PROGRAM OF INSURANCE BENEFITS
HEALTH AND WELFARE TRUST FUND
FOR
INTERNATIONAL UNION OF OPERATING ENGINEERS
LOCAL 99 AND 99A
for
Active Employee Participants
Non-Medicare Eligible Retiree Participants
and
Medicare Retiree Participants with Part A and Part B Medicare Primary Coverage

The Trustees believe this Plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the "Affordable Care Act") and can interpret and administer this Plan in a manner to preserve its grandfathered status. 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 the 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. Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Administrator at (410) 254-9595. A Participant may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

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January 1, 2025

TABLE OF CONTENTS

We urge you to read the booklet carefully and share it with your family members who are included in your coverage. Please keep in mind that this handbook is a summary of an official legal document and, if it conflicts with the wording of the actual plan document, the plan document will govern.

***** This SPD reflects the 1.1.2025 Plan document.

SUMMARY OF BENEFITS*

January 1, 2025

This Chart details the amount of "Charges" that will be paid by the Plan. The term "Charges" is generally the usual, customary and reasonable fee for a Medically Necessary service (as determined by the Plan) and the amount may be different from your bill.

SPD section	Charges for the following Benefit Category:	Active Employee Participant and their Dependents		Non-Medicare Eligible Retiree Participant and their Dependent		Medicare Retiree Participant with Part A and Part B Medicare Primary Coverage
		PPO	Non-PPO	PPO	Non-PPO	
C.3.	**BASIC MEDICAL BENEFIT**					
	Plan Year Deductible	$220 per person		$220 per person		None
	Plan Year Deductible for a family of 3 or more	$660		N/A		None
	Deductible for Medicare Part A	Does not apply		Does not apply		Paid in Full
	Deductible for Medicare Part B	Does not apply		Does not apply		Paid in Full
	Out of pocket maximum on essential benefits	$1500 for individual, $3000 for two people and $4500 for family of three or more, applied after the Plan Year deductible has been met		$1500 for each individual		No Out-of-pocket maximum

*When a Participant or his Dependents incurs medical bills, the Plan determines the amount of the bill it will pay. This is a summary chart of the percentage of the "Charges" that the Plan will pay. The term "Charge" may not be the same as your medical bill. The term "Charge" generally means the "Usual, Customary and Reasonable" fee for the medical service and it is determined by the Plan. In the case of a Medicare Retiree Participant with Part A and Part B Medicare Primary Coverage and a benefit covered by Medicare and this Plan, the term "Charge" means the Medicare Allowed Benefit. Any portion of your medical bill not paid by the Plan will be your responsibility. All Charges are generally subject to the Basic Medical Plan Benefit plan year deductible.

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		PPO	Non-PPO	PPO	Non-PPO	
(A)	**INPATIENT HOSPITAL CARE:** Precertification, retro-precertification or pre-notification is required for all in-patient admissions. Failure to do will result in a claim being suspended and then denied, which means it becomes the responsibility of the Participant.					
	Room and Board Charge:	The Charges paid by the Plan are based on the average semi-private room rate and the Plan reserves the right to establish the acceptable semi-private rate if not otherwise available.				
	Days 1-20	100% of Charges after deductible	100% of Charges after deductible	100% of Charges after deductible	80% of Charges after deductible	For a benefit covered by Medicare and the Plan, 100% of the Medicare Co-Insurance. For a benefit covered only by the Plan, 80% of Medically Necessary Room and Board Charges (based on average semi-private room rate) and Miscellaneous Charges.
	Days 21+	100% of Charges after deductible	80% of Charges after deductible			
	Miscellaneous Charges:					
	Days 1-20	100% of Charges after deductible	100% of Charges after deductible	100% of Charges after deductible	80% of Charges after deductible	
	Days 21+	100% of Charges after deductible	80% of Charges after deductible	100% of Charges after deductible	80% of Charges after deductible	
	Ambulance, including Air Ambulance					
	Transportation from home to hospital or Accident to hospital	If emergency, paid 100% of Charges after deductible		If emergency, paid 100% of Charges after deductible		For benefits covered by Medicare and the Plan, 100% of the Medicare Co-Insurance. For a benefit covered only by the Plan, if Medically Necessary, 80% of the Charges.
	Transportation from Hospital to hospital or Home to hospital	If Medically Necessary, 80% of Charges after deductible		If Medically Necessary, 80% of Charges after deductible		

SUMMARY OF BENEFITS* **January 1, 2025** **This Chart details the amount of "Charges" that will be paid by the Plan. The term "Charges" is generally the usual, customary and reasonable fee for a Medically Necessary service (as determined by the Plan) and the amount may be different from your bill.**						
SPD section	**Charges for the following Benefit Category:**	**Active Employee Participant and their Dependents**		**Non-Medicare Eligible Retiree Participant and their Dependent**		**Medicare Retiree Participant with Part A and Part B Medicare Primary Coverage**
		PPO	**Non-PPO**	**PPO**	**Non-PPO**	
(B)	**OUTPATIENT HOSPITAL CARE:** Precertification, retro-precertification or pre-notification is required for all in-patient admissions, outpatient surgical procedures, outpatient IV therapy, and outpatient continuing care therapy. Failure to do will result in a claim being suspended and then denied, which means it becomes the responsibility of the Participant.					
	Hospital Charges for sudden & serious illness	100% of Charges after deductible, but there is a $50 co-pay on all ER Facility fees if not admitted.		100% of Charges after deductible but there is a $50 co-pay on all ER Facility fees if not admitted.	80% of Charges after deductible but there is a $50 co-pay on all ER Facility fees if not admitted.	For benefits covered by Medicare and the Plan, 100% of the Medicare Co-insurance and for benefits only covered by the Plan, 80% of the Medically Necessary Charges.
	Facility fees for outpatient surgery	100% of Charges after deductible	100% of Charges after deductible	100% of Charges after deductible	80% of Charges after deductible	
	Outpatient Physical Therapy	80% of Charges after deductible	80% of Charges after deductible	80% of Charges after deductible	80% of Charges after deductible	
	Miscellaneous Outpatient Care	Depends on Itemized Charge				
	GLOBAL CASE CHARGES	100% of Charges after deductible	100% of Charges after deductible	100% of Charges after deductible	100% of Charges after deductible	

SUMMARY OF BENEFITS*

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This Chart details the amount of "Charges" that will be paid by the Plan. The term "Charges" is generally the usual, customary and reasonable fee for a Medically Necessary service (as determined by the Plan) and the amount may be different from your bill.

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		PPO	Non-PPO	PPO	Non-PPO	
(C)	**SURGICAL CARE:** Precertification, retro-precertification or pre-notification is required for all surgical care and procedures. Failure to do will result in a claim being suspended and then denied, which means it will become the responsibility of the Participant.					
	Surgeon Charges, whether in-patient or out-patient	100% of Charges after deductible	80% of Charges after deductible	100% of Charges after deductible	80% of Charges after deductible	For benefits covered by the Plan and Medicare, 100% of the Medicare Co-insurance and for benefits covered only by the Plan, 80% of the Medically Necessary Charges.
	Assistant Surgeon Charges	50% of Charges after deductible	50% of Charges after deductible	50% of Charges after deductible	50% of Charges after deductible	
(D)	**Anesthesia Charges**	100% of Charges after deductible	100% of Charges after deductible	100% of Charges after deductible	80% of Charges after deductible	
	Physician Charges: Inpatient visit, outpatient visit, home visit or telehealth visit	100% of Charges after deductible subject to $10 co-pay per visit.	80% of Charges after deductible	100% of Charges after deductible	80% of Charges after deductible	
(E)	**DIAGNOSTIC EXAMS:**					
	Independent Labs	100% of Charges after deductible, subject to $10 co-pay per visit	70% of Charges after deductible	100% of Charges after deductible	80% of Charges after deductible	
	X-ray Examinations	100% of Charges after deductible	70% of Charges after deductible	100% of Charges after deductible	80% of Charges after deductible	

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		PPO	Non-PPO	PPO	Non-PPO	
(F)	**DURABLE MEDICAL EQUIPMENT (DME),** including oral appliance therapy for sleep apnea if certain conditions are met and the purchase of a breast pump if certain conditions are met.	80% of Charges after deductible, subject to receipt of a letter of Medical Necessity and precertification if $1,000 or higher.		80% of Charges after deductible subject to receipt of a letter of Medical Necessity and precertification if $1,000 or higher		For benefits covered by Medicare and the Plan, 100% of the Medicare Co-insurance, subject to review if $1000 or higher. For benefits covered only by the Plan, 80% of the Charges, subject to Medical Necessity letter and review if $1,000 or higher.
(G)	**HEARING AIDS** for defect or disease of Active Employee Participant, subject to specific Plan criteria and $1,000 lifetime limit.	80% of Charges after deductible		0%		0%
	HEARING AIDS for routine hearing loss of covered Participant and Spouse, subject to specific Plan criteria and $4,500 limit every three years. ($4,000 limit in 2023 and 2024, $2500 limit in 2021 and 2022)	100% of Charges and not subject to deductible		100% of Charges and not subject to deductible		100%
(H)	**HOME HEALTH CARE** Charges for RN and LPN, subject to a limit of 100 visits per Plan Year	100% of Charges after deductible	80% of Charges after deductible	100% of Charges after deductible	80% of Charges after deductible	If the benefit is covered by Medicare and the Plan, 100% of the Medicare Co-insurance and if the benefit is covered only by the Plan, 80% of the Medically Necessary Charges, limited to 100 visits per plan year.

SUMMARY OF BENEFITS*

January 1, 2025

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		PPO	Non-PPO	PPO	Non-PPO	
(I)	**HOSPICE CARE** limited to 180 day lifetime maximum	100% of Charges after deductible	80% of Charges after deductible	100% of Charges after deductible	80% of Charges after deductible	100% of the Medicare Co-insurance
(J)	**EXTENDED CARE/SKILLED NURSING FACILITY** Charges, limited to certain number of days per Plan Year. The maximum number of covered days is based on total PPO and Non-PPO days:					
	Days 1-20	100% of Charges after deductible	100% of Charges after deductible	100% of Charges after deductible		100% of the Medicare Co-insurance
	Days 21-50	100% of Charges after deductible	80% of Charges after deductible	50% of Charges after deductible		50% of the Medicare Co-insurance
	Days 51-180	100% of Charges after deductible	80% of Charges after deductible	0%	0%	0%
(K)	**ORTHOTICS**, subject to an annual maximum of $700. Effective 12.14.2023, no annual maximum on covered Dependent Children under age 19.	70% of Charges after deductible	70% of Charges after deductible	70% of Charges after deductible	70% of Charges after deductible	70% of the Medicare Co-insurance
(L)	**WELL BABY CARE TO AGE 24 MONTHS**	100% of Charges after deductible subject to $10 co-pay per visit	80% of Charges after deductible	100% of Charges after deductible	80% of Charges after deductible	For a benefit covered by Medicare and the Plan, 100% of the Medicare Co-insurance and if the benefit is covered only by the Plan, 80% of the Medically Necessary Charges.

SUMMARY OF BENEFITS*

January 1, 2025

This Chart details the amount of "Charges" that will be paid by the Plan. The term "Charges" is generally the usual, customary and reasonable fee for a Medically Necessary service (as determined by the Plan) and the amount may be different from your bill.

SPD section	Charges for the following Benefit Category:	Active Employee Participant and their Dependents		Non-Medicare Eligible Retiree Participant and their Dependent		Medicare Retiree Participant with Part A and Part B Medicare Primary Coverage
		PPO	Non-PPO	PPO	Non-PPO	
(M)	**PROSTHETICS,** available only for Active Employee Participant and subject to maximum of $7,500 every 7 years	80% of Charges after deductible	0%	0%	0%	0%
(N)	**PRIMARY MAJOR-MEDICAL BENEFIT**	80% of Charges after deductible		80% of Charges after deductible		For a benefit covered by Medicare and the Plan, 100% of the Medicare Co-insurance and if the benefit is covered only by the Plan, 80% of the Medically Necessary Charges.
(O)	**RECONSTRUCTIVE JAW SURGERY**, subject to lifetime maximum of $20,000.	80% of Charges after deductible		80% of Charges after deductible		80% of the Medicare Co-insurance
(Q)	**WELLNESS BENEFIT**, subject to a lifetime maximum of $1,500 on the following three benefits: hair prosthesis (wig) subject to separate lifetime maximum of $350, nutritional counseling and a maximum of six sessions of Lactation counseling.	100% of Charges after deductible		100% of Charges after deductible		For a benefit covered by Medicare and the Plan, 100% of the Medicare Co-insurance and for a benefit covered only by the Plan, 80% of the Medically Necessary Charges, subject to lifetime maximums and session limits.

SUMMARY OF BENEFITS*

January 1, 2025

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		PPO	**Non-PPO**	**PPO**	**Non-PPO**	
(R)	**HABILITATIVE/ REHABILITATIVE THERAPY -** ABA, physical and mental health therapy, if certain conditions are met.	80% of Charges after deductible		80% of Charges after deductible		If covered by Medicare and the Plan, 100% of the Medicare Co-insurance and if covered only by the Plan, 80% of the Medically Necessary Charges.
(S)	**CELL AND GENE THERAPY**	Covered under the Plan in accordance with the Plan provisions applicable to the CPT codes and network status of the billed Charges.				Covered under the Plan in accordance with the Plan provisions applicable to the CPT codes and network status of the billed Charges and the coordination with Medicare.
C.4	**SECONDARY MAJOR-MEDICAL BENEFIT**					
	Plan Year Deductible	$200		$100		None
	Lifetime maximum	$50,000 as of 12.1.2022		$50,000 as of 12.1.2022		$50,000 as of 12.1.2022
	Outpatient acupuncture and chiropractic care visit	80% of Charges after deductible		80% of Charges after deductible		For a benefit covered by Medicare and the Plan, 100% of the Medicare Co-insurance and for a benefit covered only by the Plan, 80% of the Medically Necessary Charges.

SUMMARY OF BENEFITS January 1, 2025			
The following benefits are automatically provided for Active Employee Participants. The benefits are not available for the Dependents of Active Employee Participants, Non-Medicare Eligible Retiree Participants (and their Dependents) and Medicare Retiree Participants with Part A and Part B Primary Coverage (and their Dependents).			
		Active Employee Participant	**Dependents of Active Employee Participants, Non-Medicare Eligible Retiree Participants (and their Dependents) and Medicare Retiree Participants with Part A and Part B Primary Coverage (and their Dependents).**
C.9.	**LIFE INSURANCE**, paid only upon death of Active Employee Participant	$100,000	Not available
C.9.	**ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT**	$100,000	Not available
C.9.	**SHORT TERM DISABILITY BENEFIT**	$1,000 weekly benefit ($600 prior to 1.1.2025), for a maximum period of 26 weeks, subject to a 7 day waiting period if the disability caused by sickness and no waiting period if the disability is caused by an accident.	Not available
C.9.	**LONG TERM DISABILITY BENEFIT**	Monthly indemnity of 60% of base salary subject to maximum monthly payment of $2500, and a 180 day waiting period and paid until age 65.	Not available

	SUMMARY OF BENEFITS January 1, 2025		
C.6.	**PRESCRIPTION DRUG BENEFITS** – see separate sheets for more detail. Note: Two companies provide prescription benefits under the Plan. ● CVS Caremark (Optum RX prior to 1.1.2025) provides prescription benefits for: Active Employee Participants (and their covered Dependents) Non-Medicare Eligible Retiree Participants (and their covered Dependents) and Dependents of Medicare Retiree Participants with Part A and Part B Primary coverage. ● RetireeFirst provides prescription benefits for Medicare Retiree Participants with Part A and Part B Primary Coverage and their covered Dependents who qualify for and are enrolled in Medicare. There are two special rules: (i) If you are a covered Dependent of a Medicare Retiree Participant with Part A and Part B Primary Coverage and you do not qualify for Medicare, you will receive prescription benefits from CVS Caremark if you elect and pay for prescription coverage. (ii) If you are a Dependent of a Medicare Eligible Medicare Retiree Participant with Part A and Part B Primary Coverage or a Non-Medicare Eligible Retiree Participant and you qualify for Medicare but do not enroll, you are not eligible for any Plan benefits, including prescription.		
	Retail and Mail Order Co-Pays	**30 day Retail Participant Cost**	**90 Day Supply Mail or CVS Participant Cost**
	Generic	$10	$20
	Preferred Brand	$30	$48
	Non-Preferred Brand	$48	$72
	Specialty Medications	20% co-pay	20% co-pay
	Out of pocket limit	None	None
C.7.	**DENTAL BENEFIT**		
	Plan Year Deductible	$50 per person	
	Calendar year maximum	$4,000 ($3,500 prior to 1.1.2025 and $3,000 prior to 1.1.2023), but certain Dental benefits for covered Dependent Children under the age of 19 which qualify as “Essential Health Benefits” may not be subject to the calendar year maximum.	
	Preventive services	100%	
	Basic services	80%	
	Major services	70% (60% prior to 1.1.2023)	
	ORTHODONTIC BENEFIT limited to covered Dependent Children under age 26 and effective July 1, 2023, Active Employee Participants, and their spousal Dependents.		
	Lifetime maximum	$3,000 ($2,500 prior to 1.1.2025 and $1,500 prior to 1.1.2023)	
	Covered Charges	80%	

C.8.	**OPTICAL EXPENSE BENEFIT**	Contact the Vision Provider NVA for information
	Calendar year maximum	$600 ($450 prior to 1.1.2025), but charges for Dependent Children under the age of 19 are subject to ACA provisions.
	Lifetime Maximum for LASIK Benefit	$2500 ($2,000 prior to 1.1.2025). This benefit is effective August 1, 2023 and coverage is limited to Active Employee Participants and their Dependents.

NOTES:

1. The Plan Year Out-of-Pocket maximum for Basic Medical Benefits is $1,500 for an individual, $3,000 for two people and $4,500 for a family of three or more, after the cash deductible has been met.

2. Non-PPO Professional Fees Rendered at a PPO Hospital - Charges for professional fees from Non-PPO professionals (Emergency Room Physicians, Radiologists, Pathologist, etc.) will be paid at the PPO rate providing that (1) services were rendered while an eligible Plan Participant was either on an inpatient or outpatient status at a PPO Hospital, (2) the patient did not have a choice in selecting the provider, and (3) the services provided were a covered benefit under the Plan.

3. The Plan is intended to be a grandfathered plan. The Trustees believe this Plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the "Affordable Care Act") and can interpret and administer this Plan in a manner to preserve its grandfathered status. 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 the 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. Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Administrator at (410) 254-9595 or 1-800-367-7848. A Participant may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

4. Requirements of the No Surprises Act. Claims for covered services rendered by Non-PPO/Out-of-Network Providers may be submitted directly to the Plan by the Non-PPO/Out-of-Network Provider, or the Participant may need to submit the claim. In either case, it is the responsibility of the Participant to make sure that all claims are timely filed.

    a. For Emergency Services provided by a Non-PPO/Out-of-Network Provider:

        (i) All benefits for covered services will be payable directly to the Non-PPO/Out-of-Network Provider.

        (ii) The Participant is not responsible for the difference between the Plan's payment and the Non-PPO/Out-of-Network Provider's bill after paying any PPO cost sharing amounts (i.e., deductible, copayment and/or coinsurance).

        (iii) Benefits for Emergency Services by a Non-PPO/Out-of-Network Providers are available to the same extent as benefits available for Emergency Services provided by PPO/In-Network Providers. See the Summary of Benefits for details.

b. For covered services (other than Emergency Services) by a Non-PPO/Out-of-Network Provider in a PPO/In-Network facility (including Ancillary Services and services for unforeseen urgent medical needs):

(i) Except when the Non-PPO/Out-of-Network Provider satisfies the Notice and Consent Requirements (described below):

(A) All benefits for covered services will be payable directly to the Non-PPO/Out-of-Network Provider.

(B) The Participant is <u>not</u> responsible for the difference between the Plan's payment and the Non-PPO/Out-of-Network Provider's bill after paying any PPO cost sharing amounts (i.e., deductible, copayment and/or coinsurance).

(C) Benefits for covered services provided by a Non-PPO/Out-of-Network Provider in a PPO/ In-Network facility are available to the same extent as benefits available for covered services provided by PPO/In-Network Providers. See the Summary of Benefits for details.

(ii) Notice and Consent Requirements.

(A) The Non-PPO/Out-of-Network Provider satisfies the notice and consent criteria of 45 C.F.R. §149.420, by:

(1) Providing to the Participant a written notice in paper or, as practicable, electronic form, as selected by the Participant, that the health care provider is a Non-PPO/Out-of-Network Provider, and a good faith estimate of the charges for the covered services; and

(2) Obtaining consent from the Participant (or the Participant's Authorized Representative) to be treated and balance billed by the Non-PPO/Out-of-Network Provider. An Authorized Representative for this purpose of this section is an individual authorized under State law to provide consent on behalf of the Participant, provided that the individual is not a provider affiliated with the facility or an employee of the facility unless such provider or employee is a family member of the Participant.

(B) When the Non-PPO/Out-of-Network Provider satisfies the notice and consent requirements, covered services are subject to the provisions of section 4.c., below.

(C) Notice and consent requirements described above, do not apply to:

(1) Ancillary Services; and

(2) Covered services provided as a result of unforeseen, urgent medical needs, that arise at the time other covered services are being rendered.

(iii) For all other covered services provided by a Non-PPO/Out-of-Network Provider (except as otherwise authorized by the Plan or stated in this document):

(A) If a Participant chooses a Non-PPO/Out-of-Network Provider, covered services may be eligible for reduced benefits.

(B) All benefits for covered services will be payable to the Participant, or to the Out-of-Network Provider, at the discretion of the Plan.

(C) Out-of-Network Providers are not required to accept the allowed benefit (called "Charges") as full payment and may collect additional amounts from the Participant up to the provider's actual bill. The allowed benefit/Charges may be substantially less than the provider's actual bill to the Participant. Therefore, when covered services are provided by a Non-PPO/Out-of-Network Provider, Participants should expect to pay additional amounts to providers that exceed the Charges paid by the Plan The Participant is responsible for the difference between the Plan's payment and the Non-PPO/Out-of-Network Provider's bill.

c. Any copayment, coinsurance, and/or other cost-sharing requirement for covered services provided by Non-PPO/Out-of-Network Providers **will be the same** as the copayment, coinsurance, and/or other cost-sharing requirement stated in this Summary of Benefits for services provided by PPO/In-Network Providers, for the following services:

(i) Emergency Services provided by Non-PPO/Out-of-Network Providers.

(ii) Air Ambulance Services provided by Non-PPO/Out-of-Network Providers.

(iii) Non-emergency ancillary services and services for unforeseen urgent medical needs provided by Non-PPO/Out-of-Network Providers.

(iv) Non-emergency services provided by Non-PPO/Out-of-Network Providers at PPO/In-Network facilities except when the Non-PPO/Out-of-Network Provider has satisfied the Notice and Consent Requirements of 45 C.F.R. §149.420 (c) through (i), as stated in Note 4b(ii) above.

d. All cost-share payments made by the Participant for the following services, will contribute towards the Plan deductible and out-of-pocket maximum:

(i) Emergency Services provided by Non-PPO/Out-of-Network Providers.

(ii) Air Ambulance Services provided by Out-of-Network Providers. For this purpose, "Air Ambulance Service" means medical transport of a Participant by helicopter or airplane.

(iii) Non-emergency services provided by Non-PPO/Out-of-Network Providers at PPO/in-network facilities (including Ancillary Services and services for unforeseen urgent medical needs), except when the Out-of-Network Provider has satisfied the

Notice and Consent Requirements of 45 C.F.R. §149.420 (c) through (i), as stated in Note 4b(ii) above.

e. In the event a Participant is a continuing care patient receiving a course of treatment from a provider which is a PPO/In-network provider and that provider is terminated, not renewed, or otherwise ends for any reason other than the provider's failure to meet applicable quality standards or for fraud, the Participant shall have the following rights to continuation of care. Note that during continuation, Plan benefits will be processed as if the termination had not occurred, however, the provider may be free to pursue the Participant for any amounts above the Plan's benefit amount.

(i) The Participant shall be notified in a timely manner that the Participant has rights to elect continued transitional care from the provider. If the Participant elects in writing to receive continued transitional care, Plan benefits will apply under the same terms and conditions as would be applicable had the termination not occurred, beginning on the date the Participant was notified of the provider's termination and ending 90 days later or when the Participant ceases to be a continuing care patient, whichever is sooner.

(ii) For purposes of this provision, "continuing care patient" means an individual who:

(A) is undergoing a course of treatment for a serious and complex condition from a specific provider or facility,
(B) is undergoing a course of institutional or Inpatient care from a specific provider or facility,
(C) is scheduled to undergo non-elective surgery from a specific provider or facility, including receipt of postoperative care from such provider or facility with respect to such a surgery,
(D) is pregnant and undergoing a course of treatment for the pregnancy from a specific provider or facility, or
(E) is or was determined to be terminally ill and is receiving treatment for such illness from a specific provider or facility.

SUMMARY OF PRESCRIPTION DRUG BENEFITS
FOR
ACTIVE EMPLOYEE PARTICIPANTS AND NON-MEDICARE ELIGIBLE
RETIREE PARTICIPANTS AND COVERED DEPENDENTS

	30 Day Supply Retail Employee Cost	**90 day Supply Mail or CVS Employee Cost**
Retail and Mail Order Co-Pays		
Generic	$10	$20
Preferred Brand	$30	$48
Non-Preferred Brand	$48	$72
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-Pays (Mail Order or CVS Pharmacy)
Devices	Free Meter Program Only Continuous Glucose Monitor (CGM) without an insulin pump (normal co-pay).** ** Note that the coverage of CGMs paired with an insulin pump and transmitter could be covered under the medical portion of the Plan if the Plan requirements are satisfied. Please contact the Fund office.	
Prescription Vitamins		
Pre-Natal Vitamins	Normal Co-Pays	Normal Co-Pays
Vitamin D	Normal Co-Pays	Normal Co-Pays
Iron	Normal Co-Pays	Normal Co-Pays
Contraceptives		
Oral Medicine	Normal Co-Pays	Normal Co-Pays
Injectable Medicine	Normal Co-Pays	Normal Co-Pays
Patches	Normal Co-Pays	Normal Co-Pays
IUD & Subdermal Implants	20% co-pay	20% co-pay

Vaccinations	
Flu	(*Available August through April*) – 100% coverage 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
Routine	20% Co-Pay when filled or administered at pharmacy (includes: Haemophilus influenzae type B(Hib), Hepatitis A, Hepatitis B, Human Papilloma Virus (HPV), Measles, Mumps, Rubella, Meningococcal, Tdap-Tetanus, diphtheria, pertussis, Tetanus Diphtheria, and Varicella.)
Covid	100% coverage
RSV	Covered under the prescription drug benefit effective 12.14.2023, and subject to a prescription and 20% Co-Pay when filled or administered at pharmacy. (Prior to 12.14.2023, covered under the medical benefit.)
Smoking Cessation Products - 3 months' supply - once yearly for 3 years	
Prescription	Normal Co-pays
Over the Counter	100% coverage with a Medical Prescription. You must present your Medical/RX ID Card to the pharmacist

Prior Authorization

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

You can contact CVS Caremark directly at 1-833-300-2751 to initiate the prior authorization process.

Mandatory Generic Program

Generally, 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 doctor to discuss alternatives. Your doctor may have to provide medical documentation regarding the efficiency of the generic medication and any side effects which are necessitating the change. Sometime, based on the CVS Caremark RX formulary, a Generic drug has a high cost and is excluded from Plan coverage. When that happens, CVS Caremark works to find an alternative. If that occurs, please have your provider contact CVS Caremark.

Maintenance Drugs

Select prescriptions taken on a regular basis for a chronic condition may be considered a maintenance drug. After your 2nd 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 2nd 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 CVS Caremark system will check the medication for step therapy requirements.

Specialty Drugs

Specialty medications are handled under the regular CVS Customer Service number:

1-833-300-2751

Be sure to ask a CVS Customer Service Representative if you are eligible for any of the manufacturer co pay assistance programs.

SUMMARY OF PRESCRIPTION DRUG BENEFITS
FOR
MEDICARE RETIREE PARTICIPANTS WITH
PART A AND PART B MEDICARE PRIMARY COVERAGE

If you are a Medicare Retiree Participant with Part A and Part B Medicare Primary Coverage, you can elect prescription drug benefits which will be provided by RetireeFirst (previously called "LaborFirst"). Please contact RetireeFirst at the phone number below for specific information:

RetireeFirst
(410) 220-0811 or
toll free (833) 265-8651

Current Contact List – January 1, 2025	
Prescription Benefit Manager for Active Employee Participants and Non-Medicare Eligible Retiree Participants Rx Bin#: 004336 PCN: ADV RX GROUP: 24GQ Rx PCN: IRX	CVS Caremark 1-833-300-2751 www.CAREMARK.COM Specialty Drugs are filled through the number listed above.
Prescription Benefit Manager for Medicare Retiree Participants with Part A and Part B Medicare Primary Coverage	RetireeFirst (410) 220-0811 or Toll free (833) 265-8651
Pre-certification/Notification Vendor: Pre-certification is required for all in-patient admissions, out-patient surgical procedures, & out-patient IV-Therapy. Notification is required for dialysis (for ESRD qualifications).	American Health Holding 1-800-641-5566
CareFirst PPO Network: Group #: W29L	CareFirst Network Leasing P. O. Box 14115Lexington KY 40512-4115 www.carefirst.com/1-800-235-5160
Cigna Dental PPO Plus: Group #: 3340404	www.Cignadentalsatafthartley.com 1-800-797-3381
Vision Provider: **National Vision Administrators (NVA)**	www.e-nva.com (800) 672-7723 Username: IUOE99/ Password: vision1
Supplemental PPO: **FIRST HEALTH PPO for active members and pre-Medicare retirees who reside outside the CareFirst PPO Network** Group #: 99 Prefix A52 EDI Payer ID #01066 **To locate First Health providers: 1-800-226-5116***	FIRST HEALTH PPO P.O. Box 26127 Overland Park, KS 66225 www.myfirsthealth.com To locate First Health providers: 1-800-226-5116
* Remember that the list of FirstHealth Participating Providers may change from time to time, with or without notice, and the Member is obliged to confirm with the Participating Provider its participation in the FirstHealth Network.	
Plan Administrator – call for Benefits/Registration and Eligibility and Claim Payment	Decision Science, Inc. – Benefit Fund Office 3615 North Point Blvd., Suite C Baltimore, MD 21222 1-410-254-9595 / 1-800-367-7848
Short-Term Disability Benefits. These are provided Through IUOE Local 99 & 99A Health & Welfare Plan	
Long-Term Disability **Life Insurance** **Accidental Death**	Symetra Benefit Division 777 108th Avenue NE Suite 1200 Bellevue WA 98004-5135 Please Contact the Benefit Fund Office For More Information: 1-410-254-9595 / 1-800-367-7848

Current Trustee List –	
Employer Trustees	**Union Trustees**
Mr. Scott Barlow CEO EML, LLC 998 Elm Hill Pike Nashville, TN 37210 sbarlow@eml1.com	Don Havard, Chairman IUOE Local 99 9315 Largo Drive West – Suite 200 Upper Marlboro MD 20774 Phone: (202) 337-0099 Fax: (202) 625-7982 dhavard@iuoelocal99.org
Ms. Manjula Master CFO EMCOR Government Services 2800 Crystal Dr #600 Arlington VA 22202 mmaster@emcor.net	Steve Ruppert IUOE Local 99 9315 Largo Drive West – Suite 200 Upper Marlboro MD 20774 Phone: (202) 337-0099 Ext: 112 Fax: (202) 924-7093 sruppert@iuoelocal99.org
Mr. Rick Ellis Deputy Program Manager Amentum 1201 M St. SE Washington DC 20003 richard.ellis@amentum.com	Frank Barile IUOE Local 99 9315 Largo Drive West – Suite 200 Upper Marlboro MD 20774 Phone: (202) 337-0099 Fax: (202) 625-7982 fbarile@iuoelocal99.org
The Board of Trustees can be contacted in care of:	Decision Science, Inc. 3615 North Point Boulevard, Suite C Baltimore, MD 21222 Tele: (410) 254-9595 Fax: 410 254 -2016
Decision Science, Inc. is the agent for service of legal process. Service of legal process may also be made upon a plan trustee or the plan administrator.	

SECTION A - GENERAL PROVISIONS

This SPD covers three different groups of participants and their dependents:

(i) The Active Employee Participants
(ii) The Non-Medicare Eligible Retiree Participants
(iii)The Medicare Retiree Participants with Part A and Part B Medicare Primary Coverage

Unless the Summary of Benefits pages state otherwise, the following provisions apply to all Participants and their Dependents covered under this Plan.

1. GENERAL INFORMATION.

A. Rules for Active Employee Participants, including Extended Eligibility Periods.

(i) Definition of Active Employee Participant. Generally, an Active Employee Participant is an employee of a contributing employer who is covered by a collective bargaining unit represented by Local Union 99 for whom employer contributions to the Plan are required.

(ii) Required Employer Contributions for Active Employee Participants. An Employer is required to make contributions in accordance with its collective bargaining agreement, subject to the following special rules:

- Effective on and after January 1, 2021, in the initial month that an Employee is hired or rehired, an Employer is required to provide a monthly contribution to the Plan if the Employee works a minimum of 32 hours for the month. The 32 hour minimum requirement only applies in the initial month of hire or rehire.

- An Employer and an Active Employee Participant are not required to provide a monthly contribution for the six consecutive month period that an Active Employee Participant is receiving disability benefits, beginning with the month following the last month for which required contributions are made on the Active Employee Participant's behalf. If, in the final month of receiving disability benefits, a disabled Active Employee Participant also returns to work, the Employer does not have to remit a premium contribution for such Active Employee Participant if the return to work month is part of the six month suspended premium period.

- Except for the initial month of hire or rehire, an Employer is required to provide a monthly contribution for any month in which an Active Employee Participant works one hour, or incurs a disability which starts on the first day of the month, or has surgery on the first day of the month.

  ** Example: Frank falls off a ladder on Saturday, July 1. His Employer is required to pay the premium for July 1 because Frank is an Active Employee Participant

and on the payroll on July 1 and, but for falling off the ladder, he would have been at work on Monday July 3.

(iii) Disabled Active Employee Participant. If an Active Employee Participant is temporarily disabled and is receiving either Weekly Disability Benefits from the Plan or Workers' Compensation, no contribution needs to be made on his behalf for the six consecutive month period beginning with the month following the last month in which all required contributions were made on the Active Employee Participant's behalf. During the period in which the Active Employee Participant qualifies for the Weekly Disability Benefits under the Plan, the Active Employee Participant (and any Dependents covered prior to the disability) will remain covered under the Plan and receive the same benefits that were provided prior to the disability, including the LTD, AD&D and life insurance benefit.

If the Active Employee Participant is temporarily disabled for longer than six consecutive months, he may continue his health coverage in accordance with the COBRA rules by paying on his own behalf the necessary contributions. See the COBRA Section of the Plan (Section D).

When an Active Employee Participant is disabled due to an occupational injury or illness, he/she must submit a completed physician's statement or other satisfactory proof to be properly credited for the time disabled.

Disabled Active Employee Participants: If you become disabled you may be able to continue your benefits as detailed below during the following periods:

- Up to six months from the date of disability (1st of month after you stopped working) if you remain disabled. Note: insurance benefits (STD, LTD, AD&D and life insurance) continue during this period; and
- Up to two additional months after your six month period expires if you had a two month waiting period when you were initially eligible and you have not used up your two additional month period. Note: AD&D and life insurance continue during this period, but STD and LTD do not continue during the two month extended eligibility period); and
- Your COBRA continuation period for 18 months (if you pay the required premiums). Note that insurance benefits (STD, LTD, AD&D and life insurance) are not available during the COBRA period; and
- Extended COBRA of 11 months if you qualify for Social Security disability and timely notify DSI. Note that insurance benefits (STD, LTD, AD&D and life insurance) are not available during the extended COBRA period. See the COBRA Section of the Plan (Section D).

If an Active Employee Participant incurs successive disabilities, he is eligible for a second six month period for his second disability if he returns to work for at least two weeks and one day between the two disabilities if the two disabilities are related. There is no return to work requirement if the Disability results from a different unrelated incident. Please see the Disability Section C.9 for more information.

(iv) Extended eligibility – If an Active Employee Participant had a two month waiting period at the start of Plan coverage, the employee receives two months of additional eligibility when his employment terminates. Note that during the two month post termination continued eligibility period, STD and LTD are not available.

(v) Continuation during Family and Medical Leave. If you take a leave of absence under the Family and Medical Leave Act of 1993 ("FMLA"), benefits shall continue to be paid under the Plan as if you remained in active employment. Your employer is still required to pay the monthly premium during the FMLA period unless you qualify as having a disability. You will be considered to have terminated your employment on the earliest to occur of:

- the date you notify your Employer that you are not intending to return to work;
- the date you fail to return to employment at the end of leave; or
- the effective date of termination of the Plan.

B. Rules for Non-Medicare Eligible Retiree Participants: A Former Active Employee Participant of a contributing employer to the Local 99 & 99A Health Care Plan who meets the following conditions is eligible to continue to participate under this Plan as a Non-Medicare Eligible Retiree Participant:

- Is age 55 or older. A Participant can satisfy this requirement and reach age 55 while on COBRA coverage at the end of the Participant's working career if the Participant's employment ends for a reason other than the Participant's decision to voluntarily terminate employment.

- Is a member in good standing with I.U.0.E. Local 99 & 99A, which requires timely payment of union dues. This requirement does not apply to Dependents.

- Is receiving or is eligible to receive a pension check from the Central Pension Fund or another employer retirement plan.

- Was previously covered under the Plan as an Active Employee Participant and has not incurred a break in coverage between being an Active Employee Participant and a Non-Medicare Eligible Retiree Participant. COBRA coverage can be used to avoid a break in coverage (i.e., if the Participant has applied for retiree coverage but certain documents are missing).

- Has been covered as an Active Employee Participant under the Plan for five continuous years at the time of retirement. COBRA coverage that is incurred during a Participant's working career will count toward the five year requirement and COBRA coverage incurred at the end of a Participant's working career will count only if the Participant's employment ends for a reason other than the Participant's decision to voluntarily terminate employment. Any time receiving Weekly Disability Benefits also counts towards the five year requirement.

- Self-pays the union dues and the monthly premium at rates specified by the Plan Administration.

C. Rules for Medicare Retiree Participants with Part A and Part B Medicare Primary Coverage:

(1) A Former Active Employee Participants of a contributing employer to the Plan who meets the following conditions is eligible to continue to participate under this Plan as a Medicare Retiree Participant with Part A and Part B Medicare Primary Coverage:

- Is either (i) age 65 or older or (ii) younger than age 65 and qualifies for a Medicare special enrollment rule (i.e., ESRD or disability).

- Is a member in good standing with I.U.0.E. Local 99 & 99A, which requires timely payment of union dues.

- Is receiving or is eligible to receive a pension check from the Central Pension Fund or another employer retirement plan.

- Was previously covered under the Plan as an Active Employee Participant prior to coverage as a Medicare Retiree Participant with Part A and Part B Medicare Primary Coverage and has not incurred any break in coverage between the Active Employee Plan coverage and Plan coverage as a Medicare Retiree Participant with Part A and Part B Medicare Primary Coverage. COBRA coverage can be used to avoid a break in coverage (i.e., if the Participant has applied for retiree coverage but certain documents are missing).

- Has been covered as an Active Employee Participant under the Plan for five continuous years at the time of retirement. COBRA coverage that is incurred during a Participant's working career will count toward the five year requirement and COBRA coverage incurred at the end of a Participant's working career will count only if the Participant's employment ends for a reason other than the Participant's decision to voluntarily terminate employment. Any time receiving Weekly Disability Benefits also counts toward the five year requirement.

- Self-pays the union dues and the monthly premium at rates specified by the Plan Administration.

- Elects and maintains Medicare Part A and Part B coverage.

(2) A former Non-Medicare Retiree Participant who meets the following conditions is eligible to continue to participate under this Plan as a Medicare Retiree Participant with Part A and Part B Medicare Primary Coverage

- Is either (i) age 65 or older or (ii) younger than age 65 and qualifies for a Medicare special enrollment rule (i.e., ESRD or disability).

- Is a member in good standing with I.U.0.E. Local 99 & 99A, which requires timely payment of union dues.

- Is receiving or are eligible to receive a pension check from the Central Pension Fund or another employer retirement plan.

- Self-pays the union dues and the monthly premium at rates specified by the Plan Administration.

- Elects and maintains Medicare Part A and Part B coverage.

Note: The Fund Office will send an annual letter to retirees and ask each retiree to confirm retiree status, and if the retiree is a CPF participant, to confirm that he is receiving the CFP monthly check. The Fund office will audit a few retirees each year and reserves the right to ask for supporting documentation.

Special Rules for Retirees. If an Active Employee Participant:

- stops working prior to age 65, he is eligible to continue Plan coverage as a Non-Medicare Eligible Retiree Participant if he satisfies the requirements in Section A.1.B. Because the Active Employee Participant has terminated employment, when he becomes eligible for Medicare Part A and Medicare Part B, he is required to elect (and pay for) Medicare Part A and Medicare Part B coverage to continue Plan coverage.

- stops working at or over age 65, he is required to elect (and pay for) Medicare Part A and Medicare Part B coverage to be eligible to continue Plan coverage as a Retiree Participant.

Once Medicare Part A and Medicare Part B coverage is in effect, Medicare will become the primary payor of benefits and this Plan will become the secondary payor of benefits. The Plan will follow Medicare guidelines to determine the payment of benefits covered by the Plan.

SECTION A - GENERAL PROVISIONS

2. WHEN IS COVERAGE EFFECTIVE?

A. Effective Date of Coverage for Active Employee Participants.

(i) General Rule is a Two Month Waiting Period: Any Employee hired or rehired will become eligible for coverage as an Active Employee Participant on the first day of the month immediately following a period of two consecutive months for which the established contributions are received.

(ii) Extended Eligibility Period: If two months of contributions are remitted before an Employee becomes eligible for coverage, the Active Employee Participant will remain eligible for coverage for two calendar months after he terminates employment. The two additional month period of Plan coverage is called the "extended eligibility period". Coverage during the two month extended eligibility period shall be at the same level of coverage that existed prior to termination, except as noted in this paragraph. Such Active Employee Participant does not have the option to change his coverage level during the extended eligibility period. During the extended eligibility period, an Active Employee Participant receives all benefits available to Active Employee Participants, including AD&D and Life Insurance, but excluding Short and Long Term Disability.

If the employee is hired by a new employer or rehired by the same employer during the two-month extended eligibility period and works at least 32 hours in the first month or the second month of the two-month extended eligibility period, his termination status will be reversed and his Active Employee Participant coverage will be reinstated. The Active Employee Participant cannot make any changes to his coverage level when coverage is reinstated. Upon a subsequent termination, he will receive the two-month post-termination extended eligibility period. (Note that an employer does not report hours worked to the Fund office. Eligibility is based on whether the employer remitted the premium for the month, absent any notification otherwise.)

If the employee is hired or rehired and works at least 32 hours during the 1st month following the two-month extended eligibility period, his termination status is reversed, and his Active Employee Participant coverage is reinstated as of the first day of such month. The Active Employee Participant cannot make any changes to his coverage level. Upon a subsequent termination, he will NOT receive the two-month extended eligibility period.

(iii) Special Rules: In special situations, the two-month waiting period may be waived when a new Employer Group joins the Plan. When a new Employer Group joins the Plan, only those individuals who qualify as Employees on the date the new Employer Group joins the Plan receive immediate coverage as Active Employee Participants. Subsequent hires of the Employer Group will be subject to the two-month waiting period. If the two month waiting period is waived for a new Employer Group, the

Active Employee Participants of the new Employer Group will not receive the two month post-termination extended eligibility period.

B. Effective date of coverage for Non-Medicare Eligible Retiree Participants: Coverage for a Non-Medicare Eligible Retiree Participant starts the first day of the month after the Active Employee Participant coverage ends if the documentation is submitted on time. (See Section A.3). If the documentation is not submitted on time, you have the option to continue Plan coverage using COBRA to avoid a break in coverage.

C. Effective date of coverage for Medicare Retiree Participants with Part A and Part B Medicare Primary Coverage: Coverage for a Medicare Retiree Participant with Part A and Part B Medicare Primary Coverage starts the first day of the month after the Active Employee Participant coverage ends (or the Non-Medicare Eligible Retiree Participant coverage ends).

SECTION A - GENERAL PROVISIONS

3. **ELECTING COVERAGE AND CHANGING COVERAGE ELECTIONS**.

A. Rules for Active Employees who become Active Employee Participants.

(i) General Rules to Elect Plan Coverage Upon Date of Hire. Once you are hired, you will be asked to complete an enrollment form. If you do not timely complete the enrollment form, you will be treated as having elected single coverage. You will be an Active Employee Participant with single coverage. Unless your collective bargaining agreement provides otherwise, your plan coverage will include medical, prescription, dental, optical, life insurance, AD&D and short and long term disability coverage. Whether you are required to pay for any portion of single or family coverage depends on your employer. Any employee cost share will be determined and collected by your employer.

(ii) Rules to add Dependents when you first become eligible for Plan coverage. In order to elect family coverage, you must:

- timely complete and return the enrollment form to select family coverage (and provide the required documentation); AND
- if your documentation is not sufficient, provide proper verification of the status of your Dependents by providing documents within 60 days of the Fund's request.

If the Fund asks you to provide verification of your Dependents and you do not respond in a timely and complete manner, the Fund has the right to deny or terminate your Dependent coverage. The requested required documentation must be provided within 60 days from the date of the Fund's request. Benefits for Dependents will be suspended pending receipt of documentation deemed adequate by the Plan Administrator.

(iii) Failure to timely add Dependents. If you do not timely elect dependent coverage (see above), you will have to wait until the next annual open enrollment period to add your dependents as of the following January 1st. The only exception would be if you qualify under the Mid-Year Changes discussed below.

(iv) Annual Coverage Changes during Open Enrollment. Once you are covered under the Fund, you will have an annual opportunity to change your coverage. Your existing coverage remains in effect (from year to year) until you make a change.

In the fall of each year, the Fund will allow you to change your existing coverage under the Plan effective as of the following January 1st . To make a change, you need to complete a new registration form and indicate either individual or family coverage. The registration form needs to be sent by mail, fax or uploaded using the information on the registration form. All changes must be **received** by the Fund office by December 31st to be effective the following January 1st. (Note: electronic medium is strongly encouraged.)

If you are changing to family coverage, Dependents must be listed on the registration document. Also include copies of marriage certificates, birth certificates or other information required to establish the validity of a Dependent to receive health coverage. Please contact the Fund Office with questions by calling 1-800-367-7848 or (410) 254-9595 or using the email: registration@dsibenefitfund.org.

You need to also inform your employer of a change in coverage. You may have a payroll deduction for your share of family coverage and your employer can inform you of the amount if any.

(v) Mid-Year Coverage Changes Due to a Change in Family Status. If you have a "Change in Family Status" (as detailed below), you may be allowed to change your health coverage in the middle of a calendar year. If you have a "Change in Family Status" and the Fund is notified of the change within 30 days from the date of the change, you can make a coverage change which will be generally effective the 1st day of the month following the day of the change, except for newborns and adopted children when coverage can be retroactive to date of birth or adoption. Remember: for you to make a mid-year change, you must notify the Fund within 30 days of the date of the change and provide documentation within 60 days of the date of the change.

A "Change in Family Status" could include the following situations if it affects eligibility for coverage:

- A legal marital status change: marriage, death of spouse, and divorce.
- Number of dependents: birth, death, adoption, and placement for adoption.
- Employment status change of the Active Employee Participant or his dependents: a termination or commencement of employment with a minimum two month break, or a commencement of or return from an unpaid leave of absence.
- A dependent ceasing to satisfy the eligibility requirements.

The coverage of the Dependent and/or Employee enrolled during the Change in Family Status will be effective:

- as of the first day of the month after the date the coverage application is received;

- in the case of a Dependent's birth, as of the date of birth; or

- in the case of a Dependent's adoption or placement for adoption, the date of the adoption or placement for adoption.

(vi) Mid-Year Coverage Change Due to Loss of Health Coverage. The Plan gives Active Employee Participants special enrollment rights if the person experiences a loss of other health coverage. Retirees are not eligible for the special enrollment rules due to loss of health coverage. If an Active Employee Participant or his Dependents have a loss of other health coverage, you may be eligible for mid-year special enrollment rights if the following conditions are satisfied and coverage will be effective the first

day of the month following the date a completed enrollment form is received by the Plan:

- You and/or your Dependents were covered under a group health plan or a health insurance policy at the time coverage was offered; and

- You and/or your Dependents stated in writing that you declined coverage due to coverage under another group health plan or health insurance policy. (Note that employees covered under a collective bargaining agreement do not currently have the right to decline Plan coverage); and

- The coverage under the other group health plan or group insurance policy was:

  - COBRA continuation coverage and that coverage was exhausted; or
  - Terminated because the person was no longer eligible for coverage under the terms of that plan or policy; or
  - Terminated and no substitute coverage was offered; or
  - No longer receiving any monetary contribution toward the premium from the employer.

- You or your Dependents must request and apply for coverage under this Plan no later than 30 calendar date after the date the other coverage ended.

- You and/or your Dependents were covered under a Medicaid plan or state health plan and coverage for you or your Dependents was terminated due to loss of eligibility. You must request coverage under this Plan within 60 days after the date of termination of such coverage. or a health insurance policy at the time coverage was offered.

- You and/or your Dependents may not enroll for health coverage under this Plan if health coverage ends because you failed to timely pay the premium, your coverage was terminated for cause because you made a fraudulent claim or an intentional misrepresentation of material fact or you or your Dependent voluntarily canceled the other coverage (unless the current or former employer no longer contributed any money toward the premium).

(vii) Mid-Year Coverage Change when Newly Eligible for Premium Assistance under Medicaid or Children's Health Insurance Program. A federal law provides an Employee and his Dependents with a special enrollment period if the Employee or his Dependents becomes eligible for assistance under this Plan from the Medicaid plan or a state sponsored children's health insurance plan and the Employee requests coverage under this Plan within 60 days after the Employee is determined to be eligible for assistance. The Plan coverage will be effective the first day of the month following an approved request for coverage.

B. Rules for Non-Medicare Eligible Retiree Participants.

(i) General Rules. If you wish to continue coverage in the Fund as a "**Non-Medicare Eligible Retiree Participant",** you should contact the Fund Office at least two weeks before your Active Employee Participant coverage ends and provide the following documentation:

- the completed self-pay rate sheet showing your elected benefits and premium cost (Note that the premium cost varies depending on your years of service. Please see the Plan Administrator for details.) and
- a check for your premium payment and your union dues, and
- a letter from the CPF to confirm you are eligible to receive a pension check or an affidavit to confirm you are retired.

A Non-Medicare Eligible Retiree Participant who retires before January 1, 2024 can select from three retiree coverage levels for the period prior to January 1, 2026: medical coverage; medical and prescription coverage; or medical, prescription, dental and optical coverage.

A Non-Medicare Eligible Retiree Participant who retires on or after January 1, 2024, can select from two retiree coverage levels: medical, dental and optical coverage; or medical, dental, optical and prescription coverage.

As of January 1, 2026, all retirees (regardless of retirement date) can select from two retiree coverage levels: medical, dental and optical coverage; or medical, dental, optical and prescription coverage.

A Non-Medicare Eligible Retiree Participant cannot elect the Life Insurance Benefit, Accident Death and Dismemberment Benefits or Short or Long Term Disability Benefits.

Remember: Coverage under the Plan as a Non-Medicare Eligible Retiree Participant is an option only if Plan coverage is continuous. If you incur a break in coverage (for any reason other than the Retiree Opt-Out), you are not eligible to continue Plan participation.

(ii) Electing Coverage for Dependents. When you elect Plan coverage as a Non-Medicare Eligible Retiree Participant, you can elect to continue coverage for the dependents who were on the Plan when your Active Employee Participant coverage ended (or when your COBRA coverage ended, if later). You cannot add new Dependents to your retiree coverage except newborns and adopted children who are added to the Plan within 30 days from the date of the birth, adoption or placement for adoption.

(iii) Coverage Changes during Open Enrollment. The Plan has an open enrollment period during the fall of each calendar year. During the open enrollment period, you can drop (but not add) Dependents from coverage and change your elected coverage level (based on coverage levels available under the Plan).

(iv) Limited Mid-Year Coverage Changes Due to a Change in Family Status. Mid-year coverage changes are limited as described in this paragraph. If you have a "Change in Family Status", you may remove Dependents from coverage, add newly acquired newborns and adopted children as Dependents, change your elected coverage level (based on coverage levels available under the Plan) or switch from a Non-Medicare Retiree Participant to a Medicare Retiree Participant with Part A and Part B Medicare Primary Coverage.

C. Rules for Medicare Retiree Participants with Part A and Part B Medicare Primary Coverage.

(i) General. If you are an Active Employee Participant or a Non-Medicare Eligible Retiree Participant and wish to continue coverage in the Fund as a Medicare Retiree Participant with Part A and Part B Medicare Primary Coverage, you need to elect Medicare Part A and Part B and contact the Fund at least two weeks before your Plan coverage ends and provide the following documentation:

- the completed self-pay rate sheet showing your elected benefits and your premium cost (Note that the premium cost varies depending on your years of service. Please see the Plan Administrator for details.); and
- a check for your premium payment and your union dues; and
- a letter from the CPF confirming you are eligible to receive a pension check or an affidavit to confirm you are retired; and
- a copy of your Medicare Part A and Medicare Part B card. If you do not have your Medicare Part A and Part B card, please contact the Plan Administrator.

A Medicare Retiree Participant with Part A and Part B Medicare Primary Coverage. who retires prior to January 1, 2024 can select from three coverage levels prior to January 1, 2025: medical coverage; or medical and prescription coverage; or medical, prescription, dental and optical coverage.

A Medicare Retiree Participant with Part A and Part B Medicare Primary Coverage. who retires on or after January 1, 2024 can select from two retiree coverage levels: medical, dental and optical coverage; or medical, dental, optical and prescription coverage.

As of January 1, 2025, all retirees (regardless of retirement date) can select from two retiree coverage levels: medical, dental and optical coverage; or medical, dental, optical and prescription coverage.

A Medicare Retiree Participant with Part A and Part B Medicare Primary Coverage cannot elect the Life Insurance Benefit, Accident Death and Dismemberment Benefits or Short or Long Term Disability Benefits.

If you are switching from coverage as a Non-Medicare Eligible Retiree Participant to coverage as a Medicare Retiree Participant with Part A and Part B Medicare Primary Coverage, you may select a different retiree coverage level based on the coverage levels available under the Plan. As of January 1, 2025 all retiree coverage will be limited to

two coverage levels: medical, dental and optical coverage; or medical, dental, optical and prescription coverage.

Remember: Coverage under the Plan as a Medicare Retiree Participant with Part A and Part B Medicare Primary Coverage is an option only if Plan coverage is continuous. If you incur a break in coverage (for any reason other than the Retiree Opt-Out), you are not eligible to continue Plan participation.

(ii) Coverage of Dependents. When you elect Plan coverage as a Medicare Retiree Participant with Part A and Part B Medicare Primary Coverage, you can elect to continue coverage for the Dependents who were on the Plan when your Active Employee Participant coverage ended (or when your COBRA coverage ended or Non-Medicare Eligible Retiree Participant covered ended, if later). You cannot add new Dependents to your retiree coverage except newborns and adopted children who are added to the Plan within 30 days from the date of the birth, adoption or placement for adoption.

(iii) Coverage Changes during Open Enrollment. The Plan has an open enrollment period during the fall of each calendar year. During the open enrollment period, you can drop (but not add) Dependents from coverage and change your elected coverage level (based on coverage levels available under the Plan).

(iv) Limited Mid-Year Coverage Changes Due to a Change in Family Status. Mid-year coverage changes are limited. If you have a "Change in Family Status," you may remove Dependents from coverage, add newly acquired newborns and adopted children as Dependents or change your elected benefit coverage level (based on the coverage levels available under the Plan).

SECTION A - GENERAL PROVISIONS

4. ONGOING REQUIREMENTS TO MAINTAIN PLAN COVERAGE.

A. Rules for Active Employee Participants.

(i) General Rules. Once you become an Active Employee Participant, there is no requirement to complete a minimum number of hours to maintain your status as an Active Employee Participant, but you must remain an "active employee". An "active" Employee is an Employee (a) who is employed with a contributing employer (which means you do not have a termination date reported on the monthly list submitted to the Third Party Administrator by the contributing employer), (b) who is represented by the Union and (c) for whom the Trust Fund timely receives monthly contributions, subject to the terms of the Delinquency Collection Procedure.

(ii) Special Rules:

- A furloughed Employee receiving pay and/or benefits is considered employed and an active Employee.

- A furloughed Employee receiving no pay or benefits is not considered an active Employee.

- An Employee who is not working but is receiving disability benefits is considered employed and an Active Employee Participant for the duration of the period in which he qualifies for the weekly disability benefit income under the Plan. During that period, the Active Employee Participant will remain covered under the Plan, receiving the same Benefits that were provided prior to his Disability and Plan coverage will continue for the same Dependents covered prior to this Disability. An Active Employee Participant is deemed to have a Disability for a maximum period of six months if the Participant is receiving weekly disability benefit income or Workers Compensation. Note: If you qualify for Extended Eligibility, the two months of extended eligibility will be added to the end of the six month disability period and during the two month extended eligibility period, coverage for STD and LTD will not be provided.

B. Rules for Non-Medicare Eligible Retiree Plan Participants: Your coverage will continue as long as you timely pay both your monthly premium under this Plan and your union dues and timely respond to the annual Fund mailing to confirm your retiree status. Your monthly premiums to this Plan must be paid prior to the first day of the month of coverage. For example, the November premium must be paid by October 31.

C. Rules for Medicare Retiree Participants with Part A and Part B Medicare Primary Coverage: Your coverage will continue as long as your elect and maintain Medicare Part A and Part B coverage and you timely pay both your monthly premium under this Plan and your union dues and timely respond to the annual Fund mailing to confirm your retiree status. Your monthly premiums to this Plan must be paid prior to the first day of the month of coverage. For example, the November premium must be paid by October 31.

SECTION A - GENERAL PROVISIONS

5. TERMINATION OF COVERAGE.

If the Fund asks you to provide verification of your Dependents and you do not provide all the requested information within 60 days, the Fund has the right to terminate your Dependent coverage.

A. Rules for Active Employee Participants.

(i) All coverage to which an Active Employee Participant and his Dependents are entitled will be terminated on the last day of the month in which the first of the events listed below occurs, subject to COBRA coverage rights and the rules for termination for fraud and intentional misrepresentation set forth in Section A.5.D. The Trustees have the right to terminate your coverage under this Plan on the last day of the month in which the first of the following events occur:

- The later of (i) the date you work your final hour for a contributing employer who is a party to the collective bargaining agreement with the Union or (ii) the date you are reported as a terminated employee by a contributing employer who is a party to the collective bargaining agreement with the Union.

- The date a furloughed Employee ceases to receive pay and benefits from a contributing employer who is a party to the collective bargaining agreement with the Union.

- You are no longer eligible for coverage.

- You or your Employer do not timely make a required contribution.

- The Plan is terminated.

- Your Dependent no longer qualifies as a Dependent.

- Your Dependent coverage can terminate if you do not respond within 60 days to a Plan audit or information request.

- Your Prescription Drug benefit can terminate if, in the opinion of the Plan's Medical Consultant, you are abusing your benefit.

- Your six month period of Disability coverage ends and you do not return to work.

(ii) Coverage Termination if Employer fails to pay premiums. In the event that an Employer or group of Employers ceases to contribute or participate in the Local 99 and 99A Health and Welfare Trust Fund, for reasons other than cessation of operation, the Trustees have the right to terminate the eligibility of Active Employee Participants employed by such Employer(s), and their Dependents, upon the date that their Employer shall cease to contribute to or participate in the Fund. If the Trustees decide

to exercise their right, such termination of coverage for Employees and their Dependents shall be without regard to whether the initial eligibility of such Employees had commenced immediately upon contributions being made on their behalf or had commenced following a two month period of contributions being made on their behalf.

B. Rules for Non-Medicare Eligible Retiree Participants.

(i) All coverage to which a Non-Medicare Eligible Retiree Participant and his Dependents are entitled will be terminated on the last day of the month in which the first of the events listed below occurs, subject to the COBRA coverage rights and the rules for termination for fraud and intentional misrepresentation set forth in Section A.5.D. The Trustees have the right to terminate your coverage under this Plan on the last day of the month in which the first of the following events occur:

- You are no longer eligible for coverage.
- You fail to timely pay either your monthly premium under this Plan or your union dues.
- The Plan is terminated.
- Your Dependent no longer qualifies as a Dependent.
- Your Dependent coverage can terminate if you do not respond within 60 days to a Plan audit or information request.
- Your Prescription Drug benefit can terminate if, in the opinion of the Plan's Medical Consultant, you are abusing the benefit.
- If you elect the Retiree Opt-In to reinstate your Plan coverage and do not provide information within 30 days of the termination of the prior coverage, your coverage will not be reinstated.

C. Rules for Medicare Retiree Participants with Part A and Part B Medicare Primary Coverage.

(i) All coverage to which a Medicare Retiree Participant with Part A and Part B Medicare Primary Coverage and his Dependents are entitled will be terminated on the last day of the month in which the first of the events listed below occurs, subject to the COBRA coverage rights and the rules for termination for fraud and intentional misrepresentation set forth in Section A.5.D. The Trustees have the right to terminate your coverage under this Plan on the last day of the month in which the first of the following events occur:

- You do not maintain your Medicare Part A and Part B coverage.
- You are no longer eligible for coverage.

- You fail to timely pay either your monthly premium under this Plan or your union dues.

- The Plan is terminated.

- Your Dependent no longer qualifies as a Dependent.

- Your Dependent coverage can terminate if you do not respond within 60 days to a Plan audit or information request.

- Your Prescription Drug benefit can terminate if, in the opinion of the Plan's Medical Consultant, you are abusing the benefit.

- If you elect the Retiree Opt-In to reinstate your Plan coverage and do not provide information within 30 days after the termination of the prior coverage, your coverage will not be reinstated.

D. Coverage Termination for Fraud or Intentional Misrepresentation.

The Trustees have the right to rescind any coverage of an Active Employee Participant, Non-Medicare Eligible Retiree Participant or Medicare Retiree Participant with Part A and Part B Medicare Primary Coverage and/or their Dependents for making a fraudulent claim or an intentional material misrepresentation in applying for or obtaining coverage or obtaining benefits under the Plan. The Trustees may either retroactively void Plan coverage for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Trustee's discretion, or may immediately terminate coverage. If coverage is to be terminated or voided retroactively for fraud or misrepresentation, the Plan will provide at least 30 days' advance written notice of such action. The Trustees will refund all contributions paid for any coverage rescinded if required by law; however, claims paid will be offset from this amount. The Trustees reserve the right to collect additional monies if claims are paid in excess of the contributions paid by the Active Employee Participant, Non-Medicare Eligible Retiree Participant or Medicare Retiree Participant with Part A and Part B Medicare Primary Coverage and/or Dependent.

SECTION A - GENERAL PROVISIONS

6. SPECIAL RETIREE RULES.

A. Retiree Coverage Opt-Out and Opt-In Rights. Note that Retiree Coverage Opt-Out and Opt-In Rules do not vest and may be amended by the Trustees from time to time.

(i) Retiree Opt-Out Right.

(A) The Plan permits the following individuals to have a one-time opportunity (called a "Opt-Out Right") to temporarily stop retiree coverage under the Plan if the individual becomes enrolled in an "alternative employer group health plan" and provides timely documentation of such coverage:

- An Active Employee Participant who is eligible to become a Non-Medicare Eligible Retiree Participant or a Medicare Retiree Participant with Part A and Part B Medicare Primary Coverage;
- A Non-Medicare Eligible Retiree Participant;
- A Medicare Retiree Participant with Part A and Part B Medicare Primary Coverage; and
- Their Dependents.

(B) An "Alterative Employer Group Health Plan" is an employer group health plan which provide coverage that is primary to all other coverages, including Medicare. The following health plans do not qualify as an "Alternative Employer Group Health Plan":

- Coverage under Medicare;
- Coverage under an individual health plan; and
- Coverage under a spouse's group health plan if the spouse's group health plan coverage is secondary to Medicare.

(ii) Process to Exercise Retiree Opt-Out Right.

(A) A Participant or Dependent who wishes to exercise his Opt-Out Right must provide documentation to the Plan's third party administrator of the Alternative Employer Group Health Plan coverage. Such documentation must be provided within 60 days before the date Plan coverage is to stop.

- If adequate documentation is timely provided, Plan coverage will stop as follows:

  If a Participant elects to exercise his Opt-Out Right, Plan coverage for the Participant and all Dependents will stop (subject to reinstatement) and the Participant and his Dependents will be treated as having used their one Opt-Out Right.

If a Dependent elects to exercise his Opt-Out Right, Plan coverage for the Dependent will end (subject to reinstatement) and only the Dependent will be treated as having used his Opt-Out Right.

- If adequate documentation is not timely provided, the third party administrator will bill the Participant for Plan coverage and if the bill is not paid within 30 days, Plan coverage will be terminated with no possibility of reinstatement. The Participant or Dependent will not be able to reinstate Plan coverage.

(B) A Participant or Dependent on COBRA does not have Opt-Out Rights.

(iii) Process to Exercise Plan Coverage Opt-In (Reinstate) Right.

(A) The Participant or Dependent who wishes to exercise his Opt-In Right and resume Retiree Plan coverage must provide documentation to the Plan's third party administrator of coverage under an Alternative Employer Group Health Plan during the period which starts on the date the Plan coverage ended through the date his Plan coverage is to be reinstated. The Participant or Dependent must notify the Plan at least 30 days before the Plan coverage is to be effective. Once the Plan is notified, an enrollment form must be completed and the required premium must be paid. The Participant or Dependent must also establish that he has not had a break in coverage. Such documentation must be provided within 30 days after the termination date of the prior coverage for Plan coverage to resume.

(B) If adequate documentation is timely provided, Plan coverage will resume as follows:

(I) If a Participant had retiree Plan coverage for at least two months before he exercised his Opt-Out Right, his prior retiree coverage will be reinstated (if it is a retiree coverage level offered under the Plan at the time of reinstatement) and Plan coverage will be extended to the Dependents who were covered at the time he opted out of Plan coverage, if those individuals continue to qualify as Dependents. A Dependent has the option to extend the opt out period and elect to Opt-In to Plan coverage at a later date.

(II) If a Participant did not have retiree Plan coverage for at least two months before he exercised his Opt-Out Right, his Plan coverage will be reinstated at the lowest coverage level possible and when coverage is reinstated and he will <u>not</u> be able to cover any Dependents, except for newborn children and adopted children to the extent required by law. The Participant can change his coverage level at Open Enrollment or at a Change in Family Status but cannot add Dependents, except for a newborn or adopted child at Open Enrollment or at a Change in Family Status.

(III) If a Dependent exercises his Opt-Out Right and then elects to opt-in to retiree Plan coverage, the Dependent is able to do so only if the Dependent continues to qualify as a Dependent under the Plan, the Dependent's Participant has

current Plan coverage, and if the Dependent's Participant exercised his Opt-Out Right after having had retiree Plan coverage for a minimum period of two months. If those requirements are not satisfied, the Dependent cannot resume Plan coverage.

(C) If a Participant or Dependent does not provide at least 30 days' notice of an Opt-In request, and provide the required documentation within 30 days of the termination date of the prior coverage, Plan coverage will not resume.

B. Rules for Retiree Coverage for Surviving Dependents.

(i) If a Participant dies after Retiree Plan coverage is effective, the surviving spouse can remain in the retiree Plan (by timely paying the required premiums), but the surviving spouse and Dependents do not have an Opt-Out Right and an Opt-In Right.

(ii) If a Participant qualifies to become a Non-Medicare Retiree Participant or a Medicare Retiree Participant with Part A and Part B Medicare Primary Coverage, but dies before the retiree Plan coverage is effective, the surviving spouse can elect to be covered under the Retiree Plan as a survivor (with Dependents who were on the Plan) and self-pay the required premiums if the surviving spouse:

- Is age 55 or older;
- Was covered under the Plan at the time of the Participant's death;
- Is receiving or is eligible to receive a survivor annuity from the Central Pension Fund or another employer retirement plan;
- Has been covered as a Dependent of an Active Employee Participant under the Local 99 & 99A Health Care Plan for five continuous years at the time of the Participant's death. Except as detailed in the next sentence, any COBRA coverage period does not count to satisfy the five year requirement, but can be used to avoid a break in coverage (i.e., if the Participant has applied for retiree coverage but certain documents are missing). COBRA coverage that is incurred during a Participant's working career will count toward the five year requirement and COBRA coverage incurred at the end of a Participant's working career will count only if the Participant's employment ends for a reason other than the Participant's decision to voluntarily terminate employment;
- Self-pays the monthly premium at rates specified by the Plan Administrator;
- Elects and maintains Medicare Part A and Part B coverage if requesting coverage as a Medicare Retiree Participant with Part A and Part B Medicare Primary Coverage;
- Is not eligible for any employer-provided group coverage elsewhere, regardless of the cost or coverage level; and
- Does not remarry.

SECTION A - GENERAL PROVISIONS

7. DEFINED TERMS.

Included below are certain defined terms which are used throughout this document. If a term is capitalized in this document but not defined, the definition in the Plan document governs. Please ask to see a copy of the Plan document.

Active Employee. An "***Active Employee***" is a current Employee who is regularly employed by an Employer. An individual on COBRA is not an Active Employee.

Active Employee Participant. An ***"Active Employee Participant"*** is generally an employee of a contributing employer who is covered by a collective bargaining unit represented by the Union for whom employer contributions to the Plan are required. See Section A.1.

Ancillary Services. "Ancillary Services" mean:

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

(b) Items and services provided by assistant surgeons, hospitalists and intensivists;

(c) Diagnostic services, including radiology and laboratory services; and

(d) items and services provided by a nonparticipating provider if there is no participating provider who can furnish such item or service at such facility**.**

Benefits. "Benefits" under the Plan may include the Medically Necessary benefits as outlined in Section C and such other insured and non-insured health and welfare benefits as may be selected by the Trustees. 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 payable to an out of network provider shall not exceed the "Charges" for such services which is defined below as the usual, customary and reasonable fee for such services.

Change in Family Status. The term *"**Change in Family Status***" for an Active Employee Participant is any of the events below if it affects eligibility for coverage:

(a) A legal marital status change: marriage, death of spouse, and divorce.

(b) Number of dependents: birth, death, adoption, and placement for adoption.

(c) Employment status change of the Active Employee Participant or their dependents: a termination or commencement of employment, a commencement of or return from an unpaid leave of absence, and a change in worksite.

(d) A dependent ceasing to satisfy the eligibility requirements.

Charges. The term ***"Charge"*** or ***"Charges"*** means the usual, customary and reasonable fees for payment for services rendered or items purchased for Medically Necessary Benefits payable under the Plan as follows:

(a) ***Usual*** means the fee that is usually charged for a given service by a physician to his or her private patient (*i.e.*, his or her own usual fee).

(b) ***Customary*** means the fee within the range of usual fees charged by physicians of similar training and experience for the same service within the same specific and limited geographical area.

(c) ***Reasonable*** means the fee which meets the definitions for both usual and customary, or in the opinion of the responsible medical association's review committee, is justifiable considering the special circumstances of the particular case in question.

In the case of a benefit or service covered by this Plan and Medicare, the term "Charge" or "Charges" for a Medicare Retiree Participant with Part A and Part B Medicare Primary Coverage, is the Medicare Allowed Benefit. There are special rules for Charges for the No Surprises Act and Out-Of-Network Providers. Please see the Plan Administrator.

Excessive charges will be the responsibility of the Participants or Dependents. The Plan Administrator and/or the Plan's Board of Trustees shall determine the amount which is usual, customary and reasonable based on a review and analysis of currently available documentation and data as deemed necessary under the circumstances.

Co-insurance. The term "***Coinsurance***" or ***"Co-insurance"*** means the percentage of the Charges allocated between the Plan and the Participant.

Copayment (Co-pay). The term "***Copayment***" or "***Co-pay***" or ***"Co-payment"*** means the fixed dollar amount that a Participant pays each time certain services are rendered. Copayments do not apply toward satisfaction of the Deductible. Copayments and the deductible do not apply to satisfy the in-network and out of network out of pocket maximums.

Dependent. The term ***"Dependent"*** may include the following individuals, depending upon the coverage elected by the Participant: the Participant's Spouse (if not divorced) and each child of the Participant who has not attained his or her twenty-sixth (26^{th}) birthday. Except in the case of a disabled child who satisfies the requirements in either paragraphs (e) or (f) below, Benefits will be provided for each child until the end of the month in which he or she turned twenty-six (26). After such time, eligibility for additional Benefits will cease. For purposes of this definition, a child shall include:

(a) a natural biological child;

(b) a legally adopted child;

(c) a child placed with a Participant for adoption;

(d) a child for whom the Participant serves as a legal guardian (i) if documented in a court order which is presented to the Plan Administrator prior to the effective date of Dependent Coverage, (ii) if the child permanently resides in the household of which the Participant is the head and (iii) if the child is actually being supported solely by the Participant; or

(e) any unmarried child age twenty-six (26) or over who is incapable of self-support because of a physical or mental incapacity that commenced prior to such child's attaining the age of twenty-six (26) and who is dependent upon the Participant for support, provided that proof of such child's incapability is furnished to the Plan Administrator no later than thirty (30) days after the child attains the maximum age limit and the child was listed as a Dependent prior to age twenty-six (26). Proof of the continued existence of such incapacity may be requested by the Plan Administrator from time to time, and subject to the Plan Administrator's determination.

(f) any unmarried child age twenty-six (26) or over who is incapable of self-support because of a mental or physical incapacity that commenced prior to such child's attaining the age of twenty-six (26) and who is dependent upon the Participant for support, but proof of such child's incapability was not furnished to the Plan Administrator within thirty (30) days after the child attained the maximum age limit and the child was not listed as a Dependent prior to age twenty-six (26), if the following requirements are satisfied:

(i) The Participant and child have been continuously covered for at least five years under a health plan provided by an employer who has a collective bargaining agreement with the Union;

(ii) The Participant and the child have not incurred a break in coverage between the prior health plan and this Plan; and

(iii)The Participant's employer negotiated a group transfer so its employees become Plan participants simultaneously.

If these requirements are satisfied, and timely documentation is provided to the Administrator, coverage for the child will commence when coverage is effective for the transferred group. Coverage will remain available as long as the Participant has continuous coverage and provides periodic proof of the continued incapacity as requested by the Plan Administrator from time to time, and subject to the Plan Administrator's determination.

If an individual is classified as a Dependent because he is disabled and satisfied the requirements in paragraphs (e) or (f) above, he is eligible for Dependent coverage beyond age twenty-six (26).

(f) a stepchild if a Participant timely provides the following documentation:
(i) A marriage certificate confirming the marriage of the Participant and spouse;
(ii) Two years of federal income tax returns showing the stepchild is claimed as a dependent of the Participant or the Participant's spouse (the biological parent); and
(iii) Two years of health plan coverage for the stepchild.

Note that if the Plan coves a stepchild and the Participant divorces the stepchild's biological parent, the stepchild will cease to be a dependent under the Plan.

Legal documentation of a decree or pending proceeding to establish a Participant's status as a legal guardian of a child must be presented to the Plan Administrator before the child will be considered a Dependent of the Participant.

Newborn children shall be eligible as Dependents for Benefits under the Plan from the date of birth. You have 30 days to change your coverage level to include a newborn child. The 30 day period is measured from the date of birth and the day the newborn is born counts as a full day regardless of the time the child is born on that day.

If a Participant has no Dependents on the day he or she becomes eligible for benefits provided herein, his or her Dependent Benefits will become effective upon the date he or she does have an eligible Dependent, provided that the Participant is then still eligible for benefits and the Participant adds the Dependents during an Open Enrollment period or within 30 days of a Dependent's birth, adoption or placement for adoption. Notwithstanding the above, any child of a Participant who is named as an Alternate Recipient in a Qualified Medical Child Support Order shall be deemed to be Dependent during the period to which the Qualified Medical Child Support Order applies.

Special Rule for Members who Qualify as a Participant and a Dependent.
An individual who is entitled to Benefits as a Participant will not also be treated as a Dependent under this Plan. This means if Frank, a Participant, and his spouse Dana are working and receiving benefits under the Plan, the Plan will pay 80% of Frank's claim because Frank (Participant) is covered as a member. The Plan will not pay the remaining 20% of his claim because Frank is also covered as the Dependent of his spouse Dana.

Special Rule for Members who work for multiple employers covered by the Plan. The Plan will not coordinate benefits against itself. The Plan will not pay 80% of a claim because you work for employer A and the remaining 20% of a claim because you work for employer B.

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. The Plan does not provide coverage for ex-spouses (except for the COBRA period) regardless of the terms of a court order.

Disability. "Disability" means you are unable to perform each and every duty pertaining to your regular job because of an illness or accidental injury or are unable to perform a light duty reasonable accommodation job.

Emergency Services. "***Emergency Services***" means a medical evaluation, examination and treatment to stabilize a Participant experiencing an emergency medical condition (including a Mental Health condition) resulting in acute symptoms of sufficient severity (including severe pain)

such that a prudent layperson, who possess an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

(a) Placing the health of the individual (or with respect to a pregnant women, the health of the woman or her unborn child) in serious jeopardy; or

(b) Serious impairment to bodily functions; or

(c) Serious dysfunction of any bodily organ or part.

Employee. An ***"Employee"*** means:

(a) any person who is represented by the Union and who is working for an Employer, or any other person working for an Employer for whom contributions are made to the Trust Fund;

(b) an officer or employee of the Union who shall have been proposed for benefits under the Trust Fund by the Union and who shall have been accepted by the Trustees and for whom the Union agrees in writing to contribute to the Trust Fund at the rate fixed for contributions for other Employers;

(c) a full-time Employee of an Employer who is represented by the Union and on whose behalf such Employer is required to make payments or contributions to the Trust Fund at a rate fixed for other Employers; or

(d) a person represented by or under the jurisdiction of the Union, who shall be employed by a governmental unit or agency, and on whose behalf payment of contributions shall be made at the time and at the rate of payment equal to that paid by an Employer, in accordance with a written agreement, ordinance or resolution.

Employer. An ***"Employer"*** means:

(a) an employer (1) which is in good standing with the state in which it was formed or incorporated, (2) which has duly executed or is bound by a collective bargaining agreement with the Union providing for the making of payments to the Trust Fund with respect to employees represented by the Union and (3) effective on and after January 1, 2015, has two or more employees for at least three consecutive months in each Plan Year. Notwithstanding the foregoing, an existing Employer as of December 31, 2014 is grandfathered and not subject to the third requirement in this paragraph until its existing collective bargaining agreement is renewed;

(b) the Union, which for the purpose of making the required contributions to the Trust Fund, shall be considered as the Employer of the Employees of the Union for whom the Union contributes to the Trust Fund; or

(c) an employer which does not meet the requirements in paragraph (a) or (b), but which is required to make payments or contributions to the Trust Fund by any law or ordinance applicable to the District of Columbia and the surrounding states, or to any political

subdivision, corporation thereof or pursuant to any written agreement entered into by such employer with such state or any political subdivision or municipal corporation thereof.

(d) Employers as described in this Section shall, by the making of payments to the Trust Fund pursuant to such collective bargaining or other agreements, be deemed to have accepted and be bound by the Trust Agreement.

Extended Care/Skilled Nursing Facility. An ***"Extended Care/Skilled Nursing Care Facility"*** means an institution which is primarily engaged in providing skilled nursing care, or extended care, and related services or rehabilitative services to residents.

Fund. The term "Fund" means the Plan.

Hospice. The term ***"Hospice"*** means a facility, agency or service that:

(a) is licensed, accredited or approved by the proper regulatory authority to arrange, coordinate and/or provide programs to meet the special physical, psychological and spiritual needs of dying individuals (including terminally ill individuals) and their families (collectively "Hospice Care Services"); and

(b) maintains records of Hospice Care Services that are provided and bills for such services on a consolidated basis.

Hospital. The term ***"Hospital"*** means:

(a) a legally operated institution which is accredited by the Joint Commission on the Accreditation of Health Care Organizations;

(b) a hospital, psychiatric hospital, or a tuberculosis hospital, as those terms are defined in the Medicare Laws, which is qualified to participate and eligible to receive payments under and in accordance with the provisions of Medicare;

(c) an institution which fully meets all of the following tests: (1) it maintains on the premises diagnostic and therapeutic facilities for surgical and medical diagnosis and treatment of sick and injured persons by or under the supervision of a staff of Physicians, and (2) it continuously provides on the premises twenty-four (24) hours a day nursing service by or under the supervision of registered graduate nurses, and (3) it is operated continuously with organized facilities for operative surgery on the premises; or

(d) for purposes of substance abuse treatment, the term "Hospital " also includes a legally operated institution which is accredited by the Commission on Accreditation of Rehabilitation Facilities ("CARF Accreditation").

The term ***"Hospital"*** does not include a nursing home or any part of an institution which (1) is primarily a facility for convalescence, nursing, rest, or (2) furnishes primarily domiciliary or custodial care, including training in daily living routines, or (3) is operated as a school.

Medically Necessary. The term ***"Medically Necessary"*** means services which are:

(a) appropriate medical treatment for the Participant's or Dependent's condition;

(b) expected to provide benefits that outweigh the potential risks; and

(c) necessary to protect or restore the physical health and/or necessary to protect or restore the mental or physical health of the Participant or Dependent. The determination of what services are Medically Necessary shall be made by the Plan or an agent designated by the Trustees under the Plan. In the event of any conflict of opinion between the Plan and the provider of care, the decision made by the Plan (or its agents) in its discretion shall be final.

The Plan will generally consider a Cardiac CT scan to be Medically Necessary in the following cases:

(i) where a diagnosis of chest pain exists;

(ii) where the patient has a family history of heart disease but not current symptoms;

(iii) in cases where the test is being done as a pre-operative assessment for a planned non-coronary surgical procedure; or

(iv) in cases for persons under 30 who have suggestive symptoms (*e.g.*, angina, syncope and arrhythmia, failure to thrive, etc.).

Medicare Allowed Benefit. The "***Medicare Allowed Benefit***" for a service covered by Medicare, is the lesser of the actual charge or the amount set by Medicare based on the Medicare guidelines.

Medicare Co-insurance. The "***Medicare Co-insurance***" is the portion of the Medicare Allowed Benefit that is remaining after Medicare pays its portion of the Medicare Allowed Benefit.

Medicare Part A. **(HOSPITAL COVERAGE). "*Medicare Part A*"** covers inpatient hospital stays, care in a skilled nursing facility, hospice care, and some home health care.

Medicare Part B. **(MEDICAL INSURANCE). "*Medicare Part B*"** covers medical services and supplies that are medically necessary to treat your health condition. This can include outpatient care, preventive services, ambulance services, and durable medical equipment.

Medicare Retiree Participant with Part A and Part B Medicare Primary Coverage. A **"*Medicare Retiree Participant with Part A and Part B Medicare Primary Coverage*"** satisfies all criteria of the Plan to continue coverage and has elected and is paying for both Medicare Part A and Part B coverage.

Mental Health Benefits. Mental Health Benefits means services to treat a variety of medical conditions, including substance use disorder benefits. ***"Mental Health Benefits"*** are included under the rules for Basic Medical Expenses and are not separately stated as a category of Benefits.

Non-Medicare Eligible Retiree. A "***Non-Medicare Eligible Retiree***" satisfies all criteria of the Plan to continue coverage but has not reached the age to be eligible for Medicare or has not incurred a condition which entitles him to Medicare.

Participant. The term ***"Participant"*** means a current Employee who is an Active Employee Participant, or a former Employee who makes an election to continue coverage either as a Non-Medicare Eligible Retiree Participant or a Medicare Retiree Participant with Part A and Part B Medicare Primary Coverage or through COBRA. The rights of a Participant under the Plan and the Benefits to which he is entitled are personal to such individual and are not assignable to any provider or anyone else.

Plan. The term "***Plan***" means the Health and Welfare Plan and Trust for the International Union of Operating Engineers Local 99 and 99A.

Plan Year. The term ***"Plan Year"*** means the twelve-month period ending on December 31st.

Retiree Coverage and Retiree Opt-Out. Once you qualify for retiree coverage, you are subject to the provisions of the SPD that is specific to retirees. There are special retiree provisions discussed in Section A.6. Please see the Administrator for more details.

Retiree Participant. The term ***"Retiree Participant"*** means a former Employee who makes an election to continue coverage either as a Non-Medicare Eligible Retiree Participant or a Medicare Retiree Participant with Part A and Part B Medicare Primary Coverage or through COBRA. The rights of a Retiree Participant under the Plan and the Benefits to which he is entitled are personal to such individual and are not assignable to any provider or anyone else.

Spouse. The term "***Spouse***" is a person who is legally married to a Participant pursuant to a license issued in accordance with the laws of the state in which the marriage was conducted and could include a person validly married to a Participant of the same sex. The Plan does not recognize a common law marriage, even if such partnership is recognized as a legal marriage in the state in which the couple resides. An eligible Dependent does not include an individual from whom a Participant or Dependent has obtained a divorce.

Union. The term "***Union***" means the International Union of Operating Engineers Local 99 and 99A

SECTION B: THE MEDICAL PLAN - SUMMARY OVERVIEW

1. How the Medical Plan Works

Generally, Basic Medical Benefits are paid according to the Summary of Benefits set forth in the front of this Summary Plan Description. This SPD covers three different groups of Participants and their Dependents:

(i) The Active Employee Participants;
(ii) The Non-Medicare Eligible Retiree Participants; and
(iii)The Medicare Retiree Participants with Part A and Part B Medicare Primary Coverage.

There is one Summary of Benefit schedule in the front of this book, with different columns for each different group of participants.

In some cases, the scheduled payment is not intended to cover the full cost of all of your medical care. Therefore, the Medical Plan provides Primary Major-Medical Benefits as well.

There is no Basic Medical Benefit for treatment for chiropractic care or acupuncture. These expenses are covered only under the Secondary Major-Medical Benefit.

2. Usual, Customary and Reasonable Charges

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

The Medical Plan pays all or a percentage of the necessary, usual, customary and reasonable charge, depending upon the treatment or service provided. Please refer to the Summary of Benefits for specific details. Some doctors or physicians charge more than the usual, customary and reasonable amount or perform services that are not Medically Necessary. If your doctor or physician does so, you will have to pay your deductible and those excess fees.

3. No Vesting of Benefits

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

SECTION C: THE MEDICAL PLAN – DETAILED EXPLANATION

1. How the Medical Plan Works

Six Parts of the Medical Plan. The Medical Plan is divided into six parts as explained below. Because this Plan covers three different groups of participants and their dependents (see below), the available coverage for each group is different:

(i) The Active Employee Participants
(ii) The Non-Medicare Eligible Retiree Participants
(iii) The Medicare Retiree Participants with Part A and Part B Medicare Primary Coverage

Active Employee Participants generally receive coverage under all six parts of the Medical Plan. The Non-Medicare Eligible Retiree Participants and the Medicare Retiree Participants with Part A and Part B Medicare Primary Coverage have to elect (and pay for) their coverage and they cannot elect to be covered under the Insurance Benefits.

		Benefit coverage available to:		
	Type of benefit	**Active employee Participants**	**Non-Medicare Eligible Retiree Participants***	**Medicare Retiree Participants with Part A and Part B Medicare Primary Coverage***
1.	Basic Medical Benefit	Yes	Yes, if medical coverage is elected	Yes, if medical coverage is elected
2.	Secondary Major-Medical Benefit	Yes		
3.	Prescription Drug Benefit	Yes	Yes, if prescription drug coverage is elected	Yes, if prescription drug coverage is elected
4.	Dental/Orthodontic Benefit (Orthodontic Benefits are available only for a dependent child.)	Yes	Yes, if dental/orthodontic coverage is elected	Yes, if dental/orthodontic coverage is elected
5.	Optical Expense Benefit	Yes	Yes, if optical coverage is elected	Yes, if optical coverage is elected
6.	Insurance Benefits (Life, AD&D, STD and LTD)	Yes	No	No

*Note that effective on and after January 1, 2025, all retirees will be offered two levels of retiree coverage: medical, dental and optical coverage; or medical, dental, optical and prescription coverage.

1. The Basic Medical Benefit covers basic medical services like inpatient hospital care, outpatient hospital care, surgical care, anesthesia charges, doctors' or physicians' services, diagnostic laboratory and x-ray examinations, mental health benefits, home health care, well baby care, extended care/skilled nursing care, hospice care, orthotics, and other miscellaneous services.

2. The Secondary Major-Medical Benefit provides coverage for chiropractic care and treatment by acupuncture, subject to the tax law limitations.

3. The Prescription Drug Benefit provides prescription drug coverage for Participants and their Dependents.

4. The Dental/Orthodontic Benefit helps defray part of the cost of a wide range of dental services, including orthodontics for Dependent children.

5. The Optical Expense Benefit provides coverage for vision care.

6. The Life, Accident and Disability Benefit provides Life Insurance, Accident Insurance, a Weekly Disability benefit for temporarily disabled ill or injured Participants and a Long Term Disability Benefit for totally disabled ill or injured Participants.

***** ***Items 1-5 are available to Active Employee Participants, Non-Medicare Eligible Retiree Participants and Medicare Retiree Participants with Part A and Part B Medicare Primary Coverage. Non-Medicare Eligible Retiree Participants and Medicare Retiree Participants with Part A and Part B Medicare Primary Coverage must elect coverage under Items 1-5 at retirement or open enrollment. Item 6 applies to Active Employee Participants only***.

2. Special Rules for Non-PPO charges.

Charges incurred by a Participant or Dependent through a non-PPO Provider may be processed as though the Charges were incurred by a PPO provider if, if the determination of the Plan's third-party administrator, there is either an emergency situation or the selection of the service provider is beyond the member's control. In those situations, the Participant will be required to pay the annual deductible and the co-pay applicable to a PPO provider. The Charges will not be subject to the "usual, customary and reasonable" standard but will be subject to a rate negotiated between the Plan and the provider of services.

SECTION C.3.(B)-Basic Medical Benefit: Inpatient Hospital Care

3. **Basic Medical Benefit**. The attached Summary of Benefits details whether there is a deducible, an out of pocket maximum, a co-payment, a lifetime maximum, a plan year limit or a difference in covered benefit if you obtain services at a PPO. Please review the Summary of Benefits carefully.

There are special rules for a Medicare Retiree Participant with Part A and Part B Medicare Primary Coverage:

- You do not have an out-of-pocket maximum for the Basic Medical Benefit.
- The Basic Medical Benefit does not require a cash deductible and does not require that you obtain services at the PPO.
- If you incur a Charge for Basic Medical Benefits that is covered by both this Plan and Medicare, Medicare will pay first, and then this Plan will pay in accordance with the Summary of Benefits and Medicare guidelines. If the Charge is not covered by Medicare but is covered by this Plan, this Plan will pay in accordance with the Summary of Benefits.

(A) Inpatient Hospital Care.

(1) Covered Charges. Charges for Inpatient Hospital Care for all Participants and all Dependents are subject to the precertification, retro-precertification or pre-notification requirements. Failure to do so may cause a claim to be suspended and then denied, which means it will become the responsibility of the Participant. If you are a Medicare Retiree Participant with Part A and Part B Medicare Primary Coverage, you still need to contact the Plan's Pre-certification Vendor to obtain pre-certification to make sure you have remaining "Lifetime Reserve" days under Medicare.

Charges for Inpatient Hospital Care will be subject to the applicable deductible, if any, noted in the Summary of Benefits, co-insurance noted in the Summary of Benefits, the limitations contained in subsection (3) below, the exclusions in subsection (2) below and in Section C.5. A Participant or Dependent who is admitted to a Hospital for treatment or sickness of a non-work related accidental injury as a bed patient and who obtains treatment through a PPO provider or a non-PPO provider shall generally be entitled to payment or reimbursement of a percentage of the required Inpatient Hospital Care Charges set forth in the Summary of Benefits. Inpatient Hospital Care Charges shall 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 to the extent Medically Necessary.

(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, spontaneous abortion or miscarriage up to the maximum, if any, as set forth in the Summary of Benefits.

(s) Room and board (including meals, special diets and general nursing services) for "semi-private accommodations," up to the daily maximum, if any, as set forth in the Summary of Benefits. Private room at the most common "semi-private" rate. Intensive or coronary care unit at twice the most common "semi-private" rate. To the extent the Hospital is an all-private room facility, room and board for "private accommodations" up to the daily maximum, if any, set forth 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) Treatment for alcoholism or drug dependency.

(x) Non-PPO Professional Fees Rendered at PPO Hospital. Charges for professional fees from Non-PPO professionals (emergency room physicians, radiologists, pathologists, etc.) will be paid at the PPO rate providing that (1) services were rendered while an

eligible Plan Participant was either on an inpatient or outpatient status at a PPO Hospital, (2) the patient did not have a choice in selecting the provider and (3) the services provided were a covered Benefit under the Plan.

(2) Exclusions From Coverage. Charges for Basic Medical Benefits for Inpatient Hospital Care are not payable or reimbursable by the Plan for the services or items, or under the conditions listed in Section C.5.

(3) Coverage Limitations.

(a) Coverage During Hospital Confinements. The Summary of Benefits details the number of days of confinement covered for Inpatient Hospital Care and the payment or reimbursement percentage of Inpatient Hospital Care Charges. In computing the number of days of confinement, the day of admissions shall be counted but not the day of discharge. If the day of discharge and the day of admission are the same day, such day shall be counted.

(i) Limitation on Hospital Confinement. As detailed in the Summary of Benefits, Inpatient Hospital Care provided as a Basic Medical Benefit shall be covered beyond the twentieth (20th) day of confinement for Active Employee Participants and Non-Medicare Eligible Retiree Participants and their Dependents (including newborn children) but, the Plan's payment percentage will decrease if the care is provided by a non-PPO provider.

(ii) Successive Confinements. In the event an Active Employee Participant enters the Hospital, is later discharged upon complete recovery and/or returns to active work on a full-time basis for an Employer for at least one full working day, and then enters the Hospital again, the second hospitalization is considered separate from the first. If the Active Employee Participant does not completely recover or return to active work on a full-time basis for an Employer for at least one full working day after the first Hospital stay, the second Hospital stay will be considered part of the first, and the Hospital time under both visits will be aggregated in determining the maximum coverage limitation set forth in the Summary of Benefits.

(b) 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.

(c) 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.

SECTION C.3.(B)-Basic Medical Benefit: Outpatient Hospital Care

(B) Outpatient Hospital Care.

(1) Covered Charges. Charges for Outpatient Hospital Care for all Participants and all Dependents are subject to the precertification, retro-precertification or pre-notification requirements. Failure to do so may cause a claim to be suspended and then denied, which means it will become the responsibility of the Participant. As detailed in the Summary of Benefits, Charges for Outpatient Hospital Care will be subject to the applicable deductible, if any, set forth in the Summary of Benefits, co-pay and co-insurance noted on the Summary of Benefits, the requirements noted in the Summary of Benefits and the exclusions in subsection (2) below and in Section C.5.

(a) Facility Fee for Outpatient Surgery. Facility fees for Outpatient Surgery Charges will be subject to the applicable deductible, the limitations outlined below and the exclusions in Section C.5. A Participant or Dependent who goes to the Hospital for an outpatient surgery that is not work related shall generally be entitled to payment or reimbursement of a percentage (as set forth in the Summary of Benefits) of the required Hospital Charges for both PPO and non-PPO providers.

(b) Dental Care in Hospital. Notwithstanding the foregoing, upon the receipt of a letter of Medical Necessity from the Dependent's doctor and the written recommendation from the Fund's Medical Consultant, the Plan will pay or reimburse a percentage (based on the percentage for Facility Fees for Outpatient Surgery, as set forth in the Summary of Benefits) of the facility charges billed by a Hospital to perform dental work in a Hospital setting for a Dependent child age six or younger or for a Participant of any age or Dependent of any age who has a physical or mental impairment.

(c) Sudden and Serious. Sudden and Serious Condition Charges will be subject to the applicable deductible, if any, the limitations outlined below and the exclusions in C.5. A Participant 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 (as set forth in the Summary of Benefits) of the required Hospital Charges for a PPO or non-PPO provider and will be subject to a co-pay on the ER Facilities, as set forth in the Summary of Benefits. This category includes observation time billed by the Hospital. Note: A Medicare Retiree Participant with Part A and Part B Medicare Primary Coverage will not be subject to a co-pay on the ER Facilities.

(i) 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. Benefits are only for care received during the first visit to the emergency room of a Hospital, provided the illness is treated within 48 hours of its onset and the treatment is billed by the Hospital.

(ii) Examples of Serious and Sudden Outpatient Hospital Care:

- Acute Abdominal Pain
- Acute Chest Pains
- Acute Coronary
- Allergic reactions, Acute (except allergy tests)
- Appendicitis, Acute

- Asthmatic Attack
- Bronchitis, Severe
- Chest Pains
- 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 F – child, 04 degrees F - adult)
- 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 your doctor's and/or 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 doctor or 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, including doctors and physicians' charges, may constitute covered expenses under other parts of the Medical Plan.

(c) Miscellaneous Outpatient Hospital Care.

(i) This category includes all other services rendered as an outpatient that would not be considered surgery or sudden and serious. This is subject to the applicable deductible, if any, the limitations outlined below and the exclusions in Section C.5. Charges for non-work related services or illnesses are generally entitled to payment or reimbursement of a percentage of the charges, based on the Summary of Benefits.

(ii) Non-PPO Professional Fees Rendered at PPO Hospital. Charges for professional fees from Non-PPO professionals (emergency room physicians, radiologists, pathologists, etc.) will be paid at the PPO rate providing that (1) services were rendered while an eligible Plan Participant was either on an inpatient or outpatient status at a PPO Hospital, (2) the patient did not have a choice in selecting the provider and (3) the services provided were a covered Benefit under the Plan.

(2) Exclusions From Coverage. Charges for Basic Medical Benefits for Outpatient Hospital Care are not payable or reimbursable by the Plan for the services or items, or under the conditions listed in Section C.5.

SECTION C.3.(C) Basic Medical Benefit: Surgical Care

(C) Surgical Care.

(1) Covered Charges. Charges for Surgical Care will be subject to the applicable deductible, if any, noted in the Summary of Benefits, co-insurance noted in the Summary of Benefits, the exclusions contained in subsection (2) and the precertification, retro-precertification or pre-notification requirements. The Plan will pay or reimburse a percentage (as set forth in the Summary of Benefits) of the Charges (subject to the UCR standards of this Plan) made by a duly qualified surgeon, depending on whether the surgeon is or is not a member of the Preferred Provider Organization. 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, subject to the following:

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

(b) Charges made by an Assistant Surgeon will be paid or reimbursed at the percentage set forth in the Summary of Benefits.

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

(d) 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 at the level set forth in the Summary of Benefits under the Plan.

(e) The Plan will pay the cost of a second surgical opinion if it is rendered and billed by a provider other than the physician who performed the surgery or provided the first opinion.

(f) 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 based on the review and approval of the Fund's Medical Consultant, and subject to the Plan's cost containment procedures. Please see the Plan Administrator for more details.

(2) Exclusions from Coverage. Charges for surgical care are not payable or reimbursable by the Plan for the services or items, or under the conditions listed in Section C.5.

SECTION C.3.(D) and (E) Basic Medical Benefit: Anesthesia and Diagnostic Examinations

(D) Anesthesia.

(1) Covered Charges. Anesthesia Charges will be subject to the applicable deductible noted on the Summary of Benefits, co-insurance and co-pay noted on the Summary of Benefits and the exclusions contained in subsection (2) below. The Plan will pay or reimburse the percentage set forth in the Summary of Benefits of the Charges made by a duly qualified anesthesiologist for administering anesthetics on account of an accidental injury, sickness, surgery, or pain management involving a Participant or his Dependents.

(2) Exclusions from Coverage. Charges for Anesthesia are not payable or reimbursable by the Plan for the services or items or under the conditions listed in Section C.5.

(E) Diagnostic Examinations.

(1) Covered Charges. Diagnostic Charges at PPO Independent labs will be subject to the applicable deductible noted on the Summary of Benefits, a co-payment and co-insurance detailed on the Summary of Benefits, and the exclusions contained in subsection (2) below. A Participant or Dependent will be subject to a co-payment detailed in the Summary of Benefits per PPO date of service. A Participant or Dependent who incurs Charges rendered for Diagnostic Laboratory Examinations to diagnose a non-occupational illness or injury will generally be entitled to payment or reimbursement of the percentage set forth in the Summary of Benefits of the required Charges for a PPO provider after paying the co-payment. A Participant or Dependent who incurs Charges rendered for X-Ray Examinations to diagnose a non-occupational illness or injury will generally be entitled to payment or reimbursement of the percentage set forth in the Summary of Benefits of the required Charges for a PPO provider. In the event the treatment is obtained through a non-PPO provider, the Participant or Dependent shall be entitled to payment or reimbursement of the percentage set forth in the Summary of Benefits of the required Charges. Treatment for Cardiac CT Scans if Medically Necessary may be covered if provided by PPO providers or by non-PPO providers if there are extenuating circumstances and the member appeals.

(2) Exclusions from Coverage. Charges for Diagnostic Laboratory and X-Ray Examinations are not payable or reimbursable by the Plan for the services or items or under the conditions listed in Section C.5.

SECTION C.3.(F) Basic Medical Benefit: Durable Medical Equipment

(F) Durable Medical Equipment, including Breast Pumps.

(1) Covered Charges. Charges for Durable Medical Equipment will be subject to the applicable deductible detailed on the Summary of Benefits, coinsurance detailed on the Summary of Benefits, the limitations and exclusions contained in Subsection (2), (3) and (4) below and an internal review by the Fund's Third Party Administrator if the Covered Charge exceeds $1,000. For this purpose, "Durable Medical Equipment" will be defined as medical equipment (e.g. walker, wheelchair, safety bed if approved by the Fund's Medical Consultant) ordered by a Doctor for use in the home to assist in performing certain tasks that are not possible due to medical conditions or illnesses, and will include medically necessary acquisition, repair and replacement costs which may be subject to the written recommendation from the Fund's Medical Consultant and/or other medically necessary review and approval processes established by the Fund.

(2) Coverage Limitations for Oral Appliance Therapy for Treatment of Sleep Apnea. Effective on and after September 10, 2020, if a Participant or Dependent satisfies the requirements below, the Participant or Dependent shall be subject to the limits set forth in the Summary of Benefits on the amount paid or reimbursed for the Charges for the purchase of Oral Appliance Therapy:

(a) The Participant or Dependent provides the following documentation:

(i) A Letter of Medical Necessity for the Participant or Dependent which documents, in sufficient detail as determined by the Fund's Third Party Administrator, the prior course of treatment and explains why the CPAP device cannot be used or is contraindicated.

(ii) Documentation of sleep apnea diagnosed by a standard sleep study conducted under the supervision of a medical care provider. This requirement is not satisfied with documentation by an x-ray or other non-conventional methods.

(b) Within the past five years, the Plan has not paid the Charges to purchase an Oral Appliance Therapy device, or a CPAP for the Participant or Dependent, unless, in the case of the CPAP, the Participant or Dependent can demonstrate a significant change in circumstances. If the Plan has been paying the rental cost of a CPAP, the rented unit must be returned.

(c) Charges for purposes of Oral Appliance Therapy will not include snore guards or the replacement of lost or stolen items.

(3) Coverage of Breast Pumps. Charges for the purchase or rental of an FDA-approved breast pump for a Participant, a Participant's Spouse (if a Plan Dependent), will be subject to the applicable deductible and co-payment/co-insurance applicable to Durable Medical Equipment noted on the Summary of Benefits and the conditions and limitations in (a) and (b) below:

(a) Coverage Limitations. The following conditions must be satisfied for the Plan to reimburse or pay the Charges:

(i) The Breast Pump Charge is available only for a Participant or the Participant's Spouse (if the Spouse is a Dependent) for whom the Plan has not paid or reimbursed a Breast Pump Charge for the past three Plan Years.

(ii) The Breast Pump Charge is ordered by a Prescription.

(iii) The Breast Pump Charge is incurred for the purchase or rental of a breast pump provided from a member of the Preferred Provider Organization. The maximum Charge for a breast pump rental will be limited to the Charge incurred had the breast pump been purchased.

(iv) The Breast Pump Charge is documented with a standardized itemized bill from a Durable Medical Equipment vendor in the PPO Network.

(v) The Breast Pump is FDA-approved.

(b) Exclusions from Coverage. In addition to the exclusions in Section C.5, the Plan will not pay or reimburse Charges for the purchase or rental of breast pumps for the following treatment and/or services:

(i) Charges in excess of the Usual, Customary, Reasonable Allowance for the purchase price of a breast pump.

(ii) Charges incurred by Dependents who are not Spouses.

(iii) Charges for a purchase or rental from a non-PPO vendor.

(iv) Charges without adequate documentation, as determined by the Third-Party Administrator (i.e., both a prescription and standardized itemized bill).

(v) Charges for supplies or for comfort/convenience items.

(vi) Charges for bottles, caps, nipples, storage bags, batteries, adapters, bags, shipping costs or like items.

(vii) Charges for lost or stolen items.

(viii) Charges for warranties or extended service contracts.

(ix) Charges for a breast pump which is not FDA-approved.

(4) Exclusions from Coverage. Charges for Durable Medical Equipment are not payable or reimbursable by the Plan under the conditions referenced in Section C.5.

SECTION C.3.(G) Basic Medical Benefit: Hearing Aids

(G) Hearing Aids.

(1) Coverage for Hearing Aids needed because of a defect or a disease by an Active Employee Participant and his Dependents:

Note: This benefit is only provided for Active Employee Participants and their Dependents if covered by the Plan.

(a) Covered Charges. Charges incurred by an Active Employee Participant or his Dependents for an FDA-approved hearing aid, a hearing exam or related expenses necessitated by a functional defect caused by a congenital disease, an accidental injury or surgery resulting from a disease or hearing loss related to Meniere's disease, will be subject to the applicable deductible noted on the Summary of Benefits, the co-insurance noted on the Summary of Benefits and the lifetime maximum and the exclusions contained in subsections (b) and (c) below.

(b) Coverage Limitations. Each Active Employee Participant and his Dependent shall be subject to a lifetime limit set forth in the Summary of Benefits on the amount paid or reimbursed for Charges for Hearings Aids needed because of a defect or disease.

(c) Exclusions from Coverage. Charges for the purchase of or examination for the fitting of hearing aids that are required for any condition, disease or accident arising out of or in the course of a Participant's or Dependent's employment will not be covered under this section of the Plan. Charges for the purchase or examination for the fitting of hearing aids that are required for a defect or disease of a Retiree Participant and his Dependents is not covered under the Plan.

(2) Coverage for Routine Hearing Aids needed for reasons other than a disease or defect by a Participant and a Participant's Spouse who are covered under the Plan:

Note: This benefit is provided for a Participant and the Participant's Spouse if covered by the Plan.

(a) Covered Charges. Charges for an FDA-approved hearing aid, a hearing exam, fittings, repairs or replacements for a Participant or a Participant's Spouse (if covered by the Plan), are subject to a limit set forth in the Summary of Benefits every three calendar years and the exclusions set forth in subsection (b) below. Such Charges will not be subject to a deductible or any co-insurance. This benefit is separate from the benefit provided under Section (G)(1) above. The Routine Hearing Aid Benefit was added effective January 1, 2019 and the three calendar year benefit amount was $1,000 for 2019 and 2020, $2,500 for 2021 and 2022, $4,000 for 2023 and 2024 and $4,500 as of 2025.

(b) Exclusions from Coverage. The Plan will not pay or reimburse Charges for Routine Hearing Aids for the following treatment and/or services:

(i) Services covered by Worker's Compensation.

(ii) Charges in excess of the Usual, Customary, Reasonable Allowance.

(iii) Charges incurred by a Dependent who is not a Spouse.

(iv) Services or materials that are not specifically covered by the Plan.

(v) Hearing aids that are not FDA-approved.

(vi) Charges for Routine Hearing Aids of non-Spouse Dependents of Non-Medicare Eligible Retiree Participants and non-Spouse Dependents of Medicare Retiree Participants with Part A and Part B Medicare Primary Coverage.

SECTION C.3.(H)-Basic Medical Benefit: Home Health Care

(H) Home Health Care.

(1) Covered Charges. Home Health Care Charges will be subject to the applicable deductible noted on the Summary of Benefits, the coinsurance noted on the Summary of Benefits and the limitations and exclusions contained in subsections (2) and (3) below. A Participant or Dependent who incurs Home Health Care Charges will generally be entitled to payment or reimbursement of the percentage set forth in the Summary of Benefits of the required Home Health Care Charges rendered by a member or a non-member of the Preferred Provider Organization. This section covers Charges incurred for 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 determined by the Plan's Medical Consultants and (iv) are prescribed by the patient's physician and such prescription is documented in the medical record.

(2) Coverage Limitation. Coverage for Home Health Care is provided as a Basic Medical Benefit but is limited to a maximum number of visits per Plan Year as set forth in the Summary of Benefits. Charges in excess of the maximum visits will not be covered under any other Plan provisions. Generally, other charges associated with home health care (*i.e.*, intravenous charges, durable medical equipment) will be eligible for coverage in accordance with the rules for the Primary Major-Medical Benefits.

(3) Exclusions from Coverage. Charges for Home Health Care are not payable or reimbursable by the Plan for the services or items or under the conditions listed in Section C.5.

SECTION C.3.(I) Basic Medical Benefit: Hospice Care

(I) Hospice Care.

(1) Covered Charges. Hospice Care Charges will be subject to the applicable deductible noted in the Summary of Benefits, the co-insurance noted in the Summary of Benefits and the limitations and exclusions contained in subsections (2) and (3) below. This section covers Hospice Care benefits rendered to a Participant or Dependent who (i) has a confirmed diagnosis of terminal illness; (ii) has a life expectancy of six months or less; (iii) has no further use nor desire for other curative therapy; and (iv) has signed an informed consent indicating an acceptance and understanding of Hospice Care. A Participant or Dependent who incurs Hospice Care Charges will generally be entitled to payment or reimbursement of a percentage as set forth in the Summary of Benefits of the required Hospice Care Charges rendered by a member of the Preferred Provider Organization (PPO) or through a non-PPO.

Hospice services 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 (i) rendered in the Participant's or Dependent's home, (ii) billed by a Hospice provider, and (iii) include services from the following list:

(a) Nursing care by a registered nurse or licensed practical nurse.
(b) 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 the Hospice Care team.
(c) Homemaker services for the Participant or Dependent only.
(d) Services of a licensed or certified physical, respiratory, occupational or speech therapist or social worker.
(e) Nutritional services provided by a dietician.
(f) Rental of durable medical equipment, such as hospital beds, respirators, oxygen tents, crutches and wheelchairs when billed by the Hospice providers.
(g) Medically Necessary surgical and medical supplies.
(h) Drugs and medicines listed in the official forms billed by the Hospice providers.
(i) Radiation therapy and chemotherapy.

(2) Coverage Limitation. Charges for Hospice Care provided as a Basic Medical Benefit is limited to the Charges incurred for the maximum days set forth in the Summary of Benefits. Charges for Hospice Care in excess of the maximum days set forth in the Summary of Benefits will not be covered under any other Plan provisions.

(3) Exclusions from Coverage. Charges for Hospice Care are not payable or reimbursable from the Plan for the services or items or under the conditions listed in Section C.5. Notwithstanding the foregoing, the exclusions in Section C.5 pertaining to Hospice Services shall not apply to Hospice Care.

SECTION C.3.(J) Basic Medical Benefit: Extended Care/Skilled Nursing Care

(J) Extended Care/Skilled Nursing Care.

(1) Covered Charges. Extended Care/Skilled Nursing Care Charges will be subject to the applicable deductible noted in the Summary of Benefits, the coinsurance noted in the Summary of Benefits, the limitation on covered days noted in the Summary of Benefits and the exclusions in subsection (2) below. The Plan will generally pay or reimburse a percentage as set forth in the Summary of Benefits of the Charges incurred by Participants or Dependents for medical services while confined in an Extended Care/Skilled Nursing Care facility, which meet Medically Necessary guidelines as determined by the Plan's medical consultant, or in the case of a Retiree Participant eligible for Medicare subject to a maximum number of days per Plan Year. Charges shall be covered in this section only if ineligible for coverage elsewhere under the Plan. Covered Charges for Extended Care/Skilled Nursing Care expenses include the following medical services and supplies:

(a) Room and board, except private room charges in excess of the Extended Care/Skilled Nursing Care Facility's (the "Facility") average charge for semi-private accommodations.

(b) Routine nursing care provided by the Facility on other than a private duty basis.

(c) Physical or speech therapy provided by the Facility or others under arrangement with the Facility.

(d) Medical social services provided by the Facility.

(e) Such drugs, biological supplies, appliances and equipment which are normally provided by the Facility for the care and treatment of its inpatients.

(f) Diagnostic and therapeutic services furnished by the Hospital, including medical services of a Hospital intern or resident-in-training under the teaching program of a Hospital, with which the Facility has a transfer agreement, but not including any other medical care or treatment by a doctor, resident doctor, or intern.

(g) Such other services necessary to maintain the health of the patients as are generally provided by the Facility.

(2) Exclusions From Coverage. Charges for Basic Medical Benefits for Extended Care/Skilled Nursing Care are not payable or reimbursable by the Plan for the services or items, or under the conditions listed in Section C.5. Notwithstanding the foregoing, the exclusions in Section C.5. for Custodial Care shall not apply to Extended Care/Skilled Nursing Care Benefits.

SECTION C.3.(K) and (L) Basic Medical Benefit: Orthotics and Well Baby Care

(K) Orthotics.

(1) Covered Charges. Charges for Orthotics will be subject to the applicable deductible noted in the Summary of Benefits and the coinsurance noted in the Summary of Benefits and the limitations and exclusions contained in subsections (2) and (3) below. A Participant or Dependent who incurs Orthotics Charges will generally be entitled to payment or reimbursement of the percentage set forth in the Summary of Benefits of the required Orthotic Charges regardless of whether the service is rendered by a member or non-member of the Preferred Provider Organization. This section covers Charges for Orthotics which is defined as medical devices (such as leg, arm, back or neck braces) which are used to activate or supplement a weakened limb or function, and are recognized by Medicare. If you are not eligible for the Prosthetic benefit in Section C.3(M), this category includes prosthetics. If you are eligible for the Prosthetic benefit in Section C.3.(M), this category does not include prosthetics.

(2) Coverage Limitation. Each Participant and Dependent shall be subject to an annual limit as set forth in the Summary of Benefits on the amount paid or reimbursed for Charges for Orthotics.

(3) Exclusions from Coverage. Charges for Orthotics are not payable or reimbursable by the Plan for the services or items or under the conditions listed in Section C.5.

(L) Well Baby Care.

(1) Covered Charges. Well Baby Care Charges will be subject to the applicable deductible detailed on the Summary of Benefits, a co-payment and coinsurance noted on the Summary of Benefits and the exclusions in subsection (2) below. A Participant or Dependent will be subject to a co-payment as set forth in the Summary of Benefits per PPO Well Baby Care visit. After paying the co-payment, a Participant or Dependent who incurs Well Baby Care Charges during the twenty-four month period following birth will generally be entitled to payment or reimbursement of the required Well Baby Care Charges at the percentage set forth in the Summary of Benefits rendered by a member of the Preferred Provider Organization. For this purpose, Well Baby Care Charges include routine preventive tests, immunizations, and services that monitor the baby's physical and mental development.

(2) Exclusions from Coverage. Charges for Well Baby Care are not payable or reimbursable by the Plan for the services or items or under the conditions listed in Section C.5.

SECTION C.3.(M) Basic Medical Benefit: Prosthetics

(M) Prosthetics.

Note: This benefit is available only to Active Employee Participants.

(1) Covered Charges. Charges incurred by an Active Employee Participant for Prosthetics will be subject to the applicable deductible noted in the Summary of Benefits, the Coinsurance noted in the Summary of Benefits and the limitations and exclusions contained in subsections (2) and (3) below. If the requirements in subsection (2) below are satisfied, an Active Employee Participant will generally be entitled to payment or reimbursement as set forth in the Summary of Benefits of the required Prosthetic Charges where the service is rendered by a member of the Preferred Provider Organization. This section covers Charges for Prosthetics as defined in subsection (2) below. The Plan does not cover Charges for Prosthetics for the Dependents of an Active Employee Participant, a Non-Medicare Eligible Retiree Participant and their Dependents and a Medicare Retiree Participant with Part A and Part B Medicare Primary Coverage and their Dependents.

(2) Coverage Limitations. If an Active Employee Participant satisfies the circumstances below, each Active Employee Participant shall be subject to the limit as set forth in the Summary of Benefits on the amount paid or reimbursed for Charges for Prosthetics in the circumstances described below.

(a) The Covered Charges are for the purchase, repair or replacement of an artificial limb or device which is:

(i) designed to support a weakened or missing body part (specifically excluding specialized footwear);

(ii) custom-fitted or manufactured to an Active Employee Participant;

(iii) manufactured solely for medical use;

(iv) limited to basic equipment necessary for all activities of daily living and specifically excludes deluxe models, or equipment specific for exercising or sporting events; and

(v) qualifies as a Prosthetic under Medicare.

(b) The Covered Charges are determined to be Medically Necessary as determined by the Plan's Administrator; and

(c) Within the past seven Plan Years, the Active Employee Participant has not exceeded the limit for Prosthetic benefits as set forth in the Summary of Benefits.

(3) Exclusions from Coverage. Charges for Prosthetics are not payable or reimbursable by the Plan for the services or items or under the conditions listed in Section C.5.

SECTION C.3.(N) Basic Medical Benefit: Primary Major-Medical Benefit

(N) Primary Major-Medical Benefit.

(1) Covered Charges. Charges for Primary Major-Medical Benefits will be subject to the applicable deductible and coinsurance noted in the Summary of Benefits, and the exclusions set forth in subsection (2) below. The Plan shall provide payment for or reimbursement of a percentage (as set forth in the Summary of Benefits) of the Charges incurred by Participants or Dependents for the following Medically Necessary services, treatment or confinement, to the extent they exceed Charges covered under subsections (A) through (M) above:

(a) Services of physicians and specialists provided on an outpatient basis.

(b) Private duty nursing services in a Hospital which require the skills of a Registered Nurse (RN) or Licensed Practical Nurse (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) Medically Necessary services in a Hospital, including the following:

(i) Room and board (including meals, special diets and general nursing service) for "semi-private accommodations," up to the daily maximum, if any, as set forth in the Summary of Benefits. Private room at the most common "semi-private" rate. Intensive or coronary care unit which exceeds two times the most common "semi-private" rate.

(ii) Use of treatment rooms.

(iii) Cost of oxygen and its administration.

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

(v) Blood transfusions, including the cost of blood plasma and blood plasma expanders.

(vi) Drugs, medicines and dressings used in a Hospital.

(vii) Physicians' visits.

(viii) The Charges for room and board (as described in subsection N.(1)(c)(i) above) beyond the twentieth day of confinement for Participants and Dependents when the care is provided by a non-PPO provider.

(d) Medical supplies and surgical dressings including:

(i) Casts and splints.

(ii) Catheters.

(iii) Colostomy bags and supplies required for their use which are not readily available under the prescription mail order program.

(iv) Dressings when medically necessary for such conditions as cancer, burns or diabetic ulcers.

(v) Injectable drugs administered by a medical provider.

(vi) Rental of an artificial respirator and other durable medical or surgical equipment necessary for temporary treatment to improve functions of a malformed body member or to prevent or retard further deterioration of the Participant's or Dependent's condition.

(vii) Syringes, needles and insulin when medically necessary for conditions such as diabetes, which are not readily available under the prescription mail order program.

(e) Education or Training Charges for Diabetic self-management education and support services (including for gestational diabetes) subject to a maximum of 10 hours within 12 months of the diagnosis and 2 hours of training in subsequent years.

(f) Contraceptive coverage. Effective January 1, 2021, Charges for an intrauterine device ("IUD") will be covered by the Plan regardless if billed under the prescription portion of the Plan (subject to the applicable co-pay and PBM coverage criteria) or the medical portion of the Plan (subject to the applicable deductible and co-pay), and regardless if the medical services are provided by an in-network or out of network facility, subject to a limit of one IUD every three year period. Prior to January 1, 2021, the Plan coverage of an intrauterine device was limited to services provided by an in-network provider and facilities.

(g) All other items and Charges not previously addressed.

(2) Exclusions from Coverage. Charges for Primary Major-Medical Benefits are not payable or reimbursable by the Plan for the services or items or under the conditions listed in Section C.5.

SECTION C.3.(O) and (P) Basic Medical Benefit: Reconstructive Jaw Surgery and Routine Foot Care

(O) Reconstructive Jaw Surgery and Related Treatment.

(1) Covered Charges. Reconstructive Jaw Surgery and Related Treatment Charges will be subject to the applicable deductible, the coinsurance and the lifetime maximum noted on the Summary of Benefits, and the exclusions set forth in subsections (2) and (3) below. A Participant or Dependent who incurs Reconstructive Jaw Surgery and Related Treatment Charges will generally be entitled to payment or reimbursement of the percentage (set forth in the Summary of Benefits) of the required Charges for medical and dental treatment (including orthodontic treatment, if necessary), regardless if the services are rendered by a member or non-member of the Preferred Provider Organization. Such Charges will be covered under the section if they relate to reconstructive jaw surgery which results from any reason other than a birth defect or an accident.

(2) Exclusions from Coverage. Charges for Reconstructive Jaw Surgery are not payable or reimbursable by the Plan under the conditions referenced in Section C.5.

(3) Coverage Limitations. Each Participant and Dependent shall be subject to a lifetime maximum set forth in the Summary of Benefits for Reconstructive Jaw Surgery. The lifetime limit will include, but not be limited to, medical, dental, orthodontic treatment, surgery fees, facility fees, office visits and x-rays.

(P) Routine Foot Care.

(1) Covered Charges. Charges for Routine Foot Care as detailed below provided by a Physician to a Participant or Dependent who has a chronic condition (*i.e.*, chronic circulatory disorder or diabetic with diabetic sensory neuropathy) will be subject to the applicable deductible noted in the Summary of Benefits, and the limitations contained in subsection (2) below. For this purpose "Routine Foot Care" will be limited to (a) local care of superficial wounds, (b) debridement of corns and calluses and (c) trimming and debridement of nails. Other conditions could constitute chronic conditions, subject to receipt of a letter of Medical Necessity which explains the causation between the circulatory disorder and the condition and approval of the Fund's Medical Consultant. Charges for Routine Foot Care will be evaluated and paid per the plan benefit category under which it is billed, and will be subject to the deductible as detailed in the Summary of Benefits.

(2) Exclusions from Coverage. Charges for Routine Foot Care are not payable or reimbursable by the Plan under the conditions listed in Section C.5.

SECTION C.3.(Q) Basic Medical Benefit: Wellness Benefit

(Q) Wellness Benefits.

(1) Covered Charges. Charges for Wellness Benefits will be subject to an aggregate Lifetime Maximum and a separate Lifetime Maximum on a specific benefit category and the limitations and exclusions contained in subsections (2) and (3) below. Wellness Benefits include the following three categories of Benefits:

(a) Hair Prosthetics (wigs). A separate Lifetime Maximum as set forth in the Summary of Benefits will apply for a Hair Prosthetics when loss occurred as a result of illness or treatment of an illness such as radiation therapy for cancer patients.

(b) 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 if it is prescribed by a health care professional, offered at Hospital settings and provided by registered dieticians. Conditions for which Nutritional Counseling may be considered medically necessary include but are not limited to the following:

anorexia nervosa/bulimia	malabsorption syndrome
celiac disease	Mental health Benefits conditions
cardiovascular disease	metabolic syndrome X
Crohn's disease (CD)	multiple or severe food allergies
diabetes mellitus (DM)	nutritional deficiencies
disorders of metabolism (e.g., inborn errors of metabolism, inherited metabolic diseases, amino acid disorders)	obesity (*i.e.*, body mass index [BMI] ≥ 30 or ≥ 95th percentile)
hyperlipidemia	post-bariatric surgery
hypertension	prediabetes
liver disease	renal failure
	ulcerative colitis (UC)

(c) Lactation Counseling effective on and after September 23, 2019, subject to a Lifetime Maximum as set forth in the Summary of Benefits equal to the lesser of six sessions or $1,500.

(2) Coverage Limitations. Each Participant and Dependent shall be subject to a Lifetime Maximum as set forth in the Summary of Benefits on all amounts paid or reimbursed for Charges for Wellness Benefits (and a separate Lifetime Maximum on Hair Prosthetics).

(3) Exclusions from Coverage. Charges for Wellness Benefits are not payable or reimbursable by the Plan for the services or items or under the conditions listed in Section C.5.

SECTION C.3.(R) Habilitative/Rehabilitative Therapy

(R) Habilitative/Rehabilitative Therapy.

(1) Covered Charges. Subject to the applicable deductible and conditions set forth in subsection (2) below, and the exclusions in subsection (3), the Plan shall provide payment for or reimbursement of a percentage, as set forth in the Summary of Benefits for Charges for Habilitative/Rehabilitative Therapy provided on an outpatient basis. Habilitative/Rehabilitative Therapy are health care services that help a person keep, learn, improve, recover or relearn skills and functioning for daily living, and include, but are not limited to, physical therapy, occupational therapy, speech therapy and applied behavioral analysis.

(2) Coverage Limitations. The following conditions must be satisfied for the Plan to reimburse or pay the charges:

(a) The Habilitative/Rehabilitative Therapy must be Medically Necessary;

(b) The Habilitative/Rehabilitative Therapy must be ordered by a physician; and

(c) The treatment plan is designed and supervised by licensed therapists.

(3) Exclusions from Coverage. Charges for Habilitative/Rehabilitative Therapy are not payable or reimbursable by the Plan for the services or items or under the conditions listed in C-5. Habilitative/Rehabilitative Therapy does not include respite care, day care, recreational treatment, social services, custodial care or educational services of any kind, including vocational services.

SECTION C.3.(S) Cell and Gene Therapy

(S) Cell and Gene Therapy.

(1) Covered Charges. Subject to the Basic Benefit Annual Deductible, any Co-insurance or Copayment requirements, the conditions set forth in subsection (2) below, and the exclusions in subsection (3), the Plan shall provide payment for or reimbursement of a percentage of Medically Necessary Charges for FDA-approved Cell Therapy or Gene Therapy provided on an inpatient or outpatient basis by PPO providers or by non-PPO providers, with such coverage determined based on the Plan provisions applicable to the CPT codes and network status of the billed Charges. For purposes of this benefit, "Gene Therapy" means the transplantation of genetic material into the Participant or Dependent to replace, inactivate or introduce genes into cells for the purpose of replacing or repairing damaged tissue and/or treating or curing a disease or condition (e.g., hemophilia) and "Cell Therapy" means the transplantation of cells into the Participant or Dependent for the purpose of restoring or altering certain sets of cells or using cells to carry a therapy through the body to treat or cure a disease or condition (e.g., hemophilia).

(2) Coverage Limitations. The following conditions must be satisfied for the Plan to reimburse or pay the Charges:

(a) The Cell Therapy or Gene Therapy must be Medically Necessary;

(b) The Cell Therapy or Gene Therapy must be FDA approved;

(c) The Cell Therapy or Gene Therapy must be ordered by a physician;

(d) The Cell Therapy or Gene Therapy is subject to precertification and active participation in the case management program, which requires that the Plan's Precertification/Notification Vendor be involved prior to the treatment being provided and during the duration of the treatment, to the extent that the treatment has a duration.

(3) Exclusions from Coverage. Charges for Cell Therapy or Gene Therapy are not payable or reimbursable by the Plan for services or items or under the conditions listed in C-5 or if the requirements of Section (2) above are not satisfied or (c) for services or items specifically excluded based on the CPT codes.

SECTION C.4. Secondary Medical Benefit

4. Secondary Major-Medical Benefit.

(A) Covered Charges. Each Participant and his Dependents covered under the Plan shall be subject to a deductible and lifetime limit set forth in the Summary of Benefits on all Secondary Major-Medical Benefits under this C-4. This section will cover the Charges listed below. Secondary Major-Medical Benefits will be subject to the exclusions in subsection (B) below. There is no Inpatient Hospital Care for this benefit.

(1) Categories of Secondary Major-Medical Benefits. This section will cover 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 Hospital 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, as set forth in the Summary of Benefits of the required Charges, regardless if the Charges are rendered by a member or non-member of the Preferred Provider Organization.

(B) Exclusions from Coverage. Charges for Secondary Major-Medical Benefits are not payable or reimbursable by the Plan for the services or items or under the conditions listed in Section C.5. Notwithstanding the foregoing, the exclusions in Section C.5 pertaining to Chiropractic Care or Services, and Acupuncture will not apply to Secondary Major-Medical Benefits.

SECTION C.5 Coverage Exclusions for the Basic Medical Benefit and the Secondary Major Medical Benefit

5. Exclusions from 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 non-covered 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). Notwithstanding the foregoing, the exclusion for Ailments of the Foot will not apply to Routine Foot Care.

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

(D) Behavior Modification Techniques. Smoking cessation programs except for physician visit to obtain a prescription for a smoking cessation product, weight loss programs or treatment for obesity (including gastric by-pass surgery and similar like procedures and/or services at a health spa, gymnasiums or similar facility) and like programs. This exclusion will not apply to the benefit for nutritional counseling under the Wellness Benefit.

(E) Braces, Prosthetic Appliances, Etc. Procurement or use of special braces, appliances or equipment, except as may be required on account of accidental injury to natural teeth. Notwithstanding the foregoing, the exclusion for Braces, Prosthetic Appliances, etc. will not apply to the Orthotic Benefit or Prosthetic Benefits.

(F) Chiropractic Care or Services rendered by a Chiropractor. Notwithstanding the foregoing, 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 available without a prescription (e.g., condoms, foams, spermicide, diaphragms, cervical caps, and the like) and contraceptive materials not explicitly covered by the Plan in Section C.3(N).

(I) Cosmetic Surgery and Related Charges. Cosmetic surgery and related charges except when accident related or required under the Women's Health and Cancer

Rights Act of 1988 including but not limited to breast reduction (except as deemed medically necessary by the Plan), and breast augmentation.

(J) Coverage Under Another Plan. Any 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 Section E.

(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 non-medical care. This exclusion does not apply to Home Health Care Benefits, as provided in Section C.3(H), Hospice Benefits (as provided under Section C.3(I), or Extended Care/Skilled Nursing Care benefits, as provided under Section C.3(J)).

(L) Dental Care or Treatment. Services and supplies for dental care, including dental X-rays or treatment, dental prosthetic appliances or the fitting of any thereof, except when necessary to treat an accidental injury to natural teeth and a dentist's or oral surgeon's charges for certain cutting procedures in the oral cavity. Coverage for these items may be available under the Dental Plan. Notwithstanding the foregoing, the exclusion will not apply to the facility fee for dental work performed in a Hospital setting which satisfies the requirements of a Sudden and Serious Outpatient Hospital Care or when care is required to be rendered in a hospital setting as set forth in Section C.3(B)(1)(b).

(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) 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. This exclusion does not apply to nutritional counseling, training for basic medical home care services such as wound care IV administration or education or training for diabetic self-management in the Primary Major Medical Benefit in Section C.3(N).

(O) Experimental Procedures , Equipment and Devices and Drugs/Clinical Procedures. Procedures, operations, equipment and devices not recognized by the American

Medical Association, and drugs not approved by the U. S. Food & Drug Administration. Notwithstanding the foregoing, the Plan may pay (i) 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 and obtains the Trustees' pre-approval to participate in a clinical trial and (ii) coverage for the off-label use 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 in connection with the Fund's Third Party Administrator.

(P) Eye Care or Treatment. Eye refraction or eyeglasses, except as may be required on account of accidental bodily injury to physical organs or parts sustained by a Participant or Dependent while eligible for Benefits under this Plan. Coverage may be available under the Optical Benefit of C-7.

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

(R) Genetic testing. Genetic testing, includes but is not limited to, BRAC testing, COLARIS testing, MELARIS testing, and similar chromosome testing or DNA testing. The previous exclusion notwithstanding, the Plan will allow for Medically Necessary diagnostic, DNA, genetic and chromosome testing. The determination of being Medically Necessary will be based on the guidelines for that particular test, the clinical judgment of the provider and the standard of care. The exclusion will also not apply when testing is ordered to determine the most effective course of treatment for a previously documented medical condition. A letter documenting that a test is Medically Necessary may be required in cases where the condition is not evident upon receipt of the request. This provision will apply to the medical and prescription benefits. Preauthorization is required for panels and series of tests which in the aggregate exceed $1,000.

(S) 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, unless such confinement or treatment is not 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.

(T) Hearing Aids, Fittings or Tests. Purchase of or examination for the fitting of FDA-approved hearing aids that are not covered under the Plan under Section C.3(G)(1) or C.3(G)(2).

(U) Hospice Services. Hospice Services rendered at an inpatient facility or at the residence of a Participant or Dependent. Notwithstanding the foregoing, this exclusion does not apply to Hospice Care, provided under Section C.3(I).

(V) Injectibles. Injectibles that are not administered by a medical provider.

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

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

(Y) Injuries While Employed 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 Charges/Expenses. Any service or item not specifically listed as a covered Charge under other sections of the Plan and services, supplies or treatment of any complications arising from non-covered services to the extent such exclusion does not negate grandfathered status.

(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. 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 shall be an allowable Plan charge.

(BB) Obstetrics for Dependent Children. Obstetrical procedures, operations or pregnancy related care provided to Dependent children are not payable or reimbursable under this Plan.

(CC) Occupational Illness or Injury. Treatment or services for an occupational illness or injury.

(DD) 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, and which, in the opinion of the Trustees, constitutes "reckless endangerment".

(EE) Pre-Paid Providers. Services and supplies provided by or available from a health maintenance organization ("HMO"), preferred provider organization or association ("PPO"/"PPA") 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.

(FF) Prescription and Non-Prescription Drugs that are separately purchased by the Participants and/or their Dependents, Vitamins, and Minerals, except generally accepted standard of care vaccines are not excluded.

(GG) Radiokerototomy, Laser Eye Correction, or Like Procedures.

(HH) Self-inflicted Injuries. Services or treatment for self-inflicted injuries, including those associated with or resulting from suicide attempts. 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).

(II) Specified Examinations or Hospitalization for Examinations. Eye refractions; 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, recreational activity or school, or to obtain insurance.

(JJ) Sex Therapies. Services related to sex transformation or sexual dysfunctions or inadequacies, except if required by the Affordable Care Act Section 1557. This exclusion will not apply to the office visits and related diagnostic charges associated with organic impotence.

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

(LL) Therapies. Activity, recreational or family therapy, or marriage, pastoral, or financial counseling or similar services. Notwithstanding the foregoing, the exclusion for therapies will not apply for counseling that is Medically Necessary for Mental Health parity requirements or for the benefit of a minor child with a letter of medical necessity.

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

(NN) Treatment and Supplies Rendered by Non-Qualified Physicians.

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

(PP) 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.

(QQ) Treatment Rendered Outside the United States. Treatment for care rendered outside the United States which exceeds the allowable Charge for comparable services in the United States. Notwithstanding the foregoing, (i) prior to February 15, 2024, non-emergency care rendered outside the United States will not be paid by the Plan without detailed documentation and services for sudden and serious outpatient care will be reimbursed by the Plan (consistent with the coverage that would have been provided if the services had been performed in the United States) if an itemized bill is received and approved by the Fund's Medical Consultant and (ii) on and after February 15, 2024, non-emergency care rendered outside the United States will not be covered by the Plan.

(RR) Treatment, Services, or Supplies Rendered before a Participant or Dependent's Effective Date or after Coverage Ended.

(SS) War. Services for diseases contracted or injuries sustained as a result of war, declared or undeclared or of any act of war, or of any act of international armed conflict or conflict involving armed forces of any international authority, if such war or act occurs after the Participant or Dependent becomes eligible for Benefits under the Plan.

(TT) Workmen's Compensation. Services for any condition, disease, or accident arising out of, or in the course of a Participant's or Dependent's employment (whether by the Employer, or by any other employer) for which benefits are payable to the Participant or Dependent under any workmen's compensation law or similar legislation.

(UU) Supplies Provided by a Third Party Provider and Separately Billed. Supplies (regardless of whether they are classified as supplies, orthotics, durable medical equipment or otherwise) used for In-Patient Care, Out-Patient Care, Surgical Care or to provide Primary Major Medical Benefits, which are provided and separately billed by a third party provider are excluded under the Plan unless the third party provider receives written approval by the Plan in advance of the procedure.

(VV) Services Provided for the same or related injury during the 12-month Post Subrogation Settlement Period if the Participant accepts a settlement which exceeds the medical claims paid at the time of the settlement, except where otherwise covered by the Plan.

(WW) Charges for Services Provided for the same or related injury during the 3 year 3-month period measured from the date of the injury if the Participant does not timely return subrogation paperwork.

(XX) Cloning. Effective January 1, 2024, any expenses related to cloning, including but not limited to services, supplies and treatment expenses for cloning.

(YY) Non-Human organ/tissue transplants or zenographs. As of 1.1.2024, any expenses related to non-human organ/tissue transplants, including but not limited to services, supplies and treatment expenses for non-human organ/tissue transplants or zenographs.

SECTION C.6 Prescription Drug Benefit

6. Prescription Drug Benefit Requirements for Optum RX Coverage.
Note that this Section covers the Optum RX prescription drug benefit.

(A) Covered Charges. Subject to the Prescription Drug Co-Payment Feature and the rules set forth in this paragraph (A), the Plan shall pay for or reimburse all costs for prescription drugs for Participants and their Dependents as follows:

(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. The Plan will only cover Maintenance Prescriptions that are filled through the Pharmacy Benefit Manager's mail order program or at the Prescription Benefit Manager's preferred pharmacy. Diabetic Supplies are covered by the Plan only if purchased in a 90 day supply from the Pharmacy Benefit Manager's mail order pharmacy or at the Prescription Benefit Manager's 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 preferred participating pharmacy, the Participant or Dependent will generally be responsible to only pay for the Co-Payment, subject to the Pharmacy Benefit Manager's rules and pricing guidelines. If a Participant or Dependent obtains Non-Maintenance Prescriptions from a non-participating 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 Pharmacy Benefit Manager's rules and pricing guidelines.

(3) Mandatory Generic. Subject to the Co-Payment feature, 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. The amount the Fund will pay or reimburse for non-generic "Maintenance Prescription" or "Non-Maintenance Prescriptions" depends on the Prescription Pharmacy Manager'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 Prescription Pharmacy Manager's rules and guidelines, including the "Dispensed as Written" (DAW) rules, all of which are incorporated by reference.

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

(6) Special Rules for Diabetic Supplies. Diabetic supplies (*i.e.*, test strips, lancets and needles) are covered only if a 90 day supply is purchased from the Prescription Benefit Manager's pharmacy or the designated mail order program. Effective January 1, 2021, the Plan adopted a Diabetic Management Program which permit "High Risk" Participants to qualify to receive diabetic testing supplies without any copay.

(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 in connection with 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 Shingles, Pneumonia, and effective January 1, 2020, other elective routine nontravel immunizations 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; and.

(c) COVID19 vaccines can be provided at a pharmacy without the necessity of a prescription and without having a Participant pay a co-pay subject to the requirements of the Prescription Pharmacy Manager.

(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 Prescription Benefit Manager and limited to one fill per month.

(10) Specialty Medications. Effective January 1, 2019, subject to a 20% coinsurance feature, the Plan will pay or reimburse 80% of the cost of the 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 (i.e., Depo-Provera) prescribed and administered by a by a Physician under the Prescription Drug Benefit with the administrative fee covered under the Primary Major-Medical Benefit.

(c) Subject to the requirements for contraceptive coverage detailed in the Primary Major Medical Section in Section C.3(N), the Plan will cover Charges for intrauterine contraception devices and subdermal contraceptives regardless if billed under the Prescription Drug Benefit or the Primary Major-Medical Benefit.

(B) Exclusions From Coverage for the Prescription Drug Benefit. 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 the following items are not covered under the Prescription Drug Benefit portion of the Plan:

(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 prevent life threatening events (i.e., naxlone and EpiPen).

(h) Infertility medication.

(i) Medication which is to be taken or administered to, in whole, or in part, by the Participant or Dependent while he or she is a patient in a Hospital, nursing home, rest home, sanitarium, skilled nursing 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.

(5) 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 because of misusing the Benefit.

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

(7) Excessive amounts of the same prescription as determined by the Trustees based on advice from the Plan's Prescription Benefit Manager.

(8) Diabetic supplies which are not purchased in a 90 day supply through the mail order pharmacy or purchased at the Prescription Benefit Manager's pharmacy.

(9) 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.

SECTION C.7 Dental and Orthodontic Benefit

7. Dental and Orthodontic Benefit.

(A) Dental Benefit.

(1) Covered Charges. Subject to the annual deductible and limits set forth in the Summary of Benefits and the exclusions and limitations contained in subsection (2) below, the Plan will pay or reimburse Charges subject to the usual, customary and reasonable "UCR" fee) incurred by Participants and their Dependents for certain dental treatment and services. The allowable Charges are set forth on a separate schedule maintained by the Fund which is incorporated herein by reference. An annual limit will not be assessed on Charges for pediatric dental services that are deemed to constitute "essential health benefits" under the Patient Protection and Affordable Care Act. The list of allowable Charges includes, but is not limited to:

(a) Preventive Care.
- (i) Oral examinations, up to two per calendar year
- (ii) Cleaning, up to two per calendar year
- (iii) One full-mouth fluoride treatment per calendar year
- (iv) X-rays with a preventive exam or cleaning
- (v) Space maintainers for baby teeth

(b) Basic Care Services.
- (i) Oral surgery
- (ii) Periodontics
- (iii) Root canal therapy
- (iv) Bite guards
- (v) Dentures
- (vi) Restorations

(c) Major Care Services.
- (i) Crowns (temporary or permanent)
- (ii) Bridgework
- (iii) Inlays or Onlays

(2) Exclusions and Limitations from Coverage.

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

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

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

(iii) Cosmetic procedures except those required as a result of an injury which occurred while covered by the Dental Plan.

(iv) Dental appointment charges for canceled appointments.

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

(vi) Non-prescription drugs, medicines or supplies intended primarily for home use, such as toothpaste and cleaning supplies, oral hygiene and nutritional counselling.

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

(viii) Replacement of a lost or stolen appliance.

(ix) Services rendered by pre-paid providers which will not supply an Explanation of Benefits (E.O.B.) from the primary carrier except as provided in (e) below.

(x) Treatment of reconstructive jaw surgery. (This is covered under Section C.3.)

(xi) Charges in excess of the Usual, Customary and Reasonable Allowance.

(b) Participants and their Dependents will be responsible to pay the deductible set forth in the Summary of Benefits. Subject to the annual deductible set forth in the Summary of Benefits and the limit set forth in (c), the Plan will pay a percentage set forth in the Summary of Benefits of the Usual, Customary and Reasonable Charges for inlays, onlays, gold fillings, crowns (temporary and permanent), bridgework and all other basic care services.

(c) The maximum limit the Plan will pay for each Participant and each Dependent age 19 and older for dental preventive, basic services and major services care is set forth on a separate schedule which is incorporated by reference.

(d) Dental and orthodontic charges for reconstructive jaw surgery will not be covered under the dental benefit portion of the Plan; it will be covered under the Reconstructive Jaw Surgery and Related Treatment section.

(e) 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 and the annual deductible. Notwithstanding the foregoing, the Plan will not impose an annual limit on pediatric dental services which are deemed to be "essential health benefits" under the Patient Protection and Affordable Care Act. If the Participant can provide the Plan with (i) an itemized bill showing the date of the service, the services which were rendered and the amount charged for each service and (ii) adequate documentation to establish that the Participant paid for dental treatment or services and that such treatment or services will not be reimbursed by the pre-paid provider, the Plan will reimburse the Participant a percentage of the amount paid based on the allowances set forth in the Plan.

(3) Coordination with the Medical Plan. When a billed procedure involves a medical service, the Medical Plan will become the primary payer. Between the Medical and Dental Plan, the total paid amount will not exceed 80% of the total amount charged because the medical procedure is considered a basic service under the Dental Plan.

Example: Frank's Oral Surgeon determines that Frank has two (2) impacted wisdom teeth that must be surgically removed. Frank has oral surgery and a bill of $1,000 is submitted. Frank's Medical Benefit covers charges billed for the removal of his impacted wisdom teeth. Payment under the Medical Benefit will be calculated as follows:

	Active Participant and Non-Medicare Eligible Retiree Participant	Medicare Retiree Participant with Past A and Part B Medicare Primary Coverage
Billed	$1,000	$1,000
Less medical benefit deductible	$220	$0
Remaining bill	$780	$1000
Medical benefit coverage	80%	80%
Medical Benefit	$624	$800

If Frank was an Active Participant or a Non-Medicare Eligible Retiree Participant, he is entitled to additional benefits under the Dental Benefit because his Medical Benefit deductible reduced his Medical Benefit. Because his Dental Benefit would have paid 80% or $800 (if the Dental deductible is not met, the payment would be $760), he is entitled to an additional benefit:

	Active Participant and Non-Medicare Eligible Retiree Participant	Medicare Retiree Participant with Past A and Part B Medicare Primary Coverage
Medical Benefit deductible - amount available for possible reimbursement	$220	$0
Coverage of Basic services	80%	80%
Additional dental benefit	$176	0

If Frank had not satisfied the $50 dental benefit deductible, the results would be:

	Active Participant and Non-Medicare Eligible Retiree Participant	Medicare Retiree Participant with Past A and Part B Medicare Primary Coverage
Medical Benefit deductible - amount available for possible reimbursement	$220	$0
Less dental deductible	$50	
Benefit for possible reimbursement	$170	
Coverage of Basic services	80%	80%
Additional dental benefit	$136	0

(B) Orthodontic Benefit.

(1) Covered Charges. Subject to the lifetime maximum set forth in the Summary of Benefits, the Plan may pay or reimburse the Charges incurred by the Dependent children of Participants, and effective July 1, 2023, Active Employee Participants, and their spousal Dependents, for services in connection with straightening and re-positioning teeth.

(2) Exclusions and Limitations from Coverage. The Plan will not pay or reimburse Charges for Orthodontic Benefits for the Non-Medicare Eligible Retiree Participants and their spousal Dependents and Medicare Retiree Participants with Part A and Part B Medicare Primary Coverage and their spousal Dependents. The Plan will also not pay or reimburse charges for Orthodontic Benefits for Dependent children and effective July 1, 2023, Active Employee Participants, and their spousal Dependents, for treatment or services outlined in Section C.7(A)(2).

SECTION C.8 Optical Expense Benefit

8. Optical Expense Benefits.

(A) Covered Charges. Subject to the exclusions contained in subsection (B) below, the Plan will pay or reimburse up to the limit set forth in the Summary of Benefits, Charges (subject to the Usual, Customary and Reasonable "UCR" fee) incurred by Participants and their Dependents for the optical services listed below. Please contact the Vision Provider for information. Notwithstanding the foregoing, the Plan will not impose an annual limit on pediatric vision services which are deemed to be essential health benefits under the Patient Protection and Affordable Care Act. For pediatric vision services, the Plan will adopt the frequency limits recommended by the American Optometric Association. The annual limit imposed on Participants and Dependents age 19 and older will be determined on a calendar basis.

(1) Complete eye examination, including refractions. 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; or
(3) Contact lenses.

Effective August 1, 2023, subject to the exclusions in (B) below, the terms of the contract with the Vision Provider, and the Lifetime Limit set forth in the Summary of Benefits, the Plan pay or reimburse Charges for Lasik surgery incurred by Active Employee Participants and their Dependents.

(B) Exclusions from Coverage. Subject to the terms of the contract with the Vision Provider, the Plan will not pay or reimburse Charges for Optical Expenses for the following treatments and/or services for Participants and their Dependents:

(1) Costs of lens kits.
(2) Non-prescription items including but not limited to eyeglass cases, care kits, solutions, protection plans and warranties.

(3) Medical or surgical treatment for eye disease, which requires the services of a physician. (Coverage for care/treatment may be available thru the medical portion of the Plan.)
(4) Elective corrective vision surgery.
(5) Services covered by Worker's Compensation.
(6) Services or materials that are not specifically covered by the Plan.
(7) Replacement or repair of lenses and/or frames that have been lost, stolen or broken.
(8) Cosmetic Services or materials.
(9) Charges in excess of the Usual, Customary, Reasonable Allowance.

(C) Limitations on Coverage. 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 Optical Expense Benefits for Participants and their Dependents as follows subject to the limit set forth in the Summary of Benefits. If the Participant can provide the Plan with (1) an itemized bill showing the date of the service, the services which were rendered and the amount charged for each service and (2) adequate documentation to establish that the Participant paid for optical expense benefits and that such benefits will not be reimbursed by the pre-paid provider, the Plan will reimburse the Participant the amount paid.

SECTION C.9 Insurance Benefits (Disability, Life Insurance and AD&D)

9. Insurance Benefits.

(A) Types of Benefits. This Plan provides four categories of insurance benefits: (i) Weekly Disability Benefits, (ii) Life Insurance Benefits, (iii) Accidental Death, Dismemberment and Loss of Sight Benefits, and/or (iv) Long-Term Disability Benefits. The insurance benefits are available only to Active Employee Participants but each of the four categories of insurance benefits may not be available to all Employees. The actual benefits provided to the different groups of Active Employee Participants will be determined based on the terms of the collective bargaining agreement and the applicable Summary of Benefits.

(B) Weekly Disability Benefit.

(1) Coverage. Subject to the limitations and exclusions set forth in (3) below, the Plan will provide a "Weekly Disability Benefit" to Employees who are Active Employee Participants as defined in Section A.1 who have a Disability. The Fund will pay the Weekly Disability Benefit from the first day of the Disability resulting from an accident and from the seventh day of the Disability resulting from a sickness (including pregnancy).

(2) Amount and Length. The amount and length of Weekly Disability Benefit payments will be determined as set forth in the Summary of Benefits. The Weekly Disability Benefits will end on the earlier of (a) the date of commencement of retirement plan benefits by a Plan Participant or (b) the end of the Maximum Period of Benefits set forth in the Summary of Benefits.

(3) Exclusions and Limitations on Coverage. The Plan will not make Weekly Disability Benefit payments for the following injuries or conditions:

(a) Successive periods of Disability separated by less than two weeks and one day 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. There is no return to work requirement if the Disability results from a different, unrelated incident.

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

(c) Injuries or conditions incurred by a Dependent.

(d) Injuries or conditions occurring while an Employee is not an Active Employee Participant or a Participant is not a current Employee.

(e) Injuries or conditions resulting from a suicide, attempted suicide, or intentionally inflicted injury.

(f) Injuries or conditions resulting from an occupational illness or injury.

(g) Injuries or conditions resulting from participating in or attempting to commit a felony.

(h) Injuries or conditions 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 a driving while intoxicated conviction is received.

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

(j) Injuries or conditions 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.

(k) Participation in any reckless activity voluntarily, which is unnecessary and for recreational purposes, and which, in the opinion of the Trustees constitutes "reckless endangerment".

(l) A Participant who reaches his retirement date and commences pension benefits.

(m) The Plan will not pay for services for completing claim forms or for providing other records or reports.

(n) A Participant who is not an Active Employee Participant under Section A.1.

(C) Life Insurance Benefit, Accidental Death, Dismemberment Benefit and Long-Term Disability Benefit. The Fund will provide a Life Insurance Benefit, an Accidental Death, Dismemberment Benefit and a Long-Term Disability Benefit to Active Employee Participants where such coverage is provided by the terms of the applicable collective bargaining agreement. The amount of the coverage is set forth in the Summary of Benefits and the terms of the coverage as of the Effective Date is set forth in the Fund's separate contract with the insurance carrier, the terms of which are incorporated by reference. The Fund has purchased an insurance contract from an insurance company and you recently received a Certificate of Coverage detailing the various benefits. Please refer to your Certificate of Coverage for more information. Successor contracts are hereby incorporated by reference. The Plan will not pay for services for completing claim forms or for providing other records or reports.

SECTION D: CONTINUATION OF COVERAGE

1. IN GENERAL.

   Notwithstanding any Plan provision to the contrary, each Qualified Beneficiary who would otherwise lose Medical Care coverage hereunder as a result of a Qualifying Event shall be entitled to elect, within the election period, to obtain and pay premiums for Continuation Coverage. "Continuation Coverage" shall consist of Medical Care coverage which, as of the time such coverage is being provided, is identical to Medical Care coverage provided under the Plan to similarly situated Participants (and their Dependents) with respect to whom a Qualifying Event has not occurred.

   Medical Care coverage includes Medical Benefits, Prescription Drug Benefits, Dental and Orthodontic Benefit and Optical Benefits. COBRA coverage does not include any of the insurance benefits (disability benefits, life insurance benefits, AD&D and LTD).

   If Medical Care coverage under the Plan is modified for any group of similarly situated Participants or Dependents, such Medical Care coverage shall also be modified in the same manner for all Participants and Dependents who are Qualified Beneficiaries with respect to such group. Any such modifications will continue to credit any Deductible, Co-Payment Feature and Lifetime Maximum in effect prior to the amendment.

2. QUALIFYING EVENTS.

   For purposes of this Section, the term "Qualifying Event" means, with respect to any Participant (and his or her Dependents), any of the following events which, but for the Continuation Coverage hereunder, would result in loss of Medical Care coverage for a Qualified Beneficiary:

   (A) The death of the Participant.

   (B) The termination (other than by reason of 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 (1) 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 (2) a series of repeated violations of employment rules proving that the Participant has regularly and wantonly disregarded his or her obligations.

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

   (D) The Participant becomes entitled to Medicare benefits under Title XVIII of the Social Security Act, as amended.

   (E) A Dependent child of a Participant ceases to be a Dependent child under the specific terms of the Plan, as amended from time to time.

   (F) An Employer's filing of Chapter 11 Bankruptcy.

3. QUALIFIED BENEFICIARY.

The term "Qualified Beneficiary" means:

(A) 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 Dependent child of the Participant or (iii) the spouse of the Participant. Except as set forth in (B), no Participant, Dependent spouse or Dependent child may be considered a Qualified Beneficiary if, on the date prior to the Qualifying Event, such individual was not already eligible for Benefits under the Plan.

(B) newborn infants and children placed for adoption 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".

(C) The term "Qualified Beneficiary" shall exclude nonresident aliens to the extent permitted by law.

4. PERIOD OF COVERAGE.

(A) 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," as defined in Section 5.

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

(3) The date upon which 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 (either part A or part B, whichever occurs earlier).

(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 Title II or XVI of 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.

(B) 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.

5. MAXIMUM COVERAGE PERIODS FOR COBRA CONTINUATION COVERAGE.

(A) The Maximum Coverage Periods are based on the type of the Qualifying Event and the status of the Qualified Beneficiary, as shown below.

(1) 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.

(2) 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:

(a) 36 months after the date the Participant becomes enrolled in the Medicare program; or
(b) 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.

(3) 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.

(4) 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.

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

(B) 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.

(C) 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 II 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.

6. PREMIUM REQUIREMENTS.

(A) A Qualified Beneficiary shall be required to pay a premium for Continuation Coverage. The Plan Administrator shall cause an actuary to determine the applicable premium for each calendar year of 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 increase as measured by the GNP deflator), in a manner which complies with the Code and ERISA.

(B) The Qualified Beneficiary may elect to pay such premium in monthly installments. Payment is due within 30 days after the first day of the coverage period. If Continuation Coverage is elected after the Qualifying Event has occurred, the Qualified Beneficiary shall be permitted for a period of forty-five (45) days after the date of his or her election to pay the premium for Continuation Coverage during the period preceding his or her election. Payment is considered made on the date on which it is postmarked to the Plan.

7. INSURABILITY AND CONVERSION OPTION.

The availability of Continuation Coverage shall 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.

8. QUALIFIED BENEFICIARY'S ELECTION.

(A) 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.

(B) A Qualified Beneficiary may choose to purchase coverage for medical, dental and vision Benefits under the Plan, or coverage for only medical Benefits. At the time of election, the Plan Administrator will provide the cost of each option.

(C) The "Election Period" shall be the period which:

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

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

(a) the date on which coverage would normally terminate; or

(b) the date of the notice given by the Plan Administrator to a Qualified Beneficiary with respect to a Qualifying Event.

(D) 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.

(E) A Qualified Beneficiary who waives Continuation Coverage may revoke such waiver at any time before the end of his or her 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. Revocation of a waiver is an election of COBRA coverage. Waivers and revocations of waivers are considered made on the date they are sent to the Plan Administrator or designee, applicable.

9. NOTICE.
The following notice requirements shall apply:

(A) The Employer shall notify the Plan Administrator of a Qualifying Event by reason of death, or entitlement to Medicare benefits or the Employer's Chapter 11 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.

(B) 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.

(C) 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.

(D) 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 his or her right to elect Continuation Coverage hereunder.

(E) 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 Chapter 11 Bankruptcy filing, provided that the Plan Administrator receives notice within the time prescribed by applicable law or regulation, as summarized above.

(F) Any Qualified Beneficiary who believes he is disabled and therefore eligible for an extended period of continuation coverage must provide the requisite notices to the Plan Administrator as set forth in Code Section 4980B.

10. SPECIAL RULES FOR THE UNIFORM SERVICES EMPLOYMENT AND REEMPLOYMENT 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 his medical, dental and vision benefits 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.

SECTION E: 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 with any other group or blanket health care coverage and limited in all cases to a maximum of one hundred percent (100%) of the actual Charges to the Participant and any Dependents for eligible Benefits. Benefits shall also be coordinated in the same manner with payments made or available under a "no-fault" statute to the maximum extent permitted by law.

2. "PRIMARY-SECONDARY" PAYMENT RULES.

(A) 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 in which:

(a) The patient is a Participant; or

(b) The patient is the covered Dependent child of a Participant and the Dependent child does not have coverage elsewhere from the Dependent's employer, the employer of the Dependent's Spouse or as a Dependent of the Participant's Spouse; or

(c) the patient is the covered Dependent child of a Participant, the Dependent child has coverage under a plan of the Participant's Spouse, and the Participant's birth date precedes his or her Spouse's birth date in the calendar year.

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

(a) Another health care plan is primarily responsible because the patient is covered thereunder as an employee or Spouse of an employee; or

(b) Another health care plan is primarily responsible for a Dependent child because:

(i) the Dependent child is covered under this Plan without being on COBRA Coverage as a result of the Participant's death and the Dependent child is also 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; or

(ii) the Dependent child is covered under this Plan as a result of electing COBRA Coverage upon the Participant's death and the Dependent child is also covered under another plan as Dependent of the Participant's Spouse.

(B) Notwithstanding the foregoing, the following rules apply to the coverage of Dependent children:

(1) If the Dependent child has coverage as an employee or as the Spouse of an employee, such plan will be primary and this Plan will be secondary. This rule applies regardless of the marital status of the Participant.

(2) In the event that the Participant is divorced or legally separated from his or her Spouse and if the Dependent child does not have coverage as an employee or as the Spouse of an employee, the following rules apply. The rules set forth below will apply until the end of the month in which the Dependent child reaches age 26, notwithstanding the fact that the child may have reached the age of majority under state law or the court decree has expired.

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

(b) If there is no such 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 shall be primary, and the plan covering the other parent shall 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:

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

(2) The plan covering the Spouse of the parent who has custody (that is, the stepparent of the Dependent child).

(3) 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 him or her for the longer period of time shall be primary.

4. LACK OF COORDINATION.

Notwithstanding any other provision of the Plan, if Charges covered hereunder 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 Charges not covered by such group insurance or plan.

COB EXAMPLE:

Generally, if you are covered by an employer group health plan, that plan will pay first for you. This is also true if your spouse or your dependent is covered through his or her employer. When a health plan pays first the term used to describe the coverage responsibility is " primary." All bills are required to be billed thru the primary plan first before being submitted to the secondary plan for payment.

In a case where you and your spouse have children and are both employed and have family health coverage through your employers, the order of liability is determined as follows:

	Primary coverage	Secondary coverage
Local 99 member	Local 99 Plan pays primary	Spouse's plan pays secondary
Spouse of 99 member	Spouse's Plan pays primary	Local 99 plan pays secondary
Biological children*	The parent whose birthday (month/day) falls earliest in the year pays primary	The parent with the later birthday pays secondary

* Please note if the children are stepchildren, grandchildren or adopted the rules may be different. Please contact the Fund Office for help in determining the order of liability in special circumstances.

SECTION F: THIRD PARTY RESPONSIBILITY (SUBROGATION)

1. THIRD PERSON RESPONSIBILITY.

(A) Benefits shall be modified when a third person, other than the person for whom a claim is made, is considered responsible or liable for payment due to a sickness or injury. To the extent payment is made for such sickness or injury, or may be in the future, by or for such responsible or 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 unless the requirements of Section F-1(B) are satisfied. 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. By accepting Benefits under the Plan, the Participant or Dependent agree to (i) repay to the Plan benefits paid on his or her behalf out of the monies paid to the Participant or Dependent by the third party or insurer in accordance with Section F-1(B) and (ii) notify the Plan Administrator of any claim, actions, rights of recovery, demands, actions or lawsuits that the Participant or Dependent ay have against a third party for Benefits covered by the Plan. By accepting benefits under the Plan, the Participant and Dependent agree that: (i) the Plan has a 100% first dollar priority lien on any amounts recovered (whether or not designated as payment for medical expenses) (ii) no so-called "fund doctrine" or "common-fund doctrine" or "attorney's fund doctrine" will defeat the Plan's third party recovery or subrogation and reimbursement rights and (iii) no "collateral source" rule, any "made-whole doctrine" or "make-whole doctrine," claim of unjust enrichment nor any other equitable limitation will limit the Plan's third party recovery or subrogation and reimbursement rights.

(B) The Plan has no obligation to pay any Charges excluded from coverage under Section F-1(A) provided however, if the requirements of this Section F-1(B) are satisfied, the Plan will pay Charges excluded from coverage under Section F-1(A) in accordance with the terms of the Plan. Any bill submitted to the Plan for Charges excluded from coverage under Section F-1(A) shall be suspended for payment by the Plan pending satisfaction of the following requirements of this Section F-1(B). If the following requirements of this Section F-1(B) are not satisfied, any suspended bills for Charges excluded under Section F-1(A) will be excluded from coverage under the Plan.

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

(2) The Participant and/or Dependent notify the Plan or its agent in writing within 90 days from the earliest of the following dates:

(a) The occurrence of any injury that gives rise to a subrogated claim;

(b) The notification or filing of any claim, action, right of recovery, demand, action or lawsuit that a Participant or Dependent may have against a third party for Benefits covered under the Plan; or

(c) The engagement of an attorney to handle any subrogated claim.

In the event the Participant or Dependent does not comply with the notification requirements in Section F-1(B)(2), the Plan reserves the right to pursue any and all actions as it deems appropriate, including suspending and or denying payment of Charges, as determined by the Plan, that pertain to the injury, claim or subrogated matter.

(3) The Participant and/ or Dependent involved (or if incapable, that person's legal representative) and the Participant's and/or Dependent's attorney(ies) cooperate with the Plan's reimbursement and subrogation rights by timely executing and returning any and all documents as the Plan may require and acknowledge that:

(a) The Plan has a 100% first dollar priority lien on any amounts recovered (whether or not designated as payment for medical expenses), no so-called "fund doctrine" or "common-fund doctrine" or "attorney's fund doctrine" will defeat the Plan's third party recovery or subrogation and reimbursement rights and no "collateral source" rule, any "made-whole doctrine" or "make-whole doctrine," claim of unjust enrichment nor any other equitable limitation will limit the Plan's third party recovery or subrogation and reimbursement rights.

(b) The Subrogation Packet applies whether or not: (i) liability for the payments is admitted by the responsible persons; and (ii) such payments are itemized.

(c) The Plan will not process any Charges relating to the subrogated claim until:

(i) a complete Subrogation Packet is timely returned to the Plan within 90 days from the date of the mailing by the Plan or, if later, the date requested by the Plan. For this purpose, the Subrogation Packet for the Participant and/or Dependent consists of the following documents: (1) the Subrogation (information) Form, which must be fully completed and executed by the Participant and, if the Dependent is over 18 years of age, the Dependent, (2) the Subrogation Agreement, which must be fully completed and executed by the Participant and, if the Dependent is over 18 years of age, the Dependent, (3) the Reimbursement Agreement, which must be fully completed and executed by the Participant and, if the Dependent is over 18 years of age, the Dependent, and (4) the Acknowledgement and Consent, which must be fully completed and executed by the Participant and, if the Dependent is over the age of 18 years of age, the Dependent, and the Participant's and/or Dependent's attorney, if the Participant and/or Dependent has engaged an attorney to represent him or her in connection with the incident. The Participant and/or Dependent must also provide all supporting documentation requested by the Plan, as may be necessary for the Plan to evaluate the Participant's or Dependent's claim.

(ii) If the Participant or Dependent, as applicable, has not retained an attorney prior to the time that he or she returns the Subrogation Packet, but he or she subsequently retains an attorney to handle the subrogated matter, the Participant and/or Dependent shall notify the Plan in writing within 14 days of the engagement of the attorney and shall return the fully completed and executed Acknowledgement and Consent within 30 days of the date of mailing by the Plan.

(d) In the event the Subrogation Packet is not timely returned (as detailed in (c)(i) or (c)(ii), as applicable), all Charges related to your injury for the three year and three month period measured from the date of your injury will be denied.

(e) While the Participant and/or Dependent and their attorneys are pursuing recovery from a third party, the Participant and/or Dependent and their attorneys agree to provide the Plan or its agent with progress reports on a quarterly basis except that in the event of settlement activity, the Participant and/or Dependent and their attorneys agree to provide the Plan with more frequent updates.

(f) The Participant and/or Dependent and their attorneys shall obtain the written consent of the Plan (or its agents) prior to the resolution of an incident that a third party or insurer may have responsibility; and

(g) The Participant and/or Dependent and their attorneys shall obtain the written consent of the Plan (or its agent) prior to disbursement of any proceeds received as a result of the incident, including, but not limited to, recoveries for health care 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 incident, whether or not said losses reflect benefits covered by the Plan (hereinafter, "Proceeds"). Pending the actual receipt of the Plan's consent to disbursement of the Proceeds, the parties agree as follows:

(i) If the Participant and/or Dependent have engaged an attorney, the attorney shall hold the Proceeds in the Attorney's client trust fund/escrow account.

(ii) If the Participant and/or Dependent have not engaged an attorney or if the attorney disburses funds without first obtaining the Plan's written consent, the Participant and/or Dependent shall hold the Proceeds in a separate non-interest bearing bank account.

(1) The Participant and/or Dependent shall repay to the Plan the Proceeds within 15 days of receipt.

(2) Because all or a portion of the Proceeds represents amounts due and owing to the Plan, all or a portion of the Proceeds constitute Plan assets; the Participant and/or Dependent is a fiduciary with respect to those Plan assets.

(4) To the extent permitted by law, amounts due to repay Benefits as described above may be deducted from other Benefits payable under the Plan after payments by or for the responsible person are made. Once a Participant and/or Dependent accepts a settlement or judgment, to the extent allowed by law, the Plan reserves the right to deny future Benefits payable for the same or related injury for the 12 month period following the settlement or judgement date. Such 12 month period will not be imposed if a Participant or Dependent adequately document that the Benefits are payable for an unrelated injury or the settlement or judgement did not result in payment of an amount which exceeded the Benefits payable as of the date of the settlement or judgement.

(5) The Plan reserves the right to be reimbursed for its court costs and attorneys' fees if the Plan needs to file suit in order to recover Benefit payments from the Participant or Beneficiary.

(6) 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.

(7) The Plan shall have no obligation whatsoever to pay Charges/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. In the event the Subrogation Packet is not timely returned (as detailed in (c)(i) or (c)(ii), as applicable), all Charges related to your injury for the three year and three month period measured from the date of your injury will be denied. Further, in the event the Participant or Dependent is a minor, the Plan shall have no obligation to pay any Charges/Benefits caused by a responsible third party until after the Dependent or his authorized legal representative obtains valid court recognition, and otherwise satisfies the requirements of Section F-1(B). In the event the Participant or Dependent becomes deceased, the Plan shall have no obligation to pay any Charges/Benefits caused by a responsible third party until after the personal representative of the Participant's or Dependent's estate obtains valid court recognition, and otherwise satisfies the requirements of Section F-1(B).

(8) 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. The Plan is not required to help a Participant or Dependent pursue a claim for damages against a third party but will reduce the Plan's lien by a maximum of 33 1/3% for payment of attorney fees and expenses; provided however, that if the recovered amount is less than the lien, the Plan will reduce its share of the recovered amount by 33 1/3% and further provided that in the case of multiple payments for the benefit of the Participant or Dependent, there will be no reduction of the lien (or recovered amount) until the final payment. No so-called "fund doctrine" or "common-fund doctrine" or "attorney's fund doctrine" will defeat the Plan's third party recovery or subrogation and reimbursement rights. In addition, no "collateral source" rule, any "made-whole doctrine" or "make-whole doctrine," claim of unjust enrichment nor any other equitable limitation will limit the Plan's third party recovery or subrogation and reimbursement rights.

2. RIGHT OF REIMBURSEMENT/SUBROGATION.

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 100% first dollar priority lien to the extent of such recovery (whether by settlement, judgment or otherwise) whether or not designated as payment for medical expenses, where the Participant or Dependent does or may recover any

amount from a third person, his or her insurance company, or any other responsible party, as a result of a covered injury or illness. No so-called "fund doctrine" or "common-fund doctrine" or "attorney's fund doctrine" will defeat the Plan's third party recovery or subrogation and reimbursement rights. In addition, no "collateral source" rule, any "made-whole doctrine" or "make-whole doctrine," claim of unjust enrichment nor any other equitable limitation will limit the Plan's third party recovery or subrogation and reimbursement rights. 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. Once a Participant and/or Dependent accepts a settlement or judgment, the Plan reserves the right to deny future benefit payments to the extent allowed by law. The Plan's subrogation rights mirror the Third Party Recovery rights set forth in Section F-1 and incorporated by reference.

<u>Please note</u>: Once you accept a settlement, if less than medical expenses paid to date, the Fund may continue to pay for care. If you accept a settlement which is more than the medial claims paid to date, the Fund will require your medical expenses for the same or related injury for the 12 month period following the settlement or judgement date to be paid from the settlement amount.

SECTION G: FEDERAL LAW REQUIREMENTS

NOTICE OF COMPLIANCE UNDER THE WOMEN'S HEALTH AND CANCER RIGHTS ACT

The Women's Health and Cancer Rights Act of 1998 (the "1998 Law") 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-payment provisions which exist in the Plan.

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

NOTICE OF COMPLIANCE UNDER THE 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.

NOTICE OF YOUR RIGHTS AND PROTECTIONS AGAINST SURPRISE BILLING

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, like a copayment, coinsurance, or deductible. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You're protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other types of services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get out-of-network care. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have these protections:

- You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.

- Generally, your health plan must:
    - Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
    - Cover emergency services by out-of-network providers.
    - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
    - Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact the federal government's NSA Helpdesk at 1-800-985-3059 or the U.S. Department of Labor at 1-866-444-EBSA (3272). You may also visit www.cms.gov/nosurprises/consumers for more information about your rights under federal law.

PATIENT PROTECTION AND AFFORDABLE CARE ACT DISCLOSURE INFORMING INDIVIDUALS ABOUT NONDISCRIMINATION AND ACCESSIBLITY REQUIREMENTS

The Plan complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex (including pregnancy, sexual orientation and gender identity). The Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex (including pregnancy, sexual orientation and gender identity).

To the extent required by law, the Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters;
  - Written information in other formats (large print, audio, accessible electronic formats, other formats);
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters; and
  - Information written in other languages.

If you need these services, contact the Third Party Administrator.

If you believe that the Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex (including pregnancy, sexual orientation and gender identity), you can file a grievance with the Board of Trustees c/o the Third Party Administrator:

Decision Science, Inc.
3615 North Point Boulevard, Suite C
Baltimore, MD. 21222
Phone: 410.254.9595
Fax: 1.800.367.7848
Email:cmaggio@dsibenefitfund.org

You can file a grievance in person or by mail, fax or e-mail. If you need help filing a grievance, the Board of Trustees is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or by phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, HHH Building, Washington, D.C. 20211, 1-800-868-1019; 1-800-537-7697.

Complaint forms are available at: http://www.hhs.gov/ocr/office/file/index.html.

SECTION H: FILING A CLAIM

1. Filing a Claim

If your claim is for Hospital expenses, the Hospital will file a claim for you. Present your Medical Benefit Card when you are admitted into the Hospital. The billing instructions are printed on the back of the card.

If you need a claim form for other medical expenses, please contact the Fund Office at (410) 254-9595 or toll free 1(800)367-7848. Please note that claim forms are not mandatory but will be provided for your convenience.

Your claim must include all of the following information:

* Member's name
* Member's identification number
* Member's home address
* Patient's name and age
* Employer's name
* Doctor's diagnosis and surgical procedure, if applicable
* Doctor's Federal Tax ID Number and NPI number
* Doctor's name, address, phone number
* Doctor's signature in original form
* Appropriate procedure codes

If services have been rendered as a result of an injury of any kind, please provide a brief description of how, when and where the injury occurred.

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. Payments will not be made without both of these statements.

If you want payment to be made directly to the provider of services, please submit the provider's tax identification number and complete name and address. You must also sign an authorization in order for the Fund to release benefits to the provider. Please refer to the attending physician form, a copy of which may be obtained from the Fund Office. 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.).

2. Time Limit for Filing Claims

No amounts will be reimbursed and no benefits will be paid by the Fund for claims filed more than twelve (12) months following the date the service was rendered.

When your claim form is completed, attach original of all bills and mail to:

Operating Engineers Local 99 Benefit Fund
3615 North Point Boulevard, Suite C
Baltimore, MD 21222

3. Initial Benefit Determinations

Urgent Care Claims

In the case of an Urgent Care Claim, the Plan shall notify the claimant of the Plan's benefit determination (whether adverse or not) as soon as possible, taking into account medical exigencies, but not later than 72 hour after receipt of the claim by the Plan, unless the claimant fails to provide sufficient information to determine whether, or to what extent benefits are covered or payable under the Plan. In the case of such a failure, the Plan shall notify the claimant as soon as possible but not later than 24 hours after receipt of the claim by the Plan of specific information necessary to complete the claim. The claimant shall be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. The Plan shall notify the claimant of the Plan's benefit determination as soon as possible but in no case later than 48 hours after the earlier of (1) the Plan's receipt of the specified information, or (2) the end of the period afforded the claimant to provide the specified additional information.

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 Physician with knowledge of the claimant's medical condition, 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. An individual acting on behalf of the Plan applying the judgment of a prudent layperson that possesses an average knowledge of health and medicine may make the determination.

Concurrent care decisions

If the Plan has previously approved an ongoing course of treatment to be provided over a period of time or number of treatments, any reduction or termination by the Plan of such course of treatment (other than by plan amendment or termination) before the end of such period of time or number of treatments shall constitute an Adverse Benefit Determination. In such a case, the Plan shall notify the claimant of the Adverse Benefit Determination at a time sufficiently in advance of the reduction or termination to allow the claimant to appeal and obtain an appeal determination of that Adverse Benefit Determination before the benefit is reduced or terminated.

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

Pre-Service Claims

In the case of a pre-service claim, the Plan shall notify the claimant of the Plan's benefit determination (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim by the Plan. This period may be extended one time by the Plan for up to 15 days, provided the Plan both determines that

such an extension is necessary due to matters beyond the control of the Plan and notifies the claimant, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If such an extension is necessary due to a failure of the claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.

A claim is considered a pre-service claim if the claim requires approval, in whole or in part, in advance of obtaining the health care in question.

Post-Service Claims

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

A post-service claim is any claim for a benefit under the Plan that is not a pre-service claim, as defined above; in other words, a claim that is a request for payment under the Plan for covered medical services already received by the claimant.

Disability claims

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

Other Claims

In the case of claims that do not fall under the categories listed above, the Plan shall notify the claimant of the Plan's Adverse Benefit Determination within a reasonable period of time, but not later than 90 days after receipt of the claim, unless it is determined that special circumstances require an extension of time for processing the claim. If it is determined that an extension of time for processing is required, the Plan shall furnish written notice of the extension to the claimant prior to the termination of the initial 90-day period. In no event shall such extension exceed a period of 90 days from the end of such initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the Plan expects to render a decision.

Calculating Time Periods

For purposes of the time periods specified in this Section, the period of time within which a benefit determination shall be made begins at the time a claim is filed in accordance with Plan procedures, without regard to whether all the information necessary to make a benefit determination accompanies the claim. If a period of time is extended due to a claimant's failure to submit all information necessary to decide the claim, the period for making the benefit determination shall be tolled from the date the notification of the extension is sent to the claimant until the date the claimant responds to the request for additional information.

4. Manner and Content of Adverse Benefit Determinations

The Plan shall provide a claimant with written or electronic notification of any Adverse Benefit Determination. The notification shall set forth, in a manner calculated to be understood by the claimant:

a. The specific reason(s) for the adverse determination;

b. A reference to the specific Plan provisions on which the determination is based;

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

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

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

f. If the Adverse Benefit Determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical

judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and

g. In the case of an Adverse Benefit Determination concerning an Urgent Care Claim, a description of the expedited review process applicable to such claims.

h. In the case of an Adverse Benefit Determination with respect to disability benefits:

(i) A discussion of the decision, including an explanation of the basis for disagreeing with or not following:

(A) The views presented by the claimant to the Plan of healthcare professionals treating the claimant and vocational professional who evaluated the claimant;

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

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

(ii) If the Adverse Benefit Determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request;

(iii) Either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the Adverse Benefit Determination, or a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist; and

(iv) A statement that the claimant is entitled to receive, upon request and free of charge reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits.

In the case of an Adverse Benefit Determination concerning an Urgent Care Claim, the information described above may be provided to the claimant orally within the permitted time frame, provided that a written or electronic notification in accordance with this section is furnished to the claimant not later than three (3) days after the oral notification.

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.

5. Appeal of Adverse Benefit Determinations

A claimant has the following rights with regard to an Adverse Benefit Determination:

a. A claimant has the right to file an appeal to the Plan within 180 days following receipt of the Adverse Benefit Determination notice.

b. A claimant has the opportunity to submit written comments, documents, records and other information relating to the claim for benefits (See Section H.6.);

c. A claimant shall be provided, upon written request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits.

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

e. A claimant shall be provided a review that does not afford deference to the initial Adverse Benefit Determination and that is conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the Adverse Benefit Determination that is the subject of the appeal nor the subordinate of such individual.

f. In deciding an appeal of any Adverse Benefit Determination that is based in whole or in part on a medical judgement, including determinations with regard to whether a particular treatment, drug or other item is experimental, investigational or not medical necessary or appropriate, the appropriate named fiduciary shall consult with a health care professional who has the appropriate training and experience in the field of medicine involved in the medical judgement. Such health care professional shall be an individual who was neither consulted in connection with the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of any such individual; and

g. The Plan shall identify medical or vocational experts whose advise was obtained on behalf of the Plan in connection with a claimant's Adverse Benefit Determination, without regard to whether the advice was relied upon in making the benefit determination.

h. In addition to the above requirements, the review of a disability determination shall also require that:

   (i) Before the Plan can issue an Adverse Benefit Determination on review of a disability benefit claim, the Plan shall provide the claimant, free of charge, with any new or additional evidence considered, relied upon or generated by the Plan, insurer, or other person making the benefit determination (or at the direction of the Plan, insurer or other

such person) in connection with such claim; such evidence misty be provide as soon as possible and sufficiently in advance of the date on which the response of the Adverse Benefit Determination review information is required to give the claimant a reasonable opportunity to respond prior to that date and

(ii) Provide that, before the Plan can issue an Adverse Benefit Determination on review on a disability benefit claim based on a new or additional rationale, the Plan shall provide the claimant, free of charge, with such rationale; the rationale must be provided as soon as possible and sufficient in advance of the appeal response date to give claimant a reasonable opportunity to respond prior to that date.

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.

6. How to File an Appeal

In the event that you or your Dependents receive an Adverse Benefit Determination, you may file an appeal to your Board of Trustees. All of the information related to the appeal must be received in the Fund Office at least ten (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 Participant or Dependent briefly describing the situation and detailing the special request.

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:

Operating Engineers Local 99
3615 North Point Boulevard, Suite C
Baltimore, MD 21222
Attn: Appeal Department

The Participant's identification number should appear on all appeal items. Please contact the Fund Office if you have any questions concerning the appeal process.

7. Response Time for Appealed Adverse Benefit Determinations

The Plan Administrator shall notify the claimant in writing no later than five days after the benefit determination has been made.

In the case of a claim involving urgent care, the Plan shall notify the claimant, of the Plan's determination on review as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claimant's request for review of an Adverse Benefit Determination by the Plan. In the case of a pre-service claim, the Plan shall notify the claimant not later than 30 days after receipt by the plan of the claimant's requested review of an Adverse Benefit Determination.

The Plan shall provide the claimant with written or electronic notification of its appeal determination. In the case of an Adverse Benefit Determination, the notification shall set forth, in a manner calculated to be understood by the claimant:

a. The specific reason(s) for the adverse determination;

b. A reference to the specific Plan provisions on which the determination is based;

c. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claimant's claim for benefits.

d. A statement describing any voluntary appeal procedures offered by the Plan, and a statement of the claimant's right to bring an action under Section 502(a) of ERISA. In the case of disability benefits, a statement of the claimant's right to bring an action under Section 502(a) of ERISA and any applicable contractual limitations period that applies to the claimant's right to bring such an action.

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

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

h. A statement that the claimant may have other voluntary alternative dispute resolution options, such as mediation.

i. In the case of an Adverse Benefit Determination with respect to disability benefits:

(i) A discussion of the decision, including an explanation of the basis for disagreeing with or not following:

(A) The views presented by the claimant to the Plan of healthcare professionals treating the claimant and vocational professional who evaluated the claimant;

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

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

(ii) If the Adverse Benefit Determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request;

(iii) Either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the Adverse Benefit Determination, or a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist.

8. External Appeal Rights for No Surprises Act Claims.

Please see the Plan Administrator for details.

SECTION I: Statement of ERISA Rights

YOUR RIGHTS UNDER THE FUND

As a member of the Fund, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan Participants shall be entitled to:

Receive Information About your Plan and Benefits

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

Obtain, upon written request to the Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan descriptions. The Administrator may make a reasonable charges for the copies.

Continue Group Health Plan Coverage

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

Prudent Actions by Plan Fiduciaries

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

SECTION J: ADMINISTRATIVE AND MISCELLANEOUS INFORMATION

Fund Administration. The Board of Trustees sponsors the Fund described in this booklet. Decision Science, Inc. is the Administrator of the Fund.

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

Legal Matters. If you have a question about any legal Fund Provision, contact the Plan Administrator. You may serve legal papers on the Fund Sponsor or the Fund Administrator. The Trustees have the discretion to construe and/or interpret the terms of the Plan.

The Plan is maintained pursuant to various collective bargaining agreements. You may obtain, upon written request, a complete list of the employers participating in the Plan, the collective bargaining agreements, if any, that pertains to employers whose employees are covered by the Plan, and a list of providers included in the PPO network. Please contact the Administrator or send him a written request for more details. You may also examine the documents.

The common name for the Fund is the Operating Engineers Local 99 and 99A Health Care Fund.

Funding Medium. The Plan assets are held in a trust and contributions to the trust are made by the participating Employers. Employees may also make contributions.

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

Assignment of Benefits. Generally, no assignment for the benefit of creditors of any benefit provided under the Fund will be valid.

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.

Permitted Uses and Disclosures of Protected Health Information. The Health Insurance Portability and Accountability Act (HIPAA) privacy rules generally allow the use and disclosure of your health information without your permission for purposes of health care treatment, payment activities, and health care operations. The amount of health information used or disclosed will be limited to the "minimum necessary" for these purposes, as defined under the HIPAA rules. The Plan may also disclose your health information without your written authorization to your Employer for plan administration purposes.

SECTION K: IMPORTANT NAMES AND NUMBERS

Name of the Fund	Health and Welfare Trust Fund for International Union of Operating Engineers Local 99 and 99A
Fund Number	501
Employer Identification Number	52-6072849
Plan Year	January 1st to December 31st
Type of Fund	Self-Funded Health and Welfare Benefit Fund
Fund Sponsor	Board of Trustees of the Health and Welfare Fund for the International Union of Operating Engineers Local 99 and 99A 3615 North Point Boulevard, Suite C Baltimore, MD 21222 Tele: (410) 254-9595 1-800-367-7848
Plan Administrator	Contract Administrator: Decision Science, Inc. 3615 North Point Boulevard, Suite C Baltimore, MD 21222 Tele: (410) 254-9595 1-800-367-7848

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