SUMMARY PLAN DESCRIPTION

OF THE

OPERATING ENGINEERS LOCAL 37

HEALTH AND WELFARE FUND

AMENDED AND RESTATED
EFFECTIVE APRIL 1, 2024

Active Employees

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Introduction

To all Employees and their Dependents:

The Trustees are pleased to issue this Summary Plan Description (the "SPD") of the Operating Engineers Local 37 Health and Welfare Fund (the "Plan") which, along with any benefit booklets, descriptions or summaries, provides you and your eligible dependents with a current description of your health and welfare benefits as well as your rights and responsibilities under the Plan. This SPD has been amended and restated effective April 1, 2024.

We urge you read the SPD carefully and share it with your family members who are included in your coverage. The Trustees (as defined in the Defined Terms section below) continually review the Plan to determine how to provide benefits to participants and eligible dependents, taking into account the limitations of the Plan's assets and the complexities of complying with various laws applicable to the Plan and the benefit offerings. While the Trustees expect to continue to provide benefits under the Plan, the Trustees, in their capacity as plan sponsor, expressly reserve the right to amend, modify, suspend or terminate this Plan, or any part of it, at any time. No consent of any participant is required to terminate, modify, amend, or change the Plan.

Purpose of this SPD: This SPD is a summary of the plan document and describes the operation of the Fund, the Benefits (as defined in the Defined Terms section below) provided, and the conditions under which Benefits are payable, effective as of April 1, 2024.

This SPD supersedes any prior SPD. Please keep in mind that this SPD is a summary of an official legal document and, if it conflicts with the wording of the plan document, the official Plan document will govern. The Trustees have ultimate discretion to interpret the terms of the Plan.

The Trustees believe this Plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the "Affordable Care Act"). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Please note that this is a self-insured health plan which is governed by the Employee Retirement Income Security Act ("ERISA") and is not subject to any state-mandated benefits laws.
If you have any questions or need assistance, please do not hesitate to contact the Fund Office, whose contact information is listed below.

Sincerely yours,

The Board of Trustees

IMPORTANT NOTE REGARDING BENEFITS AND ELIGIBILITY

All members of the International Union of Operating Engineers Local 37 (the "Union") are not eligible for benefits under the Plan. Also, Union members participating in the Plan may not be eligible for all benefits described in this SPD.

Eligibility for benefits is based on whether you meet the eligibility requirements of your employee classification, i.e., whether you are a Master Group Employee or a Stationary Group Employee, (as those terms are defined in the Defined Terms section below) .

Also, **your specific benefits (if eligible) are based on the benefit plan level your Employer has selected for you.** Your Employer has provided you with information regarding your employee classification and benefit plan level. The various benefit plan levels are listed below. You are eligible for the benefits listed in the benefit plan level that you are enrolled in. Your Employer's election applies for the current Plan Year (as defined in the Defined Terms section below) and future plan years until it is changed.

Plan A Benefits	***Plan B Benefits***	***Plan E Benefits***
Medical (low deductible) Prescription Drugs Dental/Orthodontics Optical Short-term Disability Life/AD&D Telemedicine	Medical (high deductible) Prescription Drugs Short-term Disability Life/AD&D Telemedicine	Medical (mid deductible) Prescription Drugs Dental/Orthodontics Optical Short-term Disability Life/AD&D Telemedicine

OPERATING ENGINEERS LOCAL 37
HEALTH AND WELFARE FUND

FUND INFORMATION & OFFICE HOURS

As of the date of this publication, the members of the Board of Trustees are as follows:

UNION TRUSTEES	EMPLOYER TRUSTEES
Mark F. McQuay	Pierce J. Flanigan, IV
Robert Holsey	Steven Dietrich
Daniel Humbertson	

FUND OFFICE	
Address:	3615 North Point Blvd - Suite C Baltimore, MD 21222
Hours of Operation:	8:00 a.m. to 4:00 p.m.
Days of Operation:	Monday through Friday
Phone Number:	410.254.9595 or 1.800.367.7848
Web Address:	www.dsibenefitfund.org

OPERATING ENGINEERS UNION HALL	
Telephone:	410.254.2030

PLAN ADMINISTRATOR - BOARD OF TRUSTEES	
Address:	Board of Trustees OE37 H&W Fund 3615 North Point Blvd — Suite C Baltimore, MD 21222
Telephone:	410.254.9595 800.367.7848

BENEFITS CONTACT INFORMATION	
Dedicated Provider Phone Line: 410.650.4740 or 1.855.969.3419	
Medical	
CareFirst	**Member Services:** 1.800.235.5160 Go to www.carefirst.com to locate a provider in your area. **In-Patient Pre-Certification: American Health Holdings**: 1.800.641.5566 **Group Number**: W29M **Prefix**: A54 (This goes at beginning of ID) **In Network Medical Claims Address:** Carefirst P.O. Box 14115 Lexington, KY 40512-4115 **Out of Network Medical Claims Address:** O.E. Local 37 H&W Fund c/o Decision Science, Inc. 3615 North Point Blvd — Suite C Baltimore, MD 21222
Health Care One	**Member Services:** 410.254.9595 or 1.800.367.7848
First Health (the "Secondary Network")	**Provider Look Up Information Services:** 1.800.870.6252 www.myfirsthealth.com **Claims Address:** P.O. Box 26127 Overland Park, KS 66225 EDI Payer ID 01066
Telemedicine	
ReviveHealth	**Group Code:** IUOE37 **Member Services:** 877-999-7943 **Web Address:** https://www.revive.health/

BENEFITS CONTACT INFORMATION (CONTINUED)	
Prescription Benefit Manager ("PBM")	
CVS Caremark (the "PBM")	**For Active and Pre-Medicare Retired members** Rx Bin 004336 PCN: ADV RX GROUP: 24GP **Member Services**: 833-300-2751 **Web address**: www.caremark.com
Dental/Orthodontics	
Cigna Dental PPO Plus	**Phone:** 800.797.3381 (to locate providers) **Web Address:** www.cignadentalsaTaftHartley.com **Benefits Questions**: Fund Office 410.254.9595 / 1.800.367.7848 **Claims Address:** 3615 North Point Blvd, Suite C Baltimore, MD 21222
Optical Expense, Weekly Benefit (Short-term Disability), Death Benefit/AD&D	
Fund Office/Decision Science, Inc.	**Claims Address:** O.E. Local 37 c/o Decision Science Inc 3615 North Point Blvd — Suite C Baltimore, MD 21222 **Member Services:** 410.254.9595 800.367.7848

SECTION A: IMPORTANT INFORMATION ABOUT THE PLAN

Plan Name: Operating Engineers Local No. 37 Health and Welfare Fund

Plan Number: 501

Plan Sponsor:
Board of Trustees of the Operating Engineers Local 37 Health and Welfare Fund
3615 North Point Blvd — Suite C
Baltimore, MD 21222
410.254.9595
1.800.367.7848

Tax Identification Number: 52-6039006

Plan Administrator:
The Board of Trustees is the Plan Administrator and the Plan fiduciary as defined under ERISA. The Board of Trustees has engaged Decision Science, Inc. to perform many day-to-day administrative and operational functions of the Plan. Contact information for the Decision Science, Inc. is below. The Board of Trustees may also be contacted in care of Decision Science, Inc.

Decision Science, Inc.
3615 North Point Blvd — Suite C
Baltimore, MD 21222
410.254.9595
1.800.367.7848

Type of Plan and Type of Administration:
The Plan is a multiemployer welfare benefit plan subject to the provisions of ERISA. The Plan provides group health benefits, prescription drug, dental, vision, death and accidental death and dismemberment and disability benefits. The Plan is self-insured.

Establishment of the Plan:
The Plan and related trust were established on January 1, 1956. The Plan has been amended from time to time since it was established, to reflect negotiated and administrative changes and to comply with changes in applicable law, and was last restated on January 1, 2024. The Plan is maintained pursuant to collective bargaining agreements, entered into between the Union and contributing Employers.

Plan Year:
January 1 – December 31

Agent for Service of Legal Process:
Decision Science, Inc.
3615 North Point Blvd — Suite C
Baltimore, MD 21222
410.254.9595
1.800.367.7848

SECTION B: SUMMARY OF BENEFITS

EFFECTIVE APRIL 1, 2024

Medical Summary of Benefits

The below chart provides an overview of the medical benefits provided by the Plan, outlines the amount of Charges (as defined in the Defined Terms section below) that will be paid by the Fund and provides a summary of your costs, which may include paying a deductible, copayment and/or coinsurance. Fund payments for medical benefits may depend on whether you select a network provider or an out-of-network provider. Please note that for services subject to the No Surprises Act (Emergency Services, covered services provided by certain out-of-network providers network facilities, and out-of-network air ambulance services) you will pay the in-network cost. Please see **Appendix A for more information on the No Surprises Act**. For a more detailed explanation of the medical benefits available under the Plan, including coverage details and exclusions, please also see **Section D.**

	Plan A	**Plan B**	**Plan E**
MAJOR MEDICAL BENEFIT			
Annual Deductible Individual Individual Plus One Family	 $350 $650 $950	 $1,100 $2,150 $3,200	 $600 $1,150 $1,700
Out of Pocket Maximum Individual Coverage Dual Coverage Family Coverage (3 or more covered Participants) ***Applies to in-network charges (as applicable by law) after the deductible has been met. Once covered out of pocket costs reach this amount, the Plan will pay 100% of the covered Charges***	 $2,000 $3,500 $5,000	 $2,000 $3,500 $5,000	 $2,000 $3,500 $5,000
Inpatient	100% coverage (based on semiprivate room rate) after deductible		
ICU	The Plan pays 100% of the semiprivate room rate for inpatient hospital charges. The ICU rate is paid at 2 times the semi-private rate. Any amount that exceeds 2 times the semiprivate room rate is paid at 80%.		

Outpatient	**PPO (IN NETWORK)**	**Non-PPO (OUT-OF NETWORK)**
Hospital Outpatient Surgery Facility Fees	100%	100%
Hospital Charges for Sudden & Serious Illness or Accident	100% for Hosp charges which do not result in in-patient admission	100% for Hosp charges which do not result in in-patient admission.
Hospital ER Fees for Non-Sudden & Serious ($75 co-pay is waived if patient is admitted)	$75 Co-Pay— Services Paid at 80%	$75 Co-Pay — Services Paid at 80%
Ambulatory Surgical Facility Fees	100%	50%
Outpatient Physical Therapy & Other Major Medical Charges	80%	70%
Ground or Local Ambulance charges to the Hospital	100%	100%
Ambulance charges from hospital to another hospital or home	80%	80%
Non-emergency ambulance transportation	**Not covered**	**Not covered**
Surgeon Charges	80%	70%
Assistant Surgeon Charges	50%	50%
Second Opinion	100%	100%
Anesthesia	80%	80%
Hearing Aid (up to $1,500 every 3 calendar years)	80%	80%
Diabetic Self-Management Education (Limitations apply)	80%	50%
Hospice Care	70%	50%
Physician Charges	80%	70%
Diagnostic, Lab & X-Ray	80%	70%
Home Health Care (RN, LPN Charges only)	Initial $5,000 Paid 100% balance paid at 80%	Initial $5,000 Paid 100 balance paid at 80%
Orthotics/Prosthetics- $560 annual maximum	80%	80%
Mental Health — Out-Patient Care	80%	70%
Global Cases	80%	80%
Primary Major-Medical	80%	70%
Durable Medical Equipment — Pre-Notification Required for all DME $1,000 and Above	80%	70%

Health Care One	100%	100%
SECONDARY MAJOR MEDICAL*		
Annual Deductible Lifetime Maximum Out-Patient Services	$200 $15,000 80%	$200 $15,000 80%
TELEMEDICINE		
ReviveHealth Services are provided at no cost to you (no co-pays, deductibles or consultation fees).	100%	

*All expenses for acupuncture and chiropractic care are payable under the Secondary Major-Medical Benefit part of the Plan. None of these expenses are covered under the Basic Medical Benefit (as defined in the Defined Terms section below) .

Except as required under the No Surprises Act, Charges (as defined in the Defined Terms section below) for professional fees from Non-PPO (as defined in the Defined Terms section below) professionals (radiologists, pathologists, etc.) will be paid at the PPO rate provided that (1) services were rendered while an eligible Participant (as defined in the Defined Terms section below) was either on an inpatient or outpatient status at a PPO Hospital (as defined in the Defined Terms section below), (2) the Participant did not have a choice in selecting the provider, and (3) the services provided were a covered benefit under the Plan.

Prescription Drug Summary of Benefits

Prescription drug coverage is available to Employees and Dependents (as these terms are defined in the Defined Terms section below) enrolled in medical benefits. The below chart summarizes the prescription drug benefits provided by the Plan and provides an overview of the cost that must be paid by the Employee or Dependent. For more information regarding prescription drug coverage, including important coverage information, programs, and exclusions, please see **Section E**.

PRESCRIPTION DRUG BENEFITS		
	Retail	**90-Day Supply Mail Order**
Generic	$15	$25
Preferred Brand	$30	$60
Non-Preferred Brand	$50	$100
Value Generics	$3.33	$9.99
Specialty Medications	20% co-pay	20% co-pay
Diabetic Treatment		
Non-Insulin Injectables	Normal Co-pay	
Insulin	Normal Co-pay	
Non-Insulin Oral Drugs	Normal Co-pay	
Supplies		90-Day Supply at Normal Co-Pay (Mail Order or Retail)
Devices	Free Meter Program i Contact PBM for Free Diabetic meter i CGM (Continuous glucose Monitor) normal co pays i Insulin pump normal co pays	
Prescription Vitamins Pre-Natal Vitamins Vitamin D Iron	Normal Co-pay	Normal Co-pay
Contraceptives		
Oral Medicine	Normal Co-pay	Normal Co-pay
Injectable Medicine	Normal Co-pay	Normal Co-pay
Patches	Normal Co-pay	Normal Co-pay
IUD	20% Co-pay	
Vaccinations		
Flu	0% Co-pay when filled or administered at pharmacy	
Shingles	20% Co-pay when filled or administered at pharmacy	
Pneumonia	20% Co-pay when filled or administered at pharmacy	
Preventive	20% Co-pay at pharmacy	
COVID-19	20% Co-pay at pharmacy	
Smoking Cessation – 3-month supply - once yearly for 3 years Prescription - Normal Co-pay. Over the Counter - $0 Co-pay with a Medical prescription You must present your Medical/RX ID card to the pharmacist.		

Dental/Orthodontic and Optical Expense Summary of Benefits

DENTAL AND OPTICAL BENEFITS APPLY TO EMPLOYEES AND DEPENDENTS ENROLLED IN PLANS A & E ONLY AND ARE NOT AVAILABLE TO PLAN B PARTICIPANTS

The below chart provides an overview of the dental benefits provided by the Plan, outlines the amount of Charges that will be paid by the Fund and provides a summary of costs, which may include paying a deductible and/or coinsurance. Fund payments for dental benefits may depend on whether you select a network provider or an out-of-network provider. For a more detailed explanation of the dental benefits under the Plan, including coverage details, limitations, and exclusions, please see **Section F**.

The Plan also provides Optical Expense Benefits to Participants and Dependents as described below. For more information on the Optical Expense Benefits, including coverage limitations, maximums, and exclusions, please see **Section G**.

DENTAL/ORTHODONTIC		
Annual Deductible	$100 individual/$300 family	
Calendar Year Maximum	$2,000 annual maximum (No annual maximum for Dependent Children up to age 19)	
Orthodontic Benefit Lifetime Maximum	$1,000 Lifetime Maximum ($1,250 annual maximum paid at 80%)	
Coverage Cigna Dental Shared Administration Plus Program (the SA Plus Program)	PPO (**IN NETWORK**) 80%	Non-PPO (**OUT-OF-NETWORK**) 80%/UCR
OPTICAL EXPENSE BENEFITS		
Available every 2 years: exam, lens, frame and contacts	$600 (No maximum for Dependent Children up to age 19. Benefits for Dependent Children up to age 19 are payable based on a Fee Schedule.)	

Death, AD&D and Disability Benefits Summary of Benefits

The below chart provides an overview of the Death, Accidental Death & Dismemberment ("AD&D"), and Disability Benefits provided by the Plan to Employees. For a more detailed explanation of these benefits, including coverage exclusions and limitations, please see Section H (Disability Benefits), Section I (Death Benefits), and Section J (AD&D Benefits).

DEATH BENEFIT	$25,000
AD&D BENEFIT	$25,000 Principal Sum
DISABILITY BENEFIT	
Benefit	$400/week
Waiting period	7 days
Maximum benefit period	26 weeks

SECTION C: GENERAL PROVISIONS

Defined Terms

To simplify your reading of this SPD, listed below are several of the terms used in this summary. Capitalized terms used within the SPD not defined here are defined in other areas of the SPD or in the official Plan Document. If, after reading this SPD, you have any questions or would like more details, please call the Fund Office.

Adoption Agreement means any written agreement between the Union and an Employer and any side letter attached, to provide selected Benefits available under the Plan. The Benefits available under the Plan will be provided according to this Plan, the terms of the Adoption Agreement, and the Program Documents.

Allowed Amount means the amount negotiated by the Plan or an amount permitted by law.

Annual Maximum or Calendar Year Maximum means the maximum amount the Plan will pay in Benefits in the Plan Year. For "Essential Benefits", the term "Annual Maximum" means, the maximum amount that the Plan will pay for Benefits in a Plan Year for "Essential Benefits." For Benefits that are not "Essential Benefits", "Annual Maximum" means the limits in the Program Documents. All other Plan limitations will apply that are permitted by law.

Balance Billing is the practice of billing the difference between the provider's Charge and the Allowed Amount.

Bed Patient means a Participant who must be confined to a Hospital for Medically Necessary Treatment.

Beneficiary means the person designated by a Participant, on the form provided by the Trustees, to receive any Benefits provided by the Plan upon the death of the Participant.

Benefit Quarters mean the four periods of:

(1) June, July, and August
(2) September, October, and November
(3) December, January, and February
(4) March, April, and May

Benefits under the Plan are the benefits, described in Benefit Program, selected by the Trustees, or by an Employer pursuant to an Adoption Agreement (as described in the plan document). The Plan does not create vested rights in the Participants or Dependents to receive Benefits, and all Benefits under the Plan are subject to amendment at the discretion of the Trustees.

Benefits Program is a welfare benefit program or arrangement that is part of the Plan.

Charges or Charges mean the usual, reasonable and customary fees for payment for services or items for which Benefits are payable under the Plan.

To the extent permitted by law, excessive charges will be the responsibility of the Participants or Dependents. The Fund's Board of Trustees determine what expenses will be covered.

Co-Insurance is the percentage of costs of a covered health care service after you have met your Deductible.

COBRA means the continuation coverage rights provided under the Consolidated Omnibus Budget Reconciliation Act of 1985.

Collective Bargaining Agreement is the agreement entered into by and between an Employer and the International Union of Operating Engineers Local 37 and the Union and all subsequent and other agreements (including applicable amendments), negotiated between an Employer and the Union, which requires contributions to the Fund.

Covered Individual means a Participant or their Dependents.

Covered Medical Expenses means the Charges for Medically Necessary items and services for an illness or injury which are covered under the Plan, provided they were incurred after the Effective Date. Covered Medical Expenses are those permitted by the terms of the Plan, as modified by any Adoption Agreement and Program Document, and are subject to amendment.

Deductible means the amount each Participant or Dependent is responsible to pay for each year before the Fund begins to pay for Benefits.

Dependent includes the following individuals, depending on the coverage elected by the Participant:

- your husband or wife, unless you are legally separated or divorced
- children, under age 26. Benefits will be provided until the end of the month in which the child reaches age 26.
- unmarried children over the age of 26 who depend on the Participant for support because of a physical or mental handicap that existed before age 26. Proof of the child's incapability must be provided to the Plan Administrator no later than thirty-one days after the child reaches age 26 and the documentation must show that the child was listed as a Dependent prior to age twenty-six. Proof of the continued existence of the child's incapacity may be requested by the Plan Administrator from time to time.

For purposes of this definition, children include:

- a blood descendant of the first degree;
- a legally adopted child (including a child living with the adopting parents during the period of probation);
- a child (including a stepchild) for whom the Employee has been named the child's legal guardian by a court or legal jurisdiction and the appropriate documentation has been submitted and approved by the Plan. For a stepchild to be a child, a Participant must sign an affidavit attesting that the stepchild has the same primary

residence as the Participant and the Participant claims the stepchild as dependent on federal income tax documents.

Newborn children are eligible as Dependents for Benefits under the Plan from the date of birth. Adopted children are eligible for benefits on the date of placement, even though the adoption is not yet final.

If a Participant has no Dependents on the day they become eligible for Benefits, their Dependent Benefits will become effective upon the date the Participant has an eligible Dependent. Any child of a Participant who is named as an Alternate Recipient in a Qualified Medical Child Support Order (a "QMSCO") will be deemed to be a Dependent during the period to which the QMSCO applies. A birth certificate will be required in connection with the QMSCO.

An individual who is entitled to Benefits as a Participant will not be treated as a Dependent under this Plan.

** It is your responsibility to determine whether individuals qualify as Dependents and can be provided coverage under this Plan. If the Plan covers family members who do not qualify as Dependents, the Plan has the right to terminate your Dependent coverage and seek reimbursement of any claims that were improperly paid.

Disability is defined under "Total Disability."

Durable Medical Equipment means equipment which (1) can withstand repeated use; (2) is primarily and customarily used to serve a therapeutic medical purpose; and (3) is generally not useful to a person in the absence of illness or injury. Examples of durable medical equipment include wheelchairs, hospital beds, apnea monitors, insulin pumps, breast pumps, nerve and bone stimulators, crutches, canes and walkers.

Employee is a member of the Union who is actively working for an Employer or any other employee of an Employer, for whom contributions are made to the Fund. Employee also includes leased employees (as defined under the Internal Revenue Code) so long as the Employee has not been excluded by the applicable Collective Bargaining Agreement or Adoption Agreement. Employees may be classified based on their Employer's designation under the Plan. For example, Employees of a Master Group Employer will be designated as Master Group Employees.

Employer means any employer who is required by a Collective Bargaining Agreement to make contributions to the Fund. Employer also includes Affiliated Group Employers as defined under the plan document.

Essential Benefits mean health-related items and services as defined as Essential Benefits under the Affordable Care Act and applicable regulations.

Explanation of Benefits or an "***EOB***" is a statement describing what medical treatments or services received by a Participant or Dependent are covered. It is not a bill.

Global Case Bill is a bill which does not include an itemized line-by-line breakdown of the individual charges incurred by the Participant or Dependent. A Global Case bill is derived from a

global case rate, which is a special discounted rate for the actual procedures performed and which may include Physician, facilities and organ acquisition Charges.

Health & Welfare Fund or ***the Plan*** means the Operating Engineers Local 37 Health and Welfare Fund.

HIPAA means the Health Insurance Portability and Accountability Act of 1996 and applicable regulations.

Hospice or Hospice Care means a facility, agency or service that is licensed, accredited or approved by the proper authority to arrange, coordinate and/or provide programs to meet the needs of dying (including terminally ill) individuals and their families. Under Hospice Care Services, bills are maintained and billed on a consolidated basis.

Hospital is an institution constituted, licensed and operated according to applicable law. To qualify, an institution must be:

- Accredited under the Hospital Accreditation Program of the Joint Commissions on the Accreditation of Health Care Organizations;
- Supervised by a staff of Physicians with 24-hour nursing service; and
- Either a general or specialized inpatient medical care treatment center. If it provides general care, the medical, diagnostic and surgical facilities must be on the premises or under the Hospital's control. A specialty Hospital can contract with another provider for medical and diagnostic services.

Hospital also includes (A) a facility that operates primarily as a rehabilitation center or skilled nursing center or (B) an outpatient surgery center, which is defined as a licensed institution which:

- is mainly engaged in performing surgery on its premises;
- has a medical staff, including Physicians and registered graduate nurses; and
- has at least one permanent operating room and recovery room.

The following types of institutions or departments are not considered to be Hospitals, regardless of whether they are located within, in close proximity of or adjacent to a Hospital:

- a facility primarily for convalescence, rest, or the aged,
- a facility that provides custodial care, including training for daily living, or
- a facility that operates primarily as a school.

Hours of Service mean hours of work performed by an Employee for an Employer. Hours of Service are reported by the Employer and contributions are made based on the Hours of Services reported to the Plan Administrator by the Employer.

Inpatient Care means health care that you get when you're admitted as an inpatient to a health care facility, like a hospital or skilled nursing facility.

Lifetime Maximum is the total amount payable for each Participant or covered Dependent. There are separate Lifetime Maximums under the Basic Medical Benefit, the Secondary Major Medical Benefit, and the Orthodontic Benefit. The Lifetime Maximum does not apply to "Essential Benefits." All other Plan limitations apply.

Master Group Employee is an Employee of a Master Group Employer that is paid on an hourly basis.

Master Group Employer is an Employer signatory to a Collective Bargaining Agreement listed on Appendix D, as amended from time to time.

Medically Necessary means services that are:

- appropriate medical treatment for the Participant's or Dependent's condition;
- expected to provide benefits that outweigh the potential risks; and
- necessary to protect or restore the physical or mental health of the Participant or Dependent. The determination of what services are Medically Necessary will be made by the Plan or an agent designated by the Trustees under the Plan. If there is a conflict of opinion between the Plan and the provider of care, the Participant may submit an appeal to the Trustees for additional consideration.

Mental Health and Substance Use Disorder Benefits are services to treat mental health or substance abuse conditions that are listed in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) as a mental health or substance abuse condition.

MHPAEA is the Mental Health Parity Act of 1996, as amended by the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 and any applicable regulations.

No Surprises Services are the Charges submitted by a provider or healthcare facility for services or care covered under the No Surprises Act. The No Surprises Act is covered in detail in the Appendix of this SPD.

Orthotics is a type of medical device (such as leg, arm, back or neck braces), which is used to activate or supplement a weakened limb or function, and is recognized by Medicare.

Out of Pocket Maximum is the most a Participant or Dependent is required to pay in eligible Charges in one calendar year. The Out-of-Pocket Maximum does not include amounts paid toward Deductibles or amounts paid through the Plan's other cost sharing features.

Participant is a current Employee who has satisfied the eligibility provisions and who has not waived participation in the Plan or a former Employee (who is not a retiree) who makes an election to continue coverage either through self-pay or through COBRA.

Physician is any Doctor of Medicine "MD" who is legally qualified and licensed to practice medicine, and/or psychiatry, and/or to perform surgery. "Physician" also means a licensed Doctor of Osteopathy "DO", Doctor of Dental Surgery "DDS", Doctor of Podiatry "DPM", and Chiropractor, when acting within their license. "Physician" does not include a psychologist, social worker or other similar practitioner, except if required by law.

Plan means the Operating Engineers Local 37 Health and Welfare Plan.

Plan Administrator means the Board of Trustees, sometimes referred to as the "Trustees." The Board of Trustees may delegate some of the Plan's administrative duties to a third party.

Plan Year is the twelve-month period beginning on January 1st ending on December 31st of each year.

PPO means Preferred Provider Organization, which is a network of participating physicians and hospitals with which the Plan has entered into a contract. The Plan has entered into contracts with two different networks of physicians. One is called the **Carefirst PPO** and the other is called **Health Care One PPO**. These are discussed in more detail below. Non-PPO means any provider or hospital that is not a part of these networks.

Prescription Drug is a legend drug prescribed by a Physician, a Dentist, or other medical provider who is licensed by state or federal law and is able to prescribe drugs.

Program Document is the written description of the Benefits Program, including a summary plan description, schedule of benefits, benefits booklet, insurance contract or certificate, or other written Plan descriptions.

Qualified Medical Child Support Order is a court order, as defined in ERISA, which is determined by the Plan's procedures.

Room and Board is room, board, general duty nursing and any other services regularly provided by the Hospital. This does not include the professional services of Physicians.

Stationary Group Employee means an Employee of a Stationary Group Employer.

Stationary Group Employer an Employer that is signatory to an individual participation agreement providing for participation in the Plan, the list of Stationary Group Employers as of the date of the Plan is on Appendix D, as amended from time to time.

Sudden and Serious Condition is an Emergency Medical Condition which is sudden in the opinion of the treating Physician and that endangers the life of the Participant or Dependent.

Summary of Benefits mean the Benefits schedules stating the Plan's determination of current Benefits, including, but not limited to, the dollar amounts for Benefits, Deductibles, copayments, coinsurance, and Lifetime Maximums.

Total Disability or Disability means that an Employee is unable to perform each and every duty pertaining to their regular or customary occupation or employment because of an illness or accidental injury. Disability will initially be determined based on the forms submitted and completed by the Employee, their Physician and their Employer, to the Plan Administrator by the Participant. Evidence of continued Disability may be required by the Plan Administrator at intervals set by the Plan Administrator. If the Trustees require, the Disability of an Employee may be redetermined by a Physician chosen by the Plan Administrator.

UCR means the amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the Allowed Amount.

Union means the International Union of Operating Engineers, Local 37.

Work Quarter is the calendar quarter in which a Master Group Employee works a sufficient number of Hours of Service to be eligible to receive Benefits under the Plan in the next Benefit Quarter.

General Employee Eligibility and Enrollment

Master Group Employees – Initial Eligibility and Enrollment

If the Employee so elects, a Master Group Employee is first eligible for Benefits the first day of the month following their completion of 480 Hours of Service during the preceding 5-month consecutive period working for a Master Group Employer. If the Master Group Employee gains eligibility this way, they will remain eligible for Benefits through the remaining months of the Benefit Quarter.

To maintain eligibility after initially gaining eligibility based on working 480 Hours of Service during the preceding 5-month consecutive period, a Master Group Employee must have the following Hours of Service with a Master Group Employer:

300 hours in the preceding Work Quarter, OR
600 hours in the preceding two Work Quarters

A Master Group Employee can gain or resume eligibility under the special 480 Hours of Service rule only once in a 12-month period.

If a Master Group Employee does not gain eligibility based on working 480 Hours of Service for a Master Group Employer during the preceding 5-month consecutive period, the Master Group Employee will be eligible for Benefits the first day of the Benefit Quarter following the completion of 300 Hours of Service with a Master Group Employer in the preceding Work Quarter or 600 Hours of Service with a Master Group Employer in the preceding 2 Work Quarters.

If a Master Group Employee is eligible for coverage, coverage under the Plan will begin either on June 1, September 1, December 1, or March 1 as shown in the chart below:

If you worked:				
300 hrs in preceding	Jan, Feb, March	April, May, June	July, Aug, Sept	Oct, Nov, Dec
OR 600 hrs. in preceding	Oct thru March	Jan thru June	April thru Sept	July thru Dec
OR 900 firs. in preceding	July thru March	Oct thru June	Jan thru Sept	April thru Dec
OR 1,200 hrs. in preceding	April thru March	July thru June	Oct thru Sept	Jan thru Dec
You are eligible for benefits during	June, July, Aug	Sept, Oct, Nov	Dec, Jan, Feb	March, April, May

In determining eligibility for a Master Group Employee, each week of Total Disability up to 9 weeks is counted as 40 hours. After 9 weeks of Total Disability, the Master Group Employee will

be treated as automatically satisfying the Hours of Service requirement until the end of the Benefit Quarter containing the earlier of the end of the 26th week of their Total Disability, or the date the Master Group Employee returns to employment.

Stationary Employees Initial Eligibility and Enrollment

A Stationary Group Employee is eligible for the Benefits under the Plan the first of the month, following their eligibility date provided the Stationary Employee has completed their initial enrollment forms and submitted all required paperwork for enrollment within 30 days of their eligibility date.

If a Stationary Employee does not complete their initial enrollment forms and submit any required documentation within 30 days of their eligibility date for themselves, and any eligible Dependent, the Stationary Employee will have to wait until the next open enrollment period to enroll for coverage for themselves and any eligible Dependents unless the Employee or Dependent has a special enrollment right or family status change as described below.

Elections made during an Employee's initial enrollment period will remain in effect unless the Employee makes changes during the open enrollment period or the Employee or Dependent has a special enrollment right or family status change as described below.

Immediate eligibility may be granted to Master Group and non-Master Group Employees by the Trustees in compliance with any Collective Bargaining Agreement or other agreement between the Trustees and the applicable Employer and in compliance with the rules in the Program Documents.

Continued Eligibility

Master Group Employees

A Master Group Participant will remain covered under the Plan as long as he remains a Union member, if employed and continues to work the minimum number of hours listed below:

- 300 hours in the most recent Work Quarter
- 600 hours in the two most recent Work Quarters
- 900 hours in the three most recent Work Quarters
- 1,200 hours in the four most recent Work Quarters

Coverage will end for a Master Group Employee and their enrolled Dependents if a sufficient number of hours are not completed or their Employer fails to make the required contribution to the Fund, provided the Master Group Employee has exhausted all of his or her banked hours. In certain cases, the Master Group Employee may be able to elect to continue coverage under COBRA or under a self-pay option.

Stationary Group Employees

Coverage for a Stationary Group Employee will remain effective as long as the Stationary Group Employee remains employed, maintains their status as a Union Member and their Employer makes

the required monthly contributions. If a Stationary Group Employee loses coverage, they may be eligible to elect COBRA continuation.

Dependent Eligibility

A Dependent's coverage will be effective on the date they become eligible as long as the Participant is covered on that date and the Participant provides documentation to confirm the status of the Dependent.

Dependents will be covered only after the Employee provides the proper documentation/ verification. Generally, proper verification includes a birth certificate and/or a marriage certificate. In the event that these documents are unavailable, a notarized affidavit can be used. **No bills will be paid for Dependents until the proper documentation is submitted and accepted.**

Open Enrollment

Eligible Employees can enroll in, waive, or change coverage during the annual open enrollment period for themselves and any eligible Dependent. The open enrollment period normally begins on November 1st and ends on December 15th. During open enrollment, all forms or documentation required by the Fund for enrollment (for the Employee and any eligible Dependents) must be provided by the last day of the open enrollment period. If all required forms and documentation are not received by the last day of the open enrollment period, any election changes will not take effect and the Employee will have to wait until the next open enrollment period to make any changes for themselves or their eligible Dependent, unless the Employee or Dependent qualifies to make a Special Enrollment Change or Family Status Change. Elections made during open enrollment will be effective the following January 1.

If no changes are made by the Employee for themselves or any Dependent during open enrollment, the Employee's existing elections will remain in effect for the following Plan Year, beginning January 1.

However, midyear coverage changes will be permitted in special situations. For example, if you get married or have a child (through birth or adoption), your new spouse or child can be added to your Health Plan coverage before the next open enrollment period. See section "Making Changes During the Plan Year" below for more information.

Termination of Coverage

Generally, all coverage will be terminated on the last day of the month during which an Employee or Dependent is last eligible (including banked hours, to the extent possible).

In certain instances, an Employee or Dependent who loses coverage may be able to elect to continue coverage, as long as they pay for all or part of the cost.

If the Employee's Employer no longer participates in the Plan but continues operations, coverage for the Employees will terminate with the Employer's Plan termination.

Coverage for all Participants and Dependents will cease if the Plan is terminated.

Stationary Group Employees' coverage will terminate:

- The date any required contributions are not made for the Employee and any covered Dependents.

Master Group Employees' coverage will terminate:

- The first day in the Work Quarter following a Work Quarter when the Master Group Employee did not complete the required Hours of Service.
- The date the Master Group Employee begins to work in the construction industry (except if their Master Group Employer still makes contributions) if the Master Group Employee:
  - Leaves work with an Employer participating in the Plan.
  - Refuses to return to work when requested to return by an Employer or the Union.

  A Master Group Employee who loses coverage for the above reasons will forfeit any banked hours. (If eligible, the Master Group Employee will be able to continue coverage under COBRA.)
- The date any required contributions are not made for the Master Group Employee and any covered Dependents, unless the Master Group Employee has banked hours with the Fund.
- The date specified in the Collective Bargaining Agreement or Adoption Agreement. Master Group Employees who were immediately enrolled in the Plan coverage will terminate the later of:
  - The date the Master Group Employee is no longer an Employee.
  - The date the Master Group Employee is no longer eligible for coverage.

  Master Group Employees who coverage terminates for the above reasons may not apply banked hours to continue coverage

Dependents' coverage will terminate:

- The date the Dependent no longer meets the definition of Dependent.
- The date the eligible Employee does not provide the required documentation for Dependent verification.
- The date any required contributions are not made for the Dependent, as required.
- The date the Employees loses eligibility.
- The date specified in the Collective Bargaining Agreement, Adoption Agreement or other Program Documents.

Other Eligibility Rules

Reinstatement – The following Employees may be eligible for reinstatement of Benefits:

- Eligible Employees who were eligible for Benefits at the time of entry into any branch of the United States Armed Forces. These Employees will be reinstated upon their timely return to work in accordance with USERRA.

- Employees or Dependents that lose eligibility, but re-satisfy the applicable eligibility requirements.
- Upon their Employer's payment of outstanding contributions or submission of the Employees Hours of Service (as applicable) as required by the terms of the Collective Bargaining Agreement or other agreements.

Transfers from Master Group Employer or Stationary Group Employer

If a Master Group or Stationary Group Employee has been employed for 12 months or more by a Master Group or Stationary Group Employer and has been eligible for Benefits under the Plan for the 3-month period prior to their transfer, the Employee is automatically eligible for Benefits under the Plan upon their transfer.

Trustee Discretion

The Board of Trustees have the ultimate discretion to interpret the terms of the Plan, including but not limited to making determinations regarding eligibility, coverage and exclusions under the terms of the Plan, and with respect to Collective Bargaining Agreements, Program Documents, Adoption and other agreements, as applicable.

Making Changes During the Plan Year

Eligible Employees may be able to enroll in the Plan if certain changes occur during the year, such as an Employee's marriage, divorce, legal separation or loss of coverage for the Employee or eligible Dependent. It is up to the Employee to inform the Fund about **Changes in Family Status**. It is important that you notify the Fund as soon as possible and no later than 30 days after the date of the change.

Changes in Family Status include:

- Marriage, annulment, legal separation, or divorce;
- Birth, death, or adoption of a Dependent;
- Placement for adoption of a Dependent;
- Change in employment status (e.g., the Employee or Dependent terminates employment or starts new employment);
- Change from full-time to part-time employment (or vice versa) by the Employee or Dependent;
- A change in the Employee's or Dependent's employment status due to an unpaid leave of absence;
- Employee's Dependent becomes eligible or is no longer eligible for coverage under the Plan;
- Employee's Dependent elects to add or drop coverage during the open enrollment period under the Dependent's employer's plan;
- Employee's obligation under a Qualified Medical Child Support Order to provide coverage of a Dependent begins or ends;
- Employee or Dependent's obtains or loses eligibility for Medicare or Medicaid (change may only be made for the affected person); and

- Any other event the Fund determines to qualify as a family status change under the Internal Revenue Code regarding midyear pre-tax contribution changes.

When a Change in Family Status occurs, the Employee must provide all required forms and documentation to the Plan. These changes may entitle the Employee or Dependent to exercise the Special Enrollment Rights described below, if the Employee timely notifies the Plan.

Special Enrollment

Under HIPAA Special Enrollment rules, eligible Employees may change Benefit elections during the Plan year if any of the following events occur:

Change in Family Status: If the Employee has a new Dependent as a result of marriage, birth, adoption, or placement for adoption, the Employee may be able to enroll themselves and their Dependents. However, eligible Employees must request enrollment within 30 or 60 days after the marriage, birth, adoption, placement for adoption or other event. To request special enrollment or obtain more information, contact the Fund Office.

Loss of Other Insurance: If an Employee declines enrollment for themselves or their eligible Dependents because of other health insurance or group health plan coverage, the Employee may be able to enroll themself and their Dependents in the Plan if eligibility for that other coverage is lost (or if the Dependent's Employer stops contributing toward the Employee's or the Dependents' other coverage).

The Employee must request enrollment within 30 days (or 60 days if due to Medicaid or Children's Health Insurance Program-related events) after the Employee's or Dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

It's up to the Employee to report changes requiring a midyear change: If the Employee does not report the mid-year changes and provide the required paperwork within the 30-day or 60-day period, the Employee may not be able to make changes until the next open enrollment period, unless the Employee or Dependent again meet one of the conditions for an election change during the year.

Termination of the Plan

Although the Union and the Employers intend to maintain the Fund indefinitely, it may be necessary to modify or terminate the Fund. Any changes will be approved by the Board of Trustees in a written resolution and eligible Employees will be told how the coverage affects their benefits. **Notwithstanding any other provisions herein, the Board of Trustees reserves the right to amend or terminate the Fund for any reason.**

SECTION D: MEDICAL BENEFITS

The Plan provides certain Basic Medical Benefits and Secondary Major Medical Benefits for Medically Necessary hospital, physician, therapy and similar services, subject to the annual deductible, copayments, coinsurance, exclusions and limitations. The medical benefits covered under the Plan, medical benefit exclusions, and other important information are described in this section.

General Information

In Network and Out of Network Providers

The Plan does not require that you go to any particular physician. Every time you need treatment, you can select your own physician.

If you go to an in-**network provider**, you will not be responsible for any balance bill for the difference between the provider's bill and the Fund's payment for services, unless you have not met your deductible, or unless a co-pay or co-insurance applies. Please contact your medical provider's member services department for a list of current in-network providers.

If you go to **an out-of-network** provider, (except for services covered by the No Surprises Act), you will generally be responsible for any balance bill for the difference between the provider's bill and the Fund's payment for services. This may result in substantially higher costs to you.

In-Network Providers

The Plan has entered into contracts with two different networks of physicians. One is called the **Carefirst PPO** and the other is called **Health Care One PPO**. If you go to a physician who is participating in either the Carefirst PPO or the Health Care One PPO network, both you and the Plan will experience a savings because the actual cost of the services should be slightly lower. Please note that if you see a provider participating in Carefirst, you will be subject to the co-pay percentages and the deductibles which are set forth in the Summary of Benefits. If you go to a physician who is participating in the Health Care One PPO and services are rendered in the provider's office or clinic, you will not be subject to a deductible or charged a co-pay for the provider's services.

Every time you need treatment, you can decide whether to go to a physician who is participating in the Carefirst PPO, the Health Care One PPO or a physician who is not participating in either PPO. Special rules exist if you use the Carefirst PPO and the Health Care One PPO. Those rules are discussed in more detail below. In most cases if you do not choose to use an in-network provider, your share of the cost will be greater.

Carefirst PPO — You are a Carefirst Network Leasing Member

To obtain a Carefirst PPO provider, view the directory or go on-line to www.carefirst.com, or call the Carefirst Member Services at 1.800.235.5160. The physicians who participate in the Carefirst PPO may change on a daily basis. You should ask the provider if they participate in the Carefirst

PPO for each visit. The Carefirst network you are enrolled in covers providers in Maryland, Washington, DC, and northern Virginia.

When you go to a Carefirst provider, you must present your plastic ID card with the Carefirst information. All claims should be sent to Carefirst and include the member's ID and the group number. You should not be required to pay up-front. You may be responsible to pay any balance which remains after the Fund makes payment.

When Carefirst receives a claim, it will process it and normally assign a discount. The "Allowed Amount" is the maximum that a provider can charge as negotiated by the Plan or permitted by law.

Pre-Certification

All inpatient admissions must be pre-certified through American Health Holdings. The number is included on the Summary of Benefits. The member, hospital or physician should call to notify American Health Holdings. Hospital admissions must be pre-certified even if the Hospital does not participate in the Carefirst PPO.

If you or your Dependent has primary coverage through another carrier, you must obtain the explanation of benefits (the "EOB") as usual. If the provider who treated the person participates with Carefirst, then the claims must be sent to Carefirst for processing. The aggregate amount paid by the primary carrier and this Plan will not exceed the Allowed Amount.

Health Care One PPO

You can also choose to go to a physician that participates in the Health Care One PPO. For information on this PPO and the participating physicians, please call the Fund Office.

The Health Care One PPO can provide a limited range of health care services for you or your family. Physicians' services rendered in the Physician's office or clinic are paid in full under this PPO and are not subject to a deductible or a co-pay. If the Health Care One participating Physician refers you to another physician, laboratory or provider for further treatment, any separately billed Charges will be eligible to be paid or reimbursed under the regular provisions of the Basic Medical Benefits or the Secondary Major Medical Benefits. These Charges will be subject to the applicable deductibles and any co-pays.

The PPO Networks

All members are encouraged to use providers who participate with one of the PPOs affiliated with the Plan. The Plan has a primary network and a Secondary Network. The primary network, Carefirst PPO is generally available in Maryland, District of Columbia, and Northern Virginia. The Secondary Network serves members outside of Maryland, District of Columbia, and Northern Virginia. For contact information for the Secondary Network, please see p. 4.

For Participants who reside outside of the general Carefirst area, the Secondary Network is available to encourage use of in-network providers. If you are identified as residing outside of the CareFirst PPO, you will automatically be signed up for the alternate network in addition to the CareFirst Network.

The Secondary Network is available at no additional charge for members outside of the Carefirst PPO network. A separate ID card will be issued if the criteria is met.

Chiropractic care and Acupuncture

Treatment of Medical Benefits by chiropractic care or acupuncture is covered only under the Secondary Major-Medical Benefit.

Usual, Reasonable and Customary Charges

In the description of medical benefits, you will find the word, "Charges." This is a defined term that refers to the necessary, usual, reasonable and customary charge for a covered service.

The Medical Plan pays all or a percentage of the necessary, usual, reasonable and customary charge, depending upon the treatment or service provided. Please refer to the Summary of Benefits for specific details. Some Physicians charge more than the usual, reasonable and customary amount or perform services that are not Medically Necessary. Except for services covered by the No Surprises Act, if your Physician does charge more than the usual, reasonable and customary amount or perform services that are not Medically Necessary, you will have to pay your deductible and those excess fees if allowable under law.

No Vesting of Benefits

The Benefits offered under the Plan do not vest and may be amended by the Trustees from time to time.

Review Exclusions from Coverage

Charges not payable or reimbursable by the Plan for the services or items, or under the conditions, listed in the **Exclusions from Coverage** section below.

Detailed Explanation of Medical Benefit

This section details the Basic Medical Benefits available to a Participant and/or Dependent. All Benefits are subject to any applicable deductible, copay, co-insurance, maximums, limitations and exclusions as provided in the section and as set forth in the Summary of Benefits.

(A) Inpatient Care.

(1) Covered Charges. Subject to the Deductible and other cost sharing requirements, a Participant or Dependent who is admitted to a Hospital for treatment of sickness or a non-work related accidental injury as a Bed Patient will generally be entitled to payment or reimbursement of a percentage of the required "Hospital Charges" as set forth in the Summary of Benefits. "Hospital Charges," incurred when consistent with the diagnosis and treatment of the condition include:

(a) Administration of blood, blood plasma and plasma substitutes.

(b) Admissions for diagnostic studies when the studies are directed toward the definite diagnosis of a disease or injury.

(c) Anesthetic materials.

(d) Basal metabolism tests.

(e) Blood processing.

(f) Coronary and intensive care units.

(g) Dressing and bandages, casts and splints.

(h) Drugs and medicines which are officially accepted for general use at the time of hospitalization.

(i) Electrocardiograms.

(j) Electroencephalograms.

(k) Laboratory examinations, including tissue examinations.

(l) Medical services and supplies which are customarily provided by a Hospital, unless otherwise specifically excluded by this Plan.

(m) Occupational therapy while in a Hospital.

(n) Oxygen as provided by a Hospital.

(o) Physicians' visits which are billed by a Hospital.

(p) Physiotherapy, hydrotherapy and occupational therapy when performed by duly qualified therapists.

(q) Professional ambulance service used locally to a Hospital for a covered inpatient admission.

(r) Room and board, delivery room, recovery room and miscellaneous medical services for a female Participant or a Participant's spouse who is confined to a Hospital because of a pregnancy or resulting childbirth, Medically Necessary abortion or miscarriage up to the maximum, if any, as set forth in the Summary of Benefits. These charges specifically include nursery care and miscellaneous nursery services for the newborn child.

(s) Room and board (including meals, special diets and general nursing services) for "semi-private accommodations" as set forth in the Summary of Benefits. Private room at the most common "semi-private" rate. Intensive care is payable as outlined in the Summary of Benefits.

(t) Use of operating, treatment and/or recovery room.

(u) X-ray examinations.

(v) X-ray radium and radioactive isotope therapy.

(w) Charges for storage or transportation of an organ when incurred in connection with an organ transplant procedure which is covered under the Plan.

(B) Special Coverage Limitation Rules.

(1) Coverage During Hospital Confinements. Hospital Inpatient Care provided as a Basic Medical Benefit shall be covered as set forth in the Schedule of Benefits subject to the Mandatory Pre-Admission Certification Program set forth below.

(2) Costs After Discharge. The Plan shall not be responsible for any Charges for Hospital services rendered after the day for which discharge has been authorized by the confined person's Physician. Moreover, if the Hospital, pursuant to such an authorization, shall request the Participant or Dependent to vacate the room in which he has been a "Bed Patient" and such person fails or refuses to do so upon request or within two hours after such request, whichever occur later, the Plan shall not be responsible for any Charges for care rendered by the Hospital thereafter.

(3) Reserve Costs. Notwithstanding anything herein to the contrary, Hospital benefits shall be paid or reimbursed only for days of actual confinement and shall not include any Charges for holding or reserving space, or for pass or therapeutic leave days.

(4) Mandatory Pre-Admission Certification. Prior to being admitted for any nonemergency inpatient Hospital Care, Participants, and Dependents are required to obtain certification from the designated pre-admission certification agent designated by the Plan Administrator in the Program Documents ("Mandatory Pre-Admission Certification Program"). While the pre-admission certification agent may recommend the appropriate length of stay, the actual decision should be made in consultation with the Physician. The Mandatory Pre-Admission Certification requirement applies to all inpatient Hospital Care, whether provided in the State of Maryland or elsewhere.

(C) Outpatient Care. There are four different types of Covered Charges under the category of Outpatient Care: Outpatient Surgery, Sudden and Serious Illness, Outpatient Physical Therapy, and Miscellaneous Outpatient Care. Each is discussed below.

(1) Outpatient Surgery. A Participant or Dependent who goes to the Hospital for an outpatient surgery that is not work-related will be subject to the Deductible and shall generally be entitled to payment or reimbursement of a percentage of the required Hospital Charges as set forth in the Summary of Benefits. All admissions must be pre-certified through American Health Holdings. The number is included

on the Summary of Benefits. The member, hospital or physician should call to notify them.

(2) Sudden and Serious. The Fund covers Hospital charges for treating certain sudden and serious illnesses. Benefits are payable if the illness had a sudden onset, and is considered as life endangering. To the extent permitted by applicable law, Sudden and Serious Condition Charges will be subject to the applicable Deductible, the limitations outlined below, and the exclusions listed in the **Exclusions from Coverage** section. An Employee or Dependent who is treated for a non-work related Sudden and Serious condition which does not result in an inpatient admission to a Hospital shall generally be entitled to payment or reimbursement of a percentage of the required Hospital Charges, as set forth in the Summary of Benefits

(a) Examples of Serious and Sudden Outpatient Care:

- Accident or injury claim
- Acute Abdominal Pain
- Acute Chest Pains
- Acute Coronary
- Allergic reactions, Acute (except allergy tests)
- Appendicitis, Acute
- Asthmatic Attack
- Bronchitis, Severe
- Colitis
- Coma
- Convulsions and/or Seizures
- Diabetic Coma
- Diarrhea, Severe
- Drug Reaction
- Epistaxis, Severe
- Fecal Impaction, Severe
- Food Poisoning
- Foreign Body in Eye, Ear, Nose or Throat
- Gall Bladder, Acute Attack
- Heart Attack, Suspected
- Hemorrhage
- High Fever (102 degrees Fahrenheit or higher)
- Hysteria
- Insertion of Catheter (for acute urine retention)
- Insulin Shock (overdose)
- Kidney Stones
- Pleurisy
- Pneumonitis
- Poisoning (including overdose, subject to exclusions)

- Pyelitis
- Pyelonephritis
- Shock
- Spasms, Cerebral or Cardiac
- Spontaneous Pneumothorax
- Strangulated Hernia
- Stroke
- Sun Stroke
- Tachycardia
- Thrombosis and/or Phlebitis
- Unconsciousness
- Urinary Retention, Acute
- Vision Loss, Sudden Onset
- Vomiting, Severe

This is not a complete list of covered conditions. Benefits are payable only for emergency treatment, not for treatment that can be provided at home or in the Physician's office. The Fund also will pay or reimburse the charges for professional ambulance service used locally to an emergency room of a Hospital in connection with a covered condition. The opinion of the attending Physician will normally decide whether an illness was Sudden and Serious. The Fund will pay Hospital Charges per the Summary of Benefits. Other related services, doctors and physicians charges, may constitute Covered Medical Expenses under other parts of the Medical Plan.

(3) Miscellaneous Outpatient Care. This category includes all other outpatient services. The Plan will generally pay or reimburse a percentage as set forth in the Summary of Benefits of the Charges for non-work related services or illnesses.

(4) Outpatient Physical Therapy. The Plan will pay or reimburse a percentage of the Charges for outpatient physical treatment as set forth in the Summary of Benefits.

(5) Emergency Room Visits. No Surprises Services will be paid as required by law. To the extent permitted by law, emergency room Charges that result in admission to the Hospital or which are due to Sudden and Serious Conditions will be paid, as set forth in the Summary of Benefits, subject to the applicable Deductible and the exclusions. To the extent permitted by law, emergency room visits that do not result in admission to the Hospital or which are not due to Sudden and Serious Conditions are paid according to the terms of the Summary of Benefits, and are subject to a $75 co-pay, in addition to the applicable Deductible and the exclusions noted below.

(D) Surgical Care. The Plan will pay or reimburse a percentage of the Charges made by a duly qualified surgeon, as set forth in the Summary of Benefits up to a maximum as set forth in the Summary of Benefits. This section covers Physician charges for performing a surgical operation on account of a Participant's or Dependent's accidental injury, sickness, or as

necessary for pain management. The Plan will pay or reimburse a percentage of the Charges as set forth in the Summary of Benefits, subject to the rules set forth below:

(1) Charges will be covered whether the surgery is done in a Hospital, Physician's office, outpatient surgical center or the home of a Participant or Dependent.

(2) Charges billed by an assistant surgeon will be paid or reimbursed at a percentage as set forth in the Summary of Benefits.

(3) Surgery includes the treatment of fractures and dislocations.

(4) Charges for obstetrical procedures or operations performed by a Physician due to the pregnancy of a female Participant or Dependent spouse which results in childbirth, spontaneous abortion or miscarriage are also payable or reimbursable according to Surgical Care Benefits set forth in the Summary of Benefits under the Plan.

(5) Pregnancy-related surgery includes the cost of an elective abortion which occurs in the event of rape, incest, genetic deformity or abnormality of the fetus or, if necessary, to protect the mother's life. In order for elective abortions to be covered, written documentation must be submitted by two Physicians supporting the diagnosis.

(6) The Plan will pay a percentage of the cost of a second surgical opinion as set forth in the Summary of Benefits.

(7) In certain instances, the Plan will pay some or all of the Charges for services and supplies in connection with pre-approved transplant procedures which are deemed to be Medically Necessary. Please see the Plan Administrator for more details. For purposes of this Section, the term "Charges" includes the expense incurred by the transplant donor for services and supplies incurred in connection with a pre-approved transplant procedure. The donor's expenses will be treated as Charges incurred by the Covered Individual for purposes of applying the limits and exclusions of the Plan.

(8) Charges for surgical treatment for weight loss are covered under Surgical Charges for Master and Stationary Group Employees only, provided all the following conditions are met and documented:

(a) the Master or Stationary Group Employee is at least 25 years of age;

(b) the Master or Stationary Group Employee has a Body Mass Index ("BMI") (weight in kilograms/height in meters squared) of 50, or a BMI of at least 40 with a co-morbid condition, including hypertension, a cardiopulmonary condition, sleep apnea, or diabetes;

(c) the surgery must be pre-certified as medically necessary by the Fund's utilization review manager;

(d) the surgery must be performed by an in-network provider at an in-network facility.

Cosmetic surgery (i.e., body contouring) following weight loss to remove excess fat or sagging skin is not covered.

(E) Anesthesia. The Plan will pay or reimburse a percentage of the Charges per the Summary of Benefits made by a duly qualified anesthesiologist for administering anesthetics on account of an accidental injury, sickness, surgery, or pain management involving a Participant or their Dependents.

(F) Diagnostic Laboratory and X-Ray Examinations. A Participant or Dependent who incurs Charges for diagnostic laboratory and x-ray examinations to diagnose a non-occupational illness or injury will generally be entitled to payment or reimbursement of a percentage of the required Charges as set forth in the Summary of Benefits. Dental x-rays and x-rays made without digital images are not covered under this benefit.

(G) Home Health Care. A Participant or Dependent who incurs Home Health Care Charges (as defined below) will generally be entitled to payment or reimbursement of a percentage of the required Home Health Care Charges in accordance with the Summary of Benefits, subject to two rules:

(1) Home Health Care Charges are limited to private duty nursing services for a Participant or Dependent which (i) require the skills of a Licensed Practical Nurse (LPN) or Registered Nurse, (ii) are rendered in the Participant's or Dependent's home, (iii) are Medically Necessary as documented by the Participant's or Dependent's Physician in the medical record.

(2) Coverage for Home Health Care is provided as set forth in the Summary of Benefits.

(H) Orthotics. A Participant or Dependent who incurs Charges for Orthotics will generally be entitled to payment or reimbursement of a percentage of the required Orthotic Charges as set forth in the Summary of Benefits. The Plan Administrator may approve additional benefit payments of up to $1,000 for orthotics, if the Plan Administrator determines—in the Plan Administrator's discretion—that the orthotics will reduce the other benefit payments that the Fund would make without the Participant or Dependent's use of orthotics. Please contact the Fund Office for more information.

(I) Global Cases. A Participant or Dependent who incurs Global Case Charges will generally be entitled to payment or reimbursement of a percentage of the required Charges as set forth in the Summary of Benefits and will not be subject to a copayment.

(J) Primary Major-Medical.

(1) General. The Basic Medical Benefit has limits on the amount that will be paid or reimbursed for certain categories of benefits. To the extent your costs exceed the limit in one category, the balance may be paid under the Primary Major-Medical

Benefit. For example, the Primary Major-Medical Benefit may be available to pay or reimburse a Participant or Dependent for Home Health Care Charges up to the amount provided in the Summary of Benefits.

(2) Covered Charges. The Plan shall provide payment for or reimbursement of a percentage of the Charges as set forth in the Summary of Benefits incurred by Participants or Dependents for the following Medically Necessary services, treatment or confinement, to the extent they exceed Charges covered under sections A – H above:

(a) Other covered services of Physicians and specialists.

(b) Private duty nursing services in a Hospital which require the skills of an RN or LPN, provided:

i. The services are Medically Necessary as determined by the Plan's medical consultant(s), and are of such an intensive skilled level that they cannot be provided by the Hospital's general nursing staff (intermediate, custodial or personal care is not covered); and

ii. The services are prescribed by the patient's attending physician and such prescription is documented in the medical record.

(c) Medical supplies and surgical dressings including the items listed below. *(Note: Prosthetic appliances are paid under the Orthotic Benefit.)*

i. Casts and splints.

ii. Catheters.

iii. Colostomy bags and supplies required for their use which are not readily available under the Prescription program.

iv. Home intravenous therapy and necessary supplies to the extent Medically Necessary as documented by the Participant's or Dependent's Physician in the medical records.

v. Injectable, infused or inhaled drugs are covered under the Primary Major Medical Benefit subject to the following:

General Rule. Injectable, infused or inhaled drugs that are within the cost limits set forth in the Summary of Benefits and that are not required to be administered by a medical provider are only covered if approved by the Trustees. (Coverage for injectable, infused or inhaled drugs might alternatively be available under the Prescription Drug Benefit.)

Anti-coagulants. Fragmin, Lovenox, Innohep, Arixtra, and Heparin do not require Trustee approval, regardless of cost or method of administration. The Administrator may in its discretion approve coverage of other anti-coagulant injectable drugs, if the Administrator determines that it is Medically Necessary to use the other drugs instead of those listed in the preceding sentence.

vi. Durable Medical Equipment. Durable Medical Equipment will be subject to an internal review by the Plan if the Charge exceeds $1,000. Durable Medical Equipment, as defined in Section C, Defined Terms, will include Medically Necessary repair and replacement costs based on a written recommendation from the Fund's medical consultant.

vii. Oral appliances are covered to treat obstructive sleep apnea. Coverage is subject to the following additional conditions and exclusions:

a. Sleep studies to determine medical necessity must be medically appropriate for the diagnosis of obstructive sleep apnea. Such sleep studies must be covered under the Plan.

b. Oral appliances are not covered when obstructive sleep apnea is diagnosed by any means other than an eligible sleep study. For example, oral appliances are not covered when obstructive sleep apnea is diagnosed by x-ray, audio recording, or other similar means.

c. Oral appliances are not covered if the Plan has paid or reimbursed charges for a continuous positive airway pressure ("CPAP") device within five years, unless the CPAP device is rented and returned prior to the oral appliance being obtained.

d. Replacement of oral appliances are covered once every five years, unless earlier replacement is medically necessary due to a change in the patient's condition.

e. Exclusions. The following are not covered: oral appliances for snoring; compliance monitors; dental rehabilitation services; otherwise eligible oral appliances when dental rehabilitation services have been used to treat the obstructive sleep apnea; and replacement of lost, damaged, or stolen oral appliances.

viii. Breast pumps are covered subject to the following conditions and exclusions:

a. Breast pumps are not covered for non-spouse Dependents.

b. Coverage is not available if the Plan has paid or reimbursed charges for a breast pump within three years.

c. Online purchases are not covered.

d. A prescription is required.

e. Rental charges exceeding the amount that would have been covered if the appropriate breast pump had been purchased are not covered.

f. Notwithstanding the limitation described, purchase of a breast pump immediately after a period of rental is covered. However, any rental charges the Plan has paid shall be deducted from the amount the Plan pays for such purchase.

g. Exclusions. The following are not covered: supplies for comfort or convenience; bottles, caps, or nipples; baby weight scales; breast milk storage bags, ice packs, labels, or other similar products; batteries, battery packs, or adaptors; cleaning supplies; creams or ointments; garments for hands-free pump operation; bras, bra pads, shells, or nipple shields; travel or carrying bags; and replacement of lost, damaged, or stolen breast pumps.

ix. Intrauterine devices ("IUDs"), including the purchase and administration (i.e., insertion or removal) of an IUD, are covered. An IUD is not covered if the Plan has paid or reimbursed charges for an IUD within five years, unless earlier replacement or removal is Medically Necessary.

(K) Hearing Aids. The Plan will pay for hearing aids in accordance with the Schedule of Benefits.

(L) Nutritional Counseling.

(1) Covered Charges. Charges for Nutritional Counseling, including diabetes self-management education ("DSME"), will be covered as follows.

(a) Charges for Nutritional Counseling Where Deemed Medically Necessary. Nutritional Counseling is counseling for the management of any medical condition for which diet and eating habits are essential to the overall treatment program. Nutritional Counseling will be deemed medically

necessary (1) if it prescribed by a health care professional and (2) provided by a registered dietician. Conditions for which Nutritional Counseling may be considered medically necessary are limited to the following:

- Anorexia nervosa/bulimia
- Celiac disease
- Cardiovascular disease
- Crohn's disease ("CD")
- Diabetes mellitus ("DM")
- Disorders of metabolism (e.g., inborn errors of metabolism, inherited metabolic diseases, amino acid disorders)
- Hyperlipidemia
- Hypertension
- Liver disease
- Malabsorption syndrome
- Metabolic syndrome X
- Multiple or severe food allergies
- Nutritional deficiencies
- Obesity (e.g., body mass index (BMI >30 or >95th percentile)
- Post-bariatric surgery
- Prediabetes
- Renal failure
- Ulcerative colitis ("UC")

(2) Charges for Diabetes Self-Management Education Deemed Medically Necessary. DSME is the ongoing process of facilitating the knowledge, skill and ability necessary for diabetes self-care, incorporating individual needs, goals and life experiences and guided by evidence-based standards, aims to improve clinical outcomes, health status, and quality of life. DSME will be deemed medically necessary if (1) prescribed by a health care professional to an individual diagnosed with DM and (2) provided by a Certified Diabetes Educator in accordance with the National Standards for DSME. DSME is subject to the following conditions:

(a) Coverage for 1 visit each calendar year will be provided for Nutritional Counseling in accordance with the Summary of Benefits.

(b) Coverage for 3 visits (not to exceed 6 hours in total) each calendar year will be provided for DSME in accordance with the Summary of Benefits.

(c) Charges for Nutritional Counseling and DSME are not payable or reimbursable by the Plan for the services or items or under the conditions listed exclusions. The exclusions pertaining to Behavior Modification Techniques and Education or Training do not apply to the Nutritional Counseling and DSME benefits.

(M) Genetic Testing. Genetic testing, provided such testing is diagnostic, DNA, genetic or chromosomal genetic testing that is Medically Necessary, the determination of which shall include consideration of established guidelines for the applicable test, the clinical judgment of the provider and the appropriate standard of care under the circumstances, or (B) the Participant's provider orders such testing to determine the most effective course of treatment for a previously documented medical condition; and (ii) the Participant obtains prior authorization from the Trustees for the cost of any such testing that, in the aggregate, will exceed $1,000. A Participant may be requested to provide a letter from their provider certifying that genetic testing is Medically Necessary.

(N) Hospice Care.

(1) Covered Charges. Subject to the Basic Benefit Annual Deductible and to the limitations and exclusions contained in subsections (ii) and (iii) below, the Plan will pay or reimburse the percentage of Charges of an in-network provider or an out-of-network provider set forth in the Summary of Benefits for Hospice Care benefits rendered to a Participant or Dependent who: has a confirmed diagnosis of a terminal illness; has a life expectancy of six (6) months or less; has no further use nor desire for other curative therapy; and has signed an informed consent indicating an acceptance and understanding of Hospice Care.

(a) Hospice Care can be rendered on an inpatient or outpatient basis. If rendered on an inpatient basis, all treatment must be under the direction of a Physician. If rendered on an outpatient basis, the services must be rendered in the Participant's or Dependent's name; billed by a Hospice Provider; and include services from the following list:

i. Nursing care by a registered nurse or licensed practical nurse.

ii. Services of a home health agent who provides non-skilled personal care to the Participant or Dependent while under the supervision of a registered nurse or a licensed member of a Hospice Care team.

iii. Services of a licensed or certified physical, respiratory, occupational or speech therapist or social worker.

iv. Nutritional services provided by a dietician.

v. Rental of durable medical equipment, such as hospital beds, respirators, oxygen tents, crutches, and wheelchairs when billed by a Hospice Provider.

vi. Medically necessary surgical and medical supplies.

vii. Drugs and medications listed in the official forms billed by a Hospice Provider.

viii. Radiation therapy and chemotherapy (to provide comfort).

Charges for Hospice Care provided as a Basic Medical Benefit must be preauthorized by the Plan Administrator. Charges for Hospice Care are limited to a total of 180 days (outpatient and inpatient). Charges for Hospice Care provided at an inpatient facility are limited to 30 days; however, the Plan Administrator may authorize an additional 15 days of Hospice Care at an inpatient facility in connection with end of life. Charges for Hospice Care in excess of a total of 180 days will not be covered under any other Plan provisions.

(O) Cranial Prosthesis:

The Plan will pay or reimburse a Participant and eligible Dependents up to the level specified in the Summary of Benefits towards the purchase of a Cranial Prosthesis once every three calendar years provided it is Medically Necessary and verification is provided to the Board of Trustees. For purposes of this section, a Cranial Prosthesis is a wig or hairpiece of human or artificial hair designed to conceal baldness or hair loss.

(1) Medically Necessary Cranial Prosthesis. A Cranial Prosthesis is considered Medically Necessary if used to conceal hair loss or baldness as a result of: (a) chemotherapy for treatment of any form of cancer; (b) radiation therapy for the treatment of any form of cancer; or (c) a scalp injury, third degree burn, or congenital baldness since birth.

(2) A Cranial Prosthesis is not considered Medically Necessary if used to conceal hair loss or baldness due to the natural aging process, premature balding, male/female pattern baldness, or any other reason.

(3) Coverage will be considered by the Board of Trustees upon receipt of an itemized bill and a letter of medical necessity from the patient's provider. Benefits are payable according to the Major Medical Benefit and subject to the annual deductible.

(P) CAR T-Cell Therapy. The Plan will pay or reimburse a Participant, and/or a Dependent up to $325,000 per lifetime for CAR T-Cell Therapy provided that such CAR T-Cell Therapy is administered to treat stage IV mantle cell lymphoma ("MCL"), and the Trustees determine such CAR T-Cell Therapy is Medically Necessary.

Secondary Major Medical

(A) Covered Charges. Each Participant and their Dependents covered under the Plan shall be subject the limit specified in the Summary of Benefits for all Secondary Major-Medical Benefits. This section will cover the Charges listed below. Secondary Major-Medical Benefits will be subject to an annual calendar year deductible per the Summary of Benefits.

(1) Categories of Secondary Major-Medical Benefits. This section will cover Out-patient medical care and services for Participants and their Dependents (whether provided on an inpatient or outpatient basis) as follows:

(a) Chiropractic care.

(b) Treatment by acupuncture.

(2) Outpatient Care. A Participant or Dependent who incurs Secondary Major-Medical Charges which are incurred for outpatient treatment will generally be entitled to payment or reimbursement of a percentage per the Summary of Benefits of the required Charges.

The exclusions related to Chiropractic Care or Services and Acupuncture in the Exclusions from Medical Coverage section will not apply to Secondary Major Medical Benefits.

Exclusions from Medical Coverage

Except where specifically stated otherwise and except where required under the Health Insurance Portability and Accountability Act, the Basic Medical Benefit and the Secondary Major-Medical Benefit portion of the Plan will not pay or reimburse charges for the following treatment (including, but not limited to, examinations, hospitalizations, services, supplies and surgery) or under the conditions outlined below:

(A) Acupuncture. Acupuncture, anesthesia by hypnosis, or anesthesia for noncovered services. Notwithstanding the foregoing, the exclusion for Acupuncture will not apply to the Secondary Major-Medical Benefit.

(B) Ailments of the Foot. Treatment of corns, bunions (except capsular or bone surgery), calluses, nails of the feet (except surgery for ingrown nails), or symptomatic complaints of the feet (except when surgery is performed). This exclusion shall not apply if the patient has been diagnosed with diabetes, circulatory disorders like peripheral arterial disease and Reynaud's vasculitis, neuropathy, heart failure, lymphedema, skin cancers and severe venous disease and documentation of such diagnosis has been provided to the Administrator.

(C) Artificial Insemination. Artificial insemination, in vitro fertilization, chromosome studies, fertility studies, reversal of sterilization and like procedures.

(D) Behavior Modification Techniques. Behavior modification services such as smoking cessation programs, weight loss programs or treatment for obesity and/or services at a health spa, gymnasiums or similar facility and like programs.

(E) Braces, Prosthetic Appliances. Procurement or use of special braces, appliances except as may be required on account of accidental injury to natural teeth and except for as provided elsewhere in the Plan, except when covered as an Orthotic Benefit.

(F) Chiropractic Care or Services rendered by a Chiropractor. The exclusion for Chiropractic Care will not apply to the Secondary Major-Medical Benefit.

(G) Claim Processing. Services for completing claim forms or for providing other records or reports.

(H) Contraceptive Materials. Contraceptive materials and devices. Coverage for these items may be available under the Prescription Plan. The exclusion for contraceptive materials will not apply to an IUD available through the Primary Major-Medical Benefit.

(I) Cosmetic Surgery and Related Charges. Cosmetic surgery and related charges except when required for an accidental injury received while covered by the Fund; a birth defect; breast reconstruction after a radical mastectomy; removal of silicone breast implants.

(J) Coverage Under Another Plan. Any medical services or treatment to the extent available from or provided by any other coverage, except that the Plan will coordinate the payment of Charges with any other coverage where permissible under the existing laws and regulations in the manner set forth in the Plan.

(K) Custodial Care. Domiciliary, intermediate or custodial care or services in rest homes, health resorts, homes for the aged, infirmaries, or places primarily for domiciliary or custodial care or similar institutions providing primarily nonmedical care, education or training. This exclusion does not apply to Home Health Care Benefits.

(L) Dental Care or Treatment. Services, supplies or treatment for dental care, including dental X-rays or treatment, dental prosthetic appliances or the fitting of any thereof, except: (1) when necessary to treat an accidental injury to natural teeth, if treated within twelve (12) months of the accident; (2) a dentist's or oral surgeon's charges for certain cutting procedures in the oral cavity; (3) dental or oral surgeon's charges when necessary to repair oral cavity damage caused by radiation therapy to treat cancer, provided the dental services occur within twenty-four (24) months of the last radiation treatment; and (4) orthodontic treatment which is medically necessary to treat a functional defect (and not for cosmetic purposes), after surgical treatment of a cleft palate. Notwithstanding the preceding sentence, facility Charges and Charges for anesthesia are payable as Covered Medical Expenses for dental treatment when it is medically necessary that the services be provided outside of a dentist's office (for example, because it would be unsafe to render the treatment at a dentist's office). Coverage for some items excluded under this subsection may be available under the Dental or Orthodontic Benefit.

(M) Drug or Alcohol Impairment. Examinations, hospitalization, services, supplies, surgery and/or treatment incurred by a Participant or Dependent in connection with any injury resulting from the impairment or intoxication of such person from drugs or alcohol or resulting from the individual's being influenced by drugs or alcohol. The impairment, intoxication, or influence shall be determined by the attending medical personnel, or in accordance with the applicable laws of the state in which the Participant or Dependent resides, and shall include all impairment, influence or intoxication caused by ingestion or administration of drugs or alcohol other than according to a Physician's prescription. To the extent the evidence indicates that the Participant or Dependent was under the influence of drugs or alcohol, the Trustees shall have the discretion to pay or deny the requested benefits. This exclusion can be applied even if a Participant or Dependent is not formally charged with or convicted of driving while intoxicated.

(N) Durable Medical Equipment. Procurement or use of durable medical equipment, except for as provided elsewhere in the Plan.

(O) Education or Training. Any class, service or treatment incurred by a Participant or Dependent to educate or train a Participant or Dependent regarding a medical treatment, condition, disease or a healthy lifestyle.

Notwithstanding the foregoing, the Plan may pay certain "standard of care" costs, which are the minimum costs that would have been incurred by the Participant or Dependent regardless of whether the Participant or Dependent received conventional or experimental treatments if the Participant or Dependent appeals their claim and can provide the Plan with sufficiently detailed documentation which, in the Trustees' sole opinion, establishes the "standard of care" costs.

(P) Experimental Procedures and Drugs. Procedures or operations not recognized by the American Medical Association, and drugs not approved by the U.S. Food & Drug Administration.

(Q) Eye Care or Treatment. Eye refraction, eye exams or glasses. Coverage may be available under the Optical Benefits. Eye exams and refraction for a Medical Condition (for example, for glaucoma or diabetes) that are covered under the Plan are covered under the Plan.

(R) Free Services. Treatment for which a Participant or a Dependent do not have to pay.

(S) Genetic Testing. Genetic testing of any kind, except to the extent covered specifically under the Plan.

(T) Government Owned Hospital Care. Confinement in, or treatment received from (including surgery), a sanitarium, state or federal hospital, any state or political subdivision thereof, or the Veterans Administration Hospital owned or operated by the U.S. Government, to the extent that such confinement or treatment is covered by any other government sponsored health insurance, entitlement or benefit program or for which a Participant or Dependent would not be required to pay anything if there were no coverage provided under this Plan; provided, however, that nothing herein shall cause the exclusion of charges incurred by an individual who is eligible for coverage under this Plan while simultaneously eligible for coverage under a State plan for medical assistance approved under Title XIX of the Social Security Act.

(U) Hearing Aids or Fittings. Except covered specifically as provided in the Schedule of Benefits, coverage for hearing aids and fittings.

(V) Imaging Not Preserved on Film or Digital Images. X-ray examinations made where the image is not preserved on digital images.

(W) Injectables, Infused or Inhaled. Injectable, infused or inhaled drugs, except to the extent covered specifically under the Plan.

(X) Injuries While Committing a Felony or Other Illegal Activity. Services or treatment for injuries sustained while participating in or attempting to commit a felony or other illegal activity, regardless of whether the Participant or Dependent is convicted.

(Y) Injuries While Employed or Engaged in any Activity For Profit. Services or treatment in connection with injuries sustained while doing any act or thing pertaining to any occupation or employment for compensation or profit.

(Z) Non Listed Expenses. Any service or item not specifically listed as a covered Charge under other sections of the Plan.

(AA) Non Medically Necessary Care. Services, supplies or treatment deemed not to be medically necessary for the diagnosis or treatment of an injury, illness or symptomatic complaint, including elective abortions. The Plan shall have the right to submit disputed cases to a medical review committee appointed by the Trustees. Charges for medical care deemed not medically necessary, in whole or in part, shall not be payable or reimbursable by the Fund. Notwithstanding the foregoing, charges for voluntary sterilization or for, beginning December 1, 2019, the purchase and/or administration of an IUD shall be allowable Plan charges.

(BB) Non Prescription Medication. Non-prescription, over the counter medication and supplies, except colostomy supplies, lancets, and chem strips.

(CC) Obstetrics for Dependent Children. Obstetrical procedures or operations provided to Dependent children are not payable or reimbursable under this Plan, except to the extent required by law.

(DD) Occupational Illness or Injury. Treatment or services for an occupational illness or injury, except as specifically provided in the Plan and so long as there is a subrogation agreement. Coverage may be considered if workers compensation has denied liability on a case and subrogation is completed. Contact the Fund Office for more information.

(EE) Participation in Voluntary Reckless Activity. Services, supplies or treatment for injuries sustained while participating in any reckless activity voluntarily, which is unnecessary and for recreational purposes, where it was reasonably foreseeable that a serious bodily injury would result and which, in the opinion of the Trustees, constitutes reckless endangerment.

(FF) Pre-Paid Providers. Services and supplies provided by or available from a health maintenance organization ("HMO"), preferred provider organization or association or similar arrangement to which a Participant or Dependent subscribes individually or through a group unrelated to the Union or Plan, and Charges which result from failure to use the health management provisions of such organizations, such as second opinions for surgical procedures.

(GG) Prescription Drugs, Vitamins, and Minerals that are separately purchased by the Participants and/or their Dependents.

(HH) Radial keratotomy, Laser Eye Correction or like procedure.

(II) Self-inflicted Injuries. Services or treatment for self-inflicted injuries, except as a result of a medical condition (including mental health conditions).

(JJ) Sex Therapies. Services related to gender affirmations or sexual dysfunctions (including prescription drugs) or inadequacies. This exclusion will not apply to the office visits and related diagnostic charges associated with organic impotence.

(KK) Specified Examinations or Hospitalization for Examinations. Eye refractions (unless where performed for a covered medical condition of the eye); examinations for the fitting of eyeglasses or hearing aids; dental examinations; diagnostic study relating to routine physical examinations or checkups, as required by a job (except as indicated in the next sentence), recreational activity or school, or to obtain insurance. The Fund will pay the cost of a specified health examination which is required as a condition of employment or continued employment of the Participant.

(LL) Take Home Items and Personal Comfort Items. Take home drugs and personal items such as admission kits, TV, telephone, cots and visitors' meals at any institution.

(MM) Therapies. Activity therapy, recreational therapy, marriage counseling, pastoral counseling, financial counseling, or similar services. Family therapy is also excluded from coverage unless it is for the benefit of a minor Dependent child and it is medically necessary, as determined by the Trustees in their sole discretion.

(NN) Therapeutic Facilities. Confinement to a Hospital which is primarily for screening tests or physical therapy or hydrotherapy, treatment of obesity, or weight reduction programs.

(OO) Toenail Cleaning, Trimming or Debridement. This exclusion shall not apply if the patient has been diagnosed with diabetes, circulatory disorders like peripheral arterial disease and Reynaud's vasculitis, neuropathy, heart failure, lymphedema, skin cancers and severe venous disease and documentation of such diagnosis has been provided to the Fund.

(PP) Travel. Travel, whether or not recommended by a Physician, other than the local use of an ambulance.

(QQ) Treatment and Supplies to Currently Hospitalized. Treatment and supplies furnished to or surgery performed on a Participant or Dependent who, on the effective date, is confined in a Hospital or any other institution (other than for their own birth), so long as such person is continuously confined in any such institution, except to the extent required by law.

(RR) Treatment and Supplies Rendered by Non-Qualified or Non Approved Physicians. Services rendered by practitioners of healing arts which are not generally accepted in the medical community.

(SS) Treatment Not Approved by a Qualified Physician. Examination or treatment (including surgery) furnished without a Physician's approval.

(TT) Treatment of Participants as Dependents. Examination or treatment of a Dependent if such Dependent is simultaneously entitled to Benefits as a Participant. If an individual can have

simultaneous coverage both as a Participant and as a Dependent, the Plan will not recognize the dual coverage. The Plan will recognize the individual's coverage as a Participant and, when that ceases, the Plan will recognize the individual's coverage as a Dependent, to the extent applicable.

(UU) War. Examinations, hospitalization, services, supplies, surgery and/or treatment for diseases contracted or injuries sustained as a result of the war.

(VV) Weight loss surgery. Services for surgical treatment for weight loss not otherwise covered by the Plan.

(WW) Workers Compensation. Services or treatment for any condition, disease, or accident arising out of the Participant's or Dependent's employment for which benefits are payable under any workers' compensation law or similar legislation.

(XX) Late Claims. Claims filed more than twelve months after the date the Charges were incurred, unless otherwise required by law.

(YY) Gene Therapies. All Charges related to gene therapies except as specifically provided in the Plan.

(ZZ) Isokinetic Rehabilitation Devices. All Charges related to isokinetic rehabilitation devices and equipment, including but not limited to isokinetic testing and evaluation units for use in the home for purposes of post-operative rehabilitation (e.g., "ROMTech" devices).

Telemedicine

The Plan does not cover telemedicine visits unless the visit is for the purpose of providing Mental Health and Substance Use Disorder Benefits, or the care is provided by ReviveHealth.

ReviveHealth telemedicine services are provided to Employees and Dependents by the Union with no co-pays, deductibles or consultation fees. ReviveHealth is a telemedicine service that delivers quality health care directly to patients in need via phone. To get started, an Employee or Dependent should call toll free 877-999-7943 or log on to https://www.revive.health/. The Group Code is: IUOE37. For more information, please see the Appendix .

Notice of Women's Health and Cancer Rights Act of 1998 (WHCRA)

The Women's Health and Cancer Rights Act of 1998 requires the Trustees of this Plan to notify you, as a participant or beneficiary of the Plan, of your rights related to benefits provided through the Plan in connection with a mastectomy. You as a participant or beneficiary have rights to coverage to be provided in a manner determined in consultation with your attending physician for:

- all stages of reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and

- prostheses and treatment of physical complications of the mastectomy, including lymphedema. These benefits will be provided under the "Basic Medical Benefits" portion of the Plan. These benefits will be subject to the applicable deductible, the Lifetime Maximum and the general co-pay provisions which exist in the Plan.

Keep this Notice for your records and call your Plan Administrator for more information.

Notice of Newborns' and Mothers' Health Protection Act

Under federal law, the Plan generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the Plan may pay for a shorter stay if the attending provider (e.g., your Physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, the Plan may not set the level of benefits or out-of-pocket cost 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, the Plan 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 your out-of-pocket costs, you may be required to obtain pre-certification. For information on pre-certification, contact the Plan Administrator.

SECTION E: PRESCRIPTION DRUG BENEFITS

The Plan provides certain Prescription Drug Coverage for eligible Employees and Dependents. The prescription drugs covered under the Plan, including drug cost, exclusions, and other important information is described in this section and set forth in the Summary of Benefits.

IMPORTANT INFORMATION ABOUT PRESCRIPTION DRUG BENEFITS

Prior Authorization - There are some medications that have to be authorized by a physician before you can get them, because the medications are approved or effective only for some conditions. You, your pharmacist or your Physician can start the prior authorization process by contacting the PBM. A PBM representative will work with your Physician to get the information needed for the review. Once the required information is obtained from your physician a review will be conducted and a letter regarding the coverage determination will be sent to you and your physician.

Mandatory Generic Program - Any new prescription must first be filled as a Generic. If a Brand is elected when a generic is available, you will be responsible for the Brand Co-Pay plus the difference in cost between the Brand and Generic. If the generic is ineffective or you experience significant side effects talk to your physician to discuss alternatives. Your Physician may have to provide medical documentation regarding the efficiency of the generic medication and any side effects which are necessitating the change.

Maintenance Drugs - Select prescriptions taken on a regular basis for a chronic condition may be considered a maintenance drug. After your second 30 day fill of a maintenance drug at any store, you are required to use either the Mail Order program or your local CVS Pharmacy. When using the mail order program or filling at the CVS store you must have a prescription written for 90 days after the second fill.

Quantity Limits - Your pharmacy benefit plan has a quantity limits program that can help you get the best results from your medication therapy. With safe doses, quantity limits can also keep prescription drug costs lower for you. Quantity limits are meant to lower the risk of overuse. Quantity limit rules are based on: FDA-approved uses, medication instruction labels and published clinical recommendations.

Step Therapy - Most medical conditions have many medication options. Although their clinical effectiveness may be the same, the cost can be very different. The Step Therapy program gives you the treatment you need, usually at a lower cost. With this program, you must try a Step 1 medication first, before a Step 2 medication may be covered. When you bring a prescription to your pharmacy, the PBM will check the medication for step therapy requirements.

PBM Specialty - This specialty division of the PBM will take care of all of your Specialty medication needs. Be sure to ask a PBM representative if you are eligible for any of the manufacturer co-pay assistance programs. Information about the PBM is available at the beginning of the SPD.

Diabetes Management Program – If the Employee or Dependent is determined by the PBM to be at an elevated risk for diabetes, lower copayments may apply for diabetic testing supplies such

as test strips, lancets, control solution, and other benefits in accordance with the Plan's diabetes risk management program.

Covered Charges

(A) Covered Charges. Subject to the applicable copay, the Plan shall pay for or reimburse all costs for prescription drugs for Participants and their Dependents as detailed below.

(1) Maintenance Prescriptions. Drugs which are to be taken on an ongoing basis for a chronic condition (90 days or more) are "Maintenance Prescriptions." With this definition as a guide, the registered pharmacist receiving the prescription request will initially determine whether it is a Maintenance Prescription. "Maintenance Prescriptions" can be ordered by mail from the pharmacy designated by the Trustees. Diabetic supplies are covered by the Plan only if purchased in a 90 day supply from the mail order pharmacy or at a preferred pharmacy. The Plan will only cover Maintenance Prescriptions that are filled through the PBM's mail order program or at a preferred pharmacy.

(2) Non-Maintenance Prescriptions. Drugs which are to be taken for a definite period for a non-chronic condition are "Non-Maintenance Prescriptions." If a Participant or Dependent obtains Non-Maintenance Prescriptions from a participating pharmacy, the Participant or Dependent will generally be responsible to only pay for the co-pay, subject to the PBM's rules and pricing guidelines. If a Participant or Dependent obtains Non-Maintenance Prescriptions from a nonparticipating pharmacy, the Participant or Dependent will be responsible to pay for the entire cost of the prescription and request reimbursement from the Plan by timely submitting proper documentation (i.e., the PBM claim form with a copy of both the prescription and the payment receipt). The amount of the reimbursement will be subject to the PBM's rules and pricing guidelines.

(3) Mandatory Generic. Subject to any applicable co-pay, to the extent generically equivalent FDA-approved drugs are available, the maximum cost of "Maintenance Prescriptions" or "Non-Maintenance Prescriptions" which the Plan will pay for or reimburse will be limited to the cost of the generically equivalent drug, regardless of whether the Participant or their Dependents elect to receive the generically equivalent drug, with the exception of high cost generic exclusions. The amount the Fund will pay or reimburse for non-generic "Maintenance Prescription" or "Non-Maintenance Prescriptions" depends on the PBM's rules and guidelines, including the "Dispensed as Written" rules, all of which are incorporated by reference.

(4) Non-Participating Pharmacies. The amount the Fund will pay or reimburse for "Maintenance Prescription" or "Non-Maintenance Prescriptions" purchased from "Non-Participating Pharmacies" depends on the PBM's rules and guidelines, including the "Dispensed as Written" rules, all of which are incorporated by reference.

(5) Injectables. Injectables may be covered subject to a co-pay as determined by the Trustees from time to time.

(6) Special Rules for Diabetic Supplies. Diabetic supplies are covered only if a 90-day supply is purchased from the designated retail pharmacy or the mail order program.

(7) Off-label Drug Use. Coverage for the off-label use should be provided for medications which are medically appropriate for treatment of the patient's diagnosis, standard of care and not experimental/investigational, as determined by the Fund's medical consultant, in conjunction with the prescription drug manager and the Fund's third-party administrator.

(8) Vaccine Program.

(a) Flu vaccines can be provided at a pharmacy without the necessity of a prescription and without having a Participant pay a co-pay, and

(b) Vaccines for COVID-19, Shingles, Pneumonia, other elective routine nontravel immunizations, and Respiratory syncytial virus ("RSV") as detailed in the Prescription Pharmacy Manager list and subject to the requirements of the Prescription Pharmacy Manager can be provided at a pharmacy without a prescription (unless the prescription is otherwise required by state law) but subject to a 20% co-pay.

(9) Pre-approval for Compound Drugs. Pre-authorization is required for compound drugs for amounts exceeding $300 based on the Plan's discussion with its pharmaceutical representative at the PBM and the limit of one fill per month.

(10) Specialty Medications. Subject to a 20% co-insurance feature, the Plan will pay or reimburse 80% of the cost of the allowable Specialty Medications as determined by the PBM guidelines.

(11) Contraceptives. The Plan will cover Charges for the Contraceptives outlined below, with such Contraceptives paid under the Prescription Drug Benefit subject to the copay feature and the PBM coverage criteria and if paid under the Primary Major-Medical Benefit subject to the applicable deductible and copay:

(a) The Plan will cover Charges for oral contraceptives and patches prescribed by a Physician under the Prescription Drug Benefit only.

(b) The Plan will cover Charges for injectables Depo-Provera prescribed and administered by a Physician under the Prescription Drug Benefit with the administrative fee covered under the Primary Major-Medical Benefit.

(c) The Plan will cover Charges for intrauterine contraception devices and subdermal contraceptives, whether billed under the Prescription Drug Benefit or the Primary Major-Medical Benefit.

Exclusions From Coverage

The Plan will not pay for or reimburse a Participant or Dependent for the following Charges for prescriptions:

(1) Prescriptions that are not taken pursuant to orders given by a Physician.

(2) The cost of prescriptions required by a Participant or Dependent in connection with any injury resulting from the impairment or intoxication of that individual from drugs or alcohol or resulting from the individual's being influenced by drugs or alcohol. The impairment, influence or intoxication shall be determined by the attending medical personnel, or in accordance with the applicable laws of the state in which the Participant or Dependent resides and shall include all impairment, influence or intoxication caused by ingestion of drugs or alcohol other than according to a Physician's prescription. To the extent the evidence indicates that the Participant or Dependent was under the influence of drugs or alcohol, the Trustees shall have the discretion to pay or deny the requested benefits.

(3) Prescriptions for:

(a) Abdominal supports, trusses, or oxygen.

(b) Any drug labeled, "Caution - Limited by Federal Law to Investigational Use", or experimental drugs, even though charges are made to the individual.

(c) Braces, splints, dressings, bandages, sick room equipment or supplies, heat lamps or similar items.

(d) Canes, crutches, wheelchairs or any means of conveyance or locomotion.

(e) Charges payable under any other benefits of the Fund to the extent that the portion of such charges are paid.

(f) Contraceptives that are (i) over the counter contraceptives, (ii) not explicitly listed as covered under Plan provisions or (iii) provided not in accordance with the requirements for Contraceptives covered by the Plan.

(g) Immunizing agents, biological serum, blood plasma, injectables, self-administering injectables and any prescription directing parental administration or use, except insulin and other drugs necessary to treat life threatening events (e.g., naloxone and epinephrine).

(h) Infertility medication.

(i) Medication which is to be taken or administered to, in whole, or in part, by the Covered Individual while they are a patient in a Hospital, nursing home,

rest home, sanitarium, extended care facility, convalescent hospital, or similar institution.

(j) Non Legend, patent or proprietary medicine or medication not requiring a prescription.

(k) Prescriptions not included as Covered Charges.

(l) Self-administered injectables for non-Covered Charges.

(m) Smoking cessation or weight loss prescriptions, except that the exclusion will not apply to a prescription for smoking cessation aids that is limited to a three month supply once a year for a maximum of three years.

(n) The cost of prescriptions required by a Participant or Dependent in connection with any injury incurred while the Participant or Dependent was participating in or attempting to commit a felony. This exclusion does not apply if the injury results from an act of domestic violence or a medical condition (including both physical and mental health conditions).

(o) Vitamins, vitamin prescriptions, cosmetics, dietary supplements, health or beauty aids. Notwithstanding the foregoing, the exclusion will not apply to prescription vitamins, such as prenatal vitamins and vitamin D and iron at the lower of the actual cost or co-pay.

(4) Prescriptions for which a Participant or Beneficiary requests reimbursement or payment after the date the Participant's or Dependent's Prescription Drug Benefit is terminated in accordance with the Plan.

(5) Prescriptions purchased for the purpose of resale for compensation.

(6) Excessive amounts of the same prescription as determined by the Trustees based on advice from the PBM.

(7) Diabetic supplies which are not purchased in 90-day quantities from either participating pharmacies or through the mail order pharmacy.

(8) Prescriptions for Specialty Medications that are not included in the allowable PBM guidelines or are included in the allowable PBM guidelines but not approved upon review by the PBM.

(9) Digital Therapeutics. All Charges related to any treatment, prevention, modification or mitigation of a medical condition or behavior that is accessed or administered through a digital health device, software program or application.

SECTION F: DENTAL AND ORTHODONTIC BENEFITS

The Plan provides certain Dental and Orthodontic Benefits for eligible Employees and Dependents. The Dental and Orthodontic Benefits covered under the Plan, including any required coinsurance, copays, maximums, exclusions, and limitations are described in this section and set forth in the Summary of Benefits.

(A) **Covered Dental Charges**. Subject to the deductible and coinsurance noted in the Summary of Benefits, the Plan will pay or reimburse Charges incurred by Participants and Dependents for certain services provided by a licensed dentist or a hygienist who is supervised by a licensed dentist as set forth in the Summary of Benefits. In addition, the amount the Plan will reimburse is subject to the exclusions and limitations set forth below.

(B) **Exclusions and Limitations from Coverage**.

The Plan will not pay or reimburse Charges for the following dental treatments and/or services for Participants and their Dependents:

(1) Any dental procedures not started and completed while covered under the Plan.

(2) Charges resulting from failure to follow primary carrier's guidelines.

(3) Cosmetic procedures.

(4) Dental appointment charges for canceled appointments.

(5) Dental services performed by a non-licensed provider.

(6) Non-prescription drugs, medicines or supplies intended primarily for home use, such as toothpaste and cleaning supplies

(7) Prosthetic devices when teeth are restorable by other means.

(8) Replacement of full or partial dentures or bridgework more often than once every five years.

(9) Replacement of a lost or stolen appliance.

(10) Charges filed more than twelve months after the date the charges were incurred.

In the case of services rendered by pre-paid providers which will not supply an Explanation of Benefits (EOB), the Plan will reimburse charges for dental treatments for Participants and Dependents as follows, subject to the Calendar Year Maximum set forth in the Summary of Benefits:

(1) If the Participant or Dependent can provide the Plan with adequate documentation to establish that the Participant or Dependent for paid dental treatments or services that will not be reimbursed by the pre-paid provider, the Plan will reimburse the Participant or Dependent as set forth in the Summary of Benefits.

(2) If the Participant or Dependent can also provide the Plan with adequate documentation to establish the non-discounted fee charged by the pre-paid provider, the Plan will reimburse the Participant the lesser of (i) 80% of the non-discounted fee or (ii) the amount paid by the Participant.

(3) The maximum limit the Plan will pay for each Participant, and each Dependent for dental care is set forth in the Summary of Benefits. Charges are payable as services are rendered.

PLEASE NOTE: Charges are payable as services are rendered.

(C) **Dental Benefits**. With respect to all dental services benefits, the Fund will calculate benefit payments based on the usual, reasonable and customary ("URC") fee and/or service schedules and URC fee schedules for pediatric and adult dental and care charges as will be adopted by the Fund. With respect to patients under age 19, the Fund will pay for medically necessary dental services in accordance with the schedule or methodology adopted by the Trustees without regard to annual dollar limits otherwise applicable to the service.

Orthodontic Benefit Covered Charges. Subject to the Summary of Benefits, the Plan may pay or reimburse the Charges incurred by the Participants or Dependents for services in connection with straightening and repositioning teeth—including appliances to reduce harmful habits (such as bite guards and nightguards)—so long as the orthodontic provider submits an itemized bill as services are rendered. Dental implants are not subject to the Lifetime Maximum.

(D) **Exclusions and Limitations from Orthodontic Coverage**.

(1) The Plan will not pay or reimburse the following orthodontic treatments or services for Participants or Dependents:

(a) Charges resulting from failure to follow primary carrier's guidelines.

(b) Cosmetic procedures.

(c) Orthodontic appointment charges for canceled appointments.

(d) Orthodontic services performed by a non-licensed provider.

(e) Non-prescription drugs, medicines or supplies intended primarily for home use, such as toothpaste and cleaning supplies

(f) Prosthetic devices when teeth are restorable by other means.

(g) Replacement of full or partial dentures or bridgework more often than once every five years.

(h) Replacement of a lost or stolen appliance.

(i) Charges filed more than twelve months after the date the Charges were incurred.

(2) The Plan will not pay or reimburse charges for Orthodontic Benefits for Participants, or Dependents in excess of the Lifetime Maximum as set forth in the Summary of Benefits.

SECTION G: OPTICAL EXPENSE BENEFITS

The Plan provides certain Optical Expense Benefits for eligible Employees and Dependents. The Optical Expense Benefits covered under the Plan, including any maximums, exclusions, and limitations are described in this section.

(A) **Covered Charges**. Charges for Optical Expense Benefits of a Participant and their Dependents will be subject to the annual limit and the exclusions and limitations set forth in this section. The Plan will pay or reimburse the cost of exams or glasses for each Participant and/or Dependent once every two years, as set forth in the Summary of Benefits. Allowable expenses are listed below:

(1) Complete eye examination, including refractions and contact lens exams. Eye examinations performed for medical reasons would be paid for or reimbursed as a Basic Medical Benefit or a Primary Major-Medical Benefit.

(2) Eyeglasses with prescription lenses; and

(3) Contact lenses.

(B) **Exclusions from Coverage**. The Plan will not pay or reimburse Charges for Optical Expenses for the costs of lens care kits. Further, the Plan will not pay or reimburse Charges for Optical Expenses if the claim for such Charges is filed more than twelve months after the date the Charges were incurred.

(C) **Limitations on Coverage**. In the case of services rendered by pre-paid providers which will not supply an EOB, the Plan will reimburse charges for Optical Expense Benefits for Participants and their Dependents as follows subject to the Calendar Year Maximum set forth in the Summary of Benefits:

(1) If the Participant or Dependent can provide the Plan with adequate documentation to establish that the Participant or Dependent paid for optical expense benefits that will not be reimbursed by the pre-paid provider, the Plan will reimburse the Participant or Dependent, as set forth in the Summary of Benefits.

(2) If the Participant or Dependent can also provide the Plan with adequate documentation to establish the non-discounted fee charged by the pre-paid provider, the Plan will reimburse the Participant or Dependent the lesser of (i) the non-discounted fee, as set forth in the Summary of Benefits or (ii) the amount paid by the Participant, or Dependent.

(D) With respect to all vision services and items benefits provided under this Section to individuals under age 19, the Fund will calculate benefit payments based on the URC fee and/or service schedules and URC fee schedules for pediatric and adult optical care charges and frequency limitations (e.g., frames) as will be adopted by the Fund, without regard to annual dollar limits otherwise applicable to the service.

SECTION H: WEEKLY DISABILITY BENEFITS

The Plan provides Weekly Disability Benefits to Employees. Coverage details including the benefit amount, duration and exclusions are described in this section and are set forth in the Summary of Benefits.

(A) **Coverage**. Subject to the exclusions set forth below, the Plan will provide a "Weekly Disability Benefit" to (a) current and former Employees who are Plan Participants who have a Disability or (b) former Employees who stop being Plan Participants during the initial twenty-six (26) weeks of the Disability. Individuals in the latter category will be treated as Participants only for the limited purpose of receiving weekly Disability Benefits up until and through the twenty-sixth week of the Disability. Any reference to "Participant" in this subsection will be deemed limited to those individuals described in this paragraph who are eligible to receive Disability Benefits

(B) **Amount and Length of Benefits**. The Fund will pay the Weekly Disability Benefit from the eighth day of the Disability resulting from an accident or a sickness (including pregnancy), providing you comply with the Procedures for claiming disability benefits. The length of Weekly Disability Benefit payments will be determined as set forth in the Summary of Benefits. After the first week, benefits are payable on a proportionate basis for partial weeks, 1/7 of your weekly benefit for each day of Disability.

(C) **Short-Term Disability for Mesothelioma and Asbestosis-Related Care**

Effective February 1, 2021, if you: (i) contract mesothelioma or asbestosis while on the job; (ii) are entitled to workers' compensation as a result; and (iii) file a legal action relating to your injuries, you may be entitled to Weekly Disability Benefits under the Plan to help pay for treatments while your lawsuit is being resolved.

Because the Plan does not cover the costs of benefits for which a third party may be liable, to qualify for an asbestosis or mesothelioma-related Weekly Disability Benefit, you must sign the Plan's standard Subrogation and Reimbursement Agreement which acknowledges the Fund's right to recover the amount of the Weekly Disability Benefits which the Fund paid to you from any settlement, judgment or other payment you receive.

(D) **Exclusions from Weekly Disability Benefit Coverage**. The Plan will not make Weekly Disability Benefit payments for:

(1) Injuries or sickness incurred by a Dependent.

(2) Injuries or sickness resulting from a suicide, attempted suicide, or intentionally self-inflicted injury.

(3) Injuries resulting from participating in or attempting to commit a felony or other illegal activity.

(4) Injuries resulting from the impairment or intoxication of the Participant from drugs or alcohol or resulting from the individual's being influenced by drugs or alcohol.

The impairment, influence or intoxication shall be determined by the attending medical personnel, or in accordance with the applicable laws of the State in which the Participant resides and shall include all impairment, influence or intoxication caused by ingestion of drugs or alcohol other than according to a Physician's prescription. To the extent the evidence indicates that the Participant was under the influence of drugs or alcohol, the Trustees shall have the discretion to pay or deny the requested benefits, regardless of whether the Participant is charged with or convicted of driving while intoxicated.

(5) Injuries resulting from war, any act of war, military service while a country is engaged in war or military policy duty.

(6) Injuries sustained while the Participant was doing any act or thing pertaining to any occupation or employment for remuneration or profit, or sickness for which benefits are payable in accordance with the provisions of any workmen's compensation or similar law.

(7) Participation in any reckless activity voluntarily, which is unnecessary and for recreational purposes, where it was reasonably foreseeable that a serious bodily injury or death would result and which, in the opinion of the Trustees constitutes reckless endangerment.

(8) Successive periods of Disability separated by less than two weeks

i. of active full-time employment with an Employer. Such successive periods shall be considered part of the same period of Disability unless the subsequent period results from an illness or injury unrelated to the previous Disability and the Participant thereafter returns to work on a full-time basis.

Participants who are not under the care of a Physician during the period of Disability.

(9) Injuries or sickness of a Participant who is retired and receiving a

i. pension check.

(10) Injuries or sicknesses occurring while a Participant is under COBRA or is self-paying.

(a) Disability periods after the Company ceases to participate in the Plan.

(E) **<u>Taxation</u>**. A Participant's Weekly Disability Benefits are subject to both federal income tax and social security ("FICA") tax. You may also have to pay state and local taxes on them. Social security tax will be deducted automatically from your Weekly Disability Benefit. After the end of the year in which you receive Weekly Disability Benefits, you

will receive a W-2 form which will show the gross amount of benefits that were paid to you for the year and which are subject to income tax.

SECTION I: DEATH BENEFITS

The Plan provides Death Benefits to the Employee's Beneficiary upon an Employee's death. Coverage details including the benefit amount, Beneficiary Designation and exclusions are described in this section and are set forth in the Summary of Benefits.

(A) **Coverage**. Subject to the exclusions set forth below, the Plan will pay a "Death Benefit" as set forth in the Summary of Benefits to the Beneficiary of an Employee who was a Participant and was eligible as an active worker at the time of their death. Any reference to "Participant" in this subsection will be deemed limited to Participants who were active workers at the time of their death.

The Plan will pay the Death Benefit when it receives a written application for such benefit accompanied by a copy of the death certificate, provided such information is received by the Plan Administrator within sixty (60) days of the Participant's date of death. The amount of the Death Benefit payable under this Plan will be as set forth in the Summary of Benefits.

(B) **Beneficiary Designation**. Each Participant shall have the right to designate a Beneficiary to receive any sum or sums payable upon their death (a "Beneficiary Designation"). The Plan Administrator shall keep records in writing of all designations of Beneficiaries. The Participant shall have the right to change such Beneficiary by notice in writing to the Fund Office. Such change shall become effective only when it is received by the Fund Office. The Plan shall follow the Beneficiary form on file with the Fund Office at the date of death. If a Participant shall fail to validly designate a Beneficiary, or if no designated Beneficiary survives the Participant, their Death Benefit shall be paid to their surviving spouse or, if none, their surviving children and, if none, the personal representative of their estate.

***** It is the Employee's responsibility to keep Beneficiary information current even if their Dependents change.**

(C) **Exclusions from Death Benefit Coverage**. The Plan will not pay a Death Benefit in the following instances:

(1) Death of a Dependent.

(2) Death resulting from a suicide, attempted suicide, or intentionally inflicted death, whether the Participant is sane or insane.

(3) Death resulting from participating in or attempting to commit a felony or other illegal activity.

(4) Death resulting from the impairment or intoxication of the Participant from drugs or alcohol or resulting from the individual's being influenced by drugs or alcohol. The impairment, influence or intoxication shall be determined by the attending medical personnel, or in accordance with the applicable laws of the State in which the Participant resides and shall include all impairment, influence or intoxication caused by ingestion of drugs or alcohol other than according to a Physician's prescription. To the extent the evidence indicates that the Participant was under the

influence of drugs or alcohol, the Trustees shall have the discretion to pay or deny the requested benefits.

(5) Death resulting from war, any act of war, military service while a country is engaged in war or military police duty.

(6) Death sustained while the Participant was doing any act or thing pertaining to any occupation or employment for remuneration or profit, or death for which benefits are payable in accordance with the provisions of any workmen's compensation or similar law.

(7) Death resulting directly or indirectly from participation in any reckless activity voluntarily, which is unnecessary and for recreational purposes, where it was reasonably foreseeable that a serious bodily injury or death would result and which, in the opinion of the Trustees, constitutes reckless endangerment.

(8) Death which occurs while a Participant is under COBRA coverage or is self-paying.

(9) Death of a Participant who is retired and receiving a pension check but is still treated as an active employee because of banked hours.

SECTION J: ACCIDENTAL DEATH, DISMEMBERMENT, AND LOSS OF SIGHT

The Plan provides Accidental Death, Dismemberment, and Loss of Sight Benefits to Employees. Coverage details including the benefit amount, limitations and exclusions are described in this section and are set forth in the Summary of Benefits.

Accidental Death, Dismemberment and Loss of Sight Benefit.

(A) **Coverage**. Subject to the exclusions set forth in subsection below, the Plan will provide a monetary payment ("the Principal Sum") as set forth in the Summary of Benefits in the event of a severe accident which results in the death, dismemberment or complete loss of vision to a current Employee who is a Participant at the time of the accident. The amount of the Principal Sum is set forth in the Summary of Benefits. The death, dismemberment or loss of sight must occur within sixty (60) days of an accident in order for the Principal Sum to be payable. These benefits are paid only for losses to current Employees who are Participants at the time of the accident. Losses incurred by Beneficiaries or Dependents are not covered. The benefit is as follows:

For Loss of:	Amount
Life	100% of Principal Sum
Both Hands, Feet or Vision in Both Eyes	100% of Principal Sum
Any Combination of Foot, Hand, or Vision in One Eye	100% of Principal Sum
One Hand or Foot or Vision in One Eye	50% of Principal Sum

In no event will the aggregate amount paid to any individual exceed the Principal Sum.

The "Accidental Death, Dismemberment and Loss of Sight Benefit" is independent of, and in addition to, any Death Benefit. Amounts due are payable to the Participant except in the case of a loss of life, in which case payment of the Principal Sum will be made to the Beneficiary. If a Participant fails to validly designate a Beneficiary, or if no designated Beneficiary survives the Participant, their Death Benefit shall be paid to their surviving spouse or, if none, their surviving children and, if none, the personal representative of their estate. For this purpose, loss of sight means total and irreversible blindness. Loss of a hand or foot means severance above the wrist or ankle.

(B) **Exclusions from Accidental Death, Dismemberment and Loss of Sight Benefit Coverage**. The Plan will not provide Accidental Death, Dismemberment and Loss of Sight Benefits for:

(1) Losses incurred by a Dependent.

(2) Losses resulting from a suicide, attempted suicide, or intentionally inflicted injury, whether the Participant is sane or insane.

(3) Losses resulting from participating in or attempting to commit a felony or other illegal activity.

(4) Losses resulting from the impairment or intoxication of the Participant from drugs or alcohol or resulting from the individual's being influenced by drugs or alcohol. The impairment, influence or intoxication shall be determined by the attending medical personnel, or in accordance with the applicable laws of the State in which the Participant resides and shall include all impairment, influence or intoxication caused by ingestion of drugs or alcohol other than according to a Physician's prescription. To the extent the evidence indicates that the Participant was under the influence of drugs or alcohol, the Trustees shall have the discretion to pay or deny the requested benefits.

(5) Losses resulting from war, any act of war, military service while a country is engaged in war or military police duty.

(6) Losses sustained while the Participant was doing any act or thing pertaining to any occupation or employment for remuneration or profit, or sickness for which benefits are payable in accordance with the provisions of any workmen's compensation or similar law.

(7) Losses resulting directly or indirectly from participation in any reckless activity voluntarily, which is unnecessary and for recreational purposes, where it was reasonably foreseeable that a serious bodily injury or death would result and which, in the opinion of the Trustees, constitutes reckless endangerment.

(8) Losses which occur while a Participant is under COBRA coverage or is self-paying.

(9) Losses occurring while a Participant is retired and receiving a pension check.

(10) Losses arising directly or indirectly from any disease or from any medical or surgical treatment for any kind of disease.

(11) Losses contributed to by the Participant's bodily or mental infirmity, sickness or infection, except for a pyrogenic infection resulting from an accidental wound or injury.

SECTION K: CONTINUATION OF COVERAGE

In General, there are three ways to continue one's Medical Coverage: exercising COBRA rights, coverage through the Health Insurance Marketplace, and self-paying for coverage. All are discussed below.

COBRA Continuation

COBRA RIGHTS

Each Qualified Beneficiary who would otherwise lose health coverage (including medical, prescription drug, dental/orthodontics and optical benefits) as a result of a Qualifying Event shall be entitled to elect, within the election period, to obtain and pay premiums for continued insurance coverage ("Continuation Coverage"). "COBRA Coverage" includes:

- Basic Medical Benefits and Secondary Major-Medical Benefits
- Prescription Drug Benefits
- Dental/Orthodontic Benefits
- Optical Expense Benefits

COBRA coverage will not include the Death, Accident, and Disability Benefits. If health coverage under the Plan is modified for any group of similarly situated Participants or Dependents, the health coverage will also be modified in the same manner for all Participants and Dependents who are Qualified Beneficiaries under COBRA. Any modifications will continue to credit any Deductible, copayment, and Lifetime Maximum in effect prior to the amendment, to the extent required by law.

QUALIFYING EVENTS

"Qualifying Event" means, with respect to any Participant and Dependents, any of the following events which, would result in loss of health coverage for a Qualified Beneficiary:

(1) The death of the Participant.

(2) The termination (except for a Participant's gross misconduct), or reduction of hours, of the Participant's employment. The term "gross misconduct" means conduct of a Participant which is (a) a deliberate and willful disregard of standards of behavior which the Employer has a right to expect, showing a gross indifference to the Employer's interest; or (b) a series of repeated violations of employment rules proving that the Participant has regularly and wantonly disregarded their obligations.

(3) The divorce or legal separation (if recognized by state law) of the Participant from the Participant's spouse.

(4) The Participant becomes entitled to Medicare benefits.

(5) A Dependent child of a Participant ceases to be a Dependent child under the terms of the Plan

(6) An Employer's filing of Bankruptcy.

QUALIFIED BENEFICIARY

"Qualified Beneficiary" means:

(1) any Participant or Dependent who, on the day before the Qualifying Event is eligible for Benefits under the Plan on the basis of being either (i) the Participant, (ii) the spouse of the Participant or (iii) the Dependent child of the Participant. Except for newborn infants and adopted children who become Dependents during the period of time when a Participant is eligible for COBRA, no Participant, Dependent spouse or Dependent child may be considered a Qualified Beneficiary if, on the date prior to the Qualifying Event, the individual was not already eligible for Benefits under the Plan or a Dependent of a Participant.

(2) Newborn infants and adopted children who become Dependents during the period of time when a Participant is eligible for COBRA coverage but who were not covered under the Plan on the day before the Qualifying Event are still treated as "Qualified Beneficiaries."

(3) The term "Qualified Beneficiary" does not include nonresident aliens to the extent permitted by law.

PERIOD OF COVERAGE

Except for an interruption of coverage in connection with a waiver, COBRA continuation coverage that has been elected for a Qualified Beneficiary must extend for at least the period beginning on the date of the Qualifying Event and ending not before the earliest of the following dates:

(1) The last day of the applicable "Maximum Coverage Period."

(2) The first day a payment is not made to the Plan within 30 days of the first day of the coverage period.

(3) The date the Employer ceases to provide any group health plan (including a successor plan) to any employee.

(4) The date, after the date of the election, that the Qualified Beneficiary first becomes covered under any other Plan that does not contain any exclusion or limitation with respect to any pre-existing condition, other than such an exclusion or limitation that does not apply to, or is satisfied by, the Qualified Beneficiary.

(5) The date, after the date of the election, that the Qualified Beneficiary first enrolls in the Medicare program.

(6) In the case of a Qualified Beneficiary entitled to a disability extension, the later of:

(a) 29 months after the date of the Qualifying Event, or (ii) the first day of the month that is more than 30 days after the date of a final determination under the Social Security Act that the disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier; or

(b) the end of the Maximum Coverage Period that applies to the Qualified Beneficiary without regard to the disability extension.

The Plan can terminate for cause the coverage of a Qualified Beneficiary on the same basis that the Plan terminates for cause the coverage of similarly situated non-COBRA beneficiaries, for example, for the submission of a fraudulent claim.

MAXIMUM COVERAGE PERIODS FOR COBRA CONTINUATION COVERAGE

The Maximum Coverage Periods are based on the type of the Qualifying Event and the status of the Qualified Beneficiary.

In the case of a Qualifying Event that is a termination of employment or reduction of hours of employment, the Maximum Coverage Period ends 18 months after the Qualifying Event if there is not a disability extension and 29 months after the Qualifying Event if there is a disability extension.

In the case of a Participant's enrollment in the Medicare program

before experiencing a Qualifying Event that is a termination of employment or reduction of hours of employment, the Maximum Coverage Period for Qualified Beneficiaries other than the Participant ends on the later of:

- 36 months after the date the Participant becomes enrolled in the Medicare program; or
- 18 months (or 29 months, if there is a disability extension) after the date of the covered Employee's termination of employment or reduction of hours of employment.

In the case of a bankruptcy Qualifying Event, the Maximum Coverage Period for a Qualified Beneficiary who is the covered retiree ends on the date of the retiree's death. The Maximum Coverage Period for a Qualified Beneficiary who is the covered Spouse, surviving Spouse or Dependent child of the retiree ends on the earlier of the Qualified Beneficiary's death or 36 months after the death of the retiree.

In the case of a Qualified Beneficiary who is a child born to or placed for adoption with a Participant during a period of COBRA continuation coverage, the Maximum Coverage Period is the Maximum Coverage Period applicable to the Qualifying Event giving rise to the period of COBRA continuation coverage during which the child was born or placed for adoption.

In the case of any other Qualifying Event than that described above, the Maximum Coverage Period ends 36 months after the Qualifying Event.

Expanded Maximum Coverage Period. If a Qualifying Event that gives rise to an 18-month or 29-month Maximum Coverage Period is followed, within that 18- or 29-month period, by a second Qualifying Event that gives rise to a 36-months Maximum Coverage Period, the original period is expanded to 36 months, but only for individuals who are Qualified Beneficiaries at the time of both Qualifying Events. In no circumstance can the COBRA Maximum Coverage Period be expanded to more than 36 months after the date of the first Qualifying Event. The Plan Administrator must be notified of the second qualifying event within 60 days of the second qualifying event. This notice must be sent to the Plan Administrator.

Disability Extension. A disability extension will be granted if an individual (whether or not the covered Employee) who is a Qualified Beneficiary in connection with the Qualifying Event that is a termination or reduction of hours of a covered Employee's employment, is determined under Title H or XVI of the Social Security Act to have been disabled at any time during the first 60 days of COBRA continuation coverage. To qualify for the disability extension, the Qualified Beneficiary must also provide the Plan Administrator with notice of the disability determination on a date that is both within 60 days after the date of the determination and before the end of the original 18-month Maximum Coverage Period. This notice should be sent to the Plan Administrator.

PREMIUM REQUIREMENTS.

A Qualified Beneficiary shall be required to pay a monthly premium for any period of Continuation Coverage. The Plan Administrator shall cause an actuary to determine the applicable premium for Continuation Coverage, either on the basis of a reasonable estimate of the cost of providing such Medical Care coverage for similarly situated beneficiaries, or on the basis of actual cost for the preceding year for similarly situated beneficiaries (adjusted to reflect cost-of-living increases as measured by Gross National Product inflator), in a manner that complies with the Internal Revenue Code and ERISA. If Continuation Coverage is elected after the Qualifying Event has occurred, the Qualified Beneficiary shall have forty-five (45) days after the date of their election to pay the premium for Continuation Coverage.

INSURABILITY AND CONVERSION OPTION

The availability of Continuation Coverage will not be conditioned upon, or discriminate on the basis of, a lack of evidence of insurability. The Plan does not provide any Participants or Dependents with the right to convert to an individual policy. Therefore, the Plan also does not provide to a Qualified Beneficiary the option of enrollment under a conversion health plan when the Qualified Beneficiary's COBRA coverage would otherwise end.

QUALIFIED BENEFICIARY'S ELECTION/COSTS

(1) Each Qualified Beneficiary who would otherwise lose coverage under the Plan because of a Qualifying Event shall be entitled to make an independent election, within the Election Period, to have Continuation Coverage under the Plan.

(2) Continuation Coverage consists of the coverage detailed below:

- Basic Medical Benefits and Secondary Major-Medical Benefits
- Prescription Drug Benefits
- Dental/Orthodontic Benefits
- Optical Expense Benefits

A Qualified Beneficiary will not be entitled to continue their life, disability, and accidental death, dismemberment and loss of sight benefits under COBRA continuation coverage. If you elect the coverage, you generally have the option to continue only your medical coverage or to continue your medical coverage with vision and dental coverage. You may extend coverage only at the level you had as an active member — single, dual or family. If your Dependents enroll separately, they can change the level of coverage.

(3) The "Election Period" will be the period which:

(a) Is at least sixty (60) days in duration; and

(b) Ends no earlier than sixty (60) days after the later of:

- the date on which coverage would normally terminate; or
- the date of the notice given by the Plan Administrator to a Qualified Beneficiary with respect to a Qualifying Event.

(4) Except as otherwise specified in an election, any election of Continuation Coverage by a Qualified Beneficiary who is either a Participant or the spouse of a Participant shall be deemed to include an election of Continuation Coverage on behalf of any other Qualified Beneficiary who otherwise would lose coverage by reason of the Qualifying Event.

(5) A Qualified Beneficiary who waives Continuation Coverage may revoke such waiver at any time before the end of their Election Period, provided that no Benefits shall be payable for Charges incurred during the period commencing on the date that the Qualified Beneficiary's coverage under the Plan terminated and ending on the date the Participant revokes such waiver.

(6) Coverage will not be continued automatically. Qualified Beneficiaries must enroll for COBRA coverage and pay the full premium cost plus a small administrative charge. If an Employee or former Employee elect coverage, any Dependents included in active coverage may be enrolled. If an Employee or former Employee waive coverage, eligible Dependents can elect continued coverage for themselves.

NOTICE.

The following notice requirements shall apply:

(1) The Employer shall notify the Plan Administrator of a Qualifying Event by reason of death, or entitlement to Medicare benefits or the Employer's Bankruptcy filing, within thirty (30) days of the date of any such Qualifying Event. The determination of the occurrence of a Participant's termination of employment or reduction of hours as a Qualifying Event shall be made by the Plan Administrator.

(2) In the case of a Qualifying Event by reason of death, termination of employment, reduction of hours, or entitlement to Medicare benefits, the Plan Administrator shall notify each Qualified Beneficiary with respect to such event of such beneficiary's right to elect Continuation Coverage.

(3) Each Participant shall have sole responsibility for notifying the Plan Administrator of a Qualifying Event by reason of divorce, legal separation, or a Dependent child ceasing to be a Dependent under the terms of the Plan, within sixty (60) days after the date of such Qualifying Event. If notice is not given within such 60-day period, any right to elect Continuation Coverage shall be terminated.

(4) In the case of a Qualifying Event by reason of divorce, legal separation, or a Dependent child ceasing to be a Dependent under the terms of the Plan, where the Participant notifies the Plan Administrator, the Plan Administrator shall notify each Qualified Beneficiary with respect to such event of their right to elect Continuation Coverage hereunder.

(5) For purposes of giving notice to Qualified Beneficiaries, any such notice shall be given within fourteen (14) days after the date on which the Plan Administrator is notified of a Qualifying Event by reason of death, entitlement to Medicare benefits, divorce or legal separation, a Dependent child ceasing to be a Dependent under the terms of the Plan, or an Employer's Bankruptcy filing, provided that the Plan Administrator receives notice within the time prescribed by applicable law or regulation, as summarized above.

(6) Any Qualified Beneficiary who believes they are disabled and therefore eligible for an extended period of continuation coverage must provide the requisite notices to the Plan Administrator.

SPECIAL RULES FOR THE UNIFORM SERVICES EMPLOYMENT AND RE-EMPLOYMENT RIGHTS ACT OF 1994

Special rules exist under the Uniform Services Employment and Reemployment Rights Act of 1994 ("USERRA") for a Participant who is on military leave. The Plan incorporates these rules by reference.

A Participant who qualifies for these special rules is permitted to continue their prior medical, prescription drug, dental and vision benefits (if applicable) for the lesser of

- 24 months from the start of the employee's absence due to performing uniformed service; or
- when the service period is less than 24 months, the period ending on the date the employee fails to return from service or to apply for reimbursement.

A person who elects to continue coverage may be required to pay up to 102% of the full contribution under the Plan, except a person on active duty for 30 days or less cannot be required to pay more than the Employee's share, if any, for the coverage.

An exclusion or waiting period may not be imposed in connection with the reinstatement of coverage upon reemployment if one would not have been imposed had coverage not been terminated because of service. However, an exclusion or waiting period may be imposed for coverage of any Illness or Injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of uniformed service.

The USERRA continuation period runs concurrently with the COBRA continuation period.

HEALTH INSURANCE MARKETPLACE

There may be other coverage options for Employees, former Employees, and Dependents. Health coverage may be available through the Health Insurance Marketplace. Some individuals are eligible tax credit that lower monthly premiums and individuals may see what premium, deductibles and out-of-pocket costs before making a decision to enroll. Being eligible for COBRA does not limit eligibility for coverage for a tax credit through the Marketplace. Additionally, individuals that lose coverage under a group health plan 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.

SELF-PAY BENEFITS (MASTER GROUP EMPLOYEES)

If coverage under the Fund ends for a Master Group Employee because an Employee has not worked enough hours, Self-Pay Benefits are available to provide continuing coverage for the Employee and their eligible Dependents. This enables the Master Group Employee to pay the cost to continue coverage and avoid having coverage lapse, because of their reduction of hours or termination.

A Master Group Employee is eligible to self-pay if the Master Group Employee:

- was eligible for benefits in the preceding Benefit Quarter based on active service,
- is available for work with a Master Group Employer, and
- is not employed or self-employed.

A Master Group Employees can continue all health benefits that they were eligible to receive in the immediately preceding Benefit Quarter including Basic Medical Benefits, Secondary Major-Medical Benefits, Prescription Drug Benefits, Dental/Orthodontic Benefits, and Optical Expense Benefits. Master Group Employees cannot continue Death, Accident and Disability Benefits using self-pay.

HOW LONG COVERAGE LASTS.

Master Group Employees can self-pay for benefits for up to six (6) continuous additional Benefit Quarters (18 months), and must be a Union member in good standing, which includes being current on Union dues. Retired Master Group Employees cannot use self-pay to pay health plan premiums.

Special rules exist for determining the cost of self-pay:

First Quarter. If a Master Group Employee has less than 120 Hours of Service in any Benefit Quarter, he must pay the full premium rate as set forth in the Schedule of Benefits for the First Quarter. If a Master Group Employee has 120 or more Hours of Service in any Benefit Quarter, the premium for the First Quarter will be determined by subtracting from 300 the total Hours of Service and multiplying the result by the per hour charge.

Second Quarter through Sixth Quarters. The premium for the Second Quarter through the Sixth Quarters will be determined by the Trustees.

Expiration of Self-Pay. If a Master Group Employee's self-pay benefits terminate (either because the Master Group Employee received the maximum months of self-pay or he ceased to pay a required premium on time), the Master Group Employee must satisfy the eligibility requirements before becoming covered as a Plan Participant.

A Participant's COBRA period runs simultaneously with their self-pay period.

The right to self-pay extends only to Master Group Employees. Any other category of Employees who is covered under this Plan is not eligible for self-pay.

SECTION L: COORDINATION OF BENEFITS

** These rules apply based on the presumption that a family member qualifies as a Dependent. If a family member does not qualify as a Dependent, then no coverage will be provided by this Plan and this Section does not apply.

1. LIMITATION OF COVERAGE.

Benefits under the Plan will be coordinated within any other group or health care plan which provides an EOB. A special rule exists with dental and vision benefits where the Plan will coordinate with pre-paid providers that do not provide EOBs as described in the sections pertaining to these benefits. The benefits paid between the various plans will be limited in all cases to a maximum of one hundred percent (100%) of the allowable Charges to the Participant and any Dependents for eligible Benefits. Benefits will also be coordinated in the same manner with payments made or available under a "no-fault" statute to the maximum extent permitted by law. The Deductibles applicable to the Basic Medical Benefits, Secondary Major Medical Benefits and Dental Benefits will apply to Charges for which the Plan accepts secondary responsibility. The time limit for filing claims for Benefits, both where the Plan has primary and secondary responsibility, are described in the Claims and Appeals section.

2. "PRIMARY-SECONDARY" PAYMENT RULES.

PLEASE NOTE: These rules are mandatory. To the extent a Participant does not follow these rules, the Plan reserves the right to seek legal recourse against the Participant.

In processing a claim where two or more group health plans exist, the "primary-secondary" payment rule determines the provision of payment. It is applied in the following manner:

(1) The Plan will accept primary responsibility on claims when:

(a) The patient is a Participant; or

(b) The patient is the covered Dependent child of a Participant. Where the Dependent child is simultaneously covered under this Plan as a Dependent of a Participant, and under another plan as a Dependent of the Participant's spouse, this Plan will accept primary responsibility if the Participant's birth date precedes their spouse's birth date in the calendar year.

(2) The Plan will accept secondary responsibility on claims when:

(a) A Dependent-spouse patient is covered under another plan as an employee;

(b) A Dependent-child patient is covered under another plan as a dependent of the Participant's spouse and the Participant's spouse has a birthday that falls earlier in the calendar year than the Participant's (for purposes of this calculation, only the month and day are used; years of birth are not taken into consideration;

(c) A Dependent-child patient is covered under another plan as an employee or as the spouse of an employee; or

(d) A Dependent-child that is under age twenty-six (26) and married and is covered under another plan as an employee or as the spouse of an employee.

(3) The following rules apply to the coverage of Dependent children in the event that the Participant is divorced or legally separated from their spouse:

(a) If there is a court decree that establishes financial responsibility for medical or other health care expenses for the Dependent child, the plan covering the parent who has that responsibility will be primary and the plan covering the other parent will be secondary.

(b) If there is no court decree, and the parent with custody of the Dependent child has not remarried, the plan covering the parent who has custody of the Dependent child will be primary, and the plan covering the other parent will be secondary.

(c) If there is no such court decree, and the parent with custody of the Dependent child has remarried, the order of priority is:

(a) The plan covering the parent who has custody.

(b) The plan covering the spouse of the parent who has custody (that is, the stepparent of the Dependent child) and whose plan covers the stepchild.

(c) The plan covering the parent without custody.

3. DUPLICATE COVERAGE.

If a Participant is covered under more than one plan through two jobs, the primary plan shall be determined as follows:

(a) If a Participant is actively employed in only one job, the plan that covers the Participant as an active Employee shall be the primary plan.

(b) In all other cases, the plan which has covered them for the longer period of time will be primary.

4. LACK OF COORDINATION.

If Charges covered are also covered in whole or in part by any group insurance plan or group health plan which does not contain provisions for coordination of benefits, payment will be made under this Plan only with respect to those allowable Charges not covered by such group insurance or plan. If the Participant or Dependent fail to follow the proper

procedures of another plan to coordinate the benefits, the Plan may choose to pay the benefits it would have been required to pay had the proper procedures been followed.

5. COB AND YOUR PLANS.

Coordination of benefits ("COB") typically work the same way for many health care plans. If one of your plans is secondary, COB may work to reimburse the full amount of covered charges. That means the secondary plan will pay the lesser of:

- the difference between the total allowable covered cost and the amount paid by the primary plan, or
- the amount it would have paid as the primary plan.

In order to obtain secondary benefits through the Fund, you must submit (1) an itemized bill and (2) an Explanation of Benefits (EOB). Generally the provider will submit the material, but you may contact the Fund for more information.

6. COB WITH MEDICARE.

To the extent Medicare law changes, these rules may be modified. Please contact the Fund Office for further information.

Age 65

When you reach age 65, you will be eligible for Medicare. If you continue working after age 65, your coverage under the Fund will continue. If you enroll in Medicare during the time you are still working after reaching age 65, the Fund will be primary. If your spouse is entitled to Medicare and you are still working, the Fund remains primary for both you and your spouse until you retire or terminate employment.

When you retire or terminate employment, Medicare becomes primary. If you continue coverage or qualify for retiree health plan benefits, the Fund will coordinate benefits with Medicare.

You must elect to take both Parts A and B of Medicare if you wish to take the retiree health care benefits. The Fund will pay the Part A deductible. You are responsible, however, for the Part B deductible. The Part B deductible will not be covered under the Fund.

If an item is not covered under Medicare, but constitutes a Covered Medical Expense under the Fund, the Fund will pay 80% of the Covered Medical Expenses which are not covered by Medicare — as long as Participant is enrolled in Parts A or B.

In order to obtain secondary benefits through the Fund, you must submit (1) an itemized bill and (2) the Medicare EOB.

End Stage Renal Disease

Special rules exist if you have end stage renal disease ("ESRD"): you may be eligible for Medicare before you reach age 65 and before you terminate employment. Medicare will become the primary payer of your medical claims (even though you have coverage under another plan) after you have had ESRD for thirty (30) months. The thirty (30) month period is measured from the date Medicare determines that you are disabled.

Dependents

If a Dependent is disabled and entitled to Medicare, special rules apply. Please contact the Fund Office for more information.

SECTION M: THIRD PARTY RESPONSIBILITY

1. THIRD PERSON RESPONSIBILITY.

(A) Benefits may be withheld when a third person, other than the person for whom a claim is made, may be legally responsible. To the extent payment is made or expected to be made by such liable third person (as a settlement, judgment or in any other way), Charges arising from such sickness or injury are not covered and Benefits for any period of Disability resulting (in whole or in part) from such sickness or injury are not payable. Accepting Benefits under this Plan automatically assigns to the Plan any rights the Participant or Dependent may have to recover payments from any third party or insurers regardless of whether the Participant or Dependent chooses to pursue the claim. The Participant or Dependent must repay to the Plan benefits paid on their behalf out of the monies paid to the Participant or Dependent by the third party or insurer.

(B) When a Benefits claim is received, Plan benefits which would be payable except for the above modifications, will be paid if:

(1) Payment by or for the responsible third person has not yet been made; and

(2) The Participant or Dependent involved (or if incapable, that person's legal representative) acknowledges that the Plan has a 100% first dollar priority lien on any amount recovered (whether or not designated as payment for medical expenses) and agrees in writing to pay back within fifteen days of payment from such third person the Benefits paid as a result of the sickness or injury to the extent of any future payments made by or for the responsible or liable person for the sickness or injury. The agreement is to apply whether or not: (A) liability for the payments is admitted by the responsible persons; and (B) such payments are itemized. A reasonable share of fees and costs incurred to obtain such payments may be deducted from amounts to be repaid.

(3) The Plan's right to the third party recovery/subrogation still applies if the recovery received by the Participant or Dependent is less than the claimed damage, and, as a result, the claimant is not made whole.

(4) The Plan shall have no obligation whatsoever to pay Benefits to a Participant or Dependent if a Participant or Dependent refuses to cooperate with the Plan's reimbursement and subrogation rights or refuses to execute and deliver such papers as the Plan may require in furtherance of its reimbursement and subrogation rights. Further, in the event the Participant or Dependent is a minor, the Plan shall have no obligation to pay any Benefits caused by a responsible third party until after the Dependent or their authorized legal representative obtains valid court recognition and approval of the Plan's 100%, first dollar reimbursement and subrogation rights on all recoveries, as well as approval for the execution of any papers necessary for the enforcement thereof, as described herein.

(5) The third party right of recovery applies to all monies paid to the Participant or Dependent, including, but not limited to, recoveries for medical or dental expenses,

attorneys' fees, costs and expenses, pain and suffering, loss of consortium, wrongful death, lost wages and any other recovery of any form of damages or compensation whatsoever, by way of judgment, settlement, or otherwise to compensate for all losses caused by the injury or sickness, whether or not said losses reflect Benefits covered by the Plan.

(C) If you recover any money from a third party or insurer, (regardless of whether the money is identified as being reimbursement for medical expenses), the Plan has the right to be reimbursed for the expenses it has already paid on your behalf, and court costs and attorneys' fees incurred in obtaining the amount. The Participant or Dependent must repay to the Plan Benefits paid on their behalf out of the monies paid to the Participant or Dependent by the third party or insurer.

(D) General Rules.

(1) The Fund's subrogation rights apply to weekly disability benefits.

(2) The Fund's subrogation rights will not apply to work-related injuries covered by Workers' Compensation.

(3) Once you reach a settlement, no further expenses will be paid by the Fund.

(4) Any amounts you receive in a settlement must be paid to the Fund <u>first.</u>

2. RIGHT OF REIMBURSEMENT.

The Plan shall have a right of subrogation to the extent of its payment to or for the benefit of any Participant or Dependent, and shall have a lien to the extent of such payment, where the Participant or Dependent does or may recover any amount from a third person, their insurance company, or any other responsible party, as a result of a covered injury or illness. The Plan may exercise its right of subrogation either in its own name or in the name of the Participant or Dependent in order to recover payments made to such person, who shall take any such action as the Plan Administrator may reasonably require to enable the Plan to enforce its rights. The Participant or Dependent is obligated to cooperate with the Plan in order to protect the Plan's subrogation rights.

Recovery of Erroneous Payments. Any payment made by the Plan to any person or entity in excess of the amount which the Plan was obligated to pay may be recoverable by the Plan from the payee or the Participant or Dependent to whom the payment was made, or their successors or assigns. All payments made by the Plan to any person or entity are conditioned upon the Plan's right to recover excessive or erroneous payments. The Plan may recover excessive or erroneous payments from a Participant or Dependent directly and/or by offset against claims for Benefits under the Plan made to the affected Participant or Dependent. A Participant or Dependent will provide the Plan Administrator with any information and documents required to collect excessive or erroneous payments. The Plan has the right to recover all Benefits paid due to false or fraudulent statement, information, or evidence, including the withholding of a material fact. In addition to any other remedy, the Plan may collect any excessive or erroneous or overpayment by suit, arbitration, or

such other remedy as law or equity may provide, including the placement of an equitable lien and/or constructive trust on the excessive or erroneous payment. Any person or entity who has received an excessive or erroneous payment from the Plan and who does not immediately tender the excessive or erroneous payment to the Plan will be deemed to hold such funds in constructive trust for the Plan because the person is not the rightful owner and should not be in possession of the excessive or erroneous payment.

Assignment of Rights to a State Medical Assistance Plan. If services covered under this Plan have been paid for under a State plan for medical assistance, then payment by this Plan will be made in accordance with applicable laws.

Payment of Claims Assigned to the State Medical Assistance Plan. If the right to receive reimbursement for services covered under this Plan has been assigned to a state plan for medical assistance, then the Plan will make payment to the state plan for medical assistance in accordance with the state laws.

SECTION N: CLAIMS PROCEDURES

The Fund is designed so that claims will be processed as quickly as possible. Claim forms are available at the Fund Office.

FILING FOR HEALTH CARE BENEFITS

Basic Hospital Claims

If you know ahead of time that you or a family member will need Hospital care, be certain to present your ID card to the Hospital. Your card contains all of the information necessary to bill the Fund.

When you see a provider in the PPO Network, your Physician or the Hospital submits the claim and receives payment from the Fund. You are then billed for any remaining costs.

If you seek care from a provider outside of the PPO Network, you may be required to pay in advance and submit a claim to the Fund Office for direct reimbursement.

When making a claim (either directly or through your provider), be sure to attach originals of all your bills.

Bills for Hospital and provider's services must include the following information:

- Member's name
- Member's identification number
- Member's home address
- Patient's name and date of birth
- Employer's name
- Physician's diagnosis and surgical procedure, if applicable
- Physician's Federal Tax ID Number and National Provider Identifier ("NPI") number
- Physician's name, address, phone number
- Physician's signature in original form
- Applicable procedure codes

If the services have been rendered as a result of an accidental injury, please provide a brief written explanation of what happened, when, where and the nature of the injury.

If your Dependents have primary coverage through another health care plan, program, or insurance policy, please submit a copy of the itemized bill (including the information described above) and the original explanation of benefits (the "EOB"). Payments will not be made without both of these statements.

You must also sign an authorization in order for us to release benefits to the provider. If you wish to be directly reimbursed for a claim and the claim exceeds $100.00, please provide the original proof of payment (paid receipt, canceled check, etc.).

Prescription Drug Claims

Pharmacy Prescriptions

When you purchase Pharmacy Prescriptions, you are generally only required to pay the co-pay based on the type of drug per the Summary of Benefits. There may be an additional payment if you require the brand name drug rather than the generic version.

There are two situations where you may be required to pay the entire cost of the Pharmacy Prescription and then seek reimbursement from the Fund:

- You obtain a Pharmacy Prescription from a non-participating pharmacy.
- You obtain a Pharmacy Prescription from a participating pharmacy but do not have your ID card when you receive your prescription (either because you forgot your ID card or you are a new member and have not received the ID card yet).

You must obtain the pharmacy reimbursement from the PBM. In order to be reimbursed, you should contact the PBM for reimbursement procedures.

Filing for Death and AD&D Benefits

Death and AD&D benefits are not paid automatically. If you die, your beneficiary must contact the Fund Office, complete a claim form and provide a certified copy of your death certificate. Your death benefit will be paid to your designated beneficiary. If you have not completed a designated beneficiary form, the death benefits will be paid to your surviving spouse or, if none, your surviving children and, if none, the personal representative of your estate once the Fund receives evidence that a personal representative has been appointed.

If you are injured in an accident, contact the Fund office for information about the AD&D benefit.

Filing for Weekly Disability Benefits

If you are unable to work for more than seven days due to a non-work related illness or accident, you may be entitled to disability benefits. To make a claim for weekly disability benefits, please follow the following procedures:

1. Contact the Fund Office to obtain the necessary claim form (either the initial disability form or the continuation form).

2. Submit a completed initial disability form to the Fund. This form must be signed by you, your Physician, and your Employer.

3. Send a “continuation” form to the Fund once every two (2) weeks or at the frequency requested. This form must be signed by your Physician and you.

Please remember the following important notes when filing for your disability benefits:

- Incomplete claim forms (or claim forms without the required signatures) will cause a delay in processing.
- It is your responsibility to notify the Fund of your return to work. If you fail to do so, and you are overpaid as a result, you are responsible for reimbursing the Fund**.**

Time Limit for Filing Claims

As a general matter, no amounts will be reimbursed and no benefits will be paid by the Fund for claims filed more than 12 months following the date of services rendered.

Claims Procedure

The following is the Plan's procedure for Claims for benefits. A Claim is defined as any request for a Plan benefit, made by a claimant or by a representative of a claimant, which complies with the Plan's reasonable procedure for making benefit Claims. The times listed are maximum times only. A period of time begins at the time the Claim is filed. Decisions will be made within a reasonable period of time appropriate to the circumstances. "Days" means calendar days.

There are different kinds of Claims and each one has a specific timetable for either approval, payment, request for further information, or denial of the Claim. If you have any questions regarding this procedure, please contact the Plan Administrator.

The definitions of the types of Claims are detailed below. Please note that the period of time within which a benefit determination or review is required to be made with respect to a Claim or an Adverse Benefit Determination shall begin at the time the Claim or appeal is filed in accordance with the Plan's claims procedures. This timing is without regard to whether all the necessary information accompanies the filing.

Urgent Care Claim

An "Urgent Care Claim" is any Claim for medical care or treatment where using the timetable for a non-urgent care determination could seriously jeopardize the life or health of the claimant; or the ability of the claimant to regain maximum function; or in the opinion of the attending or consulting Physician, would subject the claimant to severe pain that could not be adequately managed without the care or treatment that is the subject of the Claim.

A Physician with knowledge of the claimant's medical condition may determine if a Claim is an Urgent Care Claim. If there is no such Physician, an individual acting on behalf of the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine may make the determination. Urgent Care Claims may be submitted orally or in writing.

In the case of an Urgent Care Claim, the following timetable applies:

- Notification to claimant of benefit determination: 72 hours
- Insufficient information on the Claim, or failure to follow the Plan's procedure for filing a Claim:

- Notification to claimant, orally or in writing: 24 hours
- Response by claimant, orally or in writing: 48 hours
- Benefit determination, orally or in writing: 48 hours

- Ongoing courses of treatment, notification of:
  - Reduction or termination before the end of treatment: 72 hours
  - Determination as to extending course of treatment: 24 hours

If there is an Adverse Benefit Determination on an Urgent Care Claim, a request for an expedited appeal may be submitted orally or in writing by the claimant. All necessary information, including the Plan's benefit determination on review, may be transmitted between the Plan and the claimant by telephone, facsimile, or other similarly expeditious method.

- Review of Adverse Benefit Determination: 72 hours

Pre-Service Claim

A Pre-Service Claim means any Claim for a benefit under this Plan where the Plan conditions receipt of the benefit, in whole or in part, on approval in advance of obtaining medical care. These are, for example, Claims subject to predetermination of Benefits or pre-certification.

In the case of a Pre-Service Claim, the following timetable applies:

- Notification to claimant of benefit determination: 15 days
- Extension due to matters beyond the control of the Plan: 15 days
- Insufficient information on the Claim:
  - Notification of: 15 days
  - Response by claimant: 45 days
- Notification, orally or in writing, of failure to follow the Plan's procedures for filing a Claim: 5 days
- Ongoing courses of treatment:
  - Reduction or termination before the end of the treatment: 15 days
  - Request to extend course of treatment: 15 days
- Review of Adverse Benefit Determination: 15 days, subject to a 15 day extension (if needed)

Post-Service Claim

A Post-Service Claim means any Claim for a Plan benefit that is not an Urgent Care Claim or a Pre-Service Claim; in other words, a Claim that is a request for payment under the Plan for covered medical services already received by the claimant.

In the case of a Post-Service Claim, the following timetable applies:

- Notification to claimant of benefit determination: 30 days
- Extension due to matters beyond the control of the Plan: 30 days
- Extension due to insufficient information on the Claim: 15 days
- Response by claimant following notice of insufficient Information: 45 days

- Review of Adverse Benefit Determination: Generally date of next Board Meeting, unless the request for review is filed within 10 days preceding the date of such meeting, in which case the review of the Adverse Benefit Determination shall be made no later than the date of the second meeting following the Plans' receipt of the review request.

Notice to Claimant of Adverse Benefit Determinations

Except with Urgent Care Claims, when the notification may be oral followed by written or electronic notification within three days of the oral notification, the Plan Administrator shall provide written or electronic notification of any Adverse Benefit Determination. The notice will state, in a manner calculated to be understood by the claimant:

(1) The specific reason or reasons for the adverse determination.

(2) Reference to the specific Plan provisions on which the determination was based.

(3) 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.

(4) A description of the Plan's review procedures, incorporating any voluntary appeal procedures offered by the Plan, and the time limits applicable to such procedures. This will include a statement of the claimant's right to bring a civil action under section 502 of ERISA following an Adverse Benefit Determination on review.

(5) 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 Claim. "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U. S. Department of Labor Office."

(6) If the Adverse Benefit Determination was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the Adverse Benefit Determination and a copy will be provided free of charge to the claimant upon request.

(7) If the Adverse Benefit Determination is based on the Medical Necessity or Experimental or Investigational treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terns of the Plan to the claimant's medical circumstances, will be provided.

How to File an Appeal

In the event that you or your Dependents need an item or service which is not covered by this Plan or receive an Adverse Benefit Determination, you may file an appeal to your Board of Trustees.

You have 180 days following receipt of the notification in which to appeal the decision. All of the information related to the appeal must be received in the Fund Office at least thirty (10) days prior to the scheduled quarterly meeting of the Trustees in order to ensure review. Appeals received after the cut-off period will be held until the next quarterly meeting. Please contact the Fund Office for the meeting dates.

The following information must accompany all formal appeals:

(1) A letter from the claimant briefly describing the situation and detailing the special request. The letter must include the member ID.

(2) A letter from the Physician who prescribed the item or service explaining that the item or service is Medically Necessary. The letter should include the anticipated benefits of using the item or service.

(3) A cost quote from the supplier. The estimate must be in writing and on the company's letterhead.

Please forward all appeal requests to the Plan Administrator. The Plan Administrator's address is on page 4, in the Summary of Benefits at the beginning of this document.

Your Member Identification number should appear on all appeal materials.

Please contact the Fund Office if you have any questions concerning the appeal process.

You may submit written comments, documents, records, and other information relating to the Adverse Benefit Determination. You may request free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Adverse Benefit Determination.

A document, record, or other information shall be considered relevant to an Adverse Benefit Determination if it:

(1) was relied upon in making the benefit determination;

(2) was submitted, considered, or generated in the course of making the benefit determination, without regard to whether it was relied upon in making the benefit determination;

(3) demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that benefit determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all claimants; or

(4) constituted a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit.

The review shall take into account all comments, documents, records, and other information submitted by the claimant relating to the Adverse Benefit Determinationm, without regard to

whether such information was submitted or considered in the initial benefit determination. The review will not afford deference to the initial Adverse Benefit Determination and will be conducted by a fiduciary of the Plan who is neither the individual who made the adverse determination nor a subordinate of that individual.

If the Adverse Benefit Determination was based 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 fiduciary shall consult with a health care professional who was not involved in the original benefit determination. This health care professional will have appropriate training and experience in the field of medicine involved in the medical judgment. Additionally, medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the initial determination will be identified.

Response Time for Appealed Denied Claims or Adverse Benefits Determinations

A final and binding decision on appeal shall be made by the Board of Trustees (or a subcommittee thereof) at the regularly scheduled quarterly meeting of the Board of Trustees which first occurs after the 30th day following receipt of the appeal by the Claims Administrator. The appeal may be delayed to the next regularly scheduled quarterly meeting if: (1) special circumstances require a further extension for processing and (2) the Claims Administrator provides written notice to the claimant of the extension, the special circumstances, and the date as of which the benefit determination will be made.

The Trustees (or sub-committee) hearing the appeal will consider the evidence presented and will listen to arguments for a reasonable period of time on behalf of the appeal. If any claim is based 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, those conducting the appeal will consult with a health care professional (who was not consulted in the initial benefit decision and is not the subordinate of any health care professional consulted in the initial benefit decision) who has appropriate training and experience in the field of medicine involved in the medical judgment. Any medical or vocational experts whose advise was obtained on behalf of the Plan (even if not relied on) shall be identified upon request.

The final and binding decision of the Trustees (or subcommittee) on an appeal shall be: (1) in writing; (2) final and binding on all parties; and (3) communicated not later than 5 days after the determination is made. The decision shall be written in a manner to be understood by the Claimant and shall include

(i) Reference to the specific provisions of the Plan on which the determination is based;

(ii) A statement that the Claimant is entitled to receive upon request, without charge, reasonable access to and copies of all documents, records, and other information relevant to the claim;

(iii) A statement of the Claimant’s right to bring an action under Section 502(a) of ERISA following the appeal; and

(iv) a copy of any internal rule, guideline, protocol or similar criterion relied upon in making the determination, and an explanation of the scientific or clinical judgment for any determination based on medical necessity, experimental treatment or similar exclusion or limit.

Special Rules for Disability Claims

If you file a claim for disability benefits, it will be subject to the rules set forth above with the following modifications:

1. Once you file your disability claim, the Plan Administrator will notify you within 45 days of receipt if it is denied. The 45-day period may be extended an additional 30 days if you are notified in writing before the original 45-day period ends. The 30-day extension period can be extended another 30 days if you are notified in writing before the first 30-day extension expires.

2. If your claim is denied, you will receive a written notification which will contain the information identified above, plus it will include a statement notifying you about your rights to bring a civil action. It will also notify you that you will have the right to request a copy, free of charge, of any internal rule, guideline or similar criteria, or exclusion or limitation (such as medical necessity or experimental treatment) which formed the basis for the adverse determination. You will have 180 days to appeal the decision.

Adverse Benefit Determination Defined

An "Adverse Benefit Determination" is 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 the Plan, and including a denial, reduction or termination of, or a failure to provide or make payment (in whole or part) for a benefit resulting from the application of any utilization review, as well as the failure to cover an item or service for which benefits are otherwise provided because it is deemed to be Experimental or Investigational or not Medically Necessary or appropriate.

Rights Regarding an Adverse Benefit Determination

You have the following rights with regard to the Adverse Benefit Determination:

1. You have the right to appeal this Adverse Benefit Determination in accordance with the Plan's review procedures and the time limits applicable to such procedures. If your appeal is denied, you have the right to bring a civil action under section 502(a) of ERISA.

2. You have the right to receive, upon written request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the Claim

3. If the Adverse Benefit Determination was based on an internal rule, guideline, protocol, or other similar criterion, you have the right to receive a copy of the written rule, guideline, protocol, or criterion, free of charge, upon written request to the address below.

4. If the Adverse Benefit Determination was based on the Medical Necessity or Experimental or Investigation treatment or similar exclusion or limit, you have the right to receive an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances. Such explanation will be provided free of charge, upon written request to the address below.

Statute of Limitations and Venue

If your claim for benefits and appeal has been denied, and you would like to file suit against the Fund, you have one year from the date on which your appeal was denied to do so. You must bring any such lawsuit in the U.S. District Court for the District of Maryland in Baltimore.

Address for Additional Information and/or Appeal Requests

Operating Engineers Local 37
Attn: Appeal Department
3615 North Point Blvd — Suite C
Baltimore MD 21222

IMPORTANT INFORMATION ABOUT YOUR APPEAL RIGHTS

What if I need help understanding this denial? Contact us at 1(410) 254-9595 or 1(800) 367-7848 if you need assistance understanding the Plan's claims and appeals procedures or the decision to deny you a service or coverage.

What if I don't agree with this decision? You have a right to appeal any decision not to provide you or pay for an item or service (in whole or in part).

How do I file an Appeal? Please follow the steps detailed in the Section "How to File an Appeal."

What if my situation is urgent? If your situation meets the definition of urgent under the law, your review will be conducted within 24 hours. Generally, an urgent situation is one in which your health may be in serious jeopardy or in the opinion of your physician you may experience pain that cannot be adequately controlled while you wait for a decision on your appeal. If you believe your situation is urgent, you may request an expedited appeal by following the procedures in this SPD.

Who may file an appeal? You or someone you name to act for your (your authorized representative) may file an appeal. In order to designate an authorized representative, please contact the Fund Office for the Authorized Representative Form.

Can I provide additional information about my claim? Yes, you may supply additional information. Please see the attached sheet.

Can I request copies of information relevant to my claim? Yes, you may request copies (free of charge) by contacting us at 1(410) 254-9595 or 1(800) 367-7848.

What happens next? If you appeal, the Board of Trustees will review the decision and will provide you with a written determination of the decision.

SECTION O: YOUR RIGHTS UNDER THE PLAN

As a member of the Fund, you are entitled to certain rights and protections under ERISA -- the Employee Retirement Income Security Act. This section describes those rights and explains how you can put them to work for you.

Right to Information

One right entitles you to a full summary of the Fund. This SPD is designed to provide that information. In addition to the summary, you can examine without charge at the Administrator's office and at other specified locations, all Fund documents and contracts, including financial reports, the collective bargaining agreement, the latest 5500 filed by the Fund with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration, and plan descriptions. To get copies of any legal documents, write to the Fund Office. You may have to pay a small fee for copying charges.

Continued Group Health Plan Coverage

Another right entitles you to 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.

You also have the right to reduce or eliminate exclusionary periods of coverage for preexisting conditions under your group health 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 a preexisting condition exclusion for 12 months after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the 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 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 these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance With Your Questions

If you have any questions about 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 Inquires, Pension and Welfare Benefits 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.

Assignment of Benefits

Only participants and beneficiaries are entitled to benefits under the Plan. If payment of a claim or benefit is made directly to a provider, it is for convenience only. Generally, no assignment for the benefit of creditors of any benefit provided under the Fund will be valid, and the Fund will not recognize any attempted assignment.

Qualified Medical Child Support Order

The Plan has a procedure which details how it evaluates a medical child support order. You can obtain a copy, at no addition charge, from the Plan Administrator.

SECTION P: ADMINISTRATIVE INFORMATION

Fund Administration

The Board of Trustees sponsors the Fund described in this SPD. The Board of Trustees has delegated day-to-day administration of the Fund to Decision Science, Inc..

Fund Financing

Your Employer contributes generally to the Fund to pay the premiums. All employees utilizing COBRA or self-pay, if applicable, are required to pay all or a portion of the expenses.

Fund Records

All Fund records are kept on a Plan Year basis, from January 1 to December 31.

Legal Matters

If you have a question about any Fund provision, contact the Plan Administrator. You may serve legal papers on the Fund sponsor or the Plan Administrator.

Fund Identification

The Fund described in this SPD is identified by a name and number. Be sure to use the correct name and numbers in any official correspondence about the Fund.

The common name for the Fund is the Operating Engineers Local 37 Health and Welfare Fund. The Fund number is 501. The Fund's employer identification number is 52-6039006.

Future of the Fund

The Fund expects to continue the benefits described in this SPD, but has the right to change or terminate them. Any changes must be approved by the Board of Trustees. You will be told how the change affects your benefits, if at all.

Appendix A: No Surprises Act

As of January 1, 2022, this Plan complies with the Consolidated Appropriations Act of 2021 (including the No Surprises Act) (the "NSA").

No Surprises Services - In General

All No Surprises Services (as defined below) under the Plan will be covered in accordance with the NSA. No Surprises Services are covered without any need for pre-certification or prior authorization and as if those services had been provided by an in-network provider. You cannot be balance billed by a provider or facility for any No Surprises Services.

If you receive No Surprises Services from an out-of-network provider that you thought was an in-network provider, based on inaccurate information in a current provider directory, then the No Surprises Services provided by that out-of-network provider will be covered as if the provider was an in-network provider.

No Surprises Services - Key Definitions

"**Ancillary Services**" means, with respect to an in-network facility:

1. Items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether provided by a physician or non-physician practitioner;

2. Items and services provided by assistant surgeons, hospitalists, and intensivists;

3. Diagnostic services, including radiology and laboratory services; and

4. Items and services provided by an out-of-network provider if there is no in-network provider who can furnish such item or service at such in-network facility.

"**No Surprises Services**" are charges for:

1. out-of-network Emergency Services provided in a Hospital or Independent Emergency Department,

2. non-emergency Ancillary Services for anesthesiology, pathology, radiology, neonatology and diagnostics provided by an in-network facility by an out-of-network provider

3. certain non-emergency services (other than Ancillary Services) provided by an in-network facility by an out-of-network provider with respect to which the provider does not comply with the federal Notice and Consent requirements outlined in the NSA, and

4. out-of-network air ambulance services.

"**Notice and Consent**" means, for services provided at an in-network facility by an out-of-network provider:

1. that at least 72 hours before the day of the appointment (or 3 hours in advance of services rendered in the case of a same-day appointment

    a. the Participant or Dependent is provided with a written notice, that the provider is an out-of-network provider,

    b. the estimated charges for the Participant's or Dependent's treatment and any advance limitations under the Plan,

    c. the names of any in-network providers at the in-network facility who are able to provide treatment; and

    d. that the Participant or Dependent may elect to be referred to one of the in-network providers

2. The Participant or Dependent gives consent to continued treatment by the out-of-network provider, acknowledging that they understand the continued treatment by the out-of-network provider may result in higher cost

The Notice and Consent exception does not apply to Ancillary Services and items or services provided as a result of unforeseen, urgent medical needs that happen at the time an item or service is provided, regardless of whether the out-of-network provider satisfied the Notice and Consent requirement.

"**Emergency Services**" means, with respect to an Emergency Medical Condition:

1. An appropriate medical screening examination that is within the capability of the emergency department of a hospital or of an Independent Freestanding Emergency Department, including Ancillary Services routinely available to the emergency department to evaluate such Emergency Medical Condition; and

2. Within the capabilities of the staff and facilities available at the hospital or the Independent Freestanding Emergency Department, as applicable, such further medical examination and treatment as are required to stabilize you (regardless of the department of the hospital in which such further examination or treatment is furnished).

3. Post-stabilization services provided by an out-of-network provider or facility as part of outpatient observation or an inpatient or outpatient stay related to the emergency visit, until (a) the provider or facility determines you are able to travel using nonmedical transportation or nonemergency medical transportation and (b) you are supplied with a written Notice of Consent from the provider or facility that satisfies the requirements of the NSA and you provide informed consent to give up your NSA protections.

"**Emergency Medical Condition**" means a medical condition, including mental health condition or substance use disorder, manifested by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in serious impairment to bodily functions, serious dysfunction of any bodily organ or part, or placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or the unborn child) in serious jeopardy.).

Independent Free-Standing Emergency Department means a health-care facility that is separate and distinct from a Hospital and that is licensed to provide Emergency Services.

Cost Sharing for No Surprises Services

If you receive No Surprises Services, the most the Plan can require to you pay for copayments, deductibles and coinsurance related to the No Surprises Services ("cost sharing amounts") is what you would have paid if the services had been rendered in-network.

The Plan will credit cost sharing amounts for No Surprises Services toward your in-network deductible and out-of-pocket maximum.

External Review for No Surprises Services

If you believe that the Plan has improperly denied your claim for No Surprises Services, and you have exhausted the Plan's internal claims and appeal procedures, you may be entitled to appeal the decision to an Independent Review Organization ("IRO") for external review.

You must submit your request for external review to the Fund Office within four months of receipt of your final adverse determination on appeal. If the Fund Office determines your claim is ineligible for external review, the written notification will include the reasons for your request's ineligibility for external review or a description of any materials or information necessary to perfect your request for external review.

Upon receipt of a notice of a final external review decision from an IRO reversing the Adverse Benefit Determination on appeal, the Plan shall immediately provide payment for the subject No Surprises Service claim.

Independent Dispute Resolution for No Surprises Services

There is a separate federal process that providers and facilities may use to dispute the amount the Plan pays for No Surprises Services. This process will not change the amount that you can be made to pay on these claims. For more information on this process, please contact the Fund Office.

Continuing Care Patients

If an in-network provider or facility leaves the Plan's network, a Continuing Care Patient with that provider or facility may elect continued coverage and the determination of applicable cost-sharing for such continuing care services as if that provider or facility continued to be an in-network provider or in-network facility for up to 90 days.

You are a "**Continuing Care Patient**" if you are:

1. undergoing a course of treatment for a Serious and Complex Condition,

2. scheduled to undergo non-elective surgery (including any post-operative care);

3. pregnant and undergoing a course of treatment for the pregnancy;

4. determined to be terminally ill and receiving treatment for the illness; or

5. undergoing a course of institutional or inpatient care from the provider or facility.

"**Serious and Complex Condition**" means one of the following:

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

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

Appendix B: HIPAA Privacy Notice

Health and Welfare Plan and Trust for the International Union of Operating Engineers Local 37

HIPAA PRIVACY NOTICE

Effective September 23, 2013

This Notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Health Information Privacy.

The privacy policy and practices of the Health and Welfare Plan and Trust for the International Union of Operating Engineers Local 37 (the "**Plan**") protect confidential health information that identifies you or could be used to identify you and relates to a physical or mental health condition or the payment of your health care expenses. This individually identifiable health information is known as "protected health information" ("**PHI**").

Certain types of health care information are maintained by your health care plan administrators (*e.g.*, Decision Science, Inc. ("**PSI**")) and other types are maintained by your employer. Your PHI will not be used or disclosed without a written authorization from you, except as described in this Notice or as otherwise permitted by federal or state health information privacy laws. (Throughout this Notice, the reference to "**you**" is intended to mean you and your dependents.)

Privacy Obligations of the Plan.

The Plan is required by law to:

- make sure that PHI that identifies you is kept private;
- give you this Notice of the Plan's legal duties and privacy practices with respect to your PHI;
- follow the terms of the Notice that are currently in effect; and
- notify affected individuals if there is a breach of unsecured PHI.

How the Plan May Use and Disclose Your PHI Without Your Authorization.

The Plan may use and disclose your PHI without your authorization in the following ways:

- ***For Treatment.*** The Plan may disclose your PHI to a health care provider who renders treatment on your behalf. For example, if you are unable to provide your medical history as a result of an accident, the Plan may advise an emergency room physician about the types of prescription drugs you currently take.

- ***For Payment.*** The Plan may use and disclose your PHI so that claims for health care treatment, services, and supplies you receive from health care providers may be paid according to the Plan's terms. For example, the Plan may receive and maintain information about surgery you received to enable the Plan to process a hospital's claim for reimbursement of surgical expenses incurred on your behalf.

- ***For Health Care Operations.*** The Plan may use and disclose your PHI to enable it to operate more efficiently or make certain all of the Plan's participants receive their health benefits. For example, the Plan may use your PHI for case management or to perform population-based studies designed to reduce health care costs. In addition, the Plan may use or disclose your PHI to conduct compliance reviews, audits, actuarial studies, and/or for fraud and abuse detection. The Plan may also combine health information about many Plan participants and disclose it to the Trustees in summary fashion so it can decide what coverage the Plan should provide.

- ***To a Business Associate.*** Certain services are provided to the Plan by third parties known as "business associates." For example, DSI handles most of the administration of the Plan. The Plan will disclose your PHI to its business associate, DSI, so it can perform its claims payment function. However, the Plan will require its business associates, through a contract, to safeguard your PHI.

- ***Treatment Alternatives.*** The Plan may use and disclose your PHI to tell you about possible treatment options or alternatives that may be of interest to you.

- ***As Required by Law.*** The Plan will disclose your PHI when required to do so by federal, state or local law, including any law that requires the reporting of certain types of wounds or physical injuries. In addition, the Plan is required to disclose your PHI to the Secretary of the U.S. Department of Health and Human Services when the Secretary is investigating or determining the Plan's compliance with HIPAA.

Special Use and Disclosure Situations that Do Not Require Your Authorization.

The Plan may also use or disclose your PHI without your authorization under the following circumstances:

- ***Lawsuits and Disputes.*** If you become involved in a lawsuit or other legal action, the Plan may disclose your PHI in response to a court or administrative order, a subpoena, warrant, discovery request, or other lawful due process.

- ***Law Enforcement.*** The Plan may release your PHI if asked to do so by a law enforcement official. For example, to identify or locate a suspect, material witness, or missing person or to report a crime, the crime's location or victims, or the identity, description or location of the person who committed the crime.

- ***Workers' Compensation.*** The Plan may disclose your PHI to the extent authorized by and to the extent necessary to comply with workers' compensation laws and other similar programs.

- ***Military and Veterans.*** If you are or become a member of the U.S. armed forces, the Plan may release medical information about you as deemed necessary by military command authorities.

- ***To Avert Serious Threat to Health or Safety.*** The Plan may use and disclose your PHI when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person.

- ***Public Health Risks.*** The Plan may disclose your PHI for public health activities. These activities include preventing or controlling disease, injury or disability; reporting births and deaths; reporting child abuse or neglect; or reporting reactions to medication or problems with medical products or to notify people of recalls of products they have been using.

- ***Health Oversight Activities.*** The Plan may disclose your PHI to a health oversight agency for audits, investigations, inspections and licensure necessary for the government to monitor the health care system and government programs.

- ***National Security, Intelligence Activities and Protective Services.*** The Plan may release your PHI to authorized federal officials: (1) for intelligence, counterintelligence and other national security activities authorized by law and (2) to enable them to provide protection to the members of the U.S. government or foreign heads of state or to conduct special investigations.

- ***Organ and Tissue Donation.*** If you are an organ donor, the Plan may release medical information to organizations that handle procurement of organ, eye or tissue transplantation or to an organ donation bank to facilitate organ or tissue donation and transplantation.

- ***Coroners, Medical Examiners and Funeral Directors.*** The Plan may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or to determine the cause of death. The Plan may also release your PHI to a funeral director, as necessary, to carry out their duties.

Uses and Disclosures of PHI that Require Your Written Authorization.

Any use or disclosure of PHI not covered by this Notice or by the laws that apply to the Plan will be made only with your written authorization.

If you authorize the Plan to use or disclose your PHI, you may revoke the authorization, in writing, at any time. If you revoke your authorization, the Plan will no longer use or disclose your PHI for the reasons covered by your written authorization. However, the Plan will not reverse any uses or disclosures already made in reliance on your prior authorization.

With few exceptions, the Plan must obtain your written authorization for uses and disclosures of your PHI involving (1) certain marketing communications about a product or service and whether financial remuneration is involved; (2) a sale of PHI resulting in remuneration not permitted under HIPAA; and (3) psychotherapy notes, except for certain treatment, payment and health care operations purposes, if the disclosure is required by law or for health oversight activities, or to avert a serious threat.

Uses and Disclosures that Require That You be Given an Opportunity to Agree or Disagree Prior to the Use or Release.

Disclosure of your PHI to family members, other relatives and your close personal friends is allowed if:

- the information is directly relevant to the family or friends' involvement with your care or payment for that care; and
- you have either agreed to the disclosure or have been given an opportunity to object and have not objected.

This means **unless you object**, the Plan may disclose PHI to a close friend or family member involved with or who helps pay for your health care. The Plan may also advise a family member or close friend about your condition, your location (for example, that you are in the hospital), or death. If you do not want your PHI disclosed to a close friend or family member, please complete and return the last page of this Notice.

Your Rights Regarding Your PHI.

Your rights regarding the PHI the Plan maintains about you are as follows:

- ***Right to Inspect and Copy.*** You have the right to inspect and copy your PHI. This includes information about your Plan eligibility, claim and appeal records and billing records, but does not include psychotherapy notes.

  To inspect and copy PHI maintained by the Plan, submit your request in writing to the Plan. The Plan may charge a fee for the cost of copying and/or mailing your request. In limited circumstances, the Plan may deny your request to inspect and copy your PHI. Generally, if you are denied access to health information, you may request a review of the denial.

- ***Right to Amend.*** If you feel that the PHI the Plan has about you is incorrect or incomplete, you may ask the Plan to amend it. You have the right to request an amendment for as long as the information is kept by or for the Plan.

  To request an amendment, send a detailed request in writing to the Plan. You must provide the reason(s) to support your request. The Plan may deny your request if you ask the Plan to amend the PHI that is: (1) accurate and complete, (2) not created by the Plan unless the person or entity who created the information is no longer available to make the amendment, (3) not part of the PHI kept by or for the Plan, or (4) not information that you would be permitted to inspect and copy. If the Plan denies a request, you have the right to file a statement of disagreement with the Plan, and any future disclosures of the disputed information will include such statement or a summary thereof.

- ***Right to an Accounting of Disclosures.*** You have the right to request an "accounting of disclosures." This is a list of disclosures of your PHI that the Plan has made to others, and will not include (1) disclosures for purposes of treatment, payment, or health care operations, unless HIPAA provides otherwise; (2) disclosures made to you; (3) disclosures

made pursuant to your authorization; (4) disclosures made to friends or family in your presence or because of an emergency; (5) disclosures for national security purposes, and (6) disclosures incidental to otherwise permissible disclosures.

To request an accounting of disclosures, submit your request in writing to the Plan. Your request must state a time period that may not be longer than six years prior to the date the accounting was requested.

- ***Right to Request Restrictions.*** You have the right to request a restriction on the PHI the Plan uses or discloses about you for treatment, payment or health care operations. You also have the right to request a limit on the health information the Plan discloses about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that the Plan not use or disclose information about a surgery you had.

  You have the right to request that the Plan not disclose PHI for payment or health care operations (as defined by HIPPA) if the provider has been paid in full without using any funds from the Plan.

  To request restrictions, make your request in writing and advise the Plan of: (1) what information you want to limit; (2) whether you want to limit the Plan use, disclosure or both; and (3) to whom you want the limit(s) to apply. **NOTE:** The Plan is not required to agree to your request.

- ***Right to Request Confidential Communications.*** You have the right to request that the Plan communicate with you about health matters in a certain way or at a certain location. For example, you can ask that the Plan send your "explanation of benefits" (EOB) forms about your benefit claims to a specified address.

  To request confidential communications, make your request in writing to the Plan. The Plan will make every attempt to accommodate all reasonable requests. Your request must specify how or where you wish to be contacted. **NOTE:** The Plan is not required to agree to your request.

- ***Right to Notification of a Breach.*** The Plan is required to notify affected individuals in the event of a breach of unsecured PHI, as that term is defined under federal law.

Changes to This Notice.

The Plan reserves the right to change this Notice at any time and to make the revised or changed Notice effective for health information the Plan already has about you as well as any information the Plan receives in the future. The Plan will post a copy of the current Notice in the benefits office at all times and will mail participants a copy of the revised Notice.

Complaints.

If you believe your privacy rights under this policy have been violated, you may file a written complaint with the Plan Administrator at the address listed below. Alternatively, you may

complain to the Secretary of the U.S. Department of Health and Human Services within 180 days of when the act or omission complained of occurred. You will not be penalized or retaliated against for filing a complaint.

Contact Information.

If you have any questions about this Notice, please contact the HIPAA Compliance Department at the address below. In addition, if you wish to exercise any of your rights under this Notice, such as requesting to inspect and copy your PHI, please send your requests in writing to the address below.

Decision Science, Inc.
c/o OE 37 HIPAA Compliance Department
3615 North Point Blvd — Suite C
Baltimore, MD 21222
(410) 254-9595

Appendix C: Benefit Program Documents

This section may be used to add additional descriptive materials regarding benefits that may not be in the SPD,

Appendix D: List of Master Group Employers and Stationary Group Employers

A "Master Group Employer" is an Employer signatory to any of the following Collective Bargaining Agreements:

- Heavy-Highway Construction Western Maryland Agreement, dated May 1, 2021, by and between the Western Maryland Contractors Association, Inc., and Local 37 and 37R of the International Union of Operating Engineers, affiliated with the AFL-CIO State of Maryland and District of Columbia Federation of Labor and the National Building Trades Council.
- Building Construction Western Maryland Agreement, dated May 1, 2021, by and between the Western Maryland Contractors Association, Inc., and Local 37 and 37R of the International Union of Operating Engineers, affiliated with the AFL-CIO State of Maryland and District of Columbia Federation of Labor and the National Building Trades Council.
- Building Agreement, dated April 1, 2023-March 31, 2026, by and between the Labor Relations Division of the Maryland Chapter of the Associated General Contractors of America, Inc. and Local No. 37 and 37R of the International Union of Operating Engineers, AFL-CIO.
- Crane Rental Agreement, dated June 1, 2023-May 31, 2026, by and between the Crane Employers Association of Baltimore and Locals No. 37 and 37R of the International Union of Operating Engineers, AFL-CIO.

A "Stationary Group Employer" is any of the following Employers:

- (TPA) Tradepoint Terminals
- Q R Services
- GCR
- HHS, LLC (Ft. Meade/Kimbrough)
- HHS, LLC (Ft. Detrick)
- HHS, LLC (Carlisle, PA)
- HHS, LLC (Aberdeen)
- Melwood Horticultural Train
- Decision Science, Inc.
- Dr. Goldiner
- Cloverland Farms
- Potts & Callahan Inc.
- Mt. Savage Specialty Ref.
- Dr. Jay Lebow
- Central Maintenance
- UG2
- Taylor Oil
- CTSI FM LLC
- K&K Adams, Inc.
- George S Hall Inc.

- BLV Engineering Assoc
- Brooks & Brooks Serv
- Sodexo
- Valiant Integrated ERV
- IUOE Job Corp
- Dae Sung, LLC
- Armstead Homes Gardens
- Picorp
- Bowhead
- Sookum
- Able Engineering
- Carter Paving & Excavating Inc.
- J&J Worldwide
- H&S Resources