United Food and Commercial Workers Union and Employers Calumet Region Insurance Fund

Health Benefits Plan Document

Amended and Restated January 1, 2019

Table of Contents

ARTICLE 1 — PURPOSE **1**

ARTICLE 2 — DEFINITIONS **2**

SECTION 2.01. ACTIVELY EMPLOYED OR ACTIVE EMPLOYMENT 2
SECTION 2.02. AMBULATORY CARE FACILITY 2
SECTION 2.03. AUTHORIZED REPRESENTATIVE 2
SECTION 2.04. BENEFITS FUND OFFICE 2
SECTION 2.05. BRAND-NAME DRUG 2
SECTION 2.06. CALENDAR YEAR 2
SECTION 2.07. COINSURANCE 3
SECTION 2.08. COLLECTIVE BARGAINING AGREEMENT 3
SECTION 2.09. CONTRIBUTING EMPLOYER 3
SECTION 2.10. CO-PAY 3
SECTION 2.11. COSMETIC SURGERY OR TREATMENT 4
SECTION 2.12. COVERED EXPENSE 4
SECTION 2.13. COVERED HOURS 4
SECTION 2.14. CUSTODIAL CARE 4
SECTION 2.15. DEDUCTIBLE 4
SECTION 2.16. DENTAL SERVICES 4
SECTION 2.17. DENTIST 5
SECTION 2.18. EARNINGS 5
SECTION 2.19. ELIGIBLE DEPENDENT 5
SECTION 2.20. ELIGIBLE EMPLOYEE 6
SECTION 2.21. EMERGENCY MEDICAL CONDITION 6
SECTION 2.22. EMERGENCY SERVICE(S) 6
SECTION 2.23. EMPLOYEE 7
SECTION 2.24. EXPERIMENTAL, INVESTIGATIONAL OR UNPROVEN SERVICES 7
SECTION 2.25. FUND 8
SECTION 2.26. FUND ADMINISTRATOR 8
SECTION 2.27. GENERIC DRUG 8
SECTION 2.28. HEALTH CARE PROVIDER 8
SECTION 2.29. HOME HEALTH CARE 9
SECTION 2.30. HOME HEALTH CARE AGENCY 10
SECTION 2.31. HOSPICE 10
SECTION 2.32. HOSPITAL 10
SECTION 2.33. HOSPITAL CONFINED OR HOSPITAL CONFINEMENT 11
SECTION 2.34. ILLNESS 11
SECTION 2.35. INJURY 11
SECTION 2.36. IN-NETWORK 11
SECTION 2.37. INTENTIONALLY DESTRUCTIVE ACT 11
SECTION 2.38. MEDICALLY CONFINED 12
SECTION 2.39. MEDICALLY NECESSARY AND APPROPRIATE 12
SECTION 2.40. MEDICARE 13
SECTION 2.41. MENTAL OR NERVOUS DISORDER 13
SECTION 2.42. MONTH 13
SECTION 2.43. OUT-OF-AREA 14
SECTION 2.44. OUT-OF-NETWORK 14
SECTION 2.45. PARTICIPANT 14
SECTION 2.46. PARTICIPATION AGREEMENT 14
SECTION 2.47. PHYSICIAN 14
SECTION 2.48. PLAN 14
SECTION 2.49. PLAN SPONSOR 15
SECTION 2.50. PLAN YEAR 15
SECTION 2.51. PRACTITIONER 15

SECTION 2.52. PRE-AUTHORIZATION/PRE-CERTIFICATION 15
SECTION 2.53. PREFERRED PROVIDER OPTION (PPO) 15
SECTION 2.54. PRESCRIPTION DRUGS 15
SECTION 2.55. PROSTHESIS/PROSTHETICS 16
SECTION 2.56. SKILLED NURSING FACILITY 16
SECTION 2.57. SOUND AND NATURAL TEETH 16
SECTION 2.58. SUBSTANCE USE DISORDER 16
SECTION 2.59. TOTALLY DISABLED OR TOTAL DISABILITY 17
SECTION 2.60. TRUST AGREEMENT 17
SECTION 2.61. TRUSTEES 17
SECTION 2.62. UNION 17
SECTION 2.63. USUAL AND CUSTOMARY CHARGE 17
SECTION 2.64. WORK RELATED ILLNESS OR INJURY 18

ARTICLE 3 — PARTICIPATING EMPLOYERS 19

SECTION 3.01. COMMENCEMENT OF PARTICIPATION 19
SECTION 3.02. TERMINATION OF PARTICIPATION 20
SECTION 3.03. SUSPENSION OF COVERAGE 20

ARTICLE 4 — ELIGIBILITY 21

SECTION 4.01. PLAN OF BENEFITS 21
SECTION 4.02. INITIAL ELIGIBILITY REQUIREMENTS 21
SECTION 4.03. EFFECTIVE DATE OF COVERAGE FOR INITIAL EMPLOYEE ELIGIBILITY 22
SECTION 4.04. ELECTION OF COVERAGE UNDER PLAN CLASSIFICATION G1 22
SECTION 4.05. CONTINUATION OF EMPLOYEE ELIGIBILITY 23
SECTION 4.06. EMPLOYEE TERMINATION OF ELIGIBILITY 24
SECTION 4.07. REINSTATEMENT 24
SECTION 4.08. SPECIAL ENROLLMENT PERIODS 24
SECTION 4.09. DEPENDENT ELIGIBILITY 25
SECTION 4.10. TERMINATION OF DEPENDENT ELIGIBILITY 26
SECTION 4.11. QUALIFIED MEDICAL CHILD SUPPORT ORDERS (QMCSOS) 26
SECTION 4.12. CONTINUATION OF COVERAGE DURING LEAVE OF ABSENCE (FMLA) 26
SECTION 4.13. UNIFORMED SERVICES EMPLOYMENT AND RE-EMPLOYMENT RIGHTS (USERRA) 27
SECTION 4.14. COBRA CONTINUATION COVERAGE 30
SECTION 4.15. RESCISSION OF COVERAGE 35
SECTION 4.16. CERTIFICATION OF TOBACCO USE 36

ARTICLE 5 — GENERAL PROVISIONS 37

SECTION 5.01. FUNDING 37
SECTION 5.02. ADMINISTRATION 37
SECTION 5.03. RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION 37
SECTION 5.04. RIGHT TO MAKE PAYMENT 38
SECTION 5.05. RIGHT OF RECOVERY 38
SECTION 5.06. OFFSET 38
SECTION 5.07. SUBMISSION OF FALSIFIED OR FRAUDULENT CLAIMS 38
SECTION 5.08. WORKERS' COMPENSATION NOT AFFECTED 39
SECTION 5.09. AMENDMENT AND TERMINATION 39
SECTION 5.10. PHYSICAL EXAMINATION 39
SECTION 5.11. GENDER 39
SECTION 5.12. MAXIMUM AMOUNT 39
SECTION 5.13. SEVERABILITY CLAUSE 39

ARTICLE 6 — CLAIMS AND APPEALS 40

SECTION 6.01. INTERNAL CLAIMS AND APPEAL PROCEDURES 40
SECTION 6.02. GENERAL INFORMATION 41
SECTION 6.03. CULTURALLY AND LINGUISTICALLY APPROPRIATE NOTICES 42
SECTION 6.04. DEFINITION OF A CLAIM 42
SECTION 6.05. TYPES OF CLAIMS 43

SECTION 6.06. CLAIM ELEMENTS 44
SECTION 6.07. INITIAL CLAIM DECISION TIMEFRAMES 45
SECTION 6.08. INITIAL DETERMINATIONS OF BENEFIT CLAIMS 51
SECTION 6.09. INTERNAL APPEALS PROCESS 54
SECTION 6.10. NOTICE OF ADVERSE BENEFIT DETERMINATION UPON APPEAL 57
SECTION 6.11. AUTHORIZED REPRESENTATIVE 59
SECTION 6.12. LIMITATION ON WHEN A LAWSUIT MAY BE STARTED 59
SECTION 6.13. ELIMINATION OF CONFLICT OF INTEREST 60
SECTION 6.14. FACILITY OF PAYMENT 60
SECTION 6.15. EXTERNAL REVIEW OF CLAIMS 60
SECTION 6.16. CULTURALLY AND LINGUISTICALLY APPROPRIATE NOTICES 61
SECTION 6.17. CLAIMS ELIGIBLE FOR THE EXTERNAL REVIEW PROCESS 61
SECTION 6.18. CLAIMS NOT ELIGIBLE FOR THE EXTERNAL REVIEW PROCESS 61
SECTION 6.19. EXTERNAL REVIEW OF A STANDARD (NON-URGENT CARE) CLAIM 62
SECTION 6.20. EXPEDITED EXTERNAL REVIEW OF AN URGENT CARE CLAIM 65
SECTION 6.21. WHAT HAPPENS AFTER THE IRO DECISION IS MADE? 67

ARTICLE 7 — UTILIZATION MANAGEMENT 68

SECTION 7.01. PRE-AUTHORIZATION 68
SECTION 7.02. SECOND OPINION 69

ARTICLE 8 — EMPLOYEE DEATH BENEFIT 71

SECTION 8.01. GENERAL 71
SECTION 8.02. BENEFITS PAYABLE 71
SECTION 8.03. NAMING A BENEFICIARY 71
SECTION 8.04. BENEFICIARY DESIGNATION FOLLOWING DIVORCE 71
SECTION 8.05. DEATH BENEFIT COVERAGE AS A RESULT OF A SERIOUS MEDICAL CONDITION 72

ARTICLE 9 — EMPLOYEE ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT 73

SECTION 9.01. GENERAL 73
SECTION 9.02. BENEFITS PAYABLE 73
SECTION 9.03. EXCLUSIONS AND LIMITATIONS 73

ARTICLE 10 — INCOME PROTECTION BENEFIT 75

SECTION 10.01. GENERAL 75
SECTION 10.02. BENEFITS PAYABLE 75
SECTION 10.03. PERIODS OF DISABILITY 75
SECTION 10.04. EXCLUSIONS AND LIMITATIONS 76

ARTICLE 11 — COMPREHENSIVE MEDICAL EXPENSE BENEFIT 77

SECTION 11.01. GENERAL 77
SECTION 11.02. PPO AGREEMENT 77
SECTION 11.03. BENEFITS PAYABLE 77
SECTION 11.04. DEDUCTIBLE AMOUNTS 77
SECTION 11.05. OUT-OF-POCKET MAXIMUM 78
SECTION 11.06. MAXIMUM BENEFIT 78
SECTION 11.07. COVERED MEDICAL EXPENSES 79
SECTION 11.08. APPROVED CLINICAL TRIALS 102

ARTICLE 12 — PRESCRIPTION DRUG BENEFIT 104

SECTION 12.01. GENERAL 104
SECTION 12.02. BENEFITS PAYABLE 104
SECTION 12.03. COVERED PRESCRIPTION DRUG EXPENSES 105
SECTION 12.04. EXCLUSIONS AND LIMITATIONS 106
SECTION 12.05. PRESCRIPTION DRUG BENEFIT IDENTIFICATION CARD 107

ARTICLE 13 — DENTAL EXPENSE BENEFIT 108

SECTION 13.01. GENERAL 108

SECTION 13.02. BENEFITS PAYABLE 108
SECTION 13.03. COVERED DENTAL EXPENSES 108

ARTICLE 14 — VISION BENEFIT 109

SECTION 14.01. GENERAL 109
SECTION 14.02. BENEFITS PAYABLE 109
SECTION 14.03. COVERED VISION EXPENSES 109
SECTION 14.04. EXCLUSIONS AND LIMITATIONS 109

ARTICLE 15 — SUBROGATION 110

SECTION 15.01. GENERAL 110
SECTION 15.02. RIGHT OF REIMBURSEMENT 110
SECTION 15.03. ENFORCEMENT OF RIGHTS 111
SECTION 15.04. RIGHTS AND OBLIGATIONS OF CLAIMANT 111
SECTION 15.05. ATTORNEY'S FEES 112

ARTICLE 16 — SELF-AUDIT PROGRAM 113

SECTION 16.01. GENERAL 113
SECTION 16.02. AMOUNT PAYABLE 113
SECTION 16.03. PAYMENT 113

ARTICLE 17 — GENERAL PLAN EXCLUSIONS AND LIMITATIONS 114

ARTICLE 18 — COORDINATION OF BENEFITS 120

SECTION 18.01. GENERAL 120
SECTION 18.02. OTHER PLAN 120
SECTION 18.03. ALLOWABLE EXPENSE 121
SECTION 18.04. ORDER OF BENEFIT PAYMENT 122
SECTION 18.05. EFFECT OF MEDICARE 124

ARTICLE 19 — EFFECT OF MEDICARE 125

SECTION 19.01. GENERAL 125
SECTION 19.02. DEFINITIONS 125
SECTION 19.03. EFFECT ON BENEFITS 125
SECTION 19.04. ORDER OF BENEFIT PAYMENT 125

APPENDIX A — REQUIRED SECOND OPINION REVIEW LIST 127

APPENDIX B — PPO CONTRACT 129

APPENDIX C — SUBROGATION AGREEMENT AND ASSIGNMENT 130

APPENDIX D – BARIATRIC SURGERY POLICY 131

APPENDIX E – PROPHYLACTIC MASTECTOMY AND BRCA TESTING POLICY 133

ADDENDUM 1 — HIPAA PRIVACY PROVISIONS 134

ARTICLE 1 — PURPOSE

This Health Benefit Plan is adopted by the Trustees of the United Food and Commercial Workers Union and Employers Calumet Region Insurance Fund under the terms of the Agreement and Declaration of Trust in order to establish provisions which determine the eligibility of Employees for the benefits provided by the United Food and Commercial Workers Union and Employers Calumet Region Insurance Fund and to prescribe the amount, extent, conditions and methods of payment under the United Food and Commercial Workers Union and Employers Calumet Region Insurance Fund.

Article V, Section 7 of the Trust Agreement authorizes the Trustees to prescribe rules and regulations as may be proper or necessary for the sound and efficient administration of the Trust, provided that the rules and regulations shall be consistent with the provisions of the Trust Agreement.

ARTICLE 2 — DEFINITIONS

Word and phrases appearing in this Plan shall have the respective meanings set forth in this Article, unless the context clearly indicates to the contrary.

Section 2.01. Actively Employed or Active Employment

Actual attendance at the job site and performance of job duties, including vacation, holidays and regular non-working days.

Section 2.02. Ambulatory Care Facility

A facility approved or licensed as such by an agency of the governing jurisdiction that provides medical care on an outpatient basis. There are two types of ambulatory care facilities:

(a) Hospital affiliated facilities under the direct supervision of a Physician owned and operated by and licensed through a Hospital; or

(b) Free-standing facilities under the direct supervision of a Physician, which include surgicenters, emergency care centers and urgent care centers.

Section 2.03. Authorized Representative

An individual or entity that has been named in writing by a Plan Participant to act on the Participant's behalf to submit a claim or file an appeal. Once established, an Authorized Representative may only be dismissed in writing by the Participant.

Section 2.04. Benefits Fund Office

The Benefits Fund Office is from which the Plan is administered. The office is located at 18861 90th Avenue, Suite A, Mokena, IL 60448.

Section 2.05. Brand-Name Drug

A Prescription Drug which is an original drug product marketed under a trademarked name.

Section 2.06. Calendar Year

The period of 12 months starting on January 1 of each year and ending December 31.

Section 2.07. Coinsurance

The percentage of costs of a covered health care service an Eligible Employee or Eligible Dependent pays after the Eligible Employee or Eligible Dependent pays his or her Deductible.

Section 2.08. Collective Bargaining Agreement

A written agreement to which the Union and an employer are parties, that recognizes the Union as the exclusive bargaining agent of a bargaining unit of the employer's Employees and that provides for current or future contributions to this Fund by the employer on behalf of bargaining unit Employees.

Section 2.09. Contributing Employer

Any employer who:

(a) On or after the Effective Date has a Collective Bargaining Agreement with the Union requiring periodic contributions to be made to the Fund,

(b) Signs a copy of the Trust Agreement or executes a Participation Agreement or in some other written manner indicates consent to be bound by the terms of the Trust Agreement, which is then filed at the administration office of the Fund,

(c) Is accepted for participation in the Fund in accordance with the provisions of Article 3 hereof,

(d) Makes contributions to the Fund as required by the Collective Bargaining Agreement, and

(e) Has been accepted, and has not, by resolution of the Trustees, been terminated as a Contributing Employer because of failure, for a period of ninety 90 days after the due date, to make contributions to the Fund as provided for in its Collective Bargaining Agreement or Participation Agreement.

If an employer has more than one place of business, the term "Contributing Employer" shall only apply to the place or places of business covered by the Collective Bargaining Agreement requiring contributions to the Fund. A business organization shall not be deemed a Contributing Employer simply because it is part of a controlled group of corporations or of a trade or business under common control, some other part of which is a Contributing Employer.

Section 2.10. Co-pay

That portion of the Covered Expense expressed as a flat dollar amount, which is required to be paid by the Participant and which is not subject to reimbursement by the Plan.

Section 2.11. Cosmetic Surgery or Treatment

Surgery or medical treatment which is performed primarily to improve or preserve physical appearance but not physical function or to improve self-esteem, except as set forth in Article 11.

Section 2.12. Covered Expense

The charges for Medically Necessary services and supplies for the diagnosis or care of an Eligible Employee or Eligible Dependent's Illness or Injury. A Covered Expense will not exceed the Usual and Customary Charges, as determined by the Fund Administrator, within the geographical area in which the expense is incurred. An expense must also be allowable under the benefit provisions of the Plan in order to be considered a Covered Expense.

Section 2.13. Covered Hours

Hours in which an Employee is Actively Employed and for which a Contributing Employer is obligated to contribute to the Fund.

Section 2.14. Custodial Care

Services or supplies, regardless of where or by whom they are provided, that:

(a) A person without medical skills or background could provide or be trained to provide; or

(b) Are provided mainly to help the patient with daily living activities, including but not limited to, walking, getting in or out of bed, exercising or moving, bathing, using the toilet, administering enemas, dressing and assisting with hygiene needs, assistance with tube or gastrostomy feedings and stoma and ostomy maintenance, cleaning or preparation of meals, acting as a companion or sitter, or administering or supervising the administration of medication including but not limited to the administration of insulin and other injectable medications, changing of dressings, or as part of a maintenance treatment plan not reasonably expected to improve the patient's condition, sickness, injury or functional ability.

Section 2.15. Deductible

The amount of Covered Expenses an Eligible Employee or Eligible Dependent is responsible for paying before the Plan begins to pay benefits.

Section 2.16. Dental Services

Any service involving teeth, tooth-supporting structures and tissues of the oral cavity.

Section 2.17. Dentist

A person who is licensed to practice dentistry or perform oral surgery and who is practicing within the scope of his or her license. A licensed dentist will also be considered a dentist while practicing within the scope of his or her license, and to the extent that benefits are provided.

Section 2.18. Earnings

The regular pay an Eligible Employee receives. It does not include commissions, bonuses or overtime pay.

Section 2.19. Eligible Dependent

Any or all of the following individuals:

(a) The Eligible Employee's lawful spouse;

On or after January 1, 2019 an Eligible Employee's lawful spouse will be considered by the Plan to be an Eligible Dependent if a completed spousal coverage statement is on file at the Fund office, and

The Eligible Employee's lawful spouse is either not employed or does not have coverage available with his/her employer.

(b) Children of the Eligible Employee through the end of the month in which they attain their 26th birthday. For this purpose, "children" shall include:

(i) Natural children;

(ii) Step-children; and

(iii) Legally adopted children or those for whom adoption proceedings have been started and the children are placed in the Eligible Employee's home by a licensed placement agency for the purpose of adoption or if the children have been living in the Eligible Employee's home as foster children for whom foster care payments are being made, and a petition for adoption has been filed.

(c) Those children of the Eligible Employee who have reached their 26th birthday but are unmarried and incapable of self-sustaining employment because of mental retardation or physical handicap, provided:

(i) Such incapacity commenced prior to the limiting age in subsection (b) above,

(ii) Such children reside with the Eligible Employee permanently and regularly for more than one-half of the year or live in a treatment center and are primarily dependent on the Eligible Employee for more than one-half of their financial support and maintenance, and

(iii) The Eligible Employee submits satisfactory proof of such incapacity after the upper age limit is reached. The Benefits Fund Office may require, at reasonable intervals following the date the child reaches the age limit, subsequent proof of continuing incapacity and dependency. The Trustees reserve the right to have such children examined by a Physician of their choice to determine the existence of such incapacity.

(d) If both spouses are Eligible Employees and each are eligible for dependent coverage, their children shall be considered Eligible Dependents of both.

The Benefits Fund Office may require legal documentation to determine if a person meets these requirements.

Section 2.20. Eligible Employee

An individual who satisfies the conditions for eligibility under Article 4.

Section 2.21. Emergency Medical Condition

A medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the lack of immediate medical attention to result in:

- The patient's health (or with respect to a pregnant woman, the health of her unborn child) being placed in serious jeopardy;
- Serious impairment of bodily function; or
- Serious dysfunction of a bodily organ or part.

Section 2.22. Emergency Service(s)

Any Medically Necessary service(s) which must be provided immediately.

Section 2.23. Employee

Any employee on whose behalf payments are required to be made to the Fund by a Contributing Employer pursuant to a Collective Bargaining Agreement with the Union on whose behalf such employer is obligated to make contributions to the Fund pursuant to a Participation Agreement.

The term "Employee" includes a leased employee of a Contributing Employer, within the meaning of Section 414(n) of the Internal Revenue Code, who otherwise meets the conditions for participation under the Fund.

The term "Employee" does not include:

(a) A sole proprietor or self-employed person;

(b) A partner, regardless of the size of the partnership interest; or

(c) Anyone whose inclusion would, in the opinion of the Trustees, jeopardize the tax-exempt status of the Fund or violate provisions of the Employee Retirement Income Security Act of 1974 ("ERISA").

Section 2.24. Experimental, Investigational or Unproven Services

Medical, surgical, diagnostic, psychiatric, substance abuse or other health care technologies, supplies, treatments, procedures, drug therapies or devices that are determined by the Fund Administrator (at the time a determination is made regarding coverage in a particular case) to be:

(a) Not approved by the U.S. Food and Drug Administration ("FDA") to be lawfully marketed for the proposed use and/or not identified in the American Hospital Formulary Service, the United States Pharmacopoeia Dispensing Information, or the American Medical Association Drug Evaluations as appropriate for the proposed use; or

(b) Subject to review and approval by an Institutional Review Board for the proposed use; or

(c) The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 Clinical Trial set forth in the FDA regulations, except for Covered Expenses subject to Section 11.08 of this Plan, regardless of whether the trial is actually subject to FDA oversight; or

(d) Not demonstrated through prevailing peer-reviewed medical literature to be safe and effective for treating or diagnosing the Illness or Injury for which its use is proposed.

Section 2.25. Fund

The United Food and Commercial Workers Union and Employers Calumet Region Insurance Fund, established to receive and invest contributions of the Contributing Employers and from which benefits are paid.

Section 2.26. Fund Administrator

An individual employed by or a third-party administrator engaged by the Trustees of the United Food and Commercial Workers Union and Employers Calumet Region Insurance Fund charged with any administrative duties of the Fund, such as recordkeeping, reporting and disclosure, processing of applications for benefits and related functions attendant to the administration of the Plan. The individual may be a shared chief executive with a related United Food and Commercial Workers Unions and Employers benefit plan.

Section 2.27. Generic Drug

A Prescription Drug which is a multi-source drug that is no longer under patent protection.

Section 2.28. Health Care Provider

May include, but not limited to, the institutions or persons listed below legally licensed and/or legally authorized to practice or provides medical care or diagnostic treatment to sick or injured persons under the laws of the state or jurisdiction in which the services are rendered:

(a) Home Health Agency;

(b) Ambulatory Care Facility;

(c) Licensed ambulance service;

(d) Practitioner;

(e) Physician;

(f) Hospital;

(g) Laboratory;

(h) Skilled Nursing Facility;

(i) Hospice;

(j) Licensed clinical social worker;

(k) Licensed social worker;

(l) Licensed clinical professional counselor;

(m) Occupational, physical, respiratory or speech therapist;

(n) Certified alcohol and drug counselor;

(o) Licensed nurse practitioner; and

(p) Residential treatment facilities.

Section 2.29. Home Health Care

Care provided in the home or outside of any state or federally licensed acute or chronic care facility including but not limited to all nursing, respiratory therapy, or skilled care giver of any kind providing services in the home including but not limited to services related to monitoring an acute or chronic condition or providing ancillary or supportive services including those related to providing home ventilator or respiratory care, wound care, peri-partum care, infusion services or other home therapies with the exception of therapies with limitations as stated otherwise in the Plan without regard to the venue where the service was provided.

Covered treatment shall not include the following:

Services or supplies regardless of where or by whom they are provided, that:

(a) A person without medical skills or background could provide or be trained to provide, provided that this shall not preclude coverage by the Plan for training for such person to provide the Home Health Care at the sole discretion of the Trustees; or

(b) Are provided as part of a maintenance treatment plan not reasonably expected to improve the patient's condition, sickness, injury or functional ability.

All home therapies shall be subject to all additional relevant provisions of the Plan including but not limited to Medical Appropriateness and Necessity.

Section 2.30. Home Health Care Agency

A Home Health Care Agency is a public or private agency which meets all the following requirements:

(a) Is certified as a home health agency under Medicare or is licensed as a home health agency by the state or is a Hospital possessing a valid certificate to provide home health care services;

(b) Is primarily engaged in providing skilled nursing and other therapeutic services;

(c) Has its policies set by a professional group which governs the services provided; and

(d) Maintains records for each patient.

Section 2.31. Hospice

A health care program which provides a coordinated set of palliative and supportive health care services rendered at home or in outpatient or institutional settings for terminally ill individuals assessed to have a life expectancy of six months or less. Hospice also means a public or private entity, or part of it, which is licensed or certified as a Hospice by Medicare and by the state.

Section 2.32. Hospital

(a) An institution which meets all the following requirements:

(i) Is accredited by The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or other similar credentialing entity recognized by the Centers for Medicare & Medicaid Services (Medicare) or successor entities;

(ii) Is approved by Medicare as a Hospital;

(iii) Is primarily engaged in providing by or under the supervision of Physicians, to inpatients, diagnostic and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons;

(iv) Is supervised by a staff of Physicians on the premises;

(v) Provides on the premises 24 hour nursing services rendered or supervised by registered professional nurses, and has a licensed practical nurse or registered professional nurse on duty at all times; and

(vi) Is operated with organized facilities for operative surgery on the premises, except for the following institutions:

(A) Mental/psychiatric hospitals;

(B) Drug/alcohol rehabilitation hospitals; and

(C) Physical rehabilitation hospitals.

(b) A hospital does not include any institution:

(i) Which is run mainly as a rest, nursing, or convalescent home;

(ii) For which any part is mainly for the care of the aged;

(iii) Which is engaged in the schooling of its patients; or

(iv) Which is a residential care facility that does not meet all of the requirements of 2.31(a).

Section 2.33. Hospital Confined or Hospital Confinement

Confined in a Hospital as a registered bed-patient.

Section 2.34. Illness

Any marked, pronounced deviation from a normal, healthy state. Illness also includes pregnancy.

Section 2.35. Injury

Any damage to the body.

Section 2.36. In-Network

Services and supplies provided by Health Care Providers who are members of the Plan's Preferred Provider Option (PPO) or other designated network of Health Care Providers and facilities.

Section 2.37. Intentionally Destructive Act

An Intentionally Destructive Act includes, but is not limited to, knowingly failing to comply with a prescribed course of treatment, such as

(a) Failing to take prescribed medication;

(b) Failing to enroll in and complete a prescribed course of treatment which has been recommended by a Physician after an appropriate evaluation, such as for chronic or acute conditions including, but not limited to, hypertension, diabetes or substance abuse;

(c) Failing to complete other similar Medically Necessary and Appropriate treatment or testing which is prescribed by a Physician, including completion of a course of treatment in an inpatient acute care facility or leaving an acute care facility against the medical advice of the treating Physician; and

(d) Self-administered overdose.

An Intentionally Destructive Act is not caused by or related to an underlying medical condition.

Section 2.38. Medically Confined

An inpatient in a medical facility due to Illness or Injury. Medically Confined includes confinement in a Hospital, Skilled Nursing Facility, Substance Use Disorder treatment facility, Mental or Nervous Disorder treatment center, Hospice, Residential treatment facility, or any other facility engaged in the treatment of Illness or Injury.

Section 2.39. Medically Necessary and Appropriate

(a) A medical service, supply, treatment or confinement will be determined to be "Medically Necessary" by the Plan Sponsor if it meets all the following requirements:

(i) Is provided by or under the direction of a Physician or other Health Care Provider who is licensed and authorized to provide or prescribe it;

(ii) Is determined by the Plan Sponsor or its designee to be necessary in terms of generally accepted medical standards in the U.S.; and

(iii) Is determined by the Plan Sponsor to meet all of the following requirements:

(A) It is consistent with the symptoms or diagnosis and treatment of the Illness or Injury;

(B) It is not provided solely for the convenience of the patient, Physician, Hospital, Health Care Provider, or health care facility;

(C) It is an "appropriate" service or supply given the patient's circumstances and condition;

(D) It is the most "cost-efficient" supply or level of service that can be safely provided to the patient;

(E) It is safe and effective for the Illness or Injury for which it is used; and

(F) For Hospital Confinement, it cannot be safely provided on an outpatient basis.

The fact that a Physician or other Health Care Provider orders or recommends a service, supply, treatment or confinement does not in itself make them Medically Necessary.

(b) A medical service, supply, treatment or confinement will be considered to be "Appropriate" if:

(i) It is a diagnostic procedure that is called for by the health status of the patient, and is:

(A) As likely to result in information that could affect the course of treatment as; and

(B) No more likely to produce a negative outcome than any alternative service or supply, both with respect to the Illness or Injury involved and the patient's overall health condition.

(ii) It is care or treatment that is:

(A) As likely to produce a significant positive outcome as; and

(B) No more likely to produce a negative outcome than any alternative service or supply, both with respect to the Illness or Injury involved and the patient's overall health condition.

Section 2.40. Medicare

The four health care programs, a hospital benefit plan (Part A), a supplementary medical benefits plan (Part B), the health care plans under the Medicare Advantage program (Part C), and the prescription drug program (Part D), as established by Title XVIII of the Social Security Act, as amended.

Section 2.41. Mental or Nervous Disorder

A mental illness or organic or functional nervous disorder which is identified as a mental illness or nervous disorder in the most current edition of the Diagnostic and Statistical Manual of Mental Disorders.

Section 2.42. Month

Any of the 12 months of the Calendar Year.

Section 2.43. Out-of-Area

The term used to describe medical care received in geographical areas not served, with regard to such care, by the Plan's Preferred Provider Option.

Section 2.44. Out-of-Network

Services and supplies provided by Health Care Providers who are not members of the Plan's Preferred Provider Option (PPO), but who are located in geographical areas served by the PPO.

Section 2.45. Participant

An Eligible Employee who is covered under the Plan according to the eligibility rules as set forth in Article 4.

Section 2.46. Participation Agreement

A written agreement in form or content acceptable to the Trustees pursuant to which an employer consents to be bound by the Trust Agreement and adopts the Plan.

Section 2.47. Physician

A person who is duly licensed by the appropriate state agency of the state in which the services are performed practicing within the scope of his license as:

(a) A Doctor of Medicine (M.D.);

(b) A Doctor of Osteopathy (D.O.);

(c) A Doctor of Dental Surgery (D.D.S.);

(d) A Doctor of Podiatry (D.P.M.);

(e) A Doctor of Chiropractic (D.C.); or

(f) A Doctor of Medical Dentistry (D.M.D.).

Section 2.48. Plan

The United Food and Commercial Workers Union and Employers Calumet Region Insurance Fund, the Plan set forth herein, as amended from time to time.

Section 2.49. Plan Sponsor

The Trustees of the United Food and Commercial Workers Union and Employers Calumet Region Insurance Fund.

Section 2.50. Plan Year

The twelve-month period from December 1 through November 30.

Section 2.51. Practitioner

A person, other than one defined above as a Physician, who:

(a) Upon referral by a Doctor of Medicine or a Doctor of Osteopathy, who is a Health Care Provider that provides services which are covered under the Plan; and

(b) Is practicing within the scope of his license as a Health Care Provider.

Section 2.52. Pre-authorization/Pre-certification

The approval of the Fund Administrator of a proposed treatment plan before services are provided to assure that Hospital admissions and lengths of stay, surgery and other health care services are Medically Necessary and Appropriate. For purposes of communication with an Eligible Employee, an Eligible Dependent or Health Care Provider, and for contracting with vendors providing services to the Plan, the terms Pre-authorization and Pre-certification may be used interchangeably.

Section 2.53. Preferred Provider Option (PPO)

A group or network of Health Care Providers under contract with the Plan to provide health care services and supplies at agreed-upon discounted rates as payment in full and to handle the paperwork required for submission of claims.

Section 2.54. Prescription Drugs

The following are considered Prescription Drugs:

(a) Most Federal Legend Drugs. (This is any medicinal substance which the Federal Food, Drug and Cosmetic Act requires to be labeled “Caution—Federal Law prohibits dispensing without prescription” or “Rx Only”.)

(b) Drugs which require a prescription under State law but not under Federal law.

(c) Compound drugs. (This is a drug that has more than one ingredient. At least one of the ingredients has to be a Federal Legend Drug or a drug which requires a prescription under State law.)

(d) Injectable insulin, syringes, lancets, needles and blood glucose testing strips.

(e) Certain approved over-the-counter (OTC) drugs when prescribed by a Physician.

Section 2.55. Prosthesis/Prosthetics

A durable appliance or device which replaces a lost body part or function and that is not available without a prescription or written order from a Physician.

Section 2.56. Skilled Nursing Facility

A facility which is operating legally to provide room and board for sick or injured persons under the supervision of a registered nurse or a Physician, and along with the services of nurses at all hours, meets all of the following criteria:

(a) It has available at all times the services of a Physician who is on the staff of a Hospital;

(b) It keeps a daily medical record for each patient; and

(c) It is not primarily a place for rest or Custodial Care, a residential care facility for the treatment of Mental or Nervous Disorders and Substance Use Disorders, or a hotel.

Section 2.57. Sound and Natural Teeth

Natural teeth (not dentures, bridges, pontics or artificial teeth) that:

(a) Are free of active or chronic clinical decay; and

(b) Have at least 50% bony support; and

(c) Are functional in the arch; and

(d) Have not been excessively weakened by previous dental procedures.

Section 2.58. Substance Use Disorder

A disorder which is identified as a substance use disorder in the most current edition of the Diagnostic and Statistical Manual of Mental Disorders.

Section 2.59. Totally Disabled or Total Disability

The inability of an Eligible Employee to perform all the duties of his occupation or any occupation because of an Illness or Injury, or the inability of an Eligible Dependent to perform the normal activities or duties of a person of the same age and sex.

To be considered Totally Disabled, a person must also be continuously under the care of a Physician for treatment consistent with the disability during the entire period of disability.

Section 2.60. Trust Agreement

The Agreement and Declaration of Trust creating the United Food and Commercial Workers Union and Employers Calumet Region Insurance Fund dated March 24, 2010, as amended from time to time.

Section 2.61. Trustees

The persons appointed pursuant to the provisions of the Trust Agreement and who are responsible for the operation and administration of the Plan and Fund, sometimes collectively referred to as the "Board of Trustees" or the "Board."

Section 2.62. Union

A local union, affiliated with United Food and Commercial Workers International Union, AFL-CIO & CLC, which has or shall become a party to the Trust Agreement and the Plan.

Section 2.63. Usual and Customary Charge

(a) With respect to a provider outside of the geographic area served by the PPO, the charge for Medically Necessary services or supplies will be determined by the Plan Sponsor or its designee to be the lowest of:

(i) The usual charge by the Health Care Provider for the same or similar service or supply; or

(ii) No more than 85% of the "Prevailing Charge" of most other Health Care Providers in the same or similar geographic area for the same or similar health care service or supply; or

(iii) The Health Care Provider's actual charge.

(b) With respect to a PPO provider and any other provider within the geographic area served by the PPO, the Usual and Customary Charge means the charges set forth in the agreement between the PPO provider and the PPO or the Plan.

(c) The "Prevailing Charge" of most other Health Care Providers in the same or similar geographic area for the same or similar health care service or supply shall be determined by the Fund Administrator who shall use proprietary data that is updated no less frequently than annually, and provided by a reputable company or entity.

(d) No provision of this Plan requires the Plan to pay benefits based on the charges submitted by a proprietary provider of a medical supply or service.

(e) With respect to Dental Services provided to an individual under the age of 19 or to an Eligible Dependent under the age of 19, the Usual and Customary Charge is the usual charge determined by the standards of generally accepted dental practice made by most Dentists for the same or similar service.

Section 2.64. Work Related Illness or Injury

Illness or Injury which arises from or is sustained in the course of work for pay, profit or gain.

ARTICLE 3 — PARTICIPATING EMPLOYERS

Section 3.01. Commencement of Participation

An employer shall be entitled to participate in this Plan only if the Trustees have approved its participation. An employer who is participating in the Plan on the date this amended and restated document is adopted shall continue to be a Contributing Employer.

The Trustees shall approve a business organization's participation herein only if such participation will not adversely affect the Fund, as determined by the Trustees. To enable the Trustees to make such determination, the Union, when seeking approval of a new employer, shall be required to furnish the name, Social Security Number, sex, date of birth and employment history of each Employee then covered by the Collective Bargaining Agreement between the Union and the new employer, as well as such other reasonable information as the Trustees shall request. Such determination may be made on an individual employer basis or, for purposes of administrative convenience and expense savings, by pooling the experience of all new employers whose contributions to the Fund commence within a period of one Calendar Year or other appropriate unit, in accordance with rules or guidelines established by the Trustees.

Any business organization accepted as an employer may be required to sign, with the Union, a Participation Agreement approved by the Trustees which sets forth the full details of the basis for contributions to the Fund and the basis for acceptance as a Contributing Employer. When an employer is accepted for participation, the Trustees may, in writing, impose on such acceptance any terms and conditions they consider necessary. The Trustees shall send a written notice of acceptance to any new employer who is accepted for participation herein. Participation in the Fund shall be deemed to commence on a date set forth in such written notice.

If a Contributing Employer is sold, merged or otherwise undergoes a change of corporate identify, the successor company shall participate as to the Employees theretofore covered in the Plan just as if it were the original company, provided it remains a Contributing Employer as defined in Section 2.08 of Article 2.

Section 3.02. Termination of Participation

An employer's participation in this Plan shall be effectively terminated upon the permanent cessation of contributions by such employer. If an employer no longer remains obligated under a Collective Bargaining Agreement with the Union to make contributions to the Fund, no eligibility shall be given for the period with respect to which the employer is not obligated to make contributions to the Fund. If an employer fails to make contributions due for 90 days after their due date, the Trustees may, by resolution, terminate the employer's participation in the Fund. If an employer, other than an employer who has entered into a "Maintenance of Benefits" contract with the Union, fails to make all contributions needed to provide sufficient revenue to fund the plan of benefits for 90 days after a contract expires, the Trustees may, by resolution, provide an alternate plan of benefits to the Eligible Employees of such employer.

Section 3.03. Suspension of Coverage

Coverage under the Plan for a Contributing Employer's Employees shall be suspended when the contribution for the affected individual(s) is delinquent for 120 days, provided however, that the suspension may occur at an earlier date if the Fund Administrator, in consultation with the Fund's advisors, determines that it is likely that the continuation of Plan coverage without a timely contribution will have a material financial impact on the Plan. The Board of Trustees may extend this 120-day period where it determines that it is likely that the contribution will be paid within a reasonable period of time and there are mitigating circumstances surrounding the delinquent contribution.

ARTICLE 4 — ELIGIBILITY

Section 4.01. Plan of Benefits

The Trustees shall establish a plan of benefits for Eligible Employees corresponding to (1) the levels of contributions required to be made by Contributing Employers, (2) self- contributions required to be made by the Eligible Employee, and (2) other conditions of participation. An Eligible Employee is entitled to the benefits of the Plan for which the Contributing Employer is obligated to contribute on his behalf and does so contribute and/or for which the Eligible Employee may be required to make self-contributions and does so contribute.

Section 4.02. Initial Eligibility Requirements

Eligibility for Plan coverage differs for Employees who are subject to rate-per-hour contributions or flat-rate contributions made by their Contributing Employers pursuant to the applicable Collective Bargaining Agreement. In addition, coverage may differ for Employees who are required to make self-contributions.

If the Contributing Employer makes a full-time monthly contribution, the Eligible Employee is also eligible to have coverage for his Eligible Dependents. If the Contributing Employer makes a part-time monthly contribution, only the Eligible Employee is covered.

(a) An Employee subject to rate-per-hour contributions will be eligible for all benefit coverages (except for the Income Protection Benefit and coverage for his Eligible Dependents) if: (i) he has worked an average of at least 12 Covered Hours per calendar week during the calendar weeks that end in each of two full consecutive calendar months, and (ii) his Contributing Employer has made contributions for the aforementioned two full consecutive calendar months. An Employee will be eligible for the Income Protection Benefit and coverage for his Eligible Dependents if: (i) he has worked an average of at least 12 Covered Hours per calendar week during each calendar month and an average of at least 28 Covered Hours per calendar week during the calendar weeks that end in the two of the three preceding calendar months, and (ii) his Contributing Employer has made contributions for two of the aforementioned full consecutive calendar months.

(b) An Employee subject to flat-rate contributions will be eligible for coverage if: (i) he works the minimum number of Covered Hours within the period of time required by the applicable Collective Bargaining Agreement for either a full-time or part-time Employee, and (ii) his Contributing Employer has made contributions for the number of Covered Hours within a period of time required by the Collective Bargaining Agreement.

(c) Plan Classification G1 requires an Employee to elect coverage and to pay a weekly self-pay contribution via payroll deduction as set forth in this Section. The weekly self-pay contribution payroll deduction amount shall be established by the Trustees.

(d) If the Contributing Employer makes a full-time monthly contribution, the Eligible Employee is also eligible to have his Eligible Dependents covered. If the Contributing Employer makes a part-time monthly contribution, only the Eligible Employee is covered, and no coverage is available for Eligible Dependents.

Section 4.03. Effective Date of Coverage for Initial Employee Eligibility

An Eligible Employee's coverage will become effective on the first day of the calendar month following the completion of the initial eligibility requirements set forth in Section 4.02. Under no circumstances will an Employee's coverage become effective later than 90 days following completion of the initial eligibility requirements set forth in Section 4.02. Any waiting period (i.e., the period of time between when the initial eligibility requirements are satisfied by an Eligible Employee and the effective date of his coverage) set forth in a CBA shall not have the effect of delaying coverage beyond legal limits.

Section 4.04. Election of Coverage under Plan Classification G1

(a) An Eligible Employee's weekly payroll deduction shall be made pursuant to an employer-established Section 125 Plan ("Cafeteria Plan") and the payroll deduction amount shall be applied against the Contributing Employer's contribution for the affected Eligible Employee.

To receive Single Coverage or Family Coverage, an Eligible Employee must sign an election and payroll reduction agreement pursuant to the Employer's Cafeteria Plan authorizing the Employer to reduce the Eligible Employee's weekly pay by the amount equal to the Eligible Employee's coverage election amount. Election and payroll reduction agreements are to be executed before the start of the Calendar Year.

(b) Pursuant to the provisions of the Cafeteria Plan, the Benefits Fund Office is authorized to accept a substitute election form when the following conditions are met:

(i) The Fund Administrator is satisfied that there is clear and convincing evidence that a clerical error has been made;

(ii) The Eligible Employee attests to the nature of the error;

(iii) There is a time limit of 45 days after the first payroll deduction should have been made for error to be corrected;

(iv) The Eligible Employee agrees that this is a confidential process; and

(v) The Eligible Employee may only correct a mistake one time.

Section 4.05. Continuation of Employee Eligibility

An Eligible Employee shall remain eligible by working an average of at least 12 Covered Hours per week during weeks that end in each of the preceding two full consecutive Months. In addition, Eligible Employees in classification G-1 will be required to make self-pay contributions to continue coverage each month.

(a) An Eligible Employee subject to rate-per-hour contributions will be eligible to continue coverage for all benefits (except for the Income Protection Benefit and coverage for his Eligible Dependents) if: (i) he works an average of at least 12 Covered Hours per calendar week during the calendar weeks that end in each of two full consecutive calendar months, and (ii) his Contributing Employer makes contributions for the aforementioned two full consecutive calendar months. An Eligible Employee will be eligible to continue coverage for the Income Protection Benefit and coverage for his Eligible Dependents if: (i) he works an average of at least 12 Covered Hours per calendar week during each calendar month and an average of at least 28 Covered Hours per calendar week during the calendar weeks that end in the two of the three preceding calendar months, and (ii) his Contributing Employer makes contributions for two of the aforementioned full consecutive calendar months.

(b) An Employee subject to flat-rate contributions will be eligible to continue coverage if: (i) he works the minimum number of Covered Hours within the period of time required by the applicable Collective Bargaining Agreement for either a full-time or part-time Employee, and (ii) his Contributing Employer makes contributions for the number of Covered Hours within a period of time required by the Collective Bargaining Agreement.

(c) An Eligible Employee in classification G1 may continue coverage if he makes weekly flat rate self-pay contributions via payroll deduction to the Contributing Employer as set forth in this Section.

Section 4.06. Employee Termination of Eligibility

An Eligible Employee's eligibility shall terminate upon the earliest of the following dates:

(a) The last day of the Month in which he ceases to be Actively Employed or ceases to work the Covered Hours required to qualify for the Contributing Employer's contribution for coverage under the Plan;

(b) The first day of the Month for which any self-payment is due and unpaid;

(c) The last day of the Month in which he is no longer disabled if an extension of coverage due to disability is provided for in the Collective Bargaining Agreement; or

(d) The date the Plan terminates or the Contributing Employer ceases to participate in the Plan.

Section 4.07. Reinstatement

An Employee whose eligibility has been terminated who returns to work immediately after:

(a) A leave of absence for a period of disability as provided for in the Collective Bargaining Agreement,

(b) A temporary layoff of at least one Month but not more than six Months,

(c) The last day of the Month in which he is no longer disabled if an extension of coverage due to disability is provided for in the Collective Bargaining Agreement; or

(d) A sanctioned strike, and

(e) shall become reinstated on the date he returns to work, provided he had previously satisfied the initial eligibility requirements set forth in Section 4.03 and further provided that his Contributing Employer immediately begins to make the applicable contributions on his behalf.

An Employee whose eligibility has been terminated due to failure to work required hours shall become reinstated by again meeting the initial eligibility requirements set forth in Section 4.03.

Section 4.08. Special Enrollment Periods

If an Eligible Employee or Eligible Dependent loses eligibility under another group health plan (or if an Employer stops contributing toward an Eligible Employee or Eligible Dependent's other coverage), an Eligible Employee or Eligible Dependent may be eligible for a special enrollment period. However, an

Eligible Employee or Eligible Dependent must request enrollment within 30 days after his or her other coverage ends (or after the Employer stops contributing toward the other coverage).

In addition, if an Eligible Employee has a new dependent as a result of marriage, birth, adoption or placement for adoption, an Eligible Employee may enroll himself or herself and his or her Eligible Dependent(s). However, an Eligible Employee must request enrollment within 60 days after the marriage, birth, adoption or placement for adoption. If an Eligible Employee fails to enroll a newly Eligible Dependent or provide evidence of his or her dependent's eligibility on time, coverage begins on the first of the month following the day an Eligible Employee sufficiently completes the enrollment (coverage is not retroactive to the date of birth, marriage, adoption or placement for adoption). In addition, the Plan is not responsible for any bills or charges incurred prior to the coverage effective date.

Two additional circumstances allow for a special enrollment period:

- An Eligible Employee or Eligible Dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or
- An Eligible Employee or Eligible Dependent becomes eligible for a subsidy under Medicaid or CHIP.

In either of these circumstances, an Eligible Employee must enroll himself or herself or his or her Eligible Dependent within 60 days after he or she is terminated from, or determined to be eligible for, such assistance.

Section 4.09. Dependent Eligibility

Dependents shall become eligible on the later of the following dates:

(a) On the first day of the month during which the Employee works the hours required to qualify for the Contributing Employer's full-time contribution for dependent coverage, as set forth in the Collective Bargaining Agreement; or

(b) On the date the dependent becomes an Eligible Dependent, as defined in Article 2, Section 2.18.

Notwithstanding the foregoing, Dependents of an Eligible Employee covered under the Plan Classification G1 will become eligible only if the Eligible Employee elects Family Coverage and authorizes the weekly payroll deduction as set forth in Sections 4.03 and 4.04.

Section 4.10. Termination of Dependent Eligibility

Dependent eligibility shall terminate upon the earliest of the following dates:

(a) The last day of the Month in which the dependent ceases to be an Eligible Dependent as defined in Article 2, Section 2.18;

(b) The last day of the Month in which the Eligible Employee fails to work the hours required to qualify for the Contributing Employer's full-time contribution;

(c) The last day of the month in which the date of divorce occurs for a covered spouse; or

(d) The last day of the Month in which the Eligible Employee is ineligible for coverage.

Section 4.11. Qualified Medical Child Support Orders (QMCSOs)

If a copy of a Medical Child Support Order as defined in ERISA Section 609(a) is filed with the Fund Administrator, the Fund Administrator shall promptly notify the Eligible Employee and each alternate recipient of the receipt of such order and of the Plan's procedures for determining whether the order is a Qualified Medical Child Support Order (QMCSO), as further defined in ERISA Section 609(a). The Fund Administrator shall then determine whether the order is a QMCSO pursuant to the Plan's procedures, and notify the Eligible Employee and each alternate recipient of the determination. The Plan shall provide benefits in accordance with the applicable requirements of any QMCSO. Any payment for benefits made by the Plan pursuant to a QMCSO in reimbursement for expenses paid by an alternate recipient's custodial parent or legal guardian shall be made to the alternate recipient or the alternate recipient's custodial parent or legal guardian. A copy of the Plan's QMCSO procedures are available free of charge by contacting the Benefits Fund Office.

Section 4.12. Continuation of Coverage During Leave of Absence (FMLA)

Eligible Employees may be able to continue medical benefits under the Family and Medical Leave Act of 1993 (FMLA).

(a) **Maintenance of Health Benefit**

A covered employer and an Eligible Employee must continue to make contributions for an Eligible Employee while the Eligible Employee is on FMLA leave. Notice must be made on a remittance form and the contributions must be sent to the Benefits Fund Office. For purposes of this Section

4.12, covered employer means an employer who employs 50 or more Employees on each working day during each of 20 or more work weeks in the current or preceding Calendar Year.

(b) **Termination of the FMLA Obligation to Maintain Health Care Coverage**

If a covered employer makes contributions under FMLA and the Eligible Employee is also eligible for an extension of coverage while disabled, the Fund shall consider the contributions and the extension of coverage to apply to the period of time which provides the longest period of continuous coverage to the Eligible Employee.

The obligation to maintain health care coverage during FMLA leave ends on the earliest of:

(i) When an Eligible Employee returns to work; or

(ii) When 12 weeks, or longer if allowed by law, of FMLA leave ends.

(c) **Interaction with COBRA**

If the Eligible Employee does not return to work within 12 weeks, or longer if allowed by law, he will have a COBRA qualifying event as outlined in Section 4.14.

(d) **Disputes over Eligibility and Coverage**

All disputes over an Eligible Employee's eligibility and coverage under FMLA are between the Eligible Employee and covered employer. Benefits will be suspended pending resolution of the dispute. The Trustees will have no direct role in resolving such a dispute.

Section 4.13. Uniformed Services Employment and Re-Employment Rights (USERRA)

Eligible Employees may be able to continue medical benefits under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

(a) **Definitions**

These definitions apply when the following terms and words are used in this Section 4.13.

(i) Health Coverage means Hospital, surgical, medical, dental, vision or prescription drug coverage provided under the Plan. Health Coverage is subject to change as a result of Plan modifications.

(ii) USERRA means the Uniformed Services Employment and Reemployment Rights Act of 1994 (including any amendments to such Act and any interpretive regulations or rulings).

(iii) Service in the Uniformed Services means the performance of duty on a voluntary or involuntary basis in a Uniformed Service under competent authority and includes active duty, active duty for training, initial active duty for training, inactive duty training, full-time National Guard duty, and a period for which a person is absent from a position of employment for the purpose of an examination to determine the fitness of the person to perform any such duty.

Uniformed Services means the United States Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President of the United States in time of war or emergency.

(b) **Continuation of Group Health Coverage**

(i) For an Eligible Employee and his Eligible Dependents: If Health Coverage ends because of an Eligible Employee's Service in the Uniformed Services, an Eligible Employee may elect to continue such Health Coverage, if required by USERRA, until the earlier of:

(A) The end of the period during which he is eligible to apply for reemployment in accordance with USERRA, which is the same as the end of the COBRA election period; or

(B) 24 consecutive Months after coverage ended.

To continue coverage, an Eligible Employee or his Eligible Dependent must pay the required premium, unless service in the Uniformed Service is for fewer than 31 days, in which case an Eligible Employee must pay his share, if any, of the premium. The Benefits Fund Office will inform an Eligible Employee or his Eligible Dependent of procedures to pay premiums.

<u>End of Continuation</u>

An Eligible Employee's or Eligible Dependent's continued Health Coverage will end at midnight on the earliest of:

(A) The day an Eligible Employee's former Contributing Employer ceases to provide any group health plan to any Employee;

(B) The day a premium is due and unpaid;

(C) The day an Eligible Employee or Eligible Dependent again becomes covered under the Plan; or

(D) The day Health Coverage has been continued for the period of time provided in subparagraph (i)(A) or (i)(B) above (or any longer period provided in the Plan).

Other Continuation Provisions

In the event Health Coverage is continued under any other continuation provision of the Plan, the periods of continued coverage will run concurrently. If another continuation provision provides a shorter continuation period for which a premium is paid in whole or in part by a Contributing Employer, the premium an Eligible Employee is required to pay may increase for the remainder of the period provided above.

Nonetheless, it is recognized that some provisions of Section 4.14 provide more generous coverage rights than those available under Section 4.13 (e.g., Section 4.14 provides for coverage of 29 or 36 months in some circumstances) and vice versa (e.g., Section 4.13 does not allow for termination of coverage where an individual obtains other group health plan coverage after electing continuation coverage). An individual eligible for continuation coverage rights under both Section 4.13 and Section 4.14 shall be entitled to the most generous coverage provisions available under Section 4.13 and Section 4.14.

(c) **Reemployment (following Service in the Uniformed Services)**

Following discharge from such Service, an Employee may be eligible to apply for reemployment with his former Contributing Employer in accordance with USERRA. Such reemployment includes the right to elect reinstatement in any than existing Health Coverage provided by the Contributing Employer.

(d) **Important Notice**

In the event of a conflict between this provision and USERRA, the provisions of USERRA, as interpreted by an Employee's Contributing Employer or former Contributing Employer, shall apply.

Section 4.14. COBRA Continuation Coverage

Pursuant to the provisions of the Consolidated Omnibus Reconciliation Act of 1985 ("COBRA") and regulations issued thereunder, the Fund shall offer Qualified Beneficiaries the opportunity for a temporary extension of health coverage ("continuation coverage") on a self-pay basis at group rates (or slightly higher) upon the occurrence of a Qualifying Event as defined below. COBRA continuation coverage only applies to the health coverage (including dental and vision benefits) available under the Plan, and shall not include continuation of coverage for the death benefit, accidental death and dismemberment insurance or income protection benefits. The following COBRA provisions shall be interpreted in accordance with the developing regulatory and case law under COBRA, since it is the intent of the Trustees, in their capacity as sponsor of this Plan, to meet the requirements of COBRA but not to exceed them, except as expressly set forth in paragraph (f)(ii)(A) below.

(a) **Definition of Qualified Beneficiary**

A "Qualified "Beneficiary" is any person who, as of the day before a Qualifying Event, is:

(i) An Eligible Employee covered under the Plan as of such day,

(ii) The spouse of the Eligible Employee, who is covered as an Eligible Dependent under the Plan as of such day, or

(iii) A child of the Eligible Employee, who is covered as an Eligible Dependent under the Plan as of such day.

A dependent child born to an Eligible Employee, adopted by the Eligible Employee or placed for adoption with the Eligible Employee during a period of continuation coverage is also a Qualified Beneficiary if the Eligible Employee was eligible for dependent coverage when COBRA Continuation Coverage was elected.

A spouse acquired by marriage to an Eligible Employee during a period of continuation is also a Qualified Beneficiary if the Eligible Employee was eligible for dependent coverage when COBRA Continuation Coverage was elected.

(b) **Qualifying Events**

Any of the following shall be considered to be a Qualifying Event if it would cause the Qualified Beneficiary to lose coverage under the Plan were it not for the continuation of coverage provisions of this Section 4.14.

(i) <u>Qualifying Events for an Eligible Employee</u>

A Qualified Beneficiary who is an Eligible Employee shall have the right to choose continuation coverage for himself if he loses coverage under the Plan because of the termination of his employment (except by reason of gross misconduct) or a reduction in hours of employment, which includes, but is not limited to, layoff, strike, disability, medical leave of absence or retirement.

(ii) Qualifying Events for Eligible Dependents (Spouse and Children)

(A) A Qualified Beneficiary who is the spouse of an Eligible Employee shall have the right to choose continuation coverage for himself if he loses coverage under the Plan for any of the following reasons:

(1) The death of the Eligible Employee;

(2) Voluntary or involuntary termination of the Eligible Employee's employment (for reasons other than gross misconduct);

(3) Reduction of the Eligible Employee's hours of employment;

(4) Divorce from the Eligible Employee; or

(5) The Eligible Employee's becoming entitled to Medicare.

(B) A Qualified Beneficiary who is a child of an Eligible Employee shall have the right to choose continuation coverage if his coverage under the Plan is lost for any of the following reasons:

(1) The death of the Eligible Employee;

(2) The termination of the Eligible Employee's employment (for reasons other than gross misconduct) or reduction of the Eligible Employee's hours of employment;

(3) Divorce of the Eligible Employee;

(4) The Eligible Employee's becoming entitled to Medicare; or

(5) He ceases to be an Eligible Dependent as defined under this Plan.

(c) **Notice and Election of Continuation Coverage**

(i) In order to qualify for continuation coverage, the Qualified Beneficiary has the responsibility to inform the Fund Administrator at the Benefits Fund Office immediately after a divorce or if a child ceases to satisfy the definition of "Eligible Dependent child" in the Plan. If the Qualified Beneficiary does not report such event to the Fund Administrator within 60 days after loss of coverage due to the event, continuation coverage will not be available.

(ii) It is the responsibility of the Eligible Employee's Contributing Employer to notify the Fund Administrator within 45 days of the Eligible Employee's death, termination of employment, or reduction in hours which causes a loss of medical benefits under the Plan, or the Eligible Employee's entitlement to Medicare. However, the Eligible Employee or other family member should notify the Fund Administrator if any of these Qualifying Events occurs in order to assure timely notification of eligibility for, and processing of, an election of continuation coverage.

(iii) Each Qualified Beneficiary who is determined under Title II or Title XVI of the Social Security Act to have been disabled at the time, or within 60 days, of a Qualifying Event must notify the Fund Administrator at the Benefits Fund Office of such determination within 60 days after the determination. Each Qualified Beneficiary who has been determined to have been disabled at the time of a Qualifying Event must notify the Fund Administrator at the Benefits Fund Office within 30 days of the date of any final determination under Title II or Title XVI of the Social Security Act that the Qualified Beneficiary is no longer disabled.

(iv) When the Fund Administrator is notified that a Qualifying Event has occurred, the Fund Administrator will notify all Qualified Beneficiaries within 14 days of their right to choose continuation coverage by submitting the appropriate election. Notification to a Qualified Beneficiary who is a spouse of an Eligible Employee is treated as notification to all other Qualified Beneficiaries residing with that person at the time notification is made.

(v) COBRA Continuation Coverage must be elected within 60 days from the later of the date coverage terminated or will terminate under the Plan or the date of the notice advising of rights to continuation coverage. The Qualified Beneficiary does not have to show that he is insurable to choose continuation coverage. If the Qualified Beneficiary does not elect continuation coverage within the 60-day time limit, his coverage under the Plan will not be continued.

(d) **Benefits Available Under Continuation Coverage**

If continuation coverage is elected, the Plan shall provide coverage which, at the time coverage is being provided, is identical to the coverage provided under the Plan to similarly situated Eligible Employees and their Eligible Dependents, except that a Qualified Beneficiary is not required to elect dental and vision coverage. The Plan shall not provide continuation coverage of the death benefit, accidental death and dismemberment or income protection benefits.

(e) **The Cost of Continuation Coverage**

Entitlement to continuation coverage shall be conditioned upon payment of monthly contributions equal to 102% of the cost of providing health benefits to individuals in the same benefits selection situation as the Qualified Beneficiary. However, the Trustees, in their discretion, may charge an amount up to, but not exceeding, 150% of the cost of providing health benefits during the 19th through the 29th Month of coverage for a Qualified Beneficiary who elects extended continuation coverage because of disability. The Benefits Fund Office will provide specific cost information to the Qualified Beneficiary along with notice of eligibility for continuation coverage.

Contributions for the period of continuation coverage through the Month in which the election is made must be received by the Benefits Fund Office within 45 days after the date of the election. Contributions for each Month subsequent to the Month in which the election was made must be received by the Benefits Fund Office by the first of that Month, except that a grace period shall be provided through the last day of such Month during which coverage is suspended. If continuation coverage is elected by the end of the grace period, coverage is reinstated retroactively.

(f) **The Maximum Period of Continuation Coverage**

(i) COBRA continuation coverage shall extend for the maximum periods set forth in this paragraph (A), or until the occurrence of an event described in paragraph (B) below, if earlier.

(A) Qualified Beneficiaries who are Eligible Dependents will be afforded the opportunity to continue health coverage for 36 Months after the Qualifying Event (commencing on the date coverage would otherwise terminate), except in the case where the Qualifying Event is the Eligible Employee's loss of coverage due to termination of employment or reduction in hours, in which case the continuation coverage period for all Qualified Beneficiaries (including the Eligible Employee) is 18 Months after the Qualifying Event. However, if a Qualified Beneficiary who is an Eligible Dependent is receiving COBRA continuation coverage for the 18

Month period and another Qualifying Event occurs, e.g., the Eligible Employee dies, the Eligible Dependent is eligible to have COBRA continuation coverage extended to a total of 36 Months from the date of the first Qualifying Event.

(B) In the case of a Qualified Beneficiary who is determined under Title II or Title XVI of the Social Security Act to have been disabled at the time of or within 60 days of the Qualifying Event involving the Eligible Employee's loss of coverage due to termination of employment or reduction in hours, the maximum period of continuation coverage is extended from 18 Months to 29 Months, provided that the Qualified Beneficiary has provided notice of such determination to the Fund as required in paragraph (c)(iii), within the original COBRA continuation period of 18 Months. In addition, other family members who had elected COBRA coverage can keep it for the extended period if they choose. In the event that the Qualified Beneficiary is finally determined under Title II or Title XVI of the Social Security Act to no longer be disabled, the period of extended continuation coverage beyond the 18 Months shall terminate at the end of the Month beginning at least 30 days after the date of the final determination that the Qualified Beneficiary no longer is disabled.

(C) If an Eligible Employee becomes entitled to (covered by) Medicare and subsequently terminates employment or reduces hours of employment, either of which results in loss of coverage under the Plan for a Qualified Beneficiary, the duration of continuation coverage is the greater of 36 Months from the date of Medicare entitlement or 18 Months from the Qualifying Event (commencing on the date coverage would otherwise terminate).

(D) Any period of extended coverage provided at no cost to the Eligible Employee or Qualified Beneficiary will reduce the period allowed for self-payment of contributions for COBRA continuation coverage by a period equal to the extended coverage.

Regardless of which continuation period applies, a Qualified Beneficiary's continuation coverage shall terminate upon the occurrence of any of the following events:

(A) The Contributing Employer ceases to provide any group health plan to any employee.

(B) The Qualified Beneficiary fails to make a required premium payment when due (including any grace period);

(C) The Qualified Beneficiary becomes covered under another group health plan obtained after the commencement of this COBRA continuation coverage, unless such health plan contains an exclusion or limitation with respect to a preexisting condition that such Qualified Beneficiary has; or

(D) The Qualified Beneficiary becomes entitled to Medicare after COBRA coverage was elected.

Section 4.15. Rescission of Coverage

A rescission of coverage is a cancellation or discontinuance of coverage that has retroactive effect, meaning that it will be effective back to the time that an Eligible Employee and/or his or her Eligible Dependent(s) should not have been covered by the Plan. The Plan may rescind an Eligible Employee or Eligible Dependent's health (but not income protection benefit) coverage for fraud or intentional misrepresentation of a material fact after the Plan provides an Eligible Employee and/or his or her Eligible Dependent(s) with 30 days advance written notice of that rescission of coverage. However, the following situations will not be considered rescissions of coverage and do not require the Plan to give an Eligible Employee and/or his or her Eligible Dependent(s) 30 days advance written notice:

(a) When the Plan terminates an Eligible Employee and/or his or her Eligible Dependent's coverage retroactive to the date that Eligible Employee and/or Eligible Dependent loses eligibility for coverage, if there is a delay in administrative recordkeeping between the date that Eligible Employee and/or Eligible Dependent loses eligibility and the date the Plan is notified of that Eligible Employee and/or Eligible Dependent's loss of eligibility;

(b) When the Plan retroactively terminates an Eligible Employee and/or his or her Eligible Dependent's coverage because that Eligible Employee and/or Eligible Dependent fails to make timely self-payments for his or her coverage; or

(c) When any unintentional mistakes or errors result in an Eligible Employee and/or his or her Eligible Dependent(s) being covered by the Plan when that Eligible Employee should not have been covered, the Plan will cancel that Eligible Employee and/or his or her Eligible Dependent's coverage prospectively – for the future – once the mistake is identified.

Section 4.16. Certification of Tobacco Use

Effective January 1, 2019, a tobacco surcharge will be imposed on an Eligible Employee, provided that Eligible Employee is a current user of tobacco products or has used tobacco products within six months period prior to enrollment.

The tobacco surcharge is an employee contribution, withheld from an Eligible Employee's weekly pay, by the Contributing Employer and remitted to the Fund, unless the Eligible Employee has certified to the Fund, in a manner accepted by the Trustee's, they have been tobacco free for the prior six months. Tobacco Surcharges are not imposed on Eligible Employees under Classification G1 who have declined coverage.

Weekly Tobacco Surcharges as follows are determined by the Trustees in their sole discretion and may change from time to time:

Effective 1/1/2019: $15.00 per week

Effective 1/1/2020: $30.00 per week

Effective 1/1/2021: $40.00 per week

Tobacco products are defined as tobacco or tobacco-like products intended for human consumption, and when used orally or inhaled, produces smoke or smoke-like vapor. This includes but is not limited to: cigarettes, cigars, loose tobacco smoked via pipe or hookah, chewing tobacco, snuff, dip, electronic cigarettes and vaporizers.

An Eligible Employee who completes a tobacco cessation program may avoid the tobacco surcharge.

ARTICLE 5 — GENERAL PROVISIONS

Section 5.01. Funding

All Contributing Employers shall make the contributions required under their Collective Bargaining Agreements with the Union, as well as all contributions otherwise required by law. All contributions made under the Plan shall be held in trust in the Fund until disbursed for payment of benefits (including payment of premiums on insurance to provide benefits) or administrative expenses.

The Trustees may use in their discretion assets of the Plan to purchase insurance to provide any benefit under the Plan. In addition, the Trustees may, in their discretion, use assets of the Plan to purchase "excess" or "stop loss" insurance, provided that such "excess" or "stop loss" insurance is no more than a financial device of the Plan intended to protect the Plan assets against large losses, meaning that the Trustees (or the Plan) are the named insured, and in the event of an insurable event, reimbursement under such insurance flows directly from the insurer to the Plan, and no Participant has any rights of any kind under such "excess" or "stop loss" coverage.

Except to the extent insured, all benefits under the Plan shall be paid from the assets of the Plan held in the Fund. Neither the Union nor any Contributing Employer nor any Trustee shall have any liability for payment of benefits under the Plan.

Section 5.02. Administration

The Trustees or their designee shall have all rights, duties and powers necessary or appropriate for the administration of the Plan. In particular, the Trustees or their designee shall have and shall exercise complete discretionary authority to construe, interpret and apply all of the terms of the Plan, including all matters relating to eligibility for benefits, amount, time or form of payment, and any disputed or allegedly doubtful terms. The Trustees may employ or retain the services of one or more individuals to carry out the day-to-day administration of the Plan on behalf of the Trustees, of whom the chief executive shall be known as the "Fund Administrator." Such a Fund Administrator may be a shared chief executive with a related United Food and Commercial Workers Unions and Employers benefits plan.

Section 5.03. Right to Receive and Release Necessary Information

The Trustees have the right to obtain or provide information needed to coordinate benefit payments with other plans. This information may be obtained from or provided to any insurance company, organization, or person without notice to the Participant and without the Participant's consent. Any use or disclosure of

individually identifiable information shall be conducted in accordance with the privacy and security rules of the Health Insurance Portability and Accountability Act (HIPAA).

Section 5.04. Right to Make Payment

The Trustees have the right to pay benefits to any other organization or person as needed to properly carry out the provisions of the Plan. Those payments that are made in good faith are considered benefits paid under this Plan.

Section 5.05. Right of Recovery

Whenever payments have been made by the Trustees with respect to charges in a total amount at any time in excess of the maximum amount of payment required under the provisions of this Plan, the Trustees shall have the right to recover such payments, to the extent of such excess, from among one or more of the following, as the Trustees shall determine:

(a) Any persons to or for or with respect to whom such payments were made;

(b) Any insurance companies; and

(c) Any other organizations.

Section 5.06. Offset

In the event any payment is made by the Plan to or for an individual who is not entitled to such payment, in whole or in part, the Plan shall have the right to suspend or withhold payment of incurred claims and to reduce future payments due to such person and/or his or her family members participating in the Plan (e.g., Dependents, Eligible Employees) by the amount of any erroneous payment and by the amount incurred by the Plan in pursuing the overpayment. The Plan and Trustees may take other actions to recover the erroneous payments and other amounts including, but not limited to, commencing a restitution action under ERISA.

Section 5.07. Submission of Falsified or Fraudulent Claims

All claims, enrollment forms and any other information submitted or provided to the Plan, directly or indirectly, shall be accurate and complete. If the Board of Trustees finds, at any time, that false or inaccurate information has been submitted or provided to the Plan, directly or indirectly, in support of a claim, such claim shall be denied and the Trustees shall offset the amount improperly paid and/or terminate future coverage for the affected individual and the affected individual's covered family members.

Section 5.08. Workers' Compensation Not Affected

The Plan is not in lieu of and does not affect any requirements for coverage by the applicable Workers' Compensation laws of any state.

Section 5.09. Amendment and Termination

In order that the Trustees may carry out their obligation to maintain, within the limits of the funds available to them, a sound and economical program dedicated to providing the maximum benefits for Participants, the Trustees expressly reserve the right in their sole discretion and without notice to Participants, Contributing Employers, the Union and others affected hereby, 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 Fund shall pay benefits only to the extent the Fund's assets allow. No benefits shall be payable at any time after the Plan has terminated and all Fund assets expended.

Section 5.10. Physical Examination

The Plan reserves the right to have the Eligible Employee and Eligible Dependent examined, at the Plan's own expense, as often as is reasonably necessary while a claim is pending.

Section 5.11. Gender

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

Section 5.12. Maximum Amount

For any Eligible Employee and Eligible Dependent, whether or not there has been an interruption in the continuity of his coverage, the maximum amount of benefits available at any time shall be equal to the amount by which the maximum amount exceeds the sum of the benefits previously payable on his account.

Section 5.13. Severability Clause

If any provision of the Plan or any amendment made 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 Plan.

ARTICLE 6 — CLAIMS AND APPEALS

Section 6.01. Internal Claims and Appeal Procedures

This section describes the procedures followed by the United Food and Commercial Workers and Employers Calumet Region Insurance Fund in making internal claim decisions and reviewing appeals of denied claims. These procedures apply to claims for medical, mental health, substance abuse, dental, vision, hearing aid, prescription drug, income protection, death, and accidental death and dismemberment benefits.

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

The internal claims process pertains to determinations made by the appropriate Claims Administrator about whether a request for benefits (known as an initial "claim") is payable. If the appropriate Claims Administrator denies an Eligible Employee or Eligible Dependent's initial claim for benefits (known as an "adverse benefit determination"), that Eligible Employee or Eligible Dependent has the right to appeal the denied claim under the Plan's internal appeals process.

For health benefits, an Eligible Employee or Eligible Dependent may be able to seek an external review with an Independent Review Organization (IRO) that conducts reviews of adverse benefit determinations either (i) after the Plan's internal appeals process has been exhausted, or (ii) under limited circumstances before the Plan's internal claims and appeals process have been exhausted.

Section 6.02. General Information

Claims Administrator(s)

The Fund Administrator has delegated responsibility for initial claims decisions to the following companies/organizations:

Appropriate Claims Administrator	Types of Claims Processed
Zenith American Solutions 18862 90th Avenue, Suite A Mokena, IL 60448 312-649-1200 zenith-american.com	• Medical Post-Service Claims • Income Protection Benefit Claims • Death Benefit Claims • Accidental Death and Dismemberment Claims • Vision Pre-Service and Post-Service Claims • Dental Pre-Service and Post-Service Claims • Hearing Pre-Service and Post-Service Claims
Medical Cost Management (MCM) 1-800-367-9937	• Urgent, Concurrent and Pre-Service Medical Claims • Mental Health Urgent, Concurrent and Pre-Service Claims • Substance Abuse Urgent, Concurrent and Pre-Service Claims
WellDyneRx 500 Eagles Landing Drive Lakeland, FL 33810 1-800-900-6570 www.myWDRX.com	• Pre-Service Drugs • Post-Service Drugs

Days Defined

For the purpose of the initial claims and appeal processes, “days” refers to calendar days, not business days.

Discretionary Authority of Fund Administrator and Designees

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

Adverse Benefit Determination

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

(a) A denial, reduction, or termination of, or a failure to provide or make payment in whole or in part for a benefit, including a determination of an individual's eligibility to participate in the Plan or a determination that a benefit is not a covered benefit;

(b) A reduction of a benefit resulting from the application of any utilization review decision, source-of-injury exclusion, network exclusion, or other limitation on an otherwise covered benefit or failure to cover an item or service for which benefits are otherwise provided because it is determined to be not Medically Necessary or appropriate, or Experimental or Investigational; or

(c) A rescission of coverage, whether or not there is an adverse effect on any particular health or disability/income protection benefit. An adverse benefit determination does not include rescissions of coverage with respect to accidental death and dismemberment insurance/death benefits.

Health Care Professional

A health care professional, for the purposes of the claims and appeals provisions, means a Physician or other health care professional licensed, accredited or certified to perform specified health services consistent with state law.

Section 6.03. Culturally and Linguistically Appropriate Notices

All notices sent to claimants relating to internal claims and appeal review for health and disability/income protection benefits will contain a notice about the availability of Spanish language services. Assistance with filing a claim for internal review in Spanish is available by calling 1-800-621-5133. Notices relating to internal review will be provided in Spanish upon request.

SPANISH (Español): Para obtener asistencia en Español, llame al 1-800-621-5133.

Section 6.04. Definition of a Claim

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

Section 6.05. Types of Claims

Health Benefit Claims

Health benefit claims can be filed for medical, mental health, substance abuse, dental, vision, hearing, and prescription drug benefits.

There are four categories of health claims as described below:

(a) ***Pre-Service Claims*** **(applicable to medical, mental health, substance abuse, and prescription drug benefits) -** A Pre-Service Claim is a claim for a benefit that requires approval of the benefit (in whole or in part) before health care is obtained. Under this Plan, prior approval is required for medical, mental health, substance abuse, and prescription drug benefits.

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

(c) ***Concurrent Claims*** **(applicable to medical, mental health, substance abuse, dental, and prescription drug benefits) -** A Concurrent Claim is a claim that is reconsidered after an initial approval has been made and results in a reduced or terminated benefit. Also, a Concurrent Claim can pertain to a request for an extension of a previously approved treatment or service.

(d) ***Post-Service Claims*** **(applicable to medical, mental health, substance abuse, dental, vision, hearing aid, and prescription drug benefits) -** A Post-Service Claim is a request for benefits under the Plan that is not a Pre-Service Claim. Post-Service Claims are requests that involve only the payment or reimbursement of the cost of the care that has already been provided. A standard paper claim or electronic bill submitted for payment after services have been provided are examples of a Post-Service Claim. A claim regarding the rescission of coverage will be considered to be a Post-Service Claim.

Income Protection Benefit Claims

An Income Protection Claim is a request for benefits during a period of disability. Income Protection Claims are filed after a Participant suffers a disability and benefits are paid if the Claims Administrator determines that the Participant has suffered a disability as defined by the terms of the Plan.

Accidental Death and Dismemberment Insurance/Death Benefit Claims

An Accidental Death and Dismemberment Insurance/Death Benefit Claim is a request by a designated beneficiary for benefit payment following the death of the Participant or the death of a covered dependent. A claim for Accidental Death and Dismemberment Benefits may also be filed by a Participant after he or she has provided the Plan with proof of a bodily loss.

Section 6.06. Claim Elements

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

(a) Be written or electronically submitted (oral communication is acceptable only for Urgent Care Claims);

(b) Be received by the Fund Administrator or Claims Administrator (as applicable);

(c) Name a specific individual Participant and either his/her Social Security Number or Unique Identification Number assigned by the Fund ("UID");

(d) Name a specific claimant and his/her date of birth;

(e) Name a specific medical condition or symptom;

(f) Provide a description and date of a specific treatment, service or product for which approval or payment is requested (must include an itemized detail of charges);

(g) Identify the provider's name, address, phone number, professional degree or license, and federal tax identification number (TIN); and

(h) When another plan is primary payer, include a copy of the other Plan's Explanation of Benefits (EOB) statement along with the submitted claim.

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

(a) Not made in accordance with the Plan's benefit claims filing procedures described in this section;

(b) Made by someone other than an Eligible Employee, his or her Eligible Dependent, or an Eligible Employee's (or his or her Eligible Dependent's) authorized representative;

(c) Made by a person who will not identify himself or herself (anonymous);

(d) A casual inquiry about benefits such as verification of whether a service/item is a covered benefit or the estimated allowed cost for a service;

(e) A request for prior approval where prior approval is not required by the Plan;

(f) An eligibility inquiry that does not request benefits. However, if a benefit claim is denied on the grounds of lack of eligibility, it is treated as an adverse benefit determination and the individual will be notified of the decision and allowed to file an appeal;

(g) The presentation of a prescription to a retail pharmacy or mail order pharmacy that the pharmacy denies at the point of sale. After the denial by the pharmacy, an Eligible Employee or Eligible Dependent may file a claim with the Plan; or

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

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

Section 6.07. Initial Claim Decision Timeframes

Claim Filing Deadline

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

A claim for the Income Protection Benefit must be submitted within two weeks of the onset of the disability. Subsequent reports confirming care and treatment must be submitted every three weeks thereafter.

Written notice of Illness or Injury upon which a claim for any other benefit may be based must be given to the Benefits Fund Office within 90 days of the date on which an expense was first sustained for an Illness or Injury for which benefits may be claimed.

The time period for making a decision on an initial claim request starts as soon as the claim is received by the appropriate Claims Administrator, provided it is filed in accordance with the Plan's reasonable filing procedures, regardless of whether the Plan has all of the information necessary to decide the claim. A claim may be filed by an Eligible Employee, his or her Eligible Dependent, an authorized representative, or by a network provider. In the event a claim is filed by a provider, the provider will not automatically be considered to be an Eligible Employee or his or her Eligible Dependent's authorized representative.

Health Care Claims – Decision Timeframes

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

(a) ***Pre-Service Claims*** **(applicable to medical, mental health, substance abuse, and prescription drug benefits)**

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

The time for deciding the claim may be extended by up to fifteen (15) days due to circumstances beyond the Claims Administrator's control (e.g., inability of a medical reviewer to meet a deadline);

provided the Eligible Employee or his or her Eligible Dependent is given written (or electronic, if a applicable) notification before the expiration of the initial fifteen (15) day determination period.

If an Eligible Employee or his or her Eligible Dependent improperly files a Pre-Service Claim, the Claims Administrator will notify the Eligible Employee or Eligible Dependent in writing (or electronically, as applicable) as soon as possible, but in no event later than five (5) days after receiving the claim. The notice will describe the proper procedures for filing a Pre-Service Claim. Thereafter, the Eligible Employee or Eligible Dependent must re-file a claim to begin the Pre-Service Claim determination process.

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

(b) ***Urgent Care Claims*** **(applicable to medical, mental health, substance abuse, and prescription drug benefits)**

In the case of an Urgent Care Claim, if a health care professional with knowledge of an Eligible Employee or his or her Eligible Dependent's medical condition determines that a claim constitutes an Urgent Care Claim, the health care professional will be considered by the Plan to be that Eligible Employee or Eligible Dependent's authorized representative, bypassing the need for completion of the Plan's written authorized representative form.

The appropriate Claims Administrator will decide claims for Urgent Care as soon as possible, but in no event later than 72 hours after receipt of the claim. The Claims Administrator will orally communicate its decision telephonically to the Eligible Employee or Eligible Dependent and his or

her health care professional. The determination will also be confirmed in writing (or electronically, as applicable) no later than three (3) days after the oral notification.

If an Eligible Employee or his or her Eligible Dependent improperly files an Urgent Care Claim, the Claims Administrator will notify that Eligible Employee or Eligible Dependent and his or her health care professional as soon as possible, but in no event later than 24 hours after receiving the claim. The written (or electronic, as applicable) notice will describe the proper procedures for filing an Urgent Care Claim. Thereafter, the Eligible Employee or Eligible Dependent must re-file a claim to begin the Urgent Care Claim determination process.

If a claim cannot be processed due to insufficient information, the Claims Administrator will provide the Eligible Employee or his or her Eligible Dependent and his or her health care professional with a written (or electronic, as applicable) notification about what specific information is needed as soon as possible and no later than 24 hours after receipt of the claim. Thereafter, the Eligible Employee or Eligible Dependent will have not less than 48 hours following receipt of the notice to supply the additional information. If the Eligible Employee or Eligible Dependent does not provide the information during the period, the claim will be denied (i.e., an adverse benefit determination). Written (or electronic, as applicable) notice of the decision will be provided to the Eligible Employee or Eligible Dependent and his or her health care professional no later than 48 hours after the Claims Administrator receives the specific information or the end of the period given for the Eligible Employee or Eligible Dependent to provide this information, whichever is earlier.

(c) ***Concurrent Claims*** **(applicable to medical, mental health, substance abuse, dental, and prescription drug benefits)**

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

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

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

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

(d) ***Post-Service Claims*** **(applicable to medical, mental health, substance abuse, dental, vision, hearing, and prescription drug claims)**

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

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

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

Disability/Income Protection Claims – Decision Timeframes

Claims for Disability/Income Protection benefits will be decided no later than 45 days after receipt by the appropriate Claims Administrator. An Eligible Employee or his or her Eligible Dependent will be notified

in writing (or electronically, as applicable) within the 45-day initial determination period if the claim is denied (in whole or in part).

The time for deciding the claim may be extended by 30 days due to circumstances beyond the Claim Administrator's control; provided the Eligible Employee or his or her Eligible Dependent is given written (or electronic, as applicable) notification before the expiration of the initial 45-day determination period. A decision will be made within 30 days of the date the Claims Administrator notifies the Eligible Employee or his or her Eligible Dependent of the delay. The period for making a decision may be delayed an additional 30 days if due to matters beyond the control of the Claims Administrator, provided the Eligible Employee or his or her Eligible Dependent is notified of the additional delay, before the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date by which the Claims Administrator expects to render a decision.

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

Accidental Death and Dismemberment Insurance or Death Benefit – Decision Timeframe

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

Section 6.08. Initial Determinations of Benefit Claims

Notice of Adverse Benefit Determination

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

(a) Identify the claim involved (and for health benefit claims – include the date of service, health care provider, claim amount if applicable, denial code and its corresponding meaning);

(b) Give the specific reason(s) for the denial (and for health benefit claims – include a statement that the claimant has the right to request the applicable diagnosis and treatment code and their corresponding meanings; however such a request is not considered to be a request for an internal appeal or external review for health benefit claims);

(c) If the denial is based on a Plan standard that was used in denying the claim, a description of such standard;

(d) Reference the specific Plan provision(s) on which the denial is based;

(e) Describe any additional material or information needed to perfect the claim and an explanation of why such added information is necessary;

(f) With respect to health and disability/income protection benefit claims, the opportunity, upon request and without charge, reasonable access to and copies of all documents, records and other information relevant to an initial claim for benefits;

(g) Provide an explanation of the Plan's internal appeal and external review for health benefit claims processes along with time limits and information about how to initiate an appeal and an external review for health benefit claims;

(h) Contain a statement that the Eligible Employee or his or her Eligible Dependent has the right to bring civil action under ERISA section 502(a) following an appeal;

(i) With respect to health and disability/income protection benefit claims, if the denial was based on an internal rule, guideline, protocol, standard, or similar criteria, a statement will be provided that a copy of such rule, guideline, protocol or similar criteria that was relied upon will provided to the Eligible Employee or his or her Eligible Dependent free-of-charge upon request;

(j) If the denial of a health care claim and disability/income protection claim was based on Medical Necessity, Experimental treatment, or similar exclusion or limit, a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided to the Eligible Employee or his or her Eligible Dependent free-of-charge upon request;

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

(l) For Urgent Care health benefit claims, the notice will describe the expedited internal appeal and external review processes applicable to Urgent Care Claims. In addition, the required determination may be provided orally and followed with written (or electronic, as applicable) notification; and

(m) With respect to health benefit claims, provide information about the availability of, and contact information for, any applicable ombudsman established under the Public Health Services Act to assist the Eligible Employee or his or her Eligible Dependent with the Plan's internal claims and appeal processes as well as with the external review process.

Notice of Approval of Pre-Service and Urgent Care Claims

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

Internal Appeal Request Deadline

(a) ***Health Care Claims*** **(applicable to medical, mental health, substance abuse, dental, vision, hearing, and prescription drug benefits)**

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

(b) ***Disability/Income Protection Claims***

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

(c) ***Accidental Death and Dismemberment Insurance/Death Benefits***

If an initial accidental death and dismemberment /death benefit claim is denied and you disagree with the Claims Administrator's decision, you or your authorized representative may request an appeal. You have 180 calendar days following your receipt of an initial notice of adverse benefit determination to submit a written request for an appeal. The Plan will not accept appeal requests filed after this 180-day period.

Section 6.09. Internal Appeals Process

Appeal Procedures

To file an internal appeal, you must submit a written statement to the Plan at the following address:

Board of Trustees
United Food and Commercial Workers and
Employers Calumet Region
Insurance Fund
18861 90th Avenue, Suite A
Mokena, IL 60448-8178
1-800-621-5133
ufcwmidwest.org

Appeal requests involving Urgent Care Claims may be made orally by calling the Board of Trustees at the telephone number listed above.

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

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

(a) The opportunity, upon request and without charge, reasonable access to and copies of all documents, records and other information relevant to your initial claim for benefits;

(b) The opportunity to submit to the Plan written comments, documents, records and other information relating to your initial claim for benefits;

(c) With respect to health and disability/income protection benefit appeals, the Plan will automatically provide you with a reasonable opportunity to respond to new information by presenting written evidence and testimony;

(d) A full and fair review by the Plan that takes into account all comments, documents, records and other information submitted by you, without regard to whether such information was submitted or considered in the initial claim determination;

(e) With respect to health and disability/income protection benefit claims, the Plan will automatically provide you free-of-charge, with any new or additional evidence or rationale considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the denied initial claim. The Plan will automatically provide you with any new or additional evidence or rationale as

soon as possible once it becomes available to the Plan and sufficiently in advance of the date on which notice of an adverse determination on appeal is scheduled to be provided to you. New or additional evidence or rationale will be provided to you so that you have a reasonable opportunity, sufficiently in advance of the date on which a notice of an adverse benefit determination upon appeal is required to be provided, to respond to the Plan regarding such evidence. If the new or additional evidence or rationale is received by the Plan so late that it would be impossible to provide it to you in time for you to have a reasonable opportunity to respond, then the period for providing a notice of a final adverse benefit determination will be delayed (tolled) until you have had a reasonable opportunity to respond. After you respond (or do not respond after having a reasonable opportunity to do so), the Plan (acting in a reasonable and prompt manner) will notify you of its benefit determination upon appeal as soon as it can provide a notice of determination, taking into account any medical exigencies;

(f) A review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate fiduciary or fiduciaries of the Plan who is neither the individual who made the initial adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;

(g) With respect to health and disability/income protection benefit claims appeals, continued coverage during the pendency of the appeal process; and

(h) In deciding an appeal of any adverse benefit determination regarding a health benefit claim that is based in whole or in part on a medical judgment, including whether a particular treatment, drug or other item is Experimental, Investigational, not Medically Necessary or appropriate, the fiduciary or fiduciaries will:

(i) Consult with a health care professional who has appropriate experience in the field of medicine involved in the medical judgment;

(ii) Is neither an individual who was consulted in connection with the initial adverse benefit determination that is the subject of the appeal nor the subordinate of any such individual; and

(iii) The Plan will provide, upon request, the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with an adverse benefit determination without regard to whether the advice was relied upon in making the benefit determination.

Appeal Determination Timeframes

(a) ***Health Care Claims***

(i) ***Pre-Service Claims (applicable to medical, mental health, substance abuse, and prescription drug benefits).*** A determination will be made and a written (or electronic, as applicable) notice regarding the appeal will be sent to you within 30 days from the date your written request for an appeal is received by the Plan. No extension of the Plan's internal appeal review timeframe is permitted.

(ii) ***Urgent Care Claims (applicable to medical, mental health, substance abuse, and prescription drug benefits).*** This is an expedited internal appeals process under which a written notice regarding a decision on the approval or denial of the expedited internal appeal will be sent to you (and your health care professional) no later than within 72 hours of the Plan's receipt of your (oral or written) request for appeal. If your situation involves an urgent medical condition, which the timeframe for completing an expedited internal appeal would seriously jeopardize your ability to regain maximum function, and the claim involves a medical judgment or a rescission of coverage, you may seek an expedited external review at the same time that you request an expedited internal appeal (you must seek both).

(iii) **Concurrent Claims *(applicable to medical, mental health, substance abuse, dental, and prescription drug benefits).*** You may request an internal appeal of a Concurrent Claim by submitting the request orally (for an Urgent Care Claim) or in writing to the Board of Trustees. A determination will be made on the internal appeal and you will be notified as soon as possible before the benefit is reduced or treatment is terminated.

(iv) **Post-Service Claims *(applicable to medical, mental health, substance abuse, dental, vision, hearing, and prescription drug benefits).*** The Plan will make an appeal determination no later than the date of the Board of Trustees' meeting immediately following the Plan's receipt of your written request for an internal appeal, unless the request for an internal appeal review is filed within 30 calendar days preceding the date of such meeting. In such case, an appeal determination will be made no later than the date of the second meeting following the Plan's receipt of your written request for an appeal. If special circumstances (such as the need to hold a hearing) require a further extension of time for processing, an appeal determination will be rendered not later than the third meeting following the Plan's receipt of your written request for review. If such an extension is necessary, the Plan will provide you with a written (or electronic, as applicable) notice of

extension describing the special circumstances and date the appeal determination will be made. The Board of Trustees will notify you in writing (or electronically, as applicable) of the benefit determination no later than five (5) calendar days after the benefit determination is made.

(b) ***Disability/Income Protection Benefit Claims***

The Plan will make an appeal determination no later than the date of the meeting immediately following the Plan's receipt of your written request for an appeal, unless the request for an appeal review is filed within 30 calendar days preceding the date of such meeting. In such case, an appeal determination will be made no later than the date of the second meeting following the Plan's receipt of your written request for review. If special circumstances (such as the need to hold a hearing) require a further extension of time for processing, a benefit determination shall be rendered not later than the third meeting following the Plan's receipt of your written request for review. If such an extension is necessary the Plan must provide you with a written (or electronic, as applicable) notice of extension describing the special circumstances and date the appeal determination will be made. The Board of Trustees will notify you of the benefit determination no later than five (5) calendar days after the benefit determination is made.

(c) ***Accidental Death and Dismemberment Insurance/Death Benefit Claims***

A written (or electronic, as applicable) notice regarding a determination of your appeal will be sent to you within 60 days from the date your written request for an appeal is received by the Plan.

Section 6.10. Notice of Adverse Benefit Determination upon Appeal

A written (or electronic, as applicable) notice of the appeal determination must be provided to you that includes:

(a) The specific reason(s) for the adverse benefit determination upon appeal, including (i) the denial code (if any) applicable to a health benefit claim and its corresponding meaning, (ii) a description of the Plan's standard (if any) that was used in denying the claim, and (iii) a discussion of the decision;

(b) Reference the specific Plan provision(s) on which the denial is based;

(c) A statement that you are entitled to receive upon request, free access to and copies of documents relevant to the claim;

(d) A statement that you have the right to bring civil action under ERISA Section 502(a) following the appeal;

(e) An explanation of the external review process, along with any time limits and information about how to initiate a request for an external review regarding the denied internal appeal of a health benefit claim;

(f) If the denial of a health or disability/income protection benefit claim was based on an internal rule, guideline, protocol, standard, or similar criterion a statement must be provided that such rule, guideline, protocol or criteria will be provided free of charge, upon request;

(g) If the denial of a health benefit claim or disability/income protection claim was based on a medical judgement (Medical Necessity, Experimental or Investigational), a statement must be provided that an explanation regarding the scientific or clinical judgement for the denial will be provided free of charge, upon request;

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

(i) With respect to a health benefit claim, disclosure of the availability of, and contact information for, any applicable ombudsman established under the Public Health Services Act to assist you with internal claims and appeals and external review processes.

This concludes the appeal process under this Plan.

Section 6.11. Authorized Representative

The Plan recognizes an authorized representative as any person at least 18 years old whom you have designated in writing as the person who can act on your behalf to file an initial claim and appeal an adverse benefit determination under the Plan An authorized representative under the Plan also includes a health care professional. You do not need to designate in writing that the health care professional is your authorized representative if that health care professional is part of the claim appeal. A health care provider with knowledge of your medical condition may act as your authorized representative in connection with an Urgent Care Claim without filing a written statement with the Plan.

The Plan requires you to provide a written statement declaring your designation of an authorized representative (except for a health care professional who does not require a written statement in order to appeal a claim for a claimant) along with the representative's name, address, phone number, and email address. To designate an authorized representative, you must submit a completed authorized representative form (available from the Fund Administrator).

If you are unable to provide a written statement, the Plan will require written proof that the proposed authorized representative has the power of attorney for health care purposes (*e.g.*, notarized power of attorney for health care purposes, court order of guardianship/conservatorship or is the your legal spouse, parent, grandparent, or child over the age of 18).

Once the Plan receives an authorized representative form all future claims and appeals-related correspondence will be routed to the authorized representative rather than to you. The Plan will honor the designated authorized representative until the designation is revoked in writing by the Participant, or as mandated by a court order. You may revoke a designated authorized representative status by submitting a completed change of authorized representative form available from and to be returned to the Fund Administrator.

The Plan reserves the right to withhold information from a person who claims to be your authorized representative if there is suspicion about the qualifications of that individual.

Section 6.12. Limitation on When a Lawsuit May Be Started

You or any other claimant may not start a lawsuit or other legal action to obtain Plan benefits, including proceedings before administrative agencies, until after all administrative procedures have been exhausted (including this Plan's internal claims and appeal procedures described in this section) for every issue deemed relevant by the claimant, or until 90 days have elapsed since you filed a request for appeal review if you have not received a final decision or notice that an additional 60 days will be necessary to reach a

final decision. With respect to health and disability/income protection benefits, the law also permits you to pursue your remedies under section 502(a) of the Employee Retirement Income Security Act without exhausting these appeal procedures if the Plan has failed to follow them properly.

In addition, with respect to health care claims, you are not required to exhaust external review before seeking judicial remedy.

No lawsuit may be started more than three years after the end of the year in which services were provided, or, if the claim is for disability benefits, more than three years after the start of the disability.

Section 6.13. Elimination of Conflict of Interest

With respect to health and disability/income protection benefits, to ensure that the persons involved with adjudicating claims and appeals (such as claim adjudicators, medical professionals and vocational experts) act independently and impartially, decisions related to those persons' employment status (such as decisions related to hiring, compensation, promotion, termination or retention), will not be made on the basis of whether that person is likely to support a denial of benefits.

Section 6.14. Facility of Payment

If the Board of Trustees or its designee determines that you cannot submit a claim or prove that you or your covered dependent paid any or all of the charges for health care services that are covered by the Plan because you are incompetent, incapacitated or in a coma, the Plan may, at its discretion, pay Plan benefits directly to the health care professional(s) who provided the health care services or supplies, or to any other individual who is providing for your care and support. Any such payment of Plan benefits will completely discharge the Plan's obligations to the extent of that payment. Neither the Plan, Board of Trustees, appropriate Claims Administrator nor any other designee of the Plan will be required to see to the application of the money so paid.

Section 6.15. External Review of Claims

If your initial claim for health care benefits has been denied (i.e., an adverse benefit determination) in whole or in part, and you are dissatisfied with the outcome of the Plan's internal claims and appeals process described earlier, you may (under certain circumstances) be able to seek external review of your claim by an Independent Review Organization ("IRO"). This process provides an independent and unbiased review of eligible claims in compliance with the Affordable Care Act.

Section 6.16. Culturally and Linguistically Appropriate Notices

All notices relating to external review sent will contain a notice about the availability of Spanish language services. Assistance with filing a claim for external review in Spanish is available by calling 1-800-621-5133. Notices relating to external review will be provided in Spanish upon request.

SPANISH (Español): Para obtener asistencia en Español, llame al 1-800-621-5133.

Section 6.17. Claims Eligible For The External Review Process

Post-Service, Pre-Service, Urgent Care, and Concurrent Care Claims, in any dollar amount, are eligible for external review by an IRO if:

(a) The adverse benefit determination of the claim involves a medical judgment, including but not limited to, those based on the Plan's requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit, denial related to coverage of routine costs in a clinical trial, or a determination that a treatment is Experimental or Investigational. The IRO will determine whether a denial involves a medical judgment.

(b) The denial is due to a rescission of coverage (i.e., the retroactive elimination of coverage), regardless of whether the rescission has any effect on any particular benefit at that time.

Section 6.18. Claims Not Eligible For The External Review Process

The following types of claims are not eligible for the external review process:

(a) Claims that involve only contractual or legal interpretation without any use of medical judgment.

(b) A determination that you or your dependent are not eligible for coverage under the terms of the Plan.

(c) Claims that are untimely, meaning you did not request review within the four (4) month deadline for requesting external review.

(d) Claims as to which the Plan's internal claims and appeals procedure has not been exhausted (unless a limited exception applies).

(e) Claims that relate to benefits other than health care benefits.

(f) Claims that relate to benefits that the Plan provides through insurance. Claims that relate to benefits provided through insurance are subject to the insurance company's external review process, not this process.

In general, you may only seek external review after you receive a "final" adverse benefit determination under the Plan's internal appeals process. A "final" adverse benefit determination means the Plan has continued to deny your initial claim in whole or part and you have exhausted the Plan's internal claims and appeals process.

Under limited circumstances, you may be able to seek external review before the internal claims and appeals process has been completed:

(a) If the Plan waives the requirement that you complete its internal claims and appeals process first.

(b) In an urgent care situation (see "Expedited External Review Of An Urgent Care Claim"). Generally, an urgent care situation is one in which your health may be in serious jeopardy or, in the opinion of your health care professional, you may experience pain that cannot be adequately controlled while you wait for a decision on your internal appeal.

(c) If the Plan has not followed its own internal claims and appeals process and the failure was more than a minor error. In this situation, the internal claims and appeal is "deemed exhausted," and you may proceed to external review. If you think that this situation exists, and the Plan disagrees, you may request that the Plan explain in writing why you are not entitled to seek external review at this time.

Section 6.19. External Review of a Standard (Non-Urgent Care) Claim

Your request for external review of a standard (not Urgent Care) claim must made in writing within four (4) months after you receive notice of an adverse benefit determination.

Because the Plan's internal claims and appeals process generally must be exhausted before external review is available, external review of standard claims will ordinarily only be available after you receive a "final" adverse benefit determination following the exhaustion of the Plan's internal claims and appeals process.

To begin the standard external review process, send written notification to the following:

Joshua Todd – Fund Administrator
United Food and Commercial Workers and
Employers Calumet Region
Insurance Fund
18862 90th Avenue, Suite A
Mokena, IL 60448
312-649-1200
jotodd@zenith-american.com

Preliminary Review of a Standard (Non-Urgent Care) Claim by the Plan

Within five (5) business days of the Plan's receipt of your request for external review of a standard claim, the Plan will complete a preliminary review of the request to determine whether:

(a) You are/were covered under the Plan at the time the health care item or service is/was requested; or, in the case of a retrospective review, you were covered at the time the health care item or service was provided.

(b) The adverse benefit determination satisfies the above-stated requirements for a claim eligible for external review and does not, for example, relate to your failure to meet the requirements for eligibility under the terms of the Plan; or to a denial that is based on a contractual or legal determination, or a failure to pay premiums causing a retroactive cancellation of coverage.

(c) You have exhausted the Plan's internal claims and appeals process (or a limited exception allows you to proceed to external review before that process is completed).

(d) Your request is complete, meaning that you have provided all of the information or materials required to process an external review.

Within one (1) business day of completing its preliminary review, the Plan will notify you in writing whether:

(a) Your request is complete and eligible for external review.

(b) Your request is complete but not eligible for external review. (In this situation, the notice will explain why external review is not available, and provide contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272).)

(c) Your request is incomplete. (In this situation, the notice will describe the information or materials needed to make the request complete. You must provide the necessary information or materials

within the four (4) month filing period, or, if later, within 48 hours after you receive notification that your request is not complete.)

Review of a Standard (Not Urgent Care) Claim by the IRO

If your request is complete and eligible for external review, the Plan will assign it to an accredited IRO. The Plan has arranged for at least three (3) accredited IROs to provide external review of claims, and it rotates assignments among these IROs. In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of claims.

Once the claim has been assigned to an IRO, the following procedures apply:

(a) The IRO will timely notify you in writing that your request is accepted for external review.

(b) The IRO will explain how you may submit additional information regarding your claim if you wish. In general, you must provide additional information within ten (10) business days. The IRO is not required to, but may, accept and consider additional information you submit after the ten (10) business day deadline.

(c) Within five (5) business days after the claim has been assigned to the IRO, the Plan will provide the IRO with the documents and information it considered in making its adverse benefit determination.

(d) If you submit additional information to the IRO related to your claim, the IRO must forward that information to the Plan within one (1) business day. Upon receipt of any such information (or at any other time), the Plan may reconsider its adverse benefit determination regarding the claim that is the subject of the external review. Any reconsideration by the Plan will not delay the external review. If Plan reverses its determination after it has been assigned to an IRO, the Plan will provide written notice of its decision to you and the IRO within one (1) business day. Upon receipt of such notice, the IRO will terminate its external review.

(e) The IRO will review all of the information and documents timely received. In reaching a decision, the IRO will review the claim *de novo*, meaning that the IRO is not bound by the Plan's previous internal claims and appeal decisions. However, the IRO must review the Plan's terms to ensure that its decision is not contrary to the terms of the Plan, unless those terms are inconsistent with applicable law. For example, the IRO must observe all of the Plan's standards, including standards for clinical review, Medical Necessity, appropriateness, health care setting, level of care, and effectiveness of a covered benefit.

(f) To the extent additional information or materials are available and appropriate, the assigned IRO may consider the additional information including information from your medical records, any recommendations or other information from your treating health care providers, any other information from you or the Plan, reports from appropriate health care professionals, appropriate practice guidelines, the Plan's applicable clinical review criteria and/or the opinion of the IRO's clinical reviewer(s).

(g) In a standard case, the IRO will provide written notice of its final decision to you and the Plan within 45 days after the IRO receives the request for the external review.

The IRO's decision notice will contain:

(a) A general description of the reason(s) for the request for external review, including information sufficient to identify the claim, including the date or dates of service, the health care provider, the claim amount (if applicable), and the reason for the previous denial.

(b) The date that the IRO received the assignment to conduct the external review and the date of the IRO decision.

(c) References to the evidence or documents, including the specific coverage provisions and evidence-based standards, considered in reaching its decision.

(d) A discussion of the principal reason(s) for the decision, including the rationale for the decision and any evidence-based standards relied upon.

(e) A statement that the IRO's decision is binding on you and the Plan, except to the extent that other remedies may be available to you or the Plan under applicable state or federal law.

(f) A statement that judicial review may be available to you.

(g) A statement regarding assistance that may be available to you from an applicable office of health insurance consumer assistance or ombudsman established under the Affordable Care Act.

Section 6.20. Expedited External Review of an Urgent Care Claim

You may request an expedited external review in the following situations if:

(a) You receive an adverse benefit determination regarding your initial claim that involves a medical condition for which the timeframe for completion of an expedited internal appeal would seriously

jeopardize your life or health, or would jeopardize your ability to regain maximum function, and you have filed a request for an expedited internal appeal.

(b) You receive a "final" adverse benefit determination after exhausting the Plan's internal appeals procedure that (i) involves a medical condition for which the timeframe for completion of an standard external review would seriously jeopardize your life or health, or would jeopardize your ability to regain maximum function; or (ii) concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, and you have not yet been discharged from a facility.

To begin a request for expedited external review, contact the following:

Joshua Todd – Fund Administrator
United Food and Commercial Workers and
Employers Calumet Region
Insurance Fund
18862 90th Avenue, Suite A
Mokena, IL 60448
312-649-1200
jotodd@zenith-american.com

Preliminary Review of an Urgent Care Claim by the Plan

Immediately upon receipt of a request for expedited external review, the Plan will complete a preliminary review of the request to determine whether the requirements for preliminary review are met (as described above for the standard claim external review process). The Plan will defer to your attending health care professional's determination that a claim constitutes "urgent care." The Plan will immediately notify you (e.g., telephonically, via fax) whether your request for review meets the requirements for expedited review, and if not, it will provide or seek the information described above for the standard claim external review process.

Review of an Urgent Care Claim by the IRO

Upon a determination that a request is complete and eligible for an expedited external review following the preliminary review, the Plan will assign an accredited IRO. The Plan has arranged for at least three (3) accredited IROs to provide external review of claims, and rotates assignments among those IROs. In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of claims.

The Plan will expeditiously provide or transmit to the IRO all necessary documents and information that it considered in making its internal adverse benefit determination.

The IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information or documents described in the procedures for standard review. In reaching a decision, the IRO must review the claim *de novo* meaning that it is not bound by any previous decisions or conclusions reached during the Plan's internal claims and appeals process. However, the IRO decision must not be contrary to the terms of the plan, unless the terms are inconsistent with applicable law. For example, the IRO must observe all of the Plan's standards, including standards for clinical review, Medical Necessity, appropriateness, health care setting, level of care, and effectiveness of a covered benefit.

The IRO will provide notice of the final external review decision, in accordance with the requirements set forth above for the standard claim external review process, as expeditiously as your medical condition or circumstances require, but not more than seventy-two (72) hours after the IRO receives the request for an expedited external review. If notice of the IRO decision is not provided to you in writing, the IRO must provide written confirmation of the decision to you and the Plan within forty-eight (48) hours after it is made.

Section 6.21. What Happens after the IRO Decision is Made?

(a) If the IRO's final external review decision reverses the Plan's internal adverse benefit determination, upon the Plan's receipt of such reversal, the Plan will immediately provide coverage or payment for the reviewed claim. However, even after providing coverage or payment for the claim, the Plan may, in its sole discretion, seek judicial remedy to reverse or modify the IRO's decision.

(b) If the final external review upholds the Plan's internal adverse benefit determination, the Plan will continue not to provide coverage or payment for the reviewed claim.

(c) If you are dissatisfied with the external review determination, you may seek judicial review to the extent permitted under ERISA section 502.

ARTICLE 7 — UTILIZATION MANAGEMENT

Section 7.01. Pre-authorization

The Eligible Employee or Eligible Dependent must contact the Benefits Fund Office two weeks prior to (unless otherwise noted):

(a) Non-Emergency Hospital admissions;

(b) Within 48 hours of an Emergency Hospital admission;

(c) When an Inpatient procedure of surgery is proposed;

(d) Outpatient surgeries;

(e) Durable Medical Equipment (DME);

(f) Expenses for treatment by a residential care center (Non-PPO residential care center may be used only when PPO is unavailable);

(g) Medically Necessary and Appropriate physiotherapy, acupuncture, prolo therapy, occupational therapy, and physical medicine services ordered by a qualified Physician in excess of twenty-five (25) sessions per Acute Occurrence;

(h) Ultrasound guidance for outpatient arthrocentesis or therapeutic joint injections;

(i) IV sedation in conjunction with outpatient epidural or other pain management interventional injections or procedures; and

(j) Advanced diagnostic testing (such as MRI scans, CT scans, PET scans, or Thallium stress tests).

Inpatient Pre-authorization is not required in connection with childbirth when it is a full-term vaginal delivery or a scheduled Caesarean section.

If the Eligible Employee or Eligible Dependent fails to comply with such requirements for Pre-authorization, the Non-Compliance Deductible specified in the Schedule of Benefits must be satisfied. However, the Non-Compliance Deductible does not apply to Durable Medical Equipment (DME) and Medically Necessary and Appropriate physiotherapy, acupuncture, prolo therapy, occupational therapy, and physical medicine services ordered by a qualified Physician in excess of twenty-five (25) sessions per Acute Occurrence. If Durable Medical Equipment (DME) is not pre-authorized, it will not be covered. If

Medically Necessary and Appropriate physiotherapy, acupuncture, prolo therapy, occupational therapy, and physical medicine services ordered by a qualified Physician in excess of twenty-five (25) sessions per Acute Occurrence are not pre-authorized, 50% of the Usual and Customary Charges for the Covered Expense are payable.

Pre-authorization is required in order for the Eligible Employee or Eligible Dependent to receive reimbursement for expenses to the full extent provided in the Plan. Pre-authorization does not constitute medical advice to the Eligible Employee or Eligible Dependent. Regardless of whether a particular expense is covered under the Plan, the Eligible Employee or Eligible Dependent remains free to decide, in consultation with the Physician of his choice, whether to undergo such treatment, and Pre-authorization or Pre-certification is not intended to interfere (and shall not be construed as interfering) with the Physician-patient relationship.

Section 7.02. Second Opinion

A second independent medical examination and Physician's opinion is required for any non-Emergency procedure or surgery listed in the Required Second Opinion Review List in Appendix A. If the second medical opinion does not agree with the recommended procedure or surgery, then a third medical examination and opinion is also necessary.

If a Second Opinion is not obtained, all covered charges associated with the procedure or surgery shall be payable at the lower percent specified in the Schedule of Benefits and will not be applied to the Out-of-Pocket Limit. If the majority of Physicians do not agree that the procedure or surgery is Medically Necessary or if a required third examination is not submitted to, no benefits will be payable.

In addition, the Second Opinion Requirements are satisfied only if:

(a) The second and, if necessary, the third medical examination and opinion is given by a doctor of medicine or osteopathy who, as determined by the Trustees, is board certified in the appropriate medical specialty;

(b) The patient is personally examined by the Physician giving the opinion;

(c) The examining Physician provides the Benefits Fund Office with an independent, timely and complete written report of the medical examination, in addition to an explanation of the Physician's medical opinion as to whether or not the proposed procedure or surgery is Medically Necessary for the patient's immediate condition, and the Physician's recommendations for alternate treatment, if any, together with copies of any related diagnostic x-ray or test results; and

(d) Neither the examining Physician, nor anyone in the Physician's office or who is otherwise financially connected with the examining Physician, performs, or assists in the proposed or any alternate procedure or surgery, or otherwise treats the patient's immediate condition.

Usual and Customary Charges for required second and, if necessary, third independent medical examinations and opinions including pre-authorized necessary and appropriate x-rays and diagnostic tests which satisfy this provision will be considered Covered Expenses. The Fund may request that medical records be made available by the patient for the second opinion Physician.

It is recommended that the Eligible Employee or Eligible Dependent arrange these examinations through the Benefits Fund Office. The Fund reserves the right to select the second opinion Physician.

For certain medical conditions, after an examination of the patient's medical records or if it is determined that it is unsafe for the patient to travel and be examined, the Second Opinion requirements may be waived in writing by the Trustees prior to the proposed procedure or surgery being performed.

ARTICLE 8 — EMPLOYEE DEATH BENEFIT

Section 8.01. General

Upon receipt of written proof of the death of a Participant, the Plan shall pay benefits as specified in Section 8.02 below.

Section 8.02. Benefits Payable

Benefits are payable as specified in the Schedule of Benefits. Benefits are taxable to the beneficiary.

Section 8.03. Naming a Beneficiary

A Participant may designate anyone he or she wishes as a beneficiary and may change the beneficiary at any time. To name a beneficiary or to change the named beneficiary, the Participant must complete a "Designation of Beneficiary for the Death Benefit" form available from the Benefits Fund Office. The designation will take effect when the completed form is received at the Benefits Fund Office.

If a Participant chooses to not designate a beneficiary or if the designated beneficiary is not living at the time of the death of the Participant, the Death Benefit will be paid as specified in the Schedule of Benefits to the following hierarchy:

(a) Surviving spouse, or if there is none;

(b) Surviving children in equal shares (including legally adopted children), or if there are none;

(c) Surviving parents in equal shares, or if there are none;

(d) Surviving brothers and sisters in equal shares, or if there are none;

(e) The Participant's estate.

Section 8.04. Beneficiary Designation Following Divorce

The named beneficiary shall be the person or persons designated by the Participant on a form provided for that purpose by the Trustees, which was received by the Trustees during a Participant's lifetime. The designation of a spouse as a Participant's named beneficiary shall be void upon the date of the dissolution of the Participant's marriage to that spouse. In such event, unless a new designation of beneficiary form is received by the Trustees after such divorce, the Death Benefit shall be paid as if no named beneficiary had been designated. To maintain the former spouse as a named beneficiary, the Participant must re-designate

the former spouse as beneficiary by completing a new designation of beneficiary form following the divorce and identifying the former spouse as the named beneficiary.

Section 8.05. Death Benefit Coverage as a Result of a Serious Medical Condition

In the event a Participant leaves Active Employment as a result of a serious medical condition caused by Illness or Injury, the Plan will provide the former Participant with three consecutive Months of eligibility for the Death Benefit. At the time Active Employment ceases, the Plan will require a written statement be submitted from the treating Physician indicating the Participant's Active Employment is terminating as a result of a serious medical condition.

Upon receipt of written proof of the death of a former Participant who was determined to have ceased Active Employment as a result of a serious medical condition, the Plan shall pay the Death Benefit as specified in the Schedule of Benefits, provided that:

(a) The former Participant's death occurs within the three-consecutive-Month period following the Month in which he ceased Active Employment; and

(b) Prior to the former Participant's death, a statement from the treating Physician indicating employment ceased as a result of a serious medical condition had been submitted to the Benefits Fund Office.

Benefits will be paid to the designated beneficiary or to the beneficiary hierarchy set forth in Section 8.03(a)-(e).

ARTICLE 9 — EMPLOYEE ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

Section 9.01. General

If an Eligible Employee suffers accidental bodily injury which results in loss of life or dismemberment within 90 days of the accident, benefits will be paid as specified in Section 9.02.

Section 9.02. Benefits Payable

Benefits are payable as follows:

Loss of life	$10,000
Loss of both hands or both feet or sight of both eyes	$10,000
Loss of one hand and one foot	$10,000
Loss of one hand and the sight of one eye	$10,000
Loss of one foot and the sight of one eye	$10,000
Loss of one hand or one foot	$5,000
Loss of sight of one eye	$5,000

If multiple losses are suffered in one accident, benefits will be paid only for the loss for which the largest amount is payable.

Loss of hand or foot means the limb is severed at or above the wrist or ankle joint, respectively. Loss of sight means the total and irrecoverable loss of sight.

Section 9.03. Exclusions and Limitations

No benefit is payable under this Article if death or any loss is caused directly or indirectly by the following:

(a) Bodily or mental illness, infirmity or disease of any kind;

(b) Ptomaine or bacterial infections (except infections caused by pyogenic organisms which occur with and through an accidental cut or wound) or hernia;

(c) Suicide or intentional self-destruction or self-inflicted injury;

(d) Participation in the commission of a felony;

(e) War or an act of war; or

(f) Operating or riding in any aircraft, except:

(i) As a passenger in a commercial aircraft that is on a regularly scheduled passenger flight;

(ii) As a passenger or pilot of a chartered flight; or

(iii) As a passenger or pilot of a licensed aircraft operated by a licensed pilot, including student licensees.

ARTICLE 10 — INCOME PROTECTION BENEFIT

Section 10.01. General

Upon receipt of written proof that an Eligible Employee who is Actively Employed has become Totally Disabled as a result of a non-occupational Illness or Injury and requires the regular care of a Physician, which shall be determined according to the condition for which the Eligible Employee is being treated, the Eligible Employee shall receive a weekly benefit, subject to the provisions of this Article. Telephone consultations are not considered regular care of a Physician.

Section 10.02. Benefits Payable

The weekly benefit shall be payable in the amount set forth in the Schedule of Benefits after any waiting period set forth in the Schedule of Benefits and up to the indicated maximum period.

During partial weeks of disability, the Eligible Employee shall be paid a daily rate of one-seventh of the weekly benefit amount set forth in the Schedule of Benefits.

Section 10.03. Periods of Disability

Successive periods of disability due to Injuries received in an accident will be considered one period of disability. A period of disability that results from both an Injury and an Illness will be considered one period of disability.

Successive periods of disability shall be considered one period of disability unless:

(a) Between the periods of disability, the Eligible Employee has returned to Active Employment for at least four consecutive weeks; or

(b) The disabilities are due to unrelated causes and begin after the Eligible Employee has returned to Active Employment for at least one day.

In no event will benefits be paid during any number of successive periods of disability any longer than a total aggregate period of:

(a) Up to one 26 week period as a result of any one accidental bodily Injury and related re-injuries within a 12-month period following the end of the initial convalescence, or

(b) Up to two 26-week periods because of any Illness contributed to by the same or related Illness unless acceptable evidence of good health establishing full and complete recovery is furnished.

Section 10.04. Exclusions and Limitations

No benefits shall be payable under this Article for any:

(a) Disability resulting from Illness or Injury for which an Eligible Employee is not under the regular care of a Physician;

(b) Disability arising out of or in the course of any occupation, employment or self-employment; or for which the Eligible Employee has a right to payment under any Workers' Compensation law or occupational disease law; Illness or loss for which the Eligible Employee is entitled to benefits or reimbursement under any motor vehicle insurance plan, insurance settlement, or any third party settlement or agreement;

(c) Disability resulting from a loss, problem, complaint, pain or ailment which did not arise from an objectively determined and documented medical impairment;

(d) Disability incurred by owner-operators, non-Employee operators, proprietors, owner-Employees, partners, commission-only Employees or non-bargaining unit Employees or any person participating on a voluntary basis;

(e) Periods for which the Employee receives remuneration from any employer or any source for work or services performed; or

(f) Periods after a Contributing Employer closes all stores in the geographical area of the Plan's operation or ceases to be a Contributing Employer.

ARTICLE 11 — COMPREHENSIVE MEDICAL EXPENSE BENEFIT

Section 11.01. General

If an Eligible Employee or Eligible Dependent incurs Covered Medical Expenses because of a non-occupational Illness or Injury, payment will be made for the Covered Medical Expenses incurred, up to the maximum amounts specified in the Schedule of Benefits and according to the provisions of this Article.

Section 11.02. PPO Agreement

The Fund has entered into an agreement with a Preferred Provider Option (PPO). Eligible Employees and Eligible Dependents may choose health care services provided by Hospitals and Health Care Providers which have negotiated agreements with the PPO. The Plan pays a higher percentage of the expenses when a PPO Hospital or Health Care Provider is used. Appendix B sets forth the agreement signed between the Fund and the PPO. Such agreement may be renegotiated from time to time.

Section 11.03. Benefits Payable

Benefits are payable at the percentage specified in the Schedule of Benefits for Covered Medical Expenses after any applicable Deductible has been satisfied.

Section 11.04. Deductible Amounts.

(a) **Calendar Year Deductible**

The Calendar Year Deductible is the amount specified in the Schedule of Benefits of Covered Medical Expense the Eligible Employee or Eligible Dependent pays before he is entitled to certain Comprehensive Medical Benefits.

When a family has satisfied the Calendar Year Family Deductible, as specified in the Schedule of Benefits, no further Deductible will be required for Covered Medical Expenses incurred thereafter in that Calendar Year.

The Calendar Year Deductible applies only once in any Calendar Year though the Eligible Employee or Eligible Dependent may have several different Injuries or Illnesses.

(b) **Non-Compliance Deductible**

The Non-Compliance Deductible is the amount specified in the Schedule of Benefits of inpatient Hospital expense, surgery expense, or advanced diagnostic testing expense that the Eligible Employee or Eligible Dependent must pay for each Hospital Confinement, surgery or advanced diagnostic testing which is not pre-authorized.

(c) **Non-PPO Hospital Deductible**

The Non-PPO Hospital Deductible is the amount specified in the Schedule of Benefits of inpatient non-PPO Hospital expense the Eligible Employee or Eligible Dependent must pay for each Confinement in a non-PPO Hospital. It does not apply to Emergency Confinements.

Section 11.05. Out-of-Pocket Maximum

Once an Eligible Employee or Eligible Dependent has incurred, during a Calendar Year, the applicable amount specified in the Schedule of Benefits of out-of-pocket expense (which includes satisfaction of the Calendar Year Deductible and the Participant's Co-pay), the Plan shall pay, subject to all applicable limitations and provisions, 100% of all of the Covered Medical Expenses which are incurred by that Eligible Employee or Eligible Dependent for the remainder of that Calendar Year, subject to the exclusions specified in the paragraph below.

Out-of-pocket expenses payable by an Eligible Employee or Eligible Dependent for the following shall not apply toward satisfaction of the out-of-pocket maximum:

(a) Amounts paid for failure to pre-authorize a Hospital Confinement (Non-Compliance Deductible);

(b) Amounts paid to satisfy the Non-PPO Hospital Deductible;

(c) Amounts paid for Covered Medical Expenses which are reimbursed by the Plan at 50%;

(d) Amounts paid for Out-of-Network Prescription Drugs; or

(e) Amounts paid for expenses which are not Covered Medical Expenses.

Section 11.06. Maximum Benefit

Benefits for certain Covered Medical Expenses are subject to annual, per condition limits, as specified in the Schedule of Benefits. Once the Plan has paid the annual, per condition or lifetime benefit for any of these services and supplies, no further benefits are payable.

Section 11.07. Covered Medical Expenses

Covered Medical Expenses are the Usual and Customary Charges actually incurred by an Eligible Employee or Eligible Dependent upon the recommendation or approval of the attending Physician for services and supplies which are Medically Necessary and which are required for treatment of the Eligible Employee or Eligible Dependent as a result of a non-occupational accidental bodily Illness or Injury and for which benefits are payable under this Comprehensive Medical Expense Benefit in accordance with all applicable limitations and exclusions.

Covered Medical Expenses under this Comprehensive Medical Expense Benefit include the actual Usual and Customary Charges incurred for the services and supplies listed below:

(a) Hospital expenses as follows:

(i) Hospital room and board charges up to the standard daily rate for a semi-private room;

(ii) Specialty care unit charges (e.g., intensive care unit, cardiac care unit);

(iii) Other services and supplies furnished by a Hospital; and

(iv) Emergency room charges.

Payment for a Hospital confinement for dental surgery will be limited as shown in the Schedule of Benefits. Payment will only be made if the confinement is pre-authorized in writing by the Benefits Fund Office.

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

(b) Physician's professional medical and surgical services as follows:

(i) Hospital, office and home visits;

(ii) Emergency room services;

(iii) Services for surgical procedures; and

(iv) Reconstructive surgery for the following:

(A) To correct damage caused by a congenital birth defect, developmental abnormality, infection, tumor, disease or trauma.

(B) To remove scar tissue on the neck, face or head.

(C) In the case of an Eligible Employee or Eligible Dependent who is receiving benefits under the Plan in connection with a mastectomy and who elects breast reconstruction, federal law requires coverage in a manner determined in consultation with the attending physician and the patient for:

(1) Reconstruction of the breast on which the mastectomy was performed;

(2) Surgery and reconstruction of the other breast to produce a symmetrical appearance; and

(3) Prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

This coverage is subject to the Plan's annual Deductibles and Coinsurance provisions.

(c) Emergency Services with respect to an Emergency Medical Condition (defined below), which means a medical screening examination within the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate the Emergency Medical Condition, along with additional medical examination and treatment to the extent they are within the capabilities of the staff and facilities available at the Hospital to stabilize the patient.

(i) The term "to stabilize" means, with respect to an Emergency Medical Condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility, or, with respect to an Emergency Medical Condition, to deliver a newborn child (including the placenta).

(ii) The term Emergency Medical Condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson

who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in serious jeopardy to the health of the individual (or for a pregnant woman, the health of the woman or her unborn child), serious impairment to bodily functions or serious dysfunction of any bodily organ or part.

(d) Preventive Services Benefit – Preventive Care as Required by the Patient Protection and Affordable Care Act (ACA).

(i) This Plan provides coverage for certain Preventive Services as required by the Patient Protection and Affordable Care Act of 2010. Coverage is provided with no cost-sharing (for example, no Deductibles, Coinsurance, or Copayments) on a PPO basis only, for the following services:

(A) Services described in the United States Preventive Services Task Force (USPSTF) A and B recommendations,

(B) Services described in guidelines issued by the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control (CDC), and

(C) Health Resources and Services Administration (HRSA) guidelines including the American Academy of Pediatrics Bright Futures guidelines and HRSA guidelines relating to services for women.

(ii) PPO preventive services that are identified by the Plan as part of the ACA guidelines will be covered with no cost-sharing by the Participant or dependent. This means that the service will be covered at 100% of the Plan's allowable charge, with no Coinsurance, Copayment, or Deductible. However, non-PPO Preventive Services are covered by the Plan with cost-sharing (Coinsurance and Deducible).

(iii) In some cases, federal guidelines are unclear about which preventive benefits must be covered under the ACA. In that case, the Trustees will determine whether a particular benefit is covered under this Preventive Services benefit.

(iv) **Preventive Services Benefit Overview**

Physical Examination covered after Deductible with the standard Coinsurance if charges exceed maximum amount payable at no charge per Calendar Year: Except as noted below (relating to children through age 21 and well woman visits), the Plan will cover the expense related to a routine physical examination by a Physician with the standard Coinsurance

after the Deductible is met if charges exceed the maximum amount payable per person per Calendar Year as specified in the Schedule of Benefits. Covered expenses that do not exceed the maximum amount payable per person per Calendar Year are covered at no charge. This benefit is limited to one examination per year for each Participant and each covered dependent.

Preventive Services Covered with No Cost-Sharing: The following benefits are available under the Fund's Preventive Services benefit with no cost-sharing. In certain circumstances, as determined by the Fund, the preventive benefit is only payable with an appropriate diagnosis.

Non-preventive Services are not covered without Cost-Sharing: The plan will impose cost-sharing for treatment that is not a recommended preventive service, even if the treatment results from a recommended preventive service.

Preventive Services for Dependents: All covered Participants and dependents are eligible to obtain, without cost sharing, all required PPO preventive services applicable to them (e.g., for their age group). This includes ACA-required pregnancy-related preventive services and well woman visits, which must be provided to dependent children (up to age26) where an attending provider determines that the services are age and developmentally appropriate.

(v) **Covered Preventive Services for Adults**

(A) Abdominal Aortic Aneurysm one-time screening for men ages 65-75 who have ever smoked.

(B) Alcohol Misuse screening and counseling: screening and behavioral counseling interventions to reduce alcohol misuse by adults ages 18 and older, including pregnant women, in primary care settings.

(C) Low-dose aspirin to prevent cardiovascular disease and colorectal cancer when prescribed by a health care provider and obtained from an in-network pharmacy, in adults ages 50 to 59 years who have a 10% or greater 10-year cardiovascular disease (CVD) risk, are not at increased risk for bleeding, have a life expectancy of at least 10 years, and are willing to take low-dose aspirin daily for at least 10 years. A prescription must be submitted in accordance with plan rules.

(D) Blood Pressure screening for all adults age 18 and older. Blood pressure screening is not payable as a separate claim, as it is included in the payment for a physician visit.

(E) Cholesterol screening (Lipid Disorders Screening) for men aged 35 and older and women aged 45 and older; men aged 20 to 35 if they are at increased risk for coronary heart disease; and women aged 20 to 45 if they are at increased risk for coronary heart disease.

(F) Colorectal Cancer screening using stool-based methods (such as fecal occult blood testing), sigmoidoscopy, or colonoscopy, in adults beginning at age 50 and continuing until age 75. The test methodology must be medically appropriate for the patient. The plan will not impose cost sharing with respect to a polyp removal during a colonoscopy performed as a screening procedure. The plan will not impose cost sharing with respect to the following services when these services are provided in connection with a screening colonoscopy and the attending provider determines the service is medically appropriate: anesthesia services, a pre-procedure specialist consultation, or a pathology exam on a polyp biopsy.

(G) Depression screening for adults.

(H) Type 2 Diabetes screening for asymptomatic adults with sustained blood pressure (either treated or untreated) greater than 135/80 mm Hg.

(I) Diet counseling for adults at higher risk for chronic disease.

(J) HIV screening for all adolescents and adults ages 15 to 65 and for younger and older individuals at increased risk.

(K) Obesity screening and intensive counseling and behavioral interventions to promote sustained weight loss for adults with a body mass index of 30 kg/m2 or higher.

(L) Sexually Transmitted Infection (STI) prevention counseling for adults at higher risk.

(M) Tobacco Use screening for all adults and cessation interventions for tobacco users.

(N) Syphilis screening for all adults at increased risk of infection.

(O) Counseling for young adults to age 24 who have fair skin about minimizing their exposure to ultraviolet radiation to reduce risk for skin cancer.

(P) Exercise or physical therapy to prevent falls in community-dwelling adults age 65 years and older who are at increased risk for falls.

(Q) Vitamin D supplementation to prevent falls in community-dwelling adults age 65 years and older who are at increased risk for falls. Over-the-counter supplements are covered only with a prescription.

(R) Screening for hepatitis C virus (HCV) infection in persons at high risk for infection and a one-time screening for HCV infection in adults born between 1945 and 1965.

(S) Annual screening for lung cancer with low-dose computed tomography in adults ages 55 to 80 years who have a 30 pack/year smoking history and currently smoke or have quit within the past 15 years.

(T) Screening for hepatitis B virus infection in adults at high risk for infection.

(U) Low-to-moderate-dose statin for the prevention of cardiovascular disease (CVD) events and mortality in adults ages 40-75 years with one or more CVD risk factors (i.e., dyslipidemia, diabetes, hypertension, or smoking), and a calculated 10-year risk of a cardiovascular event of 10% or greater, when identified as meeting these factors by their treating physician.

(V) Screening for latent tuberculosis infection in populations at increased risk.

(vi) **Covered Preventive Services for Women, Including Pregnant Women**

(A) Well woman office visits for women beginning in adolescence and continuing across the lifespan, for the delivery of required preventive services.

(B) Anemia screening on a routine basis for pregnant women.

(C) Bacteriuria urinary tract or other infection screening for pregnant women. Screening for asymptomatic bacteriuria with urine culture for pregnant women is payable at 12 to 16 weeks' gestation or at the first prenatal visit, if later.

(D) Low-dose aspirin after 12 weeks of gestation for women who are at high risk for preeclampsia. A prescription must be submitted in accordance with plan rules.

(E) Screening for preeclampsia in pregnant women with blood pressure measurements throughout pregnancy. Blood pressure screening is not payable as a separate claim, as it is included in the payment for a physician visit.

(F) BRCA counseling about genetic testing for women at higher risk. Women whose family history is associated with an increased risk for deleterious mutations in BRCA 1 or BRCA 2 genes will receive referral for counseling. The Plan will cover BRCA 1 or 2 genetic tests without cost sharing, if appropriate as determined by the woman's health care provider, including for a woman who has previously been diagnosed with cancer, as long as she is not currently symptomatic or receiving active treatment for breast, ovarian, tubal or peritoneal cancer.

(G) Breast cancer screening mammography for women with or without clinical breast examination and with or without diagnosis, annually for women age 40 and older. If under age 40, periodic screenings are covered for women with increased risk (i.e., those with a parent, sibling, or child who has had or who has breast cancer).

(H) Breast Cancer Chemoprevention counseling for women at higher risk. The Plan will pay for counseling by physicians with women at high risk for breast cancer and at low risk for adverse effects of chemoprevention, to discuss the risks and benefits of chemoprevention. The Plan will also pay for risk-reducing medications (such as tamoxifene or raloxifene) for women at increased risk for breast cancer and at low risk for adverse medication effects.

(I) Comprehensive lactation support and counseling by a trained provider during pregnancy and for the duration of breastfeeding, and costs for renting breastfeeding equipment. The Plan may pay for purchase of lactation equipment instead of rental, if deemed appropriate by the Fund Administrator.

(J) Cervical Cancer screening for women ages 21 to 29 with Pap smear every three years; for women ages 30-65, screening with Pap smear alone every three years, or screening with Pap smear and human papillomavirus testing every five years.

(K) Chlamydia Infection screening for all sexually active non-pregnant young women aged 24 and younger, and for older non-pregnant women who are at increased risk, as part of a well woman visit. For all pregnant women aged 24 and younger, and for older pregnant women at increased risk, Chlamydia infection screening is covered as part of the prenatal visit.

(L) FDA-approved contraceptives methods, sterilization procedures, and patient education and counseling for women of reproductive capacity. FDA-approved contraceptive methods, include barrier methods, hormonal methods, and implanted devices, as well as patient education and counseling, as prescribed by a health care provider. The plan may cover a generic drug without cost sharing and charge cost sharing for an equivalent branded drug. The plan will accommodate any individual for whom the generic would be medically inappropriate, as determined by the individual's health care provider. Services related to follow-up and management of side effects, counseling for continued adherence, and device removal are also covered without cost sharing.

(M) Folic Acid supplements for women are planning or capable of pregnancy, containing 0.4 to 0.8 mg of folic acid. Over-the-counter supplements are covered only if the woman obtains a prescription.

(N) Gonorrhea screening for sexually active women age 24 and younger and in older woman who are at increased risk for infection, provided as part of a well woman visit. The Plan will pay for the most cost-effective test methodology only.

(O) Counseling for sexually transmitted infections, once per year as part of a well woman visit.

(P) Counseling and screening for HIV, once per year as part of a well woman visit, and for pregnant women, including those who present in labor who are untested and whose HIV status is not known.

(Q) Hepatitis B screening for pregnant women at their first prenatal visit.

(R) Osteoporosis screening for women. Women aged 65 and older will be eligible for routine screening for osteoporosis. Younger women will be eligible for screening if their risk of fracture is equal to or greater than that of a 65-year-old women. The Plan will pay for the most cost-effective test methodology only.

(S) Rh Incompatibility screening for all pregnant women during their first visit for pregnancy related care, and follow-up testing for all un-sensitized Rh (D) negative women at 24-28 weeks' gestation, unless the biological father is known to be Rh (D) negative.

(T) Screening for gestational diabetes in asymptomatic pregnant women between 24 and 28 weeks' gestation and at the first prenatal visit for pregnant women identified to be at risk for diabetes.

(U) Tobacco Use screening and interventions for all women, as part of a well woman visit, and expanded counseling for pregnant tobacco users.

(V) Syphilis screening for all pregnant women or other women at increased risk, as part of a well woman visit.

(W) Screening and counseling for interpersonal and domestic violence, as part of a well woman visit.

(X) Depression screening for pregnant and postpartum women.

(vii) **Covered Preventive Services for Children**

(A) Well baby and well child visits from ages newborn through 21 years as recommended for pediatric preventive health care by "Bright Futures/American Academy of Pediatrics."[1] Visits will including the following age-appropriate screenings and assessments:

(B) Developmental screening for children under age 3, and surveillance throughout childhood

(C) Behavioral assessments for children of all ages

(D) Medical history

(E) Blood pressure screening

(F) Depression screening for adolescents ages 11 and older

(G) Vision screening

(H) Hearing screening

(I) Height, Weight and Body Mass Index measurements for children

[1] http://www.aap.org/en-us/professional-resources/practice-support/Periodicity/Periodicity%20Schedule_FINAL.pdf

(J) Autism screening for children at 18 and 24 months

(K) Alcohol and Drug Use assessments for adolescents

(L) Critical congenital heart defect screening in newborns

(M) Hematocrit or Hemoglobin screening for children

(N) Lead screening for children at risk of exposure

(O) Tuberculin testing for children at higher risk of tuberculosis

(P) Dyslipidemia screening for children at higher risk of lipid disorders

(Q) Sexually Transmitted Infection (STI) screening and counseling for sexually active adolescents

(R) Cervical Dysplasia screening at age 21

(S) Oral Health risk assessment

(T) Newborn screening tests recommended by the Advisory Committee on Heritable Disorders in Newborns and Children (such as hypothyroidism screening for newborns and sickle cell screening for newborns).2

(U) Prophylactic ocular topical medication for all newborns for the prevention of gonorrhea.

(V) Oral fluoride supplementation at currently recommended doses (based on local water supplies) to preschool children older than 6 months of age whose primary water source is deficient in fluoride. Over-the-counter supplements are covered only with a prescription.

(W) Obesity screening for children aged 6 years and older, and counseling or referral to comprehensive, intensive behavioral interventions to promote improvement in weight status.

[2] http://www.hrsa.gov/advisorycommittees/mchbadvisory/heritabledisorders/recommendedpanel/uniformscreeningpanel.pdf

(X) HIV screening for adolescents ages 15 and older and for younger adolescents at increased risk of infection.

(Y) Counseling for children, adolescents, and young adults ages 10 to 24 years who have fair skin about minimizing their exposure to ultraviolet radiation to reduce risk for skin cancer.

(Z) Interventions, including education or brief counseling, to prevent initiation of tobacco use in school-aged children and adolescents.

(AA) Screening for hepatitis B virus infection in adolescents at high risk for infection.

(BB) Application of fluoride varnish to the primary teeth of all infants and children through to age 5 starting at the age of primary tooth eruption, in primary care practices.

(CC) Syphilis screening for adolescents who are at increased risk for infection.

(DD) For adolescents, screening and counseling for interpersonal and domestic violence.

(viii) **Immunizations**

Routine adult immunizations are covered for Participants and dependents who meet the age and gender requirements and who meet the CDC medical criteria for recommendation.

(A) Immunization vaccines for adults – doses, recommended ages, and recommended populations must be satisfied:

(1) Diphtheria/tetanus/pertussis

(2) Measles/mumps/rubella (MMR)

(3) Influenza

(4) Human papillomavirus (HPV)

(5) Pneumococcal (polysaccharide)

(6) Zoster

(7) Hepatitis A

(8) Hepatitis B

(9) Meningococcal

(10) Varicella

(B) Immunization vaccines for children from birth to age 18 – doses, recommended ages, and recommended populations must be satisfied:

(1) Hepatitis B

(2) Rotavirus

(3) Diphtheria, Tetanus, Pertussis

(4) Haemophilus influenzae type b

(5) Pneumococcal

(6) Inactivated Poliovirus

(7) Influenza

(8) Measles, Mumps, Rubella

(9) Varicella

(10) Hepatitis A

(11) Meningococcal

(12) Human papillomavirus (HPV)

(ix) **Office Visit Coverage**

Preventive Services are paid for based on the Plan's payment schedules for the individual services. However, there may be limited situations in which an office visit is payable under the Preventive Services benefit. The following conditions apply to payment for PPO office visits under the Preventive Services benefit. Non-PPO office visits are not covered under the Preventive Services benefit under any condition.

(A) If a preventive item or service is billed separately from an office visit, then the Plan will impose cost-sharing with respect to the office visit.

(B) If the preventive item or service is not billed separately from the office visit, and the primary purpose of the office visit is the delivery of such preventive item or service, then the Plan will pay 100 percent for the office visit.

(C) If the preventive item or service is not billed separately from the office visit, and the primary purpose of the office visit is not the delivery of such preventive item or service, then the Plan will impose cost-sharing with respect to the office visit.

For example, if a person has a cholesterol screening test during an office visit, and the doctor bills for the office visit and separately for the lab work associated with the cholesterol screening test, the Plan will charge Coinsurance for the office visit but not for the lab work. If a person sees a doctor to discuss recurring abdominal pain and has a blood pressure screening during that visit, the Plan will charge Coinsurance for the office visit because the blood pressure check was not the primary purpose of the office visit.

Well child annual physical exams recommended in the Bright Futures Recommendations are treated as Preventive Services and paid at 100%. Well woman visits are also treated as Preventive Services and paid at 100%.

(x) **Preventive Services Coverage Limitations and Exclusions**

(A) Preventive Services are covered when performed for preventive screening reasons and billed under the appropriate preventive services codes. Service covered for diagnostic reasons are covered under the applicable plan benefit, not the Preventive Services benefit. A service is covered for diagnostic reasons if the Participant or dependent had symptoms requiring further diagnosis or abnormalities found on previous preventive or diagnostic studies that required additional examinations, screenings, tests, treatment, or other services.

(B) Services covered under the Preventive Services benefit are not also payable under other portions of the Plan.

(C) The Plan will use reasonable medical management techniques to control costs of the Preventive Services benefit. The Plan will establish treatment, setting, frequency, and medical management standards for specific Preventive Services,

which must be satisfied in order to obtain payment under the Preventive Services benefit.

(D) Immunizations are not covered, even if recommended by the CDC, if the recommendation is based on the fact that some other risk factor is present (e.g., on the basis of occupational, lifestyle, or other indications). Travel immunizations, e.g., typhoid, yellow fever, cholera, plague, and Japanese encephalitis virus) are not covered.

(E) Examinations, screenings, tests, items or services are not covered when they are investigational or experimental, as determined by the Plan.

(F) Examinations, screenings, tests, items, or services are not covered when they are provided for the following purposes:

(1) When required for education, sports, camp, travel, insurance, marriage, adoption, or other non-medical purposes;

(2) When related to judicial or administrative proceedings;

(3) When related to medical research or trials; or

(4) When required to maintain employment or a license of any kind.

(G) Drugs, medicines, vitamins, and/or supplements, whether available through a prescription or over-the-counter, are not covered under the Preventive Services benefit, except as stated above.

(H) Services related to a man's reproductive capacity, such as vasectomies and condoms.

(e) Services of a registered nurse. Payment will be limited to the dollar amount or period of care pre-authorized in writing by the Benefits Fund Office;

(f) Medical supplies, surgical dressings, casts, splints, trusses, braces and crutches;

(g) Up to four pairs of surgical stockings each Calendar Year;

(h) Up to two bras for breast Prosthesis each Calendar Year;

(i) One wig each Calendar Year payable to a maximum of $150;

(j) Anesthetics and their administration, blood and blood plasma and its administration; and oxygen and the rental of equipment for the administration of oxygen, including the one-time purchase of an oxygen concentrator for portable oxygen tanks;

(k) X-ray and laboratory examinations and x-ray, radium and radioactive isotope therapy;

(l) Confinement in a Skilled Nursing Facility if the confinement meets the following conditions:

(i) Is Preauthorized in writing by the Benefits Fund Office with respect to both duration of benefits and daily maximum and is determined by the Benefits Fund Office to be less costly than a Hospital Confinement,

(ii) Is approved and monitored by a Physician, and

(iii) Immediately follows a Hospital Confinement due to the same cause.

Payment will be limited to the expenses which are pre-authorized.

(m) Charges for Hospice care made by a Hospice only if:

(i) The expense is incurred by an Eligible Employee or Eligible Dependent diagnosed by a Physician as terminally ill with a prognosis of six Months or less to live; and

(ii) The Hospice provides a plan of care which:

(A) Is prescribed by the Physician;

(B) Is reviewed and approved by the Physician on a Monthly basis, or more frequently, if requested by the Plan during inpatient confinement;

(C) Is not for any curative treatment;

(D) States the belief of the Physician and the Hospice that the Hospice care will cost less in total than any comparable alternative to Hospice care; and

(E) Is Preauthorized by the Benefits Fund Office.

(iii) Hospice care is provided:

(A) In the patient's home by a Home Health Agency or Hospice agency; or

(B) In a Hospice inpatient facility. Charges by a Hospice inpatient facility which exceed 80% of the average Hospital semi-private room daily rate in the geographical area in which the Hospice inpatient facility is located are not covered.

(iv) Hospice care includes palliative and supportive medical and nursing services. For such Hospice care, the Plan requirement that expenses will be covered only when incurred for diagnosis or treatment of an Illness or Injury will not apply.

(n) Charges for Home Health Care made by a Home Health Care Agency as follows:

(i) The plan of care by the Home Health Care Agency:

(A) Is prescribed by a Physician;

(B) Is reviewed and approved by the Physician during the entire period; and

(C) That expenses for the plan of care are pre-authorized by the Benefits Fund Office based on the following requirements:

(1) The number of days of Home Health Care does not exceed the number of days of confinement in a Hospital or Skilled Nursing Facility which would otherwise have been required;

(2) The Home Health Care will cost less per day than the daily rate for Confinement in a Hospital or Skilled Nursing Facility; and

(3) Confinement in a Hospital or Skilled Nursing Facility would otherwise be required.

(D) Home Health Care includes:

(1) Skilled nursing care; and

(2) Any other services and supplies provided in lieu of the services which would have been covered under the Plan if the Eligible Employee or Eligible Dependent was confined in a Hospital or Skilled Nursing Facility.

Home Health Care does not include housekeeping, Custodial Care or Home Health Care aide services.

(o) Drugs or medicines which are administered while an inpatient or during a Home Health Care or Hospice visit.

(p) Varicose vein treatment expenses as specified in the Schedule of Benefits.

(q) Substance Use Disorder treatment expenses as follows:

(i) Eligibility for all inpatient and outpatient therapy will be subject to all Plan provisions including, but not limited to, a determination that the therapy is Medically Necessary and Appropriate;

(ii) Expenses for treatment by a residential care center must be pre-authorized in writing by the Benefits Fund Office;

(iii) The residential care center must:

(A) Be accredited by The Joint Commission or other similar credentialing entity acceptable to the Plan;

(B) Comply with all federal, state and local requirements including required licensing; and

(C) Be a PPO Provider unless a PPO facility is unavailable, in which case the alternative facility must be pre-authorized in writing by the Benefits Fund Office.

(r) Mental or Nervous Disorder treatment expenses as follows:

(i) Eligibility for all inpatient and outpatient therapy will be subject to all Plan provisions including, but not limited to, a determination that the therapy is Medically Necessary and Appropriate;

(ii) Expenses for treatment by a residential care center must be pre-authorized in wiring by the Benefits Fund Office; and

(iii) The residential care center must:

(A) Be accredited by The Joint Commission or other similar credentialing entity acceptable to the Plan;

(B) Comply with all federal, state and local requirements including required licensing; and

(C) Be a PPO Provider unless a PPO facility is unavailable, in which case the alternative facility must be pre-authorized in writing by the Benefits Fund Office.

(s) Chiropractic care expenses for the treatment of the back, neck, spine and vertebra, for conditions due to subluxations, strains, sprains and nerve root problems, up to the Calendar Year limit set forth in the Schedule of Benefits.

(i) For purposes of this subsection (s), chiropractic care is care provided by a licensed chiropractor or a credentialed provider under the direction of or in association with a chiropractor or a credentialed provider under the direction of or in association with a chiropractor inclusive of evaluation and management as well as manipulation or adjustment of up to two areas of the body and including no more than administration of two medically appropriate modalities.

(ii) Covered treatment shall not include services or supplies, regardless of where or by whom they are provided, that

(A) A person without medical skills or background could provide or be trained to provide; or

(B) Are provided as part of a maintenance treatment plan not reasonably expected to improve the patient's condition, Illness, Injury, or functional ability.

(t) Medically Necessary and Appropriate physiotherapy, acupuncture, prolo therapy, and physical medicine services order by a qualified Physician up to a total of twenty-five sessions per Acute Occurrence (the "Acute Occurrence Limit").

(i) For purposes of this subsection (t), an Acute Occurrence is an acute Illness or Injury be it traumatic, infectious, ischemic, congenital or related to an injury suffered at birth, or due to causes unknown that causes a loss of function or structure sufficient to require physical therapy treatment to achieve or restore normal organ system function or prevent additional loss of function to any of the following systems: musculoskeletal, digestive, genitourinary, skin and related structures, neurological, or loss of function of any one of the special senses functions as more specifically defined in The Blue Book utilized by the Social Security Administration.

(ii) An Acute Occurrence will be considered to have ended upon restoration of normal function or structure of the affected organ system without ongoing treatment or therapy for a period of not less than six Months, or in the case of a condition related to a congenital deficit or birth injury identified and/or treated within the first year of life, an Acute Occurrence will be considered to have ended coincident with the ending of the Plan Year thereafter until the person has either been considered to have reached maximum medical improvement or has been treatment-free for twelve Months at which time the condition will be subject to the Acute Occurrence Limit then applicable for all non-congenital and birth-related events. The person will be limited to twenty-five treatments annually for the treatment of all congenital or birth-related Injuries. The diagnosis of developmental delay in the absence of a specifically-identified congenital condition or birth injury will not be considered a congenital defect or birth-related Illness or Injury.

(iii) For purposes of this subsection (t), a session is all care including evaluation and management and of no more than three additional modalities, procedures, or supervised services taking place for up to one hour on any single calendar day.

(iv) No more than two times the Acute Occurrence Limit will be payable for any single event that results in impairment to two or more systems as noted above.

(v) Medically Necessary and Appropriate sessions in excess of twenty-five per Acute Occurrence will require Pre-authorization through the Benefits Fund Office. Failure to obtain Pre-authorization will result in payment of 50% of the Usual and Customary Charges for the Covered Expense.

(vi) Covered treatment for an Acute Occurrence shall not include services or supplies, regardless of where or by whom they are provided, that

(A) A person without medical skills or background could provide or be trained to provide; or

(B) Are provided as part of a maintenance treatment plan not reasonably expected to improve the patient's condition, Illness, Injury, or functional ability.

(u) Injuries to oral/facial structures including, but not limited to, jaw and facial bone fractures and Injury to Sound and Natural Teeth.

(v) Transplant expenses except that no benefits are payable for donor-related expenses.

(w) Medical transportation service expenses, as follows:

(i) Ground transportation by professional ambulance to the nearest appropriate facility as Medically Necessary for the treatment of a medical Emergency, acute Illness or Injury;

(ii) Air ambulance transportation only as Medically Necessary due to inaccessibility by ground transport and/or if the use of ground transport would be detrimental to the health status of the patient, up to $15,000 per incident in North America and $25,000 per incident elsewhere; and

(iii) Ground transportation by professional ambulance for inter health care facility transfer or hospice transfer, including hospice at home for a terminally-ill patient, ("convenience transfers") up to $300 per trip up to a maximum of five trips per Calendar Year.

(x) Durable medical equipment expenses. Durable medical equipment is equipment which meets all of the following:

(i) Is for repeated use and is not a consumable or disposable item;

(ii) Is used primarily for a medical purpose; and

(iii) Is appropriate for use in the home.

Covered Expenses for rental equipment will not exceed the allowable purchase price, except for the cost of a trial period of rental, for the equipment. Durable Medical Equipment must be preauthorized by the Benefits Fund Office or it will not be covered.

Payment for replacement of obsolete durable medical equipment may be covered after five years of continuous use.

Equipment parts which wear out in less than five years may be replaced, as determined by the Trustees. No payment will be made for operating supplies, repairs, or portable oxygen in excess of one tank when an oxygen concentrator is leased or purchased.

(y) Orthotic appliances. Payment will be made for the initial appliance and, after five years, one replacement for each five years of continuous use.

(z) Prosthetic appliances. Payment will be made for the initial appliance and, after five years, one replacement for each five years of continuous use for:

(i) Artificial limbs and eyes

(ii) External breast prosthesis

(iii) Internal breast prosthesis (implant)

(iv) Cataract or corneal transplants

(v) Penile implant, limited to one per lifetime

(aa) Medically Necessary and Appropriate speech therapy up to a total of twenty-five sessions per Acute Occurrence (the "Acute Occurrence Limit").

(i) For purposes of this subsection (aa), an Acute Occurrence is an acute Illness or Injury be it traumatic, infectious, ischemic, or due to causes unknown that causes a loss of function or structure sufficient to require speech therapy treatment to restore normal organ system function or prevent additional loss of function to any of the following systems: Musculoskeletal, Digestive, Neurological, or loss of function of any one of the Special Senses Functions as more specifically defined in The Blue Book as utilized by the Social Security Administration.

An Acute Occurrence will be considered to have ended upon restoration of normal function or structure of the affected system without ongoing treatment or therapy for a period of not less than six Months.

(ii) For purposes of this subsection (aa), a session is all evaluation and treatment provided on a single calendar day, the aggregate of which shall not exceed one hour per day.

(iii) No more than one times the Acute Occurrence Limit will be payable for any single event that results in impairment to one or more systems as noted above.

(iv) Covered treatment for an Acute Occurrence shall not include services or supplies, regardless of where or by whom they are provided, that

(A) A person without medical skills or background could provide or be trained to provide; or

(B) Are provided as part of a maintenance treatment plan not reasonably expected to improve the patient's condition, Illness, Injury, or functional ability.

(bb) Medically Necessary and Appropriate occupational therapy up to a total of twenty-five sessions per Acute Occurrence (the "Acute Occurrence Limit").

(i) For purposes of this subsection (bb), an Acute Occurrence is an acute Illness or Injury be it traumatic, infectious, ischemic, or due to causes unknown that causes a loss of function or structure sufficient to require occupational therapy treatment to restore normal organ system function or prevent additional loss of function to any of the following systems: Musculoskeletal, Genitourinary, Skin and Related Structures, Neurological, or loss of function of any one of the Special Senses Functions as more specifically defined in The Blue Book as utilized by the Social Security Administration.

An Acute Occurrence will be considered to have ended upon restoration of normal function or structure of the affected organ system without ongoing treatment or therapy for a period of not less than six Months.

(ii) For purposes of this subsection (bb), a session is all evaluation and treatment provided on a single calendar day, the aggregate of which shall not exceed one hour per day.

(iii) No more than two times the Acute Occurrence Limit will be payable for any single event that results in impairment to two or more systems as noted above.

(iv) Medically Necessary and Appropriate sessions in excess of twenty-five per Acute Occurrence will require Pre-authorization through the Benefits Fund Office. Failure to obtain Pre-authorization will result in payment of 50% of the Usual and Customary Charges for the Covered Expense.

(v) Covered treatment for an Acute Occurrence shall not include services or supplies, regardless of where or by whom they are provided, that

(A) A person without medical skills or background could provide or be trained to provide; or

(B) Are provided as part of a maintenance treatment plan not reasonably expected to improve the patient's condition, Illness, Injury, or functional ability.

(cc) Cardiac and Pulmonary rehabilitative therapy subject to all applicable terms of the Plan up to a maximum of thirty sessions per Acute Occurrence.

(i) For purposes of this subsection (cc), an Acute Occurrence is an event be it traumatic, infectious, ischemic, or due to causes unknown that causes a loss of function or structure sufficient to require treatment to restore normal Cardiovascular or Respiratory system function or prevent additional loss of function.

An Acute Occurrence will be considered to have ended upon restoration of normal function or structure of the affected organ system without ongoing treatment or therapy for a period of not less than six Months.

(ii) For purposes of this subsection (cc), a session is Medically Necessary and Appropriate supervised rehabilitation services of no more than one hour per calendar day and inclusive of no more than one low level stress test per Acute Occurrence.

(dd) Short term, active, progressive rehabilitation services, if pre-authorized by the Benefits Fund Office, that are needed to restore physical ability that has been substantially reduced due to severe Illness or Injury.

(ee) Pain management treatment for chronic pain when treatment is provided by a Practitioner in the Pain Management Provider Network established by the Plan, provided that treatment for chronic pain management by a provider or Practitioner that is not credentialed as part of such network will be paid at 50%, up to the limit specified in the Schedule of Benefits.

(ff) Hearing aid expenses as specified in the Schedule of Benefits.

(gg) Voice communication machine. Payment will be limited to the lifetime maximum specified in the Schedule of Benefits.

(hh) Obesity surgery if pre-authorized by the Benefits Fund Office in accordance with a Bariatric Surgery Policy adopted by the Board of Trustees, as amended from time to time, a copy of which is attached as Appendix D to this Plan Document.

(ii) Medically Necessary nonsurgical bariatric treatment and management (up to six visits per Calendar Year) when provided by the Eligible Employee's or the Eligible Dependent's treating Physician (M.D. or D.O.) as part of a comprehensive treatment plan for patients with a history of obesity (BMI greater than or equal to 30) when provided as part of a Plan-approved Bariatric Management Program.

(jj) Prophylactic mastectomy and BRCA testing (unless BRCA testing is covered as an ACA preventive service, in which case it is covered at no charge with no Deductible from a PPO

provider) if pre-authorized by the Benefits Fund Office and in accordance with the Prophylactic Mastectomy and BRCA Testing Policy adopted by the Board of Trustees, as amended from time to time, a copy of which is attached as Appendix E to this Plan Document.

(kk) Laboratory testing.

Section 11.08. Approved Clinical Trials

Covered Expenses include:

Charges incurred due to participation in either a Phase I, II, III, or IV Approved Clinical Trial conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition, provided the charges are those that are:

(a) Ancillary to participation in the Approved Clinical Trial and would otherwise be covered under this Plan if the individual were not participating in the Approved Clinical Trial; and

(b) Not attributable to any device, item, service, or drug that is being studied as part of the Approved Clinical Trial or is directly supplied, provided, or dispensed by the provider of the Approved Clinical Trial.

A Participant or Dependent is eligible for payment of charges related to participation in an Approved Clinical Trial if he or she:

(a) Satisfies the protocol prescribed by the Approved Clinical Trial provider; and

(b) Either:

(i) The individual's PPO provider determines that the individual's participation in the Approved Clinical Trial would be medically appropriate; or

(ii) The individual provides the Plan with medical and scientific information establishing that participation in the Approved Clinical Trial would be medically appropriate.

For the purposes of this provision, an Approved Clinical Trial means a Phase I, II, III, or IV clinical trial conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition. The Approved Clinical Trial's study or investigation must be (1) approved or funded by one or more of: (a) the National Institutes of Health (NIH), (b) the Centers for Disease Control and Prevention (CDC), (c) the Agency for Health Care Research and Quality (AHCRQ), (d) the Centers for Medicare and Medicaid Services (CMS), (e) a cooperative group or center of the NIH, CDC, AHCRQ, CMS, the

Department of Defense (DOD), or the Department of Veterans Affairs (VA); (f) a qualified non-governmental research entity identified by NIH guidelines for grants; or (g) the VA, DOD, or Department of Energy (DOE) if the study has been reviewed and approved through a system of peer review that the Secretary of HHS determines is comparable to the system used by NIH and assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review; (2) a study or trial conducted under an investigational new drug application reviewed by the Food and Drug Administration (FDA); or (3) a drug trial that is exempt from investigational new drug application requirements.

Excluded Expenses include:

(a) Expenses incurred due to participation in an Approved Clinical Trial that are: (1) the investigational items, devices, services, or drugs being studied as part of the Approved Clinical Trial; (2) items, devices, services, and drugs that are provided solely for data collection and analysis purposes and not for direct clinical management of the patient; or (3) items, devices, services, or drugs inconsistent with widely accepted and established standards of care for a patient's particular diagnosis.

(b) Expenses incurred at a Non-PPO provider if a PPO provider will accept the patient in an Approved Clinical Trial.

ARTICLE 12 — PRESCRIPTION DRUG BENEFIT

Section 12.01. General

If an Eligible Employee or Eligible Dependent incurs expenses for Prescription Drugs, the Plan shall pay benefits as specified in the Schedule of Benefits and according to the provisions of this Article.

Section 12.02. Benefits Payable

The Fund has entered into an agreement with a pharmacy benefit manager which has agreements with certain pharmacies, called participating pharmacies, to fill prescriptions at discounted rates.

When prescriptions are filled at participating pharmacies or through the Mail Order Program, the Plan will pay the discounted rate for Prescription Drugs after the applicable Co-pay specified in the Schedule of Benefits has been satisfied.

When prescriptions for drugs that fall under Tier One or Tier Two are filled through the Veterans Administration, the Eligible Employee or Eligible Dependent will be reimbursed the Co-pay.

The Board of Trustees has established the Co-pays shown in the Schedule of Benefits and may modify the Co-pays based on the following criteria:

Tier Zero. Designated ACA medications and supplies, and other selected medications. Current Tier 0 medications include Simvastatin, Lovastatin and Omeprazole.

Tier One. Most Generic Drugs as designated in Plan Formulary with the exception of certain higher-cost medications which usually will have appropriate acceptable clinical alternatives for most patients.

Tier Two. Most Preferred Brand Name Drugs as designated in Plan Formulary with the exception of certain higher-cost medications, many of which have acceptable Tier Zero or Tier One alternatives.

Tier Three: Most Non-Preferred Brand Name Drugs as designated in Plan Formulary, many of which have acceptable clinical alternatives in Tier Zero, Tier One or Tier Two.

Specialty Drugs: Higher Cost medications and medications that often require special handling and monitoring as designated in the Plan Formulary. Specialty Drugs must be obtained through a program that has been approved by the Board of Trustees.

A Participant or Beneficiary will always pay the lowest of the designated Copayment, contracted price or actual selling price of a Prescription Drug.

The Board of Trustees shall assign and modify the Co-pay terms, Tier levels, and any coverage limitations (including exclusion from Plan coverage) for any Prescription Drug from time-to-time, based on the advice and recommendation of the Plan's medical consultant. A record of the Prescription Drugs and their tier assignments shall be maintained by the Fund Administrator's office.

The Co-pay terms and Tier levels established by the Trustees may allow for prescriptions for certain drugs used to treat chronic conditions on a long-term basis to be filled for up to a 90-day supply through the Plan's Mail Order Program. If a drug is authorized for a 90-day supply through the Plan's Mail Order Program, prescriptions for such drugs that are filled at a retail pharmacy will be limited to a 30-day supply but require payment by the patient of the Co-payment designated in each Tier for a 90-day supply. The Fund Administrator may allow a reasonable grace period before the higher 90-day supply Co-pay is put into effect to allow the Eligible Employee or Eligible Dependent to transfer the prescription to the Mail Order Program.

When prescriptions are filled at non-participating pharmacies, or when the Prescription Drug Benefit Identification Card is not used at a participating pharmacy, the Plan will pay the amount it would have paid had the prescription been filled using the Identification Card at a participating pharmacy, less the applicable Co-pay. The Eligible Employee or Eligible Dependent shall be responsible for paying any balance remaining.

Section 12.03. Covered Prescription Drug Expenses

The following supplies, authorized by a Physician, will be considered Covered Prescription Drug Expenses:

(a) Legend Drugs which are lawfully obtainable only from an individual licensed to dispense drugs upon the prescription of a Physician;

(b) Injectable insulin;

(c) Needles and syringes to administer injectable insulin;

(d) Needles and syringes for any other use, up to a 30-day supply;

(e) Blood glucose testing strips;

(f) Certain approved over-the-counter drugs when prescribed by a Physician; and

(g) Lancets.

Section 12.04. Exclusions and Limitations

No benefits shall be payable under this Article for expenses for:

(a) Research drugs

(b) Non-Legend or over-the-counter drugs except as otherwise specifically noted

(c) Drugs dispensed for use by the Eligible Employee or Eligible Dependent when Medically Confined

(d) Drugs used as an aid to weight loss

(e) Drugs which require approval by the Benefits Fund Office prior to dispensing when such prior approval has not been obtained

(f) Drugs that are intended to promote fertility

(g) Non-drug items, including but not limited to, nutritional supplements, regardless of intended use

(h) More than a 30-day supply of a drug, except as determined from time to time by the Trustees, along with drugs determined by the Plan's pharmacy benefit manager to be primarily prescribed for maintenance of a chronic condition

(i) Any prescription or refill for which the pharmacist's usual and customary charge to the public is less than the Deductible amount payable by an Eligible Employee or Eligible Dependent

(j) Experimental drugs, drugs intended for Experimental treatment as determined by the Trustees, or drugs not approved by the U.S. Food and Drug Administration for the condition, dose, rate or frequency prescribed

(k) Any drugs for which an acceptable, Medically-Necessary reason for continued long-term drug usage has not been established; or which are not covered or are excluded because of their intended use including, but not limited to, drugs used for cosmetic purposes such as "Retin-A" or, in the opinion of the Trustees, because of their potential abuse

(l) Drugs consumed at the time and place of prescription

(m) Drugs in excess of the quantity specified in the prescription order

(n) Drugs which will be covered by any Workers' Compensation law, Medicare, or similar governmental program, or any other prescription program or group plan unless prohibited by federal law

(o) Prescription orders or refills filled outside the United States, except for Emergencies

(p) Drugs intended for any purpose other than the manufacturer's published use, as specifically approved by the U.S. Food and Drug Administration (FDA), or drugs prescribed in quantities in excess of the dosage recommended by the manufacturer

(q) Drugs to promote hair growth

(r) Vitamins, except prescription pre-natal vitamins

(s) Brand-Name Drug when a Generic Drug is available and medically appropriate, except for certain medical conditions as determined from time to time by the Trustees

(t) Appliances and devices

(u) Blood and blood plasma, immunization agents and biological sera

(v) Erectile dysfunction drugs

(w) Lifestyle drugs

The listing of Prescription Drugs that are covered, excluded, or limited by the Plan may be modified at any time or from time to time by the Trustees. A list of such modifications shall be maintained by the Fund Administrator's office.

Section 12.05. Prescription Drug Benefit Identification Card

An Eligible Employee is responsible for any erroneous payments made because of misuse of the Prescription Drug Benefit Identification Card and must reimburse the Fund for any overpayment of benefits. The Board of Trustees authorizes the Fund Administrator, in consultation with the Fund's Medical Consultant, to deny the use of the Identification Card to any Eligible Employee or Eligible Dependent who has abused or allowed the misuse of the benefit in any way.

ARTICLE 13 — DENTAL EXPENSE BENEFIT

Section 13.01. General

If an Eligible Employee or Eligible Dependent incurs Covered Dental Expenses for services performed by a licensed Dentist or licensed dental hygienist which are usual and customary as determined by the standards of generally accepted dental practice, payment will be made for the Covered Dental Expenses incurred, up to the maximum amounts specified in the Schedule of Benefits and according to the provisions of this Article.

Section 13.02. Benefits Payable

(a) Benefits are payable in the amount specified in the Schedule of Benefits except as specified in the following subparagraph (b).

(b) Benefits for the following Dental Services when provided to an Eligible Employee under the age of 19 or to an Eligible Dependent under the age of 19, are payable at the Usual and Customary Charge;

(i) Oral examination once per Calendar Year;

(ii) Prophylaxis, twice per Calendar Year;

(iii) Bitewing and full-mouth x-rays, each once per Calendar Year;

(iv) Fillings, including silver amalgam, silicate and acrylic restorations, and sealants; and

(v) Medically Necessary orthodontia.

Section 13.03. Covered Dental Expenses

Covered Dental Expenses include only the charges for services and supplies which:

(a) Are authorized by a Dentist;

(b) Are of the usual type furnished for the purpose; and

(c) Are performed by a Dentist or dental hygienist.

ARTICLE 14 — VISION BENEFIT

Section 14.01. General

If an Eligible Employee or Eligible Dependent incurs Covered Vision Expenses, payment will be made for the Covered Vision Expenses incurred, up to the maximum amount specified in the Schedule of Benefits and according to the provisions of this Article.

Section 14.02. Benefits Payable

Benefits are payable for Covered Vision Expenses incurred, but not to exceed the maximum specified in the Schedule of Benefits.

Section 14.03. Covered Vision Expenses

Covered Vision Expenses include expenses for:

(a) Complete eye examination including dilation of pupil and/or relaxing of focusing muscles by drops and refraction for vision by a legally qualified ophthalmologist or optometrist; and

(b) New or replacement frames and/or lenses (including contact lenses) prescribed by an ophthalmologist or optometrist, including fitting.

An expense is deemed to be incurred on the date on which the services which give rise to the expense are rendered. No Covered Vision Expense incurred for a service or supply listed in this Article will be payable under the Comprehensive Medical Expense Benefit as set forth in Article 11.

Section 14.04. Exclusions and Limitations

No benefits shall be payable under this Article for:

(a) Any expense that exceeds the maximum amount during any Calendar Year;

(b) Any lenses which do not require a prescription; or

(c) Radial keratotomies or other procedures for surgical correction of myopia and/or refractive errors.

ARTICLE 15 — SUBROGATION

Section 15.01. General

The Fund shall be subrogated, to the extent of the amount of benefits paid or to be paid by the Fund, and without limitation, to any and all recovery or claim of a Participant, his or her parent(s) and dependent(s) (including minor dependent(s)) or their representatives, guardians or trustees (collectively referred to as "Claimant"), arising out of the incident or condition, giving rise to the claim for benefits. The right of subrogation applies on a priority, first dollar basis to any recovery, whether by suit, settlement or otherwise, whether there is a partial or full recovery and regardless whether the Claimant is made whole, from any source liable for making a payment relating to the injury, illness or condition to which the claim relates.

The Fund's rights of subrogation and reimbursement shall extend to any and all sources of recovery including, but not limited to, the following:

(a) Loss or damage for which the Claimant may have a claim or cause of action against any third party or its insurer;

(b) Loss or damage covered under any Workers' Compensation or occupational disease law; or

(c) Loss or damage for which the Claimant is covered by or may have a claim against or under any other insurance policy or plan, including, but not limited to, "med-pay," "personal injury protection," "financial responsibility," "no fault," "uninsured" or "underinsured" motorist coverage.

The Fund's right of subrogation is not limited to reimbursement from proceeds covering medical expenses and specifically includes any source of recovery whatsoever by the Claimant whether by settlement, judgment, or other recovery.

Section 15.02. Right of Reimbursement

The Claimant shall first reimburse the Fund on a priority basis for all payments the Fund made or may be obliged to pay for the claim from any recovery or recovered from any source, including partial or full recoveries and regardless of whether the Claimant is made whole. Once the Fund makes or is obliged to make payments on behalf of the Claimant, the Fund is granted, and the Claimant consents to, an equitable lien by agreement or constructive trust on the proceeds of any payment, settlement or judgment received by the Claimant from any source.

Section 15.03. Enforcement of Rights

The Fund has the right to recover amounts representing the Fund's subrogation and reimbursement interests under Article 15 through any appropriate legal or equitable remedy, including but not limited to the initiation of a recognized cause of action under ERISA or applicable federal or state law, the imposition of a constructive trust or the filing of a claim for equitable lien by agreement against any Claimant for recovery from any source, whether settlement, judgment or otherwise. The Fund's subrogation and reimbursement interests, and rights to legal or equitable relief, take priority over the interest of any other person or entity.

Further, where the Claimant or its agent receives a recovery from any source but does not reimburse the Fund in full, the Fund shall have the right to reduce future benefits on the claims submitted by the Participant and Eligible Dependents associated with the Claimant until the Fund has recovered the full amount allowed under this Article 15. This right of offset however shall not limit the rights of the Fund to recover such monies in any other manner.

If the Claimant has received benefits or recovery from other sources, the Fund may demand reimbursement for the benefits paid by this Fund or may credit the benefits or recovery received from other sources against benefits that the Fund might be required to pay in the future.

Section 15.04. Rights and Obligations of Claimant

The Claimant shall hold in trust for the Fund's benefit that portion of the total recovery from any source which is due for payments made or to be made by the Fund. The Claimant shall reimburse the Fund immediately upon recovery. The Claimant must not do anything to impair, release, discharge or prejudice the Fund's rights to subrogation and/or reimbursement. The Claimant will assist and cooperate with the representatives designated by the Fund. The Claimant must do everything necessary to enable the Fund to enforce its subrogation and reimbursement rights.

Upon the request of the Fund, the Claimant or the Claimant's authorized representative shall take such action as necessary or appropriate to recover all payments made or to be made by the Fund. If the Claimant institutes legal action against another source, the Fund is entitled to intervene or participate in that action. If the Claimant fails or refuses to institute legal action, the Fund is entitled to do so in the name of that person.

Upon the request of the Fund, either before or after payment of any benefit, the Claimant shall complete and/or execute certain documentation to assist the Fund in the enforcement of its subrogation and reimbursement rights including, but not limited to, the "Subrogation Agreement and Assignment form" in effect at the time the payment of benefits is made. The "Subrogation Agreement and Assignment" set forth

in Appendix C is hereby incorporated into and made part of the Plan. Payment of benefits may be suspended or delayed indefinitely for failure of the Claimant or his legal representative or counsel to complete and/or execute such documentation as required by the Fund, including, but not limited to, the "Subrogation Agreement and Assignment form."

Section 15.05. Attorney's Fees

The Fund specifically disavows any claims the Claimant may make under the common fund doctrine. This means that the Fund shall not be responsible for any of the Claimant's attorneys' fees or costs incurred in seeking a recovery, whether by suit, settlement or otherwise, unless the Trustees or their representatives have agreed in writing to discount the Fund's claim under this Article 15 by an agreed upon amount of such fees or costs.

ARTICLE 16 — SELF-AUDIT PROGRAM

Section 16.01. General

The program is designed to provide a cash incentive to Eligible Employees or Eligible Dependents who discover and arrange for recovery of overcharges made on their own inpatient Hospital bills, which in turn results in benefit dollars saved for the Fund.

Section 16.02. Amount Payable

The cash incentive paid to an Eligible Employee or Eligible Dependent for recovering an amount that was initially overcharged on a bill for him shall be 25% of the recovered amount of the overcharge that the Hospital agrees is invalid because of direct negotiations between the Participant and the provider.

The maximum paid by the Fund to an Eligible Employee or Eligible Dependent under this program shall not exceed $500. Payment for typographical errors shall be limited to $250.

For purposes of the cash incentive, only expenses which the Plan covers shall be considered in determining the amount payable to the Eligible Employee or Eligible Dependent under this program. Claims involving coordination of benefits will be eligible only if the Plan covers the Eligible Employee or Eligible Dependent for primary coverage.

Section 16.03. Payment

Proof of eligibility for a cash incentive must be submitted to the Benefits Fund Office in the form of a copy of the initial itemized Hospital bill with the overcharges circled, and a copy of the adjusted bill showing that the Hospital dropped the discrepancy.

The Benefits Fund Office must be notified within 45 days of any dispute over a bill. Within 30 days after receipt of proof and verification that the overcharge has been recovered, the Benefits Fund Office shall disburse to the Eligible Employee or Eligible Dependent a check in the amount of the cash incentive.

The Trustees and Benefits Fund Office staff shall not be required to resolve any differences between the Eligible Employee or Eligible Dependent and the Hospital with respect to disputed charges. The Benefits Fund Office will assist in recovery, however, if the Eligible Employee or Eligible Dependent is having difficulty resolving the overcharges.

ARTICLE 17 — GENERAL PLAN EXCLUSIONS AND LIMITATIONS

Notwithstanding any other provision of the Plan to the contrary, Covered Expenses shall not include, and no payment shall be made under the Plan, for expenses for the following:

(a) Any bodily Illness or Injury for which the Eligible Employee or Eligible Dependent for whom claim is made is not under the regular care of a Physician.

(b) Any Illness, Injury or Dental Service which arises out of or in the course of any occupation or employment, or for which an Eligible Employee or Eligible Dependent has received or is entitled to receive benefits under a Workers' Compensation or occupational disease law.

(c) Any supplies or services:

(i) For which no charge is made; or

(ii) For which the person is not legally required to pay.

(d) Any expense for government provided services given to a person:

(i) Under any plan or program established under the laws or regulations of any government, including the federal state, or local government or the government of any other political subdivision of the United States, or of any other country or any political subdivision of any other country; or

(ii) Under any plan or program in which any government participates other than as an employer, unless the governmental program provides otherwise.

(e) Services and supplies which the person is entitled to receive from the Uniformed Services Medical Care Facilities. However, services and supplies received from a Veteran's Administration (VA) Hospital for care of a non-service related disability will be covered to the extent that the Plan would have considered such charges as Covered Expenses had the VA not been involved.

(f) Deductible or Co-pay amounts.

(g) Cosmetic Surgery or Treatment or complication thereof.

(h) Services or supplies for weight reduction by diet control or behavior modification, with our without drugs, except for treatment covered under Section 11.07(jj) nutritional counseling, 11.07(kk)

nonsurgical bariatric treatment, or 11.07(ii) obesity surgery, unless required by the Affordable Care Act (ACA).

(i) Diagnosis, testing or treatment of infertility.

(j) Hormone therapy, artificial insemination or any other direct attempt to induce or facilitate fertility or conception.

(k) Experimental, Investigational or Unproven Services.

(l) Services provided by a person who normally resides in the Eligible Employee's household or who is the parent, spouse, child, brother or sister of the Eligible Employee or his Eligible Dependent.

(m) Donation of a heart, organ or tissue.

(n) Expenses incurred while coverage is not in force.

(o) Physical examinations or medical certificates required for employment.

(p) Radial keratotomies or other procedures for surgical correction of myopia and/or other refractive errors.

(q) Immunizations, routine examinations or check-ups and other preventive care, except as provided under the Comprehensive Medical Expense Benefit.

(r) Custodial Care, except when provided by a Hospice.

(s) Any service not listed as a Covered Expense.

(t) Services which are not Medically Necessary and Appropriate.

(u) Blood storage charges except for use for an anticipated covered medical condition for a period not to exceed six Months.

(v) Blood donated by family members or others specifically for another patient's use.

(w) Prescription or non-prescription diet pills.

(x) Amounts in excess of Usual and Customary Charges.

(y) Treatment received outside the United States or Canada except for Emergency first aid limited to the extent and at the currency rate of exchange or appropriate value of services solely determined by the Trustees.

(z) Personal convenience or comfort items including, but not limited to, such items as televisions, telephones, first aid kits, exercise equipment, air conditioners, humidifiers, saunas and hot tubs.

(aa) Wigs or toupees (except for loss of hair resulting from treatment of a malignancy or permanent loss of hair from an accidental Injury and as provided under the Comprehensive Medical Expense Benefit), hair transplants, hair weaving or any drug if such drug is used in connection with baldness.

(bb) Examinations or treatment ordered by a court in connection with legal proceedings or obtained for the purpose of receiving favorable consideration by a court or similar body, unless such examinations or treatment would otherwise qualify as a Covered Medical Expense.

(cc) Routine foot care such as the cutting and trimming of toenails.

(dd) Failure to keep a scheduled visit.

(ee) Completion of a routine claim form or routine supplemental report.

(ff) Expenses that exceed the Plan's Co-pay percentage specified in the Schedule of Benefits for services and supplies for the care and treatment of an Illness or Injury resulting from an Intentionally Destructive Act by an Eligible Employee or Eligible Dependent, provided the Intentionally Destructive Act is not caused by or related to an underlying medical condition.

Except in the situation where the Eligible Employee or the Eligible Dependent leaves an acute care facility against the medical advice of the treating Physician, the limitation on benefits specified in the Schedule of Benefits will not be imposed by the Plan until the Eligible Employee or Eligible Dependent has been advised in writing of the requirements necessary to maintain compliance with treatment and receive unreduced benefits.

(gg) Marriage counseling, or treatment for anti-social behavior which is not the result of a Mental or Nervous Disorder or a Substance Use Disorder.

(hh) Treatment of a condition or related condition that is a result of the commission of a felony, or a condition or related condition that is a result of war or any act of war, whether war is declared or undeclared.

(ii) Telephone calls between a Physician or other provider and any patient, other provider, or representative of the Plan for any purpose whatsoever.

(jj) Reversal of a surgical procedure.

(kk) Snoring cessation and snoring correction devices for any reason.

(ll) Educational services, supplies or equipment, except for nutritional counseling under Section 11.07(kk) and as required by the ACA, including but not limited to, computers, software, printers, books, tutoring and visual aids even if they are required because of an Illness or Injury.

(mm) Foods and nutritional supplements including, but not limited to, home meals, formulas, diets, vitamins and minerals (whether they can be purchased over-the-counter or require a prescription), except when provided through a feeding tube as sole nutrition.

(nn) Expenses that a person would not have incurred or would not be required to pay if this coverage or other coverage did not exist.

(oo) Expenses for home blood pressure monitoring or home uterine monitoring equipment for any reason.

(pp) Orthopedic shoes.

(qq) Vision therapy.

(rr) Muscle stimulators in excess of $500.

(ss) Dental Services except as provided under Article 13 of this Plan and except for removal of tumors, treatment of fractures, direct surgery on the temporomandibular joint itself or surgery to correct a malocclusion of the jaw due to a skeletal deformity.

(tt) Routine circumcision of newborns.

(uu) If an Eligible Employee is employed by more than one Contributing Employer, the benefits provided to the Eligible Employee will be no greater than if the Eligible Employee was employed by only one Contributing Employer.

(vv) No expense will be covered under more than one benefit provision of the Plan.

(ww) Expenses incurred by a Medicare Eligible Employee or Medicare Eligible Dependent for which the Centers for Medicare and Medicaid Services ("CMS") deny payment to a hospital because of CMS' "never events" policy, as amended from time to time, and for whom Medicare would pay primary to the Plan under the Plan's coordination of benefits order.

(xx) All genetic testing for the purposes of screening for the presence of occult disease, or for risk stratification for the development of clinically absent or unapparent disease, or the evaluation of possible prophylactic surgical treatment, will be excluded with the exception of the following and as required by the health reform law, the Affordable Care Act (ACA):

(i) Governmentally-mandated neonatal testing and testing performed in association with amniocentesis and other covered related or equivalent procedures.

(ii) Testing where a definitive diagnosis of breast cancer or other hematologic or oncologic diagnosis has been made to determine the medical appropriateness of therapy subject to all medical necessity, Experimental/Investigational, and all other relevant provisions of the Plan.

(iii) BRCA counseling about genetic testing for women at higher risk. Women whose family history is associated with an increased risk for deleterious mutations in BRCA 1 or BRCA 2 genes will receive referral for counseling. The Plan will cover BRCA 1 or 2 genetic tests without cost sharing, if appropriate as determined by the woman's health care provider, including for a woman who has previously been diagnosed with cancer, as long as she is not currently symptomatic or receiving active treatment for breast, ovarian, tubal or peritoneal cancer.

(yy) Breast reduction surgery except for reconstruction due to breast cancer.

(zz) Skin or fat removal surgery for any reason.

(aaa) More than one medical office visit, hospital room, or wound care facility charge billed on the same day by the same Provider.

(bbb) Cochlear implants or similar implantable devices designed to restore, improve or augment hearing except as provided for under the Plan's allowance for a hearing aid.

(ccc) Covered treatment for Home Health Care shall not include services or supplies, regardless of where or by whom they are provided, that;

(i) A person without medical skills or background could provide or be trained to provide, provided that this shall not preclude coverage by the Plan for training for such person to provide the Home Health Care at the sole discretion of the Trustees; or

(ii) Are provided as part of a maintenance treatment plan not reasonably expected to improve the patient's condition, sickness, injury or functional ability.

(ddd) IV sedation or ultrasound guided assistance for Epidural Steroid Injection (ESI) and corticosteroid injection.

(eee) Charges for infection control and medical waste disposal.

(fff) Expenses for and related to travel for an Eligible Employee, Eligible Dependent or a Physician.

(ggg) More than one medical office visit, hospital room, or wound-care facility charge billed on the same day by the same Provider.

(hhh) Long-term care.

(iii) Private-duty nursing.

(jjj) Weight loss programs, except as required by the ACA.

ARTICLE 18 — COORDINATION OF BENEFITS

Section 18.01. General

The benefits payable to an Eligible Employee or Eligible Dependent under this Plan shall be reduced to the extent necessary so that the sum of the benefits payable under this Plan and the benefits payable by any "Other Plan" shall not exceed the total that would be payable under the Plan.

This Plan will not cover any costs of care, treatment, services or supplies which are furnished by or are payable under any motor vehicle or automobile insurance policy or plan, or any plan or policy covering loss, liability or damage caused by a third party, including but not limited to "no fault" and uninsured or underinsured motorist coverage. Income Protection Benefits payable under this Plan will be reduced by any coverage provided under any motor vehicle or automobile insurance policy or plan or any plan, policy or settlement of a claim or cause of action against a third party. Payment of benefits may be delayed indefinitely for failure of any covered person to provide information to the Benefits Fund Office regarding coverage under any motor vehicle or property owner insurance policy or plan.

Duplicate payment for the same covered expenses is not allowed.

For persons who qualify as both an Eligible Employee and an Eligible Dependent, this Plan will be considered an "Other Plan" in determining the amount of benefits payable to such person as an Eligible Dependent under this Plan except to the extent that such person does not comply with the Inpatient Hospital Requirements, Second Opinion Requirements, or PPO Requirements, in which case benefits will be reduced accordingly. Nursery expenses will be covered when the mother qualifies as both an Eligible Employee and Eligible Dependent.

Section 18.02. Other Plan

"Other Plan" shall mean any plan providing benefits or services for or because of medical, dental, vision or prescription drug care or treatment for which benefits or services are provided by:

(a) Group, blanket or franchise insurance coverage (including student accident coverage);

(b) Group Blue Cross or group Blue Shield coverage or other prepayment coverage on a group basis, including Health Maintenance Organizations (HMOs) whether or not HMO requirements are followed;

(c) Any coverage under labor-management trusteed plans, union welfare plans, employer organization plans, and employee benefits organization plans or any other arrangement of benefits for individuals of a group;

(d) Any coverage under governmental programs and any coverage required or provided by any statute;

(e) Any no-fault automobile insurance coverage or individual policy; or

(f) Other arrangements of covered or self-covered group coverage.

Section 18.03. Allowable Expense

"Allowable Expense" means any necessary, usual and customary expenses incurred by an Eligible Employee or Eligible Dependent during a Calendar Year and while eligible under this Plan, for medical care or treatment, part or all of which would be covered under any Other Plan, except as provided below.

(a) The difference between the cost of a semi-private room in a Hospital or specialized health care facility and a private room, unless the Eligible Employee or Eligible Dependent's confinement in a private Hospital room is Medically Necessary, is not an Allowable Expense.

(b) If the coordinating plans determine benefits because of Usual and Customary Charges, any amount in excess of the highest Usual and Customary Charge is not an Allowable Expense.

(c) If the coordinating plans provide benefits or services because of negotiated fees, any amount in excess of the highest of the negotiated fees is not an Allowable Expense.

(d) If one coordinating plan determines benefits because of Usual and Customary Charges and the other coordinating plan provides benefits or services because of negotiated fees, the primary plan's payment arrangement is the Allowable Expense for all plans.

(e) When benefits are reduced by a primary plan because a covered person did not comply with the primary plan's provisions, such as the provisions related to Utilization Management in this Plan and similar provisions in other plans, or did not obtain a required referral, the amount of those reductions will not be considered an Allowable Expense by this Plan when it pays second. In addition, if an Eligible Employee or Eligible Dependent is covered under an HMO or clinic which provides necessary treatment without charge, and the Eligible Employee or Eligible Dependent does not obtain treatment from the HMO or clinic, no benefits will be paid by this Plan.

When any Other Plan provides services rather than cash payment, the reasonable cash value of each service will be an Allowable Expense.

Section 18.04. Order of Benefit Payment

The following order of coordination of benefits shall be used to determine the amount of benefits payable under this Plan and the amounts to be paid by any Other Plans:

(a) A plan without a coordination of benefits provision shall pay its benefits before a plan which contains a coordination of benefits provision.

(b) A plan which covers a person other than as an Eligible Dependent, shall pay its benefits before a plan which covers the person as an Eligible Dependent.

If the person is covered as an Employee under this Plan and as an employee under another plan, the plan provided through the employer for whom the person worked the greatest number of average hours during the claim determination period shall pay its benefits first.

If a plan which covers a person other than as an Eligible Dependent has a provision whereby the customary coordination of benefit rules for health insurance are inapplicable and/or a reduced level of coverage is applicable under such plan because the individual in question is covered as an Eligible Dependent under this Plan, then this Plan shall coordinate on the basis as if the other plan had paid based upon the customary coordination of benefit rules for health insurance and the regular plan of benefits that would apply to a covered person under such other plan but for the reduction in benefits due to coverage under this Plan. In the event this Plan cannot disregard the other plan's provision which seeks to avoid the result under customary coordination of benefit rules for health insurance and/or which seeks to apply a reduced level of benefits because of coverage as an Eligible Dependent under this Plan, then the coverage for such Eligible Dependent under this Plan shall be limited to a maximum benefit for claims incurred in a Calendar Year of $1,000 per Calendar Year.

(c) There is one exception to the rule in Section 18.04(b) above. If the person is also a Medicare beneficiary, and as a result of the provisions of Title XVIII of the Social Security Act and implementing regulations (the Medicare rules), Medicare is:

(i) Secondary to the plan covering the person as a dependent; and

(ii) Primary to a plan covering the person as other than a dependent (that is the plan covering the person as a retired employee);

Then the order of benefit payment is reversed, so that the plan covering the person as a dependent pays first and the plan covering the person as other than a dependent (that is, as a retired employee) pays second.

(d) For claims on behalf of Eligible Dependent children who are covered under both parents' plans and the parents are not separated or divorced:

(i) The plan that covers the parent whose birthday falls earlier in the Calendar Year shall pay first,

(ii) If both parents have the same birthday, the plan covering the parent for the longer period of time shall pay first,

(iii) If one plan uses the male/female rule and the other plan coordinates using the rule based on the parents' birthdays, the plan using the male/female rule shall pay its benefits first.

(e) For a claim on behalf of Eligible Dependent children who are covered under both parents' plans and the parents are separated or divorced:

(i) If there is a court decree which established financial responsibility for medical expenses, the plan covering the Eligible Dependent children of the parent who has legal, responsibility shall be primary.

(ii) If there is no court decree and the parent with custody has not remarried, the plan which covers the parent with custody, shall be primary.

(iii) If there is no court decree and the parent with custody has remarried, the order of benefit coordination shall be

(A) The plan of the parent with custody,

(B) The plan of the stepparent with custody,

(C) The plan of the parent without custody.

If the parents have joint custody and the divorce decree does not specify that one parent has responsibility for coverage or if the parents were never married, the plan that covers the parent whose birthday falls earlier in the Calendar Year shall pay first.

If there was a court decree that no longer applies due to the age of the Eligible Dependent(s), the Fund will determine benefits as if the court decree was still in force.

(f) A plan which covers a person as an active employee, shall pay its benefits before a plan that covers the person as a laid-off or retired employee.

(g) For claims on behalf of a person who is provided COBRA continuation coverage under this Plan, this Plan shall pay its benefits secondary to any other plan which covers the person.

(h) If none of the above establishes the primary plan, the plan which has covered the person for the longer continuous period of time shall pay its benefits before the plan which has covered the person for a shorter period of time.

(i) In the event of a dispute as to which plan is primary, the Trustees may, in final settlement of all benefits due under this Plan, consider for payment up to 50% of pro-rated expenses covered under this Plan.

Under no circumstances may a Participant elect this Plan as primary contrary to the rules above.

Section 18.05. Effect of Medicare

This Plan shall coordinate benefits with Medicare as set forth in Article 19 hereof. This Plan is secondary to Medicare when allowed by law.

ARTICLE 19 — EFFECT OF MEDICARE

Section 19.01. General

The benefits payable to a Participant shall be reduced to the extent necessary so that the sum of the benefits payable under this Plan and the amounts paid under Medicare Part A and Part B shall not exceed the total of such "Allowable Expense."

Section 19.02. Definitions

"Allowable Expenses" means the reasonable charges as determined by Medicare for expenses for medical care or treatment which are covered by Medicare and this Plan.

"Small Employer" means an employer which has 20 or fewer Employees each working day in each of 20 or more calendar weeks during the current or preceding Calendar Year.

Section 19.03. Effect on Benefits

If a Participant is eligible for Hospital insurance under Medicare Part A, but not enrolled in Part A and Medicare would otherwise have primary responsibility for expenses incurred, the benefits provided to him under this Plan shall be paid as if the Participant has enrolled in Medicare Part A.

Section 19.04. Order of Benefit Payment

(a) This Plan shall pay its benefits without regard to the entitlement or potential entitlement to Medicare of an active Eligible Employee or an Eligible Dependent of an Eligible Employee provided that such Employee or Dependent has not attained age 65, is eligible for Medicare benefits because he is disabled (other than an ESRD beneficiary) and is covered by the Plan on the basis of the Eligible Employee's current employment status with a Contributing Employer.

(b) This Plan shall have primary responsibility for the first 30 Months for the claim of an Eligible Employee or Eligible Dependent who is eligible for Medicare benefits because of end-stage renal disease (ESRD) where Medicare has secondary responsibility.

(c) This Plan shall pay its benefits without regard to an active Eligible Employee's or an Eligible Dependent's entitlement or potential entitlement to Medicare if the Eligible Employee is age 65 or older and actively employed by an employer who is not a Small Employer and which pays all or part of the required contributions for eligibility, or for an Eligible Dependent spouse age 65 or older

of an active Eligible Employee of an employer which is not a Small Employer which pays all or part of the required contributions for eligibility.

(d) When subsections 18.04(a), (b) and (c) do not apply, benefits otherwise payable under this Plan for Allowable Expenses shall be reduced so that benefits payable by the Plan do not exceed the amount of Allowable Expenses reduced by the amount paid or payable by Medicare.

Medicare claims for reimbursement from the Plan, whether the Plan is primary or secondary to Medicare, shall be subject to the benefit claim and appeal procedures of the Plan, including time limits for filing and processing benefit claims.

APPENDIX A — REQUIRED SECOND OPINION REVIEW LIST

Artery and Vein Surgery

Coronary Artery Bypass—Correction of a damaged section of an artery by diverting the heart's blood flow away from the point of damage.

Ligation and Stripping of Varicose Veins—Enlarged, twisted veins that are tied and removed.

Vein Sclerosing Injection—Injecting a solution into the veins which causes the stagnant blood within to clot.

Back Surgery

Coccygectomy, Coccyx Reduction—Surgery of the tailbone.

Discectomy—Removal of a disc.

Laminectomy—Removal of a small portion of bone from the spine.

Spinal Fusion—To permanently stiffen a portion of the spine to prevent further displacement from occurring.

Breast Surgery

Digestive System Surgery

Intestinal Surgery—Intestinal bypass, intestinal stapling and reversal of covered procedures only when certified by a Physician as morbid. Intestinal bypass is the removal of part of the intestine and connection of the remaining ends. Intestinal stapling is fastening the segments of the intestine together by using staples. Reversal is unfastening the segments of the intestine.

Exploratory Surgery—The examination of an organ by surgery.

Eye Surgery

Blepharoplasty—Repair of the eyelid.

Foot Surgery—A Second Opinion is required if the surgeon's and assistant surgeon's fees total $2,000 or more.

Genital Surgery

Cystocele—Repair of a hernia of the bladder that protrudes into the vagina.

Hysterectomy—Removal of the uterus.

Penile Implant—Prosthetic appliance inserted in the penis to facilitate normal sexual functioning.

Prostatectomy or Transurethral Resection—Removal of all or part of the prostate gland.

Rectocele—Repair of a hernia of the vagina that pushes against the rectum.

Uterine Suspension—Correction of a tilted uterus.

Joint Surgery

Arthrotomy—Repair of knee joint (lateral and/or medial meniscus). (Second Opinion necessary if performed as an inpatient.)

Joint Replacement—Replacement or plastic reconstruction of a joint.

Maxillary and Mandibular Surgery—Upper and lower jaw surgery. Temporomandibular joint reconstruction is the surgical treatment for the joint in front of each ear.

Nose Surgery

Nasal Fracture Reduction (open and closed)—These fractures can be placed into normal alignment by manual manipulation or by inserting instruments into the nasal cavity to push out depressed bony fragments.

Septoplasty—Repair of the nose structure.

Submucous Resection of Nasal Septum—Straightening out of the septum by elevating the septum and removing the cartilage blocking a nostril.

APPENDIX B — PPO CONTRACT

On file at Fund Administrator's office.

APPENDIX C — SUBROGATION AGREEMENT AND ASSIGNMENT

On file at Fund Administrator’s office.

APPENDIX D – BARIATRIC SURGERY POLICY

All procedures must be pre-authorized by the Benefits Fund Office and performed at Fund-approved Bariatric Surgery Center of Excellence.

To be eligible for consideration for this benefit, the Employee must have been employed for at least 12 Months with a Contributing Employer and the Eligible Employee or Eligible Dependent entering the program must meet all medical appropriateness and eligibility criteria as required by the Fund and must agree to enroll in case management through the Plan's case management program prior to being enrolled in a pre-surgical bariatric management program.

(a) **Approved Types of Bariatric Surgery**

The Plan considers open or laparoscopic Roux-en-Y gastric bypass (RYGB) or laparoscopic gastric banding (LASGB or Lap-Band), Medically Necessary when the Eligible Employee or Eligible Dependent has met the criteria listed below:

(i) Severe obesity that has existed for at least 5 years as defined by having a BMI of 40 or above;

(ii) Is 21 years of age with documentation that full bone growth has been met;

(iii) Has attempted weight loss and life style modification in the past without successful long-term weight reduction; and

(iv) The Eligible Employee or Eligible Dependent has enrolled in and, as determined by the Fund, successfully completed a Fund-approved multidisciplinary Physician-supervised nutrition and exercise program of at least six months duration. An approved program must be pre-authorized by the Benefits Fund Office and contain each of the following:

(A) Consultation with a licensed/registered dietician or nutritionist;

(B) Reduced-calorie diet program supervised by licensed/registered dietician or nutritionist;

(C) Exercise regimen (unless contraindicated) to improve pulmonary reserve prior to surgery and demonstrate the ability to maintain appropriate supportive lifestyle modifications, supervised by an exercise therapist or other qualified professional;

(D) Behavior modification program supervised by a qualified professional;

(E) Psychological evaluation by a licensed psychologist or psychiatrist experienced in the evaluation and management of Bariatric patients certifying the Participant's fitness for surgery including the ability to comply with required lifestyle modifications and treatment programs; and

(F) Documentation in the medical record of the individual's satisfactory completion of the approved program. (A Physician's summary letter, without evidence of contemporaneous oversight, is not sufficient documentation. Documentation should include medical records of the Physician's initial assessment of the individual, and the Physician's assessment of the individual's progress at the completion of the multidisciplinary surgical preparatory regimen, and successful participation in exercise, behavior modification, meal planning and lifestyle modification programs.)

(b) **Repeat Bariatric Surgery**

The Plan may consider surgery to correct complications from Bariatric surgery, such as obstruction, slippage of band, port replacement or stricture when Medically Necessary.

The Plan considers repeat Bariatric surgery Medically Necessary for Eligible Employees and Eligible Dependents whose initial Bariatric surgery was Medically Necessary (i.e., who met all medical necessity and pre-operative criteria for their initial Bariatric surgery), and who meet either of the following medical necessity criteria:

(i) Conversion to a RYGB may be considered Medically Necessary for Eligible Employees or Eligible Dependents who have not had adequate success (defined as loss of more than 50 percent of excess body weight) three years following the primary Bariatric surgery procedure and the Eligible Employee or Eligible Dependent has been compliant with a prescribed nutrition and exercise program following the procedure; or

(ii) Revision of a primary Bariatric surgery procedure that has failed if the primary procedure was successful in inducing weight loss, and the Eligible Employee or Eligible Dependent has been compliant with a prescribed nutrition, exercise, and lifestyle modification program following the initial procedure.

APPENDIX E – PROPHYLACTIC MASTECTOMY AND BRCA TESTING POLICY

(a) The Plan does not provide benefits for prophylactic mastectomies except as may be required under the Women's Health and Cancer Rights Act and in women deemed by the Trustees to be at extraordinarily high risk of developing difficult to treat breast cancer. Women with the following conditions only will be considered by the Trustees as having extraordinarily high risk and may be eligible for benefits for prophylactic mastectomy upon submitting appropriate documentation for Pre-authorization to the Benefits Fund Office:

(i) Women who possess the BRCA1 or BRCA2 mutations confirmed by appropriate testing;

(ii) Women with a documented past history of radiation therapy treatments to the chest for Hodgkin's or other similar diseases between the ages of 10 and 30 years;

(iii) Women who have documented evidence of genetic mutations in the TP53 or PTEN genes;

(iv) Women with 2 or more first degree relatives on the same side of the family with a history of breast cancer or a combination of breast and ovarian cancer without regard to genetic testing results;

(v) Women with a documented family history of one BRCA negative first degree relative with multiple primary or bilateral breast cancers;

(vi) Women diagnosed with breast cancer at 45 years of age and younger; or

(vii) Women with multiple primary or bilateral breast cancers.

(b) BRCA counseling about genetic testing for women at higher risk. Women whose family history is associated with an increased risk for deleterious mutations in BRCA 1 or BRCA 2 genes will receive referral for counseling. The Plan will cover BRCA 1 or 2 genetic tests without cost sharing, if appropriate as determined by the woman's health care provider, including for a woman who has previously been diagnosed with cancer, as long as she is not currently symptomatic or receiving active treatment for breast, ovarian, tubal or peritoneal cancer.

ADDENDUM 1 — HIPAA PRIVACY PROVISIONS

The Plan will use and disclose Protected Health Information ("PHI") in accordance with the uses and disclosures permitted or required by the privacy regulations issued pursuant to the Health Insurance Portability and Accountability Act of 1996, 45 C.F.R. Parts 160 and 164 (the "Privacy Regulations"). The following provisions address disclosures of PHI to the Plan's Board of Trustees (the "Trustees") for Plan administration purposes. If other terms of the Plan conflict with the following provisions, the following provisions shall control. The Privacy Regulations are incorporated herein by reference. Unless defined otherwise in the Plan, all capitalized terms herein have the definition given to them by the Privacy Regulations.

(a) **Disclosure of PHI to the Trustees**

(i) **Disclosures by Plan.** The Plan may disclose PHI to the Trustees to the extent necessary for the Trustees to perform Plan administration functions that qualify as Payment or Health Care Operations.

(ii) **Disclosures by Business Associates.** The Plan's Business Associates may disclose PHI to the Trustees to the extent necessary for the Trustees to perform Plan administration functions that qualify as Payment or Health Care Operations.

(iii) **Disclosures by Other Covered Entities.** A covered Entity that provides health insurance benefits to Individuals covered by the Plan may disclose PHI to the Trustees to the extent necessary for the Trustees to perform the following Plan administration functions:

(A) The Plan's payment activities;

(B) Those Health Care Operations designated in 45 C.F.R. Section 164.506(c)(4) with respect to the Plan; and

(C) All of the Plan's Health Care Operations to the extent the Plan and the other Covered Entity are considered an Organized Health Care Arrangement under the Privacy Regulations.

(b) **Uses and Disclosures of PHI by the Trustees**

The Trustees shall use and/or disclose PHI only to the extent necessary to perform administration functions on behalf of the Plan that qualify as Payment or Health Care Operations or as otherwise permitted or required by the Privacy Regulations.

(c) **Privacy Safeguards**

The Trustees agree to:

(i) Not use or further disclose PHI other than as permitted or required under the Plan or as required by law;

(ii) Ensure that any subcontractors or agents to whom the Trustees provide PHI agree to the same restrictions and conditions that apply to the Trustees with respect to PHI;

(iii) Not use or disclose PHI for employment-related actions and decisions unless authorized by the Individual who is the subject of the PHI;

(iv) Not use or disclose PHI in connection with any other employee benefit plan unless authorized by the Individual who is the subject of the PHI or as permitted under the Privacy Regulations;

(v) Report to the Plan any use or disclosure of PHI of which the Trustees become aware that is inconsistent with the uses or disclosures provided for in the Plan;

(vi) Make PHI available to an Individual in accordance with the Privacy Regulation's access requirements and the Plan's privacy policies and procedures;

(vii) Make PHI available for amendment and incorporate any amendments to PHI in accordance with the Privacy Regulations and the Plan's privacy policies and procedures;

(viii) Make available the information required to provide an accounting of disclosures in accordance with the Privacy Regulations and the Plan's privacy policies and procedures;

(ix) Make internal practices, books, and records relating to the use and disclosure of PHI available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining the Plan's compliance with the Privacy Regulations;

(x) If feasible, return or destroy all PHI that the Trustees maintain in any form, and retain no copies of such PHI when no longer needed for the purpose for which the disclosure was made to the Trustees. If return or destruction is not feasible, the Trustees agree to restrict and limit further uses and disclosures to the purposes that make the return or destruction infeasible and shall maintain confidentiality of such PHI as long as it is retained; and

(xi) Ensure that adequate separation between the Plan and the Trustees is established, as described below.

(d) **Adequate Separation**

The Trustees may use PHI only for Plan administration activities. The Trustees may not use PHI for employment-related actions or for any purpose unrelated to Plan administration. Any Trustee who uses or discloses PHI in violation of the Plan's privacy policies and procedures or in violation of this Plan provision shall be subject to the Plan's privacy disciplinary procedure.

The Plan Sponsor will:

(a) Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of electronic PHI that it creates, receives, maintains, or transmits on behalf of the group health plan;

(b) Ensure that the adequate separation discussed in Item (d) above, specific to electronic PHI, is supported by reasonable and appropriate security measures;

(c) Ensure that any agent, including a subcontractor, to whom it provides electronic PHI agrees to implement reasonable and appropriate security measures to protect the electronic PHI; and

(d) Report to the Plan any security incident of which it becomes aware concerning electronic PHI.

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