Employee" shall also mean the employees of the Union, any Employers' association whose member contractors are signatory to Collective Bargaining Agreements with the Union, the Kentucky Laborers District Council Joint Apprenticeship and Training Trust Fund, the Kentucky Laborers District Council Health and Welfare Trust Fund, and the Kentucky Laborers-Employers Cooperation & Education Trust.

The term "Employee" shall further include the regular non-bargaining unit employees of participating Employers, provided that said employees are not represented by another labor organization whose collective bargaining agreement with the Employer requires the Employer to furnish medical coverage and other health benefits through other sources, and provided further that contributions are made to the Welfare Fund on behalf of such employees at the uniform monthly contribution rate as determined from time to time by the Trustees.

Section 1.15 - Employer

A. The term "Employer", as used herein, shall mean an Employer of labor:

1. Who is in the construction industry, or otherwise, and who is a member of an Association, and who employs Employees as defined herein and is bound by an agreement with the Union providing for the payment by such Employer of contributions to the Trust Fund; or
2. Who is in the construction industry, or otherwise, and who is a not a member of an Association, but who employs Employees as defined herein and is bound by an agreement with the Union providing for the payment by such Employer of contributions to the Trust Fund; or
3. Who employs Employees as defined herein and who shall assume all of the duties and obligations to pay regular contributions to the "Trust Fund" as an Employer. An Employer under this subsection shall, upon executing an Assent of Participation and by paying the contribution rate set by the Trustees to said Trust Fund on behalf of such Employees, become a party to the Trust and be bound by all of the provisions, terms and conditions of this Agreement and Declaration of Trust.
4. The term "Employer" shall further mean the Union, any Employers' association whose member contractors are signatory to Collective Bargaining Agreements with the Union, the Kentucky Laborers District Council Joint Apprenticeship and Training Trust Fund, the Kentucky Laborers District Council Health and Welfare Trust Fund, and the Kentucky Laborers-Employers Cooperation & Education Trust for the sole purpose of making required contributions into the Welfare Trust Fund on behalf of their full-time employees.

B. Any Employer, as defined in subsections (A)(2), (A)(3), and (A)(4) of this Section, shall be bound and abide by all of the provisions of the Declaration of Trust and of any agreement made or to be made by and between an Association and the Union in respect to the Trust and all rules, regulations, decisions and determinations which may, from time to time, be made by the Trustees and, as to any such Employer, the Employer Trustees are and shall be his agent for the purpose of this Trust.

Section 1.16 - Family and Medical Leave or FMLA Leave

The terms "Family and Medical Leave" or FMLA Leave" shall mean a leave of absence, intermittent leave or leave on a reduced schedule, not to exceed twelve (12) work weeks in a calendar year, as determined and certified by a contributing Employer pursuant to the Family and Medical Leave Act of 1993 (FMLA), the regulations promulgated thereunder, and the Fund's policies and administrative procedures pertaining thereto.

Section 1.17 - Hospital

The term "Hospital" shall mean any institution that meets all of the following requirements:

A. Maintains permanent and full-time facilities for acute care of fifty or more resident patients, possessing full accreditation and maintaining and operating a full equipped and modern operating facility; and
B. Has a legally qualified Physician in regular attendance; and
C. Continuously provides 24-hour-a-day nursing service by registered nurses (RN); and
D. Is primarily engaged in providing diagnostic and therapeutic facilities for medical and surgical care of injured and sick persons on a basis other than as a rest home, nursing home, convalescent home, or a place for the aged; and
E. Is operating lawfully in the jurisdiction where it is located.

Section 1.18 - Injury
The term "Injury" shall mean a non-occupational accidental bodily injury or injuries, resulting in loss while eligible under the Plan, independently of Sickness and other causes.

Section 1.19 - Inpatient
The term "Inpatient" shall mean a person who is treated as a registered bed patient in a Hospital or other healthcare facility and for whom a Room and Board charge is made.

Section 1.20 - Intensive Care Unit
The term "Intensive Care Unit" shall mean a specifically designed and permanently equipped unit with special equipment or supplies immediately available on a standby basis, and which is segregated from the rest of the Hospital's facilities and staffed to provide extensive care for critically and seriously ill or injured patients requiring constant audiovisual observation as prescribed by the attending Physician. Such unit shall provide room and board and nursing care by nurses whose duties are primarily confined to care of patients in the Intensive Care Unit.

Section 1.21 - Medically Necessary
The term "Medically Necessary" shall mean that the service received is required to identify or treat the Sickness or Injury which a Physician has diagnosed or reasonably suspects. The service must be consistent with the diagnosis and treatment of the individual's condition, be in accordance with standards of good medical practice, be required for reasons other than the convenience of the individual or the Physician, and be performed in the least costly setting required by the individual's condition. The fact that a service is prescribed by a Physician shall not necessarily mean that such service is Medically Necessary.

Section 1.22 - Participant
The term "Participant" shall mean an Employee or former Employee of an Employer who is, or may become, eligible to receive any type of benefit from this Fund or whose beneficiaries may become eligible to receive any such benefit.

Section 1.23 - Physician or Surgeon
The term "Physician" or "Surgeon" shall mean a person who is duly licensed to prescribe and administer drugs or to perform surgery. The term shall also include optometrists, chiropractors, osteopaths, psychologists, masters of social work, registered nurse practitioners, physician assistants, and certified registered nurse assistants operating within the scope of their license. Dentists and dental surgeons are included to the extent allowed under the specific terms of this Plan as described in Article VI, Section 6.13, Items 13 & 14; Article VIII, Section 8.18, Items 13 & 14; and Article IX.

Section 1.24 - Plan
The term "Plan" shall mean the benefit rules and regulations as adopted and amended from time to time by the Board of Trustees.

Section 1.25 - Plan Year
The term "Plan Year" shall mean a one-year period beginning January 1 and ending December 31.

Section 1.26 - Qualified Medical Child Support Order
The term "Qualified Medical Child Support Order (QMCSO)" shall mean a court order which creates or recognizes the existence of an Alternate Recipient's rights to, or assigns to an Alternate Recipient the right to receive, benefits for which a Participant or Eligible Dependent is entitled under this Plan provided:

A. The court order clearly specifies:
   1. The name and last known mailing address of the Participant and the name and mailing address of each Alternate Recipient covered by the order;
   2. A reasonable description of the type of coverage to be provided by the Plan to each such Alternate Recipient, or the manner in which such type of coverage is to be determined;
   3. The period to which such order applies; and
   4. The name of this Plan
B. The court order does not require the Plan to provide any type or form of benefit, or any option, not otherwise provided under the Plan, except to the extent necessary to satisfy the requirements of law relating to medical child support pertaining to Medicaid eligible children as described in §1908 of the Social Security Act, as added by §13623 of the Omnibus Budget Reconciliation Act (OBRA) of 1993.

Section 1.27 - Reasonable and Customary
The term "Reasonable and Customary " shall mean only those charges made for services or supplies essential to the care of the patient

which, according to standards and limits adopted by the Trustees, are (a) the most consistent charge by the Physician and/or Hospital for a given procedure, supplies, equipment or drugs; (b) the usual fee for a procedure by the majority of physicians with similar training and experience within the same locality; and (c) reasonable when such charges meet the criteria in (a) and (b) or when, in the judgment of the Trustees, merit special consideration based upon the complexity of treatment. For Emergency services from a non-network provider, reasonable and customary shall mean the greatest of the following amounts: (a) the median of the amount negotiated with each PPO provider; (b) the amount the Plan generally uses to determine payments for non-network services; or (c) the Medicare rate.

Section 1.28 - Room and Board
The term "Room and Board" shall mean all charges commonly made by a Hospital for room and meals and for all general services and activities essential to the care of patients.

Section 1.29 - Sickness
The term "Sickness" shall mean a disease, disorder or condition that requires treatment by a Physician.

Section 1.30 - Total and Permanent Disability
The term "Total and Permanent Disability" shall mean that the Eligible Active Participant is prevented, solely because of disease or injury, completely and continuously from engaging in his regular or customary occupation.

Section 1.31 - Trust Agreement
The term "Trust Agreement" shall mean the Agreement of Declaration and Trust establishing the Kentucky Laborers District Council Health and Welfare Fund.

Section 1.32 - Trust Fund or Fund
The term "Trust Fund" or "Fund" shall mean the Kentucky Laborers District Council Health and Welfare Fund.

Section 1.33 - Union
The term "Union" shall mean the Kentucky Laborers District Council and its affiliated unions having jurisdiction in the State of Kentucky, who have in effect with signatory Employer associations and/or with other Employers, Collective Bargaining Agreements providing for the establishment of a Health and Welfare Fund and for the payment of Contributions to such Fund.

ARTICLE II - SCHEDULES OF BENEFITS

Section 2.1 – Active Plan of Benefits

ACTIVE PLAN

FOR EMPLOYEES ONLY:

DEATH BENEFIT	AMOUNT	BENEFIT INFORMATION
DEATH BENEFIT	$10,000	24 hour coverage / No double indemnity **NOTE:** Beneficiary will receive Form 1099-R. Benefit may be taxable. Consult a tax professional to determine any tax liability
ACCIDENTAL DEATH & DISMEMBERMENT Life Both Hands Both Feet Both Eyes One Hand and One Foot One Hand and One Eye One Hand or One Foot or Either Eye Thumb and Index Finger of Either Hand Any Two Fingers	 $10,000 $10,000 $10,000 $10,000 $10,000 $10,000 $ 5,000 $ 2,500 $ 2,500	24 hour coverage **NOTE:** Beneficiary will receive Form 1099. Benefit may be taxable. Consult your tax professional to determine any tax liability.
ACCIDENT & SICKNESS WEEKLY BENEFIT	$400 weekly (or 1/7 of $400 benefit per day)	Benefits paid from 1st day of treatment for disability due to accident and 8th day of treatment of disability due to sickness. Accident & Sickness Weekly Benefit subject to federal / state tax. Maximum number of weeks payable per disability: 13

FOR EMPLOYEES AND ELIGIBLE DEPENDENTS

MAJOR MEDICAL BENEFITS	AMOUNT	BENEFIT INFORMATION
MAJOR MEDICAL DEDUCTIBLE AMOUNT PPO (in network) Per person / Maximum per family NON PPO (not in network) Per person / Maximum per family	 $ 500 / $ 1500 $1500 / $3000	Both PPO and Non-PPO Deductibles (per person and per family) are Per Calendar Year

EMERGENCY ROOM COPAYMENT	$250	Emergency Room Copayment will be waived ONLY if a) there is hospital inpatient admission for same or related diagnosis within 24 hours of the Emergency Room visit (Must be inpatient admission – not observation.) and b) patient has been treated for same or related diagnosis at an urgent care treatment center or Physician's office within 24 hours of the Emergency Room visit. Emergency Room Copayment applies to the Out-of-Pocket Maximum. Emergency Room visits will still be subject to Major Medical Deductible.
COINSURANCE All Non-PPO (not in network) Providers All PPO (in network) Providers Visits Related to Diagnosis of COVID-19 (including items and services furnished during visit). This does not include treatment related to COVID-19	 60% 80% 100%	 Non-PPO (not in network) Hospitals, Physicians, Other Ancillary Providers PPO (in network) Hospitals, Physicians, Other Ancillary Providers The Plan covers diagnostic testing for COVID-19 at 100%, not subject to the Major Medical Deductible or Coinsurance. The Plan covers PPO and Non-PPO Physician Office visits (including telehealth visits), Urgent Care Center visits or Emergency Room Visits related to the diagnosis of COVID-19 at 100%, not subject to the Major Medical Deductible or Coinsurance.
OUT-OF-POCKET MAXIMUM PPO (in network) Per person for 2022 / Max per family for 2022: NON PPO (not in network) Per person for 2022 / Max per family for 2022:	 $ 6650 / $13300 $ 7500 / $15000	Both PPO and Non PPO Out of Pocket (OOP) Maximums (per person & per family) are Per Calendar Year and include their respective calendar year deductibles and Participant's portion of coinsurance and any Emergency Room Copayments.. PPO / Non PPO OOP Maximums DO NOT include penalties that may be imposed. Dental, Vision and Prescription Drug claims are not included in the Major Medical OOP Maximums. OOP Maximums may be adjusted annually based on maximum allowed for calendar year in compliance with any government mandates.
WELLNESS BENEFITS	see applicable coinsurance above	Employee or Spouse: One routine physical exam per calendar year, including related diagnostic lab /x-ray, payable as any other illness . Covered Expenses related to Wellness Benefits are NOT subject to Major Medical Deductible
ANTHEM ONLINE HEALTH SERVICES Medical Service: Medical Visit Psychological Services: Session with Psychologist Session with Social Worker/Therapist Initial Visit with Psychiatry Follow up with Psychiatry	FEE FOR ELIGIBLE EMPLOYEES AND DEPENDENTS $0.00 $0.00 $0.00 $0.00 $0.00	You are eligible for Anthem Online Health Services if you an Eligible Active Employee or an Eligible Dependent
DENTAL BENEFITS THROUGH DELTA DENTAL	**AMOUNT**	**BENEFIT INFORMATION**
DENTAL	$1000 Per Family Subject to Delta Dental Schedule	Payable at 100% for Class I, 80% Class II & 50% Class III In-Network up to $1000 per calendar year per family. No coverage for: cosmetic procedures (i.e., whitening of teeth, etc.), orthodontics, prescription drugs [except as covered under Prescription Drug Benefit]. Not subject to Major Medical Deductible or Major Medical Out-of-Pocket Maximum
VISION BENEFITS	**AMOUNT**	**BENEFIT INFORMATION**
VISION	$500 per person	Payable at 100% per 24 month period. Not subject to Major Medical Deductible or Major Medical Out-of-Pocket Maximum
PRESCRIPTION DRUG BENEFITS THROUGH ENVISION	**AMOUNT**	**BENEFIT INFORMATION**
RETAIL PHARMACY: Participant Co-pays: Generic Brand (on Preferred Medication List) Brand (NOT on Preferred Medication List)	 $15 $40 $75	Maximum supply per prescription fill: 30 days for original and two subsequent refills. After your third fill, you must order a 90-day supply through either Retail Pharmacy or Mail Order and pay the applicable copayments.
MAIL ORDER: Participant Co-pays: Generic Brand (on Preferred Medication List) Brand (NOT on Preferred Medication List)	 $30 $80 $150	Maximum supply per prescription fill: 90 days. For Mail Order Prescriptions, you must file claims through the Mail Order Prescription Program and pay the applicable copayments.
SPECIALTY DRUGS: Participant Co-pays: Generic Brand (on Preferred Medication List) Brand (NOT on Preferred Medication List)	 $15 $40 $75	Maximum Supply per prescription fill: 30 days. You must file claims through Specialty Pharmacy and pay the appliable copayments.
OUT-OF-POCKET MAXIMUM Per person per calendar year for 2022 Max per family per calendar year for 2022	 $1,700 $3,400	Prescription Drug Out-of-Pocket Maximums (per person/per family) are Per Calendar Year and include prescription drug copayments. Out-of-Pocket Maximums do not include penalties for brand fills when generic is available. Dental, Vision and Medical claims are not included in the Prescription Drug Out-of-Pocket Maximums. NOTE: Out of Pocket Maximums may be adjusted annually based on maximum allowed for calendar year in compliance with any government mandates.

Section 2.2 – Retiree B Plan of Benefits for Pre-Medicare Retirees

RETIREE B PLAN

This Plan is no longer available to new Eligible Retired Participants and/or their spouses as of January 1, 2011.

FOR RETIREE ONLY:

DEATH BENEFIT	AMOUNT	BENEFIT INFORMATION
DEATH BENEFIT	$5,000	24- hour coverage / No double indemnity **NOTE:** Beneficiary will receive Form 1099-R. Benefit may be taxable. Consult a tax professional to determine any tax liability

FOR RETIREE OR RETIREE SPOUSE:

BASIC BENEFITS	AMOUNT	BENEFIT INFORMATION
HOSPITAL BENEFIT	$1,000	Payable at 100% for each inpatient hospitalization, each outpatient surgery facility and each outpatient emergency room facility (for services rendered within 24 hours after an injury). Two or more Inpatient Hospitalizations shall be considered as one (1) hospitalization unless the hospitalizations are separated by more than (1) month or are due to unrelated causes. Not subject to Major Medical Deductible, Major Medical Out-of-Pocket Maximum
OUTPATIENT LABORATORY & X-RAY BENEFIT	$50	Payable at 100% per calendar year / Not subject to Major Medical Deductible or Out-of-Pocket Maximum
MAJOR MEDICAL BENEFITS	**AMOUNT**	**BENEFIT INFORMATION**
MAJOR MEDICAL DEDUCTIBLE AMOUNT PPO (in network) NON PPO (not in network)	 $500 $1500	Both PPO and Non-PPO Deductibles are Per Calendar Year
EMERGENCY ROOM COPAYMENT	$250	Emergency Room Copayment will be waived ONLY if a) there is hospital inpatient admission for same or related diagnosis within 24 hours of the Emergency Room visit. (Must be inpatient admission – not observation.) and b) patient has been treated for same or related diagnosis at an urgent care treatment center or Physician's office within 24 hours of the Emergency Room visit. Emergency Room Copayment applies to the Out-of-Pocket Maximum. Emergency Room visits will still be subject to Major Medical Deductible.
COINSURANCE All Non-PPO (not in network) Providers All PPO (in network) Providers Visits Related to Diagnosis of COVID-19 (including items & services furnished during visit). This does not include treatment related to COVID-19	 50% 70% 100%	Non-PPO (not in network) Hospitals, Physicians, Other Ancillary Providers PPO (in network) Hospitals, Physicians, Other Ancillary Providers The Plan covers diagnostic testing for COVID-19 at 100%, not subject to the Major Medical Deductible or Coinsurance. The Plan covers PPO and Non-PPO Physician Office visits (including telehealth visits), Urgent Care Center visits or Emergency Room Visits related to the diagnosis of COVID-19 at 100%, not subject to the Major Medical Deductible or Coinsurance.
OUT-OF-POCKET MAXIMUM PPO (in network) for 2022: NON PPO (not in network) for 2022	 $6650 $7500	Both PPO & Non PPO Out of Pocket (OOP) Maximums are Per Calendar Year and include their respective calendar year deductibles and Participant's coinsurance portion. PPO/NonPPO OOP Maximums DO NOT include penalties that may be imposed. Dental, Vision & Prescription Drug claims are not included in Major Medical OOP Maximums. OOP Maximums may be adjusted annually based on maximum allowed for calendar year in compliance with government mandates.
WELLNESS BENEFITS	see applicable coinsurance above	One routine physical exam per calendar year (incl. related diagnostic lab/x-ray) payable as any other illness. Covered Expenses related to Wellness Benefits NOT subject to Major Med Deduct
ANTHEM ONLINE HEALTH SERVICES Medical Service: Medical Visit Psychological Services: Psychologist Session Social Worker/Therapist Session Initial Visit with Psychiatry Follow up with Psychiatry	RETIREE'S FEE $0.00 $0.00 $0.00 $0.00 $0.00	You are eligible for Anthem Online Health Services if you an Eligible Retired Participant who is not on Medicare
DENTAL BENEFITS THROUGH DELTA DENTAL	**AMOUNT**	**BENEFIT INFORMATION**
DENTAL	$500 Subject to Delta Dental Benefit Schedule	Payable at 100% for Class I, 80% Class II & 50% Class III In-Network up to $500 per calendar year. No coverage for: cosmetic procedures (i.e., whitening of teeth, etc.), orthodontics, prescription drugs [except as covered under Prescription Drug Benefit]. Not subject to Major Medical Deductible or Major Medical Out-of-Pocket Maximum
VISION BENEFITS	**AMOUNT**	**BENEFIT INFORMATION**
VISION	$500	Payable at 100% per 24 month period. Not subject to Major Medical Deductible or Major Medical Out-of-Pocket Maximum

PRESCRIPTION DRUG BENEFITS THROUGH ENVISION	AMOUNT	BENEFIT INFORMATION
RETAIL PHARMACY: Participant Co-pays: Generic Brand (on Preferred Medication List) Brand (NOT on Preferred Medication List)	 $15 $40 $75	Maximum supply per prescription fill: 30 days for original and two subsequent refills. After your third fill, you must order a 90-day supply through either Retail Pharmacy or Mail Order and pay the applicable copayments.
MAIL ORDER: Participant Co-pays: Generic Brand (on Preferred Medication List) Brand (NOT on Preferred Medication List)	 $30 $80 $150	Maximum supply per prescription fill: 90 days. For Mail Order Prescriptions, you must file claims through the Mail Order Prescription Program and pay the applicable copayments.
SPECIALTY DRUGS: Participant Co-pays: Generic Brand (on Preferred Medication List) Brand (NOT on Preferred Medication List)	 $15 $40 $75	Maximum Supply per prescription fill: 30 days. You must file claims through Specialty Pharmacy and pay the appliable copayments.
OUT-OF-POCKET MAXIMUM Per person per calendar year for 2022:	$1,700	Prescription Drug Out-of-Pocket Maximum is Per Calendar Year and includes prescription drug copayments. Out-of-Pocket Maximum does not include penalties for brand fills when generic is available. Dental, Vision and Medical claims are not included in the Prescription Drug Out-of-Pocket Maximum. NOTE: Out of Pocket Maximums may be adjusted annually based on maximum allowed for calendar year in compliance with any government mandates.

Section 2.3 – Retiree H Plan of Benefits for Pre-Medicare Retirees

RETIREE H PLAN

FOR RETIREE ONLY:

DEATH BENEFIT	AMOUNT	BENEFIT INFORMATION
DEATH BENEFIT	$5,000	24- hour coverage / No double indemnity **NOTE:** Beneficiary will receive Form 1099R. Benefit may be taxable. Consult a tax professional to determine any tax liability

FOR RETIREE OR RETIREE SPOUSE:

MAJOR MEDICAL BENEFITS	AMOUNT	BENEFIT INFORMATION
MAJOR MEDICAL DEDUCTIBLE AMOUNT PPO (in network) NON PPO (not in network)	 $500 $1500	Both PPO and Non-PPO Deductibles are Per Calendar Year
EMERGENCY ROOM COPAYMENT	$250	Emergency Room Copayment will be waived ONLY if a) there is hospital inpatient admission for same or related diagnosis within 24 hours of the Emergency Room visit. (Must be inpatient admission – not observation.) and b) the patient has been treated for same or related diagnosis at an urgent care treatment center or Physician's office within 24 hours of the Emergency Room visit. Emergency Room Copayment applies to the Out-of-Pocket Maximum. Emergency Room visits will still be subject to Major Medical Deductible.
COINSURANCE All Non-PPO (not in network) Providers All PPO (in network) Providers Visits Related to Diagnosis of COVID-19 (including items/services furnished during visit). Does not include treatment related to COVID-19	 60% 80% 100%	Non-PPO (not in network) Hospitals, Physicians, Other Ancillary Providers PPO (in network) Hospitals, Physicians, Other Ancillary Providers The Plan covers diagnostic testing for COVID-19 at 100%, not subject to the Major Medical Deductible or Coinsurance. The Plan covers PPO and Non-PPO Physician Office visits (including telehealth visits), Urgent Care Center visits or Emergency Room Visits related to the diagnosis of COVID-19 at 100%, not subject to the Major Medical Deductible or Coinsurance.
OUT-OF-POCKET MAXIMUM PPO (in network) for 2022: NON PPO (not in network) for 2022	 $6650 $7500	Both PPO and Non PPO Maximums are Per Calendar Year and include their respective calendar year deductibles and Participant's portion of coinsurance. PPO / NonPPO Out of Pocket Maximums DO NOT include penalties that may be imposed. Dental, Vision and Prescription Drug claims are not included in the Major Medical Out of Pocket Maximums. NOTE: Out of Pocket Maximums may be adjusted annually based on maximum allowed for calendar year in compliance with any government mandates.
WELLNESS BENEFITS	see applicable coinsurance above	Retiree or Retiree Spouse: One routine physical exam per calendar year, including related diagnostic lab /x-ray, payable as any other illness. Covered Expenses related to Wellness Benefits are NOT subject to Major Medical Deductible

ANTHEM ONLINE HEALTH SERVICES *Retired Participant Not on Medicare* Medical Service: Medical Visit Psychological Services: Session with Psychologist Session with Social Worker/Therapist Initial Visit with Psychiatry Follow up with Psychiatry *Retired Participant Enrolled in Medicare* Medical Service: Medical Visit Psychological Services: Session with Psychologist Session with Social Worker/Therapist Initial Visit with Psychiatry Follow up with Psychiatry	RETIREE FEE $0.00 $0.00 $0.00 $0.00 $0.00 $ 59.00 $ 95.00 $ 80.00 $175.00 $ 75.00	You are eligible for Anthem Online Health Services if you an Eligible Retired Participant who is not on Medicare If you are an Eligible Retired Participant and are also enrolled in Medicare and are not on the Anthem MAPD Plan, Medicare is primary and you must pay the relevant fee for service.
DENTAL BENEFITS THROUGH DELTA DENTAL	**AMOUNT**	**BENEFIT INFORMATION**
DENTAL	$500 Subject to Delta Dental Benefit Schedule	Payable at 100% for Class I, 80% Class II & 50% Class III In-Network up to $500 per calendar year. No coverage for: cosmetic procedures (i.e., whitening of teeth, etc.), orthodontics, prescription drugs [except as covered under Prescription Drug Benefit]. Not subject to Major Medical Deductible or Major Medical Out-of-Pocket Maximum
VISION BENEFITS	**AMOUNT**	**BENEFIT INFORMATION**
VISION	$500	Payable at 100% per 24 month period. Not subject to Major Medical Deductible or Major Medical Out-of-Pocket Maximum
PRESCRIPTION DRUG BENEFITS THROUGH ENVISION	**AMOUNT**	**BENEFIT INFORMATION**
RETAIL PHARMACY: Participant Co-pays: Generic Brand (on Preferred Medication List) Brand (NOT on Preferred Medication List)	 $15 $40 $75	Maximum supply per prescription fill: 30 days for original and two subsequent refills. After your third fill, you must order a 90-day supply through either Retail Pharmacy or Mail Order and pay the applicable copayments.
MAIL ORDER: Participant Co-pays: Generic Brand (on Preferred Medication List) Brand (NOT on Preferred Medication List)	 $30 $80 $150	Maximum supply per prescription fill: 90 days. For Mail Order Prescriptions, you must file claims through the Mail Order Prescription Program and pay the applicable copayments.
SPECIALTY DRUGS: Participant Co-pays: Generic Brand (on Preferred Medication List) Brand (NOT on Preferred Medication List)	 $15 $40 $75	Maximum Supply per prescription fill: 30 days. You must file claims through Specialty Pharmacy and pay the appliable copayments.
OUT-OF-POCKET MAXIMUM Per person per calendar year for 2022	 $1,700	Prescription Drug Out-of-Pocket Maximum is Per Calendar Year and includes prescription drug copayments. Out-of-Pocket Maximum does not include penalties for brand fills when generic is available. Dental, Vision and Medical claims are not included in the Prescription Drug Out-of-Pocket Maximum. NOTE: Out of Pocket Maximums may be adjusted annually based on maximum allowed for calendar year in compliance with any government mandates.

Section 2.4 – Plan of Benefits for Medicare Retirees

The amounts listed below for medical and prescription drug benefits provide an overview of covered expenses under the MAPD Plan. For a complete list of covered expenses, please contact the MAPD Plan provider.

Medicare Retirees

Death Benefit (Retiree Only)	
Death Benefit (Retiree Only)	$5,000
Medical Benefit under the MAPD Plan (Retiree and Retiree Spouse)	
Calendar Year Deductible	$500 per person
Out-of-Pocket Maximum per Calendar Year	$500 per person
Primary Care Office Visit	MAPD Plan pays 100%
Specialist Office Visit	MAPD Plan pays 100%

Diagnostic Tests	MAPD Plan pays 100%	
Preventative Screenings	MAPD Plan pays 100%	
Emergency Room	MAPD Plan pays 100%	
Urgent Care	MAPD Plan pays 100%	
Inpatient Hospital Care	MAPD Plan pays 100%	
Outpatient Care	MAPD Plan pays 100%	
Skilled Nursing Care	MAPD Plan pays 100%	
Durable Medical Equipment	MAPD Plan pays 100%	
Chiropractic Care (no visit limitation)	MAPD Plan pays 100%	
Acupuncture	MAPD pays 100% up to 12 visits in 90 days	
Hearing Aids	MAPD pays up to $3,000 per ear every 5 years	
Prescription Drug Benefit under the MAPD Plan (Retiree and Retiree Spouse)		
Out-of-Pocket Maximum per Calendar Year	$1,700 per person	
Prescription Drug Benefits	**Your Co-Payment**	
Retail Pharmacy: Generic Brand (on Preferred Medication List) Brand (Not on Preferred Medication List)	 $15 $40 $75	
Mail Order / Retail 90-Day Supply: Generic Brand (on Preferred Medication List) Brand (Not on Preferred Medication List)	 $30 $80 $150	
Specialty Pharmacy: Generic Brand (on Preferred Medication List) Brand (Not on Preferred Medication List)	 $15 $40 $75	
Vision Benefit under the MAPD Plan (Retiree and Retiree Spouse)		
	PPO Charges	***Non-PPO Charges***
Eye Exam (once every calendar year)	$0 copayment, MAPD Plan pays 100%	MAPD Plan pays up to $70
Eyeglass frame, eyeglass lenses, contact lenses and lens options (Once every two calendar years)	MAPD Plan pays up to $500 and you receive a 20% discount off the amount over $500 (except as provided below) Elective Conventional Lenses – you receive a 15% discount off the amount over $500 Elective Disposable Lenses – you receive no additional discount off the amount over $500 Non-Elective Contact Lenses – MAPD Plan pays 100%	MAPD Plan pays up to $500 (except as provided below) Non-Elective Contact Lenses – MAPD Plan pays up to $100
Dental Benefit (Retiree and Retiree Spouse)		
Calendar Year Maximum	$500	
Delta Dental Benefit Schedule	Payable at 100% for Class I, 80% Class II & 50% Class III In-Network up to $500 per calendar year. No coverage for: cosmetic procedures (i.e., whitening of teeth, etc.), orthodontics, prescription drugs [except as covered under Prescription Drug Benefit]. Not subject to Major Medical Deductible or Major Medical Out-of-Pocket Maximum	

ARTICLE III - ELIGIBILITY FOR ACTIVE BENEFITS

Section 3.1 – Initial Eligibility Requirements

A. Active Construction Unit Employees

If you are an Active Construction Unit Employee, you are eligible for Active Benefits based on the number of Credited Work Hours in your Hours Bank. Credited Work Hours include hours in Covered Employment for which Contributions are received by the Fund, and hours based on reciprocal contributions received from other plans. You can accumulate a maximum of 600 Credited Work Hours in your Hours Bank once you meet the Initial Eligibility Requirements.

You will become eligible for Active Employee Benefits on the first day of the second month after your Hours Bank is credited with 400 Credited Work Hours. These Credited Work Hours must be earned within a period not longer than six (6) consecutive months. Once you become eligible, coverage will continue for the remainder for the third month which is the corresponding Eligibility Month. Any Credited work Hours in excess of 400 will be added to your Hours Bank.

For Active Construction Unit Employees who were working in Covered Employment before February 1, 2021, you will be credited with 100 Credited Work Hours for every future month of eligibility you may have earned under the quarterly eligibility rules in effect before May 1, 2021.

B. Active Non-Construction Unit Employees

You will become eligible for Active Employee benefits on the first day of the month in which your Employer submits the required Contributions on your behalf. The Board of Trustees determines the amount of Contributions required for eligibility Your initial eligibility will continue for the remainder of the month. Thereafter, you will have to meet the Continuing Eligibility Requirements for Non-Construction Unit Employees.

Section 3.2 – Continuing Eligibility Requirements

A. Active Construction Unit Employees

Once you meet the Initial Eligibility Requirements, you will continue to be eligible for each subsequent Eligibility Month if you have either (a) worked at least 100 Credited Work Hours in the Work Month corresponding to the Eligibility Month for which eligibility is being determined, or (b) have sufficient Credited Hours in your Hours Bank to meet the Credited Work Hours requirement.

If you did not work at least 100 Credited Work Hours in the Work Month corresponding to the Eligibility Month for which eligibility is being determined, any Credited Work Hours needed to meet the 100 Credited Work Hours requirement will be deducted from your Hours Bank in order for you to be eligible for the corresponding Eligibility Month. If you have more than 100 Credited Work Hours in the Work Month, the excess over the required 100 Credited work Hours will be added to your Hours Bank up to a maximum of 600 Credited Work Hours that can be held in your Hour Bank at any given time.

The Work Months and their Related Eligibility Months are as follows:

Work Month		Eligibility Month
February	----->	May
March	----->	June
April	----->	July
May	----->	August
June	----->	September
July	----->	October
August	----->	November
September	----->	December
October	----->	January
November	----->	February
December	----->	March
January	----->	April

1. Active Construction Unit Employee Self-Payments

You are eligible to make an Active Construction Unit Employee Self-Payment if your Credited work Hours for the month and your Credited work Hours in your Hours Bank are less than the 100 Credited Work Hour monthly requirement to continue eligibility.

The amount of the Active Construction Unit Employee Self Payment depends on the hours you are short of the 100 Credited Work Hour monthly requirement. The self payment amount is equal to the number of hours you are short under the 100 Credited Work Hour monthly requirement multiplied by the current contribution rate stated in the collective bargaining agreement in effect at the time of the self payment.

You may continue to make Active Construction Unit Employee Self Payments for up to a maximum of six (6) consecutive Eligibility Months.

Active Construction Unit Employee Self Payments are due on the first day of the Eligibility Month. If you fail to make a timely self payment or you exceed your maximum six (6) consecutive months of Self Payments, your eligibility will terminate for that Eligibility Month. Thereafter, you may be eligible for COBRA Continuation Coverage. If you are gaining continued coverage by making Active construction Unit Employee Self Payments, any months of continued coverage gained will not count toward the applicable COBRA maximum coverage period.

B. Active Non-Construction Unit Employees

You will continue to be eligible for benefits under the Plan for each calendar month in which your Employer submits the required Contributions on or before the 10th day of the previous month. The Board of Trustees determines the amount of Contributions required for eligibility.

Section 3.3 – Termination of Eligibility

Your coverage for Active Employee Benefits under the Plan will end upon the earliest of the following events:

A. You cease to meet the requirements of the Continued Eligibility provisions;

B. If you are an Active Construction Unit Employee, you fail to make a timely self payment;

C. Your death; or

D. The Trustees discontinue the Plan.

Section 3.4 – Reinstatement of Eligibility

A. Active Construction Unit Employees

If you lose coverage, your coverage will be reinstated on the first day of the second month after you have worked at least 100 Credited Work Hours in the Work Month corresponding to the Eligibility Month for which eligibility is being determined. If you did not work at least 100 Credited Work Hours in the Work Month corresponding to the Eligibility Month for which eligibility is being determined, any Credited Work Hours needed to meet the 100 Credited Work Hours requirement will be deducted from your Hours Bank for you to be eligible for the corresponding Eligibility Month.

However, if you lose coverage for 24 or more consecutive Eligibility Months, you will be required to meet the Initial Eligibility provisions to become eligible for benefits.

B. Active Non-Construction Unit Employees

Coverage for you and your Dependents will be reinstated on the 1st day of the month for which your Employer submits the required Contributions on your behalf.

Section 3.5 – Disability Credits – Active Construction Employees

If you are an Active Construction Unit Employee who cannot perform covered work because you are Totally Disabled, you will be credited with disability hours to maintain your eligibility. A certified disability is a disability for which you are receiving the Accident and Sickness Weekly Disability Benefit through the Fund or weekly workers' compensation benefits. If you are receiving weekly workers' compensation benefits, you must submit proof of your receipt of those benefits to the Fund Office. Beginning with the first (1st) day following an Accident or the eight (8th) day of a Sickness, you will receive 23.10 hours of work credit for each full week or 3.30 hours for each day of certified disability (up to a maximum of 300 hours). In no event, however, shall an Employee whose Employer has reported hours on his behalf during a period of disability be entitled to receive disability credit for such period.

Disability hours that are credited pursuant to this Section in a given Work Month will be added to the Credited Work Hours in that Work Month and the hours in your Hours Bank to determine if you meet the 100 Credited Work Hours eligibility requirement. Disability hours not used to meet the 100 Credited Work Hours eligibility requirement will be applied to your Hours Bank (up to a maximum of 600 Hours). Further, if you are unable to meet the 100 Credited Work Hours eligibility requirement, your Disability hours will be used when calculating your Active Construction Unit Employee Self-Payment.

Section 3.6 – Reciprocity Agreements – Active Construction Unit Employees

The Trustees recognize that for various reasons, Active Construction Unit Employees may from time to time perform work outside the geographical jurisdiction of the Kentucky Laborers District Council. The Fund may enter into reciprocal agreements which permit Active Construction Unit Employees to authorize the transfer of all Contributions received by another fund on their behalf to this Fund in order to maintain their eligibility under the Plan. If you are performing work outside the geographical jurisdiction of the Kentucky Laborers District Council, you should contact the Fund Office to determine if a reciprocity agreement exists and to complete the necessary paperwork.

The Employee must contact his Home Fund to obtain the Authorization for Reciprocal Transfer Form. The Employee must

complete that form in full and mail the form to the Home Fund. A copy of the form must also be sent to the Reciprocating Fund so that the Reciprocating Fund can implement the procedures for reciprocal transfer of hours / contributions.

The reciprocal transfer of hours / contributions from the Reciprocating Fund to the Home Fund will continue until the Employee submits a letter to both the Reciprocating Fund and the Home Fund advising that he wishes to rescind the Authorization for Reciprocal Transfer

Section 3.7 – Effect of Military Service on Eligibility

The Plan provides benefits as described below that comply with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

If you are called into active service, your coverage under the Plan will not be affected during the initial 31-day period. Your coverage under the Plan will be suspended at the end of this initial 31-day period under Option 1 below (the default option), unless you elect otherwise.

In order to exercise your options, you must notify the Fund Office in writing when you are called to active service. You are eligible to elect one of the three options regarding your Plan benefits as follows:

Option 1: Suspend eligibility and rely on military coverage for you and your Dependents (as of the date active coverage is suspended, you will be offered the right to pay for COBRA Continuation Coverage for up to 24 months). This is the **DEFAULT OPTION.**

Option 2: Suspend active coverage under the Plan for as long as the Plan's eligibility rules permit and then elect COBRA coverage for up to 24 months.

Option 3: Continue active coverage for as long as the Plan's eligibility rules permit and then elect COBRA coverage for up to 24 months.

If your failure to provide advance notice when called to active service is excused under USERRA because of military necessity, then you can make a retroactive election to continue coverage, provided you pay any unpaid amounts that are due.

Option 1

If you elect Option 1 (suspend eligibility and rely on military coverage), your eligibility will be frozen until you are discharged from active military service. In order to reinstate active eligibility, you must provide the Fund with a copy of your discharge papers within the time periods provided under USERRA as described in the following chart:

Length of Active Military Service	Reemployment/Reinstatement Deadline
Less than 31 days	1 day after discharge (allowing 8 hours for travel)
31 through 180 days	14 days after discharge
More than 180 days	90 days after discharge

Once you provide the Fund with your discharge papers, your eligibility will be reinstated effective as of your date of discharge, or a later date as agreed to by the Fund, for the balance of the current month of coverage. Your eligibility for subsequent months will be determined under the Plan's Continued Eligibility Requirements.

Option 2

If you elect Option 2 (suspend active coverage and elect COBRA), your eligibility will be frozen until you are discharged from active military service. Under this option, you and your Dependents can pay the monthly COBRA premium for up to 24 months of COBRA coverage. The standard election and payment deadlines under COBRA apply.

In order to reinstate active eligibility upon discharge, you must provide the Fund with a copy of your discharge papers within the time periods provided under USERRA as described in the above chart.

Once you provide the Fund with your discharge papers, your eligibility, as of the end of the initial 31-day period, will be reinstated effective as of your date of discharge, or a later date as agreed to by the Fund. Your eligibility for subsequent months will be determined under the Plan's Continued Eligibility Requirements.

Option 3

If you elect Option 3 (continue active coverage), you and your Dependents will receive active coverage for as long as you

remain eligible under the Plan's Continuing Eligibility Requirements. Thereafter, you will be offered COBRA coverage for up to 24 months. The standard election and payment deadlines under COBRA apply.

Under USERRA, you must provide the Fund with a copy of your discharge papers within the time periods provided in the above chart.

If active eligibility has been exhausted under Option 3, then upon discharge you will not qualify for active eligibility until you satisfy the Initial Eligibility Requirements.

In the meantime, you will have the opportunity to pay for COBRA coverage as of the date of discharge, or a later date as agreed to by the Fund. Upon discharge, you can pay for COBRA coverage until the later of (1) the end of six months of payments or (2) the end of the original 24-month period.

Section 3.8 – Eligibility Under the Family and Medical Leave Act (FMLA)

When you take leave under the Family and Medical Leave Act of 1993 (FMLA), you must submit an application for leave to your Employer. Your Employer will submit a copy of the approved application to the Fund Office so that your rights to health care coverage are protected during your leave. You are responsible to timely notify the Fund of the type and duration of FMLA leave.

If you are eligible for FMLA leave from your employer, then you will continue to receive coverage under the plan during your absence.

You have the right to take unpaid leave if you meet the following criteria:

1. You worked for the same Employer for at least 12 months;
2. You worked at least 1,250 hours during the previous 12 months; and
3. You work at a location where at least 50 employees are employed by your Employer within a 75-mile radius.

The duration of leave available to you will depend upon the reasons for which you are taking the leave.

1. You may qualify for up to 12 weeks (during any 12-month period) of unpaid leave for your own serious illness, the birth or adoption of a child, to care for a seriously ill spouse, parent or child or qualifying exigency to deal with the affairs of your spouse, child, or parent because he or she is called into active military duty. A qualifying exigency includes short-notice deployment, military events and related activities, childcare and school activities, financial and legal arrangements, counseling, rest and recuperation, post-deployment activities and additional activities defined under the FMLA in 29 CFR Part 825.
2. You may qualify for up to 26 weeks (during any 12-month period) of unpaid leave to care for a covered service member with a serious injury or illness if the Employee is the spouse, child, parent or next of kin of the service member as defined under the FMLA in 29 CFR Part 825. However, please be aware that this 26-week leave is the maximum time period allowed and is not in addition to the 12-week leave provided above.
3. Upon your return to Covered Employment following termination of the FMLA leave, you shall be entitled to a grace period during the FMLA leave such that you will continue eligibility as if your work in Covered Employment had continued without interruption. You shall not be required to use previously accumulated credited hours of work in Covered Employment during the FMLA leave in order to maintain eligibility.

Section 3.9 – Credit of Hours from Payroll Records

Under certain circumstances, the Fund may credit an Active Construction Unit Employee's Hours Bank with Credited Work Hours worked based on payroll records, pay stubs and/or contribution reports received without monies for work performed for a delinquent Employer from the first month that the Employer is delinquent up to the date that the Fund becomes aware of the delinquency, up to a maximum of two (2) months. The credit may only be applied during the first two months of the delinquency. Under no other circumstances, including the attempt to establish Initial Eligibility for whatever reason, will the Fund credit hours from payroll records.

Section 3.10 – Dependent Eligibility

A. Dependents' Initial Eligibility for Active Employee Benefits

Your Dependents will become eligible for Active Employee Benefits on the later of the date:

1. You are eligible for coverage; or
2. He or she meets the definition of Dependent.

You may make a one-time election to cease coverage under the Plan for any Dependent at any time during the Plan Year by completing the appropriate disenrollment forms with the Fund Office. Both you and the Dependent must complete and

submit the requisite disenrollment form(s) to the Fund Office in order for the cessation of coverage to be effective. Cessation of coverage for your Dependent will be effective on the first day following the month the Fund Office receives the aforementioned documents. Once the Dependent has been disenrolled from the Plan, his or her coverage cannot be reinstated unless the special enrollment rules under HIPAA apply.

B. When Dependent Eligibility for Active Employee Benefits Ends

Your Dependents' coverage for Active Employee Benefits will terminate on the earliest of the following to occur:

1. The date your eligibility for Active Benefits ends;
2. The date your Dependent no longer meets the definition of Dependent under the Plan;
3. The date you elect coverage for Retiree Benefits;
4. The date specified in a Qualified Medical Child Support Order;
5. The date your Dependent spouse enters military service; or
6. The date the Trustees terminate the Plan.

C. Surviving Dependent Coverage for Active Employee Benefits

If you are covered under Active Employee Benefits at the time of your death, your Dependents' eligibility for Active Employee Benefits will be extended.

1. Active Construction Unit Employees.
   After your death, your Dependent's eligibility shall be extended to the last day of the Eligibility Month in which you accumulated hours in your Hours Bank are depleted. Thereafter, the Fund Office will notify the Dependent of the right to continue coverage through COBRA Continuation Coverage. The Dependent may elect to continue coverage under a Retiree Plan provided he or she satisfies the eligibility requirements.
2. Active Non-Construction Unit Employees.
   After your death, your Dependent's eligibility shall be extended to the last day of the month in which the last Employer Contribution has been made on your behalf. Thereafter, the Fund Office will notify the Dependent of the right to continue coverage through COBRA Continuation Coverage. The Dependent may elect to continue coverage under a Retiree Plan provided he or she satisfies the eligibility requirements.

D. Dependent Eligibility under a Qualified Medical Child Support Order

A Qualified Medical Child Support Order (QMCSO) is a court order regarding medical coverage for your children (called alternate recipients) in situations involving divorce, legal separation or a paternity dispute.

The Fund will honor the terms of a QMCSO regarding communication with the custodial parent of a Dependent and with regard to which plan is primary when a Dependent is covered by more than one group health plan for the purposes of the Plan's coordination of benefits rules.

The Fund Office will notify you if a QMCSO is received. You may contact the Fund if you need additional information.

Section 3.11 – COBRA Continuation Coverage

A. General Provisions

When you lose coverage because of a Qualifying Event, coverage for you or your eligible Dependents can be temporarily continued at your own expense as required under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). Qualifying events include death of the participant, a reduction of hours, loss of employment (except due to gross misconduct), the participant's entitlement to Medicare benefits, a Dependent losing their Dependent status under the Plan and separation or divorce from the participant.

The Plan provides one option for COBRA Continuation Coverage: Medical, Vision and Dental. COBRA Continuation Coverage does not include the following benefits: Death Benefit, Accidental Death and Dismemberment and Accident and Sickness Weekly Disability Benefits.

If you elect COBRA Continuation Coverage, you pay the full cost of the continued coverage plus a small administrative charge. The continuation of COBRA coverage is conditioned on timely and uninterrupted payment of premiums.
If you (as the Employee) have a newborn child, adopt a child or have a child placed with you for adoption (for whom you have financial responsibility) while COBRA Continuation Coverage is in effect, you may add the child to your coverage. You must notify the Fund Office in writing of the birth or placement to have this child added to your

coverage. Children born, adopted or placed for adoption as described above have the same COBRA rights as your spouse or Dependents who were covered by the Plan before the event that triggered COBRA Continuation Coverage. Please keep in mind that if you are gaining continued coverage by making Active Construction Unit Employee Self-Payments, any months of continued coverage gained will count toward the applicable COBRA maximum coverage period.

B. Marketplace Coverage

There may be other coverage options for you and your family. For example, you may be able to buy coverage through the Health Insurance Marketplace. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit through the Marketplace. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days. You should review your options under the Marketplace and compare them with the Plan's COBRA Continuation Coverage to determine which option is best for you and your family. If you have any questions about your rights to COBRA Continuation Coverage, you should contact the Fund Office. For information on the Marketplace, please visit www.healthcare.gov.

C. Eligibility

1. 18-Month COBRA Continuation Coverage

You and your eligible Dependents may elect up to 18 months of COBRA coverage when your coverage terminates because of the loss of employment, lay-off, retirement or a reduction in your hours of work. An eligible beneficiary generally is an individual covered by the Plan on the day before the Qualifying Event occurs. This includes your spouse and your Dependent child. Any child born to or placed for adoption with you during the period of COBRA coverage is also considered an eligible beneficiary.

Under these circumstances, the Qualifying Event will result in loss of coverage based on when you no longer meet the eligibility requirements under Section 3.1.

2. Disability Extension of 24-Month COBRA Continuation Coverage

If you or an eligible Dependent is determined by the Social Security Administration to be disabled, you and all family members previously covered under COBRA may be entitled to receive an additional 11 months of COBRA coverage. This means that COBRA Continuation Coverage will continue for a total of 29 months if the required premium is paid. Coverage for the additional 11 months may be at a higher cost.

You must notify the Fund Office of the Social Security Administration's determination of disability within 60 days of such determination and before the end of the first 18 months of continued coverage. Otherwise, you will not be eligible for the additional 11 months of coverage.

3. 36-Month COBRA Continuation Coverage

Certain Qualifying Events allow your eligible Dependents to purchase a total of 36 months of COBRA Continuation Coverage. A total of 36 months is allowed if one of the following events occurs:Your death;

a) Your divorce or legal separation;
b) You reaching eligibility for Medicare; or
c) Your Dependent child no longer qualifies as a Dependent under the terms of the Plan.

Coverage terminates at the end of the month in which the event occurs. You or your Dependent must notify the Fund Office in writing in the event of a legal separation, divorce or a child losing Dependent status within 60 days of the date coverage terminates. If you do not provide the notice to the Fund Office within 60 days of the loss of coverage, the Dependent will not be eligible for COBRA Continuation Coverage.

4. Second Qualifying Event

If your eligible Dependent experiences a second Qualifying Event (as listed above) while receiving COBRA Continuation Coverage during the first 18 months of coverage, he or she may be entitled to receive an additional 18 months of COBRA Continuation Coverage, for a maximum of 36 months, if notice of the second Qualifying Event is properly provided to the Fund Office. This extension is available only if the second Qualifying Event would have caused your Dependent to lose coverage under the Plan had the first Qualifying Event not occurred.

D COBRA Premiums

The COBRA premiums are determined by the Trustees and adjusted from time to time; however, this adjustment will occur no more than once during the Plan's fiscal year unless there is a substantial change in the Plan. The amount of the COBRA premium depends upon whether you are an Active Construction Unit Employee or an Active Non-Construction Unit Employee.

For the eighteen (18) months of COBRA Continuation Coverage, you will be charged the full amount allowed under the law. You and your eligible Dependents shall be eligible to continue coverage under the Active Employee Benefits, except that Accident and Weekly Sickness Benefits shall not apply. The monthly premium will be the same regardless of the number of family members electing coverage.

E COBRA Payments and Due Dates

COBRA payments must be made monthly to the Fund Office. The initial COBRA payment is due 45 days after the date the COBRA election is made. Each subsequent payment is due on or before the first day of each month but will be considered timely if the payment is received within 30 days of the due date.

If a COBRA payment is not received by the Fund Office within the time limits specified above, COBRA Continuation Coverage will be terminated retroactive to the last day of the month in which a timely COBRA premium payment was made. Once this coverage is terminated due to a missed payment, no benefits will be reinstated under COBRA Continuation Coverage.

F The Notification Responsibilities of the Fund Office

When the Fund Office is notified of a Qualifying Event, the Fund Office will send a COBRA Election Notice and COBRA Election Form to you and your Dependents who would lose coverage due to the Qualifying Event. The Fund Office will send the notice within 45 days of the time it receives notice of a Qualifying Event. The Election Notice tells you about your right to elect COBRA Continuation Coverage, the due dates for returning the Election Form, the amount of the payment for COBRA Continuation Coverage and the due dates for COBRA payments. To protect your Dependents' rights, you should keep the Fund Office informed of any change in your address or your Dependents' addresses.

G. Electing COBRA Continuation Coverage

You or your Dependents must complete the COBRA Election Form and send it back to the Fund Office to elect COBRA Continuation Coverage. The following rules apply to the election of COBRA Continuation Coverage:

1. Each member of your family who would lose coverage because of a Qualifying Event is entitled to make a separate election of COBRA Continuation Coverage.
2. If you elect COBRA Continuation Coverage for yourself and your Dependents, your election is binding on your Dependents. However, your Dependents have the right to revoke that election before the end of the election period.
3. If you do not elect COBRA Continuation Coverage for your Dependents when they are entitled to COBRA Continuation Coverage, your Dependents have the right to elect COBRA Continuation Coverage for themselves. Your spouse may elect COBRA Continuation Coverage for herself or himself and any minor children who were covered by the Plan on the date of the Qualifying Event.
4. The person electing COBRA Continuation Coverage has 60 days after the COBRA Election Notice is sent or 60 days after coverage would terminate, whichever is later, to send back the completed Election Form. An election of COBRA Continuation Coverage is considered to be made on the date the COBRA Election Form is postmarked.
5. If the COBRA Election Form is not mailed back to the Fund Office within the allowable period, you and/or your Dependents will be considered to have waived your right to COBRA Continuation Coverage.

H. When the COBRA Coverage Period Begins

If you properly elect COBRA Continuation Coverage, the applicable period of COBRA coverage (18, 29, or 36 months) begins on the date your eligibility or your Dependents' eligibility for coverage otherwise terminated under the Plan.

I. When COBRA Coverage Ends

COBRA Continuation Coverage may end for any of the following reasons:

1. You or your Dependent becomes covered under another group health plan. However, coverage will continue if

you or an eligible Dependent was covered under another group health plan prior to the COBRA election, or if you or the eligible Dependent has a health problem for which coverage is excluded or limited under the other group health plan;

2. The required COBRA premium is not timely paid;
3. The Trustees terminate the Plan;
4. You or your Dependent reaches the end of the 18-month, 29-month or 36-month COBRA Coverage period;
5. Your coverage under the Plan ends and you become enrolled in Medicare. However, if your eligible Dependents are entitled to COBRA Continuation Coverage, their maximum coverage period is 36 months from the initial Qualifying Event; or
6. Your Dependents become entitled to Medicare, unless they are entitled to COBRA Continuation Coverage due to your death.

Section 3.12 - Mother's and Newborn's Health Protection Act

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital stay in connection with childbirth for the mother or newborn child to less than 48 hours following vaginal delivery or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., physician, nurse midwife, or physician assistant), after consultation with the mother discharges the mother or newborn earlier. Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay. In addition, a plan or issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce out-of-pocket costs, a Participant may be required to obtain precertification.

Section 3.13 - Women's Health and Cancer Rights Act

Under federal law, group health plans and health insurance issuers offering group health insurance coverage that includes medical and surgical benefits with respect to a mastectomy shall include medical and surgical benefits for breast reconstructive surgery as part of a mastectomy procedure. Breast reconstructive surgery in connection with a mastectomy shall at a minimum provide 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 physical complications for all stages of mastectomy, including lymph edemas; in a manner determined in consultation with the attending physician and the patient.

ARTICLE IV – DEATH AND ACCIDENTAL DISMEMBERMENT BENEFIT

Section 4.1 - Death Benefit

Upon receipt of proof that a Participant died while eligible hereunder, the Fund will pay the death benefit specified in the Schedule of Benefits in accordance with the following provisions:

A. Beneficiary

Any sum becoming due by reason of the death of a Participant shall be payable to the Beneficiary designated on the Fund's records in accordance with the Participant's election or as hereinafter provided. Notwithstanding any other provision of this Plan, the Participant may designate that the Participant's death benefit (all or a portion of it) be paid directly to the funeral home providing funeral services for the deceased Participant.

Any Participant may from time to time designate a new Beneficiary by filing with the Fund Office a written request on a form provided by the Fund. Such change shall become effective upon receipt at the Fund Office and, when so received, the change shall relate back and take effect as of the date the Participant signed said written request, whether or not the Participant is living at the time of the receipt of such request, but without prejudice to the Fund for any payment made by it before receipt of such written notice.

If more than one (1) Beneficiary is designated and the Participant fails to specify the respective interests, the Beneficiaries shall share equally.

If any designated Beneficiary predeceases the Participant, the interest of such Beneficiary shall terminate and that share shall be payable equally to such other designated Beneficiaries that survive the Participant, unless the Participant had made written request to the contrary.

The designation of a spouse is automatically void upon divorce, unless the Participant redesignates such person as a beneficiary for the Death Benefit subsequent to the date of the divorce.

In the event no designated Beneficiary survives the Participant or if no Beneficiary was named by the Participant, the amount due under this Plan shall be payable to the first of the following:

1. To the surviving spouse, if living;
2. If no spouse is living, to the surviving children of the Participant in equal shares;
3. If no children survive, to either the surviving father or the surviving mother of the Participant or equally if both survive;
4. If neither survive, to the surviving brothers and sisters of the Participant in equal shares;
5. If none of the above survives, to the estate of the Participant.

Beneficiaries may not assign benefits received under this provision.

B. Continuation of Death Benefit During Total and Permanent Disability

In the event of the Total and Permanent Disability of a Participant prior to his sixtieth (60th) birthday, eligibility for the Death benefit shall not be terminated during the continuance of such Total and Permanent Disability for a period not exceeding twelve (12) months from the date the coverage would otherwise have terminated in accordance with Article III, Section 3.5. If the Participant dies within said twelve (12) months, proof of the uninterrupted existence of such Total and Permanent Disability until death must be furnished to the Fund Office within one (1) year after death.

Written Notification of such Disability must be made to the Fund office within twelve (12) months from the initial Date of Disability.

If the Fund receives proof of a Participant's Total and Permanent Disability within the three (3) month period immediately preceding the termination of the one (1) year continuation period provided above, such eligibility for the Death benefit shall be continued during Total and Permanent Disability for an additional period of one (1) year, and for further periods of one (1) year provided due proof of the continuance of Total and Permanent Disability is submitted to the Fund Office during the three (3) months immediately preceding each such year.

The Death benefit shall be the amount in effect on the date the Participant's coverage would otherwise have terminated in accordance with Article III, Section 3.5.

The Fund shall have the right at any time during the first two (2) years after receipt of due proof of Total and Permanent Disability, and thereafter once a year, to require proof of the existence and continuation of such Total and Permanent Disability and to perform an examination of the Participant.

If a Participant ceases to be Total and Permanent Disabled, returns to Covered Employment, and reestablishes eligibility under the Plan, his Death benefit coverage will be the amount specified in the Schedule of Benefits.

If a Participant ceases to be Total and Permanent Disabled and does not return to Covered Employment and reestablish eligibility under the Plan, the Death benefit coverage will terminate immediately.

C. General Exclusions and Limitations

No Death benefit shall be payable for any of the following:

1. Injuries or illness incurred directly or indirectly while participating in the commission of a felony by the Participant; or
2. Injuries incurred or illness attributable to war or an act of war, or service in the military, naval or air force of an country while such country is engaged in war, or police duty as a member of any military, naval or air organization.

Section 4.2 - Accidental Death and Dismemberment Benefit

In the event an Eligible Active Participant suffers one or more of the following losses due to an Accident, the Plan shall pay the following amounts:

Life	$10,000
Both Hands	$10,000
Both Feet	$10,000
Both Eyes	$10,000
One Hand and One Foot	$10,000
One Hand and One Eye	$10,000
One Hand	$ 5,000
One Foot	$ 5,000
Either Eye	$ 5,000
Thumb and Index Finger of Either Hand	$ 2,500
Any Two (2) Fingers	$ 2,500

Each loss must be independent of Sickness and all other causes and must have been incurred within thirteen (13) weeks of the date of the Accident.

Loss of hand or hands, or foot or feet, means severance at or above the wrist joint or ankle joint, respectively. The loss of thumb and index finger means severance of two or more entire phalanges of both the thumb and index finger. The loss of any two (2) fingers means severance of two or more entire phalanges of each severed finger. The loss of eye or eyes means the total and irrecoverable loss of the entire sight thereof. If two or more of the losses enumerated herein result from the same Accident, the Fund shall pay for only one (1) of the losses (that loss for which the largest benefit is provided).

Payment shall not be made for death or any loss resulting from or caused directly or indirectly, wholly or partly, by:

A. Bodily or mental infirmity, hernia, ptomaines, bacterial infections (except infections caused by pyogenic organisms which shall occur with and through an accidental cut or wound), or disease or illness of any kind, or
B. Intentional self-destruction or intentional self-inflicted Injury, while sane or insane, or
C. Participation in or the commission of a felony, or
D. Injuries incurred or illness attributable to an act of war, or service in any military, naval or air force of any country while such country is engaged in war, or police duty as a member of any military, naval or air organization.

ARTICLE V – ACTIVE ACCIDENT AND SICKNESS WEEKLY BENEFITS

Section 5.1 - General Provisions

When an Eligible Active Participant is disabled and unable to work due to an Accident or Sickness and is under the care of a Physician, a weekly benefit shall be paid to the Eligible Active Participant beginning with the first (1st) day for any continuous period of disability due to an Accident and with the eighth (8th) day of disability due to Sickness, up to a maximum of thirteen (13) weeks for any one (1) period of disability. A weekly benefit shall be paid to an Eligible Active Participant beginning with the first (1st) day for any continuous period of disability due to Sickness from a physician-ordered quarantine related to COVID-19, up to a maximum of thirteen (13) weeks for any one (1) period of disability. The Physician's order must specify the length of any applicable quarantine. A disabled Eligible Active Participant's weekly disability benefit will not be affected by payment of salary or compensation from an Employer while that Eligible Active Participant is considered Totally Disabled and unable to work

The Participant's Disability must be verified in writing by the Physician treating the Participant for said disability and the implementation of Disability Benefits will not commence prior to the first date of medical treatment for that disability from said physician or medical provider. In the course of the consideration of Disability Benefit payment, the Fund Office may also require further written verification from the attending physician that the Participant is still receiving medical treatment and is still disabled and unable to work.

Section 5.2 - Partial Weeks of Disability

During partial weeks of disability, the Eligible Active Participant shall be paid at the daily rate of one-seventh (1/7th) of the weekly benefit. Payments shall be made for each separate and distinct period of disability. Two or more periods of disability shall be considered as the same period unless between periods of disability, the Eligible Active Participant has returned to full-time work for at least two (2) weeks, or unless the disabilities are due to causes entirely unrelated and begin after the Eligible Active Participant has returned to full-time work.

Section 5.3 – Independent Medical Exam (IME)

The Fund may request that the Eligible Active Participant undergo an Independent Medical Exam (IME) by a Physician selected by the Fund to confirm the Participant's initial disability status or to confirm his continued disability status. Consideration of payment of Accident and Sickness Weekly Benefits may be pended until the results of the IME are received and reviewed by the Fund.

ARTICLE VI - ACTIVE COMPREHENSIVE MAJOR MEDICAL BENEFITS

Section 6.1 - Description of Benefits

The Plan shall pay the applicable co-payment percentage for covered medical expenses in excess of the calendar year Deductible Amount up to the maximum benefit payable set forth in the Schedule of Benefits.

Section 6.2 - The Deductible Amounts

The calendar year Deductible Amounts for PPO (in network) and Non PPO (not in network) claims, as shown in the Schedule of Benefits, are the amounts an individual or family unit must satisfy before Major Medical Expense Benefits are reimbursed by the Plan.

Any eligible charges incurred during the last three (3) months of a calendar year which were used to satisfy the calendar year PPO (in network) and Non PPO (not in network) Deductible Amounts for that year may be carried over to the succeeding year and combined with subsequent covered charges to satisfy the PPO (in network) and Non PPO (not in network) Deductible Amounts for the new year.

Section 6.3 - Common Accident

If an Eligible Active Participant and one or more Eligible Dependents or if two or more Eligible Dependents are injured in the same Accident, all Covered Charges incurred as a result of such Accident shall be combined and only one (1) deductible amount shall be charged, if applicable, against such Covered Charges. Nothing herein shall be construed to reduce the maximum payment for each covered person.

Section 6.4 – Coinsurance

Covered Charges are subject to coinsurance as shown in the Schedules of Benefits. Such coinsurance is not applied to the calendar year deductible.

Section 6.5 - Prescription Drug Co-payment Reimbursement

In the event an Eligible Active Participant or Eligible Dependent participates in a prescription drug card program (other than a Medicare D Prescription Benefit Plan), the Plan will reimburse the drug card copayment at 100% and such charges shall not be subject to the calendar year deductible.
If a husband and wife are both Eligible Active Participants under the Fund, the Plan will reimburse the drug card co payment at 100%.

Section 6.6 - Annual Out -of-Pocket Maximums

The annual out-of-pocket maximums for PPO (in network) and Non PPO (not in network) claims, as shown in the Schedule of Benefits, are the amounts each individual and/or each family must satisfy before Major Medical Expense Benefits are reimbursed at 100% by the Plan. The annual out-of-pocket maximums for PPO (in network) and Non PPO (not in network) claims include the calendar year deductibles and the Participant's portion of coinsurance, but do not include penalties that may be imposed. Dental, Vision, and Prescription Drug Claims are not included in the Major Medical Out-of-Pocket Maximums.

Section 6.7 - Specified Therapies

Physical therapy, speech therapy, or occupational therapy, shall be payable up to a maximum of one hundred and four (104) treatments for each of the three (3) therapies during a calendar year period provided:

A. The therapy is prescribed by a Physician and administered by a licensed therapist;

B. The therapist is not related to the Eligible Active Participant or Eligible Dependent or the attending Physician and does not reside in the household of the person receiving such treatment; and

C. The therapy is for the purpose of restoring partial or complete bodily function and/or coordination resulting from Injury, Sickness, or congenital defect.

Therapy solely for entertainment or diversion shall not be covered nor shall therapy for which there is no expectation of an improvement in the status of the condition being treated.

Section 6.8 - Weekend Hospital Admissions

Unless medically justified, Hospital and Physician's charges for weekend admissions (Friday, Saturday and Sunday) for non-emergency procedures will not be covered under the Plan. Sunday admissions are covered under normal Plan provisions if the surgery is scheduled for the following day.

Section 6.9 - Treatment of Mental / Nervous Disorders and Substance Abuse

Coverage for treatment of Mental / Nervous Disorders and Substance Abuse shall be payable as any other illness. Services provided by a licensed Chemical Dependency Unit (CDU), shall be payable provided such services are for the treatment of substance abuse and have been prescribed by a Physician.

Treatment for Chemical Dependency and Substance Abuse will be covered provided that the services are medically necessary. In order to determine medical necessity, the attending physician who orders and supervises the patient's treatment MUST complete and submit a Chemical Dependency / Substance Abuse Treatment Claim Form before EACH level of treatment, including, but not limited to detoxification, in-patient rehabilitation, out-patient therapy and out-patient medication treatment. Claims for services rendered and/or medications prescribed WILL NOT be considered until this documentation is received by the Fund and reviewed, before each level of treatment accordingly. As is required for all in-patient hospital confinements, any in-patient admission for treatment of Chemical Dependency and Substance Abuse, including but not limited to detoxification and rehabilitation, must be precertified as indicated in Article XVIII – Utilization Review and Case Management.

Section 6.10 - Hospice Care

Hospice care benefits shall be provided by the Plan for Eligible Active Participants or Eligible Dependents whose life expectancy is certified by a Physician to be six (6) months or less. Hospice care shall mean a coordinated program of home and inpatient care for a terminally ill patient and a patient's immediate family provided by a hospice care agency. Immediate family shall mean the Eligible Active Participant and any Eligible Dependent(s).

Major Medical Charges for hospice care include:

A. Room and board charged by the hospice; and

B. Special charges and supplies (i.e., pain relief therapy; drugs/medicines; physical and respiratory therapy; oxygen and equipment for its administration; rental of wheelchairs, hospital beds and other medical equipment for patient's care); and

C. Part-time nursing care by or supervised by a registered nurse (RN); and

D. Counseling for the patient and the patient's immediate family by a licensed social worker or licensed pastoral counselor; and

E. Bereavement counseling for the patient's immediate family by a licensed social worker or licensed pastoral counselor. Counseling services for the immediate family must be given within six (6) months after the patient's death.

Maximum daily benefits are the usual, reasonable and customary charges for the services provided.

Section 6.11 - Skilled Nursing Facility

A Skilled Nursing Facility shall mean a facility that is mainly engaged in providing skilled nursing care and other therapeutic services. The facility must be licensed by the state in which it is located and be an eligible provider of Medicare and Medicaid nursing care services.

Benefits shall be paid on behalf of an Eligible Active Participant or Eligible Dependent for the first sixty (60) days of confinement during a calendar year provided:

A. A Physician prescribes a written treatment plan and supervises the care and treatment; and

B. The facility maintains the treatment plan in addition to medical records on each patient; and

C. The Eligible Active Participant or Eligible Dependent was confined for at least three (3) days in a Hospital prior to confinement in the Skilled Nursing Facility; and

D. Services at the facility commenced within fourteen (14) days after release from the Hospital; and

E. The services rendered in the facility are for the same Sickness or Injury that caused the Hospital confinement; and

F. In the absence of skilled nursing care, the Eligible Active Participant or Eligible Dependent would require Hospital confinement as an inpatient.

Room and board charges by a Skilled Nursing Facility may not exceed fifty percent (50%) of the daily charge for a semi-private room in the Hospital where the patient was confined.

Section 6.12 – Distance Exclusions for Out of Network Inpatient Charges and Related Out of Network Service Provider Charges

The Plan will not cover inpatient hospital and facility charges and related service provider charges that are from out-of-network providers that are outside of a 200 mile radius of the zip code of the Covered Participant's primary address, unless:

A. the Covered Participant does not have an in-network facility or hospital that can provide the services within a 200 mile radius of the zip code of the Covered Participant's primary residence and there is not an in-network facility or hospital that can provide the services within a 200 mile radius of the zip code of the hospital or facility where the Covered Participant received treatment, and / or

B. those charges are incurred in connection with an emergency medical condition, and / or

C. they are not otherwise excluded from coverage, as indicated in exclusions stated in the Plan.

Should such charges be deemed as covered expenses, they will be subject to all Plan rules, including deductibles, co-insurance and out-of-pocket maximums.

Section 6.13 - Covered Charges

Major Medical expense benefits shall be payable for the following reasonable and customary charges:

A. Hospital services as indicated below which are recommended by the attending Physician:
   1. Semi-private room and board accommodations;
   2. Drugs, medicines and other Hospital services and supplies, if used while confined in the Hospital as a resident patient;
   3. Outpatient services.

B. Surgical charges incurred as follows:
   1. Charges made by a Physician or Surgeon for the performance of an operation.
   2. Charges for the services of a professional anesthetist provided such anesthetist is not employed by a Hospital which submits a charge for his services.

   If an operation is recommended to treat an illness or injury, the covered person may get up to two additional opinions as to its need prior to its being done. If such opinions are secured from a Board Certified Specialist in the surgical or medical specialty for which surgery is proposed, and who has in person examined the patient, the Plan will pay the specialist's usual and customary charge for the opinion. This benefit will:
   1. be conditioned on a written report from the specialist;
   2. not be paid if the specialist giving the opinion also performs the surgical procedure on the Covered Person; and
   3. include charges for diagnostic procedures performed or ordered by the specialist to verify the need for surgery.

C. Other covered services and supplies as follows which are recommended by the attending Physician and which are not included in items (A) or (B) above:
   1. Other Hospital charges incurred as an Outpatient
   2. Charges made by a Physician for his medical services including his services as an assistant Surgeon;
   3. Charges made by a qualified physiotherapist or a registered graduate nurse (R.N.) for private duty nursing services rendered solely for the Eligible Active Participant or Eligible Dependent, except for services provided by a person who ordinarily resides in the Eligible Active Participant's household or is a member of his family;
   4. Local professional ambulance service, and, if the Injury or Sickness requires special and unique Hospital treatment, transportation within the United States or Canada to the nearest Hospital equipped to furnish the treatment not available in a local Hospital, by professional ambulance, railroad or commercial airlines on a regularly scheduled flight;
   5. Medical supplies such as colostomy/ileostomy supplies, TENS unit patches and replacement batteries for TENS units. [NOTE: Insulin, syringes, glucose strips can be purchased through prescription drug program];
   6. Diagnostic X-ray and laboratory service;
   7. Oxygen and the rental of equipment for its administration;
   8. Blood or blood plasma and its administration;
   9. Radium, radioactive isotopes and X-ray therapy;

10. Casts, splints, braces, trusses and crutches;
11. Rental (up to the purchase price) of medically necessary durable medical equipment, including but not limited to, hospital type bed, wheel chair and iron lung. Repairs of medically necessary durable medical equipment, including but not limited to hospital type bed, wheelchair or iron lung, shall be covered.
12. Artificial limbs and eyes needed to replace natural limbs and eyes, and replacements for such artificial limbs and eyes no more often than once every five years, provided such replacements are certified as Medically Necessary by the attending Physician;
13. Dental services incurred that are rendered by a Physician or dentist for treatment within twenty-four (24) months of an injury to the jaw or to sound natural teeth, including the initial replacement of those teeth and any necessary dental X-rays, provided such injury is the result of an accident occurring while covered under the Plan;
14. Charges incurred for the removal of impacted wisdom teeth or tooth extractions that are medically necessary due to treatment of any illness or disease may be considered for coverage under major medical benefits provided that a letter of medical necessity and the patient's treatment plan from the attending physician is provided to the Fund and will be covered as any other major medical benefit subject to any applicable deductibles and coinsurance.
15. Admission kits for Inpatient Hospital confinements;
16. Wellness Benefits as follows:
    Eligible Active Employee or Spouse:
    One routine physical exam and all related diagnostic lab, x-ray, and other ancillary services once every calendar year payable as any other illness.
    Wellness Benefits will not be subject to a Calendar Year Major Medical Deductible but will be payable as any other illness. Dependent children are not eligible for such Wellness Benefits.
17. Charges incurred due to secondary infection of the mandible/facial muscles and soft tissues of the face.
18. Treatment rendered by a chiropractor. Such services, however, shall be limited to forty (40) visits per calendar year. X-rays shall also be considered payable provided they are consistent with the diagnosis. There shall be a limit of two (2) therapy treatments and one (1) manipulation per day. Hot and cold pack treatments will be covered in addition to the exams.
19. Orthotics and orthopedic appliances (such as heel and sole lifts), provided that the appliance is custom made for the individual at the recommendation of a Physician.
20. Breast reduction/reconstruction after removal of the breast(s). Also covered is the removal of mammary implants, surgically implanted, only if a preoperative report from a Physician specializing in the field indicates that removal is a medical necessity. If removal is not specifically recommended as a medical necessity, payment approval (although denied on the basis of the pre-operative reports) will again be considered after surgery when Hospital records, an operative report, and pathology reports are available. Prosthesis for breast removal is payable once every twenty-four months. Benefit is limited to two (2) bras and one (1) prosthesis.
21. When a Covered Person has incurred necessary expenses for Home Health Care Agency treatment, the Plan will pay the reasonable and customary amount charged, up to the limit stated in the Schedule of Benefits.
    Benefits under this provision are payable only if the treatment is prescribed and supervised by a physician under a written "Plan of Treatment" furnished to the Trustees prior to the commencement of a period of Home Health Services. For the purposes of this provision, a Plan of Treatment must include the following:
    a. a complete description of the medically necessary care and treatment to be provided to the Covered Person in his/her home;
    b. a provision that such Plan of Treatment will be reviewed and approved every sixty (60) days by the Physician with written documentation sent to the Fund Office; and
    c. the concurrent opinion by both the Physician and the Home Health Care Agency that the total period of Home Health Care will not exceed the number of days nor the cost of any other alternative treatment.

    The following Home Health Care services may be provided to the patient by qualified personnel through the Home Health Care Agency as often as the medical condition of the patient requires it:
    a. part-time nursing care rendered in the Covered Person's home by a Registered Nurse, a Licensed Practical Nurse or Licensed Vocational Nurse under the supervision of a Registered Nurse;
    b. physical or speech therapy provided in the Covered Person's home subject to the limits of the Plan;
    c. use of medical appliances or equipment, provided on an outpatient basis by a Home Health Care Agency, or by a hospital or other facility under arrangement with a Home Health Care Agency;
    d. medical supplies, drugs, and medications prescribed in writing by the Physician to the extent that such charges or costs would be covered under this Plan, had the Covered Person been confined in a hospital.

    NOTE: In the absence of a licensed Home Health Care Agency in the area, part-time or intermittent private duty nursing services rendered by a Registered Graduate Nurse (RN) or Licensed Practical Nurse (LPN) are covered, but will be limited to a maximum of 30 visits per Calendar Year.

    Counting Home Health Care Visits

A visit by any member of the Home Health Care team will be considered one Home Health Care visit, with the maximum of one hundred-twenty (120) visits per calendar year with four (4) hours considered as one (1) visit.

Period of Home Health Services

A "period of Home Health Care Services" for any cause:

1. begins on the day following the termination of the Covered Person's hospital confinement for the same or related cause; and;
2. terminates on the earliest of the following:
   a. on the 121st Home Health Care visit incurred during one Calendar Year; or
   b. the day the Covered Person's physician requests that these services be discontinued; or
   c. some later date as determined by the Trustees.

NOT COVERED

No Home Health Care Benefits will be paid for:

1. services or supplies not included in the Plan of Treatment;
2. services of a person who ordinarily resides in the Covered Person's home, or is a member of the Covered Person's family;
3. services of a social worker;
4. transportation services;
5. services which are not certified as medically necessary by the attending Physician;
6. supportive environmental materials such as hand rails, ramps telephones, air conditioners, or similar appliances and devices.

22. Prescription Drug Co-pays from Other Insurance Coverage: In the event the Eligible Participant and/or his Eligible Dependents are covered by other medical insurance that provides prescription drug benefits (other than Medicare D Prescription Benefit Plan), the Eligible Participant may purchase prescription drugs through that other medical insurance coverage and then submit copies of the prescription drug receipts to the Fund. Those receipts **MUST** show the date of purchase, patient name, drug name and dosage, cost of the drug, and the co-pay amount that the patient paid in order for the claim to qualify for reimbursement to be considered by the Fund. The prescription drug co-pays charged through the other medical insurance coverage may then be considered as a Covered Expense and payable at 100% under the Major Medical Benefits UP TO THE MAXIMUM ALLOWABLE COPAY UNDER THE FUND'S PLAN OF BENEFITS. These co-pays will not be subject to the Major Medical Deductible.

23. Coverage for all flu vaccinations and/or related booster injections and pneumonia vaccinations shall be provided at 100% per person per calendar year under Major Medical Benefits for all flu and pneumonia vaccinations received by Active members and/or their dependent spouse and/or children who are eligible for coverage at time they receive flu and/or pneumonia vaccination. Benefit is not subject to Major Medical Deductible.

24. Coverage for contraceptive management shall apply to eligible members, their spouses and dependent children. Coverage for birth control pills and devices (i.e., Depro injections, IUDs, patch, etc.) shall apply only to eligible members, their spouses and covered dependent children. However, prescription drugs and other pharmaceutical items (i.e., birth control pills and patches) should be purchased through the Plan's Prescription Drug Program as such prescription drugs and pharmaceutical items will not be payable under the Major Medical Benefits, with the exception of claims filed under Article VI, Section 6.13, Item C, Number 22. Over the Counter medications will require a prescription from the attending physician. Coverage will be at 100% for **generic drugs only** (payment for brand drugs will only be made if there is no generic equivalent or if the attending physician writes the prescription as "Dispense as Written".)

25. Charges incurred for In-Network Preventative Services as mandated by the Affordable Care Act with no cost sharing and no coinsurance and charges incurred for Out-of-Network Preventative Services as mandated by the Affordable Care Act subject to cost sharing and coinsurance (major medical deductible and out-of-network coinsurance percentage) including, but not limited to:

Covered Services for Adults:

a. Abdominal Aortic Aneurysm one time screening for men of a specified age who have smoked
b. Screening and counseling for Alcohol misuse
c. Aspirin use for men and women of certain ages. Over the Counter medications will require a prescription from the attending physician. Coverage will be at 100% for **generic drugs only** (payment for brand drugs will only be made if there is no generic equivalent or if attending physician writes the prescription as "Dispense as Written".)
d. Blood Pressure screening for all adults
e. Cholesterol screening for adults of certain age or at higher risk
f. Colorectal screening for adults over age 50
g. Depression screening for adults
h. Type 2 diabetes screening for adults with high blood pressure
i. Diet counseling for adults at higher risk for chronic disease

j. HIV screening for all adults at higher risk
k. Immunization vaccines for adults—doses, for recommended ages and varying populations
l. Obesity screening and counseling for all adults
m. Sexually Transmitted Infection (STI) prevention counseling for adults at higher risk
n. Tobacco Use screening for all adults and cessation intervention for tobacco users
o. Syphilis screening for all adults at higher risk

Covered Services for Women

a. Anemia screening on a routine basis for pregnant women
b. Bacteriuria urinary tract or other infection screening for pregnant women
c. BRCA counseling about genetic testing for women at higher risk
d. Breast Cancer Mammography screening every one to two years for women over 40
e. Breast Cancer Chemoprevention counseling for women at higher risk
f. Breastfeeding support, supplies and counseling. Comprehensive lactation support and counseling, by a trained provider during pregnancy and/or in the postpartum period, and costs for renting breastfeeding equipment in conjunction with each birth are covered. If using an In-Network Provider, benefits will be payable at 100%. If using an Out-of-Network Provider, benefits will be subject to all deductibles and coinsurance, the same as any other benefits. All purchases require prescription for proof of medical necessity and an itemized receipt. The Plan will also pay rental costs up to purchase price.
g. Cervical Cancer screening for sexually active women
h. Chlamydia Infection screening for younger women and other women at higher risk
i. Contraception: Food and Drug Administration approved contraceptive methods, sterilization procedures, and patient education and counseling not including abortifacient drugs. Over the Counter medications/methods will require a prescription from the attending physician. Coverage will be at 100% for **generic drugs/methods only** (payment for brand drugs will only be made if there is no generic equivalent or if the attending physician writes the prescription as "Dispense as Written".)
j. Domestic and interpersonal violence screening and counseling for all women
k. Folic Acid supplements for women who may become pregnant. Over the Counter medications will require a prescription from the attending physician. Coverage will be at 100% for **generic drugs only** (payment for brand drugs will only be made if there is no generic equivalent or if the attending physician writes the prescription as "Dispense as Written".)
l. Gestational diabetes screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes
m. Gonorrhea screening for all women at higher risk
n. Hepatitis B screening for pregnant women at their first prenatal visit
o. Human Immunodeficiency Virus (HIV) screening and counseling for sexually active women
p. Human Papillomavirus (HPV) DNA Test: high risk HPA DNA testing every three years for women with normal cytology results who are 30 or older
q. Osteoporosis screening for women over age 60 depending on risk factors
r. Rh Incompatibility screening for all pregnant women and follow up testing for women at higher risk
s. Tobacco Use screening and interventions for all women , and expanded counseling for pregnant tobacco users
t. Sexually Transmitted Infections (STI) counseling for sexually active women
u. Syphilis screening for all pregnant women or other women at increased risk
v. Well-women visits to obtain recommended preventive services

Covered Services for Children

a. Alcohol and Drug Use assessments for adolescents
b. Autism screening for children at 18 and 24 months
c. Behavioral assessments for children; Ages: 0 to 11 mos, 1 to 4 yrs, 5 to 10 yrs, 11 to 14 yrs, 15 to 17 yrs
d. Blood Pressure screening for children; Ages: 0 to 11 mos, 1 to 4 yrs, 5 to 10 yrs, 11 to 14 yrs, 15 to 17 yrs
e. Cervical Dysplasia screening for sexually active females
f. Congenital Hypothyroidism screening for newborns
g. Depression screening for adolescents

h. Developmental screening for children under age 3, and surveillance throughout childhood
i. Dyslipidemia screening for children at higher risk of lipid disorders: Ages 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years
j. Fluoride Chemoprevention supplements for children without fluoride in their water source. Over the Counter medications will require a prescription from the attending physician. Coverage will be at 100% for **generic drugs only** (payment for brand drugs will only be made if there is no generic equivalent or if the attending physician writes the prescription as "Dispense as Written".)
k. Gonorrhea preventive medication for the eyes of all newborns
l. Hearing screening for all newborns
m. Height, weight and Body Mass Index measurements for children: Ages 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years
n. Hematocrit or Hemoglobin screening for children
o. Hemoglobinopathies or sickle cell screening for newborns
p. HIV screening for adolescents at higher risk
q. Immunization vaccines for children from birth to age 18 – doses recommended ages and recommended populations may vary:
    Diphtheria, Tetanus, Pertussis
    Haemophilus influenza type b
    Hepatitis A
    Hepatitis B
    Human Papillomavirus
    Inactivated Poliovirus
    Influenza
    Measles, Mumps, Rubella
    Meningococcal
    Pneumococcal
    Rotavirus
    Varicella
r. Iron supplements for children ages 6 to 12 months at risk for anemia. Over the Counter medications will require a prescription from the attending physician. Coverage will be at 100% for **generic drugs only** (payment for brand drugs will only be made if there is no generic equivalent or if the attending physician writes the prescription as "Dispense as Written".)
s. Lead screening for children at risk of exposure
t. Medical History for all children throughout development Ages; 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years
u. Obesity screening and counseling
v. Oral Health risk assessment for young children Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years
w. Phenylketonuria (PKU) screening for this genetic disorder in newborns
x. Sexually Transmitted Infection (STI) prevention counseling and screening for adolescents at higher risks
y. Tuberculin testing for children at higher risk of tuberculosis
z. Vision screening for all children

With enactment of the Patient Protection and Affordable Care Act (PPACA) and Health Care and Education Reconciliations Act in March 2010, implementation of certain Plan modifications including preventive services are required. The above list is subject to modification based on regulatory changes or mandates. The Plan will offer at least the minimum standards required to comply with Federal law.

26. Coverage for hearing aids at 100% up to $3000 per ear per person once every five (5) calendar years. This benefit will NOT be subject to major medical deductible or coinsurance. Coverage will be for hearing aids only and will not cover repairs, supplies or maintenance (including calibration of hearing aid). Hearing aids for Dependent children under age 18 shall be covered at 100% once every (5) calendar years.
27. Coverage for weight reduction surgery and any complications arising therefrom for those covered surgeries performed January 1, 2015 and after, provided specific medical criteria are met and documentation of said medical criteria are submitted to the Fund in accordance with Plan requirements. In addition, coverage at 100% up to a $500 maximum [not subject to major medical deductible] for program fees related to such weight reduction surgery.
28. Additional benefits available to our participants may include: gender reassignment surgery, hormone therapy, psychotherapy and counseling and mastectomy for female-to-male transitions. Such services shall be subject to Prior Authorization. Items that are considered investigative, cosmetic, experimental and not medically necessary will be excluded.
29. Non-Experimental or non-investigative organ and tissue transplants, including patient screening, organ procurement and transportation, and surgery for the patient and a live human donor performed at a Blue

Distinction Center for Specialty Care® or a facility approved by the Plan prior to operation.
Covered expenses also include reasonable and necessary transportation and lodging for the covered person and one companion (two companions if the recipient is a Dependent child), up to the current benefit limits set forth in the Internal Revenue Code. Itemized receipts for transportation and lodging expenses must be submitted in a form satisfactory to the Plan. To ensure that you receive the proper payment, please contact the Plan prior to entering an organ transplant program.
Transportation and lodging expenses do not include the following:

a. Child care;
b. Mileage within the medical transplant facility city;
c. Rental cars, buses, taxis, or shuttle service, except as specifically approved by the Plan;
d. Frequent Flyer miles;
e. Coupons, vouchers, or travel tickets;
f. Prepayment or deposits;
g. Services for a condition that is not directly related to, or a direct result of, the transplant;
h. Telephone calls;
i. Laundry;
j. Postage;
k. Entertainment;
l. Interim visits to a medical care facility while waiting for the transplant procedure;
m. Travel expenses for donor companion/caregiver;
n. Return visits for the donor for treatment of a condition found during the evaluation; and
o. Standard meals.

ARTICLE VII - EXCLUSIONS AND LIMITATIONS ON ACTIVE BENEFITS

In addition to any other specific exclusions or limitations contained in the Plan, no benefits shall be paid for the following:

A. Sickness or Injury sustained during the commission of a felony by an Eligible Active Participant or an Eligible Dependent; or

B. Cosmetic surgery except for the following:
   1. Accidental injuries;
   2. Repair of the effects of a previous surgical Procedure performed;
   3. Reconstruction of a breast on which a mastectomy has been performed;
   4. Surgery and reconstruction of the non-diseased breast to produce a symmetrical appearance in conjunction with a mastectomy performed;
   5. Coverage for prostheses; and,
   6. Physical complications of all states of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the patient; or

C. Charges which the Eligible Active Participant or Eligible Dependent are not required to pay; or

D. Any Sickness or Injury incurred in the course or scope of employment for which the Eligible Active Participant or Eligible Dependent has received or is entitled to receive compensation under any Worker's Compensation or Occupational Disease law; or if an employer elects not to or fails to provide Worker's Compensation coverage for any employees or if an employee chooses to opt out of Worker's Compensation coverage, the Plan will NOT cover job-related claims incurred by such employees; or

E. Hospitalization or medical or surgical treatment provided by or paid for by the U.S. Government or any instrumentality thereof, except in a Veteran's Administration Hospital for a non-service related disability; or

F. Any loss caused by war or any act of war; or

G. Loss incurred while engaged in military, naval or air service; or

H. Any charge for services or supplies which is not Medically Necessary; or

I. Expenses for treatments, procedures, devices, or drugs which are experimental, investigational, or done primarily for research; or

J. Private room charges or personal items; or

K. Charges in connection with eye surgery such as radial keratotomy, when the primary purpose is to correct myopia (nearsightedness), hyperopia (farsightedness) or astigmatism (blurring); or

L. Charges for Physician's services or X-ray exams for the treatment of Temporomandibular Joint Disorders (TMJD) or malocclusion involving joints or muscles by methods including, but not limited to, crowning, wiring or repositioning teeth; or

M. Services, surgery or supplies in connection with or related to the reversal of sterilization; or

N. Abortions, except under the following circumstances:
1. Therapeutic abortions (those recommended by a Physician because of a dangerous health condition); or
2. Rape or incest; or

O. Charges for visual training; or

P. Hearing aids purchased prior to January 1, 2015.

Q. Maternity benefits for dependent children of Eligible Active Participants; or

R. Charges incurred for diagnosis and treatment of infertility; or

S. Charges in connection with the diagnosis and treatment of Seasonal Affective Disorder including Light Therapy treatment; or

T. Routine care (including well-baby or well-child benefits) and immunizations, except as specifically provided in the Plan, or

U. Coverage for sports physicals and other routine exams for administrative purposes including but not limited to licensing and employment, or

V. Claims or charges for services or products relating to the treatment of sexual dysfunction. This exclusion does not apply to penial prosthesis implants that are Medically Necessary and the sexual dysfunction is a result of prostate cancer.

W. Charges related to weight reduction surgery and complications arising from those surgeries, incurred January 1, 2006 and after and prior to January 1, 2015.

X. Tooth extractions or other dental work or surgery that involves any tooth or tooth structure, alveolar process, abscess, periodontal disease or disease of the gingival tissue, except as provided in Article IX - Dental Benefits. However, tooth extractions that are medically necessary due to treatment of any illness or disease may be considered for coverage under major medical benefits provided that a letter of medical necessity and the patient's treatment plan from the attending physician is provided to the Fund and will be covered as any other major medical benefit subject to any applicable deductibles and coinsurance.

Y. Out-of-network inpatient hospital and facility charges and related out-of-network service provider charges may not be covered pursuant to Article VI, Section 6.12 – Distance Exclusions for Out of Network Inpatient Charges and Related Out of Network Service Provider Charges.

Z. Any charges incurred for or in connection with gene therapy

ARTICLE VIII - RETIREE PROGRAM

Section 8.1 – Retiree Program Generally

Once you retire and are no longer eligible for Active Benefits, you and your Dependent spouse may be eligible for Retiree Benefits. Retiree Benefits are provided in lieu of COBRA Continuation Coverage and if you elect Retiree Benefits, you will not be eligible to receive COBRA Continuation Coverage once your coverage terminates under the Plan for any reason.

Section 8.2 - Eligibility Requirements

You will be eligible for Retiree Benefits under the Plan if the following conditions are met:

A. You have attained age fifty-five (55) and are no longer working for a contributing Employer or in the construction industry as a laborer, including industry-related self-employment, and

B. You have been eligible for Active Benefits as a result of Employer contributions or self payments, including COBRA payments, for at least twelve (12 out of the twenty-four (24) Eligibility Months immediately prior to retirement, and

C You have not attained age fifty-five (55), but you are Totally and Permanently Disabled and are no longer eligible as an Active Employee.

Section 8.3 – Retiree Benefits

The type of Retiree Benefits you and your Dependent spouse receive depends on whether you are covered under Plan B or Plan H and each individual's Medicare status.

A. Retiree Benefits for Pre-Medicare Retirees on Plans B and H

If you are eligible for Retiree Benefits but not Medicare, then you and your Dependent spouse may receive Pre-Medicare Retiree Benefits under the Plan. Retiree Benefits for Pre-Medicare Retirees include Medical, Prescription Drug, Vision, Dental and Death Benefits. The Dependent spouse of a Retired Participant is not eligible for the Plan's Death Benefit.

The Plan offers two Retiree Benefit plans for Retirees not yet eligible for Medicare: Retiree Plan B and Retiree Plan H. Retiree Plan B is closed to new enrollment as of January 1, 2011. If you meet the eligibility requirements for Retiree Benefits after January 1, 2011, you must select coverage under Retiree Plan H.

B. Retiree Benefits for Medicare Retirees

For Retirees eligible for Medicare, Retiree Benefits for the Retiree and Dependent Spouse are offered through the Medicare Advantage and Prescription Drug ("MAPD") Plan. Any covered individual **must** be enrolled in Medicare Parts A and B and pay the Medicare Part B premium to be eligible for coverage under the MAPD Plan.

The MAPD Plan provides medical, prescription and vision benefits only. Medicare Retirees will be eligible to receive Dental and Death Benefits through the Plan's Retiree Benefits. The Dependent Spouse of a Retired Participant is not eligible for the Plan's Death Benefit.

Section 8.4 – Dependent Spouse's Initial Eligibility for Retiree Benefits

If you are retired, your Dependent Spouse will become eligible for Retiree Benefits provided one of the following conditions are met:

A. You elect coverage under the Retiree Program; or

B. You do not elect coverage under the Retiree Program, but your spouse has attained age 55 or is Totally and Permanently Disabled.

If you are retired and elect coverage for Retiree Benefits, your Dependent Spouse may postpone enrollment in the Retiree Benefits program by notifying the Fund Office in writing at the time you elect Retiree Benefits. Your Dependent Spouse must provide proof of other medical insurance coverage at the time of your election of Retiree Benefits. Your Dependent Spouse will only be allowed to enroll in Retiree Benefits if he or she does so within 30 days of the loss of his or her other medical insurance coverage. Your Dependent Spouse must provide proof of termination of the medical insurance coverage.

If you are retired and get married after becoming eligible for Retiree Benefits, your Dependent Spouse may elect Retiree Benefits coverage in the same manner as above.

Section 8.5 - Effective Date of Retiree Benefits Coverage

Provided that the eligibility requirements in Section 8.1 have been met and a fully completed Retiree Program election form has been submitted by the appropriate deadline listed in Section 8.3, the effective date of coverage in the Retiree Program may be any of the following:

A. The date your coverage as an Active Construction Unit Employee terminates due to insufficient hours or your coverage as an Active Non Construction Unit Employee terminates due to your Employer's failure to submit its monthly

Contributions;

B. The date you are no longer eligible to make COBRA self-payments, or

C. The first of the month following the date you attain age fifty-five (55) and are determined to be Totally and Permanently Disabled.

Section 8.6 - Retiree Election Form

In order to be eligible for Retiree Benefits, you and your Dependent Spouse (if applicable) must submit to the Fund Office a completed Retiree election form (including documentation relating to you or your Dependent Spouse's disability (if applicable) and self-payments owed. The Fund Office must receive the completed form and self-payment within thirty (30) days prior to the effective date of Retiree coverage. If you or your Dependent Spouse are eligible for Medicare, you must also include proof of coverage with Medicare.

Section 8.7 – Retiree Self Payments

A Retiree Self Payment is a payment that you are required to make in order to maintain your eligibility for Retiree Benefits. The deadline for receipt of self payments is the first (1st) day of the Eligibility Month for which payment is being made. The amount of the self payment will depend on whether your are a Pre-Medicare Retired Participant on Plan B, a Pre-Medicare Retired Participant on Plan H or a Medicare-eligible Retired Participant on the MAPD Plan.

You may elect to have Retiree Self Payments made directly to the Fund from your bank account. You must complete an authorization for direct deposit and submit it to the Fund Office no later than the first (1st) day of the month immediately prior to the Eligibility Month you wish to begin direct payments. Direct payments occur on the first (1st) of each month. If you wish to end direct payments, you must submit a written termination notice to the Fund Office at least thirty (30) days in advance.

If your coverage is terminated due to failure to timely submit your Retiree Self Payment, your coverage may be considered for reinstatement once in the course of your lifetime if the following conditions are met:

A. You submit a letter to the Fund Office requesting reinstatement of Retiree coverage, and
B. You have not previously elected Direct Payment but agree to immediately elect Direct Payment and provide the necessary paperwork, and
C. Your Retiree coverage has been terminated for no longer than six (6) months, and
D. You immediately pay all self payments owed retroactive to the date your coverage terminated.

Section 8.8 – When Retiree Benefits End

Retiree Benefits under this Plan are not vested and will not vest at any time. Accordingly, your eligibility for Retiree Benefits will terminate on the first of the following dates to occur:

A. The last day of the month in which you or your spouse stop meeting the Retiree Benefits eligibility requirements under the Plan;

B. The date the Trustees discontinue Retiree Benefits.

C. The last day of the last month for which you or your spouse made a timely Retiree Self Payment; or

D. The date of your death.

Section 8.9 – When Retiree Spouse Eligibility for Retiree Benefits End

Your ~~R~~etiree spouse's eligibility for Retiree Benefits will terminate on the earliest of the following to occur:

1. The date your eligibility for Retiree Benefits ends;
2. Failure to timely submit the monthly Retiree Self Payment;
3. The date your spouse no longer meets the definition of Dependent under the Plan;
4. The date the Trustees terminate the Plan.

If your spouse's eligibility is terminated due to failure to timely submit a monthly Retiree Self Payment or no longer meeting the definition of Dependent under the Plan, your spouse will not be allowed to reinstate eligibility for Retiree Benefits. If your spouse's eligibility is terminated due to the termination of your eligibility for Retiree Benefits, your spouse may reinstate eligibility if he or she meets the initial eligibility requirements set forth in Section 8.4.

Section 8.10 – Surviving Spouse Coverage for Retiree Benefits

If you are covered under Retiree Benefits at the time of your death, your surviving spouse will be entitled to continue coverage until the earlier of:

A. The last day of the month in which the surviving spouse remarries; or

B. The date your surviving spouse dies.

If eligible to continue coverage, your surviving spouse must continue to pay his or her Retiree Self Payments.

Section 8.11 – Reinstatement of Retiree Benefits

Retiree Benefits will be reinstated once you meet the Retiree Benefits eligibility requirements under the Plan; however, Retiree Benefits will not be reinstated in the following circumstances:

A. If your coverage was terminated due to your failure to make timely Retiree Self Payments; or

B. If you return to work in the construction industry as a laborer, including industry-related self-employment.

C. If your Retiree Benefits are reinstated, coverage will be reinstated under the same Retiree Plan that you were covered under prior to the termination. Claims accumulated toward any maximum benefit limitations will remain in force as if you had never been terminated.

If you are an Active Participant, retire but do not elect Retiree Benefits, and later return to Covered Employment, you and your spouse, if applicable, may elect Retiree Benefits provided you and your spouse meet the eligibility requirements for Retiree Benefits.

If you terminate Retiree Benefits and later return to Covered Employment and become eligible for Active Benefits, you and your spouse, if applicable, may reinstate your Retiree Benefits upon termination of Active Benefits provided you and your spouse, if applicable, meet the eligibility requirements for Retiree Benefits. Any claims you and your spouse accumulated toward any maximum benefit limitations will remain in force as if you never terminated Retiree Benefits.

Section 8.12 – Retiree Program Death Benefit

A. Eligibility

If you are eligible for Retiree Benefits, your coverage includes a Death Benefit to be paid to your beneficiary in the event of your death. Those covered under COBRA Continuation Coverage are not eligible for this benefit. The amounts of the Death Benefit are provided in the Schedule of Benefits. Retiree spouses are not eligible for the Retiree Death Benefit.

B. Designating Your Beneficiary

Any sum becoming due by reason of the death of a Retiree shall be payable to the Beneficiary designated on the Fund's records in accordance with the Retiree's election or as hereinafter provided. Notwithstanding any other provision of this Plan, the Retiree may designate that the Retiree's death benefit (all or a portion of it) be paid directly to the funeral home providing funeral services for the deceased Retiree.

Any Retiree may from time to time designate a new Beneficiary by filing with the Fund Office a written request on a form provided by the Fund. Such change shall become effective upon receipt at the Fund Office and, when so received, the change shall relate back and take effect as of the date the Retiree signed said written request, whether or not the Retiree is living at the time of the receipt of such request, but without prejudice to the Fund for any payment made by it before receipt of such written notice.

If more than one (1) Beneficiary is designated and the Retiree fails to specify the respective interests, the Beneficiaries shall share equally.

If any designated Beneficiary predeceases the Retiree, the interest of such Beneficiary shall terminate and that share shall be payable equally to such other designated Beneficiaries that survive the Retiree, unless the Retiree had made written request to the contrary.

The designation of a spouse is automatically void upon divorce, unless the Retiree redesignates such person as a

beneficiary for the death benefit subsequent to the date of the divorce.

In the event no designated Beneficiary survives the Retiree or if no Beneficiary was named by the Retiree, the amount due under this Plan shall be payable to the first of the following:

1. To the surviving spouse, if living;
2. If no spouse is living, to the surviving children of the Retiree in equal shares;
3. If no children survive, to either the surviving father or the surviving mother of the Retiree or equally if both survive;
4. If neither survive, to the surviving brothers and sisters of the Retiree in equal shares;
5. If none of the above survives, to the estate of the Retiree.

Beneficiaries may not assign benefits received under this provision.

C. Exclusions

No Death benefit shall be payable for any of the following:

1. Commission of, or an attempt to commit, a felony, or being engaged in any illegal occupation.
2. War or any act of war, whether declared or undeclared, or service in the military.
3. For the death of a spouse or Dependent.
4. If you are eligible for an extension of the Active Plan's Death Benefit due to your total and permanent disability under Section 4.1(B)

Section 8.13 – Retiree Medical Benefits

A. Pre-Medicare Retirees on Plan B

If you are eligible for Retiree Benefits and you are not yet eligible for Medicare, your medical coverage includes the Basic Benefits and the Major Medical Benefits, payable up to the maximum specified in the Schedule of Benefis.

1. Basic Benefits
   a. Hospital Benefit
   Expenses incurred by an Eligible Retired Participant for Inpatient hospital services, Outpatient surgical services or Outpatient emergency services, provided they are rendered within twenty-four (24) hours after an Injury

   b. X-ray and Laboratory Expense Benefit
   When an X-ray or laboratory examination is performed as the result of an Injury or Sickness, benefits shall be payable for the expense incurred for such examination provided you are not confined to the Hospital as an Inpatient and the X-ray or laboratory examination is performed by or under the supervision of a Physician.

   c. Successive Periods of Hospital Confinement
   Two or more periods of Hospital confinement shall be considered one (1) period of confinement unless the confinements are separated by more than one (1) month. Confinements due to entirely unrelated causes shall be considered as separate confinements.

2. Major Medical Benefits
   The Major Medical Benefits for Pre-Medicare Retirees on Plan B are the same medical benefits as those provided for Active Comprehensive Major Medical Benefits in Article VI and subject to the same Exclusions and Limitations for Active Benefits in Article VII.

B. Pre-Medicare Retirees on Plan H

If you are eligible for Retiree Benefits and you are not yet eligible for Medicare, your coverage includes the Major Medical Benefits. The Major Medical Benefits for Pre-Medicare Retirees on Plan H are the same medical benefits as those provided for Active Comprehensive Major Medical Benefits in Article VI and subject to the same Exclusions and Limitations for Active Benefits in Article VII.

C. Medicare Retirees

If you are eligible for Retiree Benefits and you are eligible for Medicare, your medical coverage is provided through the MAPD Plan. The MAPD Plan provides for all of the benefits or original Medicare Parts A and B and Medicare Part D

prescription drug coverage. The MAPD Plan provides access to a national network of service providers. The network includes doctors, hospitals and ancillary providers. The MAPD Plan will pay for services provided by any physician, facility or hospital that accepts Medicare assignment and agrees to the MAPD Plan's payment terms and conditions.

Please be aware that the Trustees contracted with an insurance carrier to provide these benefits and the benefits will be paid in accordance with the terms of the policy. If you wish to receive a copy of the terms and limitations, please contact the MAPD Plan provider or the Fund Office.

ARTICLE IX – DENTAL BENEFITS

The Plan has entered into a contract with a dental benefits manager to provide dental benefits for the Fund's Participants.

Section 9.1 – Eligibility

Eligible Active Participants and their Eligible Dependents and Eligible Retired Participants covered by Retiree B or H Plans shall be eligible for dental benefits as set forth in the Schedules of Benefits and in accordance with the dental benefits manager's schedule of benefits.

Opt-out: In accordance with applicable Plan procedures, a Participant including his Dependents, may elect to opt-out of dental benefit coverage by providing the Plan prior written notice of such election. Coverage shall terminate for the Participant and his Dependents effective the first (1st) day of the month following written notice to terminate.

Resumption of Coverage: In accordance with applicable Plan procedures, a Participant including his Dependents, may elect to resume dental benefit coverage by providing the Plan prior written notice of such elections. Coverage shall resume for the Participant and his Dependents effective the first (1st) day of the month following receipt of written notice to resume coverage.

NOTE: Contribution rates and/or Self-payments will not be reduced if a Participant or eligible Dependents decide to opt out of dental coverage.

Section 9.2 - Frequency of Services

Dental benefits for Eligible Active Participants, Eligible Dependents, and Eligible Retired Participants shall be payable as follows:

Active Plan	Retiree B and H Plans
$1000 Benefit Per Calendar Year Per Family (Eligible Active Members and their Eligible Dependents) Payable in accordance with dental benefits manager's in and out of network schedule of benefits	$500 Benefit Per Calendar Year Per Eligible Retiree OR Eligible Retiree Spouse Payable in accordance with dental benefits manager's in and out of network schedule of benefits

Benefits are not subject to the Major Medical Deductible or Major Medical Out of Pocket Maximum.

Section 9.3 - Items Not Covered

Regarding Dental Benefits, there shall be no benefits paid for fees or expenses for the following:

A. Cosmetic procedures, including but not limited to whitening of teeth, dental jewelry and gold crowns or caps.
B. Orthodontics
C. Prescription drugs except as payable under Article IX - Prescription Drug Benefits
D. Other services deemed not covered as standard basic preventive or restorative services including services payable under Worker's Compensation.

Section 9.4 – Dental Provider

Dental services must be provided by dentists (D.D.S.) or a doctor of medical dentistry (D.M.D.) or any other dental provider who is duly licensed to perform such dental services in accordance with licensing requirements in any state or commonwealth where covered services are provided.

ARTICLE X - VISION BENEFITS

Section 10.1 – Eligibility

A. Active Participants and Pre-Medicare Retirees

Eligible Active Participants and their Eligible Dependents and Eligible Pre-Medicare Retired Participants and their Eligible Pre-Medicare Retired Spouses shall be eligible for vision benefits as shown in the Schedule of Benefits.

Opt-out: In accordance with applicable Plan procedures, a Participant including his Dependents, may elect to opt-out of vision benefit coverage by providing the Plan prior written notice of such election. Coverage shall terminate for the Participant and his Dependents effective the first (1st) day of the month following written notice to terminate.

Resumption of Coverage: In accordance with applicable Plan procedures, a Participant including his Dependents, may elect to resume vision benefit coverage by providing the Plan prior written notice of such elections. Coverage shall resume for the Participant and his Dependents effective the first (1st) day of the month following receipt of written notice to resume coverage.

NOTE: Contribution rates and/or Self-payments will not be reduced if a Participant or eligible Dependents decide to opt out of vision coverage.

B. Medicare Retirees on the MAPD Plan

Retired Participant who are eligible for Medicare shall be eligible for vision benefits through the MAPD Plan as shown in the Schedule of Benefits.

Please be aware that the Trustees contracted with an insurance carrier to provide these benefits and the benefits will be paid in accordance with the terms of the policy. If you wish to receive a copy of the terms and limitations, please contact the MAPD Plan provider or the Fund Office.

Section 10.2 - Frequency of Services

Vision benefits for Eligible Active Participants, Eligible Dependents, and Eligible Retired Participants shall be subject to the time limits shown in the Schedules of Benefits.

Section 10.3 - Items Not Covered

There shall be no benefits paid for fees or expenses for the following:

A. Any eye examination requested or required by an employer as a condition of employment by virtue of a labor agreement, or by a governmental body or agency; or
B. Services or materials for which the Eligible Active Participant, Eligible Dependent, or Eligible Retired Participant may be compensated under any Worker's Compensation Law or similar legislation, or services which the covered person can obtain without cost from any federal, state or any subdivision thereof.
C. Vision supplies (i.e. sunglasses, magnifying reading glasses, contact lens solution, etc.) purchased over-the-counter,
D. Radial keratotomy or surgery performed for the primary purpose of correcting myopia (nearsightedness), hyperopia (farsightedness) or astigmatism (blurring),
E. Medical or surgical treatment of the eyes.

ARTICLE XI - PRESCRIPTION DRUG BENEFITS

Section 11.1 – Eligibility

If you are eligible for Active or Retiree Benefits, your coverage includes the Prescription Drug Benefit. The benefit amounts, including required co-payments, are shown in the Schedule of Benefits.

Section 11.2 – General Information

The Prescription Drug Benefit covers prescription drugs and is administered by a prescription benefit manager (PBM). Accordingly, this benefit is subject to the contractual agreements between the Plan and the PBM.

Section 11.3 – Retail Pharmacy Program

The Retail Pharmacy Program offers benefits for short-term prescriptions. Your first prescription fill and two additional refills may be up to 30-day supplies; however, any subsequent refills must be 90-day supplies filled either through the Retail Pharmacy Program or the Mail Order Program. When you fill a 90-day supply, either through the Retail 90-day Program or the Mail Order Program, the applicable 90-day co-payment will apply.

Section 11.4 – Retail 90-Day Program

You may use the Retail 90-Day Program to order a 90-day supply of any covered maintenance medication that your Physician prescribes you or your Eligible Dependent. Maintenance medications are medications you or your Eligible Dependents take for long periods of time for chronic conditions such as high blood pressure, heart condition, diabetes, asthma and arthritis. Refills of maintenance medications through the Retail 90-Day Program may only be filled in 90-day supplies.

Section 11.5 – Mail Order Program

You may use the Mail Order Program to order a 90-day supply of any covered maintenance medication that your Physician prescribes you or your Eligible Dependent. Maintenance medications are medications you or your Eligible Dependents take for long periods of time for chronic conditions such as high blood pressure, heart condition, diabetes, asthma and arthritis. Refills of maintenance medications through the Mail Order Program may only be filled in 90-day supplies. For more information about the Mail Order Program, please contact the Fund Office or PBM.

Section 11.6 – Mandatory Generic Drug Program

If you have a prescription filled with a brand drug when a generic is available, you will pay the applicable b rand drug co-payment as well as the difference between the cost of the generic and the brand drug, unless your Physician checks "Dispense as Written" (DAW). The difference between the cost of the generic and the brand drug will not be applied towards your Prescription Drug out-of-pocket maximums.

Section 11.7 – Out-of-Pocket Maximum

The Prescription Drug out-of-pocket maximum is the maximum amount you pay for expenses under the Prescription Drug Benefit each year. If you reach this annual out-of-pocket maximum for expenses subject to the maximum, the Plan pays 100% of all covered Prescription Drug Benefit expenses for the rest of the calendar year. Penalties for noncompliance with the Mandatory Generic Drug Program and charges under the Medical, Vision or Dental benefits do not apply towards the Prescription Drug out-of-pocket maximum.

Section 11.8 – Medcare Part D Benefit

If you have not retired and are still an Active Participant, you may elect Medicare Part D in addition to receiving Prescription Drug Benefits under this Plan. This is known as "dual coverage". When you have dual coverage, this Plan is the primary payer and Medicare is the secondary payer. Persons with Prescription Drug Benefits under this Plan are unlikely to receive an additional benefit and generally should not sign up for Medicare Part D. Persons who are not eligible under this Plan should sign up for Medicare Part D.
If you have retired, you will automatically be enrolled in the Plan's MAPD Plan, provided you meet the eligibility requirements set forth in Article XX.

ARTICLE XII - COORDINATION OF BENEFITS AND NONDUPLICATION OF BENEFITS

Section 12.1 - General Coordination of Benefits

A. If the Participant or Eligible Dependent is entitled to benefits under any other plan (as defined below) which will pay part or all of the expense incurred for necessary, reasonable and customary charges for treatment of Injury or Sickness, the amount of benefits payable under the Fund and any other plans will be coordinated so that the aggregate amount paid shall not exceed 100% of the expense incurred. In no event will the amount of benefits paid under the Fund exceed the amount which would have been paid if there were no other plan involved. Where both spouses are Participants, benefits payable under the Fund shall be paid on a coordination of benefits basis not to exceed 100% of Covered Charges. The benefits of dependent children whose parents are each eligible for benefits as Participants shall be paid on a coordination of benefits basis not to exceed 100% of Covered Charges.

B. Definitions

1. A "Plan" includes any plan providing benefits or services for or by reason of Hospital, medical or dental care or

treatment, which benefits or services are provided by: (a) group, blanket or franchise insurance coverage; (b) group Blue Cross, Blue Shield and other prepayment coverage provided on a group basis; (c) any coverage under labor-management trusteed plans, union welfare plans, employer organization plans, employee benefit organization plans or any other arrangement of benefits for individuals of a group; (d) any coverage under governmental programs such as Medicare and Medicaid, or any coverage required or provided by any statute, including Worker's Compensation Law; and (e) any coverage under an individual's no-fault policy.

2. "Allowable Expense" means any necessary, reasonable, and customary item of expense at least a portion of which is covered under at least one of the plans covering the person for whom claim is made. When a plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered shall be deemed to be both an Allowable Expense and a benefit paid.

3. "Claim Determination Period" means a calendar year or any portion thereof during which a person subject to this provision is eligible under this Plan.

C. Effect on Benefits

1. This provision applies to determine the benefits for any covered person under this Plan as the secondary provider, during any Claim Determination Period. This Fund does not contract with our Preferred Provider Network to process secondary claims. All claims to be considered for secondary payment should be submitted directly to the Fund Office with the Primary Explanation of Benefits for claims processing. As the Fund does not utilize our Preferred Provider Network to determine allowable charges, allowable charges are determined by the Primary Explanation of Benefit that is required to be submitted in order for secondary benefits to be processed. The Allowable Expenses incurred by such person during the claim period cannot exceed the allowable charges under this Plan and said allowable expenses are required to be reduced by coverage provided under any other plan. Said payments cannot exceed any such allowed expenses under this Plan.

2. During any Claim Determination Period to which this provision applies, the benefits that would be payable under this Plan in the absence of this provision for the Allowable Expenses incurred by such person during such Claim Determination Period shall be reduced so that the sum of the reduced benefits and all the benefits payable for the Allowable Expense under all other plans, except as provided in subsection D of this Article, shall not exceed the total of such Allowable Expenses. Benefits payable under another plan include the benefits that would have been payable had claim been duly made therefore.

D. Order of Benefits Determination

The rules establishing the order of benefits determination are as follows:

1. The plan covering the patient directly, rather than as an Employee's dependent, is primary and the other is secondary, WITH THE FOLLOWING EXCEPTION:
The benefits of the Plan covering the patient as a retired employee shall be determined after the benefits of any other Plan covering that patient either as an active employee or as a dependent of an active employee.

2. With regard to dependent children, the order is as follows:
   a. In regard to an Adult Dependent Child, age 19 to 26, who has group medical coverage through his/her employer, his/her employer's plan will be primary and the Fund's plan will be secondary.
   b. In regard to an Adult Dependent Child, age 19 to 26, who does not have group medical coverage through his/her employer but does have group medical coverage through his/her spouse's employer, his/her spouse's employer's plan will be primary and the Fund's plan will be secondary.
   c. In regard to an Adult Dependent Child, age 19 to 26, who has group medical coverage through his/her employer and also has group medical coverage through his/her spouse's employer, his/her employer's plan will be primary, his/her spouse's plan will be secondary and the Fund's plan will be tertiary.
   d. In regard to an Adult Dependent Child, age 19 to 26, who does not have group medical coverage through his/her employer or his/her spouse's employer but is covered as an Adult Dependent Child through more than one parent's group medical coverage, the primary plan will be the plan of the parent whose birthday (excluding year of birth) occurs earlier in a calendar year (birthday rule).
   e. In regard to an Adult Dependent Child, age 19 to 26, who has group medical coverage through his/her employer but does not have group medical coverage through his/her spouse's employer, and is also covered as an Adult Dependent Child through more than one parent's group medical coverage, the Adult Dependent Child's employer's plan will be primary and determination of second and third place coverage through the parents' plans will be based on the "birthday rule" defined in item (d) above.
   f. In regard to an Adult Dependent Child, age 19 to 26, who has group medical coverage through his/her

employer and also has group medical coverage through his/her spouse's employer and is also covered as an Adult Dependent Child through more than one parent's group medical coverage, the Adult Dependent Child's employer's plan will be primary, his spouse's employer's plan will be secondary and determination of third and fourth place coverage through the parents' plans will be based on the "birthday rule" defined in item (d) above.

g. In regard to **ALL** dependent children the following rules will apply:
   1. The primary Plan is the Plan of the parent whose birthday (excluding year of birth) occurs earlier in a calendar year
   2. When the parents are separated or divorced, if there is a court decree which establishes financial responsibility for the medical, dental, and/or vision expenses with respect to the child, the benefit shall be determined in agreement with the court decree. Otherwise, if the parent with custody has not remarried, the Plan of the parent with custody shall be primary. If the parent with custody has remarried, the Plan of the parent with custody shall be primary, the step-parent's Plan shall be secondary and the Plan of the parent without custody shall pay third.

3. If the above rules do not establish an order of benefits determination, the Plan which has covered the person for the longer period of time shall be primary, WITH THE FOLLOWING EXCEPTION:
The benefits of the Plan covering the patient as a retired employee shall be determined after the benefits of any other Plan covering that patient either as an active employee or as a dependent of an active employee

4. If an individual is covered under a continuation plan as a result of the purchase of coverage as provided under federal or state law and also under another group plan, the following shall be benefit determination order:
   a. First, the benefits of a plan covering the person as an Employee (or as that employee's dependent);
   b. Second, the benefits of coverage purchased under the continuation plan. If the other plan does not have the rule described above and if, as a result, the plans do not agree on the order of benefits, this rule shall be ignored.

5. If an individual is covered as a Retired Participant under one of the Fund's Retiree Plans and that individual also is eligible for or has coverage with Medicare or other coverage as provided under federal or state law, the following shall be the order of benefit determination:
   a. First, Medicare or other coverage as provided under federal or state law
   b. Second, the individual's Retiree Plan coverage through the Fund

   In the event that said Retired Participant also is covered as an active employee (or active employee's dependent) with any other group plan, that active plan will be primary carrier, Medicare (or other coverage as provided under federal or state law) will be secondary and the individual's Retiree Plan coverage through the Fund will be tertiary.

   In the event that said Retired Participant also is covered as an retired employee (or retired employee's dependent) with any other group plan, Medicare will be primary carrier, secondary carrier will be the plan covering the retired employee for the longest period of time and the tertiary carrier will be the plan covering the retired employee for the shortest period of time.

6. The Plan that does not contain a coordination of benefits provision shall automatically be primary.

For Coordination of Benefits, a former Employee or dependent under COBRA or Active self-pay provision will be treated like an active Employee.

Section 12.2 - Coordination with Medicare or Medicaid

A. Eligible Active Participants and their Eligible Dependents
Benefits for Eligible Active Participants and their Eligible Dependents, regardless of age, who are eligible for Medicare or Medicaid, shall be payable first under this Plan. After an Eligible Active Participant and/or his Eligible Dependent have been reimbursed for those medical expenses covered under the Plan, the balance of said expenses shall be submitted to Medicare or Medicaid for consideration.

B. Eligible Retired Participants
If a Retired Participant is eligible for Medicare Retiree Benefits, he or she will be enrolled in the MAPD Plan, provided he or she is enrolled in both Medicare Parts A and B and purchases Medicare Part B coverage.

C End Stage Renal Disease (ESRD)
There are special rules that apply to the first 30 months of ESRD (the initial 30-month period). The primary/secondary rules depend on whether the covered person is eligible for Medicare due to age or disability at the beginning of the initial 30-month period. After the initial 30-month period, Medicare is always primary.

1. Eligibility Based on Active Participant Status:
   If a Participant is eligible for benefits because of the Participant's active status and becomes entitled to Medicare solely because of ESRD, this Plan will have primary responsibility for his claims during the initial 30-month period and Medicare pays second.
   If during the initial 30-month period the Participant becomes eligible for Retiree Benefits, the Plan will continue to pay primary during the balance of the 30-month period. After the initial 30-month period, the individual will be enrolled in the MAPD Plan.

2. Eligibility Based on Retired Participant Status
   If a Participant is retired and not otherwise eligible for Medicare at the time he becomes entitled to Medicare ESRD benefits, the Plan will have primary responsibility for ESRD during the initial 30-month period and Medicare will pay second.
   If a Participant is retired and already eligible for Medicare at the time he becomes entitled to Medicare ESRD benefits, the MAPD Plan will have primary responsibility for ESRD during the initial 30-month period. After the initial 30-month period, the MAPD Plan continues to primary.

ARTICLE XIII - SUBROGATION

In order to conserve the assets of the Kentucky Laborers District Council Health and Welfare Fund for the benefit of Covered Persons, the Fund does not provide benefits including health payments and disability payments for which a third party pays or maintains potential liability under personal injury or Workers' Compensation law. The Trustees of the Fund may provide such benefits, at which point a lien on recovery from a third party arises in favor of the Fund. Any claim, demand, action or right to recovery against a third party on the part of the Participant on whose behalf such benefit payments were made shall be subrogated to the Fund (whether or not the Fund intervenes in such action against the third party or otherwise pursues recovery), to the extent of the Fund's expenses, and any recovery against a third party shall be assigned to the Fund, regardless of whether the Participant executes an assignment or other acknowledgment of the superiority of the Fund's lien, and regardless of how any recovery is allocated, whether for emotional distress, loss of consortium for a Participant's spouse, wages, medical payments, attorney's fees, costs, interest or other designation, and irrespective of whether the Participant is made whole or third party liability is admitted or established. The lien on a Participant's recovery applies to 100% of any recovery obtained by a Participant or, if deceased, any person who succeeds to a Participant's right of recovery, including the deceased Participant's estate, personal representative, guardian, next friend, heir or other successor in interest of a deceased Participant, and shall not be reduced by attorney fees or costs which the Participant or the Participant's successor shall pay. Since the "make whole" rule is rejected by the Plan, the Fund's rights of first-dollar subrogation and/or reimbursement apply regardless of whether the covered person is made whole or receives only a partial recovery and regardless of the characterization of compensated damages or application of the recovery. In order to be eligible for the Fund to make payments, the covered person is required to complete the proper forms, as prescribed by the Fund, and shall be executed before any payment of any benefit from the Fund. However, the failure of the Fund to obtain the executed forms in no way prejudices the rights of the Fund to seek reimbursement.

In the event the claim is for a Death benefit on behalf of an Employee or Retiree, this subrogation shall have no effect.

The Fund is entitled to offset any pending or future claims against any recovery received by the covered person, to the extent such recovery exceeds the un-reimbursed benefits paid by the Fund or if no benefits have been repaid to the Fund, the offset applies to the full amount of the lien unpaid. The Fund shall have a lien to the extent of the benefits paid, which lien may be filed with any person or entity claimed to be liable to the covered person on account of the loss incurred and the damages suffered.

It shall be the duty and responsibility of each eligible individual to notify the Fund of any claim or demand he may have and of action or actions taken, or to be taken, in connection therewith. If an eligible individual fails to notify the Fund, as required herein, then upon any recovery made, whether by suit, judgment, settlement, compromise, or otherwise, by the eligible individual the Fund shall be entitled to reimbursement to the extent of benefits paid in accordance with this Plan, immediately upon demand, and the Plan shall have the right to recovery thereof, by suit or otherwise.

If an individual is eligible for coverage under Worker's Compensation and either elects not to file a claim or elects to not obtain insurance coverage for injuries occurring under conditions covered by Worker's Compensation, then their eligibility for benefits in this Plan will be denied. If an employer elects not to or fails to provide Worker's Compensation coverage for any employees or if an employee chooses to opt out of Worker's Compensation coverage, the Plan will NOT cover job-related claims incurred by such employees.

In the event a Participant elects to pursue a claim against a third party for recovery of damages on a claim partially or wholly paid by the Fund, the Participant shall notify the Trustees of the Fund in writing of the date the claim(s) was filed, the forum(s) in which it was filed and the name of the defendant(s) or respondent(s), and execute all acknowledgements of liens, subrogation agreements or other documents requested by the Trustees. In addition, the Participant will cooperate fully with the Fund and not

act in a manner that impairs the Fund in its efforts to assert its lien interest. The Participant will keep the Fund informed of the status of any legal action. Any violation by a Participant of his or her obligations to the Fund shall subject the Participant to liability for money not collected by the Fund, including the Fund denying eligibility for benefits to the Participant and his or her family until the lien is satisfied in full.

ARTICLE XIV - CLAIMS PAYMENT AND CLAIMS REVIEW PROCEDURE

Section 14.1 - Payment of Benefits

A. If a Participant becomes disabled or confined in a hospital or undergoes surgery, written notice of claim must be given to the Fund Office within 90 days after the occurrence or commencement of any loss covered by the basic Plan, or as soon thereafter as is reasonably possible.

B The Fund Office, upon receipt of a written notice of claim, will review the information submitted and determine if additional information is needed. If additional information is required, the Fund Office will notify, in writing, the Participant as well as the providers as to what information is needed and will furnish to the claimant such forms as may be required.

C Written proof of loss must be furnished to the Fund Office, in case of claim for loss for which the Plan provides any periodic payment contingent upon continuing loss, within 90 days after the termination of the period for which the Fund is liable (periodic payment will be made in case of loss of time for which benefits accrue during a period of more than two weeks) and, in case of claim for any other loss, within 90 days after the date of such loss. However, failure to furnish such proof within the time required will not invalidate nor reduce any claim in the event the Trustees determine it was not reasonably possible to give proof of loss within that time, provided such proof was furnished as soon as reasonably possible. In no event, except in the absence of legal capacity of the claimant, may such proof of loss be submitted later than one year (12 months) from the time proof is otherwise required.

Benefits payable under the Plan for any loss other than loss of time benefits will be paid as they accrue upon receipt of written proof of such loss. Subject to written proof of loss, all accrued benefits for loss of time benefits will be paid at the expiration of each two-week period and any balance remaining unpaid upon the termination of the period of liability will be paid immediately upon receipt of written proof. Benefits for loss of life will be payable in accordance with the beneficiary designation and the provisions respecting such payment which is described herein above and effective at the time of payment.

Section 14.2 - Claim Review Procedures

All claims are categorized into Pre-Service Claims (urgent and non-urgent), Post-Service Claims and Disability claims. Different time frames for the Plan to make a decision on the claim apply to each type of claim as set forth below:

Time Limits	*Type of Claim*			
THE LISTED ACTION MUST OCCUR WITHIN THESE TIME LIMITS	**Urgent health care**	**Pre-service health care (non- urgent)**	**Post-service health care**	**Disability**
To make initial claim determination (either approve or deny claim)	72 hours (depending on medical circumstances)	15 days (depending on medical circumstances)	30 days (sooner if reasonable)	45 days
To obtain extension of time (if proper notice given to claimant and delay is beyond Plan control)	None	15 days	15 days	30 days, plus another 30 days
To request missing information from claimant (from receipt of claim by Plan)	24 hours	15 days	30 days	45 days
For claimant to provide missing information (after Plan request)	48 hours	45 days	45 days	45 days

Definitions
The following terms are applicable to the procedures which apply to a denial of a claim and shall have the meaning set forth below. A Participant or beneficiary making a claim is referred to as a "claimant":

Claim Denial or Denial of Claim
The terms "Claim Denial" or "Denial of Claim" means any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Participant's or beneficiary's eligibility to participate in a Plan and including a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise

provided because it is determined to be experimental or investigational or not medically necessary or appropriate.

Claim Involving Urgent Care
A "Claim Involving Urgent Care" is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations

A. Could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or,
B. In the opinion of a physician 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.

Whether a claim is a "Claim Involving Urgent Care" is to be determined by an individual acting on behalf of the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. Except, any claim that a physician with knowledge of the claimant's medical condition determines is a "Claim Involving Urgent Care" within the meaning of this Section shall be treated as a "Claim Involving Urgent Care" for purposes of this Section.

Health Care Professional
The term "Health Care Professional" means a physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with state law.

Pre-Service Claim
The term "Pre-Service Claim" means any claim for a benefit under a group health plan, with respect to which the terms of the plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

Post-Service Claim
The term "Post-Service Claim" means any claim for a benefit under a group health plan that is not a Pre-Service Claim.

Section 14.3 - Timing of Notification of Benefit Determination In General – Claims Other Than Group Health or Disability Claims

Except as provided below, if a claim is wholly or partially denied, the Plan Administrator shall notify the claimant within a reasonable period of time, but not later than 90 days after receipt of the claim by the Plan, unless the Plan Administrator determines that special circumstances require an extension of time for processing the claim. If the Plan Administrator determines that an extension of time for processing is required, written notice of the extension shall be furnished to the claimant prior to the end of the initial 90-day period. In no event shall such extension exceed a period of 90 days from the end of such initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the Plan expects to render the benefit determination.

Health Care Claims
In the case of a claim for health care benefits, the Plan Administrator shall notify a claimant of the Plan's benefit determination, as appropriate as shown below:

A. Urgent care claims
In the case of a Claim Involving Urgent Care, the Plan Administrator shall notify the claimant of the Plan's benefit determination (whether an approval or denial) as soon as possible, taking into account the medical circumstances, but not later than 72 hours after receipt of the claim by the Plan, unless the claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. In the case of such a failure, the Plan Administrator shall notify the claimant as soon as possible, but not later than 24 hours after receipt of the claim by the Plan, of the specific information necessary to complete the claim. The claimant shall be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. Notification of any Denial of Claim shall be given to the claimant. The Plan Administrator shall notify the claimant of the Plan's benefit determination as soon as possible, but in no case later than 48 hours after the earlier of–

1. The Plan's receipt of the specified information, or
2. The end of the period afforded the claimant to provide the specified additional information.

B. Concurrent care decisions.
If the Plan has approved an ongoing course of treatment to be provided over a period of time or number of treatments:

1. Any reduction or termination by the Plan of such course of treatment (other than by Plan amendment or termination) before the end of such period of time or number of treatments shall constitute a Denial of Claim. The Plan Administrator shall notify the claimant of the Denial at a time sufficiently in advance of the reduction or termination to allow the claimant to appeal and obtain a determination on review of that Denial before the benefit is reduced or terminated.
2. Any request by a claimant to extend the course of treatment beyond the period of time or number of treatments that is a Claim Involving Urgent Care shall be decided as soon as possible, taking into account the medical circumstances, and the Plan Administrator shall notify the claimant of the benefit determination,

whether an approval or a denial, within 24 hours after receipt of the claim by the Plan, provided that any such claim is made to the Plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments. Notification of any Claim Denial concerning a request to extend the course of treatment, whether involving urgent care or not, shall be given to the claimant, and any appeal shall be governed by the procedures under the appeals rules.

C. Other claims

In the case of a claim not described above, the Plan Administrator shall notify the claimant of the Plan's benefit determination in accordance with subparagraphs i. or ii below, as appropriate.

1. Pre-Service Claims

In the case of a Pre-Service Claim, the Plan Administrator shall notify the claimant of the Plan's benefit determination (whether an approval or denial) within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim by the Plan. This period may be extended one time by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the claimant, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If such an extension is necessary due to a failure of the claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information

2. Post-Service Claims

In the case of a Post-Service Claim, the Plan Administrator shall notify the claimant within a reasonable period of time, but not later than 30 days after receipt of the claim. This period may be extended one time by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the claimant, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If such an extension is necessary due to a failure of the claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.

Disability claims

In the case of a claim for disability benefits, the Plan Administrator shall notify the claimant within a reasonable period of time, but not later than 45 days after receipt of the claim by the Plan. This period may be extended by the Plan for up to 30 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the claimant, prior to the expiration of the initial 45-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If, prior to the end of the first 30-day extension period, the Administrator determines that, due to matters beyond the control of the Plan, a decision cannot be rendered within that extension period, the period for making the determination may be extended for up to an additional 30 days, provided that the Plan Administrator notifies the claimant, prior to the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date as of which the Plan expects to render a decision. In the case of any extension under this paragraph, the notice of extension shall specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues, and the claimant shall be afforded at least 45 days within which to provide the specified information.

Calculating time periods

For purposes of this Section, the period of time within which a benefit determination is required to be made shall begin at the time a claim is filed in accordance with the procedures of a Plan, without regard to whether all the information necessary to make a benefit determination accompanies the filing. In the event that a period of time is extended due to a claimant's failure to submit information necessary to decide a claim, the period for making the benefit determination shall be paused or stopped from the date on which the notification of the extension is sent to the claimant until the date on which the claimant responds to the request for additional information.

Section 14.4 - Manner and Content of Notification of Benefit Determination

The Plan Administrator shall provide a claimant with a written or electronic notification of any Denial of Claim. The notification shall set forth, in a manner calculated to be understood by the claimant –

A. Sufficient information to identify the claim involved, including the date of service, the health care provider and the claim amount (if applicable). Upon request, the Plan will provide the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;

B. The specific reason or reasons for the denial;

C. Reference to the specific Plan provisions on which the determination is based;

D. A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;

E. A description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under Section 502(a) of ERISA following an Adverse Benefit Determination on review;

F. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Determination, either the specific rule, guideline, protocol, or other similar criterion shall be provided to the claimant; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant upon request;

G. If a Health Care Benefit or Disability Benefit claim was denied on the basis of medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances shall be provided to the claimant, or a statement that such explanation will be provided free of charge upon request.

H. In the case of an Adverse Benefit Determination by a group health plan concerning a Claim Involving Urgent Care, a description of the expedited review process applicable to such claims.

In the case of an Adverse Benefit Determination by a group health plan concerning a Claim Involving Urgent Care, the information above may be provided to the claimant orally within the time frame prescribed, provided that a written or electronic notification is furnished to the claimant not later than 3 days after the oral notification; and

I. For Disability Benefit Claims, the following additional information must be provided:
1. An explanation of the decision, including the basis for disagreeing with or not following:
   (a) The views of the health care and vocational professionals who treated or evaluated the claimant;
   (b) The views of medical or vocational experts obtained by the Plan, without regard to whether the advice was relied upon in making the Adverse Benefit Determination; and
   (c) A disability determination by the Social Security Administration.
2 If an internal rule, guideline, protocol or similar criteria was relied on in the process of making a decision on a claim, a copy of that internal rule, guideline, protocol, or similar criteria, or alternatively, a statement that such internal rules, guidelines, protocols, standards or other similar criteria do not exist.
3. A statement that the claimant is entitled to receive reasonable access to and copies of all documents relevant to his or her claim, upon request and free of charge.

Section 14.5 - Appeals of Denied Claims

All claims and appeals of claim denials are categorized into Pre-Service Claims (urgent and non-urgent), Post-Service Claims and Disability claims. Different time frames for the Plan to make a decision on the appeal of a claim apply to each type of claim as set forth below:

Time Limits	*Type of Claim*			
THE LISTED ACTION MUST OCCUR WITHIN THESE TIME LIMITS	**Urge2nt health care**	**Pre-service health care(non-urgent)**	**Post-service health care**	**Disability**
For claimant to request Appeal	180 days	180 days	180 days	180 days
To make determination on appeal	72 hours (depending on medical circumstances)	30 days	next quarterly trustees meeting after appeal filed (or second quarterly meeting if appeal filed within 30 days of meeting) Claimant to be notified within 5 days of Plan decision.	next quarterly trustees meeting after appeal filed (or second quarterly meeting if appeal filed within 30 days of meeting) Claimant to be notified within 5 days of Plan decision.

Full and fair review of claims other than Health Care or Disability claims
As part of a claimant's rights of appeal for a denial of a claim other than a claim for Health Care Benefits or Disability benefits:

A. Claimants shall have 60 days following receipt of a notification of an Adverse Benefit Determination within which to appeal the determination (other than a claim for Health Care Benefits or Disability Benefits);

B. Claimants shall have the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;

C. Claimants shall be provided, 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.

E. The review on appeal shall take into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

F. Before the Plan can issue a final internal Adverse Benefit Determination based on any new or additional evidence or rationale, claimants must be provided (free of charge) with the evidence or rationale; the evidence or rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of final internal Adverse Benefit Determination is required to be provided to give the claimant a reasonable opportunity to respond prior to that date.

Health Care Benefits
In addition to complying with the requirements of paragraphs B through E above, the appeals process for Health Care Benefits shall provide for the following:

A. Claimants shall have at least 180 days following receipt of a notification of a Denial of Claim within which to appeal the denial;

B. The review of the denial on appeal shall not afford deference to the initial denial and shall be conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the denial that is the subject of the appeal nor the subordinate of such individual;

C. In deciding an appeal of any denial that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the appropriate named fiduciary shall consult with a Health Care Professional who has appropriate training and experience in the field of medicine involved in the medical judgment;

D. The Plan shall provide to claimant the identification of any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's denial without regard to whether the advice was relied upon in making the benefit determination;

E. The appeal review process shall provide that the Health Care Professional engaged for purposes of a consultation shall be an individual who is neither an individual who was consulted in connection with the denial that is the subject of the appeal, nor the subordinate of any such individual; and

F. Provide, in the case of a Claim Involving Urgent Care, for an expedited review process pursuant to which:
   1. A request for an expedited appeal of a denial may be submitted orally or in writing by the claimant; and
   2. All necessary information, including the Plan's benefit determination on review, shall be transmitted between the Plan and the claimant by telephone, facsimile, or other available similarly expeditious method.

G. At the conclusion of the preliminary review, the Plan will then refer eligible claims to a randomly selected Independent Review Organization (IRO) and immediately provide coverage if the Plan decision is overturned. The Plan shall adhere to all terms of the contract with the IRO.

Disability Benefits
The appeals process of a claim for Disability Benefits shall comply with the requirements of paragraphs B through ~~D~~ E concerning the appeal of a claim for group health plans and paragraphs A through G of the above section on Health Care Benefit Appeals.

Section 14.6 - Timing of Notification of Benefit Determination on Review In general -- Claims Other Than Health or Disability claims

The appropriate named fiduciary shall make a benefit determination 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 30 days preceding the date of such meeting. In such case, a benefit determination may be made by no later than the date of the second meeting following the Plan's receipt of the request for review. If special circumstances (such as the need to hold a hearing, if the Plan's procedures provide for a hearing) require a further extension of time for processing, a benefit determination shall be rendered not later than the third meeting of the committee or board following the Plan's receipt of the request for review. If such

an extension of time for review is required because of special circumstances, the Plan Administrator shall provide the claimant with written notice of the extension, describing the special circumstances and the date as of which the benefit determination will be made, prior to the commencement of the extension. The Plan Administrator shall notify the claimant of the benefit determination as soon as possible, but not later than 5 days after the benefit determination is made.

Health Care Claims
In the case of an appeal of a Denial of Claim for Health Care Benefits, the Plan Administrator shall notify a claimant of the Plan's benefit determination on review as set forth below, as appropriate.

A. Urgent Care Claims
In the case of a Claim Involving Urgent Care, the Plan Administrator shall notify the claimant of the Plan's benefit determination on review on appeal as soon as possible, taking into account the medical circumstances, but not later than 72 hours after receipt of the claimant's request for review on appeal of a denial by the Plan.

B. Pre-Service Claims
In the case of a Pre-Service Claim, the Plan Administrator shall notify the claimant of the Plan's benefit determination on review on appeal within a reasonable period of time appropriate to the medical circumstances. Such notification shall be provided not later than 30 days after receipt by the Plan of the claimant's request for review of an denial.

C. Post-Service Claims
In the case of a Post-Service Claim, the appropriate named fiduciary shall make a benefit determination 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 30 days preceding the date of such meeting. In such case, a benefit determination may be made by no later than the date of the second meeting following the Plan's receipt of the request for review. If special circumstances (such as the need to hold a hearing, if the Plan's procedures provide for a hearing) require a further extension of time for processing, a benefit determination shall be rendered not later than the third meeting of the committee or board following the Plan's receipt of the request for review. If such an extension of time for review is required because of special circumstances, the Plan Administrator shall notify the claimant in writing of the extension, describing the special circumstances and the date as of which the benefit determination will be made, prior to the commencement of the extension. The Plan Administrator shall notify the claimant of the benefit determination as soon as possible, but not later than 5 days after the benefit determination is made.

Disability claims
In the case of a Disability Claim, the appropriate named fiduciary shall instead make a benefit determination 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 30 days preceding the date of such meeting. In such case, a benefit determination may be made by no later than the date of the second meeting following the Plan's receipt of the request for review. If special circumstances (such as the need to hold a hearing, if the Plan's procedures provide for a hearing) require a further extension of time for processing, a benefit determination shall be rendered not later than the third meeting of the committee or board following the Plan's receipt of the request for review. If such an extension of time for review is required because of special circumstances, the Plan Administrator shall notify the claimant in writing of the extension, describing the special circumstances and the date as of which the benefit determination will be made, prior to the commencement of the extension. The Plan Administrator shall notify the claimant of the benefit determination as soon as possible, but not later than 5 days after the benefit determination is made.

Calculating time periods
For purposes of this section, the period of time within which a benefit determination on review on appeal is required to be made shall begin at the time an appeal is filed in accordance with the reasonable procedures of a Plan, without regard to whether all the information necessary to make a benefit determination on review accompanies the filing. In the event that a period of time is extended as permitted due to a claimant's failure to submit information necessary to decide a claim, the period for making the benefit determination on review shall be paused or stopped from the date on which the notification of the extension is sent to the claimant until the date on which the claimant responds to the request for additional information.

Furnishing Documents
In the case of a denial on review on appeal, the Plan Administrator shall provide the claimant such access to, and copies of, documents, records, and other information described in paragraphs C, D and E of Section 14.7 as is appropriate.

Section 14.7 - Manner and Content of Notification of Benefit Determination on Review

The Plan Administrator shall provide a claimant with written or electronic notification of a Plan's benefit determination on review in a culturally and linquistically appropriate manner. In the case of a denial, the notification shall set forth, in a manner calculated to be understood by the claimant:

A. Sufficient information to identify the claim involved, including the date of service, the health care provider and the claim

amount (if applicable). Upon request, the Plan will provide the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;

B. The specific reason or reasons for the denial on appeal;

C. Reference to the specific Plan provisions on which the denial is based;

D. 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;

E. A statement describing any voluntary appeal procedures offered by the Plan and the claimant's right to obtain the information about such procedures, and a statement of the claimant's right to bring an action under Section 502(a) of the ERISA;

F. The availability of and contact information for any applicable office of health insurance consumer assistance or ombudsman to assist individuals with the internal claims and appeals and external review processes;

G. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the denial, either the specific rule, guideline, protocol, or other similar criterion shall be provided to claimant; or statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the denial and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the claimant upon request;

H. If a Health Care Benefit or Disability Benefit denial is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances shall be provided to the claimant, or a statement that such explanation will be provided free of charge upon request.

I. For Disability Benefit claims, the following additional information must be provided:
   1. An explanation of the decision, including the basis for disagreeing with or not following:
      a. The views of the health care and vocational professionals who treated or evaluated the claimant;
      b. The views of medical or vocational experts obtained by the Plan, without regard to whether the advice was relied upon in making the Adverse Benefit Determination; and
      c. A disability determination by the Social Security Administration.
   2. If an internal rule, guideline, protocol, or similar criteria was relied on in the process of making a decision on a claim, a copy of that internal rule, guideline, protocol, or similar criteria, or alternatively, a statement that such internal rules, guidelines, protocols, standards or other similar criteria do not exist.
   3. A description of any contractual limitations period applying to a claimant's right to bring a civil action under ERISA following an Adverse Benefit Determination on internal appeal, as well as the calendar date on which the Plan's contractual limitation for filing suit expires.

No action in law or in equity may be brought to recover benefits under this Plan prior to 60 days after proof of claim has been furnished under the Plan nor more than three years after the claim was incurred. No other actions in any way related to this Plan may be brought more than three years after the action or omission (whether known or unknown) on which the claim is based. In no event may any actions referred to in this paragraph be brought until the claimant has exhausted the claims and claims review on appeal procedure set forth above.

Section 14.8 – Adverse Benefit Determination

Adverse Benefit Determination means a denial, reduction, or termination of, or a failure to provide or make a payment (in whole or in part) for a benefit, including any such denial, reduction, termination or failure to provide or make a payment that is based on:

1. A determination of an individual's eligibility to participate in the Plan;
2. A determination that a benefit is not a covered benefit;
3. The imposition of a source-of-injury exclusion, network exclusion, or other limitation on otherwise covered benefits; or
4. A determination that a benefit is experimental, investigational, or not Medically Necessary or appropriate.

Section 14.9 – Adverse Benefit Determination

A. **External Review Filing Deadline**
If your health care claim involving medical judgment or a rescission of coverage was denied, resulting in an Adverse Benefit Determination, you have the right to file a request for an external review by an independent review organization with the Fund Office within four months of the date of the internal appeal decision.
However, a denial, reduction, termination, or a failure to provide payment for a benefit based on a determination that you or your Dependent fails to meet the requirements for eligibility under the terms of the Plan is not eligible for the external review process.

B. **External Review Process**
The external review process works as follows:
   1. Request for External Review
   Within five days of the Plan's receipt of the written request for external review, the Plan must determine whether:
      a. You are or were covered under the Plan at the time of service or requested service;

b. The Adverse Benefit Determination relates to a medical judgment determination or rescission of coverage;
c. You exhausted or are deemed to have exhausted the Plan's internal appeal process; and
d. You have provided all information and forms required to process an external review.

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

3. Referral to an Independent Review Organization (IRO)
If your request is eligible for review, the Plan will utilize an unbiased method to assign the external review to one of its three IROs. The timeline for completion of the external review is as follows:
a. The IRO will timely notify you of receipt of assignment of the external review and such notice will inform you that you may provide additional information within ten business days following receipt of the notice. The IRO is not required, but may, accept and consider additional information submitted after ten business days.
b. The Plan must provide the claim file and any information considered in making the Adverse Benefit Determination within five business days after the date of assignment to the IRO. Failure by the Plan to submit the information to the IRO may result in an immediate reversal of the Adverse Benefit Determination. The IRO mst send notice of such to you and the Plan within one business day.
c. The IRO must forward any additional information received from you to the Plan within one day of receipt and the Plan may reconsider and reverse its decision, terminating the external review. The Plan must provide notice within one business day of such a decision to you and the IRO.
d. The IRO will review all information received de novo. In addition to all information provided, the IRO may consider the following information, if the IRO deems it appropriate:
i. The claimant's medical records;
ii. The attending health care professional's recommendation;
iii. Reports from appropriate health care professionals and other documents submitted by the Plan, claimant or treating provider;
iv. The terms of the Plan;
v. Appropriate practice guidelines, which must include all evidence-based standards and may include any other practice guidelines developed by the federal government, national or professional medical societies, boards and associations;
vi. Any applicable clinical review criteria developed and used by the Plan, unless the criteria are inconsistent with the terms of the Plan or applicable law; and
vii. The opinion of the IRO's clinical reviewer or reviewers after considering the information described in this notice to the extent the information or documents are available and the clinical reviewer or reviewers consider it appropriate.

4. Request for an Expedited External Review
You may make a request for an expedited external review if the Adverse Benefit Determination involves a medical condition for which the timeframe for completion of an expedited internal appeal or standard external review as described above would seriously jeopardize the life or health of the claimant or would jeopardize the ability to regain maximum function or if the final Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which the claimant received Emergency services, but has not been discharged from a facility.
An expedited external review will occur in accordance with the procedures stated above for a standard external review, except that each step must be performed in the most expeditious method and the IRO must provide the claimant notice of its decision as expeditiously as the circumstances require, but no more than 72 hours after the IRO receives the request for an expedited external review. If the decision is not communicated in writing, the notice must provide written confirmation to you and the Plan within 48 hours after notice is provided.

C. **Timing of Notice of Decision on External Review**
The assigned IRO must provide written notice of the final external review to the claimant and the Plan within 45 days after the IRO first receives the request for review.

D. **Content of Notice of Decision on External Review**
The IRO will provide you and the Plan with a written decision. The notice of the decision will contain all of the following:
1. A general description of the reason for the request for external review including sufficient information to identify the claim involved, including the date of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning and the reason for the

previous denial.
2. The date the IRO received the assignment and the date of the IRO decision.
3. Reference to the evidence or documentation, including the specific coverage provisions and evidence-based standards that were relied on in making its decision.
4. A discussion of the principal reason(s) for the IRO's decision, including the rationale for the decision and any evidence-based standards that were relied on in making its decision.
5. A statement that the determination is binding except to the extent that other remedies may be available under state or federal law to either the Plan or the claimant.
6. A statement that judicial review may be available to the claimant.
7. Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsmen established under PHS Act section 2793.

ARTICLE XV - STANDARDS FOR USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION TO PLAN SPONSOR

Protected Health Information (PHI), as that term is defined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) shall be disclosed to the plan sponsor, and may be used by the plan sponsor, only in accordance with the following terms and conditions. As used herein, "Plan Sponsor" shall mean, in accordance with Section 3 (16) (B) of the Employee Retirement and Income Security Act, the Trustees of the Fund jointly and individually, as designated under the terms of the Agreement and Declaration of Trust under which the Fund is established.

A. Certification by Trustees. HIPAA requires that PHI will be disclosed to the Trustees only upon receipt of certification made by the Trustees that the Plan Document has been amended to incorporate the appropriate provisions. The Trustees hereby make such certification by execution of this document.

B. Disclosure of PHI to Trustees. The Plan shall disclose PHI in the form of summary health information to the Trustees only to the extent necessary for the Trustees to perform the following functions:
   1. Obtaining premium bids from health plans for providing health insurance coverage under this Plan; or
   2. Modifying, amending or terminating the Plan.

   Further, the Plan shall disclose to the Trustees PHI necessary to carry out other plan administrative functions that the plan sponsor performs, such as the review of claims appeals, consistent with the Plan Document and with applicable provisions of HIPAA.

C. Uses and Disclosures of PHI by Trustees. With regard to the use and disclosure of PHI, the Trustees hereby agree to:
   1. Not use or further disclose such information other than as permitted or required by the Plan Document or as required by law;
   2. Ensure that any agents, including any sub-contractors, to whom they provide PHI received from the Plan agree to the same restrictions and conditions that apply to the Trustees with respect to such information;
   3. Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan;
   4. Report to the Plan any use or disclosure of PHI that is inconsistent with the uses or disclosures provided for of which they become aware;
   5. Make available PHI to Plan participants in accordance with the separate Participant Privacy Policies and Procedures established by the Trustees;
   6. Make their internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the U.S. Department of Health and Human Services for the purposes of determining compliance by the Plan with applicable portions of HIPAA;
   7. If feasible, return or destroy all protected PHI received from the Plan that the Trustees still maintain in any form and retain no copies of such information when no longer needed for the purpose for which such 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
   8. Ensure that the adequate separation required in the following sub-section is established.

D. Disclosures between a Health Insurance Issuer or an HMO and the Trustees. No Health Insurance Issuer or HMO with respect to the Plan may disclose PHI to the Trustees except as described under number 2 above and as described in the following sentence. The Plan and any Health Insurance Issuer or HMO with respect to the Plan may disclose to the Trustees information on whether an individual is participating in the Plan, or is enrolled in or has dis-enrolled from a Health Insurance Issuer or an HMO offered by the Plan.

E. Adequate Separation between the Plan and the Trustees. PHI will be used only for Plan administration. *The following employee classes and/or other persons under the control of the Trustees will be given access to PHI:*

1. Administrative Staff
2. Benefit Processors
3. CCU Adjustors
4. Clerks
5. Any other employees requiring access to PHI, as applicable
6. All Vendors and Fund Professionals necessary in the administration of the Fund where Business Associate Agreements are in place

F. Reports of Non-Compliance. Reports of non-compliance by employees or other persons described in E above with the provisions outlined herein shall be reported to the Plan's "Privacy Official" designated in the separate Participant Privacy Policies and Procedures adopted by the Trustees. Such non-compliance shall be investigated and disposed of in accordance with those policies and procedures.

ARTICLE XVI - AMENDMENT AND TERMINATION OF PLAN

In order that the Plan may carry out its obligation to maintain, within the limits of its financial resources, a Plan dedicated to providing the maximum benefits for all Participants and Eligible Dependents, the Board of Trustees expressly reserves the right, in its sole discretion, at any time and from time to time:

A. To terminate or amend either the amount or conditions of entitlement to any benefits even though such termination or amendment affects claims which have already been accrued; or

B. To alter or postpone the method of payment of any benefits; or

C. To amend or rescind the provisions of the Plan.

The provisions of the Plan document may be amended from time to time by the Trustees and such amendments shall be effective when approved by majority vote of such Trustees and on the date set forth in said amendment, provided that such amendments shall be made consistent with the objectives and purposes of the Trust.

ARTICLE XVII - MISCELLANEOUS PROVISIONS

Section 17.1 - Scope of Coverage of Plan

The provisions of coverage of this Plan shall be limited to those benefits enumerated herein, only where Injury or Sickness occurs and only when the Participant or Eligible Dependent is otherwise eligible. No medical benefits shall be payable for Injury or Sickness when said Injury or Sickness was incurred in the course and scope of a Participant's or Eligible Dependent's employment. Benefits may be considered if the Participant or the Eligible Dependent provides proof of the denial of benefits from the Worker's Compensation insurance carrier.

Section 17.2 - Successive Periods of Hospital Confinement

Two or more periods of Hospital confinement shall be considered one (1) period of confinement unless between confinements the Participant has returned to active work on a full-time basis or, in the case of an Eligible Dependent, such confinements are separated by more than one (1) month. Confinements due to entirely unrelated causes shall be considered as separate confinements.

Section 17.3 - Medical Examination

No medical examination shall be required of any Participant or Eligible Dependent to secure this coverage initially. However, the Trustees shall have the right, through their medical examiner, to examine a Participant or Eligible Dependent as often as they may reasonably require during the pendency of a claim hereunder as well as the right and opportunity to perform an autopsy in case of death where it is not forbidden by law.

Section 17.4 - Right to Receive and Release Necessary Information

In order to determine the applicability of and to implement the terms of this provision or any provision of similar purpose in any other plan, the Fund may, without the consent of or notice to any person, release to or obtain from any other insurance company or other organization or person any information, with respect to any person, which the Fund deems to be necessary for such purposes. Any person claiming benefits under this plan shall furnish to the Fund such information as may be necessary to implement this provision.

Section 17.5 - Facility of Payment

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

Section 17.6 - Right of Recovery

Whenever payments have been made by the Fund with respect to Allowable Expenses in excess of the maximum amount of payment provided, the Fund shall have the right to recover such payments, to the extent of such excess, from among one or more of the following, as the Fund shall determine, any persons to or for or with respect to whom such payments were made, any insurance companies, any other organizations.

Section 17.7 – Assignment

Benefits under this Plan may be assigned by the Participant to a provider. In the event the provider has agreed to accept assignment, the Plan will issue payment for eligible benefits (subject to Plan provisions) directly to the provider. The Fund is not obligated to honor an assignment.

Section 17.8 - Trustees Authority

Subject to the stated purposes of the Trust Fund and the provisions of this Plan, the Trustees have full and exclusive authority and discretion to determine all questions or coverage and eligibility under the Trust, the Plan, and all associated documents, including the power and discretion to construe disputed, doubtful, or ambiguous terms, and to determine all methods of providing and arranging for benefits and all other related matters. They also have the sole authority and full power and discretion to interpret and construe the provisions of the Plan of Benefits, the Agreement and Declaration of Trust and all other Plan documents as adopted, amended, and rewritten form time to time and all the terms used therein, including any disputed, doubtful or ambiguous terms. Any such determination, interpretation, or construction adopted by the Trustees in good faith shall be conclusive and binding upon all of the parties hereto, including without limitation the Employers participating in the Plan and the Trust, the Union, the Plan, the Employee, their dependents and beneficiaries. The Trustees are free to use their own judgment and discretion in all things pertaining to the affairs of the Plan and the Trust Fund and will not be personally liable for any action done or omitted to be done when acting in good faith and in the exercise of their best judgment; the fact that such action or omissions are based upon advice of counsel employed by the Trustees is conclusive evidence of such good faith and best judgment.

Section 17.9 - Termination of Coverage

Benefits for Participants and Eligible Dependents shall terminate when they no longer fulfill the eligibility requirements of the Fund. Benefits for a child shall terminate on the first (1st) day of the month next following the date of his/her marriage or attainment of his/her nineteenth (19th) birthday, except as otherwise provided under the Plan. Benefits for a dependent spouse shall terminate upon divorce subject to the provisions of COBRA.

Section 17.10 – Gender

Wherever the masculine pronoun is used herein it shall include the feminine and wherever the feminine pronoun is used it shall include the masculine.

ARTICLE XVIII - UTILIZATION REVIEW AND CASE MANAGEMENT

A. Precertification

Precertification is the process of obtaining approval from the Plan before you have certain procedures performed. Precertification is mandatory for all in-patient Hospital admissions and high cost chemotherapy and specialty drugs covered under the Plan's Medical Benefit. You must notify the Plan's precertification agent prior to a non-emergency Hospital admission. If the in-patient Hospital admission is due to an emergency, you or a family member must notify the Plan's precertification agent no later than the earlier of two (2) days after admission or the date of discharge.

If you fail to contact the Plan's precertification agent for any services that require pre-certification, all charges incurred will be subject to an additional 10% penalty before any payment is made by the Plan. The penalty may not be applied towards any Deductible, co-payment, Coinsurance or Out-of-Pocket Maximum. This penalty does not apply to Skilled Nursing Facilities.

Please remember that precertification does not verify eligibility for benefits or guarantee benefit payments under the Plan. Precertification also does not constitute a guarantee or warranty of the quality of treatment you receive.

B. Concurrent Review
During a Participant's stay in a Hospital, this program will continue to monitor the length of stay to assure that the admission continues to be medically necessary. No benefits will be payable for time beyond what is determined to be medically necessary.

C. Case Management
The case management program assists seriously ill Participants in maximizing their benefits under the Plan by identifying appropriate alternative treatment settings and levels of care.

ARTICLE XIX – GENERAL INFORMATION

Section 19.1-General Information

INFORMATION REGARDING CLAIMS AND ELIGIBILITY **(Including Verification of Eligibility and Benefits)**	**FUND OFFICE** **Address:** Kentucky Laborers' District Council Health and Welfare Plan 1996 By-Pass South Lawrenceburg, KY 40342-9754 **Telephone Numbers (for all departments):** 800-598-7330 or 502-839-8166
SUBMISSION OF VISION CLAIMS **Active Participants and Pre-Medicare Retirees**	**Vision Claims Submission:** Vision Providers must send all Vision Claims directly to the following: Kentucky Laborers' District Council Health and Welfare Plan 1996 By-Pass South Lawrenceburg, KY 40342-9754 Vision Providers may also fax claims to the Fund at 1-502-839-3558.
SUBMISSION OF MEDICAL CLAIMS **Active Participants and Pre-Medicare Retirees**	**Anthem:** Anthem is the Plan's Preferred Provider Organization (PPO) **Medical Claims Submission:** Medical Providers must send all Medical Electronic Claims to Anthem. Mail In-Network and Non-Network Medical and Hospital claims to Anthem at P.O. Box 105187, Atlanta, GA 30348-5187
CLAIMS TO BE MAILED OR FAXED DIRECTLY TO THE FUND OFFICE: **Active Participants and Pre-Medicare Retirees**	**THE FOLLOWING TYPES OF CLAIMS MUST BE MAILED DIRECTLY TO THE FUND OFFICE:** 1. Loss of Time Disability Benefit Claims 2. Death and/or Accidental Death & Dismemberment Claims 3. Claims for reimbursement for Prescription Copayments when prescriptions are purchased under another group medical insurance 4. Vision Claims 5. Reimbursement for Participant's out-of-pocket expenses from providers who do not accept and/or submit claims to insurance **Address:** Kentucky Laborers' District Council Health and Welfare Plan 1996 By-Pass South Lawrenceburg, KY 40342-9754
PPO PROVIDER INQUIRIES **(To inquire if hospital, physician or ancillary provider is in PPO network)** **Active Participants and Pre-Medicare Retirees**	**Anthem: 1-800-676-BLUE**

PRECERTIFICATION OF INPATIENT HOSPITAL CONFINEMENTS **(To pre-certify emergency or non-emergency hospital confinements)** **Active Participants and Pre-Medicare Retirees**	**HealthLink:** **Your provider must call the HealthLink Pre-Certification Phone Number 1-877-284-0102**
DENTAL CLAIM INQUIRIES **Active Participants, Pre-Medicare Retirees and Medicare Retirees**	**DELTA DENTAL:** **Delta Dental is the Plan's Dental Benefits Manager.** **For Delta Dental Plan Information or to Locate Delta Dental provider:** Register at www.deltadentalky.com. Once you are registered, you may look for Delta Dental providers and/or review your benefit information. You also may call Delta Dental at 1-800-955-2030.
RETAIL AND MAIL ORDER PRESCRIPTION DRUGS **Active Participants and Pre-Medicare Retirees**	**ELIXIR AND ORCHARD PHARMACEUTICAL SERVICES** **Elixir and Orchard Pharmaceutical Services is the Plan's Prescription Benefits Manager.** To locate Retail Pharmacies in the Elixir network, you may log on to Elixir's website, www.elixirsolutions.com, or you may call the Elixir Help Desk at 1-800-361-4542. You may also find the full formulary list of preferred brand name medications on the website. **Mail Order Prescriptions:** Orchard Pharmaceutical Services provides mail order prescription drug services. You must register your information with Orchard Mail Order Pharmacy prior to mailing in a new mail order prescription. This may be done online at www.orchardrx. com. You may also call Orchard Pharmaceutical Services Customer Service at 1-866-909-5170. (Once registered, your physician can fax your prescriptions to Orchard at 1-866-5171.) **Specialty Medications:** Orchard Specialty Pharmacy provides specialty prescription drug services. **All specialty medications must be filled with Orchard Specialty Pharmacy.** Orchard Specialty Pharmacy's phone number is 1-877-437-9012. **Compound Medications:** Orchard Compounding Services provides compound drug services. **All compound medications must be filled with Orchard Compounding Services.** Orchard Compounding Services phone number is 1-866-909-5170.
MEDICARE ADVANTAGE AND PRESCRIPTION DRUG (MAPD) PLAN **(Medicare Retirees)**	**Anthem provides the MAPD Plan** **Medical Claims:** Hospital, physician and medical claims are generally filed by providers. If your claim is not submitted directly by your provider, please contact the MAPD Plan as identified on your identification card for further information about how to file a claims form **Prescription Drug Claims:** You can avoid the need for filing for direct claims by presenting your identification card to the pharmacy when you have your prescription filled. If you need to file a claim form, you may send or fax it and any accompanying receipts to the MAPD Plan as identified on your identification card. **Vision Claims through Blue View Vision:** Vision claims are generally filed by providers. If your claim is not submitted directly by your provider, please contact Blue View Vision as identified on your identification card for further information about how to file a claim form.

Section 19.2 - Certificate of Creditable Coverage

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires the Kentucky Laborers District Council Health and Welfare Plan to provide a certificate of coverage to any participant who loses eligibility. The Act provides that coverage is portable, which means that once a person is eligible for benefits under a new benefit plan, that person can use the certificate to reduce or eliminate any preexisting condition exclusion periods that might otherwise apply in the new benefit plan which covers the person after loss of eligibility under the Kentucky Laborers District Council Health and Welfare Plan. When your coverage through the Kentucky Laborers District Council Health and Welfare Plan ends, you will receive a certificate of coverage.

The Kentucky Laborers District Council Health and Welfare Plan does not impose preexisting condition exclusions and will not require a Certificate of Creditable Coverage when you enroll in the Kentucky Laborers District Council Health and Welfare Plan.

Section 19.3 - Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to

this information. Please read it carefully.

This Notice of Privacy Practices describes how protected health information may be used or disclosed by the Plan to carry out payment, health care operations, and for other purposes that are permitted or required by law. This Notice also sets out our legal obligations concerning your protected health information, and describes your rights to access and control your protected health information. Protected health information (or "PHI") is individually identifiable health information, including demographic information, collected from you or created or received by a health care provider, a health plan, your employer (when functioning on behalf of the group health plan), or a health care clearinghouse and that relates to:

A. your past, present, or future physical or mental health or condition;
B. the provision of health care to you; or
C. the past, present, or future payment for the provision of health care to you.

This Notice of Privacy Practices has been drafted to be consistent with what is known as the "HIPAA Privacy Rule", and any of the terms not defined in this Notice have the same meaning as they have in the HIPAA Privacy Rule.
If you have any questions or want additional information about the Notice or the policies and procedures described in the Notice, please contact: Kentucky Laborers District Council Health and Welfare Fund, 1996 By-Pass South, Lawrenceburg, Kentucky 40342-9754; 502-839-8166.

OUR RESPONSIBILITIES
We are required by law to maintain the privacy of your protected health information. We are obligated to provide you with a copy of this Notice of our legal duties and of our privacy practices with respect to protected health information and we must abide by the terms of this Notice. We reserve the right to change the provisions of our Notice and make the new provisions effective for all protected health information that we maintain. If we make a material change to our Notice, we will mail a revised Notice to the address that we have on record.

Primary Uses and Disclosures of Protected Health Information:
The following is a description of how we are most likely to use and/or disclose your protected health information.

Payment and Health Care Operations
We have the right to use and disclose your protected health information for all activities that are included within the definitions of "payment" and "health care operations" as set out in 45 C.F.R. 164.501 (this provision is part of the HIPAA Privacy Rule). We have not listed in this Notice all of the activities included within these definitions.

A. Payment:
We will use or disclose your PHI to pay claims for services provided to you and to obtain stop-loss reimbursements or to otherwise fulfill our responsibilities for coverage and provided benefits. For example, we may disclose your protected health information when a provider requests information regarding your eligibility for coverage under the Plan, or we may use your information to determine if a treatment that you received was medically necessary.

B. Health Care Operations:
We will use or disclose your protected health information to support our business functions. These functions include, but are not limited to: quality assessment and improvement, reviewing provider performance, licensing, stop-loss underwriting, business planning, and business development. For example, we may use or disclose your protected health information:
1. to provide you with information about one of our disease management programs;
2. to respond to a customer service inquiry from you; or
3. in connection with fraud and abuse detection and compliance programs.

C. Business Associates:
We contract with individuals and entities (Business Associates) to perform various functions on our behalf or to provide certain types of services. To perform these functions or to provide the services, our Business Associates will receive, create, maintain, use, or disclose protected health information, but only after we require the Business Associates to agree in writing to contract terms designed to appropriately safeguard your information. For example, we may disclose your protected health information to a Business Associate to administer claims or to provide service support, utilization management, subrogation, or pharmacy benefit management. Examples of our Business Associates would be the retail pharmacy and the mail order pharmacy.

D. Other Covered Entities:
We may use or disclose your protected health information to assist health care providers in connection with their treatment or payment activities, or to assist other covered entities in connection with payment activities and certain health care operations. For example, we may disclose your protected health information to a health care provider when needed by the provider to render treatment to you, and we may disclose protected health information to another covered entity to conduct health care operations in the areas of quality assurance and improvement activities, or accreditation, certification, licensing

or credentialing. This also means that we may disclose or share your protected health information with other insurance carriers in order to coordinate benefits, if you or your family members have coverage through another carrier.

E. Plan Sponsor:
We may disclose your protected health information to the plan sponsor of the Plan for purposes of plan administration or pursuant to an authorization request signed by you.

Potential Impact of State Law
The HIPAA Privacy Regulations generally do not "preempt" (or take precedence over) state privacy or other applicable laws that provide individuals greater privacy protections. As a result, to the extent state law applies, the privacy laws of a particular state, or other federal laws, rather than the HIPAA Privacy Regulations, might impose a privacy standard under which we will be required to operate. For example, where such laws have been enacted, we will follow more stringent state privacy laws that relate to uses and disclosures of protected health information concerning HIV or AIDS, mental health, substance abuse/chemical dependency, genetic testing and reproductive rights.

Other Possible Uses and Disclosures of Protected Health Information
The following is a description of other possible ways in which we may (and are permitted to) use and/or disclose your protected health information.

A. Required by Law
We may use or disclose your protected health information to the extent that federal law requires the use or disclosure. When used in this Notice, "required by law" is defined as it is in the HIPAA Privacy Rule. For example, we may disclose your protected health information when required by national security laws or public health disclosure laws.

B. Public Health Activities
We may use or disclose your protected health information for public health activities that are permitted or required by law. For example, we may use or disclose information for the purpose of preventing or controlling disease, injury, or disability, or we may disclose such information to a public health authority authorized to receive reports of child abuse or neglect. We also may disclose protected health information, if directed by a public health authority, to a foreign government agency that is collaborating with the public health authority.

C. Health Oversight Activities
We may disclose your protected health information to a health oversight agency for activities authorized by law, such as: audits, investigations; inspections; licensure or disciplinary actions, or civil, administrative, or criminal proceedings or actions. Oversight agencies seeking this information include government agencies that oversee:
1. the health care system;
2. government benefit programs;
3. other government regulatory programs; and
4. compliance with civil rights laws.

D. Abuse or Neglect
We may disclose your protected health information to a government authority that is authorized by law to receive reports of abuse, neglect, or domestic violence. Additionally, as required by law, we may disclose to a governmental entity authorized to receive such information your information if we believe that you have been a victim of abuse, neglect, or domestic violence.

E. Legal Proceedings
We may disclose your protected health information:
1. in the course of any judicial or administrative proceeding;
2. in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized); and
3. in response to a subpoena, a discovery request, or other lawful process, once we have met all administrative requirements of the HIPAA Privacy Rule. For example, we may disclose your protected health information in response to a subpoena for such information, but only after we first meet certain conditions required by the HIPAA Privacy Rule.

F. Law Enforcement
Under certain conditions, we also may disclose your protected health information to law enforcement officials. For example, some of the reasons for such a disclosure may include, but not be limited to:
1. it is required by law or some other legal process;
2. it is necessary to locate or identify a suspect, fugitive, material witness, or missing person; and
3. it is necessary to provide evidence of a crime that occurred on our premises.

G. Coroners, Medical Examiners, Funeral Directors, and Organ Donation
We may disclose protected health information to a coroner or medical examiner for purposes of identifying a deceased person, determining cause of death, or for the coroner or medical examiner to perform other duties authorized by law. We also may disclose, as authorized by law, information to funeral directors so that they may carry out their duties. Further, we may disclose protected health information to organizations that handle organ, eye, or tissue donation and transplantation.

H. Research
We may disclose your protected health information to researchers when an institutional review board or privacy board has:
1. reviewed the research proposal and established protocols to ensure the privacy of the information; and
2. approved the research.

I. To Prevent a Serious Threat to Health or Safety
Consistent with applicable federal and state laws, we may disclose your protected health information if we believe that the disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We also may disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

J. Military Activity and National Security, Protective Services
Under certain conditions, we may disclose your protected health information if you are, or were, Armed Forces personnel for activities deemed necessary by appropriate military command authorities. If you are a member of foreign military service, we may disclose, in certain circumstances, your information to the foreign military authority. We also may disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, and for the protection of the President, other authorized persons, or heads of state.

K. Inmates
If you are an inmate of a correctional institution, we may disclose your protected health information to the correctional institution or to a law enforcement official for:
1. the institution to provide health care to you;
2. your health and safety and the health and safety of others; or
3. the safety and security of the correctional institution.

L. Workers' Compensation
We may disclose your protected health information to comply with workers' compensation laws and other similar programs that provide benefits for work-related injuries or illnesses.

M. Others Involved in Your Health Care
Using our best judgment, we may make your protected health information known to a family member, other relative, close personal friend or other personal representative that you identify. Such a use will be based on how involved the person is in your care, or payment that relates to your care. We may release information to parents or guardians, if allowed by law. We also may disclose your information to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status, and location.

If you are not present or able to agree to these disclosures of your protected health information, then, using our professional judgment, we may determine whether the disclosure is in your best interest.

Required Disclosures of Your Protected Health Information
The following is a description of disclosures that we are required by law to make.

A. Disclosures to the Secretary of the U.S. Department of Health and Human Services
We are required to disclose your protected health information to the Secretary of the U.S. Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA Privacy Rule.

B. Disclosures to You
We are required to disclose to you most of your protected health information in a "designated record set" when you request access to this information. Generally, a "designated record set" contains medical and billing records, as well as other records that are used to make decisions about your health care benefits. We also are required to provide, upon your request, an accounting of most disclosures of your protected health information that are for reasons other than payment and health care operations and are not disclosed through a signed authorization.
We will disclose your protected health information to an individual who has been designated by you as your personal representative and who has qualified for such designation in accordance with relevant state law. However, before we will disclose protected health information to such a person, you must submit a written notice of his/her designation, along with

the documentation that supports his/her qualification (such as a power of attorney).
Even if you designate a personal representative, the HIPAA Privacy Rule permits us to elect not to treat the person as your personal representative if we have a reasonable belief that:

1. you have been, or may be, subjected to domestic violence, abuse, or neglect by such person;
2. treating such person as your personal representative could endanger you; or
3. we determine, in the exercise of our professional judgment, that it is not in your best interest to treat the person as your personal representative.

Other Uses and Disclosures of Your Protected Health Information

Other uses and disclosures of your protected health information that are not described above will be made only with your written authorization. If you provide us with such an authorization, you may revoke the authorization in writing, and this revocation will be effective for future uses and disclosures of protected health information. However, the revocation will not be effective for information that we already have used or disclosed, relying on the authorization.

YOUR RIGHTS

The following is a description of your rights with respect to your protected health information.

Right to Request a Restriction

You have the right to request a restriction on the protected health information we use or disclose about you for payment or health care operations.
We are not required to agree to any restriction that you may request. If we do agree to the restriction, we will comply with the restriction unless the information is needed to provide emergency treatment to you.
You may request a restriction by calling us at the number or writing to the Board of Trustees, Kentucky Laborers District Council Health and Welfare Fund, 1996 By-Pass South, Lawrenceburg, Kentucky 40342-9754, 502-839-8166. It is important that you direct your request for restriction to this number or address so that we can begin to process your request. Requests sent to persons or offices other than the number or address indicated might delay processing the request.
We will want to receive this information in writing and will instruct you where to send your request when you call. In your request, please tell us:

1. the information whose disclosure you want to limit; and
2. how you want to limit our use and/or disclosure of the information.

Right to Request Confidential Communications

If you believe that a disclosure of all or part of your protected health information may endanger you, you may request that we communicate with you regarding your information in an alternative manner or at an alternative location. For example, you may ask that we only contact you at your work address or via your work e-mail.
You may request a restriction by calling or writing us at the number listed in the summary page of this Notice. It is important that you direct your request for confidential communications to this number or address so that we can begin to process your request. Requests sent to persons or offices other than the one indicated might delay processing the request.
We will want to receive this information in writing and will instruct you where to send your written request when you call. In your request, please tell us:

1. that you want us to communicate your protected health information with you in an alternative manner or at an alternative location; and
2. that the disclosure of all or part of the protected health information in a manner inconsistent with your instructions would put you in danger.

We will accommodate a request for confidential communications that is reasonable and states that the disclosure of all or part of your protected health information could endanger you. As permitted by the HIPAA Privacy Rule, "reasonableness" will (and is permitted to) include, when appropriate, making alternate arrangements regarding payment. Accordingly, as a condition of granting your request, you will be required to provide us information concerning how payment will be handled. For example, if you submit a claim for payment, state or federal law (or our own contractual obligations) may require that we disclose certain financial claim information to the plan participant (e.g., EOB). Unless you have made other payment arrangements, the EOB (in which your protected health information might be included) will be released to the plan participant. Once we receive all of the information for such a request (along with the instructions for handling future communications), the request will be processed usually within five business days. Prior to receiving the information necessary for this request, or during the time it takes to process it, protected health information may be disclosed (such as through an Explanation of Benefits, "EOB"). Therefore, it is extremely important that you contact us at the number listed in the summary page of this Notice *as soon as* you determine that you need to restrict disclosures of your protected health information. If you terminate your request for confidential communications, the restriction will be removed for *all* your protected health information that we hold, including protected health information that was previously protected. Therefore, you should not terminate a request for confidential communications if you remain concerned that disclosure of your protected health information will endanger you.

Right to Inspect and Copy

You have the right to inspect and copy your protected health information that is contained in a "designated record set." Generally, a "designated record set" contains medical and billing records, as well as other records, that are used to make decisions about your health care benefits. However, you may not inspect or copy psychotherapy notes or certain other information that may be contained in a designated record set.

To inspect and copy your protected health information that is contained in a designated record set, you must submit your request by calling us at the number listed in the summary page of this Notice. It is important that you call this number to request an inspection and copying so that we can begin to process your request. Requests sent to persons, offices, other than the one indicated might delay processing the request. If you request a copy of the information, we may charge a fee for the costs of copying, mailing, or other supplies associated with your request.

We may deny your request to inspect and copy your protected health information in certain limited circumstances. If you are denied access to your information, you may request that the denial be reviewed. To request a review, you must contact us at the number provided in this Notice. A licensed health care professional chosen by us will review your request and the denial. The person performing this review will not be the same one who denied your initial request. Under certain conditions, our denial will not be reviewable. If this event occurs, we will inform you in our denial that the decision is not reviewable.

Right to Amend

If you believe that your protected health information is incorrect or incomplete, you may request that we amend your information. You may request that we amend your information by calling or writing to the Board of Trustees, Kentucky Laborers District Council Health and Welfare Fund, 1996 By-Pass South, Lawrenceburg, Kentucky 40342-9754, 502-839-8166. Additionally, your request should include the reason the amendment is necessary. It is important that you direct your request for amendment to this number/address so that we can begin to process your request. Requests sent to persons or offices, other than the one indicated might delay processing the request.

In certain cases, we may deny your request for an amendment. For example, we may deny your request if the information you want to amend is not maintained by us, but by another entity. If we deny your request, you have the right to file a statement of disagreement with us. Your statement of disagreement will be linked with the disputed information and all future disclosures of the disputed information will include your statement.

Right of an Accounting

You have a right to an accounting of certain disclosures of your protected health information that are for reasons other than treatment, payment, or health care operations. No accounting of disclosures is required for disclosures made pursuant to a signed authorization by you or your personal representative. You should know that most disclosures of protected health information will be for the purposes of payment or health care operations, and, therefore, will not be subject to your right to an accounting. There also are other exceptions to this right.

An accounting will include the date(s) of the disclosure, to whom we made the disclosure, a brief description of the information disclosed, and the purpose for the disclosure.

You may request an accounting by submitting your request in writing to the Board of Trustees, Kentucky Laborers District Council Health and Welfare Fund, 1996 By-Pass South, Lawrenceburg, Kentucky 40342-9754, 502-839-8166. It is important that you direct your request for an accounting to this address so that we can begin to process your request. Requests sent to persons or offices other than the one indicated might delay processing the request.

Your request may be for disclosures made up to 6 years before the date of your request, but not for disclosures made before April 14, 2003. The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at the time before any costs are incurred.

COMPLAINTS

You may complain to us if you believe that we have violated your privacy rights. You may file a complaint with us by calling the number listed in this Notice. A copy of a complaint form is available from the contact office. You also may file a complaint with the Secretary of the U.S. Department of Health and Human Services. Complaints filed directly with the Secretary must:

1. be in writing;
2. contain the name of the entity against which the complaint is lodged;
3. describe the relevant problems; and
4. be filed within 180 days of the time you became or should have become aware of the problem.

We will not penalize or any other way retaliate against you for filing a complaint with the Secretary or with us.

Section 19.4 - ERISA Rights

As a participant in the Kentucky Laborers District Council Health and Welfare Fund, you are entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

1. Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union

halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

2. 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.
3. 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.
4. Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a 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.
5. Reduction or elimination of exclusionary periods of coverage for preexisting conditions under the Plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

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 a welfare benefit or exercising your rights under ERISA.

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report 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, which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U. S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay the costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

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

Section 19.5 - Plan Information

KENTUCKY LABORERS' DISTRICT COUNCIL HEALTH AND WELFARE FUND
1996 By-Pass South
Lawrenceburg, Kentucky 40342-9754
1-800-598-7330 or 1-502-839-8166
PLAN AND SUMMARY PLAN DESCRIPTION
General Information Applicable to Plan No. 501 / Employer Identification Number for the Trust is: 23-7017526

TYPE OF ADMINISTRATION

The Board of Trustees of the Kentucky Laborers' District Council Health and Welfare Fund is the Plan Sponsor and Plan Administrator and is responsible for overall Plan administration. There are four Trustees appointed by the Union and four Trustees appointed by the Employers. The Trustees have delegated the day-to-day responsibilities for Plan administration to the Fund Administrator.

EMPLOYEE ORGANIZATION

Kentucky Laborers Local Union Numbers 189, 576, 1214, 1392 and 1445, the Kentucky Laborers' District Council Joint Apprenticeship and Training Trust Fund, the Kentucky Laborers' District Council Health and Welfare Trust Fund, and the Kentucky Laborers'-Employers Cooperation and Education Trust.

AGENT FOR SERVICE OF LEGAL PROCESS
The person and address designated as Agent for Service of Legal Process upon the Plan is the Fund Attorney, Charles Berger, Berger & Berger, LLP, 313 Main Street, Evansville, IN 47708. Service on a Trustee shall also constitute service on the Plan.

NAMED FIDUCIARY
The Named Fiduciary is the person or persons who have the authority to control and manage the operation and administration of the Plan. The Named Fiduciaries for the Plan are the Trustees of Kentucky Laborers' District Council Health and Welfare Fund.

PLAN
The name of the Plan for which the benefits and provisions for payment of same as described herein, is the Kentucky Laborers' District Council Health and Welfare Fund. This booklet constitutes the Plan Document and Summary Plan Description.

TYPE OF PLAN
The Plan is a welfare plan providing medical benefits, prescription drug benefits, vision benefits, dental benefits, weekly disability benefits and death benefits. The Plan self-funds the benefits.

PLAN MODIFICATION AND AMENDMENT
The Trustees may modify or amend the Plan at any time in their sole discretion. Notices of amendments that materially affect participants will be timely made in accordance with ERISA.

COLLECTIVE BARGAINING AGREEMENTS
The Plan is maintained pursuant to collective bargaining agreements. Copies of such agreements may be obtained upon written request to the Fund Office, which may impose a reasonable charge for the copies, and are available for examination by participants and beneficiaries at the address of the Fund Office.

TERMINATION OF PLAN
The Plan may be terminated when there is no longer in force an agreement requiring contributions to the Fund or by resolution of the Plan Sponsors. In the event of termination of the Plan, the Trustees will distribute assets of the Fund in such manner as will, in their opinion, best effectuate the purpose of the Fund, for the benefit of the Fund's participants and beneficiaries and defraying reasonable expenses in administering the Fund.

SOURCE OF FUNDING
The Fund receives contributions from Employers that have entered into Collective Bargaining Agreements or other types of agreements with Kentucky Laborers' District Council or Local Union requiring contributions to the Kentucky Laborers' District Council Health and Welfare Fund. For Construction Employees, contributions are paid monthly to the Fund based on hours worked at rates specified in the Collective Bargaining Agreements or other such agreements and enable employees working under such agreements to participate in the Fund. For Non-Construction Employees, contributions are paid monthly for monthly eligibility based on rates set by the Trustees and specified in the Collective Bargaining Agreements or other types of agreements with Kentucky Laborers' District Council or Local Union. Employees are entitled to participate in this Plan if they work under one of the Collective Bargaining Agreements or other such agreements and if their Employers make the required contributions to the Fund on their behalf. You may examine the Collective Bargaining Agreements or other such agreements at the Fund Office or, on written request you may obtain copies of applicable Collective Bargaining Agreements or other such agreements.

Other individuals eligible for benefits under the Plan are officers and employees of the Union on whose behalf the Union has agreed to contribute to Kentucky Laborers' District Council Health and Welfare Fund, and other persons whose Employers pay contributions pursuant to written agreements providing for payment of such contributions.

Section 19.6 – Non Discrimination

Kentucky Laborers District Council Health and Welfare Fund ("the Health Plan") complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. The Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

Section 19.7 – Language and Communication Services

The Health Plan:

Provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

Provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1 (502) 839-8166.

注意： 如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1 (502) 839-8166.

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1 (502) 839-8166.

ARTICLE XX – MEDICARE ADVANTAGE AND PRESCRIPTION DRUG PLAN

Section 20.1 – Eligibility

You are eligible for the MAPD Plan if you are eligible for Retiree Benefits and Medicare.

Any covered individual **must** also be enrolled in Medicare Parts A and B and pay his or her Medicare Part B premium to be eligible for coverage under the MAPD Plan.

Section 20.2 – Benefits for Retirees under the MAPD Plan

The MAPD Plan provides all of original Medicare Parts A and B and Medicare Part D prescription drug coverage. This includes medical, prescription and vision benefits.

The MAPD Plan provides access to a national network of service providers. The network includes doctors, hospitals and ancillary providers. The MAPD Plan will pay for services provided by any physician, facility or hospital that accepts Medicare assignment and agrees to the MAPD Plan's payment terms and conditions.

Please be aware that the Trustees contracted with an insurance carrier to provide these benefits and the benefits will be paid in accordance with the terms of the policy. If you wish to receive a copy of the terms and limitations, please contact the MAPD Plan provider or the Fund Office.

APPROVED:

Union Trustees:

Signature	Date
Signature	Date
Signature	Date
Signature	Date

Employer Trustees:

Signature	Date
Signature	Date
Signature	Date
Signature	Date