

Central States Joint Board Health & Welfare Fund

Plan B – Summary Plan Description

and Plan Document

2022 Edition

CENTRAL STATES JOINT BOARD HEALTH AND WELFARE FUND

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A MESSAGE FROM THE BOARD OF TRUSTEES

We are pleased to provide you with this booklet describing your health benefits under the Central States Joint Board Health and Welfare Fund – Plan B, effective March 1, 2022, unless otherwise indicated. Although this booklet is meant to be an easy-to-understand description of your Plan benefits, it also serves as the Plan Document, and the Plan’s official rules and regulations.

This booklet describes the benefits and the Plan’s eligibility rules. Important terms used throughout this booklet are capitalized and defined. Please keep this booklet with your other important papers and share this information with your family. If you have questions about information in this booklet, you should contact the Fund Office.

This booklet replaces and supersedes any previous written explanation of the Plan.

IMPORTANT REMINDERS

- Tell your family, particularly your spouse, about this booklet and where it is located.
- Please notify the Fund Office promptly if you change your address.
- Only the full Board of Trustees is authorized to interpret the benefits described in this booklet.
- No Employer, Union, nor any representative of any Employer or Union, in such capacity, is authorized to interpret this Plan, nor can any such person act as agent of the Trustees.
- The Trustees reserve the right to amend, modify or discontinue all or part of this Plan whenever, in their judgment, conditions so warrant. You will be notified in writing of any Plan changes.

PLAN VENDOR INFORMATION AS OF MARCH 1, 2022

The **Fund Office** is responsible, under the oversight of the Board, for providing various administrative services for the Fund, including maintaining eligibility records, ensuring that Plan provisions are followed on the payment of claims, handling member requests for information and providing various reports and other services that the Fund requires.

Please visit www.csjunion.org to review the Plan/SPD 24 hours a day, 7 days a week. The website contains additional links and services that you may find valuable to understand and use your coverage effectively. Please take full advantage of this service. Additionally, the Fund Office is available for any questions you or your Dependents may have regarding your benefits or eligibility at (800) 258-6466, Monday through Thursday 8:00 a.m. to 4:30 p.m., and Friday 8:00 a.m. to 2:00 p.m.

The **Preferred Provider Organization (PPO or network)** provides access to medical providers offering discounted fees in exchange for the Plan's reimbursement of their services at a higher level than for non-network providers. *The Trustees selected Blue Cross and Blue Shield of Illinois (BCBSIL) as its PPO.* The Blue Cross/Blue Shield ID card is accepted by an extremely wide range of Hospitals, Physicians and other health care providers who have agreed to participate in the network program. Please call the number provided on your ID card, the Fund Office or visit www.bcbsil.com to identify PPO providers.

The **Review Organization** helps you and the Fund reduce costs and wasteful expenses by reviewing, authorizing and certifying certain medical procedures, admissions and other medical expenses. *The Trustees selected Medical Cost Management (MCM) to provide pre-certification, case management and utilization review services to the Plan.* You may contact Medical Cost Management for any questions and/or to request pre-certification at (800) 367-9938.

The **Pharmacy Benefit Manager (PBM)** provides access to pharmacies and mail order services offering discounted prices for covered Prescription Drugs in exchange for the Plan's coverage of such services at a higher level than for non-participating pharmacies or mail order providers. *The Trustees selected OptumRx to provide the Plan's preferred Prescription Drug coverage.* Call OptumRx at (800) 797-9791 or visit www.optumrx.com for answers to your Prescription Drug questions.

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SECTION 1: SCHEDULE OF BENEFITS

A Schedule of Benefits is a list of benefit amounts and exclusions that apply to benefits offered by the Fund. Each specific benefit is described in more detail in the section concerning that particular benefit. When reading the specific benefit section, you should reference the applicable Schedule of Benefits and vice versa.

<i>Major Medical Benefit</i>		
<i>Plan Deductibles for Covered Medical Expenses</i>	<i>PPO Charges</i>	<i>Non-PPO Charges</i>
<p>Calendar Year Deductible</p> <p>(Does not apply to Co-Payments, Preventive Services, Emergency Room services, or Prescription Drugs)</p>	<p>\$1,000 per person</p> <p>\$3,000 per family</p>	<p>Not Applicable</p>
<i>Major Medical Out-of-Pocket Maximum per Calendar Year</i>	<i>PPO Charges</i>	<i>Non-PPO Charges</i>
<p>Once you reach the out-of-pocket maximum, the Plan pays 100% of any additional Covered Medical Expenses, up to any specific Plan maximums, for the calendar year up to the maximum benefit listed.</p> <p>(The maximum does not include Prescription Drug Co-Payments)</p>	<p>\$3,500 per person*</p> <p>\$10,500 per family*</p>	<p>Not Applicable</p>
<i>Covered Medical Expenses Subject to Visit Maximums</i>		
Home Health Care	60 visits per calendar year if arranged through case management. If not, 40 visits per calendar year.	
Skilled Nursing Facility	150 confinement days per calendar year if arranged through case management. If not, 120 days per calendar year.	
Sclerotherapy	3 sessions per calendar year	
<p>Weight Loss Treatment</p> <p>(Does not include nutritional plans such as Jenny Craig or Weight Watchers)</p>	4 visits per calendar year	

Major Medical Benefit

Covered Medical Benefits Subject to Dollar Maximums

Chiropractic Services	\$500 per calendar year	
Temporomandibular Joint Syndrome (TMJ) Treatment	\$500 per calendar year \$2,000 per lifetime	
Infertility Treatment (Employee and Spouse Only)	\$5,000 per lifetime	
<i>Covered Medical Expenses Paid by the Fund up to the R&C Charges</i>	<i>PPO Charges</i>	<i>Non-PPO Charges</i>
Primary Care Physician Office Visit	100% after \$25 Co-Payment	Not Covered
Specialist Office Visit	100% after \$50 Co-Payment	Not Covered
Preventive Services	100%	Not Covered
Physical Therapy	80%	Not Covered
Occupational Therapy	80%	Not Covered
Speech Therapy	80%	Not Covered
Chiropractic Services	80%	Not Covered
Podiatric Care / Foot Surgery	80%	Not Covered
Emergency Room Services *Co-Payment waived if admitted to Hospital within 48 hours	80% after \$400 Co-payment*	80% after \$400 Co-payment*
Emergency Medical Transportation	80%	80%
Surgi-Centers, Ambulatory Surgery Centers, Free Standing Surgery Facilities	80%	Not Covered
Urgent Care Services	100% after \$25 Co-Payment	Not Covered
Hospital/Facility	80%	Not Covered

Major Medical Benefit		
<i>Covered Medical Expenses Paid by the Fund up to the R&C Charges</i>	<i>PPO Charges</i>	<i>Non-PPO Charges</i>
Mental/Nervous Disorders and/or Chemical Dependency/Substance Abuse		
Inpatient Treatment	80%	Not Covered
Outpatient Treatment	80%	Not Covered
Diagnostic Tests (x-rays and blood work)	80%	Not Covered
Imaging (CT/PET scans, MRIs)	80%	Not Covered
Skilled Nursing Facility	80% if arranged through case management; 70% if not arranged through case management	Not Covered
Home Health Care	80% if arranged through case management; 70% if not arranged through case management	Not Covered
Hospice Care	80% if arranged through case management; 70% if not arranged through case management	Not Covered
Durable Medical Equipment	80%	Not Covered
Transplants	80%	Not Covered
All other Covered Medical Expenses	80%	Not Covered

Prescription Drug Benefit

<p>Out-of-Pocket Maximum per Calendar Year</p> <p>* The out-of-pocket maximums are adjusted annually so the combined out-of-pocket maximums for Prescription Drugs and Major Medical (PPO) equal the maximum permitted under the Affordable Care Act.</p>	<p align="center">\$4,400 per person* \$5,300 per family*</p>	
<p><i>Covered Prescription Drug Benefits Subject to Dollar Maximums</i></p>		
<p>Infertility Treatment (Employee and Spouse Only)</p>	<p align="center">\$5,000 per lifetime</p>	
<p><i>Your Co-Payment Amount</i></p>	<p align="center"><i>Retail (30-day supply)</i></p>	<p align="center"><i>Mail (90-day supply)</i></p>
<p>Generic</p>	<p align="center">10% up to \$200 maximum</p>	
<p>Brand</p>	<p align="center">35% up to \$200 maximum</p>	
<p>Brand with Generic Equivalent</p>	<p align="center">35% up to \$200 maximum, plus 100% of the difference in cost of the generic and brand name medication</p>	
<p>Specialty</p>	<p align="center">20% up to \$250 maximum</p>	

SECTION 2: ELIGIBILITY

2.01 Eligibility for Employee Benefits.

A. Initial Eligibility Requirements.

You will become eligible for benefits on the first day of the month for which Contributions are required to be submitted on your behalf.

B. Continued Eligibility Requirements.

You will continue to be eligible for benefits under the Plan for each calendar month in which your Contributing Employer submits the required Contributions on your behalf.

C. Maintaining Coverage by Self-Payments.

Self-Payments are generally not permitted under the Plan, unless your Employer is not required under the Collective Bargaining Agreement to make the full Contribution on your behalf for any calendar month.

Most Employers will make a payroll deduction from your wages and submit your portion of the required Contribution to the Fund Office. If your Employer fails to submit the payroll deduction, you are required to pay the difference. The Fund Office will send a notice regarding your obligation to make a Self-Payment. You must submit your Self-Payment by check or money order on or before the 10th day of the month following the month the Fund Office notifies you of your obligation to make a Self-Payment.

If you fail to make a timely Self-Payment, your eligibility will terminate under the Plan.

D. When Coverage Ends.

Your coverage for benefits under the Plan will end on the last day of the calendar month upon the earliest of the following events:

1. You fail to qualify for eligibility under any of the Plan's eligibility rules;
2. You fail to make a timely Self-Payment;
3. Your Employer ceases to be signatory to a Collective Bargaining Agreement with the Union;
4. Your death; or
5. The Trustees discontinue the Plan.

E. Reinstatement of Eligibility.

If you lose eligibility under the Plan because your Employer failed to submit Contributions on your behalf or you fail to make a timely Self-Payment, you must meet the Initial Eligibility Requirements to regain coverage.

2.02 Open Enrollment for Benefit Coverage Options.

A. General Information.

Open enrollment is the designated time each year for you to update or confirm your enrollment information or change your benefit coverage option (if applicable). You must re-enroll every year to verify or update your enrollment information, even if you do not have changes to make. Completing open enrollment every year ensures that you and your eligible Dependents have coverage for the next year beginning on January 1st, so that you can avoid any delayed or unpaid claims.

The open enrollment period is generally offered from December 1 through December 31. You will receive information from the Fund Office through your Employer that allows you to update or confirm your benefit coverage options. You must return your completed enrollment form to the Fund Office by December 31.

If you timely return your completed enrollment form, your new benefit coverage options shall become effective for services provided on or after January 1. If you do not make an election during the open enrollment period, you will keep the coverage you had the previous year.

B. Tiered Contribution Rates.

The monthly Contribution rate required on your behalf is based on the level of coverage you elect. Contribution rates are determined based on the cost of coverage. Each Employer, through the collective bargaining process, determines whether the entire Contribution amount is paid by the Employer, or split between the Employer and the Employee. Your collectively bargained Contribution rates are listed on your enrollment form. Contribution rates are periodically reviewed and subject to change at any time.

C. Coverage Options.

Employees have five coverage options from which to choose: (1) Employee only coverage; (2) Employee plus children coverage; (3) Employee plus spouse coverage; (4) Employee plus family coverage (which includes coverage for spouse and eligible children); and (5) No coverage.

If you do not choose a coverage option when you initially become eligible for benefits, you will automatically be enrolled in the Employee only coverage option. Additionally, you may only opt-out of coverage under this Plan provided you have other health insurance or group health coverage.

D. Opt-Out and Special Enrollment Rights.

If you and/or your Dependent(s) opt-out of coverage under this Plan because you and/or your Dependent(s) have other health insurance or group health coverage, federal law may allow you and/or your Dependent(s) to enroll for coverage under this Plan when:

1. You or your Dependent(s) later lose eligibility for that other coverage; or
2. You acquire a Dependent through marriage, birth, adoption or placement for adoption.

If the other health coverage was COBRA Continuation Coverage, a special enrollment is only available after the COBRA Continuation Coverage has been exhausted. If the other coverage is not COBRA Continuation

Coverage, a special enrollment is available if you are no longer eligible for coverage or employer contributions for the other coverage.

To exercise your special enrollment rights, you must notify the Fund Office within 60 days of the loss of other health coverage or the date of marriage, birth, adoption, or placement for adoption. To enroll yourself and/or your Dependent(s), you will need to complete, sign and submit enrollment forms to the Fund Office.

If you are enrolling yourself or your Dependent(s) after the other health coverage ends, coverage will become effective on the date you or your Dependent(s) lose the other health coverage provided you or your Dependent(s) enroll within 60 days of the loss of other health coverage. If enrollment occurs more than 60 days after the loss of other health coverage, coverage becomes effective on the date the Fund Office receives the completed enrollment forms.

Note that you must notify the Fund Office in writing within 60 days of the date you acquire a Dependent due to that Dependent's loss of coverage under a state Children's Health Insurance Program (CHIP) or Medicaid, and within 60 days of the date your Dependent becomes eligible for any state-sponsored premium assistance subsidy program.

2.03 Effect of Military Service on Eligibility.

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

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

In order to exercise your options, you must notify the Fund in writing when you are called to active service. The Fund will send you an election form with three options regarding your Plan benefits as follows:

- Option 1: Suspend eligibility and rely on military coverage for you and your Dependents (as of the date active coverage is suspended, you will be offered the right to pay for COBRA Continuation Coverage for up to 24 months). This is the **DEFAULT OPTION**.
- Option 2: Suspend active coverage under the Plan for as long as the Plan's eligibility rules permit, and then elect COBRA coverage for up to 24 months.
- Option 3: Continue active coverage for as long as the Plan's eligibility rules permit, and then elect COBRA coverage for up to 24 months.

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

Option 1

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

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

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

Option 2

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

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

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

Option 3

If you elect Option 3 (continue active coverage), you and your Dependents will receive active coverage for as long as Contributions are submitted on your behalf. Thereafter, you will be offered COBRA coverage for up to 24 months. The standard election and payment deadlines under COBRA apply.

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

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

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

2.04 Eligibility under the Family and Medical Leave Act (FMLA).

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

During your absence, you will continue to receive coverage under the Plan. If you return to work for an Employer within the FMLA guidelines, you will continue to receive coverage if you otherwise meet the Plan's eligibility requirements.

If your coverage terminates, you will then be eligible to purchase COBRA Continuation Coverage. Contact the Fund Office for additional information about your coverage during an FMLA leave or continuing your coverage under COBRA.

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

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

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

1. You may qualify for up to 12 weeks (during any 12-month period) of unpaid leave for your own serious illness, the birth or adoption of a child, to care for a seriously ill spouse, parent or child or qualifying exigency to deal with the affairs of your spouse, child, or parent because he or she is called to duty. A qualifying exigency includes short-notice deployment, military events and related activities, childcare and school activities, financial and legal arrangements, counseling, rest and recuperation, post-deployment activities and additional activities as defined under the FMLA in 29 CFR Part 825.
2. You may qualify for up to 26 weeks (during any 12-month period) of unpaid leave to care for a covered service-member with a serious injury or illness if the Employee is the spouse, child, parent or next of kin of the service-member as defined under the FMLA in 29 CFR Part 825. However, please be aware that this 26 week leave is the maximum time period allowed and is not in addition to the 12 week leave provided above.

2.05 Dependent Eligibility.

A. Dependents' Initial Eligibility.

Your Dependents will become eligible for benefits on the later of the following to occur:

1. The date you are eligible for coverage; or
2. The date he or she meets the definition of Dependent under the Plan.

B. When Dependent Eligibility Ends.

Your Dependents' coverage will end on the last day of the month on the earliest of the following to occur:

1. The date your eligibility ends;
2. The date he or she no longer meets the definition of a Dependent under the Plan;
3. The date the Trustees terminate Dependent benefits under the Plan;
4. The date your Dependent spouse enters military service; or
5. The date the Trustees terminate the Plan.

C. Dependent Eligibility under a Qualified Medical Child Support Order (QMCSO).

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

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

The Fund Office will notify you if a QMCSO is received. You may request a copy of the Fund's QMCSO procedures, free of charge, if you need additional information.

2.06 COBRA Continuation Coverage.

A. General Provisions.

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

If you elect COBRA Continuation Coverage, you pay the full cost of the continued coverage plus a small administrative charge. The continuation of COBRA coverage is conditioned on timely and uninterrupted payment of premiums.

If you (as the Employee) have a newborn child, adopt a child or have a child placed with you for adoption (for whom you have financial responsibility) while COBRA Continuation Coverage is in effect, you may add the child to your coverage. You must notify the Fund Office in writing of the birth or placement in order to have this child added to your coverage. Children born, adopted or placed for adoption as described above, have the same COBRA rights as your spouse or Dependents who were covered by the Plan before the Qualifying Event that triggered COBRA Continuation Coverage.

B. Marketplace Coverage.

There may be other coverage options for you and your family. For example, you may be able to buy coverage through the Health Insurance Marketplace. In the Marketplace, you could be eligible for a tax credit that

lowers your monthly premiums right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit through the Marketplace. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days. You should review your options under the Marketplace and compare them with the Plan's COBRA Continuation Coverage to determine which option is best for you and your family.

If you have any questions about your rights to COBRA Continuation Coverage, you should contact the Fund Office. For information on the Marketplace, please visit www.healthcare.gov.

C. Eligibility.

1. 18-Month COBRA Continuation Coverage.

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

Under these circumstances, the Qualifying Event will result in loss of coverage on the first day of the calendar month where you did not meet the Continued Eligibility Requirements under the Plan.

2. Disability Extension of 18-Month COBRA Continuation Coverage.

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

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

If the Social Security Administration determines that you or your eligible Dependent are no longer disabled, your disability extension will terminate. You must notify the Fund Office within 30 days of a final determination by the Social Security Administration that you or your eligible Dependent are no longer disabled.

3. 36-Month COBRA Continuation Coverage.

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

- a. Your death;

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

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

4. Second Qualifying Event.

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

D. COBRA Premiums, Payments and Due Dates.

The COBRA premium is determined by the Trustees and adjusted from time to time; however, this adjustment will occur no more than once during the Plan's fiscal year unless there is a substantial change in the Plan.

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

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

E. The Notification Responsibilities of the Fund Office.

When the Fund Office is notified of a Qualifying Event, the Fund Office will send a COBRA Election Notice and COBRA Election Form to you and your Dependents who would lose coverage due to the Qualifying Event. The Fund Office will send the notice within 45 days of the time it receives notice of a Qualifying Event. The Election Notice tells you about your right to elect COBRA Continuation Coverage, the due dates for returning the Election Form, the amount of the payment for COBRA Continuation Coverage and the due dates for COBRA payments.

To protect your Dependents' rights, you should keep the Fund Office informed of any change in your address or your Dependents' addresses.

F. Electing COBRA Continuation Coverage.

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

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

G. When the COBRA Coverage Period Begins.

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

H. When COBRA Coverage Ends.

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

1. You or your Dependent becomes covered under another group health plan. However, coverage will continue if you or an eligible Dependent was covered under another group health plan prior to the COBRA election, or if you or the eligible Dependent has a health problem for which coverage is excluded or limited under the other group health plan;
2. The required COBRA premium is not timely paid;
3. The Trustees terminate the Plan;
4. You or your Dependent reaches the end of the 18-month, 29-month or 36-month applicable Continuation Coverage period;

5. Your coverage under the Plan ends and you become entitled to Medicare after you elect COBRA Continuation Coverage. However, if your eligible Dependents are entitled to COBRA Continuation Coverage, their maximum coverage period is 36 months from the initial Qualifying Event; or
6. Your Dependents become entitled to Medicare after their coverage under the Plan ends.

SECTION 3: MAJOR MEDICAL BENEFIT

3.01 Eligibility for Major Medical Benefit.

If you are eligible for Employee Benefits, your coverage includes the Major Medical Benefit.

3.02 The Deductible.

The Deductible is the amount of Covered Medical Expenses that you and each of your eligible Dependents pay each Calendar Year before Plan benefits are paid. The amounts of the individual and family Deductibles are listed in the Schedule of Benefits.

The family Deductible may be satisfied through any combination of individual Deductibles. Once you meet the family Deductible, no further Deductible will be applied to any eligible member of your family during the remainder of the calendar year.

3.03 Percentage of Benefits Payable.

Once you pay the calendar year Deductible, the Plan will pay the percentage of your Covered Medical Expenses listed in the Schedule of Benefits up to the Reasonable and Customary Charges (R&C) and up to any Plan maximums.

3.04 Out-of-Pocket Maximum.

The maximum amount you pay for Covered Medical Expenses each calendar year is the out-of-pocket maximum listed in the Schedule of Benefits. Once you reach the applicable out-of-pocket maximum, the Fund pays 100% of any additional Covered Medical Expenses, up to any specific Plan maximums, for the remainder of the calendar year.

The family out-of-pocket maximum may be satisfied through any combination of individual out-of-pocket maximums. Once you reach the family out-of-pocket maximum, no further individual out-of-pocket maximum will be applied to any eligible member of your family during the remainder of the calendar year.

The amounts excluded from the out-of-pocket maximums are provided in the Schedule of Benefits.

3.05 Preferred Provider Organization (PPO).

The Fund contracts with a Preferred Provider Organization (PPO) to help control medical costs. A PPO is a group of Hospitals and providers that agree to provide services at fees that are generally lower as a result of the Fund's participation in the PPO. To receive a list of PPO Hospitals and providers free of charge, please contact the Fund Office.

With the exception of Emergency Room services, **the Plan only provides benefits for services rendered by PPO Hospitals and providers.** If you do not use a PPO Hospital or provider, your claim will not be covered and you will have to pay the claim out of your own pocket.

3.06 Pre-Certification, Case Management and Utilization Review.

The Fund has contracted with a provider to perform pre-certification, case management and utilization review.

A. Pre-Certification.

Pre-certification is the process of obtaining approval from the Fund before you have certain procedures performed. You, someone on your behalf, or your Physician, must contact the review organization to obtain pre-certification prior to incurring the following list of expenses:

1. Non-emergency Hospital admissions;
2. Emergency Hospital admissions (within 24 hours);
3. Outpatient treatment and procedures relating to medical benefits, surgical benefits or Mental/Nervous Disorders or Chemical Dependency/Substance Abuse;
4. Speech therapy;
5. Physical and/or occupational therapy;
6. Sclerotherapy;
7. Home Health Care;
8. Skilled Nursing Facility Care;
9. Durable Medical Equipment;
10. Transplant benefits; and
11. Dialysis and imaging.

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

B. Case Management and Utilization Review.

Case management is a process in which you as the patient, your family, Physician and/or other health care providers and the Fund work together under the guidance of the Fund's review organization to coordinate a quality, timely and cost-effective treatment plan that provides Medically Necessary services. Utilization review is the evaluation of the necessity, appropriateness and efficiency of medical services, procedures and facilities.

To ensure you receive the maximum benefits available under the Plan, you or your Physician should contact the Plan's review organization to determine if such services are subject to pre-certification, case management and/or utilization review.

3.07 Mandatory Outpatient Surgery.

Certain types of surgery must be performed on an outpatient basis. The following are the surgeries that must be performed on an Outpatient basis:

1. Arthroscopy;
2. Biopsy;
3. Bunionectomy;
4. Carpal Tunnel Release;
5. Circumcision (except for an infant immediately after birth);
6. Cystoscopy (examination of the bladder);
7. Cataract surgery;
8. Dilation and Curettage (D&C);
9. Excision of minor mass, lipoma or cyst;
10. Facial fracture repair;
11. Fracture, closed reduction (except skull or spinal);
12. Hammer toe repair;
13. Hemorrhoidectomy (external);
14. Hernia (inguinal or umbilical);
15. Hydrocelectomy (a fluid-removal procedure);
16. Laparoscopy (diagnostic or with tubal);
17. Myringotomy (inner ear surgery);

18. Nasal surgery;
19. Toe surgery;
20. Tonsillectomy; and
21. Vasectomy.

If your Physician states that an inpatient stay is necessary, your Physician must present a written request to waive the outpatient requirement before you enter the Hospital as an Inpatient.

If your surgery must be performed on an outpatient basis and it is performed on an inpatient basis, you will be charged a \$500 penalty which will not be applied toward your Deductible or any out-of-pocket maximums.

3.08 Covered Medical Expenses and Exclusions.

A. Covered Medical Expenses.

The Plan covers the Reasonable and Customary Charges (“R&C Charges”) subject to the Plan maximums and limitations provided in the Schedule of Benefits for the following services and supplies (Covered Medical Expenses) provided or ordered by a Physician (except as specifically provided otherwise) that you receive for the treatment of a non-occupational Accident or Sickness when Medically Necessary:

1. Hospital services and supplies for:
 - a) Room and board fees up to:
 - i. The Hospital’s regular daily semi-private room rate; or
 - ii. The Hospital’s regular daily rate for a private room, when required.
 - b) Drugs, medicines and other Hospital services for medical care and treatment, exclusive of professional services, while hospitalized.
 - c) Outpatient Hospital services including fees incurred for the following:
 - i. Outpatient surgical procedures; and
 - ii. Emergency treatment for an Accident or Sickness.

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother’s or newborn’s attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider

obtain authorization from the Fund or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours as applicable).

For two or more surgical procedures performed through the same incision, the Fund will only cover 1½ times the benefit allowed for the most expensive procedure.

2. Pre-admission Hospital tests performed in the Hospital where the individual is being admitted.
3. Medical care and treatment (including surgery) that is listed as a Covered Medical Expense under the Plan and is provided by a legally qualified Physician or other qualified health care professional acting within the scope of their licensure as defined by state law.
4. Physical therapy administered by a provider acting within the scope of his or her license. Such services must consist of a written individualized treatment plan and be provided with the expectation that the patient will improve significantly in a reasonable, generally predictable, period of time.
5. Speech therapy to restore speech loss, or to correct an impairment. The impairment must be from a congenital (birth) defect for which corrective surgery has been performed, or from an Accident or Sickness. Covered expenses do not include treatment of a functional nervous disorder.
6. Occupational therapy administered by a provider acting within the scope of his or her license. Such services must consist of a written individualized treatment plan and be provided with the expectation that the patient will improve significantly in a reasonable, generally predictable, period of time.
7. Services and supplies provided in a surgery center, urgent care center, or ambulatory surgery center.
8. Radiation therapy and chemotherapy.
9. Second surgical opinions.
10. Anesthesia, anesthesia services and professional charges for administration.
11. Expenses incurred for dialysis treatments of an acute or chronic kidney ailment.
12. Cardiac rehabilitation to restore an individual's functional status after a cardiac event. It must be expected that the therapy will result in a significant improvement in the level of cardiac functioning.
13. Chiropractic care, subject to the maximums listed in the Schedule of Benefits.
14. Sleep studies and CPAP (continuous position airway pressure) equipment. Covered expenses do not include sleep studies performed at home.
15. Diagnostic x-ray and laboratory services, including electrocardiogram (EKG), electroencephalogram (EEG), magnetic resonance imaging (MRI), computed tomography (CT/CAT) scans, and other electronic diagnostic medical procedures.
16. Casts, splints, trusses, braces (except dental braces) and crutches.
17. Purchase, fitting, adjustment, repairs and replacement of prosthetic devices and supplies that replace all or part of a missing body part and its adjoining tissue (which were lost while the individual was

covered under the Plan) or replace all or part of the function of a permanently useless or malfunctioning body part (only when use and functionality was lost while the individual was covered under the Plan), such as artificial limbs, eyes and larynxes.

18. Whole blood or blood plasma (not replaced or donated) and the cost of its administration.
19. Charges for oxygen and its administration.
20. Purchase and/or rental of Durable Medical Equipment. The Fund reserves the right to purchase the equipment instead of paying for rental if purchase would cost less than the reasonable and customary rental amount.

Durable Medical Equipment means equipment that (1) can withstand repeated use; (2) is primarily and customarily used to serve a medical purpose related to the person's physical disorder; (3) generally is not useful in the absence of illness or injury; and (4) is appropriate for use in the home.

Examples of Durable Medical Equipment include, but are not limited to, the following: wheel chairs, Hospital beds and equipment for giving oxygen.

Coverage for Durable Medical Equipment is not provided for (1) equipment that serves as a comfort or convenience item or (2) equipment used for environmental control or to enhance the environmental setting or surroundings of an individual.

Examples of equipment that are not covered include, but are not limited to, the following: exercise equipment, elevators, posture chairs, air conditioners, heaters, humidifiers, dehumidifiers, air filters, whirlpool tubs, waterbeds and portable Jacuzzi pumps.

21. Care provided in a Skilled Nursing Facility when the following requirements are met:
 - a) Prior approval is obtained in advanced by the review organization;
 - b) A legally qualified Physician certifies (initially and every two weeks) that the confinement is necessary for your recuperation from an injury or Sickness and that the confinement is not for the purpose of Custodial Care;
 - c) The confinement is preceded by at least three consecutive days of Hospital confinement for which Plan benefits are payable;
 - d) The confinement is due to the condition which required the previous Hospital confinement;
 - e) The confinement begins within seven days of the end of a covered Hospital confinement or within seven days of the end of a covered Skilled Nursing Facility confinement; and
 - f) The confinement is provided by a facility which meets the Plan's definition of a Skilled Nursing Facility.

Covered Medical Expenses for confinement in a Skilled Nursing Facility include charges incurred for the following services and supplies:

- a) Semi-private room and board charges;

- b) General nursing care (Physician's visits, private duty or special nursing care is not covered);
- c) X-rays and laboratory examinations;
- d) Physical, occupational and speech therapy;
- e) Oxygen and gas therapy;
- f) Prescription Drugs, solutions, dressings and casts; and
- g) Other related Medical Necessary services and supplies.

22. Home health care services and supplies where:

- a) Prior approval is obtained in advanced by the review organization;
- b) The home health care services must be established and approved in writing by the patient's Physician;
- c) The Physician must certify the home health care is for the same, or related condition for which the patient was admitted to the Hospital and that if the home health care was not available, the patient would again be hospitalized;
- d) The home health care must begin within fourteen days after a Hospital admission that lasts at least three days, unless arranged in less time by the Plan's review organization;
- e) The home health care is provided by facility which meets the Plan's definition of a Home Health Care Agency.

Covered Medical Expenses for home health care services include charges incurred for the following services and supplies:

- a) Part-time or intermittent nursing care provided by or under the supervision of a registered professional nurse (RN) or licensed practical nurse (LPN);
- b) Physical, occupational and speech therapy;
- c) Medical and surgical supplies, other than prescription drugs and biologicals, and the use of medical appliances;
- d) Medical services of interns and residents in training under the approved teaching program of a Hospital affiliated with the Home Health Care Agency;
- e) Medical social services, such as the counseling of patients, provided under the direction of a Physician; and
- f) Any services or supplies provided on an outpatient basis at a Hospital or Skilled Nursing Facility under arrangement with the Home Health Care Agency involving the use of equipment not readily

available for home use, or which can only be provided at the Skilled Nursing Facility outside the home.

One Home Health Care Agency visit is defined as each visit by a nurse and/or aide, intern and/or resident, or therapist or each 4 hours of care by a Licensed Practice Nurse. Covered Medical Expenses do not include charges for transportation, dietitian services, homemaker services, food or home delivered meals, and Custodial Care.

23. Hospice care services and supplies provided in accordance with the following rules and requirements:

- a) Prior approval is obtained in advance by the review organization;
- b) The attending Physician must certify no later than two days after beginning Hospice care that the patient's life expectancy does not exceed six months; and
- c) Services are provided by a facility which meets the Plan's definition of Hospice Organization.

Covered Medical Expenses include reasonable and necessary services for the care or management of the terminal illness as well as related conditions, including the following:

- a) Room and board charges;
- b) Professional services of a registered, licensed practical nurse, homemakers and home health aides (such services may be furnished on a 24-hour basis during crisis periods or as necessary to maintain the patient at home);
- c) Counseling services and/or therapy by a social worker or psychologist;
- d) Medical social services;
- e) Physical therapy and speech language pathology;
- f) Medical supplies and equipment used for pain and symptom control;
- g) Respite Inpatient care, up to a maximum of three consecutive days, when short term Inpatient care is required in a Hospital, nursing home or free-standing hospice facility in order to relieve the family from home care duties. Benefits for respite Inpatient care shall be paid only when the patient does not require intensive care and when general inpatient benefits are not payable; and
- h) Physician services.

Covered Medical Expenses do not include bereavement counseling, long-term patient care, administrative services, childcare and/or housekeeping services, charges for transportation, surgical operations or Hospital confinement due to medical complications of the terminal condition or chaplaincy.

24. Transportation services provided by a Hospital or a professionally licensed ambulance service where:

- a) Ground Transportation: The transportation is from the patient's home, the scene of an Accident or medical emergency to a Hospital or between Hospitals; or
- b) Special Transportation: Transportation by regular scheduled commercial airlines, railroads or professional air ambulance if the following conditions are met:
 - i. A Physician certifies that the patient's condition required specialized treatment which is not available in a local Hospital;
 - ii. Transportation is limited to the nearest Hospital from the city or town where the Accident or Sickness occurred;
 - iii. Covered expenses only include charges for the first trip to and/or from the Hospital; and
 - iv. Transportation is within the United States.

25. Professional services rendered by a Physician.

26. Private duty nursing services when provided at either a Skilled Nursing Facility or during Home Health Care.

27. Treatment of accidental injury to the jaw or sound natural teeth within twelve months of an Accident, including the initial replacement of sound natural teeth and any necessary dental x-rays. Coverage may be extended for another six months if sufficient medical information is provided showing the delay in treatment was due to the following: nerve damage, immobilization of a fractured jaw, additional time was required to stabilize the injury, a Dependent child required additional time for normal growth processes, and/or a delay in the healing process which can be shown by x-ray.

28. Services and supplies for the treatment of Temporomandibular Joint Dysfunction (TMJ), subject to the maximums listed in the Schedule of Benefits.

29. The first pair of contact lenses or eyeglasses, and the examination required, following cataract surgery.

30. Podiatric care and foot surgery.

31. Non-experimental or non-investigative human organ and tissue transplants for the following conditions: bone marrow, heart, lung, liver, pancreas, kidney and cornea. Transplant procedures must be approved by the review organization prior to operation and performed at a Blue Distinction Center or a facility approved by the Fund.

Covered Medical Expenses also include the following:

- a) Organ and tissue procurement for both the donor and recipient;
- b) Charges for HLA or other tests and procedures to find a donor match;
- c) Transportation, lodging and meal costs for the recipient and a companion (or two companions when the recipient is a minor), up to the current benefit limits set forth in the Internal Revenue Code, provided sufficient itemized receipts are submitted to the Fund;

- d) Hospital room, board and medical supplies;
 - e) Diagnosis, treatment and surgical procedures performed by a Physician;
 - f) Private nursing care by a Registered Nurse or Licensed Practical Nurse;
 - g) Rental of a wheelchair, hospital-type beds and respiratory therapy equipment;
 - h) Local ambulance services;
 - i) Medications, including anti-rejection medications;
 - j) X-rays and other diagnostic services, laboratory tests and oxygen;
 - k) Surgical dressing and supplies; and
 - l) Home care.
32. Reconstructive surgery to correct conditions resulting from accidental injuries, congenital defects or surgical procedures to correct organs of the body which perform or function improperly.
33. Medical and surgical benefits for mastectomies as required by federal law under the Women's Health and Cancer Rights Act of 1998 (WHCRA), including the following, when requested by the patient in consultation with her Physician:
- a) Reconstruction of the breast on which the mastectomy has been performed;
 - b) Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
 - c) Prosthesis and physical complications of all stages of mastectomy including lymphedemas.
34. Treatment for Mental/Nervous Disorders. Covered expenses do not include charges by a marriage counselor, naturopaths or social workers.
35. Treatment for Chemical Dependency/Substance Abuse.
36. Weight loss treatment, subject to the maximums listed in the Schedule of Benefits. Covered expenses do not include food supplements or nutritional plans such as Jenny Craig or Weight Watchers.
37. Treatment or surgery for one occurrence of morbid obesity if the covered person:
- a) Has a documented five (5) year history of morbid obesity (body mass index over 40 kg/m²), or a BMI greater than 35 and a clinically serious condition such as coronary heart disease, type 2 diabetes mellitus, obstructive sleep apnea or hypertension;
 - b) Is treated in a surgical program with experience in obesity surgery and which includes a multidisciplinary preoperative and postoperative approach;

- c) Participates in a six-month treatment plan within the year preceding surgery that includes a multidisciplinary non-surgical program including a low or very low calorie diet, increased physical activity and behavior reinforcement under the direction of the Physician who refers the patient for such surgery;
- d) Has a documented failure of non-surgical methods of weight reduction;
- e) Has an absence of significant psychopathology that can limit an individual's understanding of the procedure or ability to comply with medical/surgical recommendations;
- f) Documents that he or she has received counseling post-operatively regarding cosmetic difficulties and that the patient has agreed to post-operative treatment plans; and
- g) Is at least eighteen (18) years of age.

Treatment must be ordered by a Physician and services must be approved in advance by the review organization.

- 38. Any treatment, service, or supplies used solely to induce, facilitate, enhance and/or inhibit fertility, conception or organic impotence for only Employees and spouses. Covered expenses include invitro-fertilization, vasectomies (but not the reversal of), tubal ligations (but not the reversal of), penile implants and treatment for erectile dysfunction (up to eight pills per month), subject to the limitations set forth in the Schedule of Benefits.
- 39. Sclerotherapy, provided other more conservative measures such as support hose/TEDs, exercise and weight loss have been attempted and failed. Sclerotherapy treatment is subject to the maximums listed in the Schedule of Benefits.
- 40. Preventive Services.
- 41. Charges for "routine patient costs" incurred by a "qualified individual" who is participating in an "approved clinical trial." For purposes of this benefit, the following applies:
 - a) A "qualified individual" is someone who is eligible to participate in an "approved clinical trial" and either the individual's doctor has concluded that participation is appropriate, or the Participant provides medical and scientific information establishing that their participation is appropriate.
 - b) "Routine patient costs" generally include all items and services that typically would be covered under the Plan for an individual not enrolled in a clinical trial. Routine patient costs do not include the actual device, item or service that is being studied. Also excluded are items and services that are given only to satisfy data collection and analysis needs that are not used in the direct clinical management of the patient; or a service that is clearly consistent with widely accepted and established standards or care for a particular diagnosis.
 - c) An "approved clinical trial" means a Phase I, II, III, or IV clinical trial that studies the prevention, detection, or treatment of cancer or other life-threatening conditions. The term life-threatening condition means any disease or condition from which death is likely unless the disease or condition is treated.

42. Any procedures or services covered under the Plan as listed above that are rendered by a qualified Physician or other qualified health professional acting within the scope of his or her licensure as defined by state law.

B. Medical Expenses Not Covered.

No benefit shall be payable under the Major Medical Benefit for charges incurred which are in excess of any maximum benefit or limitation specified in the Schedule of Benefits or this Section. No benefits will be payable which are not specifically included under the terms of the Plan or which are specifically excluded from coverage. Specifically, the Major Medical Benefit does not cover the following:

1. Services or supplies that are not Medically Necessary, as determined by the Plan Administrator.
2. Treatment, care, services, supplies or procedures which are not recommended or approved by a Physician or other qualified health care professional acting within the scope of his or her licensure as defined by state law.
3. Treatment, care, services, supplies, or procedures which are not rendered for the treatment or correction of, or in connection with, a specific non-occupational Accident or Sickness except as otherwise provided under the Plan.
4. Treatment, care, services, supplies or procedures received from a physician, hospital, home health care agency, hospice organization, or skilled nursing facility which does not meet the Plan's definition of such person, facility or organization.
5. Any type of rest cure or Custodial Care (care that is designed primarily to assist a person in meeting the activities of daily living (i.e., milieu therapy) regardless of what the care is called.
6. Maintenance therapy, which is treatment given when no additional progress is apparent or expected to occur. Maintenance therapy includes treatment that preserves your present level of functioning and prevents loss of that functioning, but which does not result in any additional improvement.
7. Any losses, expenses or charges for cosmetic surgical procedures and related expenses, except as otherwise provided under the Plan.
8. Charges for dental treatment of teeth or gums, except as otherwise provided under the Plan.
9. Charges for vision services, including eye examinations and fittings, eyeglasses, contact lenses, except as otherwise provided under the Plan.
10. Hearing aids.
11. Care, treatment, services or supplies provided in a nursing home, rest home, home for the aged, convalescent home or similar establishment or facility, unless it is a facility that meets the Plan's definition of Skilled Nursing Facility.
12. Charges incurred as a result of a Friday or Saturday Hospital admission, unless for Emergency Room services.
13. Charges for a surgical assistant for podiatric surgery.

14. Charges for a nurse anesthetist, unless no other anesthetist is available.
15. Reversal or attempted reversal of vasectomies or other sterilization procedures.
16. Any charges in connection with medical services rendered to a surrogate or surrogate fees.
17. Abortion procedures unless the life of the mother is endangered.
18. Massage therapy.
19. Physical exams and immunizations required for enrollment in any insurance program, as a condition of employment, for licensing, or for other purposes.
20. Charges for marriage counseling, counseling sessions with other family members, naturopath or social worker except as otherwise provided under the Plan.
21. Acupuncture, hypnosis or biofeedback.
22. Travel or transportation except as otherwise provided under the Plan.
23. Treatment for injuries arising out of motor vehicle races or other competitions, whether sanctioned or not.
24. Charges for Keratomy, such as radial (RK), anterior lens (ALK), LASIK and/or any other procedure for the correction of eye refraction.
25. Charges for dental implants, pre-implant surgery or any surgery to facilitate dental implants.
26. Dietary or nutritional counseling and supplements, except as required under federal law.
27. Non-prescription items, including over-the-counter drugs or supplies, vitamins, and other non-prescription items except as otherwise provided under the Plan.
28. Services, supplies, treatments or surgical procedures rendered in connection with obesity or an overweight condition except as otherwise provided under the Plan.
29. Air conditioners, air-purification units, humidifiers, dehumidifiers, allergy-free pillows, blankets, mattresses, exercising equipment, electors or elevators or chair lifts, waterbeds, or whirlpools.
30. Charges for confinement in a facility providing nursing services, except as otherwise provided under the Plan.
31. Charges for services or supplies obtained outside the United States, except for Emergency Room services.
32. Services or supplies primarily for educational, vocational, or training purposes, except as otherwise provided under the Plan.
33. Education, training, or room and board while a person is confined in an institution which is primarily a school or other institution for training.

34. Homemaking services, such as housekeeping, or meal preparation.
35. Charges for services or supplies which constitute personal comfort or beautification items. Examples of items that are not covered include, but are not limited to, the following: personal hygiene items, hair appointments, electrolysis or epilation, magazines, cosmetics, television, or telephone services.
36. Any charges incurred for or in connection with gene therapy.
37. Charges for any of the circumstances listed under the General Plan Exclusions in Section 5.

3.09 Extension of Major Medical Benefit.

If you or your eligible Dependent is Totally Disabled as a result of an Accident or Sickness when coverage under the Plan would normally end, your benefits under the Major Medical Benefit will be extended only for that Accident or Sickness if the following conditions are met:

- A. The expense would have been covered if the eligibility had continued;
- B. You remain Totally Disabled until the expense is incurred;
- C. You are under the regular care of a legally qualified Physician; and
- D. You are not entitled to similar benefits under any other group health plan when the expense is incurred.

The Fund will pay benefits for treatment of the Accident or Sickness that caused your disability, subject to any limitations or maximums under the Plan at the time your eligibility ended. The Fund will continue your extension of benefits until the earliest of (1) the date you are no longer Totally Disabled, (2) the date you become covered under another group health plan, or (3) 90 days after your coverage under this Plan for the Major Medical Benefit ends.

SECTION 4: PRESCRIPTION DRUG BENEFITS

4.01 Eligibility for Prescription Drug Benefits.

If you are eligible for Employee Benefits, your coverage includes the Prescription Drug Benefit. The benefit amounts are shown in the Schedule of Benefits.

4.02 General Information.

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

The Fund Office provides the PBM with eligibility data including primary and secondary coverage information. If the coordination of benefits does not take place at the point of purchase, a claim will need to be submitted directly to the PBM.

4.03 The Retail Pharmacy Program.

A. Using a Participating Pharmacy.

The Retail Pharmacy Program offers benefits for short-term prescriptions (up to a 30-day supply). When you become eligible for benefits, you will receive the appropriate identification cards for use at any participating pharmacy. You may use your identification card at any participating pharmacy.

When you or your Dependents need to have a prescription filled or refilled, you should:

- A. Go to a participating pharmacy;
- B. Show the pharmacist your identification card; and
- C. Pay the pharmacist the applicable Deductible and/or Co-Payment per prescription.

B. If You Do Not Use a Participating Pharmacy.

You should be able to locate a participating pharmacy near your home and wherever you travel. If you choose to fill your prescription at a non-participating pharmacy or you fail to present your identification card to a participating pharmacy, you must pay the full cost of the prescription and then file a claim with the Fund Office or PBM for reimbursement. If the claim is covered, it will be reimbursed based on the R&C amount of the prescription (not full price), less any Co-Payment. Note the Plan **does not** cover prescriptions filled at Sam's Club or Walmart.

4.04 The Mail Order Program.

You may use the Mail Order Program to order up to a 90-day supply of any covered medication that your Physician prescribes for you or your eligible Dependent. You are required to use the service for maintenance medications which are medications you or your Dependents take for long periods of time for chronic conditions such as high blood pressure, heart condition, diabetes, asthma and arthritis.

If your Physician prescribes a long-term medication that you need right away, you may want to ask the Physician to write two prescriptions – one prescription to be filled at a participating pharmacy pursuant to the Retail Pharmacy Program and one prescription for the remainder of the medication to be submitted to the Mail Order Program.

For more information on the Mail Order Program, please contact the Fund Office or PBM.

4.05 Covered Prescription Drugs.

Unless otherwise excluded, the Prescription Drug Benefit covers Medically Necessary prescriptions by a Physician. For a complete list of covered Prescription Drugs, you may contact the PBM. The following are examples of covered Prescription Drugs:

- A. All federal legend drugs;
- B. Specialty drugs;
- C. State restricted drugs;
- D. Injectable insulin and syringes used for administration of insulin;
- E. Needles and syringes on prescription;
- F. Smoking cessation drugs as required under federal law;
- G. Federal legend vitamins and minerals on prescription; and
- H. Contraceptives as required under federal law.

4.06 Excluded Drugs.

The following list provides examples of medications that are not covered under the Prescription Drug Benefit:

- A. Over-the-counter medication or medical supplies other than diabetic supplies;
- B. Drugs not approved by the U.S. Food and Drug Administration (FDA), or that are not prescribed or used in a manner consistent with the FDA's intended and approved usage;
- C. Any prescription refilled in excess of the number specified by the Physician, or any refill dispensed after one year from the date of the Physician's original prescription order;
- D. Replacement prescriptions (lost, stolen or broken);
- E. Experimental, Investigational or unproven drugs;
- F. Drugs intended for cosmetic purposes only, including medications to treat baldness;
- G. Weight loss medications except as required under federal law;

- H. Vaccines (unless required under federal law), immunization agents or biological sera;
- I. Gene therapy drugs; and
- J. Medications that are not considered Medically Necessary, as determined by the Plan Administrator.

4.07 Preferred Drugs, Non-Preferred Drugs and the Specialty Drug Program.

A. Preferred and Non-Preferred Drugs.

The amount of your Prescription Drug Co-Payment will depend on whether the drug is Preferred or Non-Preferred as listed in the Schedule of Benefits. Preferred Drugs are brand drugs which are considered formulary. Non-Preferred Drugs are brand drugs which are considered non-formulary.

Please note that Prescription Drugs may change from Preferred and Non-Preferred (and vice versa) over time. For more information about which drugs are Preferred or Non-Preferred, please contact the PBM at the telephone number provided on your identification card.

B. Specialty Drug Program.

Specialty medications include high-cost biotech injectable, infusion, intravenous (IV) drugs and certain oral medications. Specialty drugs are often prescribed for diseases such as multiple sclerosis, rheumatoid arthritis, Hepatitis C and asthma.

To receive coverage for Specialty Drugs, the drugs must be received through the Plan's Specialty Drug Program. When you are prescribed a Specialty Drug, call the number listed under the PBM's Specialty Drug Administrator to enroll in the program. Once you enroll in the program, your medications will be sent directly to your home or work address via safe, temperature controlled and tested packaging at no additional cost. If you are currently taking or are prescribed a Specialty Drug, you should contact the PBM's Specialty Drug Administrator or the Fund Office for more information on the program.

4.08 Mandatory Generic Drug Program.

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

The generic name of a drug is its chemical name and the brand name is the trade name under which the drug is advertised and sold. Both generic and brand name drugs must meet the same federal requirements for safety, purity and strength.

If your Physician prescribes a brand name drug with a generic equivalent, ask if you can use the generic version instead. If you are unsure if there is a generic equivalent for a brand drug, please contact your Physician, pharmacist or the PBM.

4.09 Prior Authorization Program.

Certain Prescription Drugs require prior authorization by the PBM before the prescription may be filled to ensure that eligible individuals receive the appropriate drugs for treatment of their condition consistent with the quantities approved by the FDA.

Prior authorization may be requested by you or your Physician before the prescription is presented to the pharmacy. Otherwise, the prior authorization process begins when you present the prescription to the pharmacy. The PBM will contact your Physician to obtain the necessary documentation and will either approve or deny the request for prior authorization based on the clinical information received.

4.10 Step Therapy Program.

The Fund uses a program called Step Therapy in which the pharmacy works with you and your Physician to identify the most affordable, safe and appropriate medications when there are equivalents to certain costly brand name medications. Step therapy requires the use of a more cost-effective medication (“Step 1”) before a less cost-effective medication (“Step 2”) will be covered under the Plan. Step therapy is based on accepted medical guidelines and standards and takes place at the time the pharmacist prepares to fill a prescription for a Step 2 drug. The pharmacist will check your history to determine whether a Step 1 drug has been attempted first.

When a Step 1 drug has not been attempted first, the pharmacist will be unable to process the claim and you should discuss a Step 1 drug with your Physician. At your request, the pharmacist may fill the prescription for the Step 2 drug, but you will be responsible for the full price of the drug and the cost will not be reimbursed by the Fund.

4.11 Out-of-Pocket Maximum.

The maximum amount you pay for expenses under the Prescription Drug Benefit each year is the out-of-pocket maximum listed in the Schedule of Benefits. If you reach this annual out-of-pocket maximum for expenses subject to the maximum, the Plan pays 100% of all covered Prescription Drug Benefit expenses for the rest of the calendar year.

The family out-of-pocket maximum may be satisfied through any combination of individual out-of-pocket maximums. Once you meet the family out-of-pocket maximum, no further individual out of-pocket maximum will be applied to any eligible member of your family during the remainder of the calendar year.

SECTION 5: GENERAL PLAN EXCLUSIONS

5.01 Exclusions.

The following list of specific exclusions is not an all-inclusive listing of the Plan's limitations and excluded procedures, services, supplies and types of treatment. It is only representative of the types of services and supplies for which charges may be incurred which are not payable by the Plan.

- A. Accidents, Sicknesses or dental treatments for which you are entitled to benefits under a workers' compensation or occupational disease law.
- B. Care, treatment, procedures, services or supplies provided to a person who is not covered and/or eligible under the Plan.
- C. Any expenses or charges for services or supplies that are provided by Hospitals or medical institutions owned or operated by a federal, state or local government, or their medical practitioners, unless you are required to pay such charges.
- D. Any expenses or charges caused by your voluntary participation in a riot.
- E. Any expenses or charges caused by war or any act of war, whether declared or undeclared.
- F. Any expenses or charges incurred during the commission of a felony or involvement in a criminal enterprise.
- G. Any expenses or charges incurred while in the military service of any country, or civilian non-combatant unit serving with such forces. However, the Plan will cover expenses as required under USERRA.
- H. Any expenses or charges for which you do not have to pay.
- I. Any expenses or charges for services or supplies:
 - 1. Not provided in accord with generally accepted professional medical standards;
 - 2. Not Medically Necessary; or
 - 3. For drug therapy programs not available in the United States or available in the United States only under special license by the federal government for practitioners engaged in research.
- J. Any expense or charge for Experimental or Investigative Treatments and Procedures.
- K. Any expenses or charges for services and supplies that exceed the R&C Charges.
- L. Any expenses, charges or treatments received in any penal facility or jail or equivalent institution.
- M. Any treatments, services or supplies furnished by a person who resides in your home, or who is a member of your immediate family (i.e., your spouse, child, brother, sister or parent).

- N. Any expenses or charges (1) for failure to keep scheduled visits; (2) for completion of claim forms; or (3) for reports or medical requests not requested by the Fund; and
- O. Charges that would not have been made if this Plan did not exist.

SECTION 6: COORDINATION OF BENEFITS

6.01 Benefits Are Coordinated.

Under the Plan, your medical benefits may be coordinated if another group plan or source is obligated to make benefit payments for you or your Dependents. Benefits are coordinated so that no more than 100% of your expenses are paid through the combined coverage of the plans.

6.02 Another Group Plan Defined.

Another group plan or source refers to any plan providing benefits or services and includes:

- A. Group blanket or franchise insurance coverage (such as coverage provided to college students);
- B. Group Blue Cross or group Blue Shield coverage and other group prepayment coverage;
- C. Any coverage under labor-management trustee plans, union welfare plans, employer organization plans, employee benefits organization plans or any other arrangement of benefits or individuals of a group;
- D. Any coverage under governmental programs;
- E. Any coverage required or provided by statute; and
- F. This Plan when you are covered as:
 - 1. An Employee and as a Dependent; or
 - 2. A Dependent child of more than one Employee.

6.03 How Benefits are Paid.

Benefits coordination ensures that you receive maximum benefits, and that benefits are not paid for more than 100% of the actual charges incurred.

When health care coverage is available from more than one group plan, the primary plan pays benefits first. Your primary plan determines benefits as if that plan was the only coverage available. Then the secondary plan pays according to their coordination of benefits rules. When this Plan is secondary, it will pay the difference between your Allowable Expenses under this Plan (as though there was no other coverage) and what your primary plan paid.

This Plan defines Allowable Expenses as any necessary, reasonable and customary item of expense for medical care or treatment that is covered under at least one of the plans by which you are covered. If the Plan provides benefits in the form of service rather than cash payments, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid. Allowable Expenses do not include any portion of a charge that is not considered a Covered Medical Expense under this Plan.

If you or a Dependent is covered by another group plan or source in addition to this Plan, the order of benefit payment will be determined according to the Plan's coordination of benefits rules.

6.04 Order of Benefit Payment.

For coordination with other plans the following rules apply:

- A. A plan without coordination of benefits rules will be primary and will pay benefits before this Plan.
- B. A plan that covers a person other than as a Dependent is primary and pays benefits before a plan that covers the person as a Dependent. Additionally, a plan that covers a person as a Dependent spouse is primary and pays benefits before a plan that covers the person as a Dependent child.
- C. The plan that covers a person as an Employee, who is neither laid off nor retired, is primary. The same would hold true if a person is a Dependent of a person covered as a retiree and an Employee. However, coverage provided to an individual as a retired worker and as a Dependent of an actively working spouse will be determined under B above.
- D. For claims on behalf of Dependent children whose parents are not divorced or separated, or for claims on behalf of Dependent children whose parents share custody or shared custody prior to the child attaining age of majority, the plan that covers the parent whose birthday (month and day) falls first in the calendar year is primary and will pay benefits first. If both parents have the same birthday, the plan covering the parent for the longer period of time will be primary and pay benefits first.
- E. For claims on behalf of Dependent children whose parents are divorced or separated, whether or not they have ever been married, the following rules apply:
 1. If there is a court decree that establishes financial responsibility for medical expenses, the plan covering the parent who has such financial responsibility or had financial responsibility prior to the child attaining the age of majority will be primary.
 2. If there is no court decree and the parent with custody has not remarried, the plan that covers the parent with custody will be primary. The plan who covers the parent who had custody at the time the child reached age of majority will be primary.
 3. If there is no such court decree and the parent with custody (or who had custody at the time the child reached the age of majority) has remarried, the order of benefit coordination will be as follows:
 - a) The plan of the parent with custody is primary and pays benefits first;
 - b) The plan of the step-parent with custody pays benefits second;
 - c) The plan of the parent without custody pays benefits third; and
 - d) The plan of the step-parent without custody, if any, pays benefits fourth.
- F. A plan that covers you an employee who is not laid off or retired is primary and pays benefits before a plan that covers you as a laid-off employee or retired employee.

- G. A plan that covers you as a current full-time employee or as a Dependent of that current full-time employee is primary and pays benefits before a plan that covers you as a part-time or seasonal employee or as an employee who is eligible because of contributions or payroll deductions previously made to the plan.
- H. If a person is covered under the Plan as both an Employee and a Dependent spouse, the Plan will coordinate benefits and will pay primary employee benefits and secondary Dependent benefits, up to the maximums provided in the Schedule of Benefits.
- I. If a person who has COBRA Continuation Coverage is also covered under another plan as an employee, retiree or dependent, the COBRA Continuation Coverage is secondary.
- J. If none of the above rules apply, the plan that has covered the claimant for the longer period of time will be primary and pay benefits first.

6.05 Coordination of Benefits Implementation Rules.

The Trustees, without the consent of any person, have the following rights to implement the coordination of benefits rules:

- A. Release or obtain information considered necessary;
- B. Authorize payment directly to another group plan or source that paid claims which should have been paid by this Plan; and
- C. Recover payments in excess of the amount that should have been paid by this Plan.

6.06 Coordination of Benefits with Medicare.

If you or your Dependent is eligible for Medicare and have not enrolled in Medicare Part A, the Fund will assume that you have enrolled in Medicare Part A and will coordinate benefits under Medicare Part A. This means the Fund will only pay benefits equal to what it would have paid if you were enrolled in Medicare Part A and you will be responsible for any difference.

A. When You are an Employee Age 65 and Over.

If you are an Employee, this Plan will be primary and pay benefits first. If you are an Employee whose eligible Dependent is entitled to Medicare, the Plan will be primary to Medicare for that Dependent.

B. When You are an Employee Entitled to Medicare Due to Disability.

If you are an Employee entitled to Medicare due to disability but are not yet entitled to Medicare due to age, this Plan will be primary and pay benefits first. If you are an Employee whose eligible Dependent is entitled to Medicare, this Plan will be primary to Medicare for that Dependent.

C. End Stage Renal Disease (ESRD).

There are special rules that apply to the first 30 months of an ESRD (the initial 30-month period). The primary/secondary rules depend on whether the covered individual is eligible for Medicare due to age or

disability as of the beginning of the initial 30-month period. After the 30-month period, Medicare is always primary.

If you are eligible for benefits under the Plan because of the Employee's active status and become entitled to Medicare solely because of ESRD, this Plan will have primary responsibility for your claims during the initial 30-month period and Medicare pays second. After the initial 30-month period, Medicare has primary responsibility and this Plan will pay second.

SECTION 7: SUBROGATION OR REIMBURSEMENT

7.01 Reimbursement to the Plan.

Subrogation or reimbursement rules apply if the Fund pays any benefits that arise out of an Accident or Sickness which results in a claim against a Third Party. By accepting benefits under the Plan, you are agreeing to reimburse the Fund for all such expenses paid on your behalf.

Under these circumstances, the Fund is entitled to full and total reimbursement of its expenditures from all Third Party recoveries and as such, you shall be deemed to hold the right to recovery against such party in trust for the Plan.

7.02 Third Parties Defined.

A Third Party is defined as a person or a business entity and shall include, but is not limited to:

- A. Any person or entity legally responsible for your injury;
- B. Other benefit plans;
- C. An insurance company, including but not limited to the party at fault's insurance and first-party insurance (i.e., medical payment coverage or personal injury protection coverage);
- D. Workers' compensation; or
- E. Any other person or entity that is obligated to make payments, which the Fund would otherwise be obligated to make.

7.03 Your Responsibilities.

By accepting benefits under this Plan, your responsibilities include, but are not limited to the following:

- A. You and/or your Dependent must immediately notify the Fund Office whenever a claim against a Third Party is made for yourself and/or your Dependent regarding any loss for which benefits are received from the Fund.
- B. You and/or your Dependent must cooperate with the Fund by providing, among other things, information requested by the Fund concerning subrogation or reimbursement. You must provide the Fund Office with:
 - 1. The names and addresses of all potential third parties and their insurer, adjusters and claim numbers;
 - 2. Accident reports; and
 - 3. Any other information the Fund requests.

- C. You and/or your Dependent must provide a signed Subrogation and Reimbursement Agreement if requested by the Fund.
- D. If you fail to meet your responsibilities, the Fund may withhold future benefit payments from you and your eligible Dependents until you comply with these requirements.
- E. By accepting benefits under the Plan for these expenses, you and/or your Dependent agree to give the Fund the right to prosecute your claim and maintain an action against the third party on your behalf (subrogation).

7.04 If You Are Reimbursed by a Third Party.

The Fund is entitled to 100% reimbursement of all medical claims paid on your and/or your Dependent's behalf, related to the injury or illness, from all Third Party recoveries.

The Fund's right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of you and/or your Dependent, whether under the doctrines of causation, comparative fault or contributory negligence, or other similar doctrine in law. Therefore, if you and/or your Dependent receive payment from or on behalf of a Third Party for claims paid by the Fund, you must reimburse the Fund for 100% of benefits paid under the Plan. The proceeds from the settlement or judgment must be divided as follows:

- A. First, the Plan has priority over all monies recovered. Accordingly, you or your representative must pay a sum sufficient to fully reimburse the Fund for 100% of benefits paid related to the Injury or Illness. You must pay your own legal fees and other costs of litigation in connection with the recovery from a Third Party. No reductions or deductions are allowed for litigation costs, court costs, or attorneys' fees (i.e., the Common Fund Doctrine, Make Whole Doctrine, and/or any other state law affecting these rights are preempted by this Plan provision under ERISA); then
- B. Any remainder may be paid to you and/or your Dependent.

The proceeds of any claim against a Third Party must be divided as stated above, even if you and/or your Dependent are not fully compensated for the loss. However, the Fund is not entitled to receive reimbursement in excess of the amount you and/or your Dependent receive from all third parties.

You and/or your Dependents (if applicable) shall be responsible for compliance with these provisions and the provisions of any Subrogation and Reimbursement Agreement. You will also be responsible for compliance by your or your Dependents' agents, representatives and attorneys.

Furthermore, if you and/or your Dependent receive payment from a Third Party for Plan benefits already received and you do not reimburse the Fund as stated above, the Fund may take any action to recover 100% of the benefits paid. Such action includes, but is not limited to:

- A. Initiating a claim to compel compliance with these terms or the terms of the Subrogation and Reimbursement Agreement;
- B. Withholding benefits payable to you or your Dependents until you or your Dependents comply;
or

- C. Initiating such other equitable or legal action it deems appropriate (the Fund reserves the right to be reimbursed for its court costs and attorney's fees necessary to recovery payment).

Upon your full reimbursement to the Fund, future medical claims related to the injury or illness not already paid by the Fund will be your responsibility, unless and until you incur related medical expenses which exceed the proceeds from your ultimate recovery.

7.05 Attorney Common Fund Doctrine Claims against the Fund.

If you and/or your Dependents retain your own attorney, you are wholly responsible for all attorney's fees or other expenses incurred to obtain the Third Party recovery. If the attorney(s) that you and/or your Dependents retain in relation to an injury or illness brings a separate claim or lawsuit against the Fund to recover his/her attorney's fees under the Common Fund Doctrine, *quantum meruit*, unjust enrichment or other similar state laws, you and/or your Dependents are required to reimburse the Fund from the money you and/or your Dependents recover from any Third Party for (i) any money judgment entered against the Fund in the lawsuit brought by the attorney and (ii) the Fund's attorney's fees and costs defending the lawsuit, regardless of whether the Fund prevails or loses. You and/or your Dependents shall fully indemnify, hold harmless and defend the Fund and its Trustees, employees and agents from and against any such claims or lawsuits. The Fund shall have the right to appoint counsel.

To the extent the Fund is required to initiate a formal proceeding against you and/or your Dependents to enforce its reimbursement rights, you and/or your Dependents shall also be responsible for the Fund's attorney's fees and costs incurred. In addition, to the extent the expenses, including but not limited to attorney's fees and costs, incurred by the Fund exceed the amount you and/or your Dependents recover from any Third Party or you and/or your Dependents refuse or fail to reimburse the Fund from any Third Party recovery, the Fund shall have the right to withhold benefits to you and/or your Dependents until such time that the Fund is reimbursed in full for all expenses, including but not limited to attorney's fees and costs.

7.06 Lien on Third Party Recoveries.

You and/or your Dependents grant the Fund a lien on the monies recovered from any Third Party in the amount of (i) all medical and short term disability claims paid on your and/or your Dependents' behalf, (ii) any money judgment entered against the Fund in the lawsuit brought by the attorney, and (iii) the Fund's attorney's fees and costs in defending the lawsuit, regardless of whether the Fund prevails or loses.

SECTION 8: CLAIMS AND APPEALS

8.01 General Information.

A. Exhaustion of Remedies.

You must exhaust all of the claims and appeals procedures of the Plan before you bring any action in court or administrative action for benefits. After you have exhausted all of the procedures in this Section and if you are dissatisfied with the written decision of the Board of Trustees on review, you may institute legal action.

If you institute legal action after the denial of your internal appeal or after the denial of your external review, your lawsuit must be filed within 90 days of the date of such denial.

B. Discretionary Decision Making Authority of the Trustees.

Subject to the provisions of the Trust Agreement, the Trustees have full and exclusive authority to determine all questions of coverage and eligibility, methods of providing or arranging for benefits, and all other related matters. They have full power to construe the provisions of this Summary Plan Description/Plan Document and the terms used in this booklet. Any such determination and any such construction adopted by the Trustees will be binding upon all of the parties and beneficiaries of this Plan.

No determinations involved in or arising under the Trust Agreement or this Summary Plan Description/Plan Document will be subject to the grievance or arbitration procedure established in any Collective Bargaining Agreement between an Employer and the Union. However, this provision will not affect the rights and liabilities of any of the parties under any of such Collective Bargaining Agreements.

In carrying out their respective responsibilities under the Fund, the Trustees and/or their delegates have discretionary authority to interpret the terms of the Plan and to interpret any facts relevant to the determination, and to determine eligibility and entitlement to benefits in accordance with the terms of the Plan. Benefits under this Plan will be paid only if the Trustees and/or their delegates decide in their discretion that the applicant is entitled to them. Any interpretation or determination made under that discretionary authority will be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

8.02 Filing Your Initial Claim for Benefits.

A. What is a Claim?

A claim for benefits is a request for Plan benefits that you make in accordance with the Fund's reasonable claims procedures.

If you make an inquiry about the Plan's provisions without a claim form, the Fund will not treat the inquiry as a claim for benefits. In addition, if you request prior approval for a benefit that does not require prior approval by the Fund, it will not be treated as a claim for benefits. A claim may fall into one of the following categories:

1. Post-service claim – a claim for payment is requested for a treatment or supply that has already been received;
2. Disability claim – a Plan benefit that is conditioned upon a finding of disability;
3. Pre-service claim – a claim for pre-certification for a treatment or supply that requires approval in advance of obtaining care;
4. Urgent care claim – a pre-service claim where the application of time periods for making non-urgent care determinations could seriously jeopardize the claimant’s life, health or ability to regain maximum function, in the opinion of a Physician with knowledge of the claimant’s medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim; or
5. Concurrent care claim – a pre-service claim where a request is made to extend a course of treatment beyond the period of time or number of treatments previously approved. When you present a prescription to a participating pharmacy to be filled out under the terms of this Plan, that request is not a claim under these procedures. However, if your request for a prescription is denied, in whole or in part, you may file a claim and appeal regarding the denial by using these procedures.

B. How to File a Claim.

To file a claim for benefits offered under this Plan, you must generally submit a completed claim form within 365 days from the date that the service for the charge is rendered.

You may obtain a claim form by calling the Fund Office. A claim may be filed by a Participant, covered Dependent, an authorized representative or by a network provider. If you use the services of a PPO or other network provider, the provider will generally file your claims for you. If a claim is filed by a provider, the provider will not automatically be considered a claimant’s authorized representative.

1. Hospital, Physician and Medical Claims

The following information must be completed by you and the provider in order for your request for medical benefits to be a claim and for the Fund Office to be able to decide your claim:

- a) Employee’s name;
- b) Patient’s name;
- c) Patient’s date of birth;
- d) Social Security number of Employee or Retiree;
- e) Date of service;

- f) CPT Plus 2022 Edition (the code for Physician services and other health care services found in the *Current Procedural Terminology*, as maintained and distributed by the American Medical Association);
- g) ICD-10 (the diagnosis code found in the *International Classification of Diseases, Clinical Modification* as maintained and distributed by the U.S. Department of Health and Human Services);
- h) Billed charge;
- i) Number of units (for anesthesia and certain other claims);
- j) National Provider Identifier (NPI) of the provider; and
- k) Billing name and address.

2. Prescription Drug Claims

You can avoid the need for filing for direct claims by presenting your identification card to the pharmacy when you have your prescription filled. If you need to file a claim form, you may send or fax it and any accompanying receipts to the PBM Claims Department as identified on your identification card.

3. All Other Benefits

You should contact the Fund Office about how to file a claim for all other benefits provided under the Plan.

C. Where to File a Claim.

1. Hospital, Physician and Medical Claims

All Hospital, Physician and medical claims should be filed electronically with Blue Cross Blue Shield. The Fund will consider your claim to have been filed as soon as it is received by the Fund Office. Both PPO and non-PPO providers should complete the claim form for you and send it electronically to Blue Cross Blue Shield.

2. Prescription Drugs

For more information on where to file a Prescription Drug claim, please contact the PBM at the number located on the back of your identification card.

3. All Other Claims

All other claims should be sent to the Fund Office.

8.03 Initial Claim Determination Timeframes.

A. Claim Filing Deadline.

You must file your claim for benefits as soon as possible following the date you incurred the charges. A claim is considered to have been filed on the day it is received by the correct claims office, even if it is incomplete.

If you fail to file your claim as soon as possible, it will not invalidate or reduce your claim if it was not reasonably possible for you to file the claim within a reasonable time. However, you must submit your claim no later than 12 months from the date you incurred the charges unless you can show good cause for filing a claim beyond the 12-month deadline. The Board of Trustees will determine whether you have shown good cause.

B. Claim Processing Timeframes.

The time period for making an initial decision on a claim starts as soon as the claim is filed in accordance with the Plan's filing procedures, regardless of whether the Fund has all of the information necessary to decide the claim.

The amount of time the Plan can take to process a claim depends on the type of claim.

1. Post-service Claims

- a) Ordinarily, the Fund will notify you of the decision on your claim within 30 days from the Fund's receipt of the claim.
- b) The Fund may extend this period one time for up to 15 days if the extension is necessary due to matters beyond the control of the Fund. If an extension is necessary, the Fund will notify you before the end of the initial 30-day period of the circumstances requiring the extension of time and the date by which the Fund expects to render a decision.
- c) If an extension is needed because the Fund needs additional information from you to process your claim, the extension notice will specify the information needed. In that case, you will have 45 days from the time you receive the notification to supply the additional information. If you do not provide the information within that time, your claim will be decided on the basis of the information that the Fund has at that time and your claim may be denied. During the period in which you are allowed to supply additional information, the normal time period for making a decision on the claim will be suspended. The deadline is suspended from the date of the extension notice until either 45 days or until the date you respond to the request (whichever is earlier). The Fund then has 15 days to make a decision and notify you of the determination.

2. Disability Claims

- a) The Fund will make a decision on your Disability claim and notify you of the decision within 45 days.

- b) If the Fund requires an extension of time due to matters beyond the control of the Fund, the Fund will notify you (within the 45-day period) of the reason for the delay and the time when the decision will be made. The Fund will make its decision within 30 days of the time the Fund notifies you of the delay.
- c) The Fund may delay the period for making a decision for an additional 30 days, provided the Plan Administrator notifies you of the circumstances requiring the extension and the date as of which the Plan expects to render a decision, before the expiration of the first 30-day extension period.
- d) If an extension is needed because the Fund needs additional information from you to process your claim, the extension notice will specify the information needed. In that case you will have 45 days from the time you receive the notification to supply the additional information. If you do not provide the information within that time, your claim will be decided on the basis of the information that the Fund has at the time and your claim may be denied. During the period in which you are allowed to supply additional information, the normal period for making a decision on the claim will be suspended. The deadline is suspended from the date of the extension notice until either 45 days or until the date you respond to the request (whichever is earlier). Once you respond to the Fund's request for the information or at the expiration of the 45 days if you do not respond, the Plan will make its decision on the claim and notify you within 30 days.

3. Pre-Service Claims

- a) Ordinarily, the Fund will notify you of the decision on your claim within 15 days from the Fund's receipt of the claim.
- b) The Fund may extend this period one time for up to 15 days if the extension is necessary due to matters beyond the control of the Fund. If an extension is necessary, the Fund will notify you before the end of the initial 15-day period of the circumstances requiring the extension of time and the date by which the Fund expects to render a decision.
- c) If an extension is needed because the Fund needs additional information from you to process your claim, the extension notice will specify the information needed. In that case you will have 45 days from the time you receive the notification to supply the additional information. If you do not provide the information within that time, your claim will be decided on the basis of the information that the Fund has at the time and your claim may be denied. During the period in which you are allowed to supply additional information, the normal period for making a decision on the claim will be suspended. The deadline is suspended from the date of the extension notice until either 45 days or until the date you respond to the request (whichever is earlier). The Fund then has 15 days to make a decision and notify you of the determination.

4. Urgent Care Claims

- a) Ordinarily, the Fund will notify you of the decision on your claim within 72 hours from the Fund's receipt of the claim.

- b) If an extension is needed because the Fund needs additional information from you to process your claim, the Fund will notify you of such extension within 24 hours. In that case you will have 48 hours from the time you receive the notification to supply the additional information. If you do not provide the information within that time, your claim will be decided on the basis of the information that the Fund has at the time and your claim may be denied. During the period in which you are allowed to supply additional information, the normal period for making a decision on the claim will be suspended. The deadline is suspended from the date of the extension notice until either 48 hours or until you respond to the request (whichever is earlier). The Fund then has 48 hours to make a decision and notify you of the determination.

5. Concurrent Care Claims

- a) If the concurrent care claim is urgent and made 24 hours prior to the end of the already authorized treatment, the Fund will notify you of its decision within 24 hours.
- b) If the concurrent care claim is not an urgent claim, then the pre-service limits apply.

8.04 Notice of Initial Decision.

You must be provided with a notice of the initial determination about your claim within certain timeframes after your claim is received. The notice must provide the following information:

- A. Sufficient information to identify the claim involved, including the date of service, the health care provider and the claim amount (if applicable). Upon request, the Fund will provide the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;
- B. The specific reason(s) for the denial of benefits or other Adverse Benefit Determination;
- C. A specific reference to the pertinent provision(s) of the Plan upon which the decision is based;
- D. A description of any additional material or information that is needed to process your claim and an explanation of why the information is needed;
- E. A copy of the review procedures and time periods to appeal your claim, a statement of your right to bring a civil action under ERISA following an Adverse Benefit Determination on review;
- F. If an internal rule, guideline, protocol, or similar criteria was relied on in the process of making a decision on your claim, a copy of that internal rule, guideline, protocol, or similar criteria, or a statement that a copy is available to you at no cost upon request; and
- G. If your health or disability claim was denied on the basis of medical necessity, Experimental or Investigative Treatment or similar exclusion, a copy of the scientific or clinical judgment that was relied on in the process of making a decision on your claim or a statement that it is available to you at no cost upon request; and
- H. For disability claims, the following additional information must be provided:

1. An explanation of the decision, including the basis for disagreeing with or not following:
 - a) The views presented by you of the health care and vocational professionals who treated or evaluated you;
 - b) The views of medical or vocational experts obtained by the Fund in connection with your claim, without regard to whether the advice was relied upon in making the Adverse Benefit Determination; and
 - c) A disability determination by the Social Security Administration.
2. The specific internal rules, guidelines, protocols, standards or similar criteria the Fund relied on in deciding your claim or alternatively, a statement that such internal rules, guidelines, protocols, standards or other similar criteria do not exist.
3. A statement that you are entitled to receive reasonable access to and copies of all documents relevant to your claim, upon request and free of charge.

8.05 Internal Appeal Procedures.

A. Internal Appeal Filing Deadline.

You have the right to a full and fair review if your claim for benefits is denied by the Fund. You must file your appeal in writing, unless your appeal is an urgent care claim, which may be submitted orally by telephone. You must make your request to the Fund within 180 days after receiving notice of denial.

Your appeal application must be in writing and it must include the specific reasons you feel the denial was improper. You may submit any document you feel appropriate, as well as submitting your written statement.

B. Internal Appeal Process.

The appeal process works as follows:

1. You have the right to review documents relevant to your claim. A document, record or other information is relevant if:
 - a) It was relied upon by the Fund in making the decision;
 - b) It was submitted, considered or generated in the course of making the decision (regardless of whether it was relied upon);
 - c) It demonstrates compliance with the Fund's administrative processes for ensuring consistent decision-making; or
 - d) It constitutes a statement of Plan policy regarding the denied treatment or service.

2. Upon request, you will be provided with the identification of medical or vocational experts, if any, that gave advice to the Fund on your claim, without regard to whether their advice was relied upon in deciding your claim.
3. Before the Fund can issue a final internal Adverse Benefit Determination based on a new or additional rationale, you must be provided, free of charge, with the rationale; the rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of final internal Adverse Benefit Determination is required to be provided to give you a reasonable opportunity to respond prior to that date.
4. A different person will review your claim than the one who originally denied the claim. The reviewer will not give deference to the initial Adverse Benefit Determination. You have the right to present evidence and testimony as part of your appeal. The decision will be made on the basis of a full and fair review of the record, including such additional evidence and testimony that you may submit.
5. If your claim was denied on the basis of a medical judgment (such as a determination that the treatment or service was not Medically Necessary, or was Experimental or Investigational Treatment), a health care professional who has appropriate training and experience in a relevant field of medicine will be consulted.

C. Timing of Notice of Decision on Internal Appeal.

1. Urgent Care Claims

If the appeal is for an urgent care claim, you will be notified of the decision on appeal as soon as possible, but not later than 72 hours after the receipt of the request for appeal.

2. All Non-Urgent Pre-Service Care Claims

If the appeal is for a non-urgent pre-service claim, you will be notified no later than 30 days after receipt of the request for appeal.

3. Disability Claims and Post-Service Care Claims

Ordinarily, decisions on appeals will be made at the next regularly scheduled meeting of the Board of Trustees following receipt of your request for review. However, if your request for review is received within 30 days of the next regularly scheduled meeting, your request for review will be considered at the second regularly scheduled meeting following receipt of your request. In special circumstances, a delay until the third regularly scheduled meeting following receipt of your request for review may be necessary. The Fund will advise you in writing in advance if this extension will be necessary. Once a decision on review of your claim has been reached, you will be notified of the decision as soon as possible, but no later than five days after the decision has been reached.

8.06 Notice of Decision on Internal Appeal.

The Fund will provide you with a written decision, in a culturally and linguistically appropriate manner, on any internal appeal of your claim. However, if your claim is an urgent care claim, the Fund may

notify you of the decision in writing, via fax or orally via telephone. The notice of a denial of a claim on appeal will state:

- A. Sufficient information to identify the claim involved, including the date of service, the health care provider and the claim amount (if applicable). Upon request, the Fund will provide the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;
- B. The specific reason(s) for the determination;
- C. Reference to the specific Plan provision(s) on which the determination is based;
- D. A statement that you are entitled to receive reasonable access to and copies of all documents relevant to your claim, upon request and free of charge;
- E. A statement of your external appeal rights, an explanation regarding how to initiate those rights, and your right to bring a civil action under ERISA following an Adverse Benefit Determination on internal appeal;
- F. The availability of and contact information for any applicable office of health insurance consumer assistance or ombudsman to assist individuals with the internal claims and appeals and external review process;
- G. If an internal rule, guideline or protocol was relied upon by the Fund, you will receive either a copy of the rule or a statement that it is available upon request at no charge;
- H. If the determination was based on medical necessity or because the treatment was Experimental or Investigational Treatment or other similar exclusion, the Fund will provide you with an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to your claim, or a statement that it is available upon request at no charge; and
- I. For disability claims, the following additional information must be provided:
 - 1. An explanation of the decision, including the basis for disagreeing with or not following:
 - a) The views of the health care and vocational experts who treated or evaluated you;
 - b) The views of medical or vocational experts obtained by the Fund, without regard to whether the advice was relied upon in making the Adverse Benefit Determination; and
 - c) A disability determination by the Social Security Administration.
 - 2. If an internal rule, guideline, protocol, or similar criteria was relied on in the process of making a decision on your claim, a copy of that internal rule, guideline, protocol, or similar criteria, or alternatively, a statement that such internal rules, guidelines, protocols, standards or other similar criteria do not exist.
 - 3. A description of any contractual limitations period applying to your right to bring a civil action under ERISA following an Adverse Benefit Determination on internal appeal, as well

as the calendar date on which the Plan's 90 day limit for filing suit expires.

8.07 External Review Procedures.

A. External Review Filing Deadline.

If your health care claim involving medical judgment or a rescission of coverage was denied, resulting in an Adverse Benefit Determination, you have the right to file a request for an external review by an independent review organization with the Fund Office within four months of the date of the internal appeal decision.

However, a denial, reduction, termination, or a failure to provide payment for a benefit based on a determination that you or your Dependent fails to meet the requirements for eligibility under the terms of the Plan is not eligible for the external review process.

B. External Review Process.

The external review process works as follows:

1. Request for External Review

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

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

2. Determination of Eligibility for External Review

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

3. Referral to an Independent Review Organization (IRO)

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

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

4. Request for an Expedited External Review

You may make a request for an expedited external review if the Adverse Benefit Determination involves a medical condition for which the timeframe for completion of an expedited internal appeal or standard external review as described above would seriously jeopardize the life or health of the claimant or would jeopardize the ability to regain maximum function or if the final Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which the claimant received Emergency services, but has not been discharged from a facility.

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

C. Timing of Notice of Decision on External Review.

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

D. Content of Notice of Decision on External Review.

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

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

8.08 Physical Examination.

The Trustees have the right and opportunity, at the Plan's expense, to have a Physician they designate examine you or your Dependent as often as is reasonable while your claim for Plan benefits is pending.

8.09 Payment of Claims.

The Fund will make payments due immediately upon receipt by the Fund Office of proper written proof of loss.

The Fund may pay all or a portion of any benefits provided for health care services to the provider, unless you direct otherwise in writing at the time you file your claim. The Plan does not require that the services be rendered by a particular provider.

Upon your death, benefits accrued on your behalf will be paid at the Fund's option to the first surviving class of the following:

- A. Your spouse;
- B. Your Dependent children, including legally adopted children;
- C. Your parents;
- D. Your brothers and sisters; or
- E. Any person the Trustees determine is entitled to payment.

The Fund will rely upon an affidavit to determine benefit payments, unless it receives written notice of a valid claim before payment is made. The affidavit will release the Fund from further liability.

Any payment made by the Fund in good faith will fully discharge it to the extent of such payment.

8.10 Authorized Representatives.

An authorized representative is the person who can act on the claimant's behalf to file a claim under the Plan. The Fund requires a written statement from the individual that he/she has designated the named individual(s) as the authorized representative along with the representative's name, address and phone number. Please note that an assignment of benefits does not satisfy this provision to designate a provider as an authorized representative.

An authorized representative, such as your spouse, may complete the claim form for you if you are unable to complete it yourself and have previously designated the authorized representative to act on your behalf. You may obtain a form from the Fund Office to designate an authorized representative. The Fund may request additional information to verify that this person is authorized to act on your behalf.

8.11 Benefit Payment to an Incompetent Person.

Benefit payments under the Plan may become payable to a person who is adjudicated incompetent or to a person who in the opinion of the Trustees is unable to administer such payments properly because of mental or physical disability. The Trustees may make payments for the benefit of the incompetent person as they deem best. The Trustees will have no duty or obligation to see that the funds are used or applied for the purpose(s) for which paid if they are paid:

- A. Directly to such person;
- B. To the legally appointed guardian or conservator of such person;
- C. To any spouse, child, parent, brother or sister of such person for the welfare, support and maintenance of that person; or

D. By the Trustees directly for the support, maintenance and welfare of such person.

If any question or dispute arises concerning the proper person or persons to whom any payment will be made under the Fund, the Trustees may withhold payment until a binding adjudication of the question or dispute is made. The resolution must be satisfactory to the Trustees in their sole discretion. Alternatively, the Trustees may pay the benefits if they have been adequately indemnified to their satisfaction against any resulting loss.

8.12 Misrepresentation or Falsification by Participant.

If you make an intentional misrepresentation or falsification of any information or a matter in connection with a claim for Plan benefits, the Trustees or their representative(s) may deny all or part of the benefits that might otherwise be due.

If benefits have already been paid, based on the intentional misrepresentation or false information, the Trustees may recover the benefits from you, plus expenses incurred in such recovery, including attorney's fees, costs and any and all other expenses, and/or may reduce future benefits for your claims until the Fund has recovered the benefits paid and expenses incurred.

8.13 Prohibition on Rescission.

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

SECTION 9: DEFINITIONS

This section contains definitions of terms used throughout this booklet. The terms are listed in alphabetical order.

- A. **Accident** means an injury caused by a sudden unforeseen event. Such injury must be the result of an external source.
- B. **Employee** means a person who is working for a Contributing Employer who is required under a Collective Bargaining Agreement or other agreement to make Contributions to the Fund on his or her behalf. Also included as Employees are all full-time employees of the following organizations: the Union, the Welfare Fund and the Pension Fund.
- C. **Adverse Benefit Determination** means a denial, reduction, or termination of, or a failure to provide or make a payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make a payment that is based on:
 - 1. A determination of an individual's eligibility to participate in the Plan;
 - 2. A determination that a benefit is not a covered benefit;
 - 3. The imposition of a source-of-injury exclusion, network exclusion, or other limitation on otherwise covered benefits; or
 - 4. A determination that a benefit is Experimental, Investigational, or not Medically Necessary or appropriate.
- D. **Board of Trustees and/or Trustees** means the Trustees designated in the Trust Agreement, together with their successors designated and appointed in accordance with the terms of the Trust Agreement for the Central States Joint Board Health and Welfare Fund. The Board of Trustees is the administrator of this Plan as that term is used in the Employee Retirement Income Security Act of 1974.
- E. **Chemical Dependency/Substance Abuse** means any abuse of, addiction to or dependency on the use of drugs, narcotics, alcohol or any other chemical (except nicotine).
- F. **Collective Bargaining Agreement** is any applicable collective bargaining agreement now existing or executed in the future between the Union and an Employer which provides for Contributions to the Trust Fund, as well as any extensions, amendments, or renewals thereof.
- G. **Contributions** are payments made by Contributing Employers to the Trust Fund on behalf of their Employees.
- H. **Contributing Employer or Employer** means any person, firm, association, partnership or corporation which is signatory to a Collective Bargaining Agreement which requires Contributions to this Fund. Contributing Employer also means the Union, the Welfare Fund, the Pension Fund and any other entity that has entered into a participation agreement with the consent of the Trustees and which does in fact make Contributions to this Fund as provided for in the Fund's Trust Agreement and has agreed in writing to be bound by such Trust Agreement.

- I. **Co-Payment** means the fixed dollar amount you are required to pay for services at the time you receive services.
- J. **Covered Medical Expenses** means the Reasonable and Customary charges for expenses ordered by a Physician and incurred by a covered person for Medically Necessary services and supplies required for the treatment of a non-occupational Accident or Sickness.
- K. **Custodial Care** means care designed to help a disabled person with daily living activities when:
1. There is no plan of active medical treatment to reduce the disability; or
 2. The plan of active medical treatment cannot be reasonably expected to reduce the disability.
- L. **Dependent** means any one of the following individuals:
1. An Employee's spouse (marriage license and birth certificate required).
 2. Each child of an Employee from the date he or she first becomes a child of the Employee to the end of the month in which such child attains age 26 (birth certificate required).
 3. A child who is incapable of self-sustaining employment by reason of mental retardation or physical handicap, provided:
 - (a) Such incapacity began before the end of the month such child attains age 26;
 - (b) Such child is chiefly dependent upon the Employee for financial support and maintenance; and
 - (c) Proof of such incapacity is submitted to the Trustees within 31 days of the date such Dependent's eligibility would otherwise terminate.
 4. An Employee's children include natural and legally adopted children, children placed in the Employee's home for adoption, foster children and step children. A Dependent child will also include a child of an eligible Employee who has been appointed legal guardian by a court of competent jurisdiction. Proof of such guardianship may be required.
- M. **Emergency** is the sudden and unexpected onset of a medical condition requiring immediate medical attention. A condition will be an Emergency only if:
1. Severe symptoms occur suddenly and unexpectedly;
 2. Immediate care is secured; and
 3. The Sickness or condition is finally diagnosed as one that would normally require immediate medical care.

N. **Experimental or Investigative Treatments and Procedures** applies to a service, procedure, drug, device, or treatment modality for a specific diagnosis (referred to herein as such treatment or procedure) that meets one of the following criteria:

1. Such treatment or procedure has failed to obtain final approval for a specific diagnosis from the appropriate governmental body;
2. Reliable evidence does not establish a consensus conclusion among experts recognizing the safety and effectiveness of such treatment or procedure on health outcomes for a specific diagnosis;
3. Such treatment or procedure, or the patient-informed consent document utilized with such treatment or procedure was reviewed and approved by the treating facility “institutional review board” or other body serving a similar function, or if federal law requires such review or approval;
4. Reliable evidence shows that such treatment or procedure is (1) the subject of ongoing phase I or phase II clinical trials, (2) the subject of on-going phase III clinical trials, or (3) otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment or diagnosis; or
5. Reliable evidence shows that the prevailing opinion among experts regarding such treatment or procedure is that further studies or clinical trials are needed to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.
6. Reliable evidence means only: published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocols of another facility studying substantially the same drug, device, medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure.

The Trustees have the authority to determine whether a service, procedure, drug, device, or treatment modality is Experimental or Investigative. The fact that a Physician has prescribed, ordered, recommended or approved the service, procedure, drug, device, or treatment does not, in itself, make it eligible for payment.

O. **Fund and/or Welfare Fund** means the Central States Joint Board Health and Welfare Fund.

P. **Plan Administrator** means the Board of Trustees of the Central States Joint Board Health and Welfare Fund.

Q. **Home Health Care Agency** is a public or private agency or organization that meets all of the following requirements:

1. It is primarily engaged in providing skilled nursing services and other therapeutic services in the homes or places of residence of its patients;

2. It has established policies for governing the services that it provides, such policies being established by a group of professional personnel associated with the agency or organization, including one or more Physicians and one or more registered professional nurses;
3. It provides for the supervision of its services by a Physician or registered professional nurse;
4. It is licensed according to all the applicable laws of the state in which it is located; and
5. It is eligible to participate in Medicare.

R. **Hospice Organization** means a public or private agency or organization primarily engaged in providing a coordinated set of services at home or in an outpatient or institutional setting to persons suffering from a terminal or medical condition. The agency or organization must:

1. Be eligible to participate in Medicare;
2. Have an interdisciplinary group of personnel that includes the services of at least one Physician and one registered nurse (R.N.);
3. Maintain clinical records on all of its patients;
4. Meet the standard of the National Hospice Organization; and
5. Provide either directly or indirectly or by another arrangement, the “core services” listed as Covered Medical Expenses.

S. **Hospital** means a lawfully operating institution for the care and treatment of sick and injured persons with organized facilities for diagnosis and treatment, medical supervision, 24-hour nursing service by registered nurses, and surgery (or provides for surgical facilities on a formal arrangement). In no event, however, does the term Hospital include any institution or part of an institution which is used principally as a rest facility or facility for the aged, nor does it include a Hospital operated by the United States Government, unless the claimant is required to pay such expense.

T. **Inpatient** means a person receiving room and board while undergoing treatment in a Hospital, Skilled Nursing Facility, or other healthcare facility.

U. **Medically Necessary** means a service or supply that:

1. Is consistent with the symptoms of diagnosis and treatment of the person’s injury or Sickness;
2. Is appropriate with regard to standards of good medical practice and recognized by an established medical society in the United States; and
3. Could not have been omitted without adversely affecting the person’s condition or the quality of medical care.

- V. **Medicare** means the Hospital and Supplementary Medicare Insurance Plans established by Title XVIII of the Social Security Act of 1965, as then constituted or as later amended.
- W. **Mental Illness** means those illnesses classified as a disorder in the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association.
- X. **Mental or Nervous Disorder** means (1) a Mental Illness or (2) a neurosis, psychoneurosis, psychopathy, psychosis or mental or emotional disease or disorder of any kind, regardless of whether such disease or disorder has causes or origins which are organic, physiological, traumatic or functional.
- Y. **Participant** means an Employee who is eligible and covered under the Plan.
- Z. **Pension Fund** means the Midwest Pension Fund.
- AA. **Physician** means a person licensed as a medical doctor (MD), doctor of osteopathy (DO), doctor of podiatric medicine (D.P.M.), doctor of ophthalmology (O.D.) for optical afflictions, doctor of dental science (D.D.S.), doctor of chiropractic medicine (D.C.) or a naprapath and authorized to practice medicine, to perform surgery, and to administer drugs under the laws of the state or jurisdiction where the services are rendered and who is acting within the scope of such license.
- BB. **Plan and/or Welfare Plan** means this document as adopted by the Trustees and as amended by the Trustees.
- CC. **Prescription Drugs** means legal drugs and medicine approved by the United States Food and Drug Administration (FDA), dispensed by a pharmacist pursuant to the written prescription of a Physician.
- DD. **Preventive Services** means:
1. Evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force with respect to the individual involved, except as provided below;
 2. Immunizations for routine use in children, adolescents, and adults that have a recommendation in effect from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved (for this purpose, a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention is considered in effect after it has been adopted by the Director of the Centers for Disease Control and Prevention, and a recommendation is considered to be for routine use if it is listed on the Immunization Schedules of the Centers for Disease Control and Prevention);
 3. With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration; and

4. With respect to women, to the extent not described above, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

EE. **Reasonable and Customary Charge** means the following:

1. For service or supply covered under a Plan PPO or similar organization contract, the fee shall be the amount the service provider has agreed to accept as a payment in full under its contract with a Plan PPO or similar organization.
2. For service or supply where the fee is not determined under (1) above, the amount the Fund would have paid if the item had been covered under any such Plan PPO contract.
3. For Emergency Room services from a Non-PPO provider, the fee will be the greater of the following amounts: (a) the median of the amount negotiated with PPO providers for the Emergency room service; (b) the amount the Plan generally uses to determine payments for Non-PPO services; or (c) the Medicare rate.

The Board of Trustees reserves the right under extenuating circumstances to pay an amount greater than the fee determined under the subsections listed above.

FF. **Self-Payments** are any payments made by Employees for the purpose of maintaining coverage under the Plan.

GG. **Sickness** includes pregnancy, childbirth, abortion, and related medical conditions among other illnesses.

HH. **Skilled Nursing Facility** means a lawfully operated institution for the care and treatment of persons convalescing from a Sickness or Accident which provides room and board and 24-hour nursing service by registered licensed nurses and is under the full-time supervision of a legally qualified Physician or surgeon or a registered nurse (R.N.).

II. **Total Disability** means the inability to perform any of the substantial and material duties of the disabled person's occupation or employment. A child is deemed Totally Disabled if, as a result of Accident or Sickness, is confined to the home or in a Hospital. The Fund requires proof of a disability determination from the Social Security Administration and a certification from your treating Physician.

JJ. **Union or Unions** mean the Metal Processors Union, Local No. 16, Plastic Workers Union Local No. 18, Manufacturing Production and Service Workers Union, Local 24 and/or Chemical and Production Workers Union, Local 30.

KK. **Other Terms**

Additional terms are defined in other Sections of this Plan as follows:

Terms	Section
1. Allowable Expenses	6.03

2.	COBRA Continuation Coverage.....	2.05
3.	Deductible	3.02
4.	Durable Medical Equipment	3.08
5.	Family Medical Leave Act (FMLA).....	2.04
6.	Qualified Medical Child Support Order (QMSCO).....	2.05

SECTION 10: ADDITIONAL PLAN INFORMATION

10.01 Plan Name.

Central States Joint Board Health and Welfare Fund – Plan B.

10.02 Board of Trustees.

A Board of Trustees is responsible for the operation of this Plan. The Board of Trustees consists of an equal number of Employer and Union representatives, selected by the Employers and the Union which have entered into Collective Bargaining Agreements relating to this Plan. If you wish to contact the Board of Trustees, you may use the addresses below.

As of the date of this Plan Restatement, the Trustees of this Plan are:

Union Trustees	Management Trustees
Mr. Mark Spano Local 30, Chemical & Production Workers 245 Fencil Lane Hillside, IL 60162	Mr. Gary Fairfield Sigmatron International, Inc. 2201 Landmeier Road Elk Grove, IL 60007
Mr. Benny Castro Local 18, Plastic Workers Union 245 Fencil Lane Hillside, IL 60162	Mr. Sheldon Rosen Simon Products, Inc. 8900 W. 50 th Street McCook, IL 60525
Mr. Anthony Iori 245 Fencil Lane Hillside, IL 60162	Mr. Norman Soep Global Material Technology 750 W. Lake Cook Road Buffalo Grove, IL 60089

10.03 Plan Sponsor and Administrator.

The Board of Trustees is the Plan Sponsor and Plan Administrator.

10.04 Plan Numbers.

The Plan number assigned to this Plan by the Board of Trustees pursuant to instructions of the Internal Revenue Service is 502.

The Employer Identification Number assigned to the Board of Trustees by the Internal Revenue Service is 36-2376645.

10.05 Agent for Service of Legal Process.

Johnson & Krol, LLC
311 South Wacker Drive, Suite 1050
Chicago, Illinois 60606
(312) 372-8587

Service of legal process also may be made on the Board of Trustees or any individual Trustee at the addresses listed above.

10.06 Source of Contributions.

The benefits described in this Welfare Fund booklet are provided through Employer Contributions and Self-Payments. The amount of Employer Contributions and the employees on whose behalf Contributions are made are determined by the provisions of the Collective Bargaining Agreements. The amount of Self-Payments is determined by the Trustees.

10.07 Collective Bargaining Agreement.

The Fund is maintained pursuant to various Collective Bargaining Agreements between the Metal Processors Union, Local No. 16, Plastic Workers Union Local No. 18, Manufacturing Production and Service Workers Union, Local 24 and/or Chemical and Production Workers Union, Local 30 and the Employers. Other agreements may be in effect from time to time. The agreements specify the Contributions required.

The Fund Office will provide you, upon written request, information as to whether a particular Employer is contributing to this Fund on behalf of Participants working under a Collective Bargaining Agreement or a list of participating Employers.

10.08 Trust Fund.

All assets are held in Trust for the purpose of providing benefits to covered Participants and defraying reasonable administrative expenses. All of the benefits are provided on a self-funded basis. The Fund's assets are managed by professional asset managers selected by the Board of Trustees.

10.09 Plan Year.

The records of the Plan are kept separately for each Plan Year. The Plan Year is the same as the Plan's fiscal year which begins on January 1 and ends on December 31.

10.10 Type of Plan.

This Plan is maintained for the purpose of providing medical and prescription drug benefits. The Plan benefits are shown in the applicable Schedule of Benefits.

10.11 Gender.

Except as the context may specifically require otherwise, use of the masculine gender will be understood to include both masculine and feminine genders.

10.12 Assignment.

Generally, benefits from the Plan belong to you. You may not sell, assign, transfer or garnish these benefits.

10.13 Amendment and Termination.

You do not earn a vested right to health benefits. The Trustees expressly reserve the right, in their sole discretion, acting in accordance with the provisions of the Trust Agreement regarding Trustee acts, to amend or terminate the Plan in whole or in part at any time.

The Plan may be terminated under circumstances allowed by ERISA and the terms of the governing Trust Agreement. If the Trustees amend or terminate the Plan, they will notify you in writing of the changes that are made to your coverage.

10.14 Discretionary Authority.

In carrying out their respective responsibilities under the Fund, the Trustees and/or their delegates have discretionary authority to interpret the terms of the Plan and to interpret any facts relevant to the determination, and to determine eligibility and entitlement to benefits. Benefits under this Plan will be paid only if the Trustees and/or their delegates decide in their discretion that the applicant is entitled to them. Any interpretation or determination made under that discretionary authority will be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

10.15 Severability Clause.

If a provision of the Trust Agreement or the Plan or any amendment made to the Trust Agreement or to the Plan is determined or judged to be unlawful or illegal, such illegality will apply only to the provision in question and will not apply to any other provisions of the Trust Agreement or the Plan.

10.16 Worker's Compensation Not Affected.

The Plan is not in lieu of and does not affect any requirements for coverage by the applicable workers' compensation laws or occupational disease laws of any state.

10.17 Recovery of Benefits Paid in Error.

If for any reason, any benefit paid to a covered person under this Plan is determined to have been in error, or wholly or partially in excess of the amount to which such payee was entitled to receive under the Plan, the Trustees may collect such erroneous benefit payment or overpayment by any remedy as the law may provide.

10.18 HIPAA Privacy Policy.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that health plans protect the confidentiality of your private health information. A complete description of your rights under HIPAA can be found in the Plan's privacy notice. The privacy notice will be available from the Fund Office.

This Plan and the Plan Sponsor will not use or further disclose information that is protected by HIPAA ("protected health information"), except as necessary for treatment, payment, health plan operations and plan administration, or as permitted or required by law. In particular, the Plan will not, without authorization, use or disclose protected health information for employment-related actions and decisions or in connection with

any other benefit or employee benefit plan. The Plan also hires professionals and other companies to assist it in providing health care benefits. The Plan will require all of its business associates to also observe HIPAA's privacy rules.

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

This Fund maintains a privacy notice that provides a complete description of your rights under HIPAA's privacy rules. Please contact the Fund Office if:

- A. You need a copy of the Privacy Notice;
- B. You have questions about the privacy of your health information; or
- C. You wish to file a complaint under HIPAA.

10.19 HIPAA Security Procedures.

The Fund will comply with the security regulations issued pursuant to the Health Insurance Portability and Accountability Act of 1996, 45 C.F.R. Parts 160, 162 and 164 (the "Security Regulations"). The Board of Trustees shall, in accordance with the Security Regulations:

1. Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the protected health information (PHI) that it creates, receives, maintains or transmits on behalf of the Plan.
2. Ensure that "adequate separation" is supported by reasonable and appropriate security measures. "Adequate Separation" means the Board of Trustees will use PHI only for Plan administration activities and not for employment-related actions or for any purpose unrelated to Plan administration. Any Employee or fiduciary of the Fund who uses or discloses PHI in violation of the Plan's security or privacy policies and procedures or this Plan provision shall be subject to the Plan's sanction policy.
3. Ensure that any agent or subcontractor to whom it provides PHI agrees to implement reasonable and appropriate security measures to protect the information.
4. Take appropriate action related to any Security Incident of which it becomes aware.

The above HIPAA Security Procedures do not apply to PHI (1) that the Plan receives pursuant to an appropriate authorization (as described in 45 C.F.R. § 164.504(f)(1)(ii) or (iii)) or (2) that qualifies as Summary Health Information and that the Fund receives for the purpose of either (a) obtaining premium bids for providing health insurance coverage under the Plan or (b) modifying, amending or terminating the Plan (as authorized under 45 C.F.R. §164.508). Unless defined otherwise in this booklet, all capitalized terms in this provision have the definition given to them by the Security Regulations which are incorporated herein by reference.

10.20 The Fund's Use and Disclosure of Your Protected Health Information (PHI).

A. How the Fund Uses and Discloses Your Protected Health Information.

The Fund will use your PHI to the extent and in accordance with the uses and disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Specifically, the Fund will use and disclose PHI for purposes related to health care treatment, payment for health care and health care operations.

The Fund will use and disclose your PHI as required by law and as permitted by your authorization or the authorization of your beneficiary. With an authorization, the Fund will disclose PHI to the Midwest Pension Plan, reciprocal benefit plans or workers' compensation insurers for purposes related to administration of those plans.

B. Definition of Payment.

Payment includes activities undertaken by the Fund to determine or fulfill its responsibility for coverage and provision of Plan benefits that relate to an individual to whom health care is provided. These activities include, but are not limited to, the following:

1. Determination of eligibility, coverage and cost sharing amounts (e.g., cost of a benefit, Plan maximums and Co-Payments as determined for an individual's claim);
2. Coordination of benefits;
3. Adjudication of health benefit claims (including appeals and other payment disputes);
4. Subrogation of health benefit claims;
5. Establishing Employee Contributions;
6. Risk adjusting amounts due based on enrollee health status and demographic characteristics;
7. Billing, collection activities and related health care data processing;
8. Claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes and responding to Participant (and their authorized representatives) inquiries about payments;
9. Obtaining payment under a contract for reinsurance (including stop-loss and excess of loss insurance);
10. Medical necessity reviews, or reviews of appropriateness of care or justification of charges;
11. Utilization review, including pre-certification, pre-authorization, concurrent review and retrospective review;
12. Disclosure to consumer reporting agencies related to collection of premiums or reimbursement (the following PHI may be disclosed for payment purposes: name and address, date of birth, social security number, payment history, account number, and name and address of the provider and/or health plan); and

13. Reimbursement to the Fund.

C. Definition of Health Care Operations.

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

1. Quality assessment;
2. Population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting of health care providers and patients with information about treatment alternatives and related functions;
3. Rating provider and Plan performance, including accreditation, certification, licensing or credentialing activities;
4. Underwriting, premium rating and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing, or placing a contract for reinsurance of risk relating to claims for health care (including stop-loss insurance and excess of loss insurance);
5. Conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;
6. Business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the entity, including formulary development and administration, development or improvement of methods of payment or coverage policies;
7. Business management and general administrative activities of the entity, including, but not limited to:
 - a. management activities relating to implementation of and compliance with the requirements of HIPAA Administrative Simplification;
 - b. customer service, including the provision of data analyses for policyholders, plan sponsors or other customers;
 - c. resolution of internal grievances; and
 - d. due diligence in connection with the sale or transfer of assets to a potential successor in interest, if the potential successor in interest is a covered entity or following completion of the sale or transfer, will become a covered entity.

D. The Fund's Disclosure of Protected Health Information to the Board of Trustees.

For purposes of this section the Board of Trustees is the Plan Sponsor. With respect to PHI, the Plan Sponsor agrees to:

1. Not use or further disclose the information other than as permitted or required by this Summary Plan Description/Plan Document or as required by law;

2. Ensure that any agents, including a subcontractor to whom the Plan Sponsor provides PHI received from the Plan, agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information;
3. Not use or disclose the information for employment-related actions and decisions unless authorized by the individual;
4. Not use or disclose the information in connection with any other benefit or employee benefit plan of the plan sponsor unless authorized by the individual;
5. Report to the Plan any use or disclosure of the information of which it becomes aware that is inconsistent with the uses or disclosures provided for in this document;
6. Make PHI available to the individual in accordance with the access requirements of HIPAA;
7. Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;
8. Make the information available that is required to provide an accounting of disclosures;
9. Make internal practices, books and records relating to the use and disclosure of PHI received from the group health Plan available to the Secretary of HHS for the purposes of determining compliance by the group health Plan with HIPAA; and
10. If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made. If return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible.

Adequate separation between the Fund and the Plan Sponsor will be maintained. Therefore, in accordance with HIPAA, only the following Employees or classes of Employees will be given access to PHI:

1. The Plan Administrator; and
2. Staff designated by the Plan Administrator.

The persons described above will only have access to and will only use and disclose PHI for Plan administration functions that the Plan Sponsor performs for the Fund. If these persons do not comply with this Summary Plan Description/Plan Document, the Plan Sponsor will provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

10.21 Statement of ERISA Rights.

As a Participant in the Central States Joint Board Health and Welfare Fund you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan Participants are entitled to the following rights.

A. Receive Information about Your Plan and Benefits.

You have the right to:

1. Examine, without charge, at the Fund Office, all documents governing the Plan. These include 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 (EBSA).
2. Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan. These include insurance contracts and Collective Bargaining Agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.
3. Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report.

B. Continue Group Health Plan Coverage.

You also have the right to continue health care coverage for yourself, spouse or Dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event. You or your Dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA Continuation Coverage rights.

C. 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.

D. 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 the 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 Plan Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file a lawsuit in a court. In addition, if you disagree with the Fund's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file a lawsuit in court. You must exhaust all of the Plan's claims and appeals procedures before filing a lawsuit. 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 a lawsuit. 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.

E. Receive Assistance with Your Questions.

If you have any questions about your Plan, you should contact the Fund Office. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Fund Office, you should contact the nearest office of the Employee Benefits Security Administration (EBSA), U.S. Department of Labor, listed in your telephone directory or:

The Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue N.W.
Washington, D.C. 20210

You may also find answers to your Plan questions, your rights and responsibilities under ERISA and a list of EBSA field offices by contacting the EBSA:

1. By calling (866) 444-3272;
2. Sending electronic inquires to www.askebsa.dol.gov; or
3. Visiting the EBSA web site at www.dol.gov/ebsa.