CHICAGO REGIONAL COUNCIL
OF CARPENTERS WELFARE FUND

PLAN DOCUMENT

Restated: Effective December 1, 2020

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ARTICLE I ESTABLISHMENT AND NAME OF THE PLAN

Section 1.01 Establishment and Name of the Plan

The Board of Trustees of the Chicago Regional Council of Carpenters Welfare Fund (hereinafter referred to as the "Fund") hereby establishes a health and welfare plan for the Participants hereunder, which plan shall be known as the "Chicago Regional Council of Carpenters Health and Welfare Plan" (hereinafter referred to as the "Plan"). The Plan was established and is maintained in accordance with the provisions of the Agreement and Declaration of Trust effective August 8, 1952, as amended and restated effective January 1, 2017 (hereafter referred to as "Trust Agreement"). For purposes of ERISA, this Plan is deemed a "health and welfare plan." This Plan is restated effective December 1, 2020 unless otherwise indicated in the Plan. This Plan document supersedes any prior Plan documents.

Section 1.02 Purpose

These benefits, benefit limitations, rules and regulations are adopted by the Trustees of the Fund under the terms of the Trust Agreement in order to establish provisions that determine the eligibility of Employees, Participants, Retirees and their Dependents for the benefits provided by the Plan and to prescribe the amount, extent, condition, and method of payment under the Plan. The Plan together with the Trust Agreement, established by the Union, the Employers (and their associations) and Trustees, is intended to constitute a Plan and Trust under the Internal Revenue Code and ERISA for the purpose of providing health and welfare benefits for Covered Individuals and Employees of Contributing Employers who qualify under the terms of the Plan.

ARTICLE II DEFINITIONS

Whenever a word or phrase defined in this Article II is used in this Plan, it shall have the same meaning as defined below unless a different meaning is plainly required by the context. As described in Section 18.11, the masculine gender, where appearing in the Plan, shall be deemed to include the feminine gender and the singular shall be deemed to include the plural, unless the context clearly indicates to the contrary.

Section 2.01 Active Plan/Active Plan of Benefits

"Active Plan" or "Active Plan of Benefits" means the benefits described in this Plan and in the Schedule of Benefits as described in Appendix A. for Covered Individuals who maintain eligibility under this Plan

Section 2.02 Administrator/Plan Administrator/ COBRA Administrator

"Administrator," "Plan Administrator" and "COBRA Administrator" means the entity or individual designated by the Trustees to act as the executive administrative officer of the Trust Fund who has the authority to control and manage the administration of the Plan.

Section 2.03 Affordable Care Act

The "Affordable Care Act" means the Patient Protection and Affordable Care Act, Public Law No. 111-148, and the Healthcare and Education Reconciliation Act of 2010, Public Law No. 111-152 and the regulations and guidance promulgated thereunder.

Section 2.04 Appeals Committee

"Appeals Committee" means a committee of Trustees appointed by the Board of Trustees to handle appeals brought pursuant to the procedures set forth in Article XVI.

Section 2.05 Apprentice Program

"Apprentice Program" means the Chicago Regional Council of Carpenters Apprentice and Training Program.

Section 2.06 Authorized Personal Representative

"Authorized Personal Representative" means the person designated by a Covered Individual by means of the Fund's Authorized Personal Representative Form or Healthcare Power of Attorney to act on his behalf in receiving any information that is (or would be) provided to a Covered Individual as a Participant/beneficiary of the Plan, including but not limited to, any and all information that relates to his Claim for coverage or benefits under the Plan and any individual rights that a Covered Individual has regarding his protected health information under HIPAA.

Section 2.07 Behavioral Health/Substance Use Disorders

"Behavioral Health/Substance Use Disorders" means a neurosis, psychoneurosis, psychopathy, psychosis, or a mental or emotional disease of any kind that is defined within the mental disorders section of the current edition of the International Classification of Diseases (ICD) manual or is identified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), including Substance Use Disorders. A Substance Use Disorder is a psychological and/or physiological dependence on or addiction to alcohol, drugs or medications, regardless of any underlying physical or organic cause, and/or other drug dependency as defined in the current edition of the ICD or DSM.

Section 2.08 Calendar Quarter

"Calendar Quarter" means any three (3) month period beginning on January 1, April 1, July 1 or October 1.

Section 2.09 Calendar Year

"Calendar Year" means a twelve (12) month period starting on January 1 and ending on the following December 31.

Section 2.10 Claim

"Claim" means a demand for payment under the Plan on behalf of a Claimant pursuant to the procedures for making such requests set forth in Article XVI hereof.

Section 2.11 Claimant

"Claimant" means a Covered Individual who requests a benefit to be paid to him under the procedures set forth in Article XVI hereof. A Claimant includes a Covered Individual or an Authorized Personal Representative authorized by the Covered Individual.

Section 2.12 Claims Fiduciary

"Claims Fiduciary" means the entity that has full discretionary authority to interpret the terms of the Plan and to decide benefit claims under the Plan and the appeal of such decision, and to maintain any applicable external review process. The Plan's Claims Fiduciary is the Board of Trustees unless the Trustees take action to delegate such authority to a third party Claims Fiduciary such as to an insurance carrier or to a third party service provider responsible for maintaining a benefit program under the Plan, *e.g.*, a service provider maintaining the Plan's dental, vision, behavioral health, prescription drug, or medical benefits as designated in the Plan's summary plan description.

Section 2.13 Coinsurance

"Coinsurance" means the portion, expressed as a percentage, of Covered Services a Covered Individual will pay after the Calendar Year Deductible is satisfied, but before the Calendar Year Out-Of-Pocket Maximum is met.

Section 2.14 Collective Bargaining Agreement

"Collective Bargaining Agreement" means a written agreement between the Union and an Employer (or an association on behalf of an Employer) providing for Contributions by the Employer to the Trust Fund for an Employee, and pursuant to which an Employer consents to be bound by the Trust Agreement and the terms of the Plan and any amendment thereto.

Section 2.15 Continuation Coverage under COBRA

"COBRA" means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended from time to time. "Continuation Coverage under COBRA" means coverage offered pursuant to COBRA.

Section 2.16 Contracted Provider

"Contracted Provider" means an organization with which the Fund contracts for services on behalf of Participants and Covered Individuals, including, but not limited to provisions of a Preferred Provider Network, Utilization Review management, and other services related to Plan benefits.

Section 2.17 Contributions

"Contributions" means payments made or due to the Fund by or from Employers on behalf of Employees for work performed by such Employees, pursuant to the terms of the Trust Agreement, a Collective Bargaining Agreement, Participation Agreement, or other written agreement.

Section 2.18 Convalescent Facility

"Convalescent Facility" means an institution that:

(A) Provides skilled nursing care under twenty-four (24) hours a day supervision of a Physician or graduate registered nurse;

(B) Has available, at all times, the services of a Physician who is a staff member of a Hospital;

(C) Provides twenty-four (24) hours a day nursing service by a graduate registered nurse, licensed vocational nurse, or skilled practical nurse and has a graduate registered nurse on duty at least eight hours per day;

(D) Maintains a daily medical record for each patient; and

(E) Is not a place for rest, a place for Custodial Care, a place for the aged, or a hotel or similar institution.

Section 2.19 Coordination of Benefits

"Coordination of Benefits" means the provisions used to establish the order in which two (2) or more plans coordinate their respective benefits so the total benefits paid do not exceed one hundred percent (100%) of the total allowable charge.

Section 2.20 Co-payment or Co-pay

"Co-payment" or "Co-pay" means the dollar amount a Covered Individual will pay for certain services before the Plan pays.

Section 2.21 Cosmetic

"Cosmetic" means a procedure or treatment that is intended primarily to improve physical appearance, and/or to restore form, is not Medically Necessary, and is not a treatment requirement.

Section 2.22 Coverage Quarter

"Coverage Quarter" means the three-month period beginning on March 1, June 1, September 1 or December 1.

Section 2.23 Covered Employment

"Covered Employment" means work performed by an Employee for an Employer for which Contributions for hours worked are required to be made to this Fund under a Collective Bargaining Agreement, Participation Agreement, or other written agreement.

Section 2.24 Covered Individual

"Covered Individual" means a Participant, surviving spouse, and each Dependent eligible under the Active or Retiree Plans or an individual who elects continuation of coverage under COBRA or the Low Cost Medical Plan.

Section 2.25 Covered Medical Expenses, Covered Expenses or Covered Services

"Covered Medical Expenses," "Covered Expenses" or "Covered Services" means expenses for medical, prescription drugs, vision and/or dental services or supplies that are Medically Necessary and required for treatment as a result of a Non-Occupational Illness or Injury for which benefits are payable by the Plan in accordance with Plan provisions and as described in the Covered Individual's applicable Schedule of Benefits.

Section 2.26 Custodial Care

"Custodial Care" means services and supplies for care:

(A) Provided mainly to help the patient with activities of daily living (ADL), including, but not limited to, walking, getting in or out of bed, exercising or moving the person, bathing, using the toilet, administering enemas, dressing and assisting with hygiene needs, assistance with eating, tube feeding, or gastronomy feeding, cleaning, preparation of meals, acting as companion or sitter, administering or supervising the administration of medication, or as part of a Maintenance Care Treatment Plan not reasonably expected to improve the patient's condition, Illness, Injury or functional ability, rather than to provide medical treatment;

(B) That can safely and adequately be provided by persons who do not have the technical skills of a health care provider; and

(C) That meets one of the conditions above is “Custodial Care” regardless of:

(1) Who recommends, provides or directs the care;

(2) Where the care is provided; or

(3) Whether or not the patient or another caregiver can be or is being trained to care for himself.

Section 2.27 Deductible

“Deductible” means the amount of Covered Medical Expenses a Covered Individual pays each Calendar Year before benefits are payable by the Plan.

Section 2.28 Deferred Lather

“Deferred Lather” means a Participant who is vested in Local No. 74, Wood, Wire, and Metal Lathers' International Union of Chicago and Vicinity Pension Plan ("Lather Plan") and:

(A) Was not actively working as a Lather at the time of the merger in 1983; if a Participant stopped earning credit with the Lather Plan in 1979 or earlier, the Participant is considered “inactive” at the time of the merger; and

(B) The Participant did not earn credit under the Chicago Regional Council of Carpenters Pension Plan, or the Participant earned less than ten (10) years of vesting service under the Chicago Regional Council of Carpenters Pension Plan.

Section 2.29 Dentist

For a definition of Dentist, see the definition of Physician in Plan Section 2.73.

Section 2.30 Dependent

“Dependent” means any of the following individuals:

(A) The Participant’s lawful spouse, as recognized under applicable state law and in a manner consistent with governing Federal law and for whom all required documentation is submitted, if not legally separated or divorced from the Participant;

(B) The Participant’s biological child through the end of the calendar month in which the child attains age twenty-six (26);

(C) The Participant’s adopted child or child placed for adoption in the Participant’s home for legal adoption (before attaining the age of twenty-six (26)) through the end of the calendar month in which the child attains age twenty-six (26); or

(D) The Participant’s biological or adopted child with a physical or mental disability who is unmarried and age twenty-six (26) or older if:

(1) The child was covered by the Plan upon reaching age twenty-six (26);

(2) The disability is considered permanent and began prior to the child attaining age twenty-six (26), while the child was covered as a Dependent under this Plan, and proof of such is provided to the Fund Office;

(3) The child is chiefly dependent on the Participant for more than fifty percent (50%) of the child's financial support and maintenance during the Calendar Year and proof of such is provided to the Fund Office;

(4) The disability is a severe physical or mental impairment that causes the child to be incapable of self-support; and

(5) The child qualifies as the Participant's "qualifying child" or "qualifying relative" within the meaning of Internal Revenue Code Section 152(c) or (d).

(E) The Participant's unmarried stepchild (a) through the end of the calendar month in which the child attains age twenty-six (26), who is in a regular parent-child relationship with the Participant and who resides with the Participant for more than one-half (1/2) of the Calendar Year and who is chiefly dependent on the Participant for more than fifty percent (50%) of his financial support and maintenance during the Calendar Year and proof of such is provided to the Fund Office. A stepchild must be a child of the Participant's current spouse who was born to the spouse or legally adopted by the spouse before the marriage to the Participant. Solely for purposes of the Plan's disability extension as described in Plan Section 2.30(D), the requirement that the stepchild reside with the Participant for more than one-half the Calendar Year shall not apply. Primary coverage for a stepchild is provided only in the event that no other person is obligated to provide health coverage; and no other coverage is available through the biological parents; (b) is physically or mentally disabled and age twenty-six (26) or older, if:

(1) The stepchild was covered by the Plan upon reaching age twenty-six (26);

(2) The disability is considered permanent and began prior to the stepchild attaining age twenty-six (26), while the stepchild was covered as a Dependent under this Plan, and proof of such is provided to the Fund Office;

(3) The disability is a severe physical or mental impairment that causes the child to be incapable of self-support; and

(4) The stepchild qualifies as a "qualifying child" or "qualifying relative" of the Participant within the meaning of Internal Revenue Code Section 152(c) or (d);

(F) A Participant's eligible child named as a dependent under a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice.

(G) A minor Dependent child is a child from birth through age eighteen (18). An adult Dependent child is a child age nineteen (19) to age twenty-six (26).

Section 2.31 Developmental Disability

"Developmental Disability" means a severe, chronic impairment which originated at birth or during childhood, is expected to continue indefinitely, and substantially restricts the individual's functioning in several major life activities. More specifically, a Developmental Disability is a severe, chronic impairment which satisfies each of the following requirements:

(A) Is attributable to a mental or physical impairment or a combination of mental and physical impairments;

(B) Is manifested while a Dependent;

(C) Results in substantial functional limitations in three (3) or more of the following areas of major life activity:

(1) Self-care;

(2) Receptive and expressive language;

(3) Learning;

(4) Mobility;

(5) Self-direction;

(6) Capacity for independent living; and

(7) Economic self-sufficiency.

(D) Results in the person's need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services which are of lifelong or extended duration and are individually planned and coordinated.

Section 2.32 Disability or Disabled

“Disability” means a physical or mental condition that result in an Employee being unable to perform the duties of his occupation. The Employee must be under the active care of a licensed Physician during the entire period of the Disability and cannot be engaged in any other occupation for wage or profit.

Section 2.33 Doctor

For a definition of Doctor, see the definition of Physician in Plan Section 2.73.

Section 2.34 Durable Medical Equipment (DME) and Supplies

“Durable Medical Equipment (DME) and Supplies" means a device or instrument of a durable nature approved by the Food and Drug Administration (FDA) that:

(A) Can withstand repeated use;

(B) Is primarily and customarily used to serve a medical purpose, rather than a comfort or convenience purpose and is not generally useful in the absence of an Illness or Injury;

(C) Is not disposable or non-durable;

(D) Is appropriate for home use, ordered or prescribed by a Physician and is exclusively needed by the recipient for whom it was approved;

(E) Generally includes, but is not limited to, wheelchairs, walkers, Hospital beds, respiratory supplies including nebulizers, breast pumps, and supplies required for sleep apnea;

(F) Repair, maintenance and replacement of equipment is limited and is based on medical necessity; and

(G) Does not include home modifications to accommodate equipment.

Section 2.35 Durable Medical Equipment Provider

"Durable Medical Equipment Provider" means a supplier of DME that is licensed by a state and accredited as a supplier of DME.

Section 2.36 Emergency or Emergencies

"Emergency" means a severe condition that:

(A) Results from symptoms that occur suddenly and unexpectedly and are Non-Occupational;

(B) Poses an imminent serious threat to a Covered Individual's health; or

(C) Requires immediate Physician's care to prevent death or serious impairment of health.

Section 2.37 Emergency Room

"Emergency Room" means the section of a legally licensed Hospital facility staffed and equipped to provide immediate treatment for victims of sudden Illness, Injury or trauma.

Section 2.38 Employee

"Employee" means any individual employed by an Employer:

(A) In a bargaining unit represented by the Union for whom the Employer is obligated to contribute to the Welfare Fund pursuant to a Collective Bargaining Agreement; or

(B) For whom the Employer is obligated to contribute to the Welfare Fund pursuant to a written Participation Agreement or other written agreement.

(C) Sole proprietors, partners and other unincorporated owner/operators do not qualify as "Employees."

Section 2.39 Employer or Contributing Employer

"Employer" or "Contributing Employer" has the meaning assigned to it in the Trust Agreement.

Section 2.40 ERISA

"ERISA" means the Employee Retirement Income Security Act of 1974, as amended from time to time. Reference to any section or subsection of ERISA includes reference to any comparable or successor provisions of any legislation that amends, supplements, or replaces such section or subsection.

Section 2.41 Experimental or Investigational

"Experimental" or "Investigational" means the use of any treatment modality, service, procedure, facility, equipment, drug, device, surgery, or supply if it meets one or more of the following criteria:

(A) It has failed to obtain final approval for use of a specific service, procedure, drug, device, surgery or treatment modality for a specific diagnosis from the appropriate governmental regulatory body;

(B) Reliable evidence does not establish a consensus conclusion among experts recognizing the safety and effectiveness of the specific service, procedure, drug, device, surgery, or treatment modality on health outcomes for a specific diagnosis;

(C) If the drug, device, medical treatment or procedure, or the patient informed consent document utilized with the drug, device, surgery, treatment or procedure, was reviewed and approved by the treating facility's institutional review board or other body serving a similar function, which makes it Experimental/Investigational, or if Federal law requires such review or approval;

(D) Except as provided in accordance with Affordable Care Act requirements for Approved Clinical Trials as set forth in Plan Section 5.04(H), if reliable evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerant dose, its toxicity, its safety, or its efficacy as compared with a standard means of treatment or diagnosis; or

(E) Except as provided in accordance with Affordable Care Act requirements for Approved Clinical Trials as set forth in Plan Section 5.04(H), if reliable evidence shows that the drugs, device, medical treatments or procedure is the subject of on-going phase I or phase II clinical trials, is the research, experimental study or investigational arm of on-going phase III experimental or research clinical trials, or is otherwise under study by corresponding trials sponsored by the FDA, the National Cancer Institute, the National Institute of Health or similar body to determine its maximum tolerated dose, its toxicity, its safety, or its efficacy as compared with a standard means of treatment or diagnosis.

Notwithstanding the foregoing, to the extent required under the Affordable Care Act, the Plan will not deny the Covered Individual the right to participate in certain approved clinical trials; deny, limit, or impose additional conditions on the coverage of routine patient costs furnished in connection with participation in the clinical trials; and will not discriminate against the Covered Individual for participating in the clinical trial.

Reliable evidence shall mean only published reports and articles in the authoritative medical and scientific literature, the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure.

The Trustees or a delegated third party Claims Fiduciary shall have authority to determine, in their discretion, whether a service, procedure, facility, equipment, drug, device, surgery, supply, or treatment modality is Experimental/Investigational. The fact that a Physician has prescribed, ordered, recommended, or approved the service, procedure, facility, equipment, drug, device, surgery or treatment modality does not, in itself, make it eligible for payment.

Section 2.42 Extended Care/Skilled Nursing Facility

"Extended Care/Skilled Nursing Facility" means a nursing facility that:

(A) Is an institution, or a distinct part of an institution that has in effect a transfer agreement with one or more Hospitals;

(B) Is primarily engaged in providing inpatient skilled nursing care and related services for Covered Individuals who require medical or nursing care;

(C) Is duly licensed by the appropriate governmental authorities;

(D) Has one or more Physicians and one or more registered professional nurses responsible for the care of inpatients;

(E) Requires that every patient must be under the supervision of a Physician;

(F) Maintains clinical records on all patients;

(G) Provides twenty-four (24) hours a day nursing services;

(H) Provides appropriate methods and procedures for the dispensing and administering of drugs and biologicals;

(I) Has in effect a Utilization Review management plan;

(J) Is eligible to participate under Medicare;

(K) Is not an institution that is primarily for the care and treatment of Behavioral Health/ Substance Use Disorders or tuberculosis; and

(L) Rehabilitation services are for the rehabilitation of a Covered Individual with an Injury, Illness, or Disability.

Section 2.43 FMLA

"FMLA" means the Family Medical Leave Act of 1993 as amended from time to time.

Section 2.44 Fund, Trust Fund, or Welfare Fund

"Fund," "Trust Fund," or "Welfare Fund" means the Chicago Regional Council of Carpenters Welfare Fund.

Section 2.45 HIPAA

"HIPAA" means the Health Insurance Portability and Accountability Act of 1996 as amended from time to time.

Section 2.46 Home Health Agency

"Home Health Agency" means a program of care provided by a public agency or private organization or a subdivision of such agency or organization that:

(A) Is primarily engaged in providing skilled nursing services and other therapeutic services in the homes or places of residence of its patients;

(B) Has established policies for governing the services it provides, such policies being established by a group of professional personnel associated with the agency or organization, including one or more Physicians and one or more registered professional nurses;

(C) Provides for the supervision of its services by a Physician or registered professional nurse acting under a Physician's direction;

(D) Maintains clinical records of all patients;

(E) Is licensed according to the applicable law of the state in which it is located or provides services;

(F) Is certified or approved by Medicare and is eligible to participate under Medicare; and

(G) Is not primarily for the care of Behavioral Health and/or Substance Use Disorders.

Section 2.47 Hospice or Hospice Facility

"Hospice" or "Hospice Facility" means an agency or organization that administers a program of palliative and supportive health care services (also known as "core services") providing physical, psychological, nursing, dietary, social, and spiritual care for terminally ill persons assessed to have a life expectancy of six (6) months or less. The agency must:

(A) Be approved by Medicare as a Hospice program; and

(B) Be licensed or certified as a Hospice by the regulatory authority having responsibility for the licensing or certification under the laws of the jurisdiction in which it is located; or, if licensing is not required, the agency must:

(1) Provide service twenty-four (24) hours a day, seven (7) days per week;

(2) Be under the direct supervision of a duly qualified Physician;

(3) Have a full time administrator;

(4) Have a nurse coordinator who is a registered nurse with four (4) years of full-time clinical experience (two (2) of these years must involve caring for terminally ill patients);

(5) Have a main purpose of providing Hospice services;

(6) Maintain written records of services provided to the patient;

(7) Maintain malpractice insurance coverage; and

(8) Have established policies governing the provision of Hospice care, assess the patient's medical and social needs, develop a Hospice care program, and provide or otherwise arrange for services to meet those needs.

Section 2.48 Hospital

"Hospital" means an institution engaged primarily in providing medical care and treatment to individuals who have an Illness or Injury on an inpatient basis at the patient's expense, and that fully meets one of the following requirements:

(A) It is a Hospital accredited by the Joint Commission;

(B) It is a Hospital, as defined by Medicare, that is qualified to participate in and eligible to receive payments under and in accordance with the provisions of Medicare; or

(C) It is an institution that:

(1) In return for payment from its patients, provides on an inpatient or outpatient basis, diagnostic and therapeutic facilities for the medical and surgical diagnosis, treatment and care of injured and ill individuals under the supervision of a staff of Physicians licensed to practice medicine;

(2) Provides on the premises twenty-four (24) hours a day nursing services by or under the supervision of a graduate registered nurse; and

(3) Operates continuously with organized facilities for operative surgery on the premises and is not a place for rest, for the aged, a Residential Treatment Facility, a nursing or convalescent center, or rehabilitation center.

Section 2.49 Illness

"Illness" means a sickness, disorder, or disease that is Non-Occupational. Pregnancy is included in the definition of "Illness" under this Plan.

Section 2.50 Infusion Therapy

"Infusion Therapy" means the administration of medications, nutrients or other solutions into the blood stream/digestive system, or the membranes surrounding the spinal cord, or under the skin, which are prescribed by a Physician and obtained at a licensed, accredited pharmacy for conditions that include, but are not limited to, infections, cancer, blood disorders, and other comparable health problems.

Section 2.51 Injury or Accident

"Injury" or "Accident" means any damage to a body part resulting from a Non-Occupational trauma from an external source.

Section 2.52 Insurance Company

"Insurance Company" means the Contracted Providers providing the Retiree Plan of Benefits Dental Care Benefit described in Article VII, Vision Benefits as described in Article VI, Life

Insurance as described in Article XI and Accidental Death and Dismemberment Benefits as described in Article XII.

Section 2.53 International Reciprocal Agreement

"International Reciprocal Agreement" means The United Brotherhood of Carpenters International Reciprocal Agreement.

Section 2.54 Long Term Medication

"Long Term Medication" means a medication that must be taken on a regular basis to treat a chronic health condition.

Section 2.55 Low Cost Medical Plan

"Low Cost Medical Plan" means the benefits described in this Plan and in the Schedule of Benefits as described in Appendix C for Employees and their Dependents who maintain eligibility under this Plan. The "Low Cost Medical Plan" is the portion of the Plan that covers Employees who elect to continue health coverage, in lieu of continued coverage under COBRA, when Active Plan eligibility terminates.

Section 2.56 Maintenance Care

"Maintenance Care" means services and supplies provided primarily to maintain, support, or preserve a level of physical or mental function rather than to improve such function.

Section 2.57 Medicaid

"Medicaid" means a health insurance program under Title XIX of the Social Security Act for certain people and families with low incomes and resources as provided under Title 42, Chapter IV of the Code of Federal Regulations.

Section 2.58 Medically Necessary or Medical Necessity

(A) "Medically Necessary" means only those services, treatments, or supplies provided by a Hospital, a Physician, or other qualified provider of medical services and supplies that are required in the judgment of the Trustees, based on the opinion of a qualified medical professional, to identify or treat the Illness or Injury of a Covered Individual. A medical service, treatment, or supply shall not be considered to be "Medically Necessary" solely because a Physician or Doctor orders or recommends it. "Medical Necessity" refers to a service, treatment, or supply that is "Medically Necessary."

(B) To be considered "Medically Necessary," the service, treatment, or supply must:

(1) Be consistent with the symptoms or diagnosis and treatment of the Covered Individual's condition, Illness, Injury, disease, or ailment;

(2) Be appropriate according to industry standards of good and generally accepted medical practice;

(3) Not be solely for the convenience of a Covered Individual, a Physician, or a Hospital;

(4) Be the most appropriate treatment, services, or supplies that can safely be provided to a Covered Individual; and

(5) Not be considered Experimental or Investigational.

(C) A medical service or supply will be considered "appropriate" if, both with respect to the Illness or Injury involved and the Covered Individual's overall health condition:

(1) It is a diagnostic procedure that is called for by the health status of the Covered Individual and is as likely to result in information that could affect the course of treatment as, and no more likely to produce a negative outcome than any alternate service or supply, both with respect to the Illness or Injury involved and the Covered Individual's overall health condition; and

(2) It is care or treatment that is as likely to produce a significant positive outcome as, and no more likely to produce a negative outcome than, any alternate service or supply, both with respect to the Illness or Injury involved and the Covered Individual's overall health condition.

Section 2.59 Medicare

"Medicare" means the Federal health insurance program for individuals sixty-five (65) years or older, younger than sixty-five (65) with disabilities or with end stage renal disease, designated as the Health Insurance for the Aged Program under Title XVIII of the Social Security Act, as such Act was amended by the Social Security Amendments of 1965 (Public Law 89-97), and as such program is currently constituted, and as it may be amended from time to time.

Section 2.60 Member in Good Standing

The Fund will deem a Participant or Retiree to be a "Member in Good Standing" for periods in which the Union advises that the Participant or Retiree is in good standing under Section 45 of the Constitution of the United Brotherhood of Carpenters and Joiners of America.

Section 2.61 Negotiated Rate

"Negotiated Rate" means an amount for services rendered that does not exceed the amount agreed upon under the contract between the Welfare Fund's Contracted Provider and the service provider who participates in the Contracted Provider's Network.

Section 2.62 Network

"Network" means a group of independent Doctors, Hospitals, pharmacies or other health care providers who have agreed to contract with a single organization with which the Plan contracts for services.

Section 2.63 Non-Occupational or Non-Occupational Illness or Injury

“Non-Occupational" or "Non-Occupational Illness or Injury” means:

(A) Any Injury that does not arise out of or in the course of the Covered Individual’s employment, or

(B) Any Illness that is not caused or aggravated by employment, for which benefits are not payable in whole or in part under any Workers’ Compensation Law, Employer’s Liability Law, Occupational Diseases Law, or similar law.

Section 2.64 Non-Preferred Provider, Non-PPO or Out-of-Network

“Non-Preferred Provider,” “Non-PPO” or “Out-of-Network” means Doctors, Hospitals, or other health care providers who do not participate in the Networks of the Fund’s Contracted Providers.

Section 2.65 Occupational Illness or Injury or Work-Related Illness or Injury

“Occupational Illness or Injury” or "Work-Related Illness or Injury" means:

(A) Any Injury arising out of or in the course of the Covered Individual’s employment; or

(B) Any Illness caused or aggravated by employment, for which benefits are, or may be, payable in whole or in part under any Workers’ Compensation Law, Employer’s Liability Law, Occupational Diseases Law, or similar law.

Section 2.66 Office Visit

“Office Visit” means a direct personal contact between a Physician or other licensed health care practitioner and a Covered Individual as a patient of the Physician or health care practitioner for diagnosis or treatment associated with the use of the appropriate Office Visit Codes or Telehealth Codes in the Current Procedural Terminology (CPT) manual of the American Medical Association or the Current Dental Terminology (CDT) manual of the American Dental Association and with documentation that meets the requirements of such CPT or CDT coding. A visit to a health care practitioner’s office solely for such services as blood drawing, leaving a specimen, receiving a routine injection, or completing medical forms is not considered to be an “Office Visit” for the purpose of this Plan.

Section 2.67 Out-of-Pocket Maximum

“Out-of-Pocket Maximum” means the maximum amount that a Covered Individual is required to pay for Covered Expenses within a specified period of time. After a Covered Individual satisfies the Plan's applicable Out-of-Pocket Maximum, the Plan will pay one hundred percent (100%) of any additional Covered Expenses a Covered Individual incurs for the remainder of the Calendar Year.

Section 2.68 Outside Plan

"Outside Plan" means a plan, other than this Plan, providing health coverage to a Participant or a Dependent of a Participant. Original Medicare (Part A or Part B) is not considered an Outside Plan, but a Medicare Advantage plus Prescription Drug Plan (Parts C and D) is considered an Outside Plan; a Medicare Advantage plan (Part C) is considered an Outside Plan in order to enroll in Comprehensive Medicare Supplement Benefits; and a Medicare Prescription Drug Coverage plan (Part D) is considered an Outside Plan in order to enroll in Prescription Benefits.

Section 2.69 Participant

"Participant" means an Employee employed or previously employed in Covered Employment who meets the eligibility requirements under Articles III and IV or an individual who elects continuation of Plan coverage.

Section 2.70 Participation Agreement

"Participation Agreement" means a written agreement between an Employer (as defined in the Trust Agreement) and the Trustees, in which the Employer agrees to become an Employer hereunder obligating the Employer to make Contributions to the Fund on behalf of the Employer's covered Employees whether or not subject to the terms of a Collective Bargaining Agreement. The Trustees may also enter Participation Agreements with Employers covering independent contractors retained by the Employer.

Section 2.71 Pension Funds

"Pension Funds" means collectively the Chicago Regional Council of Carpenters Pension Fund, the Chicago Regional Council of Carpenters Millmen Pension Fund, the Carpenters Pension Fund of Illinois, and the Will County Local 174 Carpenters Pension Fund.

Section 2.72 Pension Plans

"Pension Plans" means collectively the Chicago Regional Council of Carpenters Pension Plan, the Chicago Regional Council of Carpenters Millmen Pension Plan, the Carpenters Pension Fund of Illinois Plan, and the Will County Local 174 Carpenters Pension Plan.

Section 2.73 Physician or Doctor

"Physician" or "Doctor" means an individual licensed in the state where such individual renders treatment and/or is acting within the scope of his license at the time and place the services are performed; including, but not limited to a: Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Dental Science/Surgery (DDS), Doctor of Medical Dentistry (DMD), Doctor of Optometry (OD), Doctor of Ophthalmology (MD-Ophthalmology), Doctor of Chiropractic Medicine (DC), and a Doctor of Psychology (PsyD). Additionally, to the extent required by the Affordable Care Act and available guidance, if an individual's service is covered under the Plan, the Plan will not discriminate based on the practitioner's license or certification, if the practitioner is licensed to provide such services in the state in which the services are performed and the practitioner is acting within the scope of that license.

Section 2.74 Plan, Benefit Plan, Plan of Benefits or Health and Welfare Plan

"Plan," "Benefit Plan," "Plan of Benefits" or "Health and Welfare Plan" means this Chicago Regional Council of Carpenters Welfare Plan, or the plan or program of benefits provided by the Plan set forth in this document, including any other written document designated by the Trustees as constituting a part of the Plan, established, and as it may be amended from time to time by the Board of Trustees pursuant to the provisions of the Trust Agreement.

Section 2.75 Plan Year

"Plan Year" means the twelve (12) month period beginning on July 1 of any year and ending the following June 30.

Section 2.76 Preferred Provider Organization (PPO)

"Preferred Provider Organization" means a group of independent Doctors, Hospitals or other health care providers who have agreed to contract with a single organization or Network with which the Plan contracts for services also referred to as a Contracted Provider Network.

Section 2.77 Premium Payment

"Premium Payment" means the amount a Covered Individual pays for selected coverage under the Retiree Plan, Continuation Coverage under COBRA, or the Low Cost Medical Plan or for Self-Payment of Hours. Premium Payments are subject to change from time to time.

Section 2.78 Qualified Medical Child Support Orders or National Medical Support Notice

"Qualified Medical Child Support Order" (QMCSO) or "National Medical Support Notice" as defined under ERISA means a court order requiring a medical plan to provide medical benefits to the children of the parties pursuant to a marriage dissolution, divorce, child custody action, paternity suit, family non-support action, or other state domestic relations actions, where financial support of children is involved. The Fund will treat eligible children who are the subject of a QMCSO or National Medical Support Notice (NMSN) as Dependents under the Plan pursuant to the Fund's procedures governing QMCSOs and NMSNs.

Section 2.79 Reasonable and Customary Allowance, Reasonable and Customary Allowable Charge or Reasonable and Customary Charge

"Reasonable and Customary Allowance," "Reasonable and Customary Allowable Charge" or "Reasonable and Customary Charge" means the allowance or percentage for Medically Necessary services or supplies as determined by the Trustees (or their designee such as a third party Claims Fiduciary) in their sole discretion as set forth in the Schedules of Benefits in Appendices A, B and C, as amended from time to time. In no case will the Reasonable and Customary Allowance exceed charges actually incurred.

Section 2.80 Relevant

Information is "Relevant" if it:

(A) Was relied upon by the Claims Fiduciary in making the decision;

(B) Was submitted, considered, or generated regardless of whether it was relied upon; or

(C) Demonstrates compliance with Claim processing requirements.

Relevant information for purposes of Health and Short Term Disability Claims includes but is not limited to:

(A) New or additional information considered, relied upon or generated during the appeal as well as any new or additional rationale for the denial, if any;

(B) Relevant internal rules, guidelines, protocol or other similar criteria;

(C) Explanation of the scientific or clinical judgment that formed the basis of the adverse benefit determination if the Covered Individual's Claim is denied based on Medical Necessity, Experimental treatment or similar exclusion or limit; and

(D) The identity of any medical expert who provided a determination for a Claim.

Section 2.81 Rescission

A "Rescission" is a cancellation or discontinuance of Plan coverage for health or short term disability benefits that has a retroactive effect. A cancellation or discontinuance of coverage is not a Rescission if:

(A) The cancellation or discontinuance has only a prospective effect.

(B) The cancellation or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or Contributions toward the cost of coverage.

(C) The retroactive elimination of health coverage back to the date of termination of employment is due to a delay in administrative recordkeeping if the Employee does not pay any premiums for coverage after termination of employment.

(D) The cancellation or discontinuance of health coverage is effective retroactive to the date of divorce.

Section 2.82 Residential Treatment Facility

A "Residential Treatment Facility" meets the following requirements:

(A) It is established and operated in accordance with any applicable state law;

(B) It is accredited either by the Joint Commission or the Commission on Accreditation of Rehabilitation Facilities (CARF);

(C) It provides a program of treatment approved by a Physician and the Treatment Plan Administrator;

(D) It has or maintains a written, specific, and detailed regimen requiring full-time residence and full-time participation by the patient;

(E) It provides at least the following basic services:

(1) Room and Board (if the medical plan provides for in-patient benefits at a treatment center);

(2) Conducts evaluation, diagnosis, and treatment plans;

(3) Offers individual, group and/or family counseling; and

(4) Provides referral and orientation to specialized community resources;

(F) Is a treatment center that is not qualified as a Hospital; and

(G) The treatment provided meets the generally accepted behavioral health standards of care for the condition or impairment for which the individual is being treated, and no alternative or lower level of care is available for the individual to be safely treated.

Section 2.83 Retiree

“Retiree” means an individual who worked for an Employer that paid Contributions to the Fund for the work performed in accordance with a written agreement requiring such Contributions, and is receiving a pension benefit from a Pension Fund. The term "Retiree" may also include retired Participants of other plans that merge into the Fund provided the Trustees have agreed to permit such individuals to qualify as "Retirees."

Section 2.84 Retiree Coverage

“Retiree Coverage” means the coverage available to Retirees under the Retiree Plan.

Section 2.85 Retiree Plan or Retiree Plan of Benefits

“Retiree Plan” or “Retiree Plan of Benefits” means the benefits described in this Plan and in the Schedule of Benefits as described in Appendix B for Covered Individuals who maintain eligibility under this Plan.

Section 2.86 Room and Board Charges

“Room and Board Charges” means charges made by a Hospital, an Extended Care/Skilled Nursing Facility, or a Hospice Facility, on its own behalf for room and board at a semi private room rate, general duty nursing, and any other charges that are regularly made by the Hospital or facility as a condition of occupancy of the class of accommodations occupied, but not including charges for professional services of a Physician or private duty nurse. Such charges are based on a confinement or stay of twenty-four (24) hours or any shorter period for which the Hospital or facility regularly charges a full day’s room and board rate.

Section 2.87 Schedule of Benefits

“Schedule of Benefits” means the descriptive summary that highlights key features of the Plan of Benefits as determined by the Board of Trustees and amended from time to time as set forth in Appendix A for the Active Plan, Appendix B for the for the Retiree Plan and Appendix C for the Low Cost Medical Plan. The descriptive summary provides information regarding Plan Deductibles, Coinsurance, and Co-payments.

Section 2.88 Select Specialty Medication

"Select Specialty Medication" means a medication which is designated as a non-essential health benefit under the Affordable Care Act by the Plan's Contracted Provider. Select Specialty Medications are subject to the Specialty Pharmacy Copay Assistance Program.

Section 2.89 Self-Payment of Hours

"Self-Payment of Hours" means payment by an Employee to continue coverage under the Active Plan of Benefits when the Plan does not receive the required Contributions to maintain the Employee's coverage pursuant to Plan Section 3.11.

Section 2.90 Surgi-Center or Ambulatory Surgical Center

“Surgi-Center” also referred to as an “Ambulatory Surgical Center,” means a facility that operates exclusively for the purpose of providing surgical services to patients not requiring hospitalization. The term does not include:

(A) A facility that is licensed as part of a Hospital;

(B) A facility that provides services and/or accommodations for patients who stay overnight; or

(C) A facility that is used as an office or clinic for the private practice of a Physician except when:

(1) It holds itself out to the public or other health care providers as a free standing surgical center or similar facility; or

(2) It is operated or used by a person or entity different from the Physician(s) that owns it; or

(3) Patients are charged a fee for the use of the facility in addition to the Physicians’ professional services.

Section 2.91 Treatment Plan

“Treatment Plan” means a written report, showing the prescribed course of medical treatment of any Illness or Injury, prepared by a Covered Individual’s attending Physician as a result of an examination made by a Physician.

Section 2.92 Trust Agreement

"Trust Agreement" means the Chicago Regional Council of Carpenters Welfare Trust Agreement as amended from time to time, establishing the Trust Fund and its rules of operation.

Section 2.93 Trustee, Trustees, or Board of Trustees

"Trustee," "Trustees," or "Board of Trustees" means a Trustee or the Trustees of the Chicago Regional Council of Carpenters Welfare Fund.

Section 2.94 Uniformed Services or Military Service

"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 or Military Service covers 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 in time of war or emergency.

Section 2.95 Union or Council

"Union" or "Council" means the Chicago Regional Council of Carpenters, United Brotherhood of Carpenters and Joiners of America and affiliated local Unions as identified in the Trust Agreement.

Section 2.96 Urgent/Immediate Care Facilities and Retail Clinics

"Urgent/Immediate Care Facilities" means a licensed facility outside of a Hospital Emergency Room, primarily engaged in providing minor Emergency and episodic medical care to its patients. A Physician, RN and a registered x-ray technician must be in attendance at all times when the facility is open. The Urgent/Immediate Care Facility must include x-ray and laboratory equipment and a life support system. A "Retail Clinic" means a licensed facility primarily engaged in treatment of uncomplicated minor illnesses and may provide preventive health care services. A nurse practitioner or physician's assistant must be in attendance at all times when the Retail Clinic is open.

Section 2.97 USERRA

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

Section 2.98 Utilization Review

"Utilization Review" means a process to determine whether certain health care services are Medically Necessary, appropriate, provided at a reasonable location, and/or cost-effective.

Section 2.99 Work-Related

See the definition of Occupational Illness or Injury or Work-Related Illness or Injury" in Plan Section 2.65.

ARTICLE III ELIGIBILITY

Section 3.01 Initial Eligibility for Employees

(A) An Employee will initially become a Participant in the Active Plan on the first day of the Coverage Quarter following one, but not more than two (2) consecutive Calendar Quarters during which a total of at least five hundred (500) hours of Contributions have been paid to the Fund on behalf of the Employee by one or more Employers.

(B) The Trustees may either enter into Participation Agreements or accept Collective Bargaining Agreements with Employers that permit the Employer to contribute advance payments to the Fund that accelerate participation of the Employees who had worked in a non-contributing or contributory category of employment.

(C) An Employee may not satisfy the initial eligibility requirements of this Plan Section 3.01 by Self-Payment of Hours.

Section 3.02 Initial Eligibility for Apprentices

(A) If an individual is an apprentice currently enrolled in the Apprentice Program, the apprentice will initially become a Participant on the first day of the Coverage Quarter following one, but not more than two (2) consecutive Calendar Quarters during which a total of at least four hundred (400) hours of Contributions ("400 Hours Rule") have been paid to the Fund on behalf of the apprentice by one or more Employers.

(B) Apprentices qualifying under the 400 Hours Rule will be eligible under the Active Plan for all benefits except the prescription drug and dental benefits.

(C) If an individual is an apprentice, as described above, and a total of at least five hundred (500) hours of Contributions have been paid to the Fund on behalf of the apprentice by one or more Employers during one, but not more than two (2) consecutive Calendar Quarters, the apprentice will initially become a Participant for full Active Plan benefits, including prescription drugs and dental benefits, on the first day of the next Coverage Quarter.

(D) An apprentice may not satisfy the initial eligibility requirements of this Plan Section 3.02 by Self-Payment of Hours.

Section 3.03 Eligibility for Retirees and Certain Eligible Dependents

(A) An Employee or former Employee will be eligible for the Retiree Plan of Benefits if the Employee or former Employee:

(1) Is receiving pension benefits from the Chicago Regional Council of Carpenters Pension Fund or the Chicago Regional Council of Carpenters Millmen Pension Fund based on at least ten (10) years of vesting credit as defined by the applicable Pension Fund. If at some time the Participant did not earn vesting credit for a period of three (3) or more consecutive Calendar Years, the pension must be based on at least fifteen (15) years of vesting credit under the applicable

Pension Fund. Pension Credit granted under the Chicago Regional Council of Carpenters Millmen Pension Fund for the period of time prior to June 1, 1975 will also be counted as vesting credit for determining eligibility for Retiree Coverage;

(2) Commenced receiving pension benefits from the Carpenters Pension Fund of Illinois as a member of Local Union Nos. 363, 916 or 2087 on or after March 1, 2003 based on at least ten (10) years of vesting credit earned under that Pension Fund. If at some time the Participant did not earn vesting credit for a period of three (3) or more consecutive Calendar Years, the pension must be based on at least fifteen (15) years of vesting credit under that Pension Fund;

(3) Was receiving self-pay Retiree medical insurance benefits from the Carpenters Welfare Fund of Illinois at the time of the merger on March 1, 2003 and continued making self-payments for Retiree Coverage under this Plan;

(4) Was receiving self-pay Retiree medical benefits from the Will County Local 174 Carpenters Welfare Fund at the time of the merger on January 1, 2019 and continued making self-payments for Retiree Coverage under this Plan;

(5) Commenced receiving pension benefits from the Will County Local 174 Carpenters Pension Fund on or after January 1, 2019 with a pension based on at least ten (10) years of service credit. If at some time the Participant did not earn service credit for a period of three (3) or more consecutive Calendar Years, the pension must be based on at least fifteen (15) years of service credit. For purposes of this Plan Section 3.03(A)(5) and Plan Section 3.07, service credit is determined as follows:

(a) The total years of past service credit earned prior to June 1, 1961 by Employees under the Will County Local 174 Carpenters Pension Plan, will be counted as service credit.

(b) Hours of service earned on or after June 1, 1961 by Employees under the Will County Local 174 Carpenters Pension Fund within a Plan Year, as defined by the Will County Local 174 Carpenters Pension Plan, will be counted as service credit in the following manner:

Hours of Service under the Will County Local 174 Carpenters Pension Fund within a Plan Year	Fractional Years of Service Credit
Less than 250	Zero
250 but less than 500	.25 year
500 but less than 750	.50 year
750 but less than 1,000	.75 year
1,000 or more	1.00 year

(c) Years of service credit, as determined by the above chart, will be considered to have been earned during the Calendar Year in which the Plan Year of the Will County Local 174 Carpenters Pension Fund ended.

(6) Meets all of the following requirements:

(a) Reached age sixty-five (65), retired, and filed an application for the Retiree Plan benefits prior to January 1, 2000;

(b) Was actively employed under a Collective Bargaining Agreement and was an active member of a local union within the jurisdiction of the Council for a total of thirty (30) years; and

(c) Was eligible for benefits under the Active Plan:

(i) During at least as many Calendar Quarters as the total number of fiscal years which elapsed between July 1, 1953 (or the day on which the Participant first became eligible, if later) and the date on which the Participant ceased to be eligible; or

(ii) For two (2) quarters during the last four (4) quarters immediately preceding the date on which the Participant ceased to be eligible.

(B) If a Participant earned vesting credit or service credit under more than one of the Pension Funds and has commenced receiving pension benefits from each of the Pension Funds in which credit was earned, the combined credit shall be considered when determining eligibility for benefits. However, not more than one year of combined credit shall be counted in any Calendar Year.

(C) For Retirees enrolled in the Retiree Plan of Benefits who die on or after December 1, 2018, a Dependent spouse who was enrolled or eligible to enroll under the Retiree Plan of Benefits immediately prior to the Retiree's death and any of the deceased Retiree's Dependents who were enrolled or eligible to enroll under the Retiree Plan of Benefits at the time of the Retiree's death, shall be eligible to continue participating in the Retiree Plan of Benefits, provided such surviving spouse (and any surviving Dependents) waive their rights to Continuation of Coverage under COBRA with respect to the Participant's death and notify the Fund Office of the Retiree's death within ninety (90) days of the date of death. Additionally, surviving spouses (and any surviving Dependents) enrolled in Continuation Coverage under COBRA as of January 1, 2019 as a result of a Qualifying Event involving the Retiree's death, shall be eligible to elect to continue participating in the Retiree Plan of Benefits, provided they waive their rights to Continuation of Coverage under COBRA with respect to that qualifying event.

A Dependent spouse of an Employee eligible for benefits in the Active Plan or the Low Cost Medical Plan at the time of his death shall be eligible to enroll in the Retiree Plan of Benefits, provided the following conditions are satisfied:

(1) The Employee dies on or after July 1, 2019 and at the time of his death was eligible for health benefits under the Active Plan, or the Low Cost Medical Plan, and was age sixty (60) or older;

(2) The Dependent spouse was married to the Employee for at least one (1) year preceding the Employee's death;

(3) The Employee would have qualified for coverage under the Retiree Plan at the time of his death;

(4) The surviving spouse is eligible for a Joint & Survivor Pension benefit under a Pension Fund; and

(5) The Fund Office is notified of the Employee's death within ninety (90) days of the date of death.

If the above conditions are satisfied, then in addition to the surviving spouse, any other Dependents enrolled in the Active Plan or the Low Cost Medical Plan, at the time of the Employee's death shall be eligible to enroll in the Retiree Plan of Benefits. In order to enroll in the Retiree Plan of Benefits, the surviving spouse (and any surviving Dependents) must waive their rights to Continuation of Coverage under COBRA with respect to the Participant's death.

(D) Plan Section 3.15, Change in Eligibility Rules, is applicable to this Article III, Eligibility for Retirees.

Section 3.04 Eligibility for Different Types of Retiree Coverage

(A) Retirees who satisfy the eligibility criteria in Plan Section 3.03(A), Paragraphs 1 thru 5, and their Dependents, or their surviving spouses (and any surviving Dependents) who satisfy the eligibility criteria in Plan Section 3.03(C), who are not Medicare eligible are eligible to enroll in the following coverage options; however, a Dependent may only enroll in the coverage options that the Retiree is enrolled in:

(1) The prescription drug benefit, as described in Article VIII and Appendix B, except Deferred Lathers are not eligible for the prescription drug benefit; and/or

(2) Comprehensive medical benefits as described in Article V and Appendix B; and/or

(3) Dental benefits as described in Article VII and Appendix B; and/or

(4) Vision benefits as described in Article VI and Appendix B.

Will County Local 174 Carpenters Welfare Fund retirees who retired on December 1, 2018 or earlier must elect and maintain both the prescription drug and comprehensive medical benefits under this Plan Section 3.04(A)(1) and (2), but have the option of separately electing dental or vision benefits.

(B) Retirees who satisfy the eligibility criteria in Plan Section 3.03(A), Paragraphs 1 thru 5, and their Dependents, or their surviving spouses (and any surviving Dependents) who satisfy the eligibility criteria in Plan Section 3.03(C), who are eligible for Medicare are eligible to enroll in the following coverage options; however, a Dependent may only enroll in the coverage options that the Retiree is enrolled in:

(1) The prescription drug benefits, as described in Article VIII and Appendix B, except Deferred Lathers and surviving spouses of Deferred Lathers are not eligible for prescription drug benefits; and/or

(2) Medicare Parts A and B Supplemental coverage as described in Article V and Appendix B; and/or

(3) Dental benefits as described in Article VII and Appendix B; and/or

(4) Vision benefits as described in Article VI and Appendix B.

Will County Local 174 Carpenters Welfare Fund retirees who retired on December 1, 2018 or earlier must elect and maintain both the prescription drug and Medicare Parts A and B

Supplemental coverage under this Plan Section 3.04(B)(1) and (2), but have the option of separately electing dental or vision benefits.

(C) Retirees who satisfy the eligibility criteria in Plan Section 3.03(A)(6) and their Dependents, or their surviving spouses (and any surviving Dependents) who satisfy the eligibility criteria in Plan Section 3.03(C), who are eligible for Medicare are eligible to enroll in the following coverage options; however, a Dependent may only enroll in the coverage options that the Retiree is enrolled in:

(1) The prescription drug benefits, as described in Article VIII and Appendix B; and/or

(2) The Medicare Part A Supplemental Hospital coverage as described in Article V, Plan Section 5.04(U) and Appendix B; and/or

(3) Dental benefits as described in Article VII and Appendix B; and/or

(4) Vision benefits as described in Article VI and Appendix B.

Section 3.05 Enrollment for Retiree Plan of Benefits

(A) Initial Enrollment in the Retiree Plan of Benefits:

(1) Upon request, the Fund Office will provide an Employee or former Employee who satisfies the Retiree Plan eligibility requirements set forth in Plan Section 3.03 with required enrollment forms at the time he applies for a pension benefit or, if later, the time he initially becomes eligible for the Retiree Plan. An Employee or former Employee must complete the required enrollment form(s) and return them to the Fund Office along with the same required supporting documentation as described in Plan Section 3.16(G) for the Active Plan of Benefits, prior to the effective date of the Retiree Plan, subject to the exceptions under Plan Section 3.06.

(2) If the Employee or former Employee originally retired from the Pension Plans under a Disability pension and recovers from the Disability and returns to work, the Employee or former Employee may enroll in the Retiree Plan of Benefits when he again becomes a Retiree provided he meets the eligibility requirements set forth in Plan Section 3.03.

(B) Enrollment in the Retiree Plan of Benefits (Surviving Spouses and Dependents): A surviving spouse (and any surviving Dependents) who satisfy the eligibility criteria in Plan Section 3.03(C) must elect coverage under the Retiree Program by returning enrollment forms within sixty (60) days of the date they are received by the surviving spouse (and any surviving Dependents), unless a special enrollment option is available under Plan Section 3.05(C). If a surviving spouse is eligible for coverage under the Active Plan, the surviving spouse must return the enrollment forms prior to the termination of the Active Plan coverage. The forms will be deemed received three (3) business days after they are mailed by the Fund Office. The surviving spouse and any surviving Dependents who elect to enroll must pay all outstanding premiums no later than sixty (60) days after electing coverage.

(C) Special Enrollment in the Retiree Plan of Benefits:

(1) Provided that the Retiree is enrolled, in order to enroll a newly acquired Dependent, the Retiree must request an enrollment form(s) from the Fund Office.

The completed enrollment form(s) must be returned to the Fund Office along with the required supporting documentation as described in Plan Section 3.16(G) for the Active Plan of Benefits within ninety (90) days of the date that the newly acquired Dependent is initially eligible for coverage. Eligibility will commence in accordance with Plan Section 3.06(E). If the required documentation is not received within the ninety (90) day period, the Participant will not be able to enroll the newly acquired Dependent unless eligible under Plan Section 3.06(A).

(2) Exception for Newborns, Adopted Children and Children Placed for Adoption: Provided that the Retiree elected coverage, in order to enroll a newborn child, adopted child or child placed for adoption, the Retiree must request the required enrollment form(s) from the Fund Office. The completed enrollment form(s) along with the required supporting documentation, as described in Plan Section 3.16(G) for the Active Plan of Benefits, shall also apply to the Retiree Plan. The enrollment form(s) and documentation must be received in the Fund Office within ninety (90) days of the birth, adoption or placement for adoption of the child. Eligibility will commence in accordance with Plan Section 3.06(E). If the required documentation is not received within this ninety (90) day period, coverage shall be suspended until such time that the required documentation is received. Upon receipt of all required documentation, coverage will be reinstated to the date of the newborn's birth or the date of adoption or placement for adoption.

(3) If a Retiree did not enroll himself and/or any Dependents when the Retiree and/or Dependent first became eligible for such coverage under the Plan due to existing coverage from an Outside Plan or Medicaid, the Retiree and his Dependents will only be allowed to enroll at a later date if the Retiree provides proof of creditable coverage from an Outside Plan. Creditable coverage dates must be continuous from the pension start date to the date of enrollment in the Retiree Plan. However, a Retiree and/or any Dependents may have one (1) or more gaps in continuous creditable coverage provided the gap(s) in coverage do not exceed one hundred and five (105) days in the aggregate and the Retiree and/or Dependent has coverage under an Outside Plan or Medicaid at the time of his application for enrollment in the Retiree Plan. A Dependent may only enroll if the Retiree is enrolled. The Retiree must request the required enrollment form(s) from the Fund Office. The completed enrollment form(s) must be returned to the Fund Office along with the same required supporting documentation as listed in Plan Section 3.16(G) for the Active Plan of Benefits no later than ninety (90) days after the termination of the Outside Plan or Medicaid coverage to enable Retiree Plan eligibility to commence coincident with the loss of the Outside Plan or Medicaid coverage. These enrollment rights and obligations shall also apply to surviving spouses (and any surviving Dependents) who satisfy the eligibility criteria of Plan Section 3.03(C).

(4) If a Retiree did not enroll himself and/or any Dependents when the Retiree and/or Dependent first became eligible for such coverage under the Plan, and the Participant and/or his Dependent becomes eligible for financial assistance through Medicaid or CHIP for coverage under the Plan, the Participant or Dependent may enroll in the Plan within ninety (90) days of becoming eligible for financial assistance through Medicaid or CHIP. Eligibility will commence in accordance with Plan Section 3.06(E). These enrollment rights and obligations shall also apply to surviving spouses (and any surviving Dependents) who satisfy the eligibility criteria of Plan Section 3.03(C).

(5) Provided that the Retiree elected coverage, on an annual basis, generally January 15 through March 15, the Retiree Plan allows for open enrollment of adult Dependent children between the ages of nineteen (19) and twenty-six (26). If all the requirements of the open enrollment process are met, coverage for the adult Dependent child begins April 1st. This open enrollment option is also available to adult dependent children of surviving spouses who satisfy the eligibility criteria of Plan Section 3.03(C).

(6) If a Retiree did not elect to enroll himself and any Dependents in dental benefits when the Retiree first became eligible for dental benefits on April 1, 2016, there will be an open enrollment period one (1) time per year thereafter. This open enrollment option is also available to surviving spouses (and any surviving Dependents) who satisfy the eligibility criteria of Plan Section 3.03(C).

(7) If a Retiree enrolls himself and any Dependents in dental benefits, has services, and then cancels dental coverage before being enrolled in dental coverage for at least one (1) full year, re-enrollment in dental benefit coverage will be prohibited for a period of two (2) years from the date of cancellation. This same prohibition applies to surviving spouses (and any surviving Dependents) who satisfy the eligibility criteria of Plan Section 3.03(C).

(8) If a Retiree did not elect to enroll himself and any Dependents in vision benefits when the Retiree first became eligible for vision benefits on April 1, 2017, there will be an open enrollment period one (1) time per year thereafter. This open enrollment option is also available to surviving spouses (and any surviving Dependents) who satisfy the eligibility criteria of Plan Section 3.03(C).

(9) If a Retiree enrolls himself and any Dependents in vision benefits, has services, and then cancels vision coverage before being enrolled in vision coverage for at least one (1) full year, re-enrollment in vision benefit coverage will be prohibited for a period of two (2) years from the date of cancellation. This same prohibition applies to surviving spouses and Dependents who satisfy the eligibility criteria of Plan Section 3.03(C).

(10) A surviving spouse (and any surviving Dependents) who satisfy the eligibility criteria in Plan Section 3.03(C) shall not be eligible to enroll new dependents.

Section 3.06 Effective Date of Retiree and Survivor Coverage

(A) A Retiree and the Retiree's Dependents will initially become eligible for Retiree Coverage on the first day of the month during which the Retiree's first pension check is processed. The Retiree is responsible for payment for any required premium for the full month during which coverage under the Retiree Plan begins. Retiree Coverage cannot be postponed past the date of initial eligibility unless one of the following exceptions applies:

(1) If, at the time of pension commencement, a Retiree and his Dependents are still eligible for coverage under the Active Plan, the Retiree and Dependents may postpone coverage under the Retiree Plan until the first day of the month after the Active Plan benefits terminate. The Retiree must make elections concerning the Retiree Coverage prior to the termination of the Active Plan coverage. However, the Retiree Coverage will not become effective, and the Retiree will not pay monthly premiums for the Retiree Coverage in which the Retiree and Dependents

elect to enroll until the first of the month after the Active Plan of Benefits terminates.

(2) If a Retiree and his Dependents are eligible for and elect Continuation Coverage under COBRA following the termination of the Active Plan of Benefits, the Retiree and his Dependents may postpone coverage under the Retiree Plan until the first day of the month after the Continuation Coverage under COBRA benefits terminate. The Retiree must make elections concerning the Retiree Coverage prior to the termination of the Continuation Coverage under COBRA. However, the Retiree Coverage will not become effective, and the Retiree will not pay monthly premiums for the Retiree Coverage in which the Retiree and Dependents elect to enroll until the first of the month after Continuation Coverage under COBRA benefits terminate. Postponement for the Retiree or the Retiree's Dependents is allowed only for the benefit(s) that are elected under the Continuation Coverage under COBRA.

(3) If, at the time of pension commencement, a Retiree and his Dependents are covered by the Low Cost Medical Plan, the Retiree and Dependents may postpone coverage under the Retiree Plan until the first day of the month after the Low Cost Medical Plan benefits terminate. The Retiree must make elections concerning the Retiree Coverage prior to the termination of the Low Cost Medical Plan coverage. However, the Retiree Coverage will not become effective, and the Retiree will not pay monthly premiums for the Retiree Coverage in which the Retiree and Dependents elect to enroll until the first of the month after the Low Cost Medical Plan benefits terminate. Postponement for the Retiree or the Retiree's Dependents is allowed only for the benefit(s) that are provided under the Low Cost Medical Plan.

(4) If the Retiree or the Retiree's Dependents are covered through an Outside Plan or by a government program through Medicaid, the Retiree or the Retiree's Dependents that are covered under the Outside Plan or Medicaid may postpone coverage under the Retiree Plan until the first day of the month during which the Outside Plan or Medicaid ends. However, if the Outside Plan or Medicaid ends on the last day of the month, coverage may be postponed until the first day of the next following month. Postponement for the Retiree or the Retiree's Dependents is allowed only for the benefit(s) that are provided under the Outside Plan or Medicaid. The Retiree is responsible for payment for any required premium for the full month during which coverage under the Retiree Plan begins or continues.

(B) If a Retiree's pension is processed with a retroactive annuity starting date, coverage under the Retiree Plan will not be retroactive to the annuity starting date. However, if there is an administrative delay in the processing of the initial pension check, Retiree Coverage may be retroactive to the first of the month in which the initial pension check would have been issued had the administrative delay not occurred.

(C) If a Retiree who is covered by the Retiree Plan becomes eligible for the Active Plan, coverage under the Retiree Plan will terminate on the date Active Plan coverage becomes effective. Retiree coverage will again become effective in accordance with Plan Section 3.06.

(D) If a Retiree does not satisfy the eligibility requirements for the Retiree Plan as set forth in Plan Section 3.03 at the time of pension commencement, but subsequently earns additional vesting credit as defined by the applicable Pension Plan or service credit as defined in Plan Section 3.03(A)(5), and subsequently satisfies the eligibility requirements

for the Retiree Plan, the Retiree and his Dependents will become initially eligible for the Retiree Plan on the first day of the Calendar Year following the month in which the eligibility requirements are satisfied.

(E) If a Retiree acquires a new Dependent after the Retiree's coverage under the Retiree Plan becomes effective, the Retiree's newly acquired Dependent will become initially eligible to enroll in coverage on the date of the child's birth, adoption or placement for adoption or date of Retiree's marriage for a spouse or stepchild. For a special enrollment under CHIP as described in Plan Section 3.05(C)(4), coverage begins on the first day of the month after the Fund Office's receipt of the completed and approved Enrollment Form.

(F) Coverage for a surviving spouse (and any surviving Dependents) of a Retiree who dies while enrolled in the Retiree Plan of Benefits shall commence on the first day of the month following the month in which the Retiree dies provided the surviving spouse (and any surviving Dependents) satisfy the eligibility criteria in Plan Section 3.03(C) and timely enroll under Plan Section 3.05(B).

(G) Coverage for a surviving spouse (and any surviving Dependents) of an Employee who dies while eligible for benefits in the Active Plan or Low Cost Medical Plan shall commence on the first day of the month following the month in which the Employee dies subject to the surviving spouse electing to delay coverage as permitted under Plan Section 3.06(A).

Section 3.07 Premium Payments for Retiree Coverage

(A) Premiums for Retirees and their Dependents where the Retiree has a pension annuity starting date or pension reinstatement date of July 1, 2006 or later and Covered Individuals who were eligible for the comprehensive medical benefits and prescription drug benefits as of December 31, 2010; and any Retiree or Dependent added to Retiree Coverage on or after January 1, 2011; and surviving spouses (and any surviving Dependents) who satisfy the eligibility criteria in Plan Section 3.03(C), will be determined based on the following:

(1) Each Covered Individual must pay a monthly premium for comprehensive medical benefits.

(2) Each Covered Individual must pay a separate monthly premium for the prescription drug benefit except the Deferred Lathers and their surviving spouses (and any surviving Dependents) who are not eligible for the prescription drug benefit.

(3) Each Covered Individual must pay a separate monthly premium for dental benefits. The monthly premium rates for dental benefits are determined by the Insurance Company.

(4) Each Covered Individual must pay a separate monthly premium for vision benefits. The monthly premium rates for vision benefits are determined by the Insurance Company.

(5) Each Covered Individual will have their premiums determined on a tiered basis, with premium amounts determined by the number of vesting credits that a Participant earned with the Chicago Regional Council of Carpenters Pension Fund; Chicago Regional Council of Carpenters Millmen Pension Fund; or the

Carpenters Pension Fund of Illinois; or by the number of service credits as determined in accordance with Plan Section 3.03(A)(5) under the Will County Local 174 Carpenters Pension Fund. Pension Credit granted under the Chicago Regional Council of Carpenters Millmen Pension Fund for the period of time prior to June 1, 1975 will also be counted as vesting credit for determining the applicable tier level. Surviving spouses (and any surviving Dependents) who satisfy the eligibility criteria in Plan Section 3.03(C) will have the same premium rate tier as the deceased Participant.

(6) If a Covered Individual meets the eligibility requirements of Plan Section 3.03(A)(3) but has less than ten (10) years of vesting credit, then each Covered Individual will have their premiums determined as if ten (10) years of vesting credit or service credit had been earned by the Participant. Similarly, if a Covered Individual meets the eligibility requirements of Plan Section 3.03(A)(4) and becomes subject to the tiered premium arrangement but has less than ten (10) years of service credit, as described in Plan Section 3.03(A)(5), then each Covered Individual will have their premium determined as if ten (10) years of service credit had been earned by the Participant. Surviving spouses (and any surviving Dependents) who satisfy the eligibility criteria in Plan Section 3.03(C) will have the same premium rate tier as the deceased Participant.

(7) If a Participant earned Vesting Credits or service credits under more than one of the Pension Funds and has commenced receiving pension benefits from each of the Pension Funds in which credit was earned, the combined credit shall be considered when determining the tier level for premium amounts. However, not more than one (1) year of combined credit shall be counted in any Calendar Year.

(8) The monthly medical and prescription premium rate for spouses and Dependent children (who are not yet Medicare-eligible) of pensioners receiving disability pensions is not based on the number of vesting credits, but is reduced and set by the Board of Trustees from time to time; however, surviving spouses (and any surviving Dependents) of pensioners receiving disability pensions who satisfy the eligibility criteria in Plan Section 3.03(C) will have their premium for coverage following the pensioner's death based on the tiered premium established pursuant to Plan Sections 3.07(A)(5) and (6) rather than this Plan Section 3.07(A)(8).

(9) If a Retiree subsequently earns additional vesting credit as defined by the applicable Pension Plan or service credit as defined in Plan Section 3.03(A)(5) and if the additional credit changes the premium tier level for medical and prescription coverage, the Retiree will be subject to the new tier level on the first day of the Calendar Year following the Calendar Year in which the additional credit is earned.

(10) For a period not to exceed three (3) years after the merger date of December 31, 2018 (“Grandfather Period”), Will County Local 174 Carpenters Pension Fund Retirees who commenced receiving pension benefits on or before December 1, 2018 (“Merging Fund Retirees”) will be subject to the applicable pre-merger premium rates for comprehensive medical and prescription drug benefits, but must pay the separate monthly premium applicable under this Plan for dental and vision benefits. If a Merging Fund Retiree’s coverage is cancelled, either voluntarily, due to non-payment of a required premium, or due to a suspension of the Retiree’s pension benefit, and if the Merging Fund Retiree subsequently re-enrolls in coverage during the Grandfather Period, the Merging Fund Retiree shall remain subject to these same premium rules during the Grandfather Period.

These same rules apply to Dependents and surviving spouses of Merging Fund Retirees during the Grandfather Period.

(B) Premiums for Retirees and their Dependents or their surviving spouses (and any surviving Dependents) who satisfy the eligibility criteria in Plan Section 3.03(C) where the Retiree has a pension annuity starting date of June 1, 2006 or earlier will be determined based on the following:

(1) Covered Individuals eligible for Medicare Parts A and B Supplemental coverage and prescription drug benefits must pay a separate monthly premium for Medicare Parts A and B Supplemental coverage and for the prescription drug benefits, except Deferred Lathers and their surviving spouses (and any surviving Dependents) who are not eligible for the prescription drug benefit.

(2) Covered Individuals eligible for Medicare Part A Supplemental Hospital coverage and prescription drug benefits must pay a separate monthly premium for Medicare Part A Supplemental Hospital coverage and for the prescription drug benefits except Deferred Lathers and their surviving spouses (and any surviving Dependents) who are not eligible for the prescription drug benefit.

(3) Covered Individuals eligible for prescription drug benefits must pay a monthly premium for the prescription drug benefit except Deferred Lathers and their surviving spouses (and any surviving Dependents) who are not eligible for the prescription drug benefit.

(4) Each Covered Individual must pay a separate monthly premium for dental benefits. The monthly premium rates for dental benefits are determined by the Insurance Company.

(5) Each Covered Individual must pay a separate monthly premium for vision benefits. The monthly premium rates for vision benefits are determined by the Insurance Company.

(6) Premiums for surviving spouses (and any surviving Dependents) added by the Retiree after June 1, 2006 will be subject to the tiered premiums as described in Plan Section 3.07(A).

(C) If the pension benefit of a Retiree with an annuity starting date of June 1, 2006 or earlier is terminated due to the Retiree's return to work or recovery from Disability and if the pension benefit subsequently is reinstated with an annuity starting date of July 1, 2006 or later, upon reinstatement each Covered Individual will be subject to the tiered premiums as described in Plan Section 3.07(A).

(D) Premiums for coverage are paid through deductions from the Retiree's or, if a surviving spouse pension benefit is payable, the surviving spouse's monthly pension benefit pursuant to payment assignments executed by the Retiree or the surviving spouse who satisfies the eligibility criteria in Plan Section 3.03(C). If the premium for coverage is greater than the gross monthly pension benefit, the Retiree or the surviving spouse must submit a Premium Payment directly to the Fund. Premium Payments must be received by the Fund no later than the first business day of the month for which coverage is effective. However there is a grace period as described in Plan Section 4.01(E)(3)(c) in the same manner as for Continuation Coverage under COBRA. The obligation to pay a Premium Payment for coverage from the Retiree's monthly pension benefit pursuant to a payment assignment executed by the Retiree will not apply to the extent that the Plan is

required to accept a third-party Premium Payment on behalf of the Retiree pursuant to a Qualified Medical Child Support Order.

(E) The Retiree is responsible for payment of any required premium for the newly acquired Dependent's coverage for the full month in which the newly acquired Dependent is initially eligible for coverage and for all subsequent months.

(F) The Retiree, the Retiree's surviving spouse or the Retiree's Dependent must notify the Fund Office of the death of a Dependent, or the Dependent's termination of status as a Dependent on a timely basis so that coverage for the Dependent can be terminated. If the Retiree or the Retiree's surviving spouse was paying a premium for the Dependent's coverage and the Dependent's coverage is terminated, no premiums will be refunded for any period exceeding twenty-four (24) months in which the required notice is not given.

(G) The Retiree, the Retiree's Dependent, or the Retiree's surviving spouse (and any surviving Dependents) who are eligible pursuant to Plan Section 3.03(C) must submit a copy of his Medicare card to the Fund Office as soon as he receives it from Medicare. Comprehensive Medical Benefit premiums will not be refunded for any period exceeding twenty-four (24) months.

(H) The monthly premium rate for Retiree Coverage shall be set by the Board of Trustees from time to time.

Section 3.08 Eligibility for Life Insurance and Accidental Death and Dismemberment Benefits under the Active Plan

Eligibility for the Life Insurance Benefit and the Accidental Death and Dismemberment Benefit begins on the date the Employee meets the eligibility requirements under the Active Plan. An Employee or Dependent does not have to wait until the beginning of the next Coverage Quarter to become eligible for these benefits.

Section 3.09 Continuing Eligibility for Non-Apprentice Employees under the Active Plan

(A) After an Employee who is not an apprentice meets the initial eligibility requirements in Plan Section 3.01, the Employee becomes a Participant in the Active Plan for a Coverage Quarter. Thereafter, to maintain coverage in the Active Plan, the Employee must have at least two hundred and fifty (250) hours during each succeeding Calendar Quarter of:

(1) Contributions paid on the Participant’s behalf by Contributing Employers; and/or

(2) Credit of hours under the Short Term Disability Benefit.

(B) If an Employee does not meet the requirements of Plan Section 3.09(A), the Employee will remain a Participant in the Active Plan for the next Coverage Quarter if he has at least one thousand (1,000) hours in the current and the three (3) immediately preceding Calendar Quarters of:

(1) Contributions paid on the Participant’s behalf by Contributing Employers; and/or

(2) Credit of hours under the Short Term Disability Benefit.

(C) If an Employee does not meet the requirements of Plan Section 3.09(A) or 3.09(B), the Employee may maintain coverage through Self-Payment of Hours provided certain criteria are met as described in Plan Section 3.11, through Continuation Coverage under COBRA as described in Plan Section 4.01, or through the Low Cost Medical Plan as described in Plan Section 4.04.

(D) For Employees who are covered under a Participation Agreements or a Collective Bargaining Agreement with Employers, as stated in Article 3.01(B), the Fund Office must continue to receive a monthly Contribution based on the minimum hour requirement stated in their Participation Agreement or Collective Bargaining Agreement.

Section 3.10 Continuing Eligibility for Apprentices under the Active Plan

(A) Once the initial requirements for apprentice eligibility in Plan Section 3.02 are met, an Employee who is an apprentice will be a Participant in the Active Plan for a Coverage Quarter. Thereafter, to maintain eligibility in the Active Plan for all benefits, except the prescription drug benefit and dental benefit, the apprentice must have at least two hundred (200) hours during each succeeding Calendar Quarter of**:**

(1) Contributions paid on the Participant's behalf by Contributing Employers; and/or

(2) Credit of hours under the Short Term Disability Benefit.

(B) If the apprentice does not meet the requirements of Plan Section 3.10(A), the apprentice will remain a Participant in the Active Plan (except he will not receive the prescription drug benefit and dental benefit) for the next Coverage Quarter if he has at least seven hundred and sixty (760) hours in the current and the three (3) immediately preceding Calendar Quarters of:

(1) Contributions paid on the Participant's behalf by Contributing Employers; and/or

(2) Credit of hours under the Short Term Disability Benefit.

The foregoing to the contrary notwithstanding, an apprentice who is dropped from the Apprentice Program or if he otherwise ceases to be enrolled in the Apprentice Program, and who does not meet the requirements of Plan Section 3.10(A), shall be ineligible to maintain his Active Plan benefit coverage (without prescription drug benefit and dental benefit) under this Plan Section 3.10(B).

(C) Once the initial requirements for eligibility are met, an apprentice may qualify for full Active Plan benefits (including the prescription drug benefit and dental benefit) during subsequent Coverage Quarters if the apprentice has at least two hundred and fifty (250) hours during the immediately preceding Calendar Quarter of:

(1) Contributions paid on the Participant's behalf by Contributing Employers; and/or

(2) Credit of hours under the Short Term Disability Benefit.

(D) In addition to Plan Section 3.10(C), the apprentice's eligibility for full Active Plan benefit coverage will be maintained for subsequent Coverage Quarters if the apprentice has credit for at least one thousand (1,000) hours in the current and three (3) immediately preceding Calendar Quarters of:

(1) Contributions paid on the Participant's behalf by Contributing Employers; and/or

(2) Credit of hours under the Short Term Disability Benefit.

(E) If an apprentice does not meet the requirements of Plan Section 3.10(A), 3.10(B), 3.10(C) or 3.10(D), the apprentice may maintain his current level of coverage in the Active Plan through Self-Payment of Hours provided certain criteria are met. An apprentice may not make Self-Payment of Hours to qualify for full Active Plan benefit coverage if he did not qualify for full Active Plan benefit coverage pursuant to Plan Section 3.10(C) or 3.10(D) in the preceding Coverage Quarter. The foregoing to the contrary notwithstanding, an apprentice described in Plan Section 3.02(B) who is dropped from enrollment or otherwise ceases to be enrolled in the Apprentice Program shall be ineligible to maintain his Active Plan benefit coverage (without prescription drug benefit and dental benefit) through Self-Payment of Hours. Such an apprentice may only maintain Active Plan benefit coverage (at his then current level) through Continuation Coverage under COBRA as described in Plan Section 4.01.

Section 3.11 Continuing Eligibility for the Active Plan Through Self-Payment of Hours

(A) Terms and Conditions: Whenever the following terms are used in this Plan Section, they have the meaning specified below, unless the context clearly indicates otherwise:

(1) "Current Hourly Contribution Rate" means the hourly contribution rate under the terms of the Commercial Area Agreement for Cook, Lake and DuPage Counties between the Mid-America Regional Bargaining Association and the Chicago Regional Council of Carpenters and the collective bargaining agreement between the Residential Construction Employers Council and the Chicago Regional Council of Carpenters, as each is determined from time-to-time, or such other contribution rate that the Trustees may adopt from time-to-time.

(2) "Self-Payment of Hours Premium" means the premium required to maintain Active Plan benefit coverage through Self-Payment of Hours. Self-Payment of Hours does not apply to Employees covered under Article 3.01(B).

(B) Non-Apprentice Employees: If an Employee is unable to maintain Active Plan benefit coverage under Plan Section 3.09, the Employee may continue coverage under the Active Plan of benefits through Self-Payment of Hours under the following circumstances and terms:

(1) If the Employee does not have sufficient hours contributed on his behalf in the immediately preceding Calendar Quarter, pursuant to Plan Section 3.09(A), or in the current and three (3) immediately preceding Calendar Quarters, pursuant to Plan Section 3.09(B), to maintain Active Plan benefit coverage, the Fund Office will provide the Employee, provided that the Employee is a Member in Good Standing, with the Self-Payment of Hours option prior to the end of the current Coverage Quarter unless the maximum number of Coverage Quarters through Self-Payment of Hours has been met.

(2) The Self-Payment of Hours Premium is equal to the lesser of:

(a) The difference between the credited hours for the current Calendar Quarter and two hundred and fifty (250) hours, multiplied by the Current Hourly Contribution Rate; or

(b) The difference between the credited hours for the current Calendar Quarter and the three (3) immediately preceding Calendar Quarters and one thousand (1,000) hours, multiplied by the Current Hourly Contribution Rate.

(3) The Self-Payment of Hours Premium must be paid in its entirety to the Fund and is due no later than the first business day of the month for which coverage is effective. However, there is a grace period as described in Plan Section 4.01(E)(3)(c).

(4) The Employee may continue Active Plan benefit coverage through Self-Payment of Hours for up to a maximum of four (4) Coverage Quarters, consecutive or non-consecutive, within a rolling twelve (12) Coverage Quarter period, or the Employee may elect to move to Continuation Coverage under COBRA or the Low Cost Medical Plan. However, if an Employee elects to move to Continuation Coverage under COBRA or the Low Cost Medical Plan, he will not be able to elect Self-Payment of Hours until he regains eligibility for benefits from Employer Contributions or hours credited for a Short Term Disability claim, and subsequently loses eligibility for benefits.

(5) To maintain eligibility through Self-Payment of Hours, an Employee must be eligible for Active Plan benefit coverage from Employer Contributions or hours credited for a Short Term Disability claim or through Self-Payment of Hours in the Coverage Quarter immediately preceding the Coverage Quarter for which the Self-Payment of Hours applies. An Employee is not eligible for the Self-Payment of Hours option if he was Continuing Coverage under COBRA or the Low Cost Medical Plan for the prior Coverage Quarter. An Employee Continuing Coverage under COBRA or the Low Cost Medical Plan is not eligible for the Self-Payment of Hours option until he regains eligibility for Active Plan benefits from Employer Contributions or hours credited for a Short Term Disability claim, and subsequently loses eligibility for benefits.

(6) In addition to the requirements set forth in Plan Section 3.11(B)(5), to be eligible to maintain eligibility through Self-Payment of Hours, an Employee who is participating in the Plan pursuant to a Collective Bargaining Agreement must be a Member in Good Standing. Eligible Employees participating under a Participation Agreement or other written agreement (other than a Collective Bargaining Agreement) may maintain eligibility through Self-Payment of Hours unless the Participation Agreement, other written agreement, or rule adopted by the Trustees prohibits eligible Employees of the Employer from maintaining eligibility through Self-Payment of Hours.

(7) Self-Payment of Hours serves solely to maintain Active Plan benefit coverage. Self-Payment of Hours does not count towards meeting future eligibility requirements. Only hours credited from Employer Contributions or hours credited from a Short Term Disability claim count towards calculating future eligibility.

(C) Apprentices: If an apprentice is unable to maintain Active Plan benefit coverage under Plan Section 3.10, the apprentice may continue coverage under the Active Plan of benefits through Self-Payment of Hours under the following circumstances and terms:

(1) If the apprentice does not have sufficient hours contributed on his behalf in the immediately preceding Calendar Quarter, pursuant to Plan Section 3.10(A) and 3.10(C), or in the current and the three (3) immediately preceding Calendar Quarters, pursuant to Plan Section 3.10(B) and 3.10(D), to maintain his current level of Active Plan benefit coverage, the Fund Office will provide the Employee with the Self-Payment of Hours option prior to the end of the current Coverage Quarter unless the maximum number of Coverage Quarters through Self-Payment of Hours has been met. The foregoing to the contrary notwithstanding, an apprentice described in Plan Section 3.02(B) who is dropped from enrollment or otherwise ceases to be enrolled in the Apprentice Program shall be ineligible to maintain his Active Plan benefit coverage (without prescription drug benefit and dental benefit) through Self-Payment of Hours. Such an apprentice may only maintain Active Plan benefit coverage (at his then current level) through Continuation Coverage under COBRA as described in Plan Section 4.01.

(2) The Self-Payment of Hours Premium, without prescription drug and dental benefits, is equal to the lesser of:

(a) The difference between the credited hours for the current Calendar Quarter and two hundred (200) hours, multiplied by Current Hourly Contribution Rate; or

(b) The difference between the credited hours for the current Calendar Quarter and the three (3) immediately preceding Calendar Quarters and seven hundred and sixty (760) hours, multiplied by the Current Hourly Contribution Rate.

(3) The Self-Payment of Hours Premium, with prescription drug and dental benefits, is equal to the lesser of:

(a) The difference between the credited hours for the current Calendar Quarter and two hundred and fifty (250) hours, multiplied by the Current Hourly Contribution Rate; or

(b) The difference between the credited hours for the current Calendar Quarter and the three (3) immediately preceding Calendar Quarters and one thousand (1,000) hours, multiplied by the Current Hourly Contribution Rate.

(4) The Self-Payment of Hours Premium must be paid in its entirety to the Fund and must be received by the Fund Office no later than the first business day of the month for which coverage is effective. However, there is a grace period as described in Plan Section 4.01(E)(3)(c).

(5) The apprentice may continue Active Plan benefit coverage through Self-Payment of Hours for up to a maximum of four (4) Coverage Quarters, consecutive or non-consecutive, within a rolling twelve (12) Coverage Quarter period, or an Apprentice may elect to continue coverage under COBRA or the Low Cost Medical Plan. However, if an Apprentice elects to move to Continuation Coverage under COBRA or the Low Cost Medical Plan, he will not be able to elect to Self-Payment of Hours until he regains eligibility for benefits from Employer Contributions or hours credited for a Short Term Disability claim.

(6) To maintain eligibility through Self-Payment of Hours, an apprentice must be eligible for Active Plan benefit coverage through Employer Contributions or hours

credited for a Short Term Disability claim or through Self-Payment of Hours in the Coverage Quarter immediately preceding the Coverage Quarter for which the Self-Payment of Hours applies. An apprentice is not eligible for the Self-Payment of Hours option if he was Continuing Coverage under COBRA or the Low Cost Medical Plan for the prior Coverage Quarter. An apprentice Continuing Coverage under COBRA or the Low Cost Medical Plan is not eligible for the Self-Payment of Hours option until he regains eligibility for Active Plan benefits from Employer Contributions or hours credited for a Short Term Disability claim and subsequently loses eligibility.

(7) In addition to the requirements set forth in Plan Section 3.11(C)(6), to be eligible to maintain eligibility through Self-Payment of Hours, an apprentice must be a Member in Good Standing.

(8) Self-Payment of Hours serves solely to maintain Active Plan benefit coverage. Self-Payment of Hours does not count towards meeting future eligibility requirements. Only hours credited from Employer Contributions or hours credited for a Short Term Disability claim count towards calculating future eligibility.

(D) Retirees: Retirees and their dependents are not eligible to extend eligibility for the Active Plan of Benefits through Self-Payment of Hours.

Section 3.12 Termination of Eligibility for the Participant under the Active Plan

A Participant's eligibility for Active Plan benefits will terminate:

(A) On the last day of the second calendar month immediately following any Calendar Quarter in which the Participant does not meet the requirements of Plan Sections 3.09 or 3.10;

(B) The last day of the month in which the Participant enters the Uniformed Services to the extent permitted by law;

(C) Employees as described in Article 3.01(B) will terminate eligibility on the first day of the month for which Contributions have not been received unless the Employee at the time he terminated employment is maintaining eligibility under the rules of Plan Section 3.09(A) or (B), in which case the Plan's general termination and eligibility rules shall apply; or

(D) On the date the Plan is discontinued.

Section 3.13 Termination of Eligibility under the Retiree Plan

(A) A Retiree's coverage will terminate in the Retiree Plan on the first to occur of the following:

(1) On the date of the Retiree's death;

(2) The last day of the month prior to the month in which the Retiree's pension benefit is suspended due to a recovery from Disability or a return to work in prohibited employment as defined by the applicable Pension Plan;

(3) Upon voluntary cancellation of coverage by the Retiree;

(4) The first (1st) day of the month for which the Premium Payment as required by Plan Section 3.07(D) is not received by the Fund Office on a timely basis. A payment is considered timely if it is received on or before the first business day of the month for which it applies. However, there is a thirty (30) day grace period as described in Plan Section 4.01(E)(3)(c) in the same manner as for Continuation Coverage under COBRA;

(5) The date the Plan or Retiree coverage is discontinued; or

(6) The date the Retiree enters active Uniformed Services.

(B) The Retiree Plan coverage for a surviving spouse (and any surviving Dependents) who is eligible pursuant to Plan Section 3.03(C) will terminate upon the first to occur of the following:

(1) On the date of the surviving spouse's or Dependent's death;

(2) Upon voluntary cancellation of coverage by the surviving spouse or Dependent;

(3) For the surviving spouse and any step children of the Participant defined in Plan Section 2.30(E), the last day of the month in which the surviving spouse remarries;

(4) For a non-spouse Dependent, an event described in Plan Section 3.17(B), (D), (F), (J), (K), or (L);

(5) For a surviving spouse and Dependent, an event described in Plan Section 3.17(L); or

(6) The date the Plan or Retiree coverage is discontinued.

(C) A Retiree who engages in prohibited employment as defined by the applicable Pension Plan or recovers from a Disability is no longer eligible for Retiree Plan coverage. The Retiree and Dependents may be offered a conversion policy on a self-pay basis through the Contracted Provider to the extent permitted by the Insurance Company. This conversion coverage may not be the same coverage provided by the Plan and a conversion fee may apply. However, a Retiree who returns to Covered Employment will be eligible for Active Plan coverage if he satisfies the eligibility requirements of Plan Section 3.01.

(D) To voluntarily cancel Retiree benefit coverage a Retiree or surviving spouse (and any surviving Dependents) who is eligible pursuant to Plan Section 3.03(C) and enrolled pursuant to Plan Section 3.05(B), must obtain the required forms from the Fund Office and return the completed forms to the Fund Office by the fifteenth (15th) day of the month prior to the month that coverage will be cancelled. If coverage is cancelled for the Retiree or surviving spouse, it will also be cancelled for the enrolled Dependents. Once coverage under the Retiree Plan is cancelled for a Retiree, Dependent, or surviving spouse (and any surviving Dependents), coverage under the Retiree Plan cannot be reinstated for the Retiree, Dependent or surviving spouse (and any surviving Dependents) at a later date for any reason, even following subsequent re-employment, except as provided in Plan Section 3.05. If Retiree Plan coverage is voluntarily cancelled for a Retiree's surviving spouse or Dependent (including surviving Dependents) due to the surviving spouse or Dependent obtaining coverage through an Outside Plan or Medicaid, re-enrollment in the Retiree Plan is only allowed until the first (1st) day of the month after the Outside Plan or

Medicaid coverage terminates for the Dependent. Re-enrollment for the surviving spouse or Dependent (including surviving Dependents) is allowed only for the benefit(s) that are provided under the Outside Plan or Medicaid. The Retiree must re-enroll the Retiree's Dependent in the Retiree Plan no later than the first (1st) day of the month following the termination of the Outside Plan or Medicaid coverage; this deadline also applies to surviving spouses (and any surviving Dependents).

Section 3.14 Reinstatement of Eligibility for a Participant under the Active Plan

(A) If a Participant loses eligibility for benefits under the Active Plan because the Employee did not have the required Contribution hours paid for a period of less than twelve (12) consecutive Calendar Quarters (three (3) years), the Employee may again become eligible on the first day of the Coverage Quarter following a Calendar Quarter in which Contributions for at least two hundred and fifty (250) hours were paid on the Employee's behalf by one or more Contributing Employers.

(B) If an Employee returns to work after being away for longer than twelve (12) or more consecutive Calendar Quarters (three (3) years), with no contribution hours paid on the Employee's behalf, the Employee must again meet the Initial Eligibility requirements as a new Participant as stated under Plan Section 3.01.

(C) If the Employee's absence from Covered Employment was the result of a Disability, the Employee's reinstatement will be effective on the first (1st) day of the Coverage Quarter following a Calendar Quarter in which at least two hundred and fifty (250) hours were credited on the Employee's behalf.

(D) If the Participant's eligibility for benefits is suspended because the Participant goes on a leave as defined under USERRA, eligibility will be immediately reinstated, as it was on the day before termination, upon the Participant's release from service as described in Plan Section 4.03.

Section 3.15 Change in Eligibility Rules

The Trustees reserve the right, at their discretion, to change, modify, or discontinue all or part of the eligibility rules or the benefits provided under the Plan at any time by an amendment adopted by the Trustees from time to time. The Trustees also have the authority to establish contribution rates and self-payment rules and they reserve the right to change such rates and rules at any time in the Trustees' sole and unrestricted discretion by resolution adopted by the Trustees from time to time.

Section 3.16 Dependent Eligibility

(A) If an Employee is eligible for benefits under the Active Plan, then the Employee's Dependents are also eligible for benefits under the Active Plan in accordance with Plan Section 2.30.

(B) If a Covered Individual is eligible for and elects Continuation Coverage under COBRA, the Covered Individual may elect coverage for his Dependents in accordance with Plan Sections 2.30 and 4.01.

(C) If a Participant is eligible for and elects coverage under the Low Cost Medical Plan, the Participant may elect coverage for his Dependents under the Low Cost Medical Plan in accordance with Plan Sections 2.30 and 4.04.

(D) If a Participant is eligible for and enrolled under the Retiree Plan then the Participant may enroll his eligible Dependents under the Retiree Plan in accordance with Plan Sections 2.30, 3.05, 3.06 and 3.07.

(E) A child is not considered an eligible Dependent if the child is in the Uniformed Services, to the extent permitted by law.

(F) An individual cannot be covered as both an Employee and a Dependent child or cannot be covered as both a Dependent child and a spouse under this Plan, to the extent permitted by law.

(G) Initial Enrollment in the Active Plan of Benefits: Within ninety (90) days from the date of initial eligibility, and from time to time as required by the Trustees, the Participant must complete all required forms and provide supporting documentation as described below to substantiate a Dependent's eligibility. If the required documentation is not provided within the ninety (90) day period, coverage will be prospective only and begin on the first (1st) day of the month after the Fund Office receives all required documentation. Upon request, foreign language documents must be accompanied by a notarized English translation.

(1) The Participant must submit proof of Dependent status in the form of a county certified marriage certificate as may be requested by the Plan for determining the marriage date, county certified birth certificate and, if necessary, additional information or proof as requested by the Plan for identifying the names of the parents (such as a paternity test document that lists the Participant as one of the biological parents), Qualified Medical Child Support Order or a National Medical Support Notice, Interim Order of Placement and/or the Final Adoption Order identifying the Participant as the child's parent. Photocopies and Hospital or church certificates are not acceptable documentation. A voluntary acknowledgement of paternity will not be accepted as proof of paternity;

(2) Exception for Newborns, Adopted Children and Children Placed for Adoption: Within ninety (90) days of the birth, adoption or placement for adoption of the child, the Participant must submit proof of Dependent status, as described in Plan Section 3.16(G)(1). If timely proof of Dependent status is not received within this ninety (90) day period, coverage shall be suspended until such time that proof of Dependent status is received. Upon receipt of all required documentation, coverage will be reinstated to the date of the newborn's birth or the date of adoption or placement for adoption;

(3) The Participant must submit the following documentation for a stepchild:

(a) If the biological parents were married:

(i) a county certified birth certificate and, if necessary, additional information or proof as requested by the Plan for identifying the names of the parents; and

(ii) a county certified divorce decree of the biological parents or a county certified death certificate if the biological parent is deceased; and

(iii) certain required forms or information that is reasonably necessary or helpful in the determination of Dependent status.

(b) If the biological parents were never married:

(i) a county certified birth certificate, and, if necessary, additional information or proof as requested by the Plan for identifying the names of the parents; and

(ii) a notarized letter from the biological parent stating that he was never married to the other biological parent and does not receive any support from the other parent or a county certified death certificate if the biological parent is deceased; and

(iii) certain required forms or information that is reasonably necessary or helpful in the determination of Dependent status.

(4) The Participant must provide all information necessary to assist in the Coordination of Benefits;

(5) The Participant must provide proof of Medicaid, Medicare, or Outside Plan coverage; and

(6) If the parents are not married to each other, the Participant must submit certain required forms or information that is reasonably necessary or helpful in the determination of Dependent status. If the Participant is divorced from the child's parent, the Participant must provide the Participant's county certified divorce decree from the child's parent.

(H) If an Employee dies in a Work-Related accident while eligible for Active Plan benefits (not including Continuation Coverage under COBRA), , coverage for the Dependent(s) may continue in accordance with Section 4.05 provided that the individual continues to meet the definition of Dependent, with the exception of financial requirements under Plan Sections 2.30(D)(3) and 2.30(E).

Section 3.17 Termination of Dependent Eligibility

Coverage of a Dependent terminates on the first to occur of the following:

(A) When a Participant no longer meets the eligibility requirements under Plan Section 3.09 or 3.10;

(B) For failure to provide documentation in order to verify Dependent status;

(C) Upon the Dependent's death;

(D) The last day of the month the Covered Individual no longer meets the Plan's definition of a Dependent subject to Plan Section 3.16(H);

(E) Coverage of a spouse terminates on the last day of the month of the effective date of a divorce or legal separation from the Participant;

(F) Coverage of a Dependent child terminates on the last day of the month in which the child attains age twenty-six (26) unless the child satisfies the requirements of Plan Section 2.30(D) for a child with a disability;

(G) Coverage for a newborn child will be suspended ninety (90) days after the date of the child's birth if an original county certified birth certificate is not received;

(H) Coverage of a Dependent stepchild terminates on the last day of the month in which the Participant divorces or legally separates from the stepchild's parent;

(I) Coverage for a Dependent spouse ends on the last day of the month in which the Dependent spouse enters the Uniformed Services, to the extent permitted by law;

(J) Coverage of a Dependent child terminates when the Dependent child becomes an eligible Employee to the extent permitted by law. In the event the Dependent child gains eligibility as an Apprentice while still an eligible Dependent of another Participant in the Plan, the Dependent child may elect to remain covered as a Dependent and forgo coverage as an Apprentice. This election must be made in writing on forms provided by the Fund Office;

(K) Coverage of a Dependent child terminates when the Dependent child becomes a spouse of another Participant to the extent allowed by law. In the event that a Dependent child gains eligibility under the Plan as a spouse while still an eligible Dependent of another Participant under the Plan, the Dependent child may elect to remain covered as a Dependent child and forego coverage as a spouse. This election must be made in writing on forms provided by the Fund Office.

(L) The first day of the month for which the Premium Payment as required by Plan Section 3.07(D), Plan Section 4.01(E)(3) or Plan Section 4.04(E) is not received by the Fund Office on a timely basis. A payment is considered timely if it is postmarked by the U.S. Postal Service on or before the first business day of the month for which it applies. However there is a thirty (30) day grace period as described in Plan Section 4.01(E)(3)(c);

(M) The coverage of a Dependent of a Retiree enrolled in the Retiree Plan of Benefits terminates on the last day of the month in which the Retiree dies, except as provided in Plan Section 3.03(C) and 3.05(B);

(N) On the last day of the month prior to the month in which the Retiree's pension benefit is suspended due to a recovery from Disability or a return to work in prohibited employment as defined by the applicable Pension Plan;

(O) The date the Plan of Benefits is discontinued;

(P) The date the Retiree no longer meets the Plan's continuing eligibility requirements;

(Q) Upon voluntary cancellation of coverage by a Retiree: To voluntarily cancel Retiree benefit coverage for a Dependent, a Retiree must obtain the required cancellation form(s) from the Fund Office and return them to the Fund Office by the fifteenth (15^{th}) day of the month prior to the month that coverage will be cancelled. If coverage is cancelled for the Retiree, it will also be cancelled for the Retiree's Dependents. Once coverage under the Retiree Plan is cancelled for a Dependent, coverage under the Retiree Plan cannot be reinstated for the Dependent at a later date except as provided in Plan Sections 3.05 and 3.06; or

(R) Upon voluntary waiver of coverage pursuant to Plan Section 3.24.

Section 3.18 Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN)

This Plan provides benefits according to the requirements of a QMCSO or a NMSN under QMCSO administrative procedures adopted by the Plan. A Dependent covered under a QMCSO or NMSN will be enrolled in the coverage option in which the Employee or Retiree is enrolled. The Plan will not terminate a Dependent child's coverage when the child is covered by a QMCSO or NMSN provided that the Employee or Retiree is eligible for and enrolled in coverage and the necessary Premium Payments are received by the Fund Office in accordance with terms of the Plan. The Administrator will furnish a copy of the Plan's QMCSO procedures to a Participant upon request and free of charge.

Section 3.19 Effect of Disability on Eligibility under the Active Plan

If a Participant suffers a Disability during a Coverage Quarter in which the Participant is eligible for benefits under the Active Plan, and the Participant is not a Retiree, the Participant may qualify for benefits as described in Article X, Benefits for Short Term Disability. However, if the Participant suffers a Work-Related Illness or Injury while working for a non-Employer, the Employee is not eligible to receive Short Term Disability Benefits described in Article X, regardless of the Participant's eligibility status under the Active Plan.

Section 3.20 Effect of Retirement on Eligibility

An Active Plan Participant who becomes a Retiree may be eligible for COBRA Continuation Coverage of health benefits in accordance with Plan Section 4.01 or Retired Participant Benefits, in accordance with Article III, Plan Sections 3.03, 3.04, 3.05, 3.06 and 3.07.

Section 3.21 Credit for Hours received under Reciprocal Agreements

(A) Reciprocal Agreements with Other Welfare Funds in the Area. The Welfare Fund has entered into reciprocal agreements with other welfare funds in nearby areas (referred to as “Out of Area Funds”). The reciprocal agreements allow the Participant to receive credit for the hours the Participant worked for employers contributing to the Out of Area Funds, provided Contributions are paid by employers to these Out of Area Funds on behalf of the Participant and are transferred to the Welfare Fund. Reciprocal contributions are converted before they are credited when the hourly rates differ.

(B) United Brotherhood of Carpenters International Reciprocal Agreement: If the Participant works temporarily in the jurisdiction of an Out of Area Fund that is not a party to an existing reciprocal agreement with the Welfare Fund, but which participates in the International Reciprocal Agreement, the Participant may request the Out of Area Fund to transfer Contributions paid on the Participant’s behalf to the Welfare Fund. These Contributions will then be converted to hours under the Welfare Fund and applied toward the Participant’s eligibility for benefits under the Welfare Fund.

(C) Participants who are working in another jurisdiction that have agreed to participate in a Reciprocal Agreement must immediately contact the Contributions department of the

Welfare Fund to request a Reciprocal Transfer of Hours Form. The Participant must complete the form and return it to the Welfare Fund. The Welfare Fund will then forward the form to the Out of Area Fund. Before hours can be credited, the Welfare Fund must receive the hours and Contribution payments from the Out of Area Fund. When the hours and Contribution payments are received by the Welfare Fund, the Participant will receive credit. Because some area funds have a lower rate than the Welfare Fund, the Participant may not receive a full hour of credit for each hour that is transferred.

(D) The reciprocity agreement will establish the manner in which Contributions will be transferred to the Welfare Fund. The Plan shall govern the manner in which the Welfare Fund will maintain eligibility and provide benefits for Participants covered by a reciprocity agreement. Other than transferring Contributions pursuant to the terms of the reciprocity agreement, the Welfare Fund shall have no obligations with respect to individuals working in the jurisdiction of an Out of Area Fund under a reciprocity agreement.

Section 3.22 Change in Status

A Covered Individual must notify the Fund Office within sixty (60) days of a change in status, complete any form required by the Fund Office, and provide original documentation of a status change, such as the following:

(A) A change in home address;

(B) Acquisition of a Dependent by marriage, birth, adoption or placement for adoption;

(C) A covered Dependent no longer meeting the Plan's definition of Dependent;

(D) The death of a Dependent;

(E) Marital status, including a legal separation and/or divorce;

(F) Gaining or losing coverage under an Outside Plan; or

(G) Returning to prohibited employment as defined by the applicable Pension Fund.

Section 3.23 Special Enrollment to Add Dependents to the Active Plan of Benefits

(A) If an Employee subsequently acquires a new spouse and stepchildren through marriage the Employee shall enroll such new Dependents within ninety (90) days after the date of the marriage in accordance with Plan Section 3.16(G). If timely proof of Dependent status is received by the Fund Office, coverage is retroactively granted to the date the new Dependent is acquired. If timely proof of Dependent status is not provided within this ninety (90) day period, coverage shall be prospective only and begin on the first (1st) day of the month after the Fund Office receives the required documentation.

(B) If an Employee acquires a new Dependent child through birth, adoption or placement for adoption, the Employee shall enroll such Dependent child no later than ninety (90) days after the date of birth or date of adoption or placement for adoption, of the child in accordance with Plan Section 3.16(G). If timely proof of Dependent status is received by the Fund Office, coverage is retroactively granted to the date the new Dependent is acquired. If timely proof of Dependent status is not received within this ninety (90) day period, coverage shall be suspended until such time that proof of Dependent status is

received. Upon receipt of all required documentation, coverage will be reinstated to the date of the newborn's birth or the date of adoption or placement for adoption.

(C) If an Employee did not enroll any Dependent (including his spouse) when the Employee's Dependent first became eligible for such coverage under the Plan because his Dependent had health coverage under another group health plan or health insurance policy, and subsequently the spouse and/or Dependent child(ren) loses coverage under such other group health plan or health insurance policy, the Employee may enroll his spouse or Dependent child in the Plan within thirty-one (31) days after the termination of coverage under such other group health plan or health insurance policy. The Fund will require evidence that the other coverage has terminated.

(D) If an Employee did not enroll any Dependents (including his spouse) when the Dependent first became eligible for such coverage under the Plan because his Dependent had other coverage under Medicaid or the State Children's Health Insurance Program ("CHIP"), and his Dependent loses eligibility for that coverage, the Employee may enroll the Dependent in the Plan within ninety (90) days of the loss of such coverage.

(E) If an Employee did not enroll any Dependents (including his spouse) when the Dependent first became eligible for such coverage under the Plan, and the Dependent becomes eligible for financial assistance through Medicaid or CHIP for coverage under the Plan, the Employee may enroll the Dependent in the Plan within ninety (90) days of becoming eligible for financial assistance through Medicaid or CHIP.

(F) Once an Employee or an Employee's Dependents meet the eligibility requirements under the Plan, the person becomes a Covered Individual. An Employee may waive coverage for a Dependent who has other group coverage in accordance with Plan Section 3.24.

Section 3.24 Waiver of Active Plan of Benefits Coverage for Dependents

(A) An Employee covered by the Active Plan of Benefits may waive coverage for his Dependents under the Plan by completing all required forms, except as required under Plan Section 3.18. Coverage will cease for the Dependent(s) on the first day of month that is coincident with or follows the receipt of all required forms. The decision to waive health coverage for a Dependent is voluntary and is made by the individual Employee and, if applicable, his or her spouse. Voluntary waiver of coverage is not a COBRA qualifying event for the Dependent. Elimination of coverage in anticipation of an event (such as legal separation or divorce) is not considered a voluntary waiver and is disregarded in determining whether the event causes a loss of coverage for purposes of Continuation Coverage under COBRA.

(B) To enroll a Dependent in the Plan after waiving coverage, the Employee must provide all required forms and provide supporting documentation to the Fund Office as required in Plan Section 3.16. Benefits will become effective for the Dependent on the first day of the month that is coincident with or follows the receipt of all required forms and supporting documentation, provided the Plan's eligibility provisions for the Employee and Dependent are satisfied. The Special Enrollment Rights in Plan Section 3.23 also apply if an Employee waives coverage for a Dependent due to other group health coverage.

ARTICLE IV CONTINUATION COVERAGE FOR PARTICIPANTS, RETIRED PARTICIPANTS, DEPENDENTS AND EMPLOYEES ON LEAVE UNDER FMLA AND USERRA

Section 4.01 Continuation Coverage under COBRA

(A) Description of Continuation Coverage Requirements: In compliance with Sections 601 through 607 of ERISA, as amended by COBRA, the Fund will provide health care continuation coverage, known as "Continuation Coverage under COBRA," for Participants, Retiree Participants and Dependents whose coverage under the Plan would otherwise end because of the Participant's termination of employment, death or certain other Qualifying Events.

(B) Terms and Conditions: Whenever the following terms are used in this Plan Section, they have the meaning specified below unless the context clearly indicates otherwise:

(1) "Continuation Coverage under COBRA" means the health care coverage provided during the required continuation period. Continuation Coverage under COBRA is identical to the health care coverage provided under the Plan to similarly situated Participants and Dependents who have not had their health care coverage terminated as a result of a Qualifying Event. Participants eligible for HRA Program benefits must elect Continuation Coverage under COBRA for comprehensive medical benefits in order to elect Continuation Coverage under COBRA for HRA Program benefits.

(2) Active Plan:

(a) The Plan provides the option under which a Covered Individual may choose to pay for and receive full or limited coverage for the Active Plan of benefits. Full Continuation Coverage under COBRA includes comprehensive medical, prescription drug, dental, vision benefits, and the HRA Program. This is referred to as "Core Plus" coverage. Limited Continuation Coverage under COBRA includes comprehensive medical benefits, HRA Program and prescription drug benefits. This is referred to as "Core" coverage. Continuation Coverage under COBRA does not include benefits for Short Term Disability, Life Insurance or Accidental Death and Dismemberment.

(b) The Plan provides the option under which a Covered Individual whose coverage ended under the Active Plan for all benefits except the prescription drug and dental benefits, as described in Plan Sections 3.02(B), 3.10 (A) or 3.10 (B), may choose to pay for and receive coverage for the Active Plan of benefits, except prescription drug and dental benefits. This is referred to as "Apprentice" coverage. Continuation Coverage under COBRA does not include benefits for Short Term Disability pursuant to Article X, Life Insurance pursuant to Article XI, or Accidental Death and Dismemberment Benefits pursuant to Article XII.

(3) Retiree Plan:

(a) The Plan provides the option under which a Covered Individual may choose to pay for and receive coverage identical to the type of coverage in which the Covered Individual was enrolled while receiving benefits under the Retiree Plan.

(b) The Plan will offer Continuation Coverage under COBRA under this Article IV to a Dependent of a Retiree who experiences a qualifying event provided that the Dependent was covered under the Retiree Plan upon termination of coverage under the Retiree Plan (subject to the Plan receiving timely notice of the loss of coverage, where notice is required).

(4) "Qualified Beneficiary" means the Participant, the Participant's spouse, the Participant's former spouse, legally separated spouse, the Participant's surviving spouse or the Participant's Dependent who is covered under the Plan on the day before a Qualifying Event and whose health care coverage would otherwise end upon the occurrence of a Qualifying Event.

(5) A new spouse or Dependent child born to the Participant, adopted by the Participant, or placed for adoption with the Participant, during a period of Continuation Coverage under COBRA is also considered a Qualified Beneficiary.

(6) "Qualifying Event" means one or more of the following:

(a) Voluntary or involuntary termination of a Participant's employment (for a reason other than gross misconduct);

(b) Death of a Participant;

(c) Reduction of a Participant's work hours;

(d) Divorce or legal separation of a Participant from the Participant's spouse;

(e) Event that causes an individual to no longer be considered a Dependent; or

(f) Participant's entitlement to, eligibility for, and enrollment in Medicare coverage.

The loss of Plan coverage due to work in prohibited employment as defined by the applicable Pension Plan is not a Qualifying Event.

(C) General Rule: In the event a Qualified Beneficiary loses coverage as a result of a Qualifying Event, the Fund must offer such Qualified Beneficiary the right to elect continued health care coverage.

(D) Election and Length of Continuation Coverage under COBRA for Qualifying Events:

(1) A Qualified Beneficiary must elect Continuation Coverage under COBRA within the "Election Period." "Election Period" is the sixty (60) day period that commences on the later of:

(a) The date the Qualified Beneficiary would otherwise lose coverage under the Plan by reason of the Qualifying Event, or

(b) The date the Qualified Beneficiary receives the election notice required by the Act.

(2) In the event that a Participant loses coverage, pursuant to Plan Section 4.01(B)(6)(a) or (c) the Participant may elect Continuation Coverage under COBRA at his own expense for eighteen (18) months from the date of the Qualifying Event at a monthly rate determined by the Board of Trustees not to exceed one hundred and two percent (102%) of the cost of coverage for Participants. Upon the occurrence during the first eighteen (18) months of Continuation Coverage of one of the Qualifying Events set forth in Plan Section 4.01(B)(6)(b), (d) or (e) of this Plan, a Qualified Beneficiary who is a spouse or Dependent child has the right to elect Continuation Coverage under COBRA for a total of thirty-six (36) months from the date of the first Qualifying Event.

(3) In the event of a Qualified Beneficiary who is determined by the Social Security Administration to have been disabled at the time, or within sixty (60) days of a Qualifying Event, the maximum period of Continuation Coverage under COBRA will be extended from eighteen (18) months to twenty-nine (29) months from the date of the Qualifying Event for the disabled person and any covered family members who elect Continuation Coverage under COBRA, provided that the Qualified Beneficiary has given notice of the determination to the Fund Office within sixty (60) days of receiving the notice and before the end of the eighteen (18) month period of Continuation Coverage under COBRA.

(4) In the event the Qualified Beneficiary is finally determined by the Social Security Administration to no longer to be disabled, the period of extended Continuation Coverage under COBRA beyond eighteen (18) months will terminate at the end of the month that begins more than thirty days after the date of a final determination that the Qualified Beneficiary is no longer disabled. The Qualified Beneficiary is required to notify the Fund Office within thirty (30) days of the determination of non-Disability by the Social Security Administration.

(5) In the event that a Participant's Dependent loses coverage pursuant to Plan Section 4.01(B)(6)(b), (d) or (e), the Participant's Dependent may elect Continuation Coverage under COBRA at his own expense for a total of thirty-six (36) months at a monthly rate determined by the Board of Trustees not to exceed one hundred and two percent (102%) of the cost of coverage for Employees. In no event, however, will Continuation Coverage under COBRA last beyond thirty-six (36) months from the date of the first Qualifying Event.

(6) A Qualified Beneficiary who is a spouse or Dependent child has the right to elect Continuation Coverage under COBRA for thirty-six (36) months from the date of the Participant's entitlement to Medicare coverage as an Employee if the Participant terminates employment or has a reduction in work hours within eighteen (18) months after becoming entitled to Medicare.

(7) The Fund has developed notice and election procedures in accordance with COBRA as follows:

(a) The Trustees will provide written notice of the Continuation Coverage under COBRA provisions to each Participant and Dependent within ninety (90) days of the date coverage under the Plan commences or within ninety (90) days of a significant change in procedures. Notice provided to the Participant will be deemed notice to all Dependents, unless the Fund has notice that a Dependent resides at a different address.

(b) An Employer will notify the Fund of the Qualifying Events described in Plan Section 4.01(B)(6)(a), (b) or (c).

(c) The Participant or other Qualifying Beneficiary is responsible for notifying the Fund in writing within sixty (60) days of the Qualifying Events described in Plan Section 4.01(B)(6)(d), (e) or (f). Failure to provide such notice within sixty (60) days will result in loss of eligibility for Continuation Coverage under COBRA. The Fund will notify the individual if Continuation Coverage under COBRA is unavailable.

(d) Within fourteen (14) days after receiving the notices described above, the Fund will notify each affected Qualified Beneficiary of the right to elect Continuation Coverage under COBRA and provide the Qualified Beneficiary with an enrollment form. Notice to a Qualified Beneficiary who is the spouse of the Participant will be deemed notice to all other Qualified Beneficiaries residing with the spouse at the time notification is made. Notice provided to the Participant will be deemed notice to all Dependents, unless the Fund has notice that a Dependent resides at a different address.

(e) To elect Continuation Coverage under COBRA, a Qualified Beneficiary must, upon receipt of such notice of entitlement to Continuation Coverage under COBRA, complete and return the enrollment form to the Fund's COBRA Administrator within the sixty (60) day Election Period. Failure to return the enrollment form within the Election Period will result in loss of eligibility for Continuation Coverage under COBRA.

(f) A Qualified Beneficiary may elect Continuation Coverage under COBRA for his Dependents. However, each Qualified Beneficiary has an independent right to elect Continuation Coverage under COBRA.

(g) Any Qualified Beneficiary who elects Continuation Coverage under COBRA must notify the Fund's COBRA Administrator within fourteen (14) days of becoming covered under another group health plan.

(E) Permissible Charge for Continuation Coverage under COBRA:

(1) The Fund will charge each Qualified Beneficiary who elects Continuation Coverage under COBRA the applicable premium for such coverage. In no event will such premiums for Continuation Coverage under COBRA exceed one hundred and two percent (102%) of the applicable cost of providing coverage to similarly situated Participants, as determined by the Board of Trustees from time to time, except in the case of Plans Subsection (E)(2) below. No Claims will be paid under Continuation Coverage under COBRA until the proper Premium Payment is received by the Fund.

(2) The premiums required for extended Disability Continuation Coverage under COBRA during the nineteenth (19th) through the twenty-ninth (29th) month, will not exceed one hundred and fifty percent (150%) of the applicable cost of providing coverage for similarly situated Participants as determined by the Board of Trustees from time to time.

(3) Premium Payment:

(a) The Qualified Beneficiary's first Premium Payment for Continuation Coverage under COBRA must include payments for any months retroactive to the day a Covered Individual's coverage ended. The first Premium Payment is due no later than forty-five (45) days after the date the Qualified Beneficiary signed the election form and returned it to the Fund's COBRA Administrator.

(b) Subsequent Premium Payments are due on the first business day of each month for which coverage is provided (due date).

(c) There is a grace period from the due date of the Premium Payment by which the Premium Payment must be paid. Coverage will be reinstated as long as payment for that month is received by the Fund with a post mark date no later than the latter of thirty (30) days after the due date or, for months with thirty-one (31) days, the last day of the month in which the Premium Payment is due. However, if a monthly payment is paid later than the first day of the month, but before the end of the grace period, coverage will be suspended as of the first day of the monthly coverage period. Upon receipt by the Fund of the monthly Premium Payment, coverage will be retroactively reinstated going back to the first day of the month. Any Claim submitted for benefits while coverage is suspended will be denied by the Plan and must be resubmitted for payment once coverage is reinstated.

(F) Termination of Continuation Coverage under COBRA: The Fund will automatically terminate Continuation Coverage under COBRA in all instances permitted by the COBRA statute and its regulations, including if:

(1) The Covered Individual fails to make timely Premium Payments under the Plan;

(2) The Covered Individual becomes covered under another health care plan that does not exclude coverage for preexisting conditions that are covered by this Plan;

(3) The Covered Individual becomes entitled to, eligible for, and enrolled in Medicare coverage; or

(4) The Trustees discontinue all eligibility under the Plan.

(5) The Plan will also provide a Qualified Beneficiary with a notice if there is an early termination of Continuation Coverage under COBRA.

(G) Legal Requirements: It is the intent of the Trustees to provide Continuation Coverage under COBRA in accordance with the Federally required minimum benefits provisions of COBRA. The Fund has developed administrative guidelines and interpretive procedures to be used in complying with the continuation of benefits provisions of COBRA. To the

extent that this Article IV or any administrative guidelines or interpretive procedures inadvertently conflict with COBRA, the applicable sections of COBRA will prevail.

(H) Electing Alternative Coverage Through the Low Cost Medical Plan: A COBRA Qualified Beneficiary, as described in Plan Section 4.01(B)(4), who elected Continuation Coverage under COBRA under the Active Plan following a Qualifying Event as set forth in Plan Section 4.01(D)(1) may subsequently qualify for coverage, on a prospective basis, under the Low Cost Medical Plan, described in Plan Section 4.04, at any time during the eighteen (18) month coverage period so long as the Participant who is an Employee elects to convert to the Low Cost Medical Plan. The option to convert is only available once per Qualifying Event. By converting from Continuation Coverage under COBRA to alternative coverage under the Low Cost Medical Plan, all former Qualified Beneficiaries of the Active Plan effectively waive all existing and future COBRA Continuation Coverage rights under the Active Plan for that specific Qualifying Event, described in Plan Section 4.01(B)(6), and further waive all COBRA rights for that Qualifying Event under the Low Cost Medical Plan. Further, these individuals must satisfy all election procedures for the Low Cost Medical Plan, described in Plan Section 4.04, to convert to the Low Cost Medical Plan. Combined coverage consisting of Continuation Coverage under COBRA in the Active Plan and alternative coverage under the Low Cost Medical Plan shall not exceed the maximum period of eighteen (18) months from the date of the original Qualifying Event under the Active Plan for each Qualified Beneficiary enrolling in the Low Cost Medical Plan.

(I) Continuing Coverage Under the Active Plan Through Self-Payments: An Employee who is a COBRA Qualified Beneficiary, as described in Plan Section 4.01(B)(4), may continue coverage under the Active Plan, on a prospective basis, through Self-Payment of Hours as described in Plan Section 3.11. The Employee may make Self-Payment of Hours for one (1) or more Coverage Quarters, up to a maximum of four (4) Coverage Quarters, per Qualifying Event. Combined coverage consisting of Continuation Coverage under COBRA in the Active Plan and coverage in the Active Plan through Self-Payment of Hours under Plan Section 3.11 shall not exceed the maximum continuation coverage period from the date of the original Qualifying Event.

Section 4.02 Leave under the Family Medical Leave Act (FMLA)

(A) In the event an Employee employed by an Employer who is subject to FMLA, takes a leave under FMLA, the Plan will provide coverage to the Employee to the extent the Plan receives Contributions from the Employer for time spent on the leave under FMLA. The amount of monthly Contributions from an Employer required to continue an Employee's current level of coverage while on a leave under FMLA shall be determined using the average monthly hours worked by the Employee during the twelve (12) month period preceding the month in which the Participant begins a leave under FMLA.

(B) An Employer of an Employee on a leave under FMLA shall provide the Fund with proof of approval of the Employee's leave under FMLA, as determined sufficient by the Board of Trustees.

(C) Taking a leave under FMLA is not a COBRA Qualifying Event. Continuation Coverage under COBRA shall be offered if an Employee fails to return to work from an FMLA leave. At this time, the Employee will have a COBRA Qualifying Event subject to Plan Section 4.01.

Section 4.03 Leave under the Uniformed Services Employment and Reemployment Rights Act (USERRA)

(A) An Employee may be able to continue health coverage benefits under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), as amended, when he serves in the Uniformed Services as described in Plan Section 2.94.

(B) Continuation of Group Health Coverage under USERRA:

(1) If Health Coverage ends because an Employee leaves employment to perform service in the Uniformed Services, an Employee may elect to continue such health coverage, if required by USERRA, until the earlier of:

(a) The end of the period during which the Employee is eligible to apply for reemployment in accordance with USERRA, or

(b) Twenty-four (24) consecutive months after coverage ends.

(2) To continue coverage, and Employee must elect Continuation Coverage under COBRA or the Low Cost Medical Plan and pay the required premium as set forth in Plan Sections 4.01(E), unless service in the Uniformed Service is for fewer than thirty-one (31) days, in which case coverage is provided free of charge. The Fund Office will inform an Employee or the Employee's Dependents of procedures to pay premiums, as set forth in Plan Section 4.01(E).

However, in the event of a conflict between the provisions of USERRA and those of Plan Section 4.01 of this Article, an Employee who is eligible for continuation coverage rights under the provisions of USERRA and under Plan Section 4.01 will be entitled to the more generous coverage provisions of USERRA or Plan Section 4.01 during these periods in which the Employee is eligible under both provisions, and USERRA and Continuation Coverage under COBRA will run concurrently. The administrative procedures with regard to notice, election and payment under Plan Section 4.01 of the Plan for Continuation Coverage under COBRA apply to continuation coverage under USERRA.

(C) End of Continuation Coverage under USERRA: An election of continuation coverage under the provisions of this Plan Section 4.03 may terminate before the expiration of the maximum period described in paragraph (B) above for any of the following reasons:

(1) The Employee loses his rights under USERRA, such as for a dishonorable discharge,

(2) The Employee fails to pay the premium for USERRA continuation coverage,

(3) The Plan ceases providing group health plan coverage, or

(4) The Employee fails to return to work or apply for reemployment within the time required under USERRA.

(D) In the event that 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 the premium is paid in whole or

in part by an Employer, then the premium an Employee is required to pay may be adjusted for the remainder of the period provided above.

(E) Reemployment following service in the Uniformed Services can include the right to elect immediate reinstatement in any then existing health coverage provided by the Employer.

(F) In the event of a conflict between this Plan Section 4.03 and USERRA, the provisions of USERRA will prevail.

Section 4.04 Low Cost Medical Plan

(A) As an alternative to Continuation Coverage under COBRA or USERRA coverage, an Employee may elect to continue health coverage under the Low Cost Medical Plan. Coverage for any Employee or Dependent under the Low Cost Medical Plan shall not exceed eighteen (18) consecutive months (or eighteen (18) months total when combined with prior Continuation Coverage under COBRA or Self-Payment of Hours) or twenty-four (24) months of consecutive coverage for USERRA coverage. Retirees or their dependents are not eligible to elect the Low Cost Medical Plan. Health coverage benefits provided under the Low Cost Medical Plan are described in Appendix C. Health coverage is subject to change as a result of Plan modifications.

(B) An Employee who has lost coverage and elects coverage under the Low Cost Medical Plan may also elect to cover his Dependents under the Low Cost Medical Plan; provided he submits timely Premium Payments. The Employee has the option of electing single coverage or family coverage. Dependents may not independently elect coverage under the Low Cost Medical Plan.

(C) An Employee must elect and pay monthly Premium Payments for coverage under the Low Cost Medical Plan. The amount of the Premium Payments shall be determined by resolution adopted by the Trustees from time to time. No Claims will be paid under the Low Cost Medical Plan until the proper Premium Payment is received by the Fund.

(D) An Employee or Dependent who is covered under the Low Cost Medical Plan must waive his rights to Continuation Coverage under COBRA (with consent as required).

(E) Premium Payments:

(1) The submission of the first Premium Payment to the Fund for the Low Cost Medical Plan must be postmarked by the last day of the month immediately after the last day of eligibility.

(2) Subsequent monthly Premium Payments are due on the first business day of each month for which coverage is available.

(3) There is a grace period from the due date by which the Premium Payment must be paid. Coverage will be provided as long as payment for that month is received by the Fund with a post mark date no later than thirty (30) days after the due date or, for months with thirty-one (31) days, the last day of the month in which the Premium Payment is due. However, if a monthly payment is paid later than the first (1st) day of the month, but before the end of the grace period, coverage will be suspended as of the first (1st) day of the monthly coverage period. Upon receipt by the Fund of the monthly Premium Payment, but before the end of the grace period, coverage will be retroactively reinstated going back to the first day

of the month coverage was lost. Any Claim submitted for benefits while the coverage is suspended will be denied by the Plan until such time as the payment is received. Once the payment is received and processed by the Fund Office, claims received during the suspension period will be reconsidered for payment.

(F) Coverage under the Low Cost Medical Plan terminates upon the first to occur of:

(1) Premium Payments are not paid on a timely basis;

(2) Eighteen (18) consecutive months under the Low Cost Medical Plan, or eighteen (18) months total when combined with prior Continuation Coverage under COBRA, or twenty-four (24) months of consecutive USERRA coverage have elapsed;

(3) The Fund ceases to maintain any group health care coverage; or

(4) The Low Cost Medical Plan is terminated.

(G) If eligibility for the Low Cost Medical Plan terminates, an Employee may not elect the Low Cost Medical Plan again until he has reinstated and lost his eligibility under the Active Plan.

(H) The Low Cost Medical Plan does not cover:

(1) Any Hospital and medical expenses that the Active Plan does not cover;

(2) Certain medical expenses as specifically indicated in Plan Section 5.04;

(3) Hearing Care;

(4) Vision Care Benefits;

(5) Dental Care Benefits;

(6) Short Term Disability Benefits; and

(7) Accidental Death and Dismemberment Benefits.

Section 4.05 Extension of Coverage under the Active Plan of Benefits for a Work-Related Accidental Death

If an Employee, who is not an apprentice dies in a Work-Related accident while eligible for Active Plan benefits (not including Continuation Coverage under COBRA), his eligible Dependents will maintain Comprehensive Medical, dental, prescription drug and vision coverage as applicable to the Employee through the date his Active Plan coverage would have terminated. If an Employee, who is an apprentice dies in a Work-Related accident while eligible for Active Plan benefits (not including Continuation Coverage under COBRA), his eligible Dependents will maintain Comprehensive Medical and vision coverage as applicable to the Employee through the date his Active Plan coverage would have terminated. Additionally, his eligible Dependents will continue eligibility, free of charge, from the point his coverage would have terminated for an additional five (5) years. Extension of coverage is contingent upon proof of a Work-Related accidental death and other required forms.

Section 4.06 Other Continuation Coverage Option - Health Insurance Marketplace

In addition to Continuation Coverage under COBRA, other coverage options may be available to a former Employee and his Dependents if the Employee loses coverage under the Plan. The former Employee may buy coverage through the Health Insurance Marketplace. Additionally, the former Employee may qualify for a special enrollment opportunity for another group health plan for which the former Employee is eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if the former Employee requests enrollment within thirty (30) days after losing other health insurance.

ARTICLE V COMPREHENSIVE MEDICAL BENEFITS

The Plan provides coverage for Covered Medical Expenses as specified in this Article V and in the applicable Schedule of Benefits incurred as a result of a Non-Occupational Illness or Injury. For Medicare Eligible Individuals, benefits will be coordinated with Medicare as described in Plan Section 14.02, 14.03 and 14.05. Benefits are subject to the Deductible, Coinsurance and Co-payment and considered up to the amounts determined by the Trustees from time to time and in accordance with the limitations as specified below and in the Schedule of Benefits. For the Active Plan, see Appendix A, for the Retiree Plan, see Appendix B and for the Low Cost Medical Plan, see Appendix C. The following conditions apply:

Section 5.01 Deductible

The following conditions apply to the Deductible:

(A) A Deductible applies to each Covered Individual, except Medicare Eligible Individuals covered under the Retiree Plan of Benefits. A family Deductible is reached when the cumulative individual Deductibles of three (3) or more family members, who are Covered Individuals, meet the family Deductible.

(B) The PPO Deductible and Non-PPO Deductible are separate Deductibles, and cannot be combined to reach maximums.

(C) Dental coverage has a separate Deductible from the Comprehensive Medical Benefit Deductible and these Deductibles cannot be combined to reach maximums.

(D) The Plan will keep a separate record of expenses for the Calendar Year Deductible for each Covered Individual.

(E) Deductibles do not carry over from or to the Active Plan of benefits, the Low Cost Medical Plan, and/or to the Retiree Plan of benefits. When a Dependent becomes an Employee, or an Employee becomes a Dependent, Deductibles do not carry over from an Employee to a Dependent or from a Dependent to an Employee. When a Dependent child becomes a Dependent spouse or a Dependent spouse becomes a Dependent child, Deductibles do not carry over from a Dependent child to a Dependent spouse or a Dependent spouse to a Dependent child.

(F) Deductible Carryover: Any Covered Medical Expenses incurred in the last three (3) months of a Calendar Year (October, November and December) that are applied towards the Calendar Year Deductible may also be applied to the Calendar Year Deductible for the next Calendar Year.

(G) Deductibles do not apply to preventive care, hearing, prescription drug or vision benefits, as provided in the applicable Schedule of Benefits.

(H) Emergency Room Co-payment, Coinsurance amounts, and amounts charged above the Reasonable and Customary Allowance for out-of-network services, amounts paid for hearing, vision care and excluded services do not count toward the Deductible.

Section 5.02 Out-of-Pocket Maximum

The following conditions apply to the Out-of-Pocket Maximum:

(A) The Out-of-Pocket Maximum applies to each Covered Individual.

(B) A family Out-of-Pocket Maximum is reached when the cumulative individual Out-of-Pocket Maximums of three (3) or more covered family members meet the family Out-of-Pocket Maximum.

(C) PPO and Non-PPO Out-of-Pocket expenses are separate and cannot be combined to reach Out-of-Pocket Maximums.

(D) The Plan will keep a separate record of expenses for the Out-of-Pocket Maximum for each Covered Individual.

(E) Out-of-Pocket Maximums do not carry over from or to the Active Plan of Benefits, the Low Cost Medical Plan, and/or the Retiree Plan of Benefits. When a Dependent becomes an Employee, or an Employee becomes a Dependent, Out-of-Pocket Maximums do not carry over from an Employee to a Dependent or from a Dependent to an Employee. When a Dependent child becomes a Dependent spouse or a Dependent spouse becomes a Dependent child, Out-of-Pocket Maximums do not carry over from a Dependent child to a Dependent spouse or a Dependent spouse to a Dependent child.

(F) There are separate Out-of-Pocket Maximums for Comprehensive Medical and Prescription Drug Benefits. Additionally, the Retiree Plan has separate Out-of-Pocket Maximums for Comprehensive Medical Benefits, Generic/Multi Source Brand Prescription Drug Benefits, Single Source Brand Prescription Drug Benefits, and Non-Select Specialty Prescription Drug Benefits. This means that charges incurred from prescription drug Co-payments, count only toward meeting the applicable prescription drug Out-of-Pocket maximums and do not count toward the comprehensive medical Out-of-Pocket Maximum.

(G) The Plan does not apply all expenses to the Out-of-Pocket Maximum. Whether an expense applies to the Out-of-Pocket Maximum depends on whether it is a PPO or Non-PPO expense. The following expenses are not applied to the Out-of-Pocket Maximum:

(1) Expenses not considered Covered Medical Expenses;

(2) Co-payment amounts for prescription drugs;

(3) Vision and dental expenses;

(4) Amounts in excess of the Reasonable and Customary Allowance for Non-PPO Covered Medical Expenses; and

(5) Amounts in excess of a benefit maximum or lifetime maximum for non-essential health benefits, as described under the Affordable Care Act.

Section 5.03 Charges for Services Incurred when an Individual is Not Eligible Under the Plan

Charges for services incurred prior to the first day an individual becomes eligible and after an individual no longer meets the eligibility rules as described in Article III are not covered.

Section 5.04 Covered Services and Exclusions

The Plan cannot specifically delineate all treatment, expenses or charges that will be covered or subject to the Plan's exclusions because coverage and exclusions will be applied based on the facts and circumstances of the Claim. In addition to the exclusions listed in this Plan Section 5.04, the Plan's Exclusions and Limitations as listed in Article XIII or other sections of this Plan shall also apply. Covered Services are provided as described below and as specified in the Schedules of Benefits.

(A) Acupuncture:

(1) The Plan covers acupuncture for a Participant and Participant's spouse when performed by a licensed acupuncturist or, as appropriate, another provider acting within the scope of the provider's license.

(2) The Plan excludes the following:

(a) Acupuncture care for Dependent children;

(b) Prescription drugs, nutritional supplements and homeopathic medicine(s);

(c) Educational materials such as books or videos;

(d) Exercise equipment; and

(e) Preventive wellness services.

(3) All covered services provided pursuant to this subsection shall be subject to a combined annual limit for acupuncture, chiropractic care and naprapathy.

(B) Ambulance Service:

(1) The Plan covers professional ambulance service when used to transport a Covered Individual from the place where the Covered Individual is Injured as a result of an Accident, or from the place the Covered Individual is stricken by an Illness as follows:

(a) To the nearest Hospital for treatment;

(b) From one Hospital to another Hospital;

(c) From a Hospital to a rehabilitation facility;

(d) From a Hospital to an Extended Care/Skilled Nursing Facility; and

(e) From a Hospital to a Hospice Facility or home Hospice.

(2) Air or water Ambulance will be provided for Emergency transportation to the nearest facility for a life threatening condition that dictates that the time needed to transport by ground ambulance would endanger health and/or survival, or the point of pick-up is inaccessible by a land vehicle.

(3) Non-PPO charges will be considered at the applicable PPO Coinsurance rate and subject to the PPO Calendar Year Deductible.

(4) The Plan excludes the following:

(a) Charges in connection with travel for the patient's or the family's convenience;

(b) Hospital-to-home charges unless Medically Necessary; and

(c) Non-Emergency ambulance transports, except as specified above.

(C) Anesthesia or Sedation:

(1) The Plan covers general anesthesia or sedation as follows:

(a) When sedation is Medically Necessary to perform a surgical procedure for the treatment of an Illness or Injury;

(b) For dental procedures resulting from a proven accidental Injury. Dental benefits must be exhausted before anesthesia charges can be considered under the Medical portion of the Plan;

(c) For dental procedures when sedation is Medically Necessary in a Hospital or an Outpatient Medical Facility. Dental benefits must be exhausted before anesthesia charges can be considered under the Medical portion of the Plan. Services must be preauthorized and approved by the Fund Office prior to services being rendered. Not applicable to the Retiree Plan of Benefits or the Low Cost Medical Plan; and

(d) When administered in a Dentist's office for an approved Medically Necessary dental procedure. Not applicable to the Retiree Plan of Benefits or the Low Cost Medical Plan.

(2) The Plan excludes the following:

(a) General anesthesia or sedation that is not Medically Necessary;

(b) General anesthesia or sedation for the convenience of the Covered Individual or Physician; and

(c) General anesthesia or sedation to alleviate fear, stress or anxiety.

(D) Bariatric Surgery for Morbid Obesity:

(1) The Plan covers bariatric surgery for the treatment of morbid obesity based on Medical Necessity. A Covered Individual must:

(a) Contact the Fund Office;

(b) Obtain a letter from his Physician to support the Medical Necessity of the bariatric surgery and provide substantiating medical documentation to the Fund Office; and

(c) Enroll, participate and successfully complete all the requirements of the bariatric program maintained by the Contracted Provider.

(2) The Plan excludes coverage for bariatric surgery for morbid obesity or any other surgeries or procedures relating to weight reduction or obesity, including, but not limited to, complications resulting from any weight reduction surgery for which the patient did not follow the Active Plan's procedures for participating in the Contracted Provider's bariatric program.

(E) Behavioral Health Care:

The Plan provides coverage for Behavioral Health care as follows:

(1) A Covered Individual may obtain prior authorization for treatment by contacting the Contracted Provider for an authorization before seeking treatment whether the Covered Individual uses a Network provider or an Out-of-Network provider.

(2) The Plan excludes the following under Behavioral Health care benefit:

(a) Treatment for educational disorders related to learning, motor skills, communication and pervasive developmental conditions, except as described under Plan Section 5.04(MM).

(b) Services including custodial services, educational training, vocational rehabilitation, hypnosis, sleep therapy, employment counseling, back-to-school counseling, return to work services, work hardening programs, driving safety and services, training, educational therapy or non-medical ancillary services for learning disabilities, and Developmental Disabilities, except as described under Plan Section 5.04(MM).

(c) Charges for treatment of a medical condition that are covered under any other portion of the Plan;

(d) Charges for treatment of a condition that requires care in a custodial facility or group home;

(e) Room and Board Charges beyond the discharge time;

(f) Private room charges for the patient's convenience; and

(g) Charges for personal services or items and guest food trays.

(F) Breast Feeding Support and Equipment:

(1) The Plan covers lactation counseling and Durable Medical Equipment (DME) and Supplies for a female Covered Individual when provided through a PPO provider as follows:

(a) Lactation support and counseling for prenatal and postnatal lactation; and

(b) Equipment for a female Covered Individual who is lactating and requests a breast pump (which may be purchased up to three (3) months prior to the expected due date of the child) in accordance with Plan Section 5.04(N), Durable Medical Equipment (DME) and Supplies, as follows:

(i) Purchase of one (1) breast pump and related initial supplies (tubing, shields and bottles);

(ii) Rental of a Hospital-grade breast pump for the period of time a newborn is confined in the Hospital after the mother is discharged. A Hospital-grade breast pump is not considered Medically Necessary once the newborn is discharged; or

(iii) Rental of a Hospital-grade breast pump is considered Medically Necessary for up to twelve (12) months of age for babies who have congenital disorders that interfere with feeding.

(2) The Plan excludes the following:

(a) Breast pumps purchased at a retail location;

(b) The purchase or rental of Hospital-grade breast pumps, unless Medically Necessary as described in Plan Section 5.04(F)(1)(b)(ii) or (iii);

(c) Ongoing supplies, replacement tubing, bottles, or storage bags;

(d) Nursing bras, pads, or creams;

(e) Services provided by individuals who are not licensed under state law to provide medical services or an individual who is not a certified lactation consultant; and

(f) Donor breast milk and all related services and fees.

(G) Chiropractic Care:

(1) The Plan covers chiropractic manual manipulations or adjustments and therapeutic physical therapy modalities for musculoskeletal conditions when performed by a licensed chiropractor or, as appropriate, another provider acting within the scope of the provider's license as follows:

(a) For a Participant and a Participant’s spouse; and

(b) All Covered Medical Services related to chiropractic care including evaluations, x-rays, diathermy, laboratory, orthotics, therapy, Office Visits, and any other Covered Services will be considered and applied toward the chiropractic care maximum.

(2) The Plan excludes the following:

(a) Chiropractic care for Dependent children;

(b) Prescription drugs, nutritional supplements and homeopathic medicine(s);

(c) Educational materials such as books or videos;

(d) Exercise equipment; and

(e) Preventive wellness services.

(3) All covered services provided pursuant to this subsection shall be subject to a combined annual limit for acupuncture, chiropractic care and naprapathy.

(H) Clinical Trials:

(1) The Plan covers Routine Patient Costs, as defined in Plan Section 5.04(H)(4)(a), associated with Approved Clinical Trials, as defined in Plan Section 5.04(H)(4)(c), to the extent required under the Affordable Care Act.

(2) A Qualified Individual, as defined in Plan Section 5.04(H)(4)(b), must use a PPO Provider if a PPO Provider is participating in an Approved Clinical Trial and the PPO Provider will accept the Qualified Individual as a participant in the Approved Clinical Trial.

(3) To the extent required under the Affordable Care Act, the Plan will not deny any Qualified Individual the right to participate in an Approved Clinical Trial; deny, limit or impose additional conditions on the coverage of Routine Patient Costs for items and services furnished in connection with participation in an Approved Clinical Trial; and will not discriminate against any Qualified Individual who participates in an Approved Clinical Trial.

(4) For purposes of this Plan Section 5.04(H), the following definitions apply:

(a) "Routine Patient Costs" include items and services typically provided under the Plan for a Covered Individual not enrolled in an Approved Clinical Trial. However, such items and services do not include (a) the investigational item, device or service itself; (b) items and services not included in the direct clinical management of the patient, but instead provided in connection with data collection and analysis; or (c) a service clearly not consistent with widely accepted and established standards of care for the particular diagnosis.

(b) "Qualified Individual" is a Covered Individual who is eligible, according to the trial protocol, to participate in an Approved Clinical Trial for the treatment of cancer or other life-threatening Condition and either (a) the referring health care professional is a participating provider and has concluded that the Covered Individual's participation in the Approved Clinical Trial would be appropriate or (b) the Covered Individual provides medical and scientific information establishing that participation in the Approved Clinical Trial would be appropriate.

(c) "Approved Clinical Trial" is a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening Condition and is:

(i) Approved or funded by one of the following:

1. The National Institute of Health,

2. The Centers for Disease Control and Prevention,

3. The Agency for Health Care Research and Quality,

4. A cooperative group or center of any of the above entities or the Departments of Defense or Veterans Affairs,

5. A qualified non-governmental research entity identified in the guidelines issue by the National Institutes of Health for center support grants, or

6. The Departments of Veterans Affairs, Defense, or Energy if certain conditions are met.

(ii) Conducted under an investigational new drug application reviewed by the FDA, or

(iii) A drug trial that is exempt from having such an investigational new drug application.

(d) "Life-threatening Condition" is a disease or condition likely to result in death unless the disease or condition is interrupted.

(5) The Plan does not otherwise cover services or items defined as Experimental or Investigational.

(l) Contraceptives:

(1) The Plan covers education, counseling and contraceptive methods for women with reproductive capacity, to the extent required under the Affordable Care Act, as follows:

(a) FDA approved pharmaceutical contraceptives or contraceptive methods when prescribed by a Physician are covered in accordance with Article VIII, limited to the following:

(i) Generic oral contraceptives;

(ii) Generic emergency contraceptives;

(iii) Patches; and

(iv) Vaginal rings.

(b) FDA approved contraceptives or contraceptive methods (including (insertion and removal of devices and associated procedures) are covered under Comprehensive Medical Benefits when prescribed by a Physician:

(i) Diaphragms, sponges, cervical caps, female condoms and spermicide;

(ii) Intrauterine devices (IUDs);

(iii) Implants or implantable rods; and

(iv) Injectables.

(2) The Plan excludes the following:

(a) Brand name oral contraceptives; and

(b) Abortion/abortifacient drugs.

(J) Cosmetic Surgery:

(1) The Plan covers Cosmetic surgery to repair defects that result from a surgery provided the subsequent repair is performed within one (1) year from the date of the surgery that caused the defect.

(2) The Plan excludes the following:

(a) Cosmetic surgery that is not Medically Necessary or is performed solely to improve appearance;

(b) Charges for vein treatments that are Cosmetic and are not Medically Necessary; and

(c) Liposuction.

(K) Dental Services for a Non-Occupational Injury Resulting in Damage to Teeth:

(1) The Plan covers dental services to repair tooth damage resulting from a proven accidental Non-Occupational Injury as follows (not applicable to the Retiree Plan of Benefits or the Low Cost Medical Plan):

(a) The calendar year maximum dental benefit must be exhausted;

(b) Dental damage must be severe enough that the Covered Individual sought treatment from a Doctor or Dentist within forty-eight (48) hours of the time of the accidental Non-Occupational Injury;

(c) Repair of teeth must occur within one (1) year from the date of the accidental Non-Occupational Injury;

(d) Treatment is limited to the teeth involved at the time of the accidental Non-Occupational Injury; and

(e) Proof of the accidental Non-Occupational Injury must be submitted to the Fund Office.

(2) The Plan excludes the following:

(a) Damage or Injury to teeth as a result of daily living activities such as chewing and/or biting;

(b) Charges that exceed the Reasonable and Customary Allowance under the Plan;

(c) Charges related to Orthodontic Care as described in Plan Section 7.01(D);

(d) Charges related to periodontal treatment as described in Plan Section 7.01(B);

(e) Charges related to Preventive/Diagnostic care as described in Plan Section 7.01(A);

(f) Charges related to Temporomandibular Joint Disorders ("TMJ"), except as described in Plan Section 5.04(LL); and

(g) Any treatment or service rendered more than one (1) year from the date of the accidental Non-Occupational Injury.

(L) Diagnostic X-rays and Laboratory Tests:

(1) The Plan covers diagnostic x-rays and laboratory tests for services that are consistent with the diagnosis.

(2) The Plan excludes the following:

(a) Routine charges outside the Wellness Care benefit as described in Plan Section 5.04(PP);

(b) Pre-employment physicals; and

(c) Laboratory tests performed more often than industry standards recommend.

(M) Diagnostic Imaging:

(1) The Plan covers diagnostic imaging (MRI, CAT/CT, PET, Bone Scans, mammography, etc.) for services that are consistent with the diagnosis.

(2) The Plan excludes routine charges outside the Wellness Care benefit as described in Plan Section 5.04(PP).

(N) Durable Medical Equipment ("DME") and Supplies:

(1) The Plan covers DME and supplies as follows:

(a) When prescribed by a Physician;

(b) The DME provider must be licensed and accredited;

(c) The Covered Individual must submit to the Fund Office or Contracted Provider documentation establishing Medical Necessity for all DME purchases or rentals;

(d) Repair, maintenance and replacement of equipment is based on Medical Necessity and limitations may apply; and

(e) The Plan allows for a sealed battery required for electric wheelchairs.

(2) The Plan excludes the following:

(a) Rental fees in excess of the purchase price for the DME;

(b) Non-sealed lead acid or alkaline batteries;

(c) Home modifications to accommodate equipment;

(d) Repair, maintenance or replacement of DME due to misuse or abuse;

(e) Replacement of DME that has been lost or stolen;

(f) Repairs, replacement and maintenance of rented items; and

(g) Charges for air purifiers, air humidifiers, water purifiers, swimming pools, spas, saunas, escalators, motorized modes of transportation for patient convenience, pillows, mattresses, water beds, air conditioners, exercise equipment, exercise programs, or for any personal convenience items that are not corrective devices or appliances.

(O) Emergency Room Care:

The Plan covers Emergency Room care as follows:

(1) An Emergency Room Co-payment is applicable when a Covered Individual utilizes a Hospital Emergency Room and is treated and released without being admitted to the Hospital as an inpatient;

(2) The Emergency Room Co-payment will not apply:

(a) If a Covered Individual is admitted to the Hospital as an inpatient for the same condition within seventy-two (72) hours of the Emergency Room visit;

(b) If a Covered Individual utilizes a Hospital Emergency Room and is subsequently held in the observation unit of the Hospital for more than twenty-four (24) hours;

(c) If the condition is so severe that it results in death of the Covered Individual while in the Emergency Room;

(d) If a Covered Individual has met the applicable Out-of-Pocket Maximum.

(3) Non-PPO charges will be considered at the applicable PPO Coinsurance rate and subject to the Non-PPO Calendar Year Deductible.

(P) Extended Care/Skilled Nursing Facility:

(1) The Plan covers Extended Care/Skilled Nursing Facilities as follows: a single convalescent period for certain facilities which provide Medically Necessary inpatient care following a hospitalization. Such facilities may be known as Convalescent Facilities, Extended Care Facilities or Skilled Nursing Facilities. A convalescent period begins when the Covered Individual first enters an approved confinement in a Convalescent Facility, Extended Care Facility or Skilled Nursing Facility and continues until a Covered Individual has been free of confinement for

sixty (60) days. A new convalescent period begins when the Covered Individual is free of confinement for sixty (60) days and is readmitted to the Hospital for a minimum of three (3) consecutive days.

(2) An approved confinement is one where the:

(a) Attending Physician certifies that such confinement and nursing care is essential for recuperation from an Illness or Injury and that it is not for Custodial Care;

(b) Confinement is due to an Illness or Injury that required and was preceded by at least three (3) consecutive days of a Hospital confinement for which Plan benefits are payable;

(c) Confinement commences within thirty (30) days after termination of a Hospital confinement or within fourteen (14) days after termination of an Extended Care/Skilled Nursing Facility confinement for which Plan benefits are payable;

(d) Assessment of the condition is performed by the attending Physician and skilled nursing staff. The first assessment must be within the first (1st) eight (8) days; and

(e) The attending Physician continues to treat the Covered Individual and personally sees the Covered Individual and assessments are recorded on days fourteen (14), thirty (30), sixty (60) and ninety (90) until the Covered Individual is discharged.

(3) Covered Services include:

(a) Room and Board Charges including charges for services such as general nursing care made in connection with occupying a room; coverage is limited to the most common semi-private room rate.

(b) Other Medically Necessary services and supplies including the use of special treatment rooms, x-ray and laboratory examinations; physical, occupational or speech therapy; medications; medical supplies and equipment used in the facility; medical social services; dietary counseling; and Medically Necessary ambulance transportation to the nearest medical facility that renders needed services that are not available at the Extended Care/Skilled Nursing Facility.

(4) The Plan excludes the following:

(a) Personal services and items;

(b) Guest food trays; and

(c) Private rooms for patient convenience.

(Q) Genetic Testing:

(1) The Plan covers the following genetic testing when prescribed by a treating Physician:

(a) Genetic testing required under the Affordable Care Act, including colon cancer screening tests collected at home (e.g., Cologuard); and

(b) Diagnostic genetic testing.

(2) The Plan does not cover non-diagnostic genetic testing. Non-diagnostic genetic testing includes, but is not limited to, the following:

(a) Forensic testing used to identify an individual for legal purposes;

(b) Genetic testing used to determine the paternity of an individual;

(c) Genealogical testing used to determine the ancestry of an individual; and

(d) Genetic testing performed for the purpose of research.

(R) Hearing Care:

(1) The Plan covers hearing care as follows:

(a) Charges for a hearing examination and related testing performed by a state licensed otologist, otolaryngologist or, as appropriate, another provider acting within the scope of the provider's license. Not applicable to the Low Cost Medical Plan; or

(b) Charges for a hearing aid instrument or its repair. Not applicable to the Low Cost Medical Plan.

(2) If a Covered Individual uses an Out-of-Network provider for services described in Plan Section 5.04(R)(1), the Covered Individual or his provider must file a Claim with the Fund Office or the Contracted Provider and submit the following:

(a) A copy of itemized bills for the hearing exam and hearing aid; and

(b) A copy of the prescription indicating the name, model number, battery power, and frequency response of the recommended hearing aid.

(3) The Plan excludes the following:

(a) Examinations and/or hearing aid instruments not prescribed by an otologist or otolaryngologist or, as appropriate, another provider acting within the scope of the provider's license; and

(b) Replacement of hearing aid batteries.

(S) Home Health Care:

The Plan covers home health services and supplies in a Covered Individual's home when ordered by a treating Physician and services are provided by a Home Health Agency in order to obtain a specified medical outcome. Each house call made by a member of the home health care team counts as one (1) visit. Each house call up to four (4) hours made by a home health aide also counts as one (1) visit. However, if all visits are performed on the same day, by the same agency, they count as only one (1) visit. The following apply:

(1) Medically Necessary home health services provided in a Covered Individual's residence as an appropriate cost-effective alternative to care in another health care setting (*e.g.*, inpatient hospital, inpatient skilled nursing facility, long term care facility) include:

(a) Physical, occupational, respiratory and speech therapy when used to restore loss of an established function caused by an Illness or Injury;

(b) Medical supplies, DME, prescription drugs and medicines, enteral feeding, diagnostic x-ray and laboratory tests for services if these services and supplies would have been covered had the Covered Individual been confined in a Hospital or Convalescent Facility;

(c) Skilled nursing care on a part-time or intermittent basis, including services and care that can only be performed safely and effectively by a licensed nurse (either a registered nurse or licensed practical nurse), licensed vocational nurse or another provider acting within the scope of the provider's license; and

(d) Medical social services, under the direction of a Physician.

(2) A prescribed Treatment Plan outlining the treatment goals must be submitted with the request for specific services and supplies. Periodic review of the prescribed Treatment Plan and progress towards those goals may be required for continued skilled nursing care needs.

(3) The Plan excludes the following:

(a) Twenty-four (24) hours a day home health care;

(b) Home delivery of meals;

(c) Homemaker services such as shopping, cleaning, and laundry when this is the only care needed and when these services are not related to a Covered Individual's Treatment Plan;

(d) Custodial care, domiciliary care, respite care, rest cures or personal care given by a home health aide such as bathing, dressing, and using the bathroom when this is the only care provided; and

(e) Private duty nursing.

(T) Hospice Care:

(1) The Plan covers Hospice care as follows:

(a) For a Covered Individual with a terminal medical condition who receives palliative care provided at home, an outpatient setting or in an institutional setting and is under the direction of a Medicare approved Hospice program;

(b) A Covered Individual is considered terminal when a Physician certifies that the medical condition and prognosis indicates a life expectancy of six (6) months or less;

(c) Hospice care benefit begins on the date the attending Physician of a Covered Individual certifies a diagnosis of terminal Illness and the Covered Individual is placed into a Hospice program;

(d) Covered Hospice care expenses include the following services and supplies, if such services and supplies are provided by or through an organization that meets the Plan's definition of a Hospice Facility or a Hospice care program:

(i) Room and Board Charges. Services are not to exceed the facility's most common semi-private room rate.

(ii) Other services and supplies:

[a] Doctor Services;

[b] Nursing care;

[c] Medical equipment (such as wheelchairs or walkers);

[d] Medical supplies (such as bandages and catheters);

[e] Prescription drugs to alleviate symptoms or pain management;

[f] Hospice aide;

[g] Enteral feedings; and

[h] Short-term inpatient care for pain and symptom management.

(2) The Plan excludes the following:

(a) Room and Board Charges if Hospice services are provided in the home;

(b) Long-term inpatient care in a hospital;

(c) Prescription drugs to cure an Illness;

(d) Administrative services;

(e) Homemaker or caretaker services and any services or supplies not solely related to the care of the Covered Individual, including sitter or companion services for the Covered Individual who has an Illness, house cleaning, general maintenance of the Covered Individual's home or childcare;

(f) Transportation except when Medically Necessary;

(g) Any services or supplies not provided as core services by the Hospice program providing the Hospice care;

(h) Home delivered meals;

(i) Funeral arrangements;

(j) Pastoral or bereavement counseling; and

(k) Respite Care Services.

(U) Hospital Care

(1) The Plan covers Hospital care as follows:

(a) Inpatient Hospital:

(i) A semi-private room with nursing services and supplies;

(ii) Private room charges with nursing services and supplies if Medically Necessary for conditions that include, but are not limited to, contagious or communicable diseases;

(iii) Intensive and coronary care units;

(iv) Operating rooms and equipment;

(v) Drugs, biological, supplies, appliances, and equipment for use in the Hospital that are ordinarily furnished by the Hospital for the care and treatment of a Covered Individual; and

(vi) Nursery charges for newborns.

(b) Outpatient Hospital:

(i) Services and supplies provided on an outpatient Hospital basis;

(ii) Facility fees for outpatient surgery; and

(iii) Treatment including x-rays, radium therapy and other radioactive substances, chemotherapy, laboratory and diagnostic radiology and imaging.

(c) Dental Services: For certain dental procedures that are preauthorized and approved by the Fund Office prior to services being rendered. Not applicable to the Retiree Plan of Benefits or the Low Cost Medical Plan.

(d) The Plan provides a Hospital Recovery Incentive Program ("Hospital Recovery Program") that allows a Covered Individual to receive up to twenty-five percent (25%) of any savings that result from a Covered Individual discovering overbilled charges on his Hospital bill, in accordance with the following provisions:

(i) Notify the Fund Office of the overbilled charges;

(ii) To be eligible for the twenty-five percent (25%) cash incentive a Covered Individual must arrange with the Hospital to have the overbilled charges reversed and a corrected Claim submitted to the Contracted Provider;

(iii) The maximum paid by the Fund in any Calendar Year to any Covered Individual under the Hospital Recovery Program will not exceed five hundred dollars ($500);

(iv) Overbilled charges that total less than twenty-five dollars ($25) are not eligible for reimbursement under the Hospital Recovery Program; and

(v) The Hospital Recovery Program does not apply to Physician charges.

(2) The Plan excludes the following:

(a) Room and Board Charges beyond the approved discharge time;

(b) Charges for personal services or items and guest food trays;

(c) Hospital admission charges solely for x-rays, laboratory, electrocardiographic examinations or physical therapies;

(d) Private rooms or private nursing charges for patient convenience; and

(e) Charges for medical records or to review medical records, write evaluations or special reports, or to complete school, camp, or immunization records, or to complete a Claim form.

(V) Infertility:

(1) The Plan covers infertility services as follows:

(a) Services and supplies for the treatment of infertility or the promotion of conception;

(b) Infertility care is only available for a Participant and the Participant's spouse; and

(c) Infertility prescriptions are covered under the Comprehensive Medical Benefits portion of the Plan, subject to applicable PPO and Non-PPO Deductibles and Coinsurance.

(2) The Plan excludes the following:

(a) Reversal of an elective sterilization procedure;

(b) Infertility treatments after the reversal of an elective sterilization procedure;

(c) Medical services rendered to a surrogate for purposes of childbearing when the surrogate is not a Covered Individual;

(d) Cryopreservation or similar procedures for the storage of sperm, eggs and embryos;

(e) Any expenses incurred by an egg or sperm donor;

(f) Harvesting of eggs or semen from a donor other than the Participant or the Participant's spouse;

(g) Infertility treatments that are Experimental or Investigational in nature;

(h) Ovulation kits, sperm testing kits and supplies; and

(i) Infertility treatment or services for a Dependent child.

(W) Infusion Therapy:

The Plan covers infusion therapy prescribed by a Physician as follows:

(1) Infusion therapy includes the services and supplies required in the administration of medication, nutrients or other solutions into the bloodstream, digestive system or the membranes surrounding the spinal cord or under the skin; and

(2) When administered in a Physician's office, the medication should be obtained through the Contracted Provider for prescription drugs.

(X) Member Assistance Program:

Through its Contracted Provider, the Plan provides short-term support, resources and information for personal and work life issues through a Member Assistance Program ("MAP"). A Covered Individual may, but is not required to, obtain services under the MAP prior to receiving the benefits described in Plan Section 5.04(E) or (HH). In addition, if treatment is required beyond the benefits available through the MAP, the Covered Individual will be referred for additional counseling under the Behavioral Health/Substance Use Disorder benefit. MAP services are available to Covered Individuals up to twelve (12) months beyond the loss of eligibility. Not applicable to the Retiree Plan of Benefits.

(Y) Naprapathy:

(1) The Plan covers naprapathy when performed by a doctor of naprapathy or, as appropriate, another provider acting within the scope of the provider's license.

(2) The Plan excludes the following:

(a) Naprapathic care for Dependent children;

(b) Prescription drugs, nutritional supplements and homeopathic medicine(s);

(c) Educational materials such as books or videos;

(d) Exercise equipment; and

(e) Preventive wellness services.

(3) All covered services provided pursuant to this subsection shall be subject to a combined annual limit for acupuncture, chiropractic care and naprapathy.

(Z) Nutritional Counseling:

(1) The Plan covers the following nutritional counseling on limited basis when prescribed by an in-network Physician:

(a) To the extent required under the Affordable Care Act for the diagnosis of obesity, diabetes, cardiovascular and kidney disease;

(b) For Covered Individuals who participate in the bariatric program maintained by the Contracted Provider; and

(c) For treatment of eating disorders.

The services can be provided by a registered dietician, a Medicare-approved nutrition professional or, as appropriate, by another provider acting within the scope of the provider's license.

(2) The Plan excludes nutritional counseling for conditions other than those stated above.

(AA) Oral and Maxillofacial Surgery:

The Plan covers oral and maxillofacial surgery by a Doctor of Medicine (MD) or, as appropriate, another provider acting within the scope of the provider's license, as follows:

(1) Excision and/or biopsy of tumors and cysts of the jaw, cheek, lip, tongue, roof and floor of the mouth. An explanation of benefits must be received from the Contracted Dental Provider indicating that the excision or biopsy has not been covered or only partially covered through the Contracted Dental Provider. An excision and/or biopsy will be covered through either the Contracted Dental Provider or through the Comprehensive Medical Benefits;

(2) Removal of teeth which is Medically Necessary in order to perform radiation therapy as treatment of oral and/or facial cancer;

(3) Stabilization of facial bone fractures;

(4) External excision and drainage of abscess (cellulitis);

(5) Surgery of accessory sinuses, salivary glands or ducts;

(6) Resection of osteomyelitis; and

(7) A frenulectomy.

The Plan excludes the following:

(1) Orthodontic, periodontics, endodontic, prosthetic services;

(2) Dental services, including:

(a) Restorative care to the dentition including crowns, fillings, bridges, partial and full dentures;

(b) Occlusal adjustments or equilibration to the teeth except as allowed in Plan Section 5.04(LL);

(c) Dental applications including bite splints and metal based occlusal appliances;

(d) Extraction of unerupted or partially erupted, malpositioned or impact teeth;

(e) Surgical preparation of mouth for dentures;

(f) Surgery for gum disease;

(g) Surgery which is part of an orthodontic treatment;

(h) Alveolectomy and alveoplasty;

(i) Frenulectomy when performed by a Dentist;

(j) Vestibuloplasty;

(k) Services for oral surgery procedures covered under the Dental Benefit; and

(l) Unsubstantiated or unproven accidental Injuries.

(BB) Organ or Tissue Transplants:

(1) The Plan covers organ or tissue transplants as follows:

(a) For organ and tissue procurement and transplant surgery;

(b) For complications from organ procurement and surgery; and

(c) Donor expenses associated with living donor evaluations, donation surgery procedure and required postoperative care.

(2) The Plan excludes the following:

(a) Expenses for treatment of any other donor health-related concerns that may be identified during the donor evaluation process;

(b) Expenses that fall outside the transplant donor evaluation such as, but not limited to, annual physicals, travel, lodging, lost wages and other non-medical expenses;

(c) Costs of anti-rejection drugs following discharge, other than those covered under Plan Section VIII, Prescription Benefits; and

(d) Charges incurred by organ donors that are not related to the original donor transplant procedure, or complications that result from such surgeries, procedures, or treatments.

(CC) Physician Services:

The Plan covers services of a Physician, but excludes the following:

(1) Services that are inconsistent with the diagnosis;

(2) Charges for medical records or to review medical records, write evaluations or special reports, to complete school, camp or immunization records or to complete claim forms;

(3) Multiple charges for Office Visits for the same condition or diagnosis from the same Physician for the same date of service; and

(4) Charges for missed appointments.

(DD) Pregnancy Care:

(1) The Plan covers obstetrical care, pre- and post-natal care, and delivery when provided by a Physician or a Certified Nurse Mid-Wife as follows:

(a) Pregnancy is covered the same as an Illness; and

(b) The Plan does not limit or require authorization for any child-birth related stays of less than forty-eight (48) hours following a normal vaginal delivery, or of less than ninety-six (96) hours following a cesarean section. The Covered Individual's Physician may discharge the mother and/or newborn in less than forty-eight (48) hours (or ninety-six (96) hours) after consultation with the mother.

(2) The Plan excludes the following:

(a) Prenatal classes;

(b) Services provided by a doula, unless licensed by a recognized state licensing entity;

(c) Home pregnancy tests;

(d) Paternity testing; and

(e) Non-prescription prenatal vitamins.

(EE) Prosthetics:

(1) The Plan covers prosthetics and replacement prosthetics if Medically Necessary as follows:

(a) Artificial limbs, including artificial legs, arms and eyes when prescribed by a Physician; and

(b) Hair prosthesis including a wig or hair piece for an individual with hair loss due to chemotherapy or radiation therapy as a result of a cancer diagnosis or from taking medications associated with an organ transplant. Not applicable to the Low Cost Medical Plan.

(2) The Plan excludes the following:

(a) Hair transplants, hair plugs or hair weaves;

(b) The cost of maintenance for a wig, hair piece or scalp prosthetic, including styling and cleaning;

(c) Diagnostic or therapeutic methods intended to encourage hair regrowth;

(d) Wigs, hairpieces or other scalp prosthetics for hair loss caused by something other than a cancer diagnosis or medications associated with an organ transplant`; and

(e) Replacement of a prosthetic due to loss or theft.

(FF) Reconstructive Breast Surgery:

(1) The Plan covers reconstructive breast surgery and breast prosthesis as follows:

(a) Post mastectomy without regard to the time elapsed since the mastectomy;

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

(c) Surgery and reconstruction of the other breast for the purpose of achieving reasonable breast symmetry; and

(d) Prostheses and treatment for physical complications at all stages of the mastectomy, including lymphedemas in a manner determined in consultation with the attending provider and the patient.

(GG) Sterilization:

(1) The Plan covers sterilization as follows:

(a) Elective sterilization for a Participant; and

(b) Elective sterilization for a Participant’s spouse.

(2) The Plan excludes the following:

(a) Reversal of an elective sterilization procedure; and

(b) A sterilization procedure for a Dependent child, except as required by the Affordable Care Act.

(HH) Substance Use Disorders:

The Plan provides coverage for Substance Use Disorders as follows:

(1) A Covered Individual may obtain prior authorization for treatment by contacting the Contracted Provider for an authorization before seeking treatment whether the Covered Individual uses a Network provider or an Out-of-Network provider.

(2) The Plan excludes the following under the Substance Use Disorder benefit:

(a) Charges for treatment of a medical condition that are covered under any other portion of the Plan;

(b) Care in a custodial facility or group home;

(c) Room and Board Charges beyond the approved discharge time;

(d) Private room charges for the patient's convenience; and

(e) Charges for personal services or items and guest food trays.

(II) Surgi-Centers:

(1) The Plan covers Surgi-Center services and supplies as follows:

(a) A PPO Surgi-Center; and

(b) A PPO or Non-PPO Surgi-Center affiliated with a Hospital.

(2) The Plan excludes coverage for Non-PPO Surgi-Center facilities that are not affiliated or associated with a Hospital, as well as, all associated charges for services that may have been performed at such facility.

(JJ) Surgical Assistant and Assistant Surgeon:

The Plan covers fees for surgical assistants and/or assistant surgeons when the procedure warrants the necessary assistance of another Physician (Assistant Surgeon) or other trained personnel such as a Physician Assistant or Registered Nurse First Assistant to assist the primary Physician.

(KK) Surgical Consultations:

The Plan covers fees for a surgical consultation and the charges for any laboratory or x-ray examinations made in connection with such surgical consultation.

(LL) Temporomandibular Joint Disorders (TMJ):

(1) The Plan covers services and supplies for the diagnosis and treatment of temporomandibular joint disorders (TMJ) as follows:

(a) Diagnostic imaging procedures;

(b) Physical or occupational therapy;

(c) Appliances and their adjustments for TMJ and bruxism (occlusal);

(d) Non-surgical treatments; and

(e) Surgical procedures including related hospitalization.

(2) The Plan excludes coverage for the treatment of restorations of the dentition, supporting tissues, and bone.

(MM) Therapy Services (Outpatient Physical, Speech and Occupational):

The Plan covers outpatient physical, occupational or speech therapy as follows:

(1) Restorative/Rehabilitative therapy: Outpatient physical, occupational or speech therapy for a Covered Individual prescribed by a Physician to restore or rehabilitate an established physical function lost or impaired due to disease, acute Illness, acute Injury or surgical procedure with an expectation that the Covered Individual's condition will improve significantly.

After the benefit maximum has been reached as described in the Schedule of Benefits, no other payments is made under the Plan with the following exception: If the maximum benefit is reached for the outpatient treatment of cerebral palsy, cerebral vascular incident (stroke), intracranial bleed or other head traumas, spinal cord injuries, multiple or complicated fractures or other catastrophic diagnoses with neurological implications, significant or multiple Injuries and or Illnesses. Medical records will be required for additional benefit consideration.

(2) Developmental Disability/Habilitative Therapy to Teach a Physical Function: The Plan covers Medically Necessary outpatient habilitative (to teach) physical, occupational and speech therapies for eligible Dependents through age eighteen (18) diagnosed to have Developmental Disabilities. The Plan will consider benefits only after supporting documentation is received from the attending Physician for the therapies prescribed. Supporting documentation may include, but is not limited to, the initial evaluation, Treatment Plan and/or progress notes.

(NN) Urgent/Immediate Care Facilities and Retail Clinics:

The Plan covers Urgent/Immediate Care Facilities and Retail Clinics.

(OO) Vision Surgery:

(1) The Plan covers vision surgery (e.g., glaucoma, cataract surgery with our without lens replacement).

(2) The Plan excludes coverage for vision surgery and related expenses for correction of refractive disorders, refractive lenses, refractive keratoplasty procedures and Cosmetic blepharoplasty.

(PP) Wellness Care under the Affordable Care Act:

The Plan intends to comply with preventive services as required under the Affordable Care Act.

(1) The Plan covers items or services with an A or B rating as recommended or defined by the U.S. Preventive Service Task Force, immunizations recommended by the Centers for Disease Control, preventive care and screenings for infants, children and adolescents supported by the Health Resources and Services Administration (HRSA) and screenings for women supported by HRSA subject to the following:

(a) Wellness Care services covered under the Affordable Care Act are not payable under other portions of the Plan.

(b) The Plan will use reasonable medical management techniques to control costs of Wellness Care services provided under the Affordable Care Act. However, if the Plan does not have an in-network provider to provide a particular Wellness Care item or service, the Plan will cover the item or service provided by an out-of-network provider without cost-sharing, upon receipt of substantiating documentation.

(c) If a Wellness Care item or service is billed separately from an Office Visit, and the primary purpose is not the delivery of such Wellness Care item or service covered under the Affordable Care Act, then the Plan will impose the applicable Deductible and Coinsurance with respect to the Office Visit.

(2) Smoking cessation interventions based on requirements of the Affordable Care Act.

(3) Comprehensive Health Evaluation and Physical Exam: The Plan covers a comprehensive health evaluation and physical exam through the Fund's Contracted Provider for a Participant and Spouse. The plan excludes coverage for Dependent children and Medicare eligible retirees and spouses.

(4) The Plan excludes the following services unless otherwise required under the Affordable Care Act:

(i) Services related to a symptomatic or diagnostic condition;

(ii) Examinations and tests to diagnose or verify a pregnancy;

(iii) Premarital examinations;

(iv) Paternity testing;

(v) Pre-employment physicals;

(vi) Services that are not consistent with Wellness Care under the Affordable Care Act;

(vii) Additional testing or services to confirm an Illness or Injury diagnosed as a result of a wellness care examination or procedure;

(viii) Wellness Care services under the Affordable Care Act are covered when performed for preventive screening reasons and billed under the appropriate preventive services codes. Other services are covered under the applicable Plan benefit, not the Wellness Care services benefit; and

(ix) Travel immunizations (e.g., typhoid, yellow fever, cholera, plague, and Japanese encephalitis virus) are not covered.

Section 5.05 Carpenters Center for Health Benefits

(A) Eligibility for Services

The Plan has established the Carpenters Center for Health ("Health Center") for eligible Covered Individuals who are enrolled in Comprehensive Medical Benefits under the Fund's Active, Retiree and Low Cost Medical Plans. All enrolled Covered Individuals except the following are eligible for Health Center services:

(1) Dependents younger than the age of two; and

(2) Retirees and their eligible Dependents who are not enrolled in either the Comprehensive Medical Benefits or the Medicare Part A and B Supplemental coverage.

(B) Deductible, Coinsurance, and Co Payments

Services provided through the Health Center, as described in this Section 5.05, are provided at no charge to eligible and enrolled Covered Individuals. Health Center services are not subject to the Deductible, Coinsurance or Co-payment.

Services ordered by the Health Center staff including laboratory testing, screenings or imaging not provided at the Health Center are covered under the Comprehensive Medical Benefits, and may be subject to the Deductible, Coinsurance and Co-payment.

(C) Scope of Services

Services provided at the Health Center are limited to those described in this Section 5.05. Services include but are not limited to:

(1) Primary Care;

(2) Preventive Care Services;

(3) Sports and school physicals;

(4) Clinical Laboratory Services, which include, but are not limited to:

(5) Diagnostic testing performed on-site; and

(6) Specimen collection and diagnostic testing for routine Physician-ordered tests that are sent by the Health Center to a qualified off-site laboratory for results.

(7) Disease Management Services, including physician services and counseling for the management of chronic diseases and conditions; and

(8) Health and Wellness Services, which include, but are not limited to:

(9) Biometric testing;

(10) Health Risk Assessments; and

(11) Education and counseling for disease prevention and wellness promotion.

(D) Health Center Prescription Drug Dispensing

The Health Center may dispense on-site commonly prescribed generic medications, except controlled substances, as approved from time-to-time by the Trustees.

(E) Health Center Exclusions

The Health Center does not cover any service excluded under Plan Section 15.01(A) unless the Covered Individual complies with the requirements of Plan Section 15.01(B), including execution of a subrogation and reimbursement agreement.

ARTICLE VI VISION CARE BENEFITS

The Plan provides coverage for vision care expenses for a Covered Individual as a result of a Non-Occupational Illness or Injury through a Contracted Provider.

Vision benefits are fully insured and shall exclusively be considered for payment pursuant to the insurance policy maintained by the Plan with the Insurance Company. The Plan shall not be responsible for paying insured vision benefits in the event it is determined that vision benefits are not payable under the insurance policy by the Insurance Company. If there is any discrepancy between the benefits described in this Article VI, in the Schedule of Benefits for the Active Plan, see Appendix A, in the Schedule of Benefits for the Retiree Plan see Appendix B, and the insurance policy issued by the Insurance Company, the terms of the insurance policy shall govern.

Vision benefits in this Article VI shall be characterized as an excepted benefit under HIPAA and the Affordable Care Act. The following conditions apply:

Section 6.01 Covered Services

The Plan provides coverage for vision care as follows:

(A) A vision examination with refraction;

(B) Lenses and frames; and

(C) Contact lenses.

Section 6.02 Vision Benefit Exclusions

The Plan excludes the following services:

(A) Special procedures such as orthoptics or vision training, special supplies or non-prescription sunglasses, and sub-normal vision aides;

(B) Visual field analysis that does not include refraction;

(C) All vision surgeries, except as covered under Plan Section 5.04(OO); and

(D) Expenses for artificial eyes, except as covered under Plan Section 5.04(EE).

Section 6.03 Vision Benefits under the Low Cost Medical Plan

Vision benefits are not available under the Low Cost Medical Plan.

ARTICLE VII DENTAL CARE BENEFITS

The Plan provides coverage for dental care expenses for a Covered Individual in the Active Plan as a result of a Non-Occupational Illness or Injury through a Contracted Provider. Benefits for the Active Plan are considered up to the amounts determined by the Trustees from time to time and in accordance with the limitations as specified below and in the Schedule of Benefits for the Active Plan, see Appendix A.

Dental benefits under the Retiree Plan of Benefits are fully insured and shall exclusively be considered for payment pursuant to the insurance policy maintained by the Plan with the Insurance Company. The Plan shall not be responsible for paying insured dental benefits in the event it is determined that dental benefits are not payable under the insurance policy by the Insurance Company. If there is any discrepancy between the benefits described in this Article VII, in the Schedule of Benefits for the Retiree Plan, see Appendix B, and the insurance policy issued by the Insurance Company, the terms of the insurance policy shall govern.

Dental benefits in this Article VII shall be characterized as an excepted benefit under HIPAA and the Affordable Care Act. The following conditions apply:

Section 7.01 Covered Services

The Plan provides coverage for dental care as follows:

(A) Preventive/Diagnostic care includes:

(1) Prophylaxis (cleaning);

(2) Routine oral examination;

(3) X-rays;

(a) Bitewings;

(b) Full mouth or panoramic; and

(c) Cephalometric.

(4) Topical fluoride applications;

(5) Sealants on first (1st) and second (2nd) molars; and

(6) Emergency palliative treatment.

(B) Basic Dental Care includes expenses incurred as a result of a dental disease or defect as follows:

(1) Fillings including amalgam, synthetic porcelain or plastic restorations/fillings, or gold restorative services when the teeth cannot be restored with another filling material; except synthetic porcelain and gold restorative services are covered under Major Services for the Retiree Plan of Benefits.

(2) Oral Surgery for extraction of a tooth, including pre and post-operative care;

(3) Periodontal treatment;

(4) Endodontic treatment;

(5) Removal of cysts and tumors by a Dentist or Doctor of Dentistry;

(6) General anesthesia (for Retiree Plan of Benefits, in conjunction with oral surgery);

(7) Consultations; and

(8) Space maintainers.

(C) Major Dental Care includes:

(1) Placement of a crown, jacket or veneer, when a tooth cannot be restored with a filling material;

(2) Prosthetics including bridges, partial dentures, complete dentures, space maintainers;

(3) Orthodontic retainers (Active Plan of Benefits only);

(4) Dental implants, bone lengthening and related dental procedures; and

(5) Synthetic porcelain and gold restorative fillings (Retiree Plan of Benefits only).

(D) Orthodontic Care includes the placement of orthodontic appliances. Charges for orthodontic care are not considered for payment until the orthodontic services are rendered. Not applicable to the Retiree Plan of Benefits.

Section 7.02 Dental Benefit Exclusions

Except as covered under comprehensive medical benefits in Plan Section 5.04, the Plan excludes the following:

(A) Services compensable under Workers' Compensation or Employers' liability laws;

(B) Treatments, including prosthetics, which were started prior to the date a Covered Individual became eligible under the Active Plan;

(C) Any service for which coverage is not specifically provided under the Plan's dental benefits including Hospital or prescription drug charges; except as covered in Plan Section 5.04.

(D) Temporary restorations;

(E) Any treatment to whiten teeth;

(F) Services performed for Cosmetic purposes;

(G) Replacement of a dental appliance (prosthetic) due to loss or theft;

(H) Occlusal, bruxism and TMJ appliances and adjustments; except as covered in Plan Section 5.04

(I) Treatment of oral and/or facial cancer;

(J) Treatment of fractures of facial bones;

(K) External excision and drainage of an abscess;

(L) Surgery of accessory sinuses, salivary glands or ducts;

(M) Resection of osteomyelitis;

(N) Emergency facility care to stabilize dental structures following an acute Injury to teeth; except as covered in Plan Section 5.04;

(O) Services provided or paid for by any governmental agency or under any governmental program or law, except as to charges that the person is legally obligated to pay. This exception extends to any benefits provided under the U.S. Social Security Act and its amendments; and

(P) Services covered under any other group program or employer, Union or association sponsored program, to the extent that more than one hundred percent (100%) recovery would be made for any charges that are at least partially covered under any one or more of such programs, including this Plan.

Section 7.03 Dental Coverage after Termination of Eligibility under the Active Plan

If coverage terminates while a Covered Individual is receiving Major Dental Care that started before the Covered Individual's eligibility terminated under the Active Plan, benefits will continue to be payable for such treatment incurred within thirty (30) days from the Covered Individual's termination of eligibility. This extension of coverage does not apply to orthodontic treatment. Not applicable to the Retiree Plan of Benefits.

Section 7.04 Dental Benefits under the Low Cost Medical Plan

Dental benefits are not available under the Low Cost Medical Plan.

Section 7.05 Dental Benefits for Apprentices

Dental Benefits are not available to apprentices, except as described in Plan Sections 3.02(C) and 3.10(C).

Section 7.06 Dental Calendar Year Maximum Carryover for the Active Plan of Benefits

Covered Individuals can carry over their qualified, unused Calendar Year maximum dental benefit dollars from one Calendar Year to the next. The Plan's dental benefit administrator will establish a "To Go Bank" for Covered Individuals to be credited with unused maximum dollars that will increase total dollars for dental treatment the following Calendar Year. The following applies:

(A) A Covered Individual must have been covered under the Plan for the full Calendar Year;

(B) A Covered Individual must have submitted at least one (1) dental Claim during the Calendar Year that would apply to his annual dental maximum with allowed dollar amounts that are greater than zero dollars.

(C) The carryover amount may not exceed the amount of the annual dental maximum.

(D) Unused annual dental maximums are only available while the Covered Individual is covered under the Plan and cannot be carried over or transferred to another dental plan.

ARTICLE VIII PRESCRIPTION DRUG BENEFITS

The Plan provides coverage for prescription drugs for a Covered Individual as a result of a Non-Occupational Illness or Injury through a Contracted Provider who provides a network of retail pharmacies (hereinafter referred to as “network pharmacies”) and a mail order program. Benefits are considered up to the amounts determined by the Trustees from time to time and in accordance with the limitations as specified below and in the Schedule of Benefits. For the Active Plan, see Appendix A, for the Retiree Plan, see Appendix B and for the Low Cost Medical Plan, see Appendix C. The following conditions apply:

Section 8.01 Covered Services

The Plan provides coverage for prescription drugs as follows:

(A) The Plan covers prescribed "legend" drugs, syringes and hypodermic needles that are lawfully obtainable only from a person licensed to dispense drugs upon the written order (prescription) of a Physician or Dentist. A "legend" drug is any medicinal substance that the Federal Food, Drug and Cosmetic Act require to be labeled: “Caution - Federal law prohibits dispensing without prescription” or “Rx Only.”

(B) The Plan covers prescribed specialty medications that are lawfully obtainable only from a person licensed to dispense drugs upon the written order (prescription) of a Physician. Specialty medications are used to treat complex chronic or rare medical conditions and may require special handling, administration, and monitoring.

(C) Clinical Management Programs: A Covered Individual is required to participate in the Clinical Management Programs, such as the Preferred Drug Step Therapy Program, the Preferred Therapy Prior Authorization Program, or the Partial Fill Program, as administered by the Plan’s Contracted Provider for prescription drugs.

(D) Specialty Pharmacy Copay Assistance Program: Covered Individuals who use Select Specialty Medications are required to participate in the Specialty Pharmacy Copay Assistance Program administered by the Plan's Contracted Provider. When Covered Individuals enroll in this program there is no Co-payment for the Select Specialty Medication. If the Covered Individual does not enroll in this program, the Covered Individual is responsible for the full cost of the Select Specialty Medication and the costs are not applied toward satisfying the Deductible or the applicable Prescription Drug Benefit Out-of-Pocket Maximum. The Contracted Provider determines and identifies the Select Specialty Medications that are a part of the Specialty Pharmacy Copay Assistance Program.

(E) Retail Pharmacy Program:

(1) Quantity Limitations: See the Schedule of Benefits for the Active Plan, Appendix A, the Schedule of Benefits for the Retiree Plan, Appendix B and the Schedule of Benefits for the Low Cost Medical Plan, Appendix C for the amount of medication that may be purchased at one (1) time through the retail pharmacy program.

(2) Limitation on the use of the Retail Pharmacy Program: If a Covered Individual takes Long Term Medication(s), the Covered Individual will be allowed to have

that prescription(s) filled at a retail pharmacy a maximum of three (3) times. Thereafter, a Covered Individual's Long Term Medication prescription(s) will be covered by the Plan only when the Covered Individual uses the mail order program of the Contracted Provider.

(3) Out of Network Retail Pharmacy: If a Covered Individual purchases a prescription medication at a pharmacy that is not a Network pharmacy, the Covered Individual will pay the full cost of the drug charged by the Out of Network retail pharmacy. For reimbursement, the Covered Individual must file a Claim with the Contracted Provider. The reimbursement amount is based on the discounted amount the Contracted Provider would have paid to a Network pharmacy for the same drug.

(F) Mail Order Program:

(1) The Plan provides coverage of Long Term Medications if purchased through the mail order Program administered by the Contracted Provider.

(2) Quantity Limitations: See the Schedule of Benefits for the Active Plan, Appendix A, the Schedule of Benefits for the Retiree Plan, Appendix B and the Schedule of Benefits for the Low Cost Medical Plan, Appendix C for the amount of medication that may be purchased at one (1) time through the mail order program.

(3) Extended Care/Skilled Nursing or Assisted Living Facility Exceptions: The Fund Office will make an exception to the mandatory mail order program if a Covered Individual is a resident of a licensed and accredited Extended Care/Skilled Nursing or assisted living facility and the facility is unable to use the mail order program. A Covered Individual must provide documentation from the facility verifying residency and stating the specific reason why the facility is unable to utilize the Contracted Provider's mail order program.

Section 8.02 Out-of-Pocket Maximum for the Active Plan

The Plan limits the amount a Covered Individual pays out-of-pocket for prescription medications in a Calendar Year as provided in the Schedule of Benefits for the Active Plan, see Appendix A. Amounts paid out-of-pocket for prescription medications in a Calendar Year apply only to the Prescription Drug Benefit Out-of-Pocket Maximum and cannot be applied to the Comprehensive Medical Benefit Out-of-Pocket Maximum. Amounts paid for Select Specialty Medications do not apply toward satisfying the Prescription Drug Benefit Out-of-Pocket Maximum.

Section 8.03 Out-of-Pocket Maximum for the Low Cost Medical Plan

The Plan limits the amount a Covered Individual pays out-of-pocket for prescription medications in a Calendar Year as provided in the Schedule of Benefits for the Low Cost Medical Plan, see Appendix C. Amounts paid out-of-pocket for prescription medications in a Calendar Year apply only to the Prescription Drug Benefit Out-of-Pocket Maximum and cannot be applied to the Comprehensive Medical Benefit Out-of-Pocket Maximum. Amounts paid for Select Specialty Medications do not apply toward satisfying the Prescription Drug Benefit Out-of-Pocket Maximum.

Section 8.04 Out-of-Pocket Maximums for the Retiree Plan

The Plan limits the amount a Covered Individual pays Out-of-Pocket for single source brand, specialty, and generic/multi-source brand medications in a Calendar Year as provided in the Schedule of Benefits for the Retiree Plan, see Appendix B. Single source brand medication, specialty medication, and generic/multi-source brand medication Out-of-Pocket Maximums are separate and cannot be combined. Amounts paid for Select Specialty Medications do not apply toward satisfying the specialty medication Out-of-Pocket Maximum.

Section 8.05 Medicare Part D Enrollment for the Retiree Plan

A Covered Individual who is enrolled in Medicare Part D prescription drug coverage is not eligible for Retiree Plan prescription drug coverage. If the Participant is not eligible for Retiree Plan prescription drug coverage, then the Participant's Dependents are not eligible for Retiree Plan prescription drug coverage.

Section 8.06 Prescription Drug Exclusions

The Plan excludes the following:

(A) Prescription drugs, indications and/or dosage regimens determined to be not Medically Necessary or Experimental, Investigational or unproven medication or therapies, or drugs not approved by the United States Food and Drug Administration (FDA) for the intended use (off label);

(B) Prescription drugs requiring prior authorization that are dispensed without prior authorization from the Contracted Provider;

(C) Any medication prescribed in a manner other than in accordance with criteria developed by the Contracted Provider;

(D) Erectile dysfunction drugs, except if prescribed as a Medically Necessary Treatment Plan for an Illness, other than erectile dysfunction;

(E) Drugs or medicines lawfully obtainable without a prescription from a Physician or Dentist, except to the extent required under the Affordable Care Act;

(F) Therapeutic devices, support garments, or other appliances regardless of their intended use;

(G) Any charges for the administration of a prescription drug;

(H) Medication that is to be taken by or administered to the Covered Individual, in whole or in part, while a patient in a licensed Hospital, Extended Care/Skilled Nursing or assisted living facility, or similar institution, which operates a facility for dispensing pharmaceuticals on its premises or allows to be operated on its premises, except as provided in Plan Section 8.01(F)(3) for Extended Care/Skilled Nursing or assisted living facility Exceptions;

(I) A prescription in excess of the quantity specified by the Physician or Dentist, or any refill dispensed after one (1) year from the order of a Physician or Dentist;

(J) Prescription drugs that may be properly received without charge under local, state, or federal programs, including workers compensation;

(K) Weight loss drugs;

(L) Smoking cessation products, except as coordinated with the Contracted Provider or as required for preventive care under the Affordable Care Act;

(M) Drugs to stimulate hair growth;

(N) Infertility drugs (when treatment of infertility is covered, infertility prescriptions are covered under the Comprehensive Medical Benefit);

(O) Acne drugs for Cosmetic reasons;

(P) Vitamins, food supplements, infant formulas or homeopathic drugs;

(Q) Growth hormones unless Medically Necessary, as determined by the Contracted Provider and obtained through the Specialty Care Pharmacy Program; and

(R) Drugs that industry monitoring entities, such as the UBC Clinical Advisory Committee, recommend for exclusion, subject to Trustee ratification.

Section 8.07 Prescription Drug Benefits for Apprentices

Prescription drug benefits are not available to apprentices except as described in Plan Sections 3.02(C) and 3.10(C).

ARTICLE IX HEALTH REIMBURSEMENT ACCOUNT (HRA) PROGRAM

Section 9.01 General Provisions and Definitions

(A) Eligibility: An Employee shall be eligible to participate in the Plan's Health Reimbursement Account (HRA) Program as long as he remains a Member in Good Standing, including apprentices, who otherwise meet the eligibility provisions of Article III for participation in the Plan. In addition, a Retiree who retired with a balance credited to his Account at the time he retired is eligible to continue receiving reimbursement from the Plan's HRA Program as long as he remains a Member in Good Standing and, to the extent any contributions are received on the Retiree's behalf, the Retiree will also be eligible to participate in the HRA Program.

(B) Access to Funds: A Participant, who is a Member in Good Standing, shall have access to funds credited to his individual Account to obtain reimbursement for out-of-pocket expenses for Qualifying Medical Expenses and Qualifying Premium Expenses. In addition, a Participant's Dependents shall have access to the funds credited to the HRA upon the Participant's death, provided the Dependents were covered under the Plan at the time of the Participant's death.

(C) Intent: The HRA Program is intended to qualify as a self-funded medical expense reimbursement plan under Internal Revenue Code Section 105 and regulations thereunder and to comply with guidance issued by the Internal Revenue Service (IRS) on health reimbursement arrangements in order that benefits paid to Participants will be excludable from their gross income for federal income tax purposes. The HRA Program is also intended to meet the requirements of Internal Revenue Code Section 106 in order that Employer contributions on behalf of participating Participants will be excludable from gross income for federal income tax purposes.

(D) Definitions:

(1) Account: "Account" means the Account established under the HRA Program pursuant to Plan Section 9.03 on behalf of an Employee. Contributions are credited to an Employee's Account, which is considered a notional Account, in a manner determined by the Trustees.

(2) HRA Program Administrator: "HRA Program Administrator" means the individual or firm retained by the Trustees to administer the day-to-day operations of the HRA Program.

(3) Qualifying Medical Expenses: "Qualifying Medical Expenses" means the substantiated out-of-pocket health care expenses incurred by or on behalf of a Covered Individual, after the Participant becomes eligible to participate in the HRA Program and an Account is established on his behalf, which qualify as medical care under Internal Revenue Code Section 213(d) for the diagnosis, care, medication, treatment or prevention of disease, affecting any structure or function of the body and transportation primarily for and essential for such medical care with the following requirements:

(a) Are required to be paid by the Covered Individual;

(b) Are not payable under the regular benefits provided by this Plan or by any other insurance or group health benefits available to the Covered Individual;

(c) Have not been previously taken as a tax deduction by the Covered Individual; and

(d) Are not expenses for long-term care services.

In no event shall Qualifying Medical Expenses be provided in the form of cash other than reimbursement.

(4) Qualifying Premium Expenses: "Qualifying Premium Expenses" means the coverage costs such as Self-Payment of Hours Premiums or Retiree Coverage Premiums; Premiums for Continuation Coverage under COBRA or the Low Cost Medical Plan; and substantiated premium payments for long-term care insurance. Qualifying Premium Expenses do not include premiums for accident or health insurance as defined in Internal Revenue Code Section 213(d); fixed indemnity, cancer or hospital indemnity insurance premiums paid by an employer or premiums that are or could be deducted pre-tax through an Internal Revenue Code Section 125 cafeteria plan (including a spouse's plan). Notwithstanding the above, Qualifying Premium Expenses shall include Medicare Parts B and D Medicare Supplement policies, Group Medicare Advantage premiums and Group Health Plan premiums, for Retirees and Dependents of deceased Participants (unless the premium can be paid on a pre-tax basis) that qualify as accident or health insurance as defined in Internal Revenue Code Section 213(d). In no event shall Qualifying Premium Expenses be provided in the form of cash other than reimbursement.

Section 9.02 Funding

(A) The HRA Program is funded solely with Contributions that an Employer submits to the Fund on behalf of Employees. Contributions submitted shall be credited to the Employee's individual Account in a manner determined by the Trustees. Under no circumstances will benefits under the HRA be funded directly or indirectly with salary reductions or other contributions under an Internal Revenue Code Section 125 cafeteria plan maintained by the Fund or an Employer.

(B) The Trustees may also credit additional amounts to Accounts to reflect assets the Fund receives pursuant to transfer agreements the Trustees enter into.

Section 9.03 Account

(A) Balance Carry-Over: If there is any balance remaining in the Account after all reimbursements have been paid for the Calendar Year, such balance shall be carried over to the following Calendar Year. The Employee, Retiree, Dependent, or any other individual may not assign, transfer, or alienate any interest in the Accounts.

(B) General: A Participant with a positive balance in his Account may access amounts in the Account for the reimbursement of Qualifying Medical Expenses and Qualifying Premium Expenses while an active or inactive Employee or Retiree for periods in which the Participant is considered a Member in Good Standing. Retirees who postpone retiree coverage may access their Account while their Plan coverage is suspended for

reimbursement of Qualifying Medical Expenses and Qualifying Premium Expenses, as long as the Retiree is considered a Member in Good Standing.

(C) Account Balance Information: The HRA Program Administrator will develop procedures and methods to provide Participants with Account balance information and/or to enable Participants to access that information.

Section 9.04 Forfeiture of Accounts

The Accounts are subject to the following forfeiture rules:

(A) Upon Death: If a Participant dies while a Member in Good Standing, the entire balance of his Account becomes immediately available to individuals who qualify as the Participant's Dependents under the Plan at the time of death for the reimbursement of Qualifying Medical Expenses or Qualifying Premium Expenses. The balance credited to the Account at the time of death will be available for use by the surviving Dependents until the earliest of when the Account balance is zero, the Account is forfeited due to inactivity under Plan Section 9.04(B), or the Plan ends. In no event will amounts credited to the Account be paid in cash to any person for other than reimbursement of an eligible expense (for example, there are no lump sum distributions of the Account balance as a death or termination benefit). The Member in Good Standing requirement shall not apply to the Dependents who survive a deceased Participant. The balance shall be forfeited if the Participant has no Dependents or if the Participant was not a Member in Good Standing at the time of death.

(B) Forfeiture of an Inactive Account: The Participant's Account shall be forfeited if it is inactive for twenty-four (24) consecutive months and has a balance less than one hundred dollars ($100). An Account is considered "inactive" if there is no Employer contribution credited to the Account or reimbursement paid from the Account. The forfeiture time period shall be tolled during periods in which the Covered Individuals have opted-out of Plan coverage pursuant to rules adopted by the Trustees.

(C) Forfeiture for Ceasing to be a Member in Good Standing: The Participant's Account shall be forfeited after twelve (12) consecutive months in which the Participant is not considered a Member in Good Standing.

Section 9.05 Frozen Accounts

(A) An Account may be frozen in the following instances:

(1) During periods in which the Participant ceases to qualify as a Member in Good Standing;

(2) If the Participant fails to provide substantiating documentation as required by the IRS;

(3) Upon annual opt-out. If a Participant elects to opt-out of his Account, the Account shall be frozen as of the date of opt-out and any HRA contributions received on an Employee's behalf shall be forfeited to the Plan until the Account is reinstated.

(4) Upon opt-out due to loss of eligibility. If the Employee opts-out of his Account, the Account shall be frozen as of the date of the opt-out.

(5) Upon opt-out due to becoming eligible for the Retiree Plan.

(6) Upon opt-out due to the death of a Participant. If the Dependent opts-out of the Account, any amounts remaining in the Account shall be frozen as of the date of the opt-out.

(B) Accounts frozen under Plan Sections 9.05(A)(1), (2), and (4) shall remain subject to the forfeiture rule in Plan Section 9.04.

(C) While an Account is frozen, no Covered Individual may receive any reimbursements from the Account.

(D) A frozen Account shall be reinstated as follows:

(1) An Account frozen per Section 9.05(A)(1): If the Participant returns to Member in Good Standing status.

(2) An Account frozen per Section 9.05(A)(2): If the substantiating documentation is provided or the deficit is repaid.

(3) An Account frozen per Section 9.05(A)(3): the earlier of:

(a) the January 1 following the twelve (12) month period to which the opt-out applied, unless the Participant elects to opt-out for a subsequent twelve (12) month period; or

(b) the Participant's death.

(4) An Account frozen per Section 9.05(A)(4): if the Employee regains Plan and HRA Program eligibility.

(5) An Account frozen per Section 9.05(A)(5): the earlier of:

(a) the January 1 following the twelve (12) month period to which the opt-out applied, unless the retiree elects to opt-out for a subsequent twelve (12) month period;

(b) loss of coverage under either group health plan coverage due to loss of eligibility or termination of the group health plan; or

(c) the Retiree's death.

(6) An Account frozen per Section 9.05(A)(6): the January 1 following the period to which the initial opt-out applied, unless the Dependent elects to opt-out for a subsequent twelve (12) month period. Any amounts remaining in the Account shall forfeit to the Plan upon the Dependent's death.

(E) Notwithstanding anything to the contrary above, a Participant or Employee must remain a Member in Good Standing in order for a frozen Account to be reinstated.

Section 9.06 Expenses Eligible for Reimbursement

A Participant may receive reimbursement from his Account for Qualifying Medical Expenses or Qualifying Premium Expenses that are incurred while the Covered Individual is eligible for coverage under the Plan's HRA. An expense is "incurred" when the Covered Individual receives medical care or services giving rise to the claimed expense. The determination of whether an individual is a Dependent whose Qualifying Medical Expenses and Qualifying Premium Expenses are covered by the HRA Program shall be made at the time such expenses are incurred. A Participant cannot be reimbursed for any medical expenses that were incurred before the HRA Program was established or before he became a participant in the HRA Program. Qualifying Medical Expenses must not be reimbursed by insurance or by any other source, must be expenses that the Covered Individual is required to pay, and must not be expenses for which the Covered Individual has taken (or will take) a deduction for income tax purposes. Orthodontia Exception: Amounts paid in advance for Qualifying Medical Expenses will be deemed incurred to the extent permitted by the IRS for uninsured orthodontia services.

Section 9.07 Claims for Reimbursement Benefits and Debit Card Program

(A) A Participant must submit his reimbursement request to the HRA Program Administrator with a properly completed request form that the HRA Administrator will provide or make available. A copy of the itemized bill when applicable also must be included. The HRA Program Administrator will establish a process for Participants to submit claims and supporting documentation and will communicate that process to Participants. The process may permit Participants to file paper and/or electronic submissions.

(B) The Trustees may impose other terms and conditions on the payment of benefits, such as minimum claim submission amounts or a schedule. Expenses and substantiating documentation must be submitted so that they are received no later than March 31 following the Calendar Year in which the expenses are incurred.

(C) Upon receipt of a properly completed reimbursement request, the HRA Program Administrator shall issue payment to the Participant in the manner elected by the Participant and shall deduct the amount of the reimbursement from his HRA. If there is an insufficient amount in his HRA to cover the reimbursement request, the HRA Program Administrator will distribute what is available as a partial payment and distribute additional reimbursement in an amount not to exceed the total cost upon the Account's being credited with additional Contributions.

(D) If a claim for reimbursement is denied, the Participant shall be notified of the denial and his right to appeal the denial within certain time limits under the claims procedures for the Plan. Rejection of reimbursement at the point of sale using an HRA debit card is not considered to be a denial of a claim for benefits under the Plan.

(E) Payment Card Program: A Participant may be reimbursed for Qualifying Medical Expenses or may pay for Qualifying Medical Expenses at the point of sale by using a payment card issued by the Plan's HRA Program Administrator and linked to his Account. To the extent required by applicable law, the Participant may be required to submit to the HRA Program Administrator substantiation supporting the basis for the Qualifying Medical Expense purchase. The Fund may suspend a Participant's ability to use his payment card under rules adopted by the Trustees.

Section 9.08 Ordering Rules

(A) Plan Coverage: If a Qualifying Medical Expense is also covered under the Plan, the expense must first be submitted to the Plan and then submitted to the HRA Program.

(B) Health Flexible Spending Account: If a Covered Individual's expenses are covered under the HRA Program and a health flexible spending account under an Internal Revenue Code Section 125 cafeteria plan, such claims must be submitted to the health flexible spending account before they are submitted to the HRA Program.

Section 9.09 Coordination of Benefits

(A) General: The HRA Program shall not be considered a group health plan for coordination of benefits purposes under the Plan, and its reimbursement benefits shall not be taken into account when determining other benefits payable under this Plan or benefits payable under any other health plan except for Medicare. The use of benefits under the HRA Program may be restricted under some circumstances for active Employees or their Dependents who are enrolled in Medicare pursuant to the Medicare Secondary Payer Rules.

(B) Medicare Part D: The eligibility of a Covered Individual for prescription drug benefits under the HRA Program shall terminate, effective on the date of enrollment in a Medicare Part D plan, including enrollment in an Employer Group Waiver Plan (EGWP).

Section 9.10 Reciprocity

The Trustees shall adopt policies for crediting the Accounts from reciprocal contributions that the Plan receives. For plans that are party to the United Brotherhood of Carpenters and Joiners of America Master Reciprocal Agreement for Health and Welfare Funds, or similar agreements requiring that reciprocal hours be prorated to reflect differences in contribution rates among the plans, then the Plan shall credit to a Participant's Account an HRA contribution based on the prorated number of hours that the Plan recognizes in accordance with the governing reciprocal agreement. Contributions reciprocated as an HRA-designated contribution will be credited to the Participant's Account.

Section 9.11 Interest and Expenses

The Trustees may assess a reasonable fee for Account maintenance and for expenses related to the processing of reimbursements. No interest shall be credited to an Account.

Section 9.12 Overpayment

In addition to the actions the Trustees may take under Plan Section 18.07 to recover erroneous or excess payments, the Trustees may offset or forfeit all or a portion of an Account to recoup erroneous or excess payments (including payments from the Account that are not properly substantiated). Recoupment procedures will comply with applicable IRS guidance, including treatment of an improper payment as taxable wages in the year in which the indebtedness was forgiven.

ARTICLE X SHORT TERM DISABILITY BENEFITS

The Plan provides an Employee with Short Term Disability Benefits for a Non-Occupational Illness or Injury (called "Non-Occupational Short Term Disability Benefits" or "Non-Occupational Disability") and for an Occupational Illness or Injury (called "Occupational Short Term Disability Benefits" or "Occupational Disability") as specified in this Article X. Benefits are determined by the Trustees from time to time and provided in the Schedule of Benefits for the Active Plan, see Appendix A.

Section 10.01 Short Term Disability Benefits under the Active Plan

(A) Non-Occupational Illness or Injury: For an Employee who suffers a Non-Occupational Illness or Injury resulting in Disability that began in a Coverage Quarter in which the Employee is eligible for benefits and is not a Retiree. Employees who are subject to a Participation Agreement and who do not work in a bargaining unit represented by the Union are also subject to Plan Section 10.05. The following conditions apply:

(1) Maximum Period: The Employee will receive a weekly payment and will be credited with a maximum of forty (40) Contribution hours to this Plan for each calendar week of Physician certified or proven Disability up to a maximum of fifty-two (52) weeks (two thousand and eighty (2,080) hours) during the period of time the Employee remains Disabled for any single period of Disability for the same or related Non-Occupational Illness or Injury.

(2) Weekly payments and credit of Contribution hours for a Non-Occupational Injury or Accident begin from the first full day of the proven Disability regardless of the length of the disability.

(3) Weekly payments and credit of Contribution hours for a Non-Occupational Illness begin from the eighth (8th) calendar day after the Employee first becomes Disabled, except if the Employee is continuously Disabled for four (4) weeks or longer, benefits are payable beginning as of the first full day of a Disability.

(4) Continuous Disability: Disabilities occurring in any twelve (12) month period of time are considered as one and the same Claim if the Disability is for the same or related Non-Occupational Illness or Injury.

(B) Occupational Illness or Injury: For an Employee who suffers an Occupational Illness or Injury resulting in Disability which began in a Coverage Quarter in which the Employee is eligible for benefits, and is not a Retiree. Employees who are subject to a Participation Agreement and who do not work in a bargaining unit represented by the Union are also subject to Plan Section 10.05. The following conditions apply:

(1) Maximum Period: The Employee will be credited with a maximum of forty (40) Contribution hours to this Plan for each week of proven Disability up to a maximum of fifty-two (52) weeks (two thousand and eighty (2,080) hours) during the period of time the Employee remains Disabled for any single period of continuous Disability for the same or related Occupational Illness or Injury.

(2) Credit of Contribution hours for an Occupational Disability begins from the first full day of the Physician certified or proven Disability regardless of the length of the disability.

(3) Continuous Disability: Disabilities occurring in any twelve (12) month period of time are considered as one and the same Claim if the Disability is for the same or related Occupational Illness or Injury.

(4) A weekly benefit payment is not available for an Occupational Illness or Injury.

(5) The Plan will not pay Covered Medical Expenses for an Occupational Illness or Injury.

(6) Short Term Disability Benefits are not available for Employees whose Occupational Illness or Injury occurred while employed by a non-Employer.

(C) Subsequent Disability: A new Claim for Short Term Disability Benefits will begin only if the following two (2) criteria are met:

(1) A subsequent Disability is due to a Non-Occupational Illness or Injury or Occupational Illness or Injury unrelated to the previous Disability; and is separated by a return to work for at least 200 hours of Covered Employment with one (1) or more Employers.

(2) If a subsequent Disability is caused by a Non-Occupational Illness or Injury or Occupational Illness or Injury related to a previous Disability, the Employee must provide proof of recovery from the previous Illness or Injury and must remain non-Disabled for a period of at least twelve (12) consecutive months before the Employee can apply for a new Short Term Disability claim.

(D) The required forms must be completed in full by the Employee and the Employee's attending Physician to apply for Short Term Disability Benefits. Periodic completion of a recertification Claim form must be completed in full by the Employee and Employee's attending Physician to continue to be considered for Short Term Disability Benefits. For an Occupational Illness or Injury, proof of receipt of Workers' Compensation benefit payments can be accepted in lieu of a physician recertification Claim.

(E) An Employee may be required to submit to a physical examination by a Physician selected by the Fund in order to verify that the Employee is Disabled. If the Fund Office requests such examination, the cost of the examination and any related medical expenses will be paid for by the Fund.

(F) An Employee must be credited each and every Calendar Quarter with Contribution hours sufficient to maintain eligibility under the Active Plan, as described in Plan Sections 3.09, 3.10, and 3.11, to receive Short Term Disability Benefits. Contribution hours credited to an Employee during a Calendar Quarter include Contribution hours paid on behalf of an Employee by an Employer and Contribution hours credited to the Employee as described in Plan Section 10.01(A) and (B).

(G) Tax Withholdings: The Plan will follow Federal and State tax withholding rules when paying an Employee’s weekly payment for Non-Occupational Short Term Disability Benefits.

(H) Short Term Disability Benefits Terminate at Retirement: A Participant will not be eligible to receive more than six (6) days of Short Term Disability Benefits in any month in which the Participant becomes a Retiree. Such Retiree will not be eligible to receive any additional Short Term Disability Benefits.

Section 10.02 Short Term Disability Benefits under COBRA

Short Term Disability Benefits are not available under Continuation Coverage under COBRA.

Section 10.03 Short Term Disability Benefits under the Low Cost Medical Plan

Short Term Disability Benefits are not available under the Low Cost Medical Plan.

Section 10.04 Short Term Disability Benefits under the Retiree Plan

Short Term Disability Benefits are not available under the Retiree Plan, except as noted in Plan Section 10.01(H).

Section 10.05 Employees Subject to a Participation Agreement and Who Do Not Work in a Bargaining Unit Represented by the Union

In addition to satisfying the conditions imposed under Plan Section 10.01(A) and (B), Employees who are subject to a Participation Agreement and who do not work in a bargaining unit represented by the Union must be actively employed by their Employer on the date they suffer a Disability to qualify for Short Term Disability Benefits.

Section 10.06 Short Term Disability Benefits for Employees Employed by a Non-Signatory Employer

Short Term Disability Benefits are not available for Employees whose Work-Related Illness or Injury occurred while employed by a non-Employer.

ARTICLE XI LIFE INSURANCE BENEFITS

Section 11.01 Life Insurance Benefits for an Eligible Employee under the Active and Low Cost Medical Plans

An Employee who is eligible for benefits under the Active Plan or the Low Cost Medical Plan is eligible for a Life Insurance Benefit as determined by the Trustees from time to time and as provided in the Schedule of Benefits for the Active Plan, see Appendix A and for the Low Cost Medical Plan, see Appendix C. In the event of the death of the Employee, the Life Insurance Benefit will be payable in a lump sum to the beneficiary designated by the Employee or to the beneficiary determined pursuant to Plan Section 11.04(C)(3).

Life Insurance Benefits for Covered Individuals under the Active Plan of Benefits shall exclusively be considered for payment pursuant to insurance policies maintained by the Plan. The Plan shall not be responsible for paying insured Life Insurance Benefits in the event it is determined that Benefits are not payable under the insurance policy by the Insurance Company. If there is any discrepancy between the benefits described in this Article XI and the insurance policy issued by the Insurance Company, the terms of the insurance policy shall govern.

Life Insurance Benefits for Covered Individuals under the Low Cost Medical Plan are self-insured and paid directly by the Trust Fund.

Section 11.02 Life Insurance Benefit under Continuation Coverage under COBRA

Life Insurance Benefits do not apply to Covered Individuals eligible for coverage under Continuation Coverage under COBRA.

Section 11.03 Life Insurance Benefit under the Retiree Plan

A Retiree who is enrolled in Comprehensive Medical benefits or Medicare Parts A and B Supplemental coverage as described in Article V and Appendix B and dies prior to attaining age sixty-five (65) is eligible for a Life Insurance Benefit as determined by the Trustees from time to time and as provided in the Schedule of Benefits for the Retiree Plan, see Appendix B. In the event of the death of the Retiree prior to his attaining age sixty-five (65), the Life Insurance Benefit will be payable in a lump sum to the beneficiary designated by the Retiree or to the beneficiary determined pursuant to Plan Section 11.04(C)(3). All insured Life Insurance Benefits shall exclusively be considered for payment pursuant to insurance policy maintained by the Plan. The Plan shall not be responsible for paying insured Life Insurance Benefits in the event it is determined that Benefits are not payable under the insurance policy by the Insurance Company. If there is any discrepancy between the benefits described in this Article XI and the insurance policy issued by the Insurance Company, the terms of the insurance policy shall govern.

Section 11.04 Beneficiary Designation for the Life Insurance Benefit

(A) The Employee or Retiree may designate one (1) or more beneficiaries, and change the designation of his beneficiary at will by completing a beneficiary designation form.

(B) The designation or change of beneficiary will take effect on the date such request is received at the Fund Office; however, receipt of the designation or change of beneficiary must be received by the Fund Office prior to the Employee's death.

(C) Any amount payable to a beneficiary by the Insurance Company for the Active Plan or by the Welfare Fund for the Low Cost Medical Plan will be paid to the beneficiary or beneficiaries designated by the Employee in accordance with the following rules:

(1) If more than one (1) beneficiary is designated, the designated beneficiaries will share equally unless the Employee stipulates otherwise on the beneficiary designation form;

(2) If any designated beneficiary dies before the Employee, the share that such beneficiary would have received if he had survived the Employee's death will be payable equally to the remaining designated beneficiary or beneficiaries, if any, who survive the Employee; and

(3) If no designated beneficiary survives the Employee, or if no beneficiary has been designated, payment will be made in the following order:

(a) The Employee's surviving spouse;

(b) If no spouse survives the Employee, in equal shares to the biological and adoptive children who survive the Employee;

(c) If no spouse or biological or adoptive children survive the Employee, to the Employee's living parents equally, or to the surviving parent;

(d) If no spouse, biological or adoptive children, and neither parent survives the Employee, in equal shares to the Employee's biological brothers and sisters who survive the Employee; and

(e) If no spouse, biological or adoptive children, parents, or siblings survive the Employee, to the Employee's estate.

(4) A beneficiary may request that the Insurance Company deduct an amount payable directly to a funeral home for funeral expenses on behalf of the deceased Employee.

(5) If a death should occur within thirty-one (31) days after the Employee's eligibility for Active Plan coverage has terminated, the Life Insurance Benefit will still be payable by the Insurance Company. Not applicable to the Low Cost Medical Plan.

(6) If a death should occur after the eligibility requirements in Plan Section 3.01 or 3.02 are met but before the first Coverage Quarter begins, the Life Insurance benefit will still be payable by the Insurance Company. Not applicable to the Low Cost Medical Plan or Retiree Plan.

To the extent any of the above rules are not consistent with the insurance policy issued by the Insurance Company, the terms of the insurance policy will control.

Section 11.05 Accelerated Death Benefit for Active Plan Participants

The Active Plan allows for an Employee to receive an accelerated death benefit which is a partial payment of the Life Insurance benefit in a lump sum when an Employee is diagnosed with a terminal Illness and not expected to survive more than twenty-four (24) months. The following conditions apply:

(A) The required forms must be completed by the Employee and the Employee's attending Physician.

(B) The amount of Life Insurance covering the Employee will be reduced by the amount of the Accelerated Death Benefit payment.

(C) The lump sum cannot be less than $5,000 and no more than seventy five (75%) of the Life Insurance Benefit.

(D) The Accelerated Death Benefit payment is exempt from any legal or equitable process for the Employee's debts.

Section 11.06 Accelerated Death Benefit for Low Cost Medical Plan or Retiree Plan Participants

Accelerated death benefits does not apply to the Low Cost Medical Plan or the Retiree Plan.

Section 11.07 Extension of Life Insurance Benefits for an Employee Who Becomes Totally and Permanently Disabled under the Active Plan

If an Employee who is eligible for benefits under the Active Plan of Benefits becomes totally and permanently Disabled while eligible for Life Insurance Benefits, but before the Employee reaches age sixty (60), the Fund will continue the Employee's Life Insurance Benefit by paying the Insurance Company the required premium as long as the Employee remains totally and permanently disabled. The following conditions apply:

(A) An Employee must be considered totally and permanently Disabled. An Employee is considered totally and permanently Disabled if:

(1) The Illness or Injury prevents the Employee from working at his job or any other job for pay or profit; and

(2) The Employee has been totally Disabled for at least nine (9) months.

(B) The totally and permanently Disabled Employee must request and file an application for an extension of Life Insurance Benefits with the Fund Office within twelve (12) months after the loss of eligibility.

(C) Proof of total and permanent Disability and subsequent proof must be submitted to the Insurance Company upon request. If the Insurance Company determines that the Employee is no longer totally and permanently Disabled, or if the Employee has recovered from his disability and is able to work, the Fund will discontinue paying the Insurance Company the required premium and the Employee's Life Insurance will terminate.

(D) In the event the group policy is discontinued, the Employee's Life Insurance will terminate.

(E) Applying for, or qualifying for a Disability Benefit under a Pension Fund does not constitute application for this Life Insurance Benefit extension. The totally and permanently disabled Employee must file a separate application with the Welfare Fund.

Section 11.08 Extension of Life Insurance Benefits for the Low Cost Plan or the Retiree Plan

Extension of the life insurance benefits does not apply to the Low Cost Medical Plan or the Retiree Plan.

Section 11.09 Life Insurance Benefits for a Dependent

An Employee's Dependents who are eligible for benefits under the Active Plan or the Low Cost Medical Plan are eligible for a Life Insurance Benefit as determined by the Trustees from time to time and as provided in the Schedule of Benefits for the Active Plan, see Appendix A or for the Low Cost Medical Plan, see Appendix C. In the event of the death of an Employee's Dependent, from any cause at any time, the Life Insurance Benefit will be payable by the Insurance Company for the Active Plan, or by the Welfare Fund for the Low Cost Medical Plan, in a lump sum to the Employee. The following conditions apply:

(A) If the Employee's Dependent dies while Dependent coverage is in force for that Dependent, the Insurance Company for the Active Plan, or the Welfare Fund for the Low Cost Medical Plan, will pay the Employee if the Employee is still living at the time of payment; otherwise payment will be made to the Employee's estate, or, at the option of the Insurance Company or Welfare Fund, to the Employee's surviving spouse.

(B) If a death should occur within thirty-one (31) days after the Employee's eligibility for Active Plan coverage has terminated, the Life Insurance Benefit will still be payable by the Insurance Company. Not applicable to the Low Cost Medical Plan.

(C) If a death of a Dependent should occur after the Employee meets the eligibility requirements in Plan Section 3.01 or 3.02 but before the first Coverage Quarter begins, the Life Insurance benefit for the Dependent will still be payable by the Insurance Company for the Active Plan. Not applicable to the Low Cost Medical Plan.

Section 11.10 Conversion of Life Insurance Benefit for the Active Plan

(A) When an Employee's eligibility terminates, the Employee can apply with the Insurance Company, to the extent permitted by the Insurance Company, to convert his Life Insurance to an individual life insurance policy.

(B) When an Employee's eligibility terminates, the Employee can apply to the Insurance Company, to the extent permitted by the Insurance Company, to convert his Dependent's Life Insurance to an individual life insurance policy

(C) The Employee must obtain and file with the Insurance Company an application for the conversion policy in accordance with the instructions on the application form within thirty-one (31) days after eligibility terminates.

Section 11.11 Conversion of Life Insurance Benefit for the Retiree Plan

(A) If a Retiree's coverage terminates, the Retiree can apply with the Insurance Company, to the extent permitted by the Insurance Company, to convert his Life Insurance to an individual life insurance policy.

(B) The Retiree must obtain and file with the Insurance Company an application for the conversion policy in accordance with the instructions on the application form within thirty-one (31) days after coverage terminates.

Section 11.12 Conversion of Life Insurance under the Low Cost Medical Plan

Conversion of the Life Insurance Benefit does not apply to the Low Cost Medical Plan.

Section 11.13 Lump Sum Death Benefit for Certain Retirees of the Will County Local 174 Carpenters Pension Fund

Upon the death of any Will County Local 174 Carpenters Pension Fund Retiree who: (1) retired on December 1, 2018 or earlier; and (2) was enrolled in the Comprehensive Medical Benefits and the prescription drug benefits at the time of his death, and (3) dies after attaining age sixty-five (65), a lump sum death benefit of four thousand dollars ($4,000) shall be paid by the Welfare Fund to the beneficiary designated by the Participant. If there is no designated beneficiary, then the benefit shall be payable in the same manner and order of preference set forth in Plan Section 11.04(C)(3).

ARTICLE XII ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

Section 12.01 Employee's Accidental Death and Dismemberment Benefit under the Active Plan

An Employee who is eligible for benefits under the Active Plan of Benefits is eligible for the Accidental Death and Dismemberment Benefit as determined by the Trustees from time to time and as provided in the Schedule of Benefits for the Active Plan; see Appendix A. All insured Accidental Death and Dismemberment Benefits shall exclusively be considered for payment pursuant to insurance policies maintained by the Plan. The Plan shall not be responsible for paying Accidental Death and Dismemberment Benefits in the event it is determined that benefits are not payable under the insurance policy by the Insurance Company. If there is any discrepancy between the benefits described in this Article XII and the insurance policy issued by the Insurance Company, the terms of the insurance policy shall govern. The following conditions apply:

(A) This benefit applies only to the Employee.

(B) Accidental Death and Dismemberment Benefits provide payment for the Employee's loss, while insured, of life, limbs or the entire and irrecoverable loss of sight, including such losses resulting from Occupational Injury or Accidents. Benefits are payable only if the loss results directly from bodily injuries sustained solely through accidental means and occur within ninety (90) days after the date of the Accident causing the loss.

(C) No more than the amount of one (1) principal payment is payable for multiple Injuries or death incurred in one (1) Accident.

Section 12.02 Beneficiary Designation for Accidental Death and Dismemberment Benefit under the Active Plan

The Plan will pay dismemberment benefits to an Employee eligible under the Active Plan. The Plan will pay accidental death benefits to the beneficiary designated by the Employee. If no designated beneficiary survives the Employee, or if no beneficiary has been designated, payment will be made to:

(A) The Employee's surviving spouse;

(B) If no spouse survives the Employee, in equal shares to the biological and adoptive children who survive the Employee;

(C) If no spouse and no biological or adoptive children survive the Employee, to the Employee's living parents equally, or to the surviving parent;

(D) If no spouse, biological or adoptive children, and neither parent survives the Employee, in equal shares to the Employee's biological brothers and sisters who survive the Employee; and

(E) If no spouse, biological or adoptive children, parents, or siblings survive the Employee, to the Employee's estate.

To the extent any of the above rule is not consistent with the insurance policy issued by the Insurance Company, the terms of the insurance policy will control.

Section 12.03 Accidental Death and Dismemberment Benefit under Continuation Coverage under COBRA

Accidental Death and Dismemberment Benefits are not available under Continuation Coverage under COBRA.

Section 12.04 Accidental Death and Dismemberment Benefit under the Low Cost Medical Plan

Accidental Death and Dismemberment Benefits are not available under the Low Cost Medical Plan.

Section 12.05 Accidental Death and Dismemberment Benefit under the Retiree Plan

Accidental Death and Dismemberment Benefits are not available under the Retiree Plan.

ARTICLE XIII PLAN EXCLUSIONS AND LIMITATIONS

Section 13.01 General

The Plan pays for expenses or charges for treatment provided to a Covered Individual as a result of a Non-Occupational Illness or Injury as determined by the Trustees from time to time, unless identified below as expenses or charges not covered under the Active Plan of Benefits, the Low Cost Medical Plan or the Retiree Plan of Benefits. The Plan cannot specifically delineate all treatment, expenses or charges that will be subject to the Plan's general exclusions because these exclusions will be applied based on the facts and circumstances of the Claim. The following are not Covered Expenses:

(A) Any expenses incurred during a period in which a Covered Individual is not eligible for benefits under the Plan, except as indicated in Plan Sections 11.09(B) and (C).

(B) Any expenses incurred by a person who does not meet the Plan's definition of a Dependent.

(C) Charges for services or supplies that exceed the Reasonable and Customary Allowance.

(D) Charges that would not have been made if no coverage existed or charges that a Covered Individual would not be required to pay.

(E) Expenses that may result from a Covered Individual's failure to use an HMO provider when required to do so by another insurance plan.

(F) Charges that exceed the various benefit maximums that apply to the different benefits under this Plan.

(G) Charges for services and supplies that (1) are not Medically Necessary for treatment of a Non-Occupational Illness or Injury, or (2) are inconsistent with a diagnosis, (3) inconsistent with industry standards or (4) are not recommended, performed or approved by the attending Physician or another provider acting within the scope of the provider's license.

(H) Charges incurred due to any Occupational Illness or Injury sustained while performing any act of employment or doing anything pertaining to any occupation or employment for remuneration or profit.

(I) Charges for items defined by the Food and Drug Administration (FDA) as Experimental or Investigational. However, to the extent required under the Affordable Care Act, the Plan will not deny you the right to participate in certain approved clinical trials; deny, limit, or impose additional conditions on the coverage of routine patient costs furnished in connection with participation in the clinical trial; and will not discriminate against you for participating in the clinical trial.

(J) Expenses excluded under the Plan's Coordination of Benefit provisions.

(K) Charges in connection with the services of blood donation, storage of autologous blood or umbilical-cord blood banking.

(L) Charges for physical examinations required for employment purposes or court-ordered examinations.

(M) Charges for all medications, medical supplies, or Durable Medical Equipment that may be purchased over the counter, except while confined in a Hospital.

(N) Food supplements or baby formulas, unless administered through a feeding tube.

(O) Charges for penile implants, erect-aids or erectile enhancement prescription drugs except if the prescription drugs are prescribed as a Medically Necessary Treatment Plan for an Illness other than impotency.

(P) Premarital examinations or counseling.

(Q) Paternity testing.

(R) Expenses of an elective abortion or the abortion pill, except when the mother's life is in danger as determined by a medical diagnosis or in instances of verifiable rape or incest.

(S) Charges for care or services, including medications, implants, hormone therapy and surgery, for any operation or treatment in connection with a sex transformation, transsexualism, gender dysphoria or sexual reassignment or transfer, except for (1) services provided by the Contracted Provider for Behavioral Health/Substance Use Disorders, or (2) prescription drugs related to the gender reassignment process that are otherwise eligible for coverage under the Plan, including the requirements and exclusions established in Article VIII.

(T) Personality or emotional testing and/or examinations except to the extent specifically covered by the MAP as described in Plan Section 5.04(X), or under the Behavioral Health/Substance Use Disorders benefit.

(U) Charges for bereavement counseling, pastoral counseling, financial or legal counseling, marital counseling and funeral arrangements except to the extent covered by the MAP as described in Plan Section 5.04(X).

(V) Colonics or homeopathic remedies or procedures.

(W) Vitamin supplements, except to the extent required under the Affordable Care Act.

(X) Vitamin K-1, except when used to counteract a prescription blood thinner, such as Warfarin or Coumadin.

(Y) Charges for massage therapy unless prescribed for therapeutic purposes to treat an Illness or Injury in a clinical setting.

(Z) Charges for hypnosis treatment.

(AA) Charges for chelation therapy, except when approved by the Food and Drug Administration (FDA) as an appropriate Medically Necessary course of treatment. Prior authorization and appropriate laboratory testing may apply.

(BB) Charges for smoking cessation therapies or products except to the extent required under the Affordable Care Act or covered by a Contracted Provider.

(CC) Charges for hair prostheses, wigs, toupees, hair implant plugs or hair loss products except those covered under Plan Section 5.04 (EE).

(DD) Charges for treatment of alopecia.

(EE) Charges for treatment of hirsutism.

(FF) Charges for removal of excessive hair, electrolysis, depilatories, or other hair removal treatments and products.

(GG) Charges for care or treatment in a health resort, at an alternative medical center or a holistic center.

(HH) Charges for homemaker or caretaker services, such as sitter or companion services, transportation, housecleaning, and house maintenance.

(II) Custodial Care.

(JJ) Instruction, classes, or testing relating to motor vehicle accidents.

(KK) A dental expense not covered under Article VII, Dental Care Benefits, will not be covered under Article V, Comprehensive Medical Benefits, unless it is the result of a traumatic Injury. Does not apply to the Retiree Plan or the Low Cost Medical Plan.

(LL) Charges for services or supplies that are paid for or otherwise provided for under any law of a government except where the payments or the benefits are provided under a plan specifically established by a government for its own civilian employees and their dependents.

(MM) Charges for services or supplies that are furnished, paid for, or otherwise provided for, by reasons of past or present service of any person in the Uniformed Services.

(NN) Charges from a Veterans Administration Hospital or a Physician employed by such Hospital when the Veterans Administration Hospital has the responsibility to provide the service or care for an Illness or Injury related to Uniformed Services.

(OO) Charges for treatment that requires care in a group home.

ARTICLE XIV COORDINATION OF BENEFITS

Section 14.01 Rules Governing Coordination of Benefits for the Active and Retiree Plans of Benefits and the Low Cost Medical Plan

(A) When Covered Individuals are members of the same family and are covered for health care under more than one health plan, this Plan will coordinate benefits with another plan so that the total payment from all plans does not exceed one hundred percent (100%) of the allowable Covered Expense. The Plan does not coordinate with itself except when two (2) Employees are legally married to each other.

(B) "Another plan" means any of the following, whether insured or uninsured, that provide benefits or services for hospital, medical, behavioral health and substance use disorders, prescription drug, hearing care, or dental treatment:

(1) Group insurance coverage other than school accident type coverage;

(2) Group subscriber contracts;

(3) Coverage through HMOs and other prepayment, group practice and individual practice plans;

(4) The medical benefits coverage in group, group-type and individual automobile "no fault" and traditional automobile "fault" type contracts;

(5) A Governmental plan, including Medicare as provided for under the Social Security Act, and coverage required or provided by law (such as through the Veterans Administration) but not Medicaid; or

(6) Individual insurance policies.

(C) This Plan will follow the general Coordination of Benefits ("COB") rules that apply throughout the insurance industry. Under those COB rules, one plan has "primary" responsibility and pays first. When a plan pays first it is called the primary plan. The other plan has "secondary" responsibility and considers any additional benefits beyond what was paid by the primary plan. When a plan pays second, it is called the secondary plan. When there is a third payer, it is called the tertiary plan. The following chart shows which plan is designated as primary or secondary in the case of a Participant and spouse who work for different employers and also have a child eligible for Dependent coverage:

Covered Individual	***Primary Plan***	***Secondary Plan***
Participant	Participant's	Spouse's
Spouse	Spouse's	Participant's
Child	The plan of the parent whose birthday (month and day) falls first in the Calendar Year*	The plan of the parent whose birthday (month and day) falls second in the Calendar Year*
*If both parents have the same birthday, the plan covering the parent for the longer period of time will pay first.		

(D) If the person is covered as an Employee under this Plan and is covered as an employee under another plan, the plan that has been in effect for the individual the longest will be the primary plan.

(E) If another group plan, which is sponsored, maintained, or contributed to by an eligible person's employer, contains a provision which: (1) excludes the eligible person from eligibility under the other group plan due to coverage under another group plan; (2) has the effect of either: shifting coverage liability to this Plan in a manner designed to avoid any liability under the other group plan; or avoiding the customary operation of this Plan's coordination of benefit rules; or (3) modifies, limits or reduces benefits for the eligible person due to coverage under another group plan; this Plan will consider such provision to have no force or effect. The Plan will coordinate benefits payable under this Plan with benefits which would have been payable under the other group plan if such provision had not existed. If the other group plan does not provide the information needed by this Plan to determine its benefits within sixty (60) days after it is requested to do so, the Plan shall assume that the benefits of the other group plan are identical to its own and shall pay its benefits accordingly. However, the Plan shall adjust any payments it makes based on such assumption whenever information becomes available as to the actual benefits of the other group plan.

(F) Coverage of Dependent Children in Divorce Situations: If the parents of a Dependent child are divorced or legally separated, a copy of the county-certified divorce decree or court order must be furnished to the Plan to ensure proper Coordination of Benefits. The Plan will determine the order of benefits based on the following rules:

(1) If the court order or divorce decree establishes responsibility for providing medical insurance, the primary plan will be the plan of the parent who has responsibility for providing medical insurance for that dependent as determined by a court order or divorce decree.

(2) If there is no court order or divorce decree establishing responsibility for providing medical insurance, the plan covering the custodial parent will be the primary plan, the plan covering the spouse of the custodial parent will be secondary, the plan covering the non-custodial parent third and the plan covering the spouse of the non-custodial parent last.

(3) Upon receiving a signed statement from the Participant, biological or adopted children of an eligible Participant will be covered under this Plan as primary if the other parent fails to carry insurance as directed by the court order or divorce decree.

(4) Primary coverage by this Plan for stepchildren is provided only in the event that no other person is obligated to provide insurance and no other insurance is available through the biological or adoptive parents' employment. Coverage for stepchildren terminates the last day of the month of the divorce or legal separation from the Covered Individual.

(G) Other Insurance Where Dependent Spouse Coverage Is Not Elected: If the Participant's Dependent spouse elects not to be covered by a health benefit program maintained by his employer at no expense to the Dependent spouse, this Plan will coordinate with the other Plan on the same basis as if the Dependent spouse had elected such coverage.

(H) Other Insurance for an Adult Dependent Child: If an adult Dependent child has insurance coverage through his employer, the adult Dependent child's employer plan will pay first and this Plan will pay second.

(I) Health Maintenance Organization (HMO) or a Point of Service (POS) Coverage Not Used: If the Participant's Dependent is covered by a HMO or a POS and does not use the coverage of the HMO or the POS, no benefits will be paid by this Plan.

(J) Services provided by the Veterans Administration: The Veterans Administration (VA) is secondary to the Plan when a Participant receives treatment at a VA facility for an Illness or Injury not related to Uniformed Service.

Section 14.02 Coordination of Benefits with Medicare under the Active Plan of Benefits and the Low Cost Medical Plan

(A) Effect of Medicare for Covered Individuals: Health benefits under this Plan for Covered Individuals who are also eligible for Medicare will be paid as required by law. The benefits payable for a Covered Individual under this Plan will 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 or Part B will not exceed the total of allowable expense as defined by Medicare.

(B) This Plan will have primary responsibility for Medical Expenses incurred by a Covered Individual who is Medicare-eligible under the Active Plan or Low Cost Medical Plan if:

(1) Eligibility for Medicare is due to the Covered Individual being at least age sixty-five (65) or disabled and the Participant is employed by an Employer; or

(2) Eligibility for Medicare is due to End-Stage Renal Disease ("ESRD"). This Plan is primary for a period of thirty (30) months. However, if Medicare is primary for a Covered Individual due to age or Disability and then the Covered Individual becomes entitled to Medicare due to ESRD Medicare remains primary. A Covered Individual may have more than one (1) thirty (30) month period if he has a kidney transplant that subsequently fails, leading to a second transplant and a second (2nd) period of thirty (30) months.

(C) This Plan will have secondary responsibility for Medical Expenses incurred by a Covered Individual under the Active Plan or Low Cost Medical Plan who is Medicare-eligible if:

(1) Eligibility for Medicare is due to the Covered Individual's being disabled or at least age sixty-five (65) and the Covered Individual does not have current employment status with an Employer as defined by Federal law, or

(2) Eligibility for Medicare is due to ESRD, but only after the first thirty (30) months of either sole or dual entitlement to Medicare due to ESRD (unless Medicare was already primary for the Covered Individual due to age or Disability).

If a Covered Individual is covered as an employee or dependent under more than one plan, then the plan covering the Covered Individual as an active employee or dependent of an active employee is primary over the plan covering the Covered Individual under COBRA or under the Plan's Low Cost Medical Plan. If a Covered Individual is also a Medicare beneficiary and, as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is:

(3) Secondary to the plan covering the Covered Individual as a dependent; and

(4) Primary to the plan covering the Covered Individual other than as a dependent (e.g., a retired employee or COBRA beneficiary);

then the benefits of the plan covering the Covered Individual as a dependent are determined before those of the plan covering that person as other than as a dependent.

Section 14.03 Coordination of Benefits with Medicare under the Retiree Plan of Benefits

(A) Effect of Medicare for Covered Individuals: Health benefits under this Plan for Covered Individuals who are also eligible for Medicare will be paid as required by law. The benefits payable for a Covered Individual under this Plan will 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 will not exceed the total of allowable expense as defined by Medicare except as described in Plan Section 14.03(B).

(B) This Plan will have primary responsibility for Medical Expenses incurred by a Covered Individual who is Medicare-eligible under the Retiree Plan if initial eligibility for Medicare is due to ESRD. This Plan is primary only for a period of thirty (30) months. If a Retiree is Medicare-eligible due to age or Disability and then becomes entitled to Medicare due to ESRD, this Plan remains secondary.

(C) For Retirees and their Dependents who are eligible for Medicare, this Plan will take Medicare Part A and Medicare Part B benefits into account when coordinating coverage under the Coordination of Coverage provisions, whether or not the Covered Individual enrolls in Medicare.

(D) The Retiree Plan will not coordinate coverage with Medicare Part D.

Section 14.04 Coordination of Benefits with Medicaid for the Active and Retiree Plans of Benefits and the Low Cost Medical Plan

The Plan honors any Medicaid assignment of rights made on behalf of a Covered Individual. The Plan also honors any reimbursement or subrogation rights that a state may have by virtue of payment of Medicaid benefits for Medical Expenses covered by the Plan. In addition, the Plan is primary and will not consider Medicaid eligibility or medical assistance provided by Medicaid in determining Plan benefits or eligibility.

Section 14.05 Coordination of Benefits with Medicare Replacement Plans for the Retiree Plan of Benefits

For Covered Individuals enrolled in a Medicare Replacement Plan (such as Medicare Advantage or Medicare Part C) this Plan remains secondary. The Covered Individual must follow the rules of the Medicare Replacement Plan, including seeking services from that plan's participating provider and this Plan will coordinate coverage with such Medicare Replacement Plan as if the services were covered under Medicare Parts A and B (regardless of whether the Covered Individual has taken action to obtain such coverage).

ARTICLE XV SUBROGATION AND REIMBURSEMENT

Section 15.01 Rules Governing Subrogation and Reimbursement

(A) The Fund provides no benefits for Claims of a Covered Individual that are related to any Illness or Injury which is caused by third parties or which is Work-Related or the responsibility of any other entity. The Fund will deny any Claim for an Illness or Injury which is caused by third parties, which is Work-Related or the responsibility of any other entity except as otherwise provided in this Plan Section 15.01.

(B) If the Fund chooses to advance benefits for the Injuries and Illnesses caused by third parties or that are Work-Related or the responsibility of any other entity, a Covered Individual:

(1) Upon final adjudication, settlement and/or receipt of case proceeds, agrees to reimburse the Fund up to (i) the amount of benefits paid by this Fund or amounts that the Fund is obligated to pay as well as (ii) any future benefits to be paid relating to the Illness or Injuries caused by the third party or for which a third party is responsible from any recovery received from any third party, insurer or any other source (including but not limited to persons, insurance carriers, estates, special trusts or other entities, hereinafter collectively referred to as “Source") or from any no fault coverage, uninsured motorist coverage, underinsured motorist coverage, employers’ Workers Compensation insurance policies, personal injury protection coverage, medical payments coverage, financial responsibility, other insurance policies, funds or any other sources of recovery (hereinafter collectively referred to as "Coverage");

(2) Agrees, without limiting what is stated in Plan Subsection 15.01(B)(1), to allow the Fund to subrogate against or seek reimbursement with regard to any and all Claims, causes of action or rights that a Covered Individual has against any Source who has or who may have caused, contributed to or aggravated the Injuries or conditions for which a Covered Individual claims benefits from this Fund and to any Claims, causes of action or rights that a Covered Individual may have against any Coverage. The Covered Individual agrees to cooperate fully with the Fund in the prosecution of any Claims, causes of action or rights against any Source and/or Coverage;

(3) Agrees to enter into a subrogation and reimbursement agreement (hereinafter collectively referred to as "Agreement") that is given to a Covered Individual by the Fund, which Agreement the Fund may require before a Covered Individual can receive any advancement of benefits (hereinafter collectively referred to as "Advance"). The Fund may withhold benefits until such Agreement is signed. If the Agreement is not executed by the Covered Individual(s), at the Fund’s request, or if the Agreement is modified in any way without the consent of the Fund, the Fund may refuse to make any Advance. However, in its sole discretion, if the Fund makes an Advance in the absence of an Agreement, or if the Fund makes an Advance in error, that Advance will not waive, compromise, diminish, release or otherwise prejudice any of the Fund’s rights to reimbursement or subrogation. The Agreement shall be in a form provided by or on behalf of the Fund. If the Covered Individual is a minor or incompetent to execute that

Agreement, that person's parent, the Participant (in the case of a minor dependent child), the Participant's spouse, or legal representative (in the case of an incompetent adult) must execute that Agreement upon request by the Fund. A Covered Individual must comply with all of the terms of the subrogation and reimbursement agreement, including the establishment of a trust for the benefit of the Fund. In this regard, the Covered Individual agrees that out of any recovery he receives from any Source or Coverage, as described in Plan Subsection 15.01(B)(1), the identified amount that the Fund has Advanced or is obligated to Advance in benefits will be immediately deposited into a trust for the Fund's benefit and the Fund shall have an equitable lien by agreement in the amount set forth in this paragraph which shall be enforceable as part of an action to enforce the Plan terms under ERISA Section 502(a)(3), including injunctive action to ensure that these amounts are preserved and not disbursed;

(4) The Fund's equitable lien by agreement imposes a constructive trust upon the assets received as a result of a recovery by the Covered Individual, as opposed to the general assets of the Covered Individual, and enforcement of the equitable lien by agreement does not require that any of these particular assets received be traced to a specific account or other destination after they are received by the Covered Individual;

(5) The Agreement will grant the Fund a priority, first dollar security interest and a lien in any recovery received from any Source or from any Coverage, whether by suit, settlement or otherwise, whether there is a full or partial recovery and regardless of whether the amounts are characterized or described as payment for medical expenses or as amounts other than for medical expenses of such Illness or Injury;

(6) Acknowledges that the Fund specifically disavows the common fund doctrine, attorneys fund doctrine, fund doctrine, the double-recovery rule or any similar doctrine or theory, including the contractual defense of unjust enrichment. This means that the Fund's subrogation and reimbursement rights apply on a priority, first dollar basis to any recovery by the Covered Individual from any Source or Coverage without regard to legal fees and expenses of the Covered Individual. This also means the Covered Individual will be solely responsible for paying all legal fees and expenses in connection with any recovery from any Source or Coverage for the underlying Illness or Injury, and the Fund's recovery shall not be reduced by such legal fees or expenses;

(7) Agrees to waive the common fund doctrine and in the event that the Covered Individual retains an attorney or law firm to prosecute a claim on their behalf, agrees to hire an attorney or law firm that waives the common fund doctrine. The Covered Individual agrees to indemnify and hold harmless the Fund against any claim or cause of action brought by the attorney or law firm against the Fund for attorneys' fees or costs, including a common fund doctrine claim, relating to the Fund's entitlement to and recovery of the Advance, and/or the attorney's or law firm's representation of the Covered Individual related to the Injury. The Covered Individual agrees that the Fund has the right to clawback benefits previously advanced to the Covered Individual or withhold future benefits of the Covered Individual or family member of the Covered Individual to offset any claim made by the Covered Individual's attorney or law firm seeking fees from the Fund.

(8) Acknowledges that the Fund specifically disavows the make-whole rule or any other similar doctrine or theory. This means that the Fund's subrogation and

reimbursement rights shall apply on a priority, first dollar basis to any recovery by a Covered Individual from any Source or Coverage, whether by suit, settlement or otherwise, whether there is a partial or full recovery and regardless of whether the Covered Individual believes he did not receive the amount that he is entitled to receive, or if the amounts are categorized or described as medical expenses or as amounts other than for medical expenses;

(9) Agrees that if the recovery is reduced due to a Covered Individual's negligence (sometimes referred to as contributory negligence) or any other common law defense, the amount of the Plan's reimbursement is not affected or reduced;

(10) Agrees that the Fund's right to reimbursement applies regardless of the existence of any State law or common law rule (including, but not limited to, the Illinois Workers' Compensation Act, 820 ILCS 305/1, *et seq*. and the Illinois Wrongful Death Act, 740 ILCS 180/0.01, *et seq*.) that would serve to ban or limit recovery of the Advance by the Fund from the Covered Individual or from any other Source;

(11) Agrees that the Fund's right to reimbursement applies regardless of the existence of any state law or common law rule that would ban recovery from a person or entity that caused the Illness or Injury, or from the insurer of that person or entity (sometimes referred to as the "collateral source" rule);

(12) Agrees not to do anything that will waive, compromise, diminish, release or otherwise prejudice the Fund's reimbursement rights or subrogation rights;

(13) Agrees to notify and consult with the Fund or its designee in writing before starting any legal action or administrative proceeding against a Third Party alleged to be responsible for the Illness or Injury that resulted in the Advance, and before entering into any settlement agreement with that Third Party or Third Party's insurer based on those allegations;

(14) Agrees that the Fund has the right to suspend all benefit payments due to the Covered Individual and family member of the Covered Individual arising out of the current incident or any other unrelated future Illness or Injury until the Fund is fully reimbursed related to the Covered Individual;

(15) Recognizes that no loan transaction is intended to be created under any subrogation or reimbursement agreement; and

(16) Agrees not to assign a Covered Individual's rights with respect to subrogation and reimbursement to anyone (except as otherwise stated in this Plan Section 15.01). This means that a Covered Individual cannot give anyone else the right to pursue whatever rights that a Covered Individual has or had with respect to subrogation and reimbursement. Any attempt to do so will be void and have no effect.

(C) For purposes of this Plan Section 15.01, the term "Covered Individual" shall also include representatives, guardians, trustees, estate representatives, heirs, executors, administrators of special needs trusts and any other agents, persons or entities that may receive a benefit on behalf of or for Covered Individuals.

(D) The Fund's subrogation and reimbursement rights and the Covered Individual's obligation set forth in this Plan Section 15.01 shall apply regardless whether the Covered Individual executes a subrogation and reimbursement agreement.

(E) For purposes of this Plan Section 15.01, benefits that are paid for medical, Hospital, behavioral health and substance use disorders, dental, vision, prescription drug and the Short Term Disability benefit (except those set forth in Plan Section 11.05(D)) are recoverable through subrogation or reimbursement.

ARTICLE XVI CLAIMS AND APPEALS

Section 16.01 Required Forms

(A) When first eligible for Plan coverage and thereafter on an annual basis or upon request, Covered Individuals must complete certain required forms that validate census data including information about spouse, Dependent child(ren), and other insurance coverage. Coverage will not be effective for Dependents until the required forms are fully completed and accepted by the Fund Office.

(B) Participants must update information on file with the Fund Office by notifying the Fund Office as soon as possible of any change described in Plan Section 3.22. Coverage may be delayed or suspended if the update is not received in a timely manner.

Section 16.02 General Rules Governing Claims

(A) Covered Individuals may submit Claims in paper form or their providers may submit Claims in paper form or through Electronic Data Interchange ("EDI"). Claims must be submitted to the Plan's Contracted Provider of service.

(B) If a Covered Individual's provider and service(s) were obtained outside the Contracted Provider's Network area, the provider must file the Claim with the Contracted Provider or the local affiliate of the Contracted Provider, if applicable.

(C) Each Claim must include:

(1) Patient name and date of birth;

(2) Participant name and social security number or other ID number assigned by the Fund;

(3) Date of service or date of fill or refill for prescription drug Claims;

(4) Specific services performed and expenses charged for each service;

(5) Diagnosis and type of service defined by HCPCS, CPT, ICD, CDT, or other nationally recognized codes, including individual charges, for each service;

(6) Attending Physician's or care provider's name and federal tax ID number (not required for prescription drug Claims);

(7) Place of service;

(8) Billing address; and

(9) Previous balances paid.

(D) A Covered Individual must pay any amounts not paid by the Fund, with the exception of PPO Network discounts or discounts that may be negotiated between the Plan and the provider on Out-of-Network Claims. PPO or other negotiated discounts do not apply to expenses that are not covered by the Plan.

(E) A Covered Individual is prohibited from assigning his rights under the medical portion of the Plan to a third party or in any way alienating the Covered Individual's Claims for benefits. Any attempt to assign rights or in any way alienate a Claim for benefits will be void and will not be recognized by the Fund as an assignment. The Fund will treat any document attempting to assign a Participant's rights, or to alienate a Claim for benefits to a provider, as an authorization for direct payment by the Fund to the provider. In the event that the Fund receives a document claiming to be an assignment of benefits, the Fund may send payments for the Claims to the provider, but will send all Claim documentation, such as an explanation of benefits, and any procedures for appealing a Claim denial directly to the Covered Individual or his Authorized Representative. If the Fund denies the Claim, only the Participant, the Participant's spouse, the patient or his Authorized Representative will have the right to appeal.

(F) The Fund will pay Claims only when covered under the terms of the Plan provisions under which a Covered Individual is eligible. If the Fund pays Claims that it is not required to pay as an erroneous payment or excess payment, the provisions of Plan Section 18.07 shall apply.

Section 16.03 Claimant May Act Through an Agent

If the Claimant designates an Authorized Personal Representative to act on his behalf, the Claimant must notify the Fund Office by completing and submitting to the Fund Office an Authorized Personal Representative Form or other form or procedure required by a designated third party Claims Fiduciary to the Fund Office. A Claimant's representative may act on behalf of a Claimant by presenting a power of attorney for health care or the Fund's Authorized Personal Representative Form or other form or procedure required by a designated third party Claims Fiduciary. If an Authorized Personal Representative is designated, all correspondence relating to the Claim or subsequent appeal will be sent directly to the Authorized Personal Representative, unless otherwise specified.

Section 16.04 Claim Types

There are three (3) basic types of Claims under the Plan:

(A) Health Care Claims include medical, behavioral health and substance use disorders, prescription drug, dental, hearing, and vision Claims. Health Care Claims include the following:

(1) Pre-Service Health Care Claim: any Claim for a benefit for which the Plan requires approval of the benefit (in whole or in part) before the Covered Individual obtains medical care;

(2) Urgent Health Care Claim: any Claim for medical care or treatment with respect to which the application of the periods for making pre-service Claim determinations would, in the opinion of a Physician with knowledge of the Covered Individual's condition, seriously jeopardize the Covered Individual's life or health or ability to regain maximum function if normal pre-service standards were applied; or would subject the Covered Individual to severe pain that cannot be adequately managed without the care or treatment for which approval is sought;

(3) Post Service Health Care Claim: any Claim for health care benefits for which the Covered Individual has already received the services in the Claim; and

(4) Concurrent Care Claim: any Claim that is reconsidered after it is initially approved and the reconsideration results in reduced benefits, an extension of benefits, or a termination of benefits;

(B) Short Term Disability Claims for benefits as described in Article X; and

(C) Other Benefit Claims, which include Life Insurance Benefits as described in Article XI and Accidental Death and Dismemberment Benefits as described in Article XII.

Section 16.05 Submission of Claims

(A) Claims may be submitted in paper form specified by the designated Claims Fiduciary or through EDI. A Provider may submit a Claim on behalf of a Claimant. Claims recognized under the Plan include requests for benefits for:

(1) Medical benefits accompanied by a HCFA, Hospital, prescription, behavioral health and substance use disorders, dental, hearing, or vision bill or other type of invoice that includes the details specified in Plan Section 16.02;

(2) Short Term Disability Benefits accompanied by a Claim form completed by the Employee and the Employee's Physician; or

(3) Life Insurance Benefits and/or Accidental Death and Dismemberment Benefits, accompanied by a certified death certificate and/or other required documentation as required by the insurance carrier or Fund Office.

(B) Incomplete Claims: If the Plan receives a document or transmission that contains, at a minimum, the following six (6) items, it will be considered a Claim, even if additional information is required to process the Claim. If additional information is required, an extension will be given to the Claimant as provided in Plan Section 16.07(B) and (C).

(1) Patient name and date of birth;

(2) Participant name and social security number or other ID number assigned by the Fund Office;

(3) Date of service or date of fill or refill for prescription drug Claims;

(4) Specific services performed and expenses charged for each service;

(5) Diagnosis and type of services as defined by HCPCS, CPT, ICD, CDT, or other nationally recognized codes, including individual charges for each; or

(6) Attending Physician's or care Provider's name and federal tax ID number (not required for prescription drug Claims).

(C) Items not treated as Claims for Benefits include any general inquiry about benefits or the circumstances under which benefits might be paid under Plan terms.

Section 16.06 When a Claim Must be Filed

A Claim for benefits must be filed with the designated Claims Fiduciary within twenty-four (24) months from the date of service, or other period specified by a third party Claims Fiduciary.

Section 16.07 Processing Procedures for Initial Claims

When a Claim is submitted for Plan benefits, the Fund Office or the designated third party Claims Fiduciary on behalf of the Trustees will determine if the Covered Individual is eligible for benefits and will calculate the amount of any benefits payable. The Plan intends to comply with the claims procedures set forth in Sections 503 and 715 of ERISA.

(A) The deadlines for processing the initial determination of a Claim vary as follows:

(1) Health Care Claims will be determined as follows:

(a) Urgent Health Care Claims: within seventy-two (72) hours of receipt of the Claim.

(b) Pre-Service Health Care Claims: within fifteen (15) days of receipt of the Claim.

(c) Post Service Health Care Claims: within thirty (30) days of receipt of the Claim.

(d) Concurrent Care Claims: as soon as possible and in time to receive a decision before reduction or termination of the benefit.

(2) Short Term Disability Claims will be determined within forty-five (45) days of receipt of the Claim.

(3) Other Benefit Claims will be determined within ninety (90) days of receipt of the Claim, *i.e.*, Life Insurance, Accidental Death and Dismemberment.

(B) Extension of Initial Determination Period: In some instances, an extension of the initial determination period may be required due to matters beyond the Claims Fiduciary's control. If an extension is necessary, a Covered Individual will be notified. The Claims Fiduciary will notify the Claimant of the extension and the notice will include the special circumstances requiring the extension and the date the Claims Fiduciary expects to render a decision, as follows:

(1) Pre-Service Health Care Claims: Claimant will be notified within the fifteen (15) day initial determination period that one (1) fifteen (15) day extension is necessary.

(2) Post-Service Health Care Claims: Claimant will be notified within the thirty (30) day initial determination period that one (1) fifteen (15) day extension is necessary.

(3) Short Term Disability Claims: Claimant will be notified within the forty-five (45) day initial determination period that up to an additional sixty (60) days maximum is necessary. However, if a determination is not made within the first seventy-five (75) days, the Claimant will be notified that an additional thirty (30) days is necessary.

(4) Other Benefit Claims: Claimant will be notified within the ninety (90) day initial determination period that up to an additional ninety (90) days may be necessary. The extension cannot be more than ninety (90) days from the end of the initial ninety (90) day period, or one hundred and eighty (180) days total.

(C) When additional information is needed to process a claim, the Claimant will be notified, for:

(1) Health Care Claims, within the fifteen (15) or thirty (30) day initial determination period. A Covered Individual (or his provider, if his provider is notified) has up to forty-five (45) days to provide the requested information. If the Claims Fiduciary receives the requested information in the forty-five (45) day period, the Claim will be processed within fifteen (15) days following the receipt of the additional information. For an Urgent Care Claim, the deadline for additional information is as soon as possible but within twenty-four (24) hours of the receipt of the Claim. The Claims Fiduciary must notify the Covered Individual of the specific information needed and the Covered Individual has at least forty-eight (48) hours to provide the information.

(2) Claims for Short Term Disability Benefits within the forty-five (45) day initial determination period. The Claimant has up to forty-five (45) days to provide the requested information.

(3) Other Benefit Claims, within the ninety (90) day initial determination period. The ninety (90) day extension of initial determination period listed above includes any time needed by the Claims Fiduciary to obtain this information.

(D) If a Claim is denied, in whole or in part, the Claims Fiduciary will send the claimant a written notice of the Adverse Benefit Determination that includes the following information:

(1) For Health Care Claims:

(a) The specific reason or reasons the Claim was denied in whole or in part;

(b) Reference to the specific Plan provisions on which the denial was based;

(c) A description of any additional information that a Covered Individual will need to submit in support of his Claim and an explanation of why the additional information is needed;

(d) An explanation of the Plan’s Claim review procedures and applicable time limits and notice that the Claimant may request an external review with an independent review organization after the Plan's Claims procedure have been exhausted;

(e) Copy of any internal rule, guideline, protocol or similar criteria that was relied on, or the notice will include a statement that a copy is available at no cost upon request if relevant;

(f) Copy of the scientific or clinical judgment, or the notice will include a statement that a copy of the scientific or clinical judgment is available to a Covered Individual at no cost upon request, and

(g) A statement of a Covered Individual’s rights under ERISA to bring a civil action and the applicable deadlines.

(2) For Health Care Claims, *except* dental and vision:

(a) Information sufficient to identify the Claim including: date of service; provider; Claim amount; the denial codes and their respective meanings: a description of any standard used in determining the denial; a provision stating that diagnosis and treatment codes and their corresponding meanings are available upon request without charge, and disclosure of the availability of, and contact information for, any applicable ombudsman established under the Affordable Care Act to assist individuals with the internal Claims and appeals and external review processes.

(b) Notice that the Claimant may request an external review with an independent review organization after the Plan's procedures have been exhausted.

(3) For Short Term Disability Claims:

(a) The specific reason or reasons the Claim was denied including a discussion of the decision and, if applicable, an explanation of the basis for disagreeing with or not following:

(i) The views of a health care or vocational professional who treated or evaluated the Employee;

(ii) The views of a medical or vocational expert whose advice was solicited by the Plan in connection with the claim; or

(iii) A disability determination made by the Social Security Administration;

(b) Reference to the specific Plan provisions on which the denial was based;

(c) A description of any additional information that an Employee will need to submit in support of his Claim and an explanation of why the additional information is needed;

(d) An explanation of the Plan's Claim review procedures and applicable time limits;

(e) Copies of any internal rule, guideline, protocol or similar criteria relied on, or a statement that no such rule, guideline, protocol or similar criteria exists;

(f) Copy of the scientific or clinical judgment, or the notice will include a statement that a copy of the scientific or clinical judgment is available to an Employee, or his Authorized Personal Representative, at no cost upon request;

(g) A statement that the Employee, or his Authorized Personal Representative, is entitled to receive reasonable access to, and copies of, all documents, records and other information relevant to his claim upon request, free of charge; and

(h) A statement of an Employee's rights under ERISA section 502(a) to bring a civil action and the applicable deadlines.

(4) For Other Benefit Claims:

(a) The specific reason or reasons the Claim was denied;

(b) Reference to the specific Plan provisions on which the denial was based;

(c) A description of any additional information that an Employee or an Employee's designated beneficiary will need to submit in support of his Claim and an explanation of why the additional information is needed;

(d) An explanation of the Plan's Claim review procedures and applicable time limits;

(e) A statement of the Employee's rights under ERISA Section 502(a) to bring a civil action and the applicable deadlines.

Section 16.08 Adverse Benefit Determination Appeal Process

(A) Health Care Claims.

(1) An Adverse Benefit Determination is:

(a) A denial, reduction, or termination of, or failure to provide or make payment in whole or in part for a benefit; or

(b) Rescission of coverage, whether or not there is an adverse effect on any particular benefit at that time.

An Explanation of Benefits (EOB) serves as the notice of an adverse benefit determination for a Health Care Claim.

(2) All appeals must be in writing, contain the signature of the Claimant on the forms required by the applicable Claims Fiduciary and addressed to the applicable Claims Fiduciary.

(a) A written appeal should include evidence or specific facts and Benefit Plan provisions that support a Claim for benefits. A Claimant should submit a completed Appeal Form and any additional information to substantiate the appeal to the applicable Claims Fiduciary.

(b) An appeal must contain all of the information listed in Plan Section 16.02(C) as well as any denial codes corresponding meanings. Appeals must be made on the Fund Office approved form. An appeal for claims from an applicable third party Claims Fiduciary must contain all of the information required by the applicable Claims Fiduciary on the forms required by such insurance carrier.

(3) Only a Claimant has the right to appeal a Claim for benefits that was denied in whole or in part. General inquiries by a provider or a Claimant for information on whether a certain medical procedure, prescription, Treatment Plan or other similar request is covered by the Plan is not considered a Claim for benefits.

(4) If a post service Claim has been denied, in whole or in part, a Claimant has no more than one hundred and eighty (180) days after the receipt of an adverse benefit determination to file an appeal.

(5) Upon appeal, a Covered Individual has the right to:

(a) Designate an Authorized Personal Representative (who may be an attorney);

(b) Submit additional material, including comments, statements, or documents;

(c) Be advised of the identity of any medical expert; and

(d) Receive copies, free of charge, of:

(i) All new or additional evidence considered, relied upon or generated by the Plan or the Trustees; or

(ii) Any new or additional rationale relied upon in connection with the claim.

Such new or additional evidence or rationale shall be provided as soon as possible and sufficiently in advance of the Trustees' final decision in order to give the Claimant a reasonable opportunity to respond. If the new or additional evidence is received so late that the Claimant will not have a reasonable opportunity to respond, the time period in Plan Sections 16.08(A)(7) and (8) will be tolled until the Claimant has an opportunity to respond. After the Claimant responds, or fails to respond, the Claims Fiduciary will issue its decision as soon as reasonably practical.

(6) Preliminary Review. For post-service Health Care Claims and eligibility Claims for which the Board of Trustees is the Claims Fiduciary, the Fund Office will complete a preliminary review of the request within five (5) business days of the Fund's receipt of the request for an appeal to determine:

(a) If the Covered Individual was eligible under the Plan at the time the health care item or service is/was requested or, in the case of a retrospective review, were covered under the Plan at the time the health care item or service was provided;

(b) The adverse benefit determination does not relate to the Covered Individual's failure to meet the requirements for eligibility under the terms of the Plan; and

(c) The Claimant has completed and provided all of the required information and forms to process the appeal.

If the additional information provided in the course of an Appeal is found to clearly fall within the guidelines and protocols for claim payment, the claim will be reconsidered and paid. The Covered Individual will receive a new EOB showing the additional benefits paid. In the case of an eligibility reversal, coverage will be updated to cover any additional period of eligibility supported by the additional

information provided, and the Claimant will be notified of the extension and claims denied for that period will be reopened and reconsidered.

(7) Review of Appeals by the Appeals Committee of the Board of Trustees. Properly filed appeals for post-service Health Care Claims and eligibility Claims for which the Board of Trustees is the Claims Fiduciary will be reviewed at the next regularly scheduled appeals meeting of the Trustees, who meet at least quarterly. However, if the request for review is received within thirty (30) days of the next regular meeting, the request for review will be considered at the second regularly scheduled meeting following receipt of the request. If special circumstances require a further extension of time for processing (for example, if the appeal must be tolled in accordance with Plan Section 16.08(A)(5)(d)), a determination will be made at the third regularly scheduled meeting following receipt of the request for review. Prior to the start of the extension, the Claimant will be advised in writing in advance if this extension will be necessary, and will be notified of the special circumstances and the date by which a determination will be made. Once the decision has been made, the Trustees will mail their decision to the Claimant within five (5) business days after making the determination. The Trustees' determination on review is binding on all parties.

(8) Review of Appeals Where the Claims Fiduciary is a Third Party. The designated Claims Fiduciary will review the Claims appeal and provide its written decision to the Claimant within sixty (60) days of receiving the appeal. The Claimant will receive written notice of the decision within thirty (30) days after the appeal was received if the Claims Fiduciary has two (2) levels of appeal.

(9) The Claimant has the right to access and copy (free of charge) all documents, records and other information Relevant to his appeal. A Covered Individual has the right to bring a civil action suit under Section 502(A) of ERISA. Any such civil action must be commenced within twelve (12) months following the date of the determination letter.

(B) Short Term Disability Claims.

(1) An Adverse Benefit Determination is:

(a) A denial, reduction, a termination of or failure to provide or make a payment in whole or in part, for a benefit; or

(b) A Rescission of coverage.

The Board of Trustees is the Claims Fiduciary for Short Term Disability Benefits. The Trustees will send the Employee a written notice of the Adverse Benefit Determination for a Short Term Disability Claim.

(2) All appeals must be in writing, on the form required by the Fund Office, and contain the signature of the Employee or his Authorized Personal Representative.

(a) A written appeal should include evidence or specific facts and Benefit Plan provisions that support a Claim for benefits. An Employee or his Authorized Representative must submit a completed Appeal Form and any additional information to substantiate the appeal to the Fund Office.

(b) A written appeal must contain all of the information listed in Plan Section 16.02(C) as well as any denial codes' corresponding meanings. Appeals must be made on the Fund Office approved form.

(3) Only an Employee or his Authorized Personal Representative has the right to appeal a Claim for benefits that was denied in whole or in part. General inquiries by an Employee or his Authorized Personal Representative for information on whether the Employee qualifies for Short Term Disability Benefits is not considered a Claim for benefits.

(4) If a Claim for Short Term Disability Benefits has been denied, in whole or in part, the Employee or his Authorized Personal Representative have no more than one hundred and eighty (180) days after the receipt of an adverse benefit determination to file an appeal.

(5) Upon appeal, an Employee has the right to:

(a) Designate an Authorized Personal Representative (who may be an attorney);

(b) Submit additional material, including comments, statements, or documents;

(c) Be advised of the identity of any medical expert; and

(d) Receive copies, free of charge, of:

(i) All new or additional evidence considered, relied upon or generated by the Plan or the Trustees; or

(ii) Any new or additional rationale relied upon in connection with the claim.

Such new or additional evidence or rationale shall be provided as soon as possible and sufficiently in advance of the Trustees' final decision in order to give the Employee or his Authorized Personal Representative a reasonable opportunity to respond.

(6) Preliminary Review. The Fund Office will complete a preliminary review of a Claim request within five (5) business days of the Fund's receipt of the request for an appeal to determine:

(a) If the Employee was eligible for Short Term Disability Benefits under the Plan;

(b) The adverse benefit determination does not relate to the Employee's failure to meet the requirements for eligibility under the terms of the Plan; and

(c) The Employee or his Authorized Personal Representative has completed and provided all of the required information and forms to process the appeal.

If the additional information provided in the course of an appeal is found to clearly fall within the guidelines and protocols for claim payment, additional weekly

benefits will be paid on the next following weekly payment cycle for any retroactive time that is approved based on the new information.

In the case of an eligibility reversal, coverage will be updated to cover any additional period of eligibility supported by the additional information provided, and the Employee or his Authorized Personal Representative will be notified of the extension and claims denied for that period will be reopened and reconsidered.

(7) Review of Claim Appeals by the Appeals Committee of the Board of Trustees. Properly filed appeals will be reviewed at the next regularly scheduled appeals meeting of the Trustees, who meet at least quarterly. However, if the request for review is received within thirty (30) days of the next regular meeting, the request for review will be considered at the second regularly scheduled meeting following receipt of the request. If special circumstances require a further extension of time for processing, a determination will be made at the third regularly scheduled meeting following receipt of the request for review. Prior to the start of the extension, the Employee or his Authorized Personal Representative will be advised in writing in advance if this extension will be necessary, and will be notified of the special circumstances and the date by which a determination will be made. Once the decision has been made, the Trustees will mail their decision to the Employee or his Authorized Personal Representative within five (5) business days after making the determination. The Trustees' determination on review is binding on all parties.

(8) The Employee or his Authorized Personal Representative has the right to access and copy (free of charge) all documents, records and other information Relevant to his appeal. The Employee has the right to bring a civil action suit under Section 502(A) of ERISA. Any such civil action must be commenced within twelve (12) months following the date of the determination letter.

(C) Other Benefit Claims.

(1) An Adverse Benefit Determination is a denial, reduction, or termination of, or failure to provide or make payment in whole or in part for a benefit.

(2) All appeals regarding Other Benefit Claims must be in writing, contain the signature of the Claimant on the forms required by the applicable Claims Fiduciary and addressed to the applicable Claims Fiduciary.

(3) The written appeal should include evidence or specific facts and Benefit Plan provisions that support a Claim for benefits and all of the information required by the applicable Claims Fiduciary on the forms required by the Claims Fiduciary. The Claimant should submit a completed Appeal Form and any additional information to substantiate the appeal to the applicable Claims Fiduciary.

(4) Only a Claimant or, if applicable, his designated beneficiary has the right to appeal a Claim for benefits that was denied in whole or in part. General inquiries by a Claimant or, if applicable his designated beneficiary for information on whether a Covered Individual qualifies for benefits under the Insured program is not considered a Claim for benefits.

(5) If a Claim has been denied, in whole or in part, the Claimant or, if applicable, his designated beneficiary has no more than ninety (90) days after receipt of an adverse benefit determination to file an appeal.

(6) Upon appeal, a Covered Individual or, if applicable, his designated beneficiary has the right to:

(a) Designate an Authorized Personal Representative (who may be an attorney);

(b) Submit additional material, including comments, statements, or documents.

(7) Review of Appeals: The Claims Fiduciary will review the Claim appeal and provide its written decision within sixty (60) days of receiving the appeal. In some instances the Covered Individual or, if applicable, his designated beneficiary will be notified in the original sixty (60) day period that an extension is required and that the Claims Fiduciary will provide a written decision no later than one hundred and twenty (120) days after receiving the appeal.

(8) The Claimant has the right to access and copy (free of charge) all documents, records and other information Relevant to his appeal. The Covered Individual also has the right to bring a civil action suit under Section 502(A) of ERISA. Any lawsuit must be initiated within twelve (12) months of the denial on appeal.

Section 16.09 Notice of Appeals Decision

When the Plan notifies a Claimant of its decision on a Claim on appeal, it must provide:

(A) For Health Care Claims:

(1) The specific reason or reasons for its decision;

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

(3) A statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of, all documents, records, and other information Relevant to the Claimant's Claim for benefits;

(4) A statement describing any further appeal procedures offered by the Plan including the Claimant's right to obtain the information about such procedures,

(5) Copy of any internal rule, guideline, protocol or similar criteria that was relied on or a statement that a copy is available at no cost upon request if relevant to a Claim;

(6) A statement that a copy of the scientific or clinical judgment is available to the Claimant at no cost upon request if Relevant to a Claim that is denied due to a medical judgement which includes but is not limited to:

(a) Medical Necessity;

(b) Experimental or Investigational treatment; or

(c) Similar exclusion or limit.

(7) A statement that if the appeal is denied, the Covered Individual has the right to initiate a lawsuit under ERISA Section 502(a). Any lawsuit must be initiated within

twelve (12) months of the denial on appeal. The notice shall also include the calendar date by which the Covered Individual must initiate the lawsuit.

(B) For Health Care Claims *except* dental and vision:

(1) Information sufficient to identify the Claim involved, including: date of service; provider; Claim amount; and any denial codes and their respective meanings; a description of any standard used to determine the denial; and a provision stating that diagnosis and treatment codes and their corresponding meanings are available upon request without charge;

(2) An explanation of the basis for the adverse benefit determination;

(3) For a Claim based on medical judgement, to request an external review from an independent review organization after the Plan's Claims appeal procedures have been exhausted.

(4) Disclosure of the availability of, and contact information for, any applicable ombudsman established under the Affordable Care Act to assist individuals with the internal Claims and appeals and external review processes for Health Care Claims.

(C) For Short Term Disability Claims:

(1) The specific reason or reasons for its decision including a discussion of the decision, and, if applicable, an explanation of the basis for disagreeing with or not following:

(a) The views of a health care or vocational professional who treated or evaluated the Employee;

(b) The views of a medical or vocational expert whose advice was solicited by the Plan in connection with the claim; or

(c) A disability determination made by the Social Security Administration;

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

(3) An explanation of the basis for the adverse benefit determination;

(4) A statement that the Employee is entitled to receive, upon request and free of charge, reasonable access to and copies of, all documents, records, and other information Relevant to the Employee’s Claim for benefits;

(5) Copies of any internal rule, guideline, protocol or similar criteria relied on by the Trustees, or a statement that no such rule, guideline, protocol or similar criteria was considered; and

(6) A statement that the Employee or his Authorized Personal Representative may receive, free of charge, upon request, an explanation of the scientific or clinical judgment for the denial, applying the terms of the Plan to the Employee’s medical circumstances, if the Plan's decision is based on a medical necessity, experimental treatment, or similar exclusion or limitation.

(7) A statement that if the Employee's appeal is denied, he has the right to initiate a lawsuit under ERISA Section 502(a). Any lawsuit must be initiated within twelve (12) months of the denial on appeal. The notice shall also include the calendar date by which the Employee must initiate the lawsuit.

(D) For Other Benefit Claims:

(1) The specific reason or reasons for its decision;

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

(3) An explanation of the basis for the adverse benefit determination;

(4) A statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of, all documents, records, and other information Relevant to the Covered Individual's Claim for benefits;

(5) A statement that if the Claimant's appeal is denied, the Participant has the right to initiate a lawsuit under ERISA Section 502(a). Any lawsuit must be initiated within twelve (12) months of the denial on appeal. The notice shall also include the calendar date by which the Employee must initiate the lawsuit.

Section 16.10 External Review of Health Care Claims

If an appealed Health Care Claim is denied by the Appeals Committee of the Board of Trustees or a third party Claims Fiduciary, the Claimant may request further review by an independent review organization ("IRO") as described below. External review does not apply to dental and vision claims. Only denied Health Care Claims that involve medical judgment and Rescission claims are eligible for external review.

Generally, a Claimant may only request an external review after he has exhausted the internal review and appeals process described above. If a Covered Individual's Claim is denied due to his failure to meet the requirements for eligibility under the terms of the Plan, an external review is not available. The External Review of Claims is intended to comply with applicable law and regulations and guidance as issued by the Department of Labor, Department of Health and Human Services and the Internal Revenue Service.

The External Review process is as follows:

(A) A request for an external review of a non-urgent Claim must be made, in writing, within four (4) months of the date of the EOB indicating an adverse benefit determination or the date of the letter advising of an adverse appeal Claim benefit determination whichever is later. The Plan's internal review and appeals process generally must be exhausted before an external review is available. External review of a Claim will only apply to an adverse benefit determination or final internal adverse benefit determination involving a medical judgment.

(B) The Claims Fiduciary will complete a preliminary review of the request within five (5) business days of the Claims Fiduciary's receipt of the Covered Individual's external review request to determine whether:

(1) The Covered Individual has exhausted the Plan's internal Claims and appeals process (except, in limited, exceptional circumstances); and

(2) The Covered Individual has completed the proper form to request an external review. Additional information is not required, as the information submitted for the Appeal in Plan Section 16.08 is deemed complete, however if there is additional information available, it may be submitted for consideration.

The Claims Fiduciary will notify the Claimant in writing within one (1) business day of completing its preliminary review if the request meets the requirements for external review. If applicable, the notification will inform the Claimant that the request is complete but not eligible for external review, in which case the notice will include the reasons for its ineligibility, and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)).

(C) If the request is complete and eligible, the Claims Fiduciary will assign the request to an IRO and provide, within five (5) business days after the assignment to the IRO, documents and information it considered in making its adverse benefit determination. The IRO is not eligible for any financial incentive or payment based on the likelihood that it would support the denial of benefits. The Claims Fiduciary will rotate assignment among IROs with which it contracts.

(D) Once the Claim is assigned to an IRO, the following procedure will apply:

(1) If additional information is needed, the assigned IRO will notify the Claimant in writing of how to submit additional information regarding the Claim (generally, the Claimant must submit such information within ten (10) business days following the Claimant's receipt of notice from the IRO).

(2) If the Claimant submits additional information related to the Claim, the assigned IRO must within one (1) business day forward that information to the Claims Fiduciary. Upon receipt of any such information, the Claims Fiduciary may reconsider its adverse benefit determination that is the subject of the external review. Reconsideration by the Claims Fiduciary will not delay the external review. However, if upon reconsideration, the Claims Fiduciary reverses its adverse benefit determination, it will provide written notice of its decision to the Claimant and the IRO within one (1) business day after making that decision. Upon receipt of such notice, the IRO will terminate its external review.

(3) The IRO will review all timely received information and documents. In reaching a decision, the IRO will review the Claim *de novo* (as if it is new) and will not be bound by any decisions or conclusions reached during the Claims Fiduciary's internal Claims and appeals process. However, the IRO will be bound to abide by the terms of the Plan to ensure that the decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law. The IRO also must abide by the Plan's requirements for benefits, including:

(a) The Plan's standards for clinical review criteria,

(b) Medical Necessity,

(c) Industry standards or appropriateness,

(d) Health care setting, or

(e) Level of care of a covered benefit.

In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and appropriate, may consider additional information, including:

(a) Information from the Covered Individual's medical records,

(b) Any recommendations or other information from his treating health care providers,

(c) Any other information from the Claimant or the Claims Fiduciary,

(d) Reports from appropriate health care professionals,

(e) Appropriate practice guidelines,

(f) The Plan's applicable clinical review criteria and/or the opinion of the IRO's clinical reviewer(s).

(4) After the IRO receives the request for the external review, the assigned IRO will provide written notice of its final external review decision to the Claimant and the Claims Fiduciary within forty-five (45) days. The assigned IRO's decision notice will contain:

(a) A general description of the reason for the request for external review, including information sufficient to identify the Claim, including:

(i) the date or dates of service,

(ii) the health care provider,

(iii) the Claim amount (if applicable),

(iv) a statement that the diagnosis and treatment codes, and their corresponding meanings, are available upon request, and

(v) 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 documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;

(d) A discussion of the principal reason(s) for its decision, including the rationale for the decision and any evidence-based standards that were relied upon in making its decision; including:

(i) A statement that the determination is binding except to the extent that other remedies may be available to the Claimant or the Fund under applicable State or Federal law;

(ii) A statement that judicial review may be available to the Claimant; and

(iii) Current contact information, including phone number, for the health insurance consumer assistance or ombudsman established under law to assist with external review processes.

(E) A Claimant may request an expedited external review if:

(1) The Covered Individual receives an initial adverse benefit determination that involves a medical condition for which the timeframe for completion of an internal appeal would seriously jeopardize his life or health, or would jeopardize his ability to regain maximum function, and the Claimant has filed a request for an urgent care internal appeal; or

(2) The Claimant receives an adverse appeal benefit determination that involves a medical condition for which the timeframe for completion of a standard external review would seriously jeopardize the Covered Individual's life, his health or would jeopardize his ability to regain maximum function; or, the Claimant receives an adverse appeal benefit determination that concerns an admission, availability of care, continued stay, or health care item or service for which the Covered Individual received Emergency services, but has not yet been discharged from a facility.

The process of the expedited external review will not differ from that explained in Plan Section 16.10 (A) thru (C), but the following time frames will apply.

(1) The Claims Fiduciary's preliminary review from Plan Section 16.10(B) will be completed immediately.

(2) The Claims Fiduciary will immediately notify the Claimant whether the request meets the requirements of Plan Section 16.10(B) for an external review.

(3) If requirements of Plan Section 16.10(C) are met, the Claims Fiduciary will assign an IRO and provide the documents and information it considered in making its adverse benefit determination to the IRO expeditiously.

(4) The IRO will provide a decision in accordance with Plan Section 16.10(D)(4) within seventy-two (72) hours. If the notice is not in writing, the IRO must provide written confirmation of its decision within forty-eight (48) hours of providing the notice.

(F) After External Review:

(1) If the final external review reverses the Claims Fiduciary's adverse benefit determination, upon the Claims Fiduciary's receipt of notice of such reversal, the Plan will immediately provide coverage or payment for the reviewed Claim.

(2) If the final external review upholds the Claims Fiduciary's adverse benefit determination, the Plan will uphold the denial of coverage or payment for the reviewed Claim. If the Claimant is dissatisfied with the external review determination, he may seek judicial review as permitted under ERISA Section 502(a). Any lawsuit must be initiated within twelve (12) months of the denial on appeal.

Section 16.11 Powers of the Trustees, Claims Fiduciaries and Other Delegates

The Trustees, the Appeals Committee or their designated Claims Fiduciaries, have sole, full and discretionary authority to make final determinations regarding any claim for benefits, the interpretation of the Plan and all documents, rules, procedures and terms of the Plan, and any administrative rules adopted by the Claims Fiduciaries. It is the intention of the drafters of this Plan that the decisions of the Trustees will be accorded judicial deference in any subsequent administrative or court proceeding, to the extent the decisions do not constitute an abuse of discretion. Benefits will only be paid under the Plan if the Trustees or their delegate Claims Fiduciaries decide, in their discretion, that the Claimant is entitled to them.

Section 16.12 Exhaustion of Remedies

Generally, a Covered Individual must follow and completely exhaust the Plan's appeal procedures (including time limits) before the Covered Individual can file a lawsuit under ERISA or initiate proceedings before any administrative agency. If the Plan fails to adhere to all Claims and Claims appeal requirements, the Covered Individual is deemed to have exhausted the Claims appeal process and may seek an external review or file a lawsuit, unless the Plan's failure is *de minimis*. In the event a Covered Individual submits a Claim for review and the Claim is denied, any legal action must begin within twelve (12) months of the date the adverse benefit appeal determination is provided.

Section 16.13 Facility of Claims Payment

In the event the Fund determines that a Covered Individual is incompetent or incapable of executing a valid receipt and no guardian has been appointed, the Fund may pay any amount otherwise payable to that Covered Individual, to the spouse, or any other person or institution determined by the Fund to be equitably entitled to payment. Any payment in accordance with this provision discharges the Fund from any further obligation.

Section 16.14 Right to Information in Claims and Appeals Process

A Claimant has the right to receive, upon written request, copies of all documents relevant to the decision made on his appeal.

Upon request from the Claimant, the Claims Fiduciary is required to provide a Claimant with the identification of medical or other experts whose advice was obtained for reviewing the Covered Individual's appeal. The names of medical or other experts will be disclosed by the Claims Fiduciary only upon receipt of a written request, signed by the Claimant, for this specific information. Any and all disclosures shall be made in accordance with HIPAA.

ARTICLE XVII PRIVACY OF HEALTH INFORMATION

Section 17.01 Use and Disclosure of Protected Health Information

(A) The Plan will use protected health information (hereinafter referred to as "PHI") to the extent and in accordance with the uses and disclosures permitted by HIPAA. Specifically, the Plan will use and disclose protected health information for purposes related to (1) health care treatment, (2) payment for health care, and (3) health care operations.

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

(1) Determination of eligibility, coverage, and cost sharing amounts (e.g. cost of a benefit, Plan maximums, and Co-payments as determined for an individual's Claim);

(2) Coordination of Benefits;

(3) Adjudication of health benefit Claims (including appeals and other payment disputes);

(4) Subrogation of health benefit Claims;

(5) Establishing Participant contributions;

(6) Risk adjusting amounts due based on enrollee health status and demographic characteristics;

(7) Billing, collection activities and related health care data processing;

(8) Claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes and responding to Participant inquiries about payments;

(9) Obtaining payment under a contract for reinsurance (including stop-loss and excess of loss insurance);

(10) Medical Necessity reviews, or reviews for appropriateness of care or justification of charges;

(11) Utilization Review, including precertification, preauthorization, concurrent review and retrospective review;

(12) Disclosure to consumer reporting agencies related to collection of premiums or reimbursement (the following PHI may be disclosed for payment purposes: name and address, date of birth, Social Security Number, payment history, account number, and name and address of the provider and/or health plan); and

(13) Reimbursement to the Plan.

(C) "Health care operations" include, but are not limited to, the following activities:

(1) Quality Assessment;

(2) Population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting of health care providers and patients with information about treatment alternatives and related functions;

(3) Rating provider and Plan performance, including accreditation, certification, licensing, or credentialing activities;

(4) Underwriting, premium rating, and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing, or placing a contract for reinsurance of risk relating to Claims for health care (including stop-loss insurance and excess of loss insurance);

(5) Conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;

(6) Business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the entity, including formulary development and administration, development or improvement of methods of payment or coverage policies;

(7) Business management and general administrative activities of the entity, including, but not limited to:

(a) Management activities relating to implementation of and compliance with the requirements of HIPAA Administrative Simplification;

(b) Customer service, including the provision of data analyses for policyholders, Plan sponsors, or other customers;

(c) Resolution of internal grievances; and

(d) Due diligence in connection with the sale or transfer of assets to a potential successor in interest, if the potential successor in interest is a covered entity or, following completion of the sale or transfer, will become a covered entity.

(8) Compliance with and preparation of all documents as required by ERISA, including Forms 5500, Summary Annual Reports, and other documents.

(D) The Plan will use and disclose PHI as required by law and as permitted by authorization of the Participant or beneficiary. The Plan discloses and shares certain information with the Carpenters Pension Fund pursuant to a business associate agreement.

(E) For purposes of this Plan Section 17.01, the Board of Trustees is the Plan Sponsor. The Plan will disclose PHI to the Plan Sponsor only upon receipt of a certification from the Plan Sponsor that the Plan documents have been amended to incorporate the following provisions. The Plan will use and disclose 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, as amended 45 C.F.R. Parts 160 and 164 (the "Privacy Regulations") and the Health Information Technology for Economic and Clinical Health Act ("HITECH"), as amended. The capitalized terms used below are as defined by the Privacy Regulations. The following provisions address disclosures of PHI to the Plan Sponsor for Plan administration purposes.

(1) Disclosure of PHI to the Plan Sponsor:

(a) Disclosures by Plan: The Plan may disclose PHI to the Plan Sponsor to the extent necessary for the Plan Sponsor to perform Plan administration functions that qualify as Payment or Health Care Operations.

(b) Disclosures by Business Associates: The Plan's Business Associates may disclose PHI to the Plan Sponsor to the extent necessary for the Plan Sponsor to perform Plan administration functions that qualify as Payment or Health Care Operations.

(c) Disclosures by Other Covered Entities: A Covered Entity that provides health insurance benefits to Covered Individuals covered by this Plan may disclose PHI to the Plan Sponsor to the extent necessary for the Plan Sponsor to perform the following Plan administration functions:

(i) The Plan's payment activities,

(ii) Those Health Care Operations designated in 45 C.F.R. Section 164.506(c)(4) with respect to the Plan, and

(iii) 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.

(2) Uses and Disclosures of PHI by the Plan Sponsor: The Plan Sponsor shall use and/or disclose PHI only to the extent necessary to perform Plan administration functions that qualify as Payment or Health Care Operations, or as otherwise permitted or required by the Privacy Regulations.

(3) Privacy Safeguards: The Plan Sponsor agrees to:

(a) Not use or further disclose PHI other than as permitted or required under the Plan or as required by law;

(b) Ensure that any subcontractors or agents to whom the Plan Sponsor provides PHI agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to PHI;

(c) Not use or disclose PHI for employment-related actions and decisions unless authorized by the Individual who is the subject of the PHI;

(d) 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;

(e) Report to the Plan any use or disclosure of PHI of which the Plan Sponsor becomes aware that is inconsistent with the uses or disclosures provided for in the Plan;

(f) Make PHI available to an Individual in accordance with the Privacy Regulation's access requirements and the Plan's privacy policies and procedures;

(g) 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;

(h) 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;

(i) 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;

(j) If feasible, return or destroy all PHI that the Plan Sponsor maintains 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 Plan Sponsor. If return or destruction is not feasible, the Plan Sponsor agrees to restrict and limit further uses and disclosures to the purposes that make the return or destruction infeasible and shall maintain the confidentiality of such PHI as long as it is retained; and

(k) Ensure that adequate separation between the Plan and the Plan Sponsor is established, as described below.

(4) Adequate Separation: Adequate separation between the Plan and the Plan Sponsor must be maintained. Therefore, in accordance with HIPAA, only the following Employees or classes of Employees may be given access to PHI:

(a) The Plan Administrator; and

(b) Staff designated by the Plan Administrator.

(5) Limitations of PHI Access and Disclosure: The persons described in Plan Section 17.01(E)(4) may only have access to and use and disclose PHI for Plan administration functions that the Plan Sponsor performs for the Plan as described above.

(6) Noncompliance Issues: If the persons described in Plan Section 17.01(E)(4) do not comply with these privacy requirements, the Plan Sponsor shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

(F) For purposes of complying with the HIPAA privacy rules, this Plan is a Hybrid Entity because it has both health plan and non-health plan functions. The Plan designates that its health care components that are covered by the privacy rules include only health benefits and not other Plan functions or benefits.

Section 17.02 Security of Protected Health Information

The Plan and the Plan Sponsor as named in Plan Section 17.01 will comply with the security regulations issued pursuant to the Health Insurance Portability and Accountability Act of 1996, 45 C.F.R. Parts 160, 162 and 164 (the "Security Regulations").

(A) Overview: The following provisions apply to Electronic Protected Health Information ("ePHI") that is created, received, maintained or transmitted by the Plan Sponsor on behalf of the Plan, except for ePHI (1) it receives pursuant to an appropriate authorization (as described in 45 C.F.R. Section 164.504(f)(1)(ii) or (iii)), or (2) that qualifies as Summary Health Information and that it receives for the purpose of either (a) obtaining premium bids for providing health insurance coverage under the Plan, or (b) modifying, amending, or terminating the Plan (as authorized under 45 C.F.R. Section 164.508). The Security Regulations are incorporated herein by reference. The capitalized terms are defined by the Security Regulations.

(B) Security Safeguards: The Plan Sponsor agrees to:

(1) Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the ePHI that it creates, receives, maintains, or transmits on behalf of the Plan.

(2) Ensure that any agent or subcontractor to whom it provides ePHI agrees to implement reasonable and appropriate security measures to protect ePHI.

(C) Adequate Separation: Ensure that "adequate separation" is supported by reasonable and appropriate security measures. "Adequate separation" means the Plan Sponsor will use ePHI only for Plan administration activities and not for employment-related actions or for any purpose unrelated to Plan administration. Any Employee of the Plan sponsor or Plan fiduciary who uses or discloses ePHI in violation of the Plan's security or privacy policies and procedures or this Plan amendment shall be subject to the Plan Sponsor's disciplinary procedure.

(D) Noncompliance Issues: Report to the Plan any Security Incident of which it becomes aware.

ARTICLE XVIII GENERAL PROVISIONS

Section 18.01 Amendment or Termination of the Plan and Trustee Discretion

(A) The Trustees have the power and authority to amend or terminate the Plan, to increase, decrease, or change benefits and premiums, or change eligibility rules or other provisions of the Plan of Benefits for the Active Plan, the Retiree Plan and the Low Cost Medical Plan, at their discretion as may be proper or necessary for the sound and efficient administration of the Fund, provided that such changes are not inconsistent with law or with the provisions of this Plan or with the provisions of the Trust Agreement.

(B) The Trustees and other Plan fiduciaries and individuals, to whom responsibility for the administration of the Plan has been delegated, have the full discretionary authority available under applicable law to construe the Trust Agreement, Summary Plan Description, the Plan, the Plan documents and related documents including but not limited to Collective Bargaining Agreements, Participation Agreements and reciprocity agreements, and the procedures of this Fund, and to interpret any facts relevant to such construction. This authority extends to every aspect of their administration of the Plan including benefit determinations, eligibility determinations, and entitlement to Plan benefits. Any interpretation or determination made under this discretionary authority will be given full force and effect and will be accorded judicial deference, unless it can be shown that the interpretation or determination was arbitrary and capricious. Benefits under the Plan will be paid only if the Trustees (or other Plan fiduciaries, such as a third party Claims Fiduciary) decide in their discretion that the Covered Individual is entitled to them. In addition, any interpretation or determination made pursuant to this discretionary authority is binding on all involved parties.

(C) Any amendment made by the Trustees will be reduced to writing and may be effective prospectively or retrospectively, provided, however, no amendment to the Plan will retroactively reduce benefit entitlement or benefit levels then in effect. All amendments are subject to the limitation of the Trust Agreement and the applicable law and administrative regulations. Written notice of amendment or termination of the Plan will be provided to Participants in accordance with Federal regulations.

(D) In the event of a termination, any and all assets remaining after the payment of all obligations and expenses will be used, in accordance with a dissolution plan adopted by the Trustees, to continue the benefits provided by the existing Plan until such assets have been exhausted or in such manner as will best serve the purposes of the Fund. In no event will assets be paid to or be recoverable by any Contributing Employer, association, or labor organization.

Section 18.02 Severability Clause; Conformity with Law

(A) Should any provision of the Plan, this Plan document, or any amendment thereto be deemed or held to be unlawful, or unlawful as to any person or instance, such facts will not adversely affect the other provisions, or the application of those provisions to any other person or instance, unless such illegality makes the functioning of the Plan impossible or impracticable.

(B) To the extent permitted by law, the Trustees will not be held liable for any act done or performed in pursuance of any provisions of the Plan prior to the time that such act or provision is held unlawful by a court of competent jurisdiction.

(C) If any provision of this Plan is contrary to any law to which it is subject, such provision is hereby amended to conform to such law.

Section 18.03 Workers' Compensation

This Plan is not in lieu of and does not affect any requirement for coverage under any Workers' Compensation Act or Occupational Diseases Act or similar law.

Section 18.04 Governing Law

All questions pertaining to the validity and construction of the Trust Agreement, the Plan, and of the acts and transactions of the Trustees or of any matter affecting the Fund will be determined under Federal law where applicable Federal law exists. Where no applicable Federal law exists, the laws of the State of Illinois will apply.

Section 18.05 Precedence of Plan Document

If any discrepancy exists between the provisions contained in a Summary Plan Description of this Plan of Benefits and the provisions contained in this document, the provisions of this document will take precedence.

Section 18.06 Examination

The Trustees have the right:

(A) To employ a Physician or an independent medical consultant to examine the person whose Illness or Injury is the basis of a Claim hereunder when and so often as they may reasonably require during the pending of a Claim hereunder;

(B) To examine any and all Hospital or medical records relating to a Claim under this Plan; and

(C) To request and have an autopsy performed in case of death, provided an autopsy is not forbidden by law.

Section 18.07 Excess Payments

If payments are made which are erroneous payments or are in excess of the maximum payment authorized under this Plan in whole or in part, the Fund shall have the right to seek or recover such payments plus related amounts (e.g., interest and costs) from the Covered Individual, family member of the Covered Individual, the Covered Individual's estate or legal representative, insurance carrier, the provider that received the overpayment, or any other person with respect to whom such payments were made. The Fund shall be permitted to pursue legal and equitable remedies (e.g., restitution, constructive trust, offset or setoff) to recover excess payments and related amounts. The Fund may recover excess payments and related amounts by offsetting amounts payable to the Covered Individual and family members of the Covered Individual. Every Claimant shall be required to provide all information, agreements, and assignments necessary to protect the Fund's rights. Failure to comply shall be considered a violation of Plan Section 15.01.

Section 18.08 Fraudulent Claims

Notwithstanding any other provisions of the Plan, the Trustees may in their sole discretion determine that a Covered Individual, or an Authorized Personal Representative on the Covered Individual's behalf, who fails to comply with the terms of Plan Section 15.01, who willfully and knowingly defrauds the Fund in any manner, or who is guilty of deceit, theft or fraud in connection with the Fund:

(A) Shall forfeit all rights to benefits paid or payable to the Covered Individual, any assignee, any Dependent, or to any other beneficiary, in connection with the Claim or Claims to which the subrogation agreement, deceit, theft, or fraud relates and shall reimburse the Fund for any benefit payments already made by the Fund, and the Fund's attorney's fees and costs incurred in recovering said benefit payments, all upon such terms and conditions as the Trustees in their sole discretion shall determine;

(B) Effective from and after the date of violation of this Plan Section, the Covered Individual shall forfeit all rights to benefits payable hereunder to himself, any assignee, any Dependent, or to any other beneficiary. A Covered Individual's right to again become eligible for any or all benefits provided by the Fund shall commence at such time and upon such terms and conditions as the Trustees in their sole discretion shall determine; and

(C) May be subject to legal action by the Fund and liable for any related attorneys' fees, all upon such terms and conditions as the Trustees in their sole discretion may determine.

It shall be considered fraud if a Covered Individual willfully and knowingly fails to report the existence of any other available coverage or the Covered Individual's rights against a third party or insurance company in connection with a Claim filed for benefits under this Plan.

Section 18.09 No Vested Right to Health and Welfare Benefits

Coverage under the Plan does not confer any rights to or promise of continuing benefits for any Covered Individual or beneficiary. The benefits provided under the Active Plan, the Retiree Plan, and the Low Cost Medical Plan are not vested benefits.

Section 18.10 Headings

The headings of articles and sections are included solely for convenience of reference, and if there is any conflict between such headings and the text of this Plan, the text shall control.

Section 18.11 Gender and Number

The masculine gender, where appearing in the Plan, shall be deemed to include the feminine gender and the singular shall be deemed to include the plural, unless the context clearly indicates to the contrary.

Section 18.12 Rescission of Coverage

(A) This provision is intended to comply with the provisions of the Affordable Care Act. The Fund will not Rescind health coverage under the Plan with respect to a Covered Individual (including a group to which the Covered Individual belongs or family coverage in which

the individual is included), unless the Covered Individual (or persons seeking coverage on behalf of the individual) performs an act, practice or omission that constitutes fraud or the Covered Individual makes an intentional misrepresentation of material fact as prohibited by the terms of the Plan.

(B) The Plan is required to provide at least thirty (30) days advance written notice to each Covered Individual who is affected by a Rescission of coverage before the coverage may be Rescinded, regardless of whether the Rescission applies to an entire group or only to an individual within the group. Retroactive termination of coverage in cases of an unreported divorce or failure to timely pay premiums is not a Rescission and, therefore, the thirty (30) day advance notice requirement does not apply.

Section 18.13 Tax Consequences

Payment of benefits by the Plan to a Covered Individual or his Authorized Personal Representative, or to the service provider releases and discharges the Plan from any liability for the tax consequences of such payment.

Section 18.14 Furnishing Required Information and Documentation

Every Claimant and Covered Individual shall, upon reasonable request, furnish the Board of Trustees such information or proof as may be reasonably necessary or helpful in determining eligibility or benefit payments. Failure on the part of the Claimant or Covered Individual to comply with any request for information shall be grounds for denying or discontinuing benefits to the Covered Individual until the request is complied with. If any Claimant knowingly makes any false statement concerning any fact material to his claims for benefits, the Board of Trustees shall have the right to recover any payment made to such person in reliance on such false statements in accordance with Plan Section 18.08.

Section 18.15 Will County Local 174 Carpenters Welfare Fund Merger

The Plan shall provide medical and disability benefits to Participants, surviving spouses, and Dependent of the Will County Local 174 Carpenters Welfare Fund (“Will County Fund”) as of the December 31, 2018, the effective date of the merger between the Will County Fund and the Plan pursuant to Plan Section 7(c)(iv) of the Merger Agreement between the Will County Fund and the Plan.

ARTICLE XIX COVID-19 TEMPORARY RELIEF

This Article XIX is intended to provide temporary relief for Employees and Employers affected by the COVID-19 Public Health Emergency. The provisions in this Article XIX will override any sections of this Plan stating information contrary to what is stated herein for the effective dates listed below.

Section 19.01 COVID-19 Plan Coverage

(A) Effective March 1, 2020, the Plan is amended to provide the following temporary relief:

(1) COVID-19 Testing: The Plan will provide one hundred percent (100%) coverage for In-Network and Out-of-Network Office Visits, Emergency Room, and Urgent Care Facility visits in which related services include a COVID-19 test or evaluation for a test, consistent with the Families First Coronavirus Response Act ("FFCRA") and related guidance. To the extent permitted by law, all Out-of-Network COVID-19 claims are subject to the Reasonable and Customary Allowance. Deductibles and Coinsurance do not apply.

(2) COVID-19 Claims: The Plan will provide one hundred percent (100%) coverage for Office Visits, Emergency Room and Urgent Care Facility visits related to the treatment of a COVID-19 diagnosis. Out-of-Network COVID-19 claims are subject to the Reasonable and Customary Allowance. Deductibles and Coinsurance do not apply.

(3) Telehealth and Virtual Visits: The Plan will provide one hundred percent (100%) coverage for all In-Network and Out-of-Network medical and behavioral health virtual and telehealth visits. To the extent permitted by law, all Out-of-Network COVID-19 medical and behavioral telehealth and virtual visit claims are subject to the Reasonable and Customary Allowance. Deductibles and Coinsurance do not apply.

Effective January 1, 2021, the Plan will provide one hundred percent (100%) coverage for all In-Network and Out-of-Network COVID-19 related medical telehealth and virtual visits. To the extent permitted by law, all Out-of-Network COVID-19 for telehealth and virtual visit claims are subject to the Reasonable and Customary Allowance. Deductibles and Coinsurance do not apply. All other medical telehealth and virtual visit claims will be subject to applicable deductible and coinsurance.

(4) In-Network Hospital Claims: The Plan will provide one hundred percent (100%) coverage for In-Network Hospital charges for individuals hospitalized and receiving in-patient care for a COVID-19 diagnosis. Deductibles and Coinsurance do not apply. This provision does not apply to separate medical charges received relating to in-patient treatment, for example: physician fees, readings of x-rays and CT Scans, etc. These additional charges (generally professional fees) are subject to Deductibles and Coinsurance.

(B) Effective March 18, 2020, the Plan is amended to provide one hundred percent (100%) coverage for In-Network and Out-of-Network Office Visits, Emergency Room visits, and Urgent Care Facility visits in which related services include serological tests for detection

of COVID-19 antibodies to the extent required by FFCRA and related guidance. To the extent permitted by law, all Out-of-Network COVID-19 claims are subject to the Reasonable and Customary Allowance. Deductibles and Coinsurance do not apply.

Section 19.02 Temporary Eligibility Extension

(A) Effective for the June 1, 2020 Coverage Quarter, eligibility is temporarily extended for active Employees who were covered for the March 1, 2020 Coverage Quarter, but who would otherwise lose eligibility for the June 1, 2020 Coverage Quarter due to a reduction of hours. The eligibility extension excludes Participants covered during the March 1, 2020 Coverage Quarter by Continuation Coverage under COBRA, the Low Cost Medical Plan, the Self-Payment of Hours option, or Retirees in pay status as of June 1, 2020 that were eligible for the Active Plan of Benefits in the March 1, 2020 coverage quarter.

(B) Effective for the September 1, 2020 Coverage Quarter, eligibility is temporarily extended for active Employees who were covered for the March 1, 2020 Coverage Quarter, but who would otherwise lose eligibility for the September 1, 2020 Coverage Quarter due to a reduction of hours. In addition to the Participants excluded under section 19.02(A), the September 1, 2020 Coverage Quarter extension excludes: Participants whose last hours credited were not paid by a Contributing Employer (e.g., Short Term Disability hours credited under Plan Section 10.01); Retirees in pay status as of September 1, 2020; Employees participating under a Collective Bargaining Agreement or Participation Agreement establishing month-to-month eligibility; Employees employed as superintendents whose coverage was transferred to another plan sponsored by their Employer; Employees of the Fund Office or Council whose employment terminated in 2019; and deceased Participants.

(C) Effective for the December 1, 2020 Coverage Quarter, eligibility is temporarily extended for active Employees who were covered for the March 1, 2020 Coverage Quarter but who would otherwise lose eligibility for the December 1, 2020 Coverage Quarter due to a reduction of hours. In addition to the Participants excluded under section 19.02(A), the December 1, 2020 Coverage Quarter extension excludes: Participants whose last hours were not paid by a Contributing Employer for work performed in 2020 (e.g., Short Term Disability hours credited under Plan Section 10.01); Retirees in pay status as of December 1, 2020; Employees participating under a Collective Bargaining Agreement or Participation Agreement establishing month-to-month eligibility; Employees of the Fund Office or Council whose employment terminated in 2019 or 2020; and deceased Participants.

Section 19.03 Temporary Reduction of Continuing Eligibility Requirements

Effective with the June 1, 2020 Coverage Quarter, the continuing eligibility hours requirement as described in Plan Section 3.09(B) is temporarily reduced from one thousand (1,000) hours to seven hundred and fifty (750) hours effective through the March 1, 2021 Coverage Quarter. For apprentices, the continuing eligibility hours requirement as described in Plan Section 3.10(B) is temporarily reduced from seven hundred and sixty (760) hours to five hundred (500) hours, effective through the March 1, 2021 Coverage Quarter. The reduction in the continuing eligibility hours in this Plan Section 19.03 excludes Retirees in pay status as of the beginning of each of these Coverage Quarters. Effective with the December 1, 2020 Coverage Quarter, the reduction in the continuing eligibility hours in this Plan Section 19.03 also excludes: Employees participating under a Collective Bargaining Agreement or Participation Agreement establishing

month-to-month eligibility; Employees of the Fund Office or Regional Council whose employment ended in 2019 or 2020; and deceased Participants.

Section 19.04 Temporary Reduction of Monthly COBRA and Low Cost Premiums

Monthly COBRA and Low Cost premiums will be reduced by twenty-five percent (25%) for the coverage months of April 2020 through March 31, 2021.

Section 19.05 Temporary Expansion of Short Term Disability Benefits

Effective March 1, 2020, the definition of Non-Occupational Illness under the Short Term Disability benefit is temporarily expanded to include coverage for imposed quarantine or self-quarantine of an eligible Employee who is unable to work because their attending Physician has certified that such quarantine is (1) Medically Necessary or appropriate because the eligible Employee has been diagnosed with COVID-19; (2) the eligible Employee had exposure or suspected exposure to COVID-19; and/or (3) a member of the eligible Employee's household has been diagnosed with COVID-19 according to the accepted guidelines of the Centers for Disease Control and Prevention and/or the respective state Department of Health. This benefit change does not apply to Employees currently covered by Continuation Coverage under COBRA or the Low Cost Medical Plan.

Section 19.06 Temporary Waiver of Waiting Period for Short Term Disability Benefits for COVID-19 Disabilities

Effective March 1, 2020, the seven (7) calendar day waiting period for Short Term Disability benefits is waived for qualifying COVID-19 Disabilities under Plan Section 19.05.

ARTICLE XX CERTIFICATION

The undersigned do hereby attest that this Plan Document of the Chicago Regional Council of Carpenters Welfare Fund was restated effective December 1, 2020, and was adopted by resolution of the Board of Trustees at a meeting at which a quorum was present as reflected in the minutes of the November 24, 2020 Board of Trustees meeting.

UNION TRUSTEE

Signature

Gary Perlmar
Print Name

EMPLOYER TRUSTEE

Signature

Gerald W. Thiel, Jr.
Print Name

Appendix A

SCHEDULE OF BENEFITS
FOR THE ACTIVE PLAN OF BENEFITS

The schedule on the following pages highlights key features of the Active Plan of Benefits for Covered Individuals.

- The amounts charged for Covered Medical Expenses provided by Network Providers are subject to the PPO allowed contractual amounts. A Covered Individual will not be balance billed for amounts over the allowed contractual amount.
- The amounts charged for Covered Medical Expenses provided by Out-of-Network providers are subject to the Reasonable and Customary Allowance (R&C Allowance). R&C Allowances are determined by the Trustees (or their designee) in their sole discretion, and are amended from time to time. Out-of-Network charges are paid at 285% of the Medicare Physician Fee Schedule National Payment Amount Schedule. A Covered Individual is responsible to pay for amounts over the R&C Allowance.

COMPREHENSIVE MEDICAL BENEFITS

	PPO Provider	Out-of-Network Provider
Coinsurance	80% paid by Plan	60% paid by Plan
Deductible per Calendar Year	$300 per Covered Individual $900 per family	$600 per Covered Individual $1,800 per family
Out-of-Pocket Maximum per Calendar Year	$2,300 per Covered Individual $6,900 per family (includes Calendar Year Deductible)	$6,000 per Covered Individual $18,000 per family (Does not include Calendar Year Deductible)
	After a Covered Individual satisfies the Deductible and Out-of-Pocket Maximum, the Plan will pay 100% of most eligible Covered Services for the remainder of the Calendar Year. PPO and Non-PPO Deductibles and Out-of-Pocket Maximums are separate and cannot be combined	

MEDICAL BENEFITS

Contracted Network Provider: BlueCross BlueShield of Illinois (BCBSIL)

	BCBS PPO Provider	Out-of-Network Provider
• **Acupuncture Care**	See *Chiropractic, Acupuncture and Naprapathic Care,* page App A-2	
• **Ambulance Service**	80% paid by Plan subject to the PPO Deductible	
• **Anesthesia or Sedation**	80% paid by Plan	60% paid by Plan
• **Bariatric Surgery** (only for the diagnosis and treatment of morbid obesity)	80% paid by Plan	60% paid by Plan
	Prior to surgery, a Covered Individual is required to contact the Fund Office to enroll in and successfully complete ComPsych's Bariatric Support Service Program (BSSP). Participation in the BSSP is mandatory for coverage.	
• **Behavioral Health Care**	See page App. A-5	
• **Breast Feeding Support and Equipment** to the extent required under the Affordable Care Act o Lactation support and counseling o Breast pump rental up to the purchase price and initial supplies (tubing and shields). Limited to one non-retail purchase per pregnancy. o Hospital-grade breast pump must be Medically Necessary.	100% paid by Plan Calendar Year Deductible does not apply	No coverage

	BCBS PPO Provider	Out-of-Network Provider
• **Chiropractic, Acupuncture and Naprapathic Care** (Combined Benefit)	80% paid by Plan	60% paid by Plan
	Maximum visit limit per Employee: 50 visits per Calendar Year Maximum visit limit per spouse: 30 visits per Calendar Year No coverage for Dependent children	
• **Clinical Trials** to the extent required by the Affordable Care Act	80% paid by Plan	60% paid by Plan
	See Plan Sections 5.04(H)	
• **Contraceptives**, including related office visits, to the extent required under the Affordable Care Act for FDA approved methods for females with reproductive capacity: o Contraceptive support and counseling o Diaphragms, sponges, cervical caps, female condoms & spermicides o Vaginal rings o Emergency contraceptives (generic morning after pill only) o Implants & implantable rods o Oral contraceptives, generic only o Patch o Injectables o IUD	100% paid by the Plan Calendar Year Deductible does not apply	No coverage
• **Cosmetic Surgery** solely to improve appearance	No coverage	
• **Dental Service for a Non-Occupational Injury to Teeth**	80% paid by Plan	60% paid by Plan
	Annual Dental Benefit must be exhausted	

	Absolute Solutions Network	BCBS PPO Provider	Out-of-Network Provider
• **Diagnostic Imaging Benefit – MRI, CAT/CT and PET Scans**	100% paid by Plan (Calendar Year Deductible does not apply)	80% paid by Plan	60% paid by Plan

	BCBS PPO Provider	Out-of-Network Provider
• **Diagnostic X-Rays and Lab Tests**	80% paid by Plan	60% paid by Plan
• **Durable Medical Equipment**	80% paid by Plan	60% paid by Plan
• **Emergency Room** o Facility	80% paid by Plan	80% paid by Plan
o Physician fees	80% paid by Plan	80% paid by Plan
• **Emergency Room Co-payment**	$250 per Emergency Room visit Waived if admitted to the Hospital as an In-Patient within 72 hours or held in the observation unit for more than 24 hours Emergency Room Co-Payment no longer applicable after Covered Individual meets the applicable Calendar Year Out-of-Pocket Maximum	
• **Extended Care/Skilled Nursing Facility**	80% paid by Plan	60% paid by Plan
	Maximum of 120 days per convalescent period	
• **Genetic Testing Benefit**		
o Genetic testing to the extent required under the Affordable Care Act	100% paid by Plan Calendar Year Deductible does not apply	60% paid by Plan Subject to Calendar Year Deductible, Out-of-Pocket Maximum and the combined annual maximum benefit of $7,500
o Diagnostic genetic testing	80% paid by Plan	60% paid by Plan
	Subject to Calendar Year Deductible, Out-of-Pocket Maximum, and the combined annual maximum benefit of $7,500	
o Non-diagnostic genetic testing	No coverage	No coverage

	BCBS PPO Provider	Out-of-Network Provider
• **Hearing Benefit**		
○ Hearing evaluation/exam for a newborn (ages 0 to 31 days) as required under the Affordable Care Act	100% paid by Plan. Calendar Year Deductible does not apply	80% paid by Plan Calendar Year Deductible does not apply
○ Hearing evaluation/exam	Paid at 100% per Covered Individual once every two (2) consecutive Calendar Years. Calendar Year Deductible does not apply	No coverage
○ Hearing aid instrument	**Preferred Contracted Provider: EPIC Hearing Service (Hearing Aid Only)** / **BCBS PPO Provider**	**Out-of-Network Provider**
➢ Dependent children through age 18	Paid at 100% up to $2,500 maximum per Covered Individual once every three (3) consecutive Calendar Years Calendar Year Deductible does not apply	
➢ Participant, spouse and Dependent children age 19 and older	Paid at 100% up to $2,500 maximum per Covered Individual once every five (5) consecutive Calendar Years Calendar Year Deductible does not apply	
	BCBS PPO Provider	**Out-of-Network Provider**
• **Home Health Care**	80% paid by Plan	60% paid by Plan
	Maximum of 120 visits per year	
• **Hospice Care**	80% paid by Plan	60% paid by Plan
	Lifetime maximum of 180 days per Covered Individual	
• **Hospital Care**	80% paid by Plan	60% paid by Plan
	Confinement maximum: 180 days per Calendar Year for in-patient care	
• **Infertility Services** including Hospital, Physician, prescription drugs & treatments. except diagnostic genetic testing which may be covered above	80% paid by Plan	60% paid by Plan
	Combined lifetime maximum of $10,000 for services provided to the Employee and spouse. No coverage for dependent children.	
• **Infusion Therapy** for the administration of an intravenous prescription drug	80% paid by Plan	60% paid by Plan
• **Member Assistance Program**	See page App. A-5	
• **Naprapathic Care**	See *Chiropractic, Acupuncture and Naprapathic Care*, page App A-2	
• **Nutritional Counseling** to the extent required under the Affordable Care Act, for individuals who participate in the bariatric program and for treatment of eating disorders	100% paid by Plan Calendar Year Deductible does not apply	No coverage
• **Oral and Maxillofacial Surgery**	80% paid by Plan	60% paid by Plan
• **Organ Transplant**	80% paid by Plan	60% paid by Plan
• **Physician Services**	80% paid by Plan	60% paid by Plan
• **Pregnancy Care**	80% paid by Plan, except to the extent required under the Affordable Care Act. Services covered under the Affordable Care Act are paid at 100% by the Plan and the Calendar Year Deductible does not apply.	60% paid by Plan
• **Prosthetics**	80% paid by Plan	60% paid by Plan
○ Artificial limbs and eyes ○ Wigs and hairpieces for hair loss as a result of treatment for a cancer diagnosis or an organ transplant	100% paid by Plan, subject to a $500 lifetime maximum. Calendar Year Deductible does not apply	
• **Reconstructive Breast Surgery**	80% paid by Plan	60% paid by Plan

	BCBS PPO Provider	Out-of-Network Provider
• **Sterilization** o Females to the extent required under the Affordable Care Act	100% paid by Plan. Calendar Year Deductible does not apply	No coverage
o Males	80% paid by Plan	No coverage
o Sterilization reversals (female/male)	No coverage	No coverage
• **Substance Use Disorder**	See page App. A-5	
• **Surgi-Center Facility** o Hospital affiliated	80% paid by Plan	60% paid by Plan
o No Hospital affiliation	80% paid by Plan	No coverage
• **Surgical Assistant or Assistant Surgeon**	80% paid by Plan	60% paid by Plan, limited to 20% of surgical procedure's R&C Allowance
• **Surgical Consultations**	80% paid by Plan	60% paid by Plan
• **Temporomandibular Joint Care** (TMJ) o Physician and therapy services	80% paid by Plan	60% paid by Plan
o Appliances, and their adjustments, for TMJ and bruxism (occlusal)	80% paid by Plan once every 3 consecutive years. Maximum of two (2) appliances per lifetime.	
Therapy Services • **Physical and Speech Outpatient Therapy**	80% paid by Plan	60% paid by Plan
	Maximum 50 visits per Calendar Year	
- (For additional benefits beyond the 50 visit maximum, see Section 5.04(MM))	60% paid by Plan	40% paid by Plan
• **Occupational Outpatient Therapy**	80% paid by Plan	60% paid by Plan
	Maximum 50 visits per Calendar year	
- (For additional benefits beyond the 50 visit maximum, see Section 5.04(MM))	60% paid by Plan	40% paid by Plan
• **Physical, Occupational and Speech Outpatient Therapy for Developmental Disabilities** (Habilitative or to teach; for Covered Individuals through age 18)	80% paid by Plan	60% paid by Plan
• **Urgent/Immediate Care Facilities and Retail Clinics**	80% paid by Plan	60% paid by Plan
• **Vision Surgery** (excluding cosmetic or refractive corrections)	80% paid by Plan	60% paid by Plan
• Premium Lens replacements in conjunction with cataract surgery	$1,000 maximum per lens (maximum two lenses per lifetime)	$1,000 maximum per lens (maximum two lenses per lifetime)
• **Wellness and Preventive Care**		
o **Wellness and Preventive Care** to the extent required under the Affordable Care Act including routine screenings, immunizations and other services (see **www.healthcare.gov** for list of services)	100% paid by Plan. Calendar Year Deductible does not apply	No coverage
o **Comprehensive Health Evaluation and Physical Exam** (blood, glucose and cholesterol analysis, strength and flexibility testing, mammogram or prostate screening and more)	**Preferred Contracted Provider: Health Dynamics** 100% paid by Plan for Employee and spouse once every Calendar Year. Calendar Year Deductible does not apply Not available to Dependent children	

HEALTH CENTER BENEFITS For Eligible Covered Individuals Only	
• **Health Center Services**	100% paid by Plan. Calendar Year Deductible does not apply

MEMBER ASSISTANCE PROGRAM Contracted Network Provider: ComPsych, Guidance Resources®		
	ComPsych In-Network Provider	**Out-of-Network Provider**
• **Member Assistance Program (MAP)**	100% paid by Plan for five short-term counseling sessions per issue Calendar Year Deductible does not apply	No coverage

BEHAVIORAL HEALTH & SUBSTANCE USE DISORDER BENEFITS Contracted Network Provider: ComPsych, Guidance Resources®		
	ComPsych In-Network Provider	**Out-of-Network Provider**
• **Emergency Room**		
o Facility	80% paid by Plan	80% paid by Plan
o Physician fees	80% paid by Plan	80% paid by Plan
• **Emergency Room Co-payment**	$250 per Emergency Room Visit Waived if admitted to the Hospital as an In-Patient within 72 hours or held in the observation unit for more than 24 hours Emergency Room Co-Payment no longer applicable after Covered Individual meets the applicable Calendar Year Out-of-Pocket Maximum	
• **Hospital Care and Residential Treatment Facilities**	80% paid by Plan	60% Paid by Plan
	Confinement maximum: 180 days per Calendar Year combined for Hospital and Residential Treatment in-patient care	
• **Hospital Outpatient Diagnostic Tests**	80% paid by Plan	60% paid by Plan
• **Outpatient Therapy** (including partial hospitalization)	80% paid by Plan	60% paid by Plan
• **Custodial or Group Homes**	No coverage	

VISION CARE BENEFITS Contracted Network Provider: Vision Service Plan of Illinois (VSP) Vision coverage is provided by the contracted provider and is described in the insurance policy issued by the contracted provider. Vision coverage includes, but is not limited to:		
	VSP In-Network Provider (Participant's Cost)	**Out-of-Network Provider (Maximum Amount Plan Pays)**
Frequency • **Exam** • **Lenses or contacts** • **Frame**	Once per Calendar Year	
Exam Co-payment	$0 Co-pay	Up to $45
Frame Allowance • Frames up to $200 ($220 for VSP featured frame brands)	$0 Co-pay* *20% savings on amounts above allowance	Up to $70
Lenses • Single vision • Bifocal lined • Trifocal lined • Standard progressive lens • Premium progressive lens • Custom progressive lens	 $0 Co-pay $0 Co-pay $0 Co-pay $0 Co-pay $95-$105 Co-Pay 150-$175 Co-pay	 Up to $30 Up to $50 Up to $65 Up to $50 Up to $50 Up to $50
Contacts (in lieu of Glasses) • $125 allowance for contacts • Contact lens exam (fitting and evaluation)	$0 Co-pay $40	Up to $105
Safety Glasses (Employees Only) • **Safety Frame** from the ProTec Eyewear Collection • **Lenses –** Prescription single vision, lined bifocal and lined trifocal. Polycarbonate and Progressives covered in full	$10 Co-Pay for frame and lenses	No coverage

DENTAL BENEFITS

Contracted Network Provider: Delta Dental of Illinois

Dental benefits are not available to an apprentice except as described in Plan Sections 3.02(C) and 3.11(C) of the Plan Document.

	Delta Dental PPO	Delta Dental Premier	Out-of-Network
Annual Maximum	$2,500		
Annual Deductible (applies only to Basic and Major Care)	$50/person / $100/family		
Balance Billing (the difference between the dentist's actual charge and the amount allowed by Delta Dental.)	Does not apply	Does not apply	Applies. A Covered Individual is responsible for charges exceeding Delta Dental's maximum plan allowance
• **Preventive/Diagnostic Care (1)**			
○ Covered Individual through age 18	Paid at 100% of Delta Dental's PPO reduced schedule, not subject to the annual Deductible or annual maximum	Paid at 100% of Delta Dental's maximum plan allowance, not subject to the annual Deductible or annual maximum	Paid at 100% of Delta Dental's maximum plan allowance, not subject to the annual Deductible or annual maximum
○ Covered Individual - age 19 and older	Paid at 100% of Delta Dental's PPO reduced schedule, not subject to the annual Deductible, but subject to the annual maximum	Paid at 100% of Delta Dental's maximum plan allowance, not subject to the annual Deductible, but subject to the annual maximum	Paid at 100% of Delta Dental's maximum plan allowance, not subject to the annual Deductible, but subject to the annual maximum
• **Basic Care (2)** (all ages)	Paid at 80% of Delta Dental's PPO reduced schedule, subject to the annual Deductible and the annual maximum	Paid at 80% of Delta Dental's maximum plan allowance, subject to the annual Deductible and the annual maximum	Paid at 80% of Delta Dental's maximum plan allowance, subject to the annual Deductible and the annual maximum
• **Major Care (3)** (all ages)	Paid at 80% of Delta Dental's PPO reduced schedule, subject to the annual Deductible and the annual maximum	Paid at 80% of Delta Dental's maximum plan allowance, subject to the annual Deductible and the annual maximum	Paid at 80% of Delta Dental's maximum plan allowance, subject to the annual Deductible and the annual maximum
• **Orthodontia (4)**	Effective January 1, 2020, when services are rendered by a Delta Dental provider, the orthodontia charges are paid at 80% subject to a lifetime maximum of $5,000.		Paid at 80% of the Dentist's usual fee subject to a lifetime maximum of $2,000

(1) Preventive/Diagnostic Care includes:

- ✓ Oral evaluations (two in 12 month period)
- ✓ Prophylaxis/Cleaning (two in a 12 month period)
- ✓ X-rays (bitewings two in a 12 month period; full mouth or panoramic once in 36 month period; cephalometric once in a 24 month period)
- ✓ Fluoride Treatment (once in a 12 month period for Dependent children through age 18)
- ✓ Palliative Treatment
- ✓ Sealants (once per lifetime on 1st and 2nd molars only, for Dependent children through age 14)

(2) Basic Care includes:

- ✓ Fillings
- ✓ Oral Surgery
- ✓ General Anesthesia
- ✓ Periodontics
- ✓ Endodontics
- ✓ Consultations
- ✓ Removal of cysts & tumors in the mouth
- ✓ Space Maintainers (5-year interval for Dependent children up to age 13)

(3) Major Care includes (services are covered once in a 5 year period) include:	
✓ Crowns, Jackets & Case Restoration ✓ Fixed & Removable Bridges ✓ Partial & Full Dentures	✓ Veneers (Permanent Teeth Only) ✓ Implants and related services

Note: All Frequency limitations listed above are to the day.

PRESCRIPTION BENEFITS

Contracted Network Provider: Express Scripts, Inc. and

Accredo Specialty Pharmacy

Prescription drug benefits are not available to an apprentice except as described in Plan Sections 3.02(C) and 3.11(C) of the Plan Document.

	ESI Network Retail Pharmacy (Lesser of 100 units or a 30 day supply)	**ESI By Mail** (Up to a 90 day supply through mail order)	**Accredo Specialty Pharmacy** (For specialty drugs)
Out-of-Pocket Maximum per Calendar Year	$2,000 per Covered Individual / $4,000 per family		
Generic Co-payment	$5	$12.50	Does not apply
Single-Source Brand Co-payment (A generic is not available)	20% $10 minimum Co-payment per drug with a $100 maximum	20% $25 minimum Co-payment per drug with a $250 maximum	Does not apply
Multi-Source Brand Co-payment (A generic is available)	35% $20 minimum Co-payment	35% $50 minimum Co-payment	Does not apply
Non-Select Specialty Medication Co-payment (used to treat complex conditions such as cancer, hemophilia, immune deficiency, rheumatoid arthritis, etc. and require a higher level of care)	Does not apply		20% $20 minimum Co-payment per drug with a $100 maximum
Select Specialty Medications	Does not apply		See Plan Sections 8.01(D) and 8.02.

SHORT TERM DISABILITY BENEFITS

(For Employees Only)

Non-Occupational (Not work-related)	Weekly benefits include a payment up to $450 and credit of up to 40 hours for a Disability from the date certified by a Physician. Not to exceed a maximum of 52 weeks.
Occupational (Work-related)	Weekly benefits include credit of up to 40 hours for a Disability from the date certified by a Physician. Not to exceed a maximum of 52 weeks.

LIFE INSURANCE BENEFITS

Contracted Provider: Aetna Life Insurance Company

	Eligible Participant	**Spouse**	**Child**
Policy amount	$50,000	$2,500	$2,000

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE BENEFITS FOR ELIGIBLE EMPLOYEES ONLY Contracted Provider: Aetna Life Insurance Company				
Type of Loss	**Benefit Amount**		**Type of Loss**	**Benefit Amount**
Life	$50,000		Both feet	$50,000
One hand and one foot	$50,000		Both hands	$50,000
One foot and sight of one eye	$50,000		Sight of one eye	$25,000
One hand and sight of one eye	$50,000		One foot	$25,000
Sight of both eyes	$50,000		One hand	$25,000
Speech and hearing in both ears	$50,000		Thumb and index finger	$12,500

Appendix B

SCHEDULE OF BENEFITS
FOR THE RETIREE PLAN OF BENEFITS

The schedule on the following pages highlights key features of the Retiree Plan of Benefits for Covered Individuals.

- The amounts charged for Covered Medical Expenses provided by Network Providers are subject to the PPO allowed contractual amounts. A Covered Individual will not be balance billed for amounts over the allowed contractual amount.
- The amounts charged for Covered Medical Expenses provided by Out-of-Network providers are subject to the Reasonable and Customary Allowance (R&C allowance). R&C Allowances are determined by the Trustees (or their designee) in their sole discretion, and are amended from time to time. Out-of-Network charges are paid at 285% of the Medicare Physician Fee Schedule National Payment Amount Schedule. A Covered Individual is responsible to pay for amounts over the R&C Allowance.

COMPREHENSIVE MEDICAL BENEFITS FOR COVERED INDIVIDUALS THAT ARE NOT MEDICARE ELIGIBLE

	PPO Provider	Out-of-Network Provider
Coinsurance	80% paid by Plan	60% paid by Plan
Deductible per Calendar Year	$300 per Covered Individual $600 per family	$600 per Covered Individual
Out-of-Pocket Maximum per Calendar Year	$2,000 per Covered Individual $4,000 per family (includes deductible)	$6,000 per Covered Individual
	After a Covered Individual satisfies the deductible and Out-of-Pocket Maximum, the Plan will pay 100% of most eligible Covered Services for the remainder of the Calendar Year. PPO and Non-PPO deductibles and Out-of-Pocket Maximums are separate and cannot be combined	

BENEFITS FOR COVERED INDIVIDUALS THAT ARE NOT MEDICARE ELIGIBLE AND ARE ENROLLED IN COMPREHENSIVE MEDICAL BENEFITS

Contracted Network Provider: BlueCross BlueShield of Illinois (BCBSIL)

	BCBS PPO Provider	Out-of-Network Provider
• **Acupuncture Care**	See *Chiropractic, Acupuncture and Naprapathic Care (Combined Benefit), see page App B-2*	
• **Ambulance Service**	80% paid by Plan subject to the PPO Deductible	
• **Anesthesia or Sedation**	80% paid by Plan	60% paid by Plan
• **Bariatric Surgery** (only for the diagnosis and treatment of morbid obesity)	80% paid by Plan	60% paid by Plan
	A Covered Individual is required to contact BCBSIL before any treatment is given and must be approved for surgery.	
• **Behavioral Health Care**	See page App. B-5	
• **Breast Feeding Support and Equipment** as required under the Affordable Care Act o Lactation Support and Counseling o Breast Pump rental up to the purchase price and initial supplies (tubing and shields). Limited to one non-retail purchase per pregnancy. o Hospital-grade breast pump must be Medically Necessary.	100% paid by Plan Calendar Year Deductible does not apply	No coverage

	BCBS PPO Provider	Out-of-Network Provider
• **Chiropractic, Acupuncture and Naprapathic Care (Combined Benefit)**	80% paid by Plan	60% paid by Plan
	Maximum visit limit per Employee: 50 visits per Calendar Year Maximum visit limit per spouse: 30 visits per Calendar Year No coverage for Dependent children	
• **Clinical Trials** to the extent required by the Affordable Care Act	80% paid by Plan	60% paid by Plan
• **Contraceptives,** to the extent required under the Affordable Care Act for FDA approved methods for females with reproductive capacity: o Contraceptive support and counseling o Diaphragms, sponges, cervical caps, female condoms & spermicides o Vaginal rings o Emergency contraceptives (generic morning after pill only) o Implants & implantable rods o Oral contraceptives, generic only o Patch o Injectables o IUD	100% paid by the Plan Calendar Year Deductible does not apply	No coverage
• **Cosmetic Surgery** solely to improve appearance	No coverage	
• **Dental Service for a Non-Occupational Injury to Teeth**	No coverage	
• **Diagnostic Imaging Benefit – MRI, CAT/CT and PET Scans**	80% paid by Plan	60% paid by Plan
• **Diagnostic X-Rays and Lab Tests**	80% paid by Plan	60% paid by Plan
• **Durable Medical Equipment**	80% paid by Plan	60% paid by Plan
• **Emergency Room** o Facility o Physician fees	 80% paid by Plan 80% paid by Plan	 80% paid by Plan 80% paid by Plan
• **Emergency Room Co-payment**	$250 per Emergency Room visit Waived if admitted to the Hospital as an in-patient within 72 hours or held in the observation unit for more than 24 hours Emergency Room Co-payment no longer applicable after Covered Individual meets the applicable Calendar Year Out-of-Pocket Maximum	
• **Extended Care/Skilled Nursing Facility**	80% paid by Plan	60% paid by Plan
	Maximum of 120 days per convalescent period	
• **Genetic Testing Benefit**		
o Genetic testing to the extent required under the Affordable Care Act	100% paid by Plan Calendar Year Deductible does not apply	60% paid by Plan Subject to Calendar Year Deductible, Out-of-Pocket Maximum and the combined annual maximum benefit of $7,500
o Diagnostic genetic testing	80% paid by Plan	60% paid by Plan
	Subject to Calendar Year Deductible, Out-of-Pocket Maximum and the combined annual maximum benefit of $7,500	
o Non-diagnostic genetic testing	No coverage	No coverage

<table>
<tr><th></th><th colspan="2">BCBS PPO Provider</th><th>Out-of-Network Provider</th></tr>
<tr><td>• Hearing Benefit
o Hearing evaluation/exam</td><td colspan="3">Paid at 100% up to $150 maximum per Covered Individual once every two consecutive Calendar Years (except as required by the Affordable Care Act under the Wellness and Preventive Care benefit)</td></tr>
<tr><td>oHearing aid instrument</td><td>Preferred Contracted Provider: EPIC Hearing Service (Hearing Aid Only)</td><td>BCBS PPO Provider</td><td>Out-of-Network Provider</td></tr>
<tr><td>➢ Dependent children through age 18</td><td colspan="3">Paid at 100% up to $1,500 maximum per Covered Individual once every three (3) consecutive Calendar Years. Calendar Year Deductible does not apply</td></tr>
<tr><td>➢ Participant, spouse and Dependent children age 19 and older</td><td colspan="3">Paid at 100% up to $5,000 maximum per Covered Individual once every five (5) consecutive Calendar Years. Calendar Year Deductible does not apply</td></tr>
<tr><th></th><th colspan="2">BCBS PPO Provider</th><th>Out-of-Network Provider</th></tr>
<tr><td rowspan="2">• Home Health Care</td><td colspan="2">80% paid by Plan</td><td>60% paid by Plan</td></tr>
<tr><td colspan="3">Maximum of 120 days per convalescent period</td></tr>
<tr><td rowspan="2">• Hospice Care</td><td colspan="2">80% paid by Plan</td><td>60% paid by Plan</td></tr>
<tr><td colspan="3">Lifetime maximum of 180 days per individual</td></tr>
<tr><td rowspan="2">• Hospital Care</td><td colspan="2">80% paid by Plan</td><td>60% paid by Plan</td></tr>
<tr><td colspan="3">Confinement maximum: 180 days per Calendar Year for in-patient care</td></tr>
<tr><td rowspan="2">• Infertility Services including Hospital, Physician, prescription drugs & treatments, except diagnostic genetic testing, which may be covered above</td><td colspan="2">80% paid by Plan</td><td>60% paid by Plan</td></tr>
<tr><td colspan="3">Combined lifetime maximum of $10,000 for services provided to the Retired Employee and spouse.
No coverage for dependent children.</td></tr>
<tr><td>• Infusion Therapy for the administration of an intravenous prescription drug</td><td colspan="2">80% paid by Plan</td><td>60% paid by Plan</td></tr>
<tr><td>• Naprapathic Care</td><td colspan="3">See Chiropractic, Acupuncture and Naprapathic Care, page App B-2</td></tr>
<tr><td>• Nutritional Counseling to the extent required under the Affordable Care Act, for individuals who participate in the bariatric program and for treatment of eating disorders</td><td colspan="2">100% paid by Plan
Calendar Year Deductible does not apply</td><td>No Coverage</td></tr>
<tr><td>• Oral and Maxillofacial Surgery</td><td colspan="2">80% paid by Plan</td><td>60% paid by Plan</td></tr>
<tr><td>• Organ Transplant</td><td colspan="2">80% paid by Plan</td><td>60% paid by Plan</td></tr>
<tr><td>• Physician Services</td><td colspan="2">80% paid by Plan</td><td>60% paid by Plan</td></tr>
<tr><td>• Pregnancy Care</td><td colspan="2">80% paid by Plan, except to the extent required under the Affordable Care Act. Services covered under the Affordable Care Act are paid at 100% by the Plan and the Calendar Year Deductible does not apply.</td><td>60% paid by Plan</td></tr>
<tr><td rowspan="2">• Prosthetics
o Artificial limbs and eyes
o Wigs and hairpieces for hair loss as a result of treatment for a cancer diagnosis or an organ transplant</td><td colspan="2">80% paid by Plan</td><td>60% paid by Plan</td></tr>
<tr><td colspan="3">100% paid by Plan, subject to a $500 lifetime maximum
Calendar Year Deductible does not apply</td></tr>
<tr><td>• Reconstructive Breast Surgery</td><td colspan="2">80% paid by Plan</td><td>60% paid by Plan</td></tr>
</table>

	BCBS In-Network Provider	Out-of-Network Provider
• **Sterilization** ○Females to the extent required under the Affordable Care Act	100% paid by Plan, Deductible does not apply	No coverage
○Males	80% paid by Plan	No coverage
○Sterilization reversals (female/male)	No coverage	No coverage
• **Substance Use Disorder**	See Page App. B-5	
• **Surgi-Center Facility** ○Hospital affiliated	80% paid by Plan	60% paid by Plan
○No Hospital affiliation	80% paid by Plan	No coverage
• **Surgical Assistant or Assistant Surgeon**	80% paid by Plan	60% paid by Plan, limited to 20% of surgical procedure's R&C allowance
• **Surgical Consultations**	80% paid by Plan	60% paid by Plan
• **Temporomandibular Joint Care** (TMJ) ○Physician and therapy services	80% paid by Plan	60% paid by Plan
○Appliances, and their adjustments, for TMJ and bruxism (occlusal)	80% paid by Plan once every 3 consecutive years. Maximum of two (2) appliances per lifetime.	
• **Therapy Services** ○**Physical and Speech Outpatient Therapy**	80% paid by Plan	60% paid by Plan
	Maximum 50 visits per Calendar Year	
- (For additional benefits beyond the 50 visit maximum, see Section 5.04(MM))	60% paid by Plan	40% paid by Plan
○**Occupational Outpatient Therapy**	80% paid by Plan	60% paid by Plan
	Maximum 50 visits per Calendar Year	
- (For additional benefits beyond the 50 visit maximum, see Section 5.04(MM))	60% paid by Plan	40% paid by Plan
○**Physical, Occupational and Speech Outpatient Therapy for Developmental Disabilities** (Habilitative or to teach; for Covered Individuals through age 18)	80% paid by Plan	60% paid by Plan
• **Urgent/Immediate Care Facilities and Retail Clinics**	80% paid by Plan	60% paid by Plan
• **Vision Surgery** (excluding cosmetic or refractive corrections)	80% paid by Plan	60% paid by Plan
• **Wellness and Preventive Care**		
o **Wellness and Preventive Care** to the extent required under the Affordable Care Act, including routine screenings, immunizations and other services (see www.healthcare.gov for list of services)	100% paid by Plan. Calendar Year Deductible does not apply	No coverage
o **Comprehensive Health Evaluation and Physical Exam** (blood, glucose and cholesterol analysis, strength and flexibility testing, mammogram or prostate screening and more	**Preferred Contracted Provider: Health Dynamics** 100% paid by Plan for Covered Employee and spouse once every Calendar Year. Calendar Year Deductible does not apply Not available to Dependent children	

HEALTH CENTER BENEFITS FOR COVERED INDIVIDUALS THAT ARE NOT MEDICARE ELIGIBLE	
• **Health Center Services**	100% paid by Plan. Deductibles and Coinsurance do not apply.

BEHAVIORAL HEALTH & SUBSTANCE USE DISORDER BENEFITS FOR COVERED INDIVIDUALS THAT ARE NOT MEDICARE ELIGIBLE AND ARE ENROLLED IN COMPREHENSIVE MEDICAL BENEFITS Contracted Network Provider: BlueCross BlueShield of Illinois (BCBSIL)		
	BCBS In-Network Provider	**Out-of-Network Provider**
• **Emergency Room** ○Facility	80% paid by Plan	80% paid by Plan
○Physician fees	80% paid by Plan	80% paid by Plan
• **Emergency Room Co-payment**	$250 per Emergency Room visit Waived if admitted to the Hospital as an in-patient within 72 hours or held in the observation unit for more than 24 hours. Emergency Room Co-payment no longer applicable after Covered Individual meets the applicable Calendar Year Out-of-Pocket Maximum	
• **Hospital Care and Residential Treatment Facilities**	80% paid by Plan	60% Paid by Plan
	Confinement Maximum: 180 days per Calendar Year combined for Hospital and Residential Treatment in-patient care	
• **Outpatient Therapy** (including partial hospitalization)	80% paid by Plan	60% paid by Plan
• **Custodial or Group Homes**	No coverage	

BENEFITS FOR COVERED INDIVIDUALS THAT ARE MEDICARE ELIGIBLE AND ARE ENROLLED IN HOSPITAL BENEFITS ONLY AS DESCRIBED IN PLAN SECTION. 5.04(U) **Per Benefit Period*** ***A "benefit period" begins on the first day the Covered Individual receives services as an in-patient in a Hospital and ends after the Covered Individual has been out of the Hospital and has not received skilled care in any other facility for 60 days in a row.** Contracted Network Provider: BlueCross BlueShield of Illinois (BCBSIL)	
Out-of-Pocket Maximum per Calendar Year	$2,000 per Covered Individual / $4,000 per family
• **Medicare Part A Supplement (Hospital Benefit)**	**Plan Pays secondary to Medicare Maximum 180 inpatient days per Calendar Year**
○ First 60 days	Plan pays Medicare Part A Deductible
○ 61st through 90th days	Plan pays Medicare Part A Co-payment
○ 91st day and after while using 60 lifetime reserve days	Plan pays Medicare Part A Co-payment
○ Additional 365 days	Plan pays 100% of Medicare eligible expenses

BENEFITS FOR COVERED INDIVIDUALS THAT ARE MEDICARE ELIGIBLE AND ARE ENROLLED IN COMPREHENSIVE MEDICARE SUPPLEMENT BENEFITS Per Benefit Period*

***A "benefit period" begins on the first day the Covered Individual receives services as an in-patient in a Hospital and ends after the Covered Individual has been out of the Hospital and has not received skilled care in any other facility for 60 days in a row.**

Contracted Network Provider: BlueCross BlueShield of Illinois (BCBSIL)

Out-of-Pocket Maximum per Calendar Year	$2,000 per Covered Individual / $4,000 per family
• **Medicare Part A Supplement (Hospital Benefit)***	**Plan Pays secondary to Medicare Maximum 180 inpatient days per Calendar Year**
○ First 60 days	Plan pays Medicare Part A Deductible
○ 61st through 90th days	Plan pays Medicare Part A Co-payment
○ 91st day and after while using 60 lifetime reserve days	Plan pays Medicare Part A Co-payment
○ Additional 365 Days	Plan Pays 100% of Medicare eligible expenses
• **Medicare Part B Supplement**	
○ Medicare Part B Deductible	Plan pays Medicare Part B Deductible
○ Medical expenses	Plan pays 20% of Medicare eligible expenses at the Medicare approved amount, after the Medicare Part B Deductible
• **Blood**	Plan pays for three (3) pints
• **Skilled Nursing Facility Care*** - Covered Individual must meet Medicare's requirements, including having been in a Hospital for at least three days and enter a Medicare approved facility within 30 days of leaving the Hospital	
○ First 20 days	Medicare pays all approved amounts
○ 21st through 100th day	Plan pays Medicare Part A Co-Payment
• **At Home Recovery Services Not Covered by Medicare** – Home care certified by a Covered Individual's Doctor, for personal care during recovery from an injury or sickness for which Medicare approved a home treatment plan.	
○ Benefit for each visit	Plan pays up to $40 per visit Up to a Calendar Year Maximum of $1,600
• **Foreign Travel**	
○ Calendar Year Deductible	$250 per Covered Individual
	Plan pays 80%. The Plan does not pay for expenses in excess of the Reasonable and Customary Allowance for non-PPO Out-of-Network providers. Amounts over the Reasonable and Customary Allowance are the Covered Individual's responsibility
○ Lifetime Maximum for Foreign Travel	$50,000

• **Hearing Benefit** ○ Hearing evaluation/exam	Paid at 100% up to $150 maximum per Covered Individual once every two consecutive Calendar Years (except as required by the Affordable Care Act under the Wellness and Preventive Care benefit)		
○ Hearing aid instrument	**Preferred Contracted Provider: EPIC Hearing Service (Hearing Aid Only)**	**BCBS PPO Provider**	**Out-of-Network Provider**
➢ Dependent children through age 18	Paid at 100% up to $1,500 maximum per Covered Individual once every three (3) consecutive Calendar Years. Calendar Year Deductible does not apply		
➢ Participant, spouse and Dependent children age 19 and older	Paid at 100% up to $5,000 maximum per Covered Individual once every five (5) consecutive Calendar Years. Calendar Year Deductible does not apply		

HEALTH CENTER BENEFITS FOR COVERED INDIVIDUALS THAT ARE MEDICARE ELIGIBLE AND ARE ENROLLED IN COMPREHENSIVE MEDICARE SUPPLEMENT BENEFITS	
• **Health Center Services**	100% paid by Plan. Calendar Year Deductible does not apply.

PRESCRIPTION BENEFIT Contracted Network Provider: Express Scripts, Inc. (ESI) and Accredo Specialty Pharmacy Not available to Deferred Lathers or to Medicare-eligible individuals with Medicare Part D coverage.			
	ESI Network Retail Pharmacy (Lesser of 100 pills or a 30 day supply)	**ESI by Mail** (Up to a 90-day supply through mail order)	**Accredo Specialty Pharmacy** (For specialty drugs)
Generic Co-payment	$5	$12.50	Does not apply
Single-Source Brand Co-payment (A generic is not available)	20% $10 minimum Co-payment per drug with a $100 maximum	20% $25 minimum Co-payment per drug with a $250 maximum	Does not apply
Multi-Source Brand Co-payment (A generic is available)	35% $20 minimum Co-payment	35% $50 minimum Co-payment	Does not apply
Non-Select Specialty Medication Co-payment (used to treat complex conditions such as cancer, hemophilia, immune deficiency, rheumatoid arthritis, etc.)	Does not apply		20% $20 minimum Co-payment per drug with a $100 maximum
Generic/Multi-Source Brand Out-of-Pocket Maximum per Calendar Year	$1,500 per Covered Individual / $3,000 per family		Does not apply
Single-Source Brand Out-of-Pocket Maximum per Calendar Year	$1,500 per Covered Individual / $3,000 per family		Does not apply
Non-Select Specialty Medication Out-of-Pocket Maximum per Calendar Year	Does not apply		$1,500 per individual / $3,000 per family
Select Specialty Medications (Co-payment and Out-of-Pocket Maximum per Calendar Year)	Does not apply		See Plan Sections 8.01(D) and 8.04.

INSURED BENEFITS	CARRIER
• Dental Benefits	Delta Dental of Illinois
• Vision Benefits	Vision Service Plan of Illinois (VSP)
• Life Insurance Benefit ($25,000, Retirees Under Age 65 Only)	The Hartford

Appendix C

SCHEDULE OF BENEFITS
FOR THE LOW COST MEDICAL PLAN OF BENEFITS

The schedule on the following pages highlights key features of the Low Cost Medical Plan of Benefits for Covered Individuals.

- The amounts charged for Covered Medical Expenses provided by Network Providers are subject to the PPO allowed contractual amounts. A Covered Individual will not be balance billed for amounts over the allowed contractual amount.
- The amounts charged for Covered Medical Expenses provided by Out-of-Network providers are subject to the Reasonable and Customary Allowance (R&C Allowance). R&C Allowances are determined by the Trustees (or their designee) in their sole discretion, and are amended from time to time. Out-of-Network charges are paid at 285% of the Medicare Physician Fee Schedule National Payment Amount Schedule. A Covered Individual is responsible to pay for amounts over the R&C Allowance.

COMPREHENSIVE MEDICAL BENEFITS

	PPO Provider	Out-of-Network Provider
Coinsurance	70% paid by Plan	50% paid by Plan
Deductible per Calendar Year	$600 per Covered Individual / $1,800 per family	
Out-of-Pocket Maximum per Calendar Year	$4,600 per Covered Individual / $9,200 per family (includes Deductible)	
	After a Covered Individual satisfies the Deductible and Out-of-Pocket Maximum, the Plan will pay 100% of most eligible covered services for the remainder of the Calendar Year.	

MEDICAL BENEFITS

Contracted Network Provider: BlueCross BlueShield of Illinois (BCBSIL)

	BCBS PPO Provider	Out-of-Network Provider
• **Acupuncture Care**	See *Chiropractic, Acupuncture and Naprapathic Care, page App C-2*	
• **Ambulance Service**	70% paid by Plan subject to the PPO Deductible	
• **Anesthesia or Sedation**	70% paid by Plan	50% paid by Plan
• **Bariatric Surgery** (only for the diagnosis and treatment of morbid obesity)	70% paid by Plan	50% paid by Plan
	Prior to surgery, a Covered Individual is required to contact the Fund Office to enroll in and successfully complete ComPsych's Bariatric Support Service Program (BSSP). Participation in the BSSP is mandatory for coverage.	
• **Behavioral Health Care**	See page App. C-5	
• **Breast Feeding Support and Equipment** to the extent required under the Affordable Care Act o Lactation Support and Counseling o Breast Pump rental up to the purchase price and initial supplies (tubing and shields). Limited to one non-retail purchase per pregnancy. o Hospital-grade breast pump must be Medically Necessary.	100% paid by Plan Calendar Year Deductible does not apply	No coverage

	BCBS PPO Provider	Out-of-Network Provider
• **Chiropractic, Acupuncture and Naprapathic Care (Combined Benefit)**	70% paid by Plan	50% paid by Plan
	Maximum visit limit per Employee: 50 visits per Calendar Year Maximum visit limit per spouse: 30 visits per Calendar Year. No coverage for Dependent children	
• **Clinical Trials** to the extent required by the Affordable Care Act	70% paid by Plan	50% paid by Plan
	See Plan Section 5.04(H)	
• **Contraceptives** to the extent required under the Affordable Care Act for FDA approved methods for females with reproductive capacity: o Contraceptive support and counseling o Diaphragms, sponges, cervical caps, female condoms & spermicides o Vaginal rings o Emergency contraceptives (generic morning after pill only) o Implants & implantable rods o Oral contraceptives, generic only o Patch o Injectables o IUD	100% paid by the Plan Calendar Year Deductible does not apply	No coverage
• **Cosmetic Surgery** solely to improve appearance	No coverage	
• **Dental Service for a Non-Occupational Injury to Teeth**	No coverage	
• **Diagnostic Imaging Benefit – MRI, CAT/CT and PET Scans**	70% paid by Plan	50% paid by Plan
• **Diagnostic X-Rays and Lab Tests**	70% paid by Plan	50% paid by Plan
• **Durable Medical Equipment**	70% paid by Plan	50% paid by Plan
• **Emergency Room**	70% paid by Plan	70% paid by Plan
o Facility fees o Physician fees	70% paid by Plan	70% paid by Plan
• **Emergency Room Co-payment**	$300 per Emergency Room visit Waived if admitted to the Hospital as an in-patient within 72 hours or held in the observation unit for more than 24 hours Emergency Room Co-payment no longer applicable after Covered Individual meets the Calendar Year Out-of-Pocket Maximum	
• **Extended Care/Skilled Nursing Facility**	70% paid by Plan	50% paid by Plan
	Maximum of 120 days per convalescent period	
• **Genetic Testing Benefit**		
o Genetic testing to the extent required under the Affordable Care Act	100% paid by Plan Calendar Year Deductible does not apply	50% paid by Plan Subject to Calendar Year Deductible, Subject to Out-of-Pocket Maximums and the combined annual maximum benefit of $7,500
o Diagnostic genetic testing	70% paid by Plan	50% paid by Plan
	Subject to Calendar Year Deductible, Out-of-Pocket Maximum and the combined annual maximum benefit of $7,500	
o Non-diagnostic genetic testing	No coverage	No coverage
• **Hearing Benefit**	No coverage, except as required by the Affordable Care Act under the Wellness and Preventive Care benefit	
• **Home Health Care**	70% paid by Plan	50% paid by Plan
	Maximum of 120 visits per year	

	BCBS PPO Provider	Out-of-Network Provider
• **Hospice Care**	70% paid by Plan	50% paid by Plan
	Lifetime maximum of 180 days per Covered Individual	
• **Hospital Care**	70% paid by Plan	50% paid by Plan
	Confinement maximum: 180 days per Calendar Year for in-patient care	
• **Infertility Services** including Hospital, Physician, prescription drugs & treatments, except diagnostic genetic testing which may be covered above	70% paid by Plan	50% paid by Plan
	Combined lifetime maximum of $10,000 for services provided to the Employee and spouse. No coverage for dependent children.	
• **Infusion Therapy** for the administration of an intravenous prescription drug	70% paid by Plan	50% paid by Plan
• **Member Assistance Program**	See page App. C-5	
• **Naprapathic Care**	See *Chiropractic, Acupuncture and Naprapathic Care*, page App C-2	
• **Nutritional Counseling** to the extent required under the Affordable Care Act, for individuals who participate in the bariatric program and for treatment of eating disorders	100% paid by Plan Calendar Year Deductible does not apply	No coverage
• **Oral and Maxillofacial Surgery**	70% paid by Plan	50% paid by Plan
• **Organ Transplant**	70% paid by Plan	50% paid by Plan
• **Physician Services**	70% paid by Plan	50% paid by Plan
• **Pregnancy Care**	70% paid by Plan, except to the extent required under the Affordable Care Act. Services covered under the Affordable Care Act are paid at 100% by the Plan and the Calendar Deductible does not apply.	50% paid by Plan
• **Prosthetics** o Artificial limbs and eyes	70% paid by Plan	50% paid by Plan
o Wigs and hairpieces for hair loss as a result of treatment for a cancer diagnosis or an organ transplant	No coverage	
• **Reconstructive Breast Surgery**	70% paid by Plan	50% paid by Plan
• **Sterilization** o Females to the extent required under the Affordable Care Act	100% paid by Plan. Calendar Year Deductible does not apply	No Coverage
o Males	70% paid by Plan	No Coverage
o Sterilization reversals (female/male)	No Coverage	No Coverage
• **Substance Use Disorder**	See page App. C-5	
• **Surgi-Center Facility** o Hospital Affiliated	70% paid by Plan	50% paid by Plan
o No Hospital Affiliation	70% paid by Plan	No coverage
• **Surgical Assistant or Assistant Surgeon**	70% paid by Plan	50% paid by Plan, limited to 20% of surgical procedure's R&C Allowance
• **Surgical Consultations**	70% paid by Plan	50% paid by Plan

	BCBS PPO Provider	Out-of-Network Provider
• **Temporomandibular Joint Care** (TMJ) ○ Physician and therapy services	70% paid by Plan	50% paid by Plan
○ Appliances, and their adjustments, for TMJ and bruxism (occlusal)	70% paid by Plan once every 3 consecutive years. Maximum of two (2) appliances per lifetime.	
• **Therapy Services** ○ **Physical and Speech Outpatient Therapy**	70% paid by Plan	50% paid by Plan
	Maximum 50 visits per Calendar Year	
- For additional benefits beyond the 50 visit maximum, see Plan Section 5.04(MM)	50% paid by Plan	30% paid by Plan
○ **Occupational Outpatient Therapy**	70% paid by Plan	50% paid by Plan
	Maximum 50 visits per Calendar Year	
- For additional benefits beyond the 50 visit maximum, see Plan Section 5.04(MM)	50% paid by Plan	30% paid by Plan
○ **Physical, Occupational and Speech Outpatient Therapy for Developmental Disabilities** (Habilitative or to teach; for Covered Individuals through age 18)	70% paid by Plan	50% paid by Plan
• **Urgent/Immediate Care Facilities and Retail Clinics**	70% paid by Plan	50% paid by Plan
• **Vision Surgery** (excluding cosmetic or refractive corrections)	70% paid by Plan	50% paid by Plan
• **Wellness and Preventive Care** ○ **Wellness and Preventive Care** to the extent required under the Affordable Care Act including routine screenings, immunizations and other services (see www.healthcare.gov for list of services)	100% paid by Plan. Calendar Year Deductible does not apply	No coverage
○ **Comprehensive Health Evaluation and Physical Exam** (blood, glucose and cholesterol analysis, strength and flexibility testing, mammogram or prostate screening and more)	**Preferred Contracted Provider: Health Dynamics** 100% paid by Plan for Participant and spouse once every Calendar Year. Calendar Year Deductible does not apply. No coverage for Dependent children	

HEALTH CENTER For Eligible Covered Individuals Only	
• **Health Center Services**	100% paid by Plan. Calendar Year Deductible does not apply.

MEMBER ASSISTANCE PROGRAM Contracted Network Provider: ComPsych, Guidance Resources®		
	ComPsych In-Network Provider	**Out of Network Provider**
• **Member Assistance Program (MAP)**	100% paid by Plan for 5 short-term counseling sessions per issue. Calendar Year Deductible does not apply.	No coverage

BEHAVIORAL HEALTH & SUBSTANCE USE DISORDER BENEFITS

Contracted Network Provider: ComPsych, Guidance Resources®

	ComPsych In-Network Provider	Out of Network Provider
• **Emergency Room** ○ Facility	70% paid by Plan	70% paid by Plan
○ Physician fees	70% paid by Plan	70% paid by Plan
• **Emergency Room Co-payment**	$300 per Emergency Room visit Waived if admitted to the Hospital as an in-patient within 72 hours or held in the observation unit for more than 24 hours Emergency Room Co-payment no longer applicable after Covered Individual meets the Calendar Year Out-of-Pocket Maximum	
• **Hospital Care and Residential Treatment Facilities**	70% paid by Plan	50% Paid by Plan
	Confinement maximum: 180 days per calendar year combined for Hospital and Residential Treatment in-patient care)	
• **Hospital Outpatient Diagnostic Tests**	70% paid by Plan	50% paid by Plan
• **Outpatient Therapy** (Including Partial Hospitalization)	70% paid by Plan	50% paid by Plan
• **Custodial or Group Homes**	No coverage	

PRESCRIPTION BENEFITS

Contracted Network Provider: Express Scripts, Inc. and Accredo Specialty Pharmacy

Prescription drug benefits are not available to an apprentice except as described in Plan Sections 3.02(C) and 3.11(C) of the Plan Document.

	ESI Network Retail Pharmacy (Lesser of 100 units or a 30 day supply)	**ESI By Mail** (Up to a 90 day supply through mail order)	**Accredo Specialty Pharmacy** (For specialty drugs)
Out-of-Pocket Maximum per Calendar Year	$2,000 per Covered Individual / $4,000 per family		
Generic Co-payment	70% paid by Plan		Does not apply
Single-Source Brand Co-payment (A generic is not available)	70% paid by Plan		Does not apply
Multi-Source Brand Co-payment (A generic is available)	70% paid by Plan		Does not apply
Non-Select Specialty Medication Co-payment (Used to treat complex conditions such as cancer, hemophilia, immune deficiency, rheumatoid arthritis, etc. and require a higher level of care)	Does not apply		70% paid by Plan
Select Specialty Medications (Co-Payment and Out-of-Pocket Maximum per Calendar Year)	Does not apply		See Plan Sections 8.01(D) and 8.03.

LIFE INSURANCE BENEFITS Contracted Provider: Self-Funded			
	Eligible Participant	**Spouse**	**Child**
Policy amount	$5,000	$1,000	$1,000

EXCLUDED BENEFITS	
Vision Benefits	No coverage
Dental Benefits	No coverage
Short Term Disability Benefits	No coverage
Accidental Death and Dismemberment Insurance Benefits	No coverage