GREATER ST. LOUIS CONSTRUCTION LABORERS' WELFARE FUND PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION

As Amended and Restated as of July 1, 2021

To Covered Individuals:

Welcome. This Booklet has been prepared to provide you with a guide to your benefits under the Plan. It is strongly recommended that you take the time to read this Booklet, since it offers an explanation of the benefits to which you are entitled as a Covered Individual under the Greater St. Louis Construction Laborers' Welfare Fund (the "Plan").

This Plan Document and Summary Plan Description describes the medical, prescription drug, Behavioral Care, dental, vision, hearing aid, life insurance and weekly Disability benefits provided by the Plan. Please check your collective bargaining agreement or call the Benefit Office to determine the specific benefits for which you and your dependents are eligible.

In order to become eligible for benefits under the Plan, an employee is required to have worked at least 275 hours which are validly reported and paid to the St. Louis Benefit Office for a signatory contractor in a qualifying quarter (Sept.-Nov., Dec.-Feb., Mar.-May or Jun.-Aug.). Before coverage can begin, the employee must complete the enrollment card provided by the Benefit Office, which lists the employee and the employee's spouse and child dependents and submit the enrollment card to the Benefit Office along with the other information requested on the card. The employee must also notify the Benefit Office if the employee acquires a new dependent or if any of the employee's current dependents are no longer eligible under the Plan. (For example, if the employee and the employee's spouse become divorced or if the employee's child is no longer eligible.) Further, the Plan requires birth certificates, marriage licenses and divorce decrees, where relevant, with respect to all Covered Individuals. From time to time, the Benefit Office may request updated enrollment information. The employee must provide that updated information in order to ensure Plan benefits continue without interruption. No benefits will be paid for any individual without a properly completed enrollment card and any additional requested documentation.

Plan benefits include medical, prescription drug, Behavioral Care (including Member Assistance Program (MAP)), dental, vision, hearing aid, life insurance and weekly Disability benefits. Generally, the employee's employer pays the entire cost of these benefits for the employee while the employee is employed, which greatly adds to the value of the employee's employment. Not all benefits are provided to eligible Retired Employees or to individuals who are covered under any kind of continuation coverage. In making coverage decisions, the Plan does not consider the gender or gender identity of the individual seeking benefits.

Please note that the benefits provided by this Plan (except life insurance benefits) are not available for charges attributable to an Accident, Injury or Illness arising from the employee's employment or self-employment, regardless of whether the employee's employment or self-employment is the employee's primary occupation, or for charges arising from an occupational Accident, Injury or Illness for the employee's dependents, unless the employee and his/her attorney, if any, signs a Workers' Compensation reimbursement form and files it with the Benefit Office.

Prior authorization is required for all Hospitalizations and certain other benefits provided under the Plan before the services are rendered or the supplies are received. If prior authorization of those benefits is not obtained, a claim for those benefits under the Plan will be denied regardless of whether the service or supply is otherwise covered by the Plan. Network Providers are responsible for obtaining the required prior authorization. If the health care provider is an Out-of-Network Provider, the Covered Individual or the Covered Individual's Out-of-Network Provider should contact the Medical Network and Managed Care Administrator or the Behavioral/Mental Health Administrator, as applicable, to obtain the required prior authorization.

The employee has the responsibility to inform the Benefit Office if any changes occur with regard to the employee's address, dependent coverage (i.e. marriage, divorce, separation, dependent status, etc.), whether a third party may be required to compensate a Covered Individual for an Injury or Illness, etc.

Covered Individuals may also access the Plan's website www.stllaborers.com for more information and required forms.

If you have any questions, please contact the Benefit Office at (314) 644-2777 or toll free (800) 489-0228 ext. 2, or send an e-mail to benefits@stllaborers.com.

Sincerely,

Trustees of Greater St. Louis Construction Laborers' Welfare Fund

TABLE OF CONTENTS

TABLE OF CONTENTS (Cont.)

TABLE OF CONTENTS (Cont.)

SECTION 1. DEFINITIONS

A. INTRODUCTION

This Section 1. contains important definitions for most of the capitalized terms used throughout this Booklet, and you should review this section carefully. In addition, there are capitalized terms used in this booklet that are defined in the text where the term appears.

B. DEFINITIONS

Accident or Accidental Injury – an Accident is an external event that is sudden, violent and unforeseen and exact as to time and place. An Accidental Injury is an Injury that is caused by such an event and that is independent of all other causes.

Active Employee – an Eligible Employee covered by the Plan by virtue of having met one of the eligibility categories described in Section 3, Subsection A.1.a. of this Booklet.

Behavioral Care – Medically Necessary inpatient and outpatient services for the treatment of Mental Health and Substance Use Disorders. Such services are provided by licensed mental health clinicians and facilities.

Beneficiary – a person or entity named, on a form and in a manner approved by the insurer or the Benefit Office, as applicable, to receive benefits for loss of life.

COBRA – the Consolidated Omnibus Budget Reconciliation Act of 1985, commonly known as COBRA, which requires the Plan to offer a Covered Individual the opportunity to elect temporary continuation of health coverage in certain instances called "qualifying events."

Co-insurance – a percentage amount of Covered Charges which must be paid by the Covered Individual.

Contributing Employer:

1. any employer (including an employer association) who has a collective bargaining agreement with the Union (or with another labor union which may, from time to time, bargain jointly with the Union), which collective bargaining agreement requires periodic contributions to the Plan, and who makes the contributions to the Plan as required by that agreement;
2. such other employer who has been accepted for participation by the Trustees, and who has agreed to contribute and does contribute on substantially the same basis as other contributing employers;
3. the Laborers' International Union of North America AFL-CIO, Locals No. 42 and 110 of St. Louis and St. Louis County; or
4. the Greater St. Louis Construction Laborers' Welfare Fund and Construction Laborers' Pension Trust of Greater St. Louis.

Co-payment or Co-pay – a set amount of covered charges which must be paid by the Covered Individual in order to receive a benefit under the Plan.

Covered Charges – charges for services and supplies covered under the Plan as set forth in this Booklet that meet the following criteria:

1. the charges must be for a service or supply prescribed by a physician.
2. the charges must be for a service or supply which is Medically Necessary in connection with the diagnosis or therapeutic treatment of an Injury or Illness.
3. the charges must not exceed the lesser of:
    a. the Usual and Reasonable Charges for such treatment, or
    b. in the case of a Network Provider, the discounted fee negotiated between the Medical Network and Managed Care Administrator and the Network Provider.
4. the charges must not be excluded under the Exclusions and Limitations sections of this Plan.

Covered Employment – employment with a Contributing Employer in a position for which the employer is required to contribute and does contribute to the Plan. You will be given credit for the hours you work in Covered Employment only if your employer actually makes the required contribution.

Covered Individual – an individual who is eligible for benefits under the Plan.

Custodial Care – a type of care or service, wherever furnished and by whatever name called, which is designed primarily to assist a person, whether or not Disabled, in the activities of daily living. Such activities include, but are not limited to, bathing, dressing, feeding, preparation of special diets, assistance in walking or in getting out of bed, and supervision over medication which can normally be self-administered.

Deductible – a set amount of Covered Charges which must be paid each calendar year by the Covered Individual before the Plan will pay most medical benefits.

Disability or Disabled – when an Active Employee is unable to perform his regular work because of Illness or Injury, or when any other Covered Individual is prevented because of Illness or Injury from engaging in all the normal activities of a person of like age and sex who is in good health.

Durable Medical Equipment – equipment which can withstand repeated use, is not disposable, is prescribed only when Medically Necessary, is appropriate for use in the home and is not useful in the absence of an Illness or Injury.

Eligible Employee – an employee who:

1. is an employee of a Contributing Employer;
2. has satisfied the other eligibility requirements of the Plan; and
3. whose employer has made the required contributions.

The term "Employee" does not include a self-employed person, sole proprietor or partner of a business organization that is a Contributing Employer.

Emergency – an Emergency involves:

1. an acute or sudden Illness or Injury that without immediate medical care could result in death or cause serious impairment to bodily functions;
2. a medical situation which if not promptly addressed could seriously jeopardize the life or health of the individual or the ability of the individual to regain maximum function; or
3. a medical situation which in the opinion of a physician with knowledge of the individual's medical condition, would, if not promptly addressed, subject the individual to severe pain that cannot be adequately managed without prompt care or treatment.

Experimental or Investigative – a drug, device, treatment or procedure is experimental or investigative if:

1. with respect to the Illness being treated, the drug, device, treatment, or procedure cannot be lawfully marketed in the U.S. or has not been approved by the U.S. Food and Drug Administration (FDA) at the time the drug or device is furnished; or
2. with respect to the Illness being treated, the drug, device, treatment or procedure, or the patient informed consent document used with the drug, device, treatment or procedure, requires review and approval by the treating facility's Institutional Review Board or other body serving a similar function, or if U.S. federal law requires such review and approval; or
3. with respect to the Illness being treated, reliable evidence shows the drug, device, treatment or procedure is the subject of on-going phase I, phase II or phase III clinical trials, is the research, experimental, study or investigational arm of on-going phase II or phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, toxicity, safety, efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or
4. with respect to the Illness being treated, reliable evidence shows that the prevailing opinion among experts in the appropriate field regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum

tolerated dose, toxicity, safety, efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

Reliable evidence means only published reports and articles in medical and scientific literature, including the opinions of the FDA, Medicare, Council of Medical Specialty Services (CMSS), National Institute of Health (NIH) and Mental Health (NIMH), Office of Health Technology Assessment (OHTA), American Medical Association (AMA), American Dental Association (ADA) or Clinical Efficacy Assessment Program (CEAP); the written protocol(s) used by the treating facility or 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.

This Experimental or Investigative definition and its application by the Plan does not include participation in or the "Routine Patient Costs" for "Approved Clinical Trials" for which coverage is required by the PPACA. An Approved Clinical Trial is a phase I, II, III or IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition, and is either (i) a federally funded or approved study or investigation, (ii) a study or investigation conducted under an investigational new drug application reviewed by the Food and Drug Administration, or (iii) a study or investigation that is a drug trial exempt from having such an investigational new drug application. The routine patient costs for Approved Clinical Trials include all items and services typically covered by the Plan for individuals not enrolled in an Approved Clinical Trial.

Geographic Area – the Greater St. Louis Metropolitan area and any area within a 250-mile radius of Covered Individual's residence.

Hospital – a facility which:

1. operates pursuant to law; and
2. has organized facilities for the care and treatment of sick and injured persons on a resident or inpatient basis, including facilities for diagnosis and surgery under the supervision of a staff of one or more doctors; and
3. provides 24-hour nursing services by registered nurses on duty or call; and
4. is not a convalescent home, nursing home, rest home or extended care facility, or facility operated exclusively for the treatment of the aged, drug addict or alcoholic, whether such facility is operated as a separate institution or as a section of an institution operated as a hospital; or
5. is an approved ambulatory surgical center facility. An "ambulatory surgical center" is any public or private establishment operated primarily for the purpose of performing surgical procedures or primarily for the purpose of performing childbirth, and which does not provide services or other accommodations for patients to stay more than twelve hours within the establishment.

Hospitalization, Hospital Confinement, Hospital Admission or Inpatient Confinement – any stay in a Hospital for any reason or in any sort of room for more than 23 hours.

Illness – means:

1. a disorder or disease of the body or mind; or
2. pregnancy of an Eligible Employee or Retired Eligible Employee or the covered dependent spouse of an Eligible Employee or Retired Eligible Employee.

All Illnesses due to the same cause, or to a related cause, will be deemed to be one Illness.

Injury – means an accidental bodily injury caused suddenly and unforeseeably.

Medical Supplies – the following items, if prescribed by a legally qualified physician:

1. drugs and medicines that require a written prescription of a physician and which must be dispensed by a licensed pharmacist or physician;
2. blood and other fluids to be injected into the circulatory system;

3. prosthetic or artificial limbs, breasts and eyes and their replacement, regardless of when the original loss of the limb, breast or eye occurred, and certain supplies necessary for the use of an artificial breast or limb;

4. casts, splints, trusses, braces, surgical dressings; and

5. crutches, wheelchairs, hospital beds, iron lungs, equipment for the administration of oxygen, and other Durable Medical Equipment. (See definition of Durable Medical Equipment above.)

Medically Necessary or Medical Necessity – means the charge must be for a service or supply that meets all of the following requirements.

1. The service or supply must be prescribed by a physician for the diagnosis or treatment of an Injury or Illness;

2. The service or supply must be commonly and customarily recognized by the physician's profession in the United States as safe, effective, appropriate and reasonably necessary treatment for the diagnosed Injury or Illness. To determine whether a service or supply meets this part of the definition of Medical Necessity, the Plan may have board certified physicians review medical records and proposed services. The reviewing physician will consider whether certain standard criteria used by the medical profession to determine the necessity of services or supplies have been met. For instance, when considering the necessity of surgical intervention to treat back pain, the reviewing physician may consider whether conservative care such as physical therapy, pain control medication, and injections, etc. were used to achieve treatment goals prior to recommending surgery;

3. The service or supply must not be educational, Experimental or Investigative in nature nor provided primarily for research;

4. The service or supply must not be for Custodial Care; and

5. The service or supply must not be primarily for the convenience of the patient or provider nor be more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the patient's Injury or Illness.

Mental Health and Substance Use Disorders – conditions that disrupt a person's emotions, or involve patterns of problematic thoughts or behaviors that interfere with daily functioning or satisfaction with life. These disorders may result from or be affected by genetic predispositions, difficult past life experiences, physical conditions or recent life stressors. The impact to the individual is beyond the normal stresses and problems of daily living and life transitions. Substance use disorders involve significant misuse of mood-altering substances, including alcohol and prescribed or illegal drugs. The misuse of these substances negatively affects emotions, thoughts and behaviors, daily functioning and personal relationships, up to and including physical dependence and psychological addictions.

Network Provider – a doctor or other provider of medical care or supplies who is part of the Medical Network and Managed Care Administrator's or the Behavioral/Mental Health Administrator's network of providers who provide services to Covered Individuals at negotiated rates.

Notice and Proof of Claim – written notice of a loss for which a Covered Individual has a claim, which must be submitted to the Benefit Office as soon as possible. "Loss", as used in this provision, means Covered Charges the Covered Individual incurs, the Eligible Employee's Disability, or the Eligible Employee's, Retired Eligible Employee's or dependent's death, accidental death or accidental dismemberment, as applicable.

Nurse Practitioner – a registered nurse who has advanced preparation for practice that includes supervised clinical experience in the diagnosis and treatment of illnesses and who is licensed as a nurse practitioner in the state in which the individual practices.

Occupational Therapist – an individual who is licensed to perform Occupational Therapy by the state in which the individual performs services, if that state requires licensing.

Occupational Therapy – treatment which consists primarily of instructing a Covered Individual to perform the normal activities of daily living.

Out-of-Network Provider – a doctor or other provider of medical care or supplies who is not a Network Provider.

Out-of-Pocket Maximum – the limit on the total amount you are required to pay in a calendar year for in-network Covered Charges before the Plan pays 100% of in-network covered benefits. The annual Out-of-Pocket Maximum need only be met once per Covered Individual per calendar year. Co-payments, Co-insurance, and the annual Deductible count toward the Out-of-Pocket Maximum. There are separate Out-of-Pocket Maximums for Medical and Prescription Benefits. The Medical Out-of-Pocket Maximum does not apply to Vision or Dental benefits.

Physical Therapist – an individual who is licensed to perform Physical Therapy by the state in which the individual performs services, if that state requires licensing.

Physical Therapy – treatment given to improve the physical capabilities of a Covered Individual in an attempt to restore such individual to a previous level of good health.

Physician Assistant or PA – a person who

1. has graduated from a Physician Assistant program accredited by the American Medical Association's Committee on Allied Health Education and Accreditation (or by its successor agency);
2. has passed the certifying examination administered by the National Commission on Certification of Physician Assistants;
3. has active certification by the National Commission on Certification of Physician Assistants; and
4. provides health care services delegated by a licensed physician.

A person who has been employed as a Physician Assistant for three years prior to August 28, 1989, and who has passed the National Commission on Certification of Physician Assistants examination and has an active certification of the National Commission on Certification of Physician Assistants, is also included in this definition. In order to meet this definition a Physician Assistant must clearly identify him/herself as a Physician Assistant and shall not refer to him/herself as a doctor, a physician or a surgeon.

Plan – this plan of benefits provided by the Greater St. Louis Construction Laborers' Welfare Fund.

Psychiatric Residential Treatment Center Services – a level of care that includes individualized and intensive mental illness or substance abuse treatment on a 24-hour basis in a residential setting. Treatment may be focused on psychiatric illness or substance abuse, or both. While crisis intervention services are available, this level of care is not appropriate for individuals at risk of harming themselves or others. Twenty-four hour skilled nursing services are required and daily supervision of a patient by a physician is available.

Qualified Medical Child Support Order (QMCSO) – an order issued by a court or issued through an administrative process established by state law, which orders the Plan to provide medical benefits to the child of an Eligible Employee or a Retired Eligible Employee. In order to be qualified, the order must clearly specify:

1. the name and last known mailing address of each child of the Eligible Employee or Retired Eligible Employee to be covered (or the name and address of a state official who may be substituted for the name and address of the child);
2. a description of the coverage; and
3. the period to which the order applies.

A QMCSO may not require the Plan to provide any benefit or option not provided under the Plan.

An appropriately completed National Medical Support Notice recognized under Section 401(b) of the Child Support Performance and Incentive Act is deemed to be a QMCSO.

Qualifying Quarters –

1. Hours reported and paid to the St. Louis Benefit Office by a signatory contractor for the months of September – November, December – February, March – May or June – August, with each month's contribution covering work ending with the last payroll period in that month; or

2. Hours reported and paid to the St. Louis Benefit Office by a signatory contractor including hours for the last days of a qualifying quarter although they were reported and paid for in the following month(s).

    a. In this situation, the employee must present to the St. Louis Benefit Office satisfactory documentation of having worked 275 hours in the Qualifying Quarter.

    b. An employee cannot count hours worked in the last week of the quarter in two "coverage quarters" of the year. "Coverage quarters" are explained in Section 3(A)(2) on p. 3:1.

Retired Eligible Employee – An Eligible Employee who retired from Covered Employment with a Contributing Employer and who is eligible for any Retiree coverage provided or negotiated by the Plan in accordance with the provisions of Section 14 of this Booklet.

Skilled Nursing Facility – an institution, other than a Hospital, which meets all of the following requirements:

1. maintains permanent and full-time facilities for bed care of 10 or more resident patients;
2. has available at all times the services of a doctor;
3. has a registered nurse (RN) or doctor on full-time duty in charge of patient care and one or more registered nurses (RN) or licensed practical nurses (LPN) on duty at all times;
4. maintains a daily medical record for each patient;
5. is primarily engaged in providing continuous skilled nursing care for sick or injured persons during the convalescent state of their Illness or Injury and is not, other than incidentally, a rest home or a home for Custodial Care for the aged; and
6. is operating lawfully as a Medicare-accredited nursing home in the jurisdiction where it is located. In no event, however, shall such term include an institution primarily engaged in the care and treatment of drug addicts or alcoholics.

Speech Therapist – an individual who is licensed to perform Speech Therapy by the state in which the individual performs services, if that state requires licensing.

Speech Therapy – treatment administered by a Speech Therapist to improve or restore a Covered Individual's speech capabilities after a decrease in those capabilities following an Illness or Injury.

Subrogation – the substitution of one person in the place of another with respect to a claim, demand or right.

Totally and Permanently Disabled – an Eligible Employee shall be considered Totally and Permanently Disabled only if the Board of Trustees, in their sole and absolute judgment, find, on the basis of medical evidence, that:

1. such Disability will be permanent and continuous during the remainder of his life; and
2. the Eligible Employee has been totally Disabled by Injury or Illness so as to be prevented thereby from engaging in any further employment or gainful pursuit in the Building Trades Industry, or, in the case of non-laborer Eligible Employees, employment of the same or similar nature as that in which employed just prior to such Disability.

Union – Locals 42 and 110 of the Laborers' International Union of North America.

Usual and Reasonable Charge – a charge which is not higher than the usual charge made by the provider of the care or supply and does not exceed the usual charge made by most providers of like service in the same area. This standard will consider the nature and severity of the condition being treated and the medical complications or unusual circumstances that require more time, skill or experience. The Plan will pay benefits on the basis of the actual charge billed if it is less than the Usual and Reasonable Charge.

You or Your – Eligible Employees, Retired Eligible Employees and/or their dependents who are covered by the Plan, depending on the context.

SECTION 2. PLAN'S COST CONTAINMENT FEATURES

The Trustees of the Greater St. Louis Construction Laborers' Welfare Fund continue to strive to provide you and your family with the highest-quality benefits and at the same time to hold down costs to protect the future of those benefits. In pursuit of those dual goals, the Trustees have adopted a number of features that require your participation and cooperation:

- Medical prior authorization, utilization review and case management program
- Medical network
- Reimbursement and Subrogation when the Plan provides benefits for an Injury or Illness for which a third party is responsible

A. MEDICAL AND BEHAVIORAL HEALTH CARE PRIOR AUTHORIZATION, UTILIZATION REVIEW AND CASE MANAGEMENT

1. Prior Authorization

As discussed further below, the Plan participates in a medical network which has made arrangements with a large number of doctors, Hospitals, and other providers (collectively called Network Providers) to provide health care to you and your family, often at reduced costs. Under the terms of the utilization management program applicable to Network Providers, the Network Providers must obtain prior authorization for elective Hospital admissions, some outpatient surgeries, ambulatory services, home health care, and certain Behavioral Care. While you will not be penalized solely because of the failure of a Network Provider to obtain prior authorization, it is in your interest that prior authorization be obtained so that the Plan does not pay for any care or treatment which is not Medically Necessary. Prior authorization is designed to greatly reduce the possibility that you will receive care or treatment which is not Medically Necessary and thus not covered by the Plan.

The prior authorization procedures are explained in detail at Section 6., Subsection B. of this Booklet. Generally, you obtain prior authorization by calling the number shown on your Plan identification card.

2. Medical Utilization Review and Case Management Services

The Trustees have made arrangements for a case management program. This program is coordinated by the Medical Network and Managed Care Administrator indicated in the Insert to this Booklet in conjunction with the Plan and offered at no additional cost to you.

Case management is a voluntary program designed to help coordinate health care benefits for certain individuals who have serious immediate or long-term health care needs.

Case management program staff members work with your physician as your physician develops a care plan that meets your needs. In the event of such health care needs, a case manager will be assigned to work with you. All case managers are registered nurses with clinical experience.

The Medical Network and Managed Care Administrator shares information with health care providers who are involved in your treatment, so that the Medical Network and Managed Care Administrator can determine the benefits that may be available under the Plan for medical care you receive.

You can always refuse any treatment or services that are recommended; however, if you refuse treatment you may not receive the maximum benefits available under the Plan. You will be notified when case management services are changed or terminated and the reason(s) for such action will be explained to you.

B. NETWORK PROVIDERS

The Plan participates in a medical network which has made arrangements with a large number of doctors, hospitals, and other providers of health care services to provide health care to you and your family, often at reduced costs. A current list of doctors, hospitals and other providers who are members of the network can be obtained online (see the Insert to this Booklet for the website address).

Under the medical portion of the Plan, there are two levels of doctors, hospitals, and other providers:

- Tier 1 – Network Providers
- Tier 2 – Out-of-Network Providers

The Tier 1 – Network Providers generally charge the Plan the least for your care. The level of your benefits is determined by which level of provider you choose. If you choose a Tier 1 – Network Provider, the Plan will generally pay 90% of the Covered Charges after the Deductible and any applicable Co-payment, and you will pay 10% coinsurance. If you choose a Tier 2 – Out-of-Network Provider, the Plan will pay 60% of the Covered Charges, (Tier 2 – Out-of-Network Provider charges are limited to the Usual and Reasonable charges as defined in Section 1., Subsection B. of this Booklet), after the Deductible and any applicable Co-payment, and you will pay 40% coinsurance and any non-Covered Charges.

By using the Network Providers, you benefit in two ways. First, you benefit directly and immediately when you use one of the Network Providers, because the Plan pays 90% of the Covered Charges, rather than the 60% it pays when you use an Out-of-Network Provider. Thus, you only have to pay 10% of the Covered Charges when you use a Network Provider. Further, the fees charged by the Network Providers are often lower than those charged by Out-of-Network Providers. In such cases, you save by paying the lower percentage of a lower fee. Second, you benefit indirectly, because as indicated, the Network Providers have agreed in many cases to charge less for treating you and your family, so the Plan is required to pay less than it would have to pay if you used an Out-of-Network Provider. Therefore, you help to maintain the financial stability of the Plan and to ensure the availability of monies for your future health benefits.

You should always urge your doctor to refer you only to Hospitals and other health care providers who are members of the Network.

The Network Provider will normally automatically contact the Medical Network and Managed Care Administrator for prior authorization, so you will not be penalized for failing to get prior authorization or pre-approval for a Hospitalization. However, even if you are using a Network Provider, you may confirm, and are encouraged to confirm, that prior authorization has been received by calling the prior authorization number shown on your identification card prior to your treatment.

If you have any questions about the prior authorization requirements, about whether a health care provider is a member of the Network, or about how to receive the benefits of using a Network Provider, please contact the Benefit Office at (314) 644-2777 or toll free (800) 489-0228.

C. REIMBURSEMENT AND SUBROGATION

The Plan has adopted reimbursement and subrogation provisions that will affect Covered Individuals who suffer an Illness or Injury for which some third person may be responsible. This means that if you or a dependent suffers any Injury or Illness caused by someone else, the Plan will have the right to be reimbursed for amounts it pays out for treatment of that Illness or Injury (medical, prescription drug, Disability, etc.), from any monies you recover from the responsible person or from any insurer, including your own insurer. In the alternative, the Plan will become "subrogated" to your claim against the responsible person or insurer. This means that to the extent of the benefits it pays out for the Injury or Illness, the Plan has the same rights you have against the responsible parties. In other words, the Plan "stands in your shoes" with respect to claims against the responsible parties. The Plan can bring its own lawsuit against the responsible parties or intervene in any lawsuit you bring.

You must tell the Benefit Office when you or your dependents suffer an Illness or Injury for which a third person may be responsible. The Benefit Office will, before paying out any benefits with respect to such an Illness or Injury, require that you provide information and documentation sufficient to permit the Plan to protect its rights and will require you to execute an agreement confirming the Plan's rights. See Section 16. of this Booklet for more information about subrogation and reimbursement.

D. COORDINATION OF BENEFITS RULES

The coordination of benefits (COB) rules are used when a person is covered by more than one medical or prescription benefits plan to determine which plan must pay its benefits first. See Section 15. of this Booklet for more information about coordination of benefits.

E. OTHER COST SAVING FEATURES OF PLAN

You may also be able to reduce the cost of your medical care by taking advantage of other cost saving features of the Plan.

If you need long-term maintenance prescription drugs, you should use the mail-in drug program or the Retail 90 program, both of which are described at Section 7. Subsection E. of this Booklet.

Be sure to carefully review your Hospital bill. If there are any errors, contact the Hospital and have them send you an adjusted bill. Then send the original bill and the corrected bill to the Benefit Office, and you will receive 50% of the amount you saved, up to a maximum payment of $1,000 per Hospital stay. You must have the Hospital correct the error (billing errors under $25.00 will not be honored).

SECTION 3. ELIGIBILITY

A. ELIGIBILITY OF EMPLOYEES

1. Generally

a. If you work in Covered Employment in any of the following categories, you may become eligible to participate in the Plan:

(1) all employees represented by, or working as laborers in the negotiated jurisdiction of, the Laborers' International Union of North America AFL-CIO Locals No. 42 and 110 of St. Louis and St. Louis County;

(2) all employees of the above named locals;

(3) all employees of the Greater St. Louis Construction Laborers' Welfare Fund and the Construction Laborers' Pension Trust of Greater St. Louis; and

(4) all employees represented or working in the construction industry for which this Plan has a reciprocal agreement with the represented fund.

b. In addition, non-bargaining unit individuals may become eligible to participate in the Plan pursuant to participation agreements established by the Trustees of the Plan, except that their Plan benefits do not include life insurance, AD&D benefits, weekly disability or Retired Eligible Employee benefits.

c. The participation of employees in a(2) and (3) above shall be pursuant to participation agreements established by the Trustees of the Plan.

2. Commencement of Eligibility

You become eligible for benefits by:

a. working 275 hours of Covered Employment in a "qualifying quarter"; or

b. working a total of 800 hours of Covered Employment in four consecutive "qualifying quarters" with hours worked in each "qualifying quarter." The four consecutive "qualifying quarters" are not required to be in the same Plan year.

Your coverage starts on the first day of the first "coverage quarter" following the "qualifying quarter(s)" in which you earned the coverage.

Qualifying quarters and coverage quarters are as follows:

QUALIFYING QUARTERS				COVERAGE QUARTERS		
September	October	November		January	February	March
December	January	February		April	May	June
March	April	May		July	August	September
June	July	August		October	November	December

EXAMPLE:

c. You work 275 hours of Covered Employment during March, April and May. You are covered July 1.

QUALIFYING QUARTERS				COVERAGE QUARTER		
March	April	May		July	August	September

d. You work 800 hours of Covered Employment between March and February (of the next year), including hours in each "qualifying quarter". You are covered effective in the "coverage quarter" beginning April 1.

QUALIFYING QUARTERS				COVERAGE QUARTER		
March	April	May		x	x	x
June	July	August		x	x	x
September	October	November		x	x	x
December	January	February		April	May	June

You will remain eligible to participate in the Plan until you no longer meet the Plan's eligibility requirements.

The initial eligibility requirements of this Section are waived if you were employed in the construction industry or a related industry immediately prior to your Covered Employment and you can provide proof of existing health coverage through that prior employment. In such case, coverage will commence on the date you begin Covered Employment. All eligibility under this provision shall be subject to Trustee discretion.

3. Continued Coverage

You may continue your coverage by any of the following:

a. By Working 275 Hours in a Qualifying Quarter or 800 Hours in Four (4) Consecutive Qualifying Quarters

After you initially become eligible for coverage, your coverage will continue for an additional coverage quarter (i) for each additional qualifying quarter in which you work 275 hours in Covered Employment or (ii) if you have worked a total of 800 hours in Covered Employment in four consecutive qualifying quarters following the end of the quarter resulting in coverage. The four consecutive qualifying quarters are not required to be in the same Plan year.

b. By Accumulating Hour Bank Credits

All hours worked in Covered Employment in excess of 275 in a qualifying quarter are saved or "banked" to be used in the next qualifying quarter if needed to continue your coverage. You may bank up to a maximum of 275 hours.

c. By Receiving Credit During Disability

If you are receiving Disability benefits from the Plan, you will be credited with eight hours for each working day for which you receive such benefits. You will also be credited with eight hours per day credit if you are unemployed because of a contested workers' compensation claim for which you are not receiving workers' compensation benefits. Disability and contested workers' compensation hours will not be credited beyond 13 weeks and can only be used in the same quarter in which they are credited. These hours cannot be banked. The credit is subject to reimbursement if you ultimately receive payment in any manner for your contested workers' compensation claim.

d. By Making Self-Payments

(1) Underemployment

If during a period of underemployment, you have exhausted all other methods of continuing coverage, you may continue coverage for yourself and your dependents by paying for your coverage ("self-payment"). You may make self-payments for a maximum of two consecutive coverage quarters. You may not change your self-pay election in the middle of a coverage quarter unless you

have had a Qualifying Event as defined in Section 5.D. You may not make a self-payment if you have had any interruption or gap in your coverage. For example, if you did not work enough hours in the March, April, May qualifying quarter, and did not make a self-payment for the July, August, September coverage quarter, you would not be eligible to make a self-payment for the October, November, December coverage quarter, because you would have had a gap in your coverage.

(2) Weekly Disability

If you fail to have enough hours in a qualifying quarter to qualify for coverage in the next coverage quarter because you are prevented from working by a Disability, you may make self-payments for two quarters. You must provide the Benefit Office with acceptable proof that you are Disabled.

(3) Workers' Compensation

If you are unemployed during a qualifying quarter due to an Injury or Illness for which you are receiving worker's compensation benefits, you may make a self-payment for the corresponding coverage quarter. You may do this two additional consecutive quarters for a total of four consecutive quarters. You must provide the Benefit Office with acceptable proof that you are receiving worker's compensation benefits and have not returned to work. At no time will you be able to make more than four consecutive quarters of self-payments.

(4) General Rules

All self-payments are due by the last day of each month of the coverage quarter during which coverage is to be continued. If the Benefit Office does not receive a timely self-payment, you will need to elect and pay for COBRA (as described in Section 5. of this Booklet) in order to keep your coverage. In the event your self-payment check is returned due to insufficient funds or otherwise does not clear, you will be required to make all subsequent self-payments with a cashier's check or money order for the balance of the self-payment period.

You cannot make a self-payment under this subsection if you:

- have actually lost coverage for failure to self-pay during a previous quarter as described above;
- have actually retired (although you may be eligible for Retired Eligible Employee self-pay coverage as described in Section 14 of this Booklet);
- have become totally disabled (see Special Disability Extension in Subsection 3.f. below);
- return to or engage in any work for a non-Contributing Employer that would be Covered Employment if performed for a Contributing Employer;
- are covered under any other group plan (such as through your spouse's employer) on the date your coverage under the Plan would otherwise terminate;
- are not a member of Union Local 42 or 110;
- are not actually available for Covered Employment as determined by Union Locals 42 and 110.

The cost of self-pay will be determined by the Trustees and is subject to change at any time.

e. COBRA Continuation Coverage

By making COBRA payments as explained in Section 5. of this Booklet.

f. Special Disability Extension

In the event you become Totally and Permanently Disabled prior to the time you are no longer eligible for coverage based on hours (either worked or banked, including coverage provided in connection with weekly Disability benefits), all Plan benefits, except Weekly Disability Benefits (see Section 13. of this Booklet), will be continued for you and your covered dependents for six months following the date on which your Plan benefits would otherwise terminate due to lack of hours worked or banked hours.

In determining whether an Eligible Employee applying for a Disability Extension is Totally and Permanently Disabled, the Trustees may:

- require that the Eligible Employee submit to an examination by a physician or physicians; or
- accept as evidence of such Total and Permanent Disability a determination by the Social Security Administration that the Eligible Employee is entitled to a Social Security Disability Benefit in connection with his Old Age and Survivors Insurance coverage.

Additionally, the Trustees may require an Eligible Employee to submit to reexamination, by a physician or physicians, periodically as the Trustees may direct. The determination of the Trustees shall be final and binding.

If determination of disability is delayed through no fault of the Eligible Employee, extended coverage will be retroactive to the date on which your benefits would otherwise terminate. However, if determination of disability occurs more than one year after the date on which benefits would otherwise terminate and any coverage extension by making self-payments or electing COBRA as provided in Section 3.A.3.d. or e., respectively, has expired, retroactive extension of coverage is not available.

g. Special Provision for Active Military Service

If you are engaged in military service in one of the uniformed services of the United States, including full-time active duty, training or drills, your coverage and that of your eligible dependents will be continued for a period of 30 days. If the period of military service exceeds 30 days, employee and dependent health coverage may be continued for up to 24 months from the first day of active military service by electing and paying the Plan's applicable COBRA continuation coverage rates. The election and payment rules for continuation of coverage under this provision are the same as the Plan's COBRA continuation coverage rules (see Section 5 of this Booklet).

If your eligibility for coverage terminated on account of entry into active duty in one of the uniformed services of the United States and you return from such service and are reemployed with a Contributing Employer prior to the expiration of your period of re-employment rights under any applicable Federal or State law, any unused eligibility earned by virtue of credited/banked hours accumulated prior to the military leave will be immediately reinstated. If you had not earned sufficient hours prior to your leave to reinstate coverage upon your return to work, you may self-pay for coverage until you have earned enough credits after reemployment to resume normal eligibility.

Any Eligible Employee entering active duty in one of the uniformed services of the United States should notify the Benefit Office before leaving for such duty, unless advance notice is impossible, unreasonable or precluded by military necessity. The Benefit Office should also be notified upon return to work with a Contributing Employer.

Continuation of coverage under this provision is provided pursuant to the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), as amended, and applicable regulations. Any conflict between this provision and USERRA or any other applicable provision of the law shall be reconciled in favor of compliance with USERRA or other applicable law.

4. Hours Crediting in Connection with Reciprocity Agreements

For employees working in another jurisdiction for which this Plan has a reciprocal agreement with the represented fund, the Trustees will determine the manner in which employer contributions made on behalf of the employee are applied for purposes of crediting hours (including possibly prorating hours) and establishing eligibility for coverage under Subsections A.2. and A.3. above.

B. ELIGIBILITY OF DEPENDENTS

Your dependents are automatically eligible to participate in the Plan upon meeting the requirements described below. After your dependents have met the Plan's eligibility requirements, they will remain eligible to participate in the Plan until they no longer meet the eligibility requirements.

1. Your Eligible Dependents

Your eligible dependents are:

- your lawful spouse to whom you are married regardless of gender and from whom you are not legally separated; and
- each child who is under the age of 26.

The term "child" means:

a. the natural child of an Eligible Employee (in order for a child of an unmarried Eligible Employee to be eligible for coverage under the Plan, the Eligible Employee must be shown as the parent of the child on the child's birth certificate. A copy of the birth certificate must be submitted to the Benefit Office before that child will be added to the Plan);

b. the adopted child of an Eligible Employee, including a child lawfully placed with the Eligible Employee in anticipation of legal adoption. A child is considered "adopted" only when the child is adopted or placed for adoption, and only if the adoption or placement occurs before the child reaches the child's 18th birthday. A child is placed for adoption when an Eligible Employee assumes and retains a legal obligation for total or partial support of the child in anticipation of adoption;

c. the stepchild of an Eligible Employee;

d. a child for whom an Eligible Employee has legal guardianship pursuant to an order by a court of competent jurisdiction; or

e. a child for whom an Eligible Employee is required to provide coverage pursuant to a Qualified Medical Child Support Order (QMCSO).

For purposes of life insurance only, the preceding definition of "child" does not apply and the term "child" means:

f. an Eligible Employee's natural child;

g. an adopted child, from the date the child is placed in the Eligible Employee's home;

h. a stepchild, or foster child, if such child is chiefly dependent upon the Eligible Employee for support and maintenance.

A dependent who is also an Eligible Employee under the Plan shall not be considered to be an eligible dependent for life insurance purposes.

The Trustees may require proof of dependent status and or evidence satisfactory to them that a child is in fact an Eligible Employee's child or otherwise eligible for coverage. These records include, but are not limited to, birth records, school records, proof of residency, proof of support, or court orders.

It is your responsibility to notify the Benefit Office of any changes in dependent status and all requests for coverage changes and/or additions of dependents must be in writing.

2. Disabled Children

If upon reaching the limiting age, your covered child is Disabled, your child will continue to be covered by the Plan as long as you have coverage, provided your child continues to be Disabled and satisfies all other eligibility rules of the Plan. Satisfactory proof of Disability must be on file with the Benefit Office in order for benefits to continue. The Benefit Office may require continued proof of Disability at reasonable intervals, usually every year.

3. Ineligible Dependents

Eligible dependents do not include:

- parents or other relatives even if supported by you;
- a spouse on active duty in the armed forces of any country.

4. Effective Date of Dependent Coverage

a. Generally

Coverage for dependents you have on the date you are covered will generally become effective on the same date as your coverage. Coverage for dependents you acquire after you are covered will generally become effective on the date the dependent becomes an eligible dependent.

However, before any benefits will be provided to your dependents, you must provide proof that your dependents are eligible dependents. Documents that prove eligibility include the following: birth certificate; social security card; marriage license; adoption papers; and court orders.

In order to activate coverage for any dependent you have on the date your coverage begins, you must complete an enrollment form with respect to the dependent and return it and proof of eligibility to the Benefit Office within 30 days of the date your coverage begins. In order to activate coverage for any dependent you acquire after you are covered, you must complete an enrollment form with respect to the new dependent and return it and proof of eligibility to the Benefit Office within 30 days of the date you acquire that dependent. For newborns, you will have 90 days from the date of birth to provide proof of eligibility to the Benefit Office. The deadlines for providing proof of eligibility will only be waived if there is proof of extenuating circumstances.

Other than for newborns, no benefits will be paid on behalf of your dependent until the enrollment form and proof of eligibility are returned to the Benefit Office. It is therefore strongly recommended that you submit these documents as soon as possible.

If you fail to submit both the completed enrollment form and the required proof of eligibility documentation within 30 days of the effective date of your coverage (for an existing dependent) or of the date you acquire a new dependent (unless the new dependent is a newborn in which case you have 90 days to provide proof of eligibility), coverage for that dependent will be effective the first day of the first month following receipt of the completed enrollment form and the proof of eligibility documentation.

b. Court Order

A child who is enrolled pursuant to a Qualified Medical Child Support Order will be enrolled as of the date the order is received in the Benefit Office unless a later date is specified in the order.

If the order does not contain all the information required by the Benefit Office, you will be required to complete an enrollment form. Benefits will not be paid until the requested enrollment form is received.

C. EFFECT OF EMPLOYER'S FAILURE TO MAKE REQUIRED CONTRIBUTIONS

If you are a covered employee of a Contributing Employer who fails to make the required contributions on behalf of the employer's employees, you and your dependents, as well as the other employees of that Contributing Employer and their dependents, will be ineligible for benefit coverage

for claims incurred during those months for which your employer failed to make the required contributions. Contributions received from a delinquent Contributing Employer will be credited back to the first month of delinquency. When the required contributions are received for a month, all claims incurred during that month will be considered for payment.

D. SPECIAL CHIPRA ENROLLMENT RIGHTS

Effective April 1, 2009, CHIPRA (Children's Health Insurance Program Reauthorization Act of 2009) created two new special enrollment events if you are eligible to participate in the Plan but not enrolled in the Plan. First, if you or your dependents were covered under Medicaid or a state CHIP plan and lose that coverage, you or your dependents are entitled to a special enrollment period in this Plan. Second, if you or your dependents become eligible for the state's premium assistance, you are entitled to a special enrollment period. You have 60 days to notify the Plan of the event, and 31 days to provide proof of eligibility and enroll. To request Special CHIPRA Enrollment or obtain more information, contact the Benefit Office at (314) 644-2777 or toll-free at (800) 489-0228.

SECTION 4. TERMINATION OF ELIGIBILITY

A. EMPLOYEES

Your coverage and the coverage of your dependents will end on the last day of the last coverage quarter for which you qualify for coverage by virtue of hours worked, banked hours, self-payments, special Disability or military leave extension or such other date that you become ineligible to participate in the Plan.

B. DEPENDENTS

1. Spouse

In addition to the reasons set forth in Subsection A. above, the eligibility of your spouse will end for the reasons and on the dates as set forth below:

a. The last day of the month after you and your spouse become divorced or legally separated; or

b. Upon your death, the last day of the last coverage quarter for which you had qualified for coverage by virtue of worked and/or banked hours.

2. Children

In addition to the reasons set forth in Subsection A. above, the eligibility of your children will end for the reasons and on the dates set forth below:

a. The last day of the month in which your child reaches the applicable limiting age;

b. The date your Disabled child (who is over the limiting age) is no longer incapable of self-support due to physical or mental handicap;

c. The date your child otherwise ceases to meet all of the requirements for eligibility under the Plan; or

d. Upon your death, the last day of the last coverage quarter for which you had qualified for coverage by virtue of worked and/or banked hours.

C. COVERAGE DURING FAMILY AND MEDICAL LEAVE

If you are granted leave under the Family and Medical Leave Act, please notify the Benefit Office, so that the Plan can make sure your Contributing Employer continues to make contributions on your behalf to continue your coverage during such leave.

D. CONTINUATION OF COVERAGE

In certain circumstances where your benefits or those of your dependents would otherwise terminate, you or your dependents may be entitled to continue coverage as set forth in Section 5.

E. YOUR DUTY TO INFORM PLAN OF TERMINATION OF DEPENDENT'S ELIGIBILITY

You must notify the Benefit Office when one of your dependents ceases to be eligible to participate in the Plan. If you fail to inform the Benefit Office when one of your dependents ceases to be eligible, your dependent may lose your dependent's right to COBRA continuation coverage. Further, if because you have fraudulently failed to inform the Benefit Office when one of your dependents ceases to be eligible or intentionally misrepresent any material fact to the Benefit Office relating to the eligibility of your dependents and the Plan pays out benefits for an ineligible dependent, the Plan will have the right to recover such benefits from you, your dependent, or any provider to whom such benefits were paid. The Plan may at its option withhold future benefits due to you and your other covered dependents in order to recoup amounts it paid on behalf of an ineligible dependent. If the Plan brings a legal action to collect such benefits, the Plan, upon prevailing, will be entitled to receive and you will be required to pay not only the overpayments, but also pre-judgment interest and the reasonable attorney's fees and costs the Plan incurs in such action.

F. RESCISSION

Your eligibility for coverage and your dependent(s)' eligibility for coverage may end due to a rescission by the Plan. A rescission is the retroactive termination of your coverage and/or your

dependent(s)' coverage. The Plan may retroactively terminate your coverage and/or your dependent(s)' coverage due to you or your dependent(s) committing an act, practice, or omission that constitutes fraud or if you or your dependent(s) make an intentional misrepresentation of material fact. You and/or your dependent(s) will receive 30 days' written notice of any rescission. The Plan may exercise its rights to recover overpayments due to the fraud or intentional misrepresentation.

For example, if you or your dependent(s) knowingly submit information to the Plan which conceals your eligibility or your dependent(s)' eligibility for Medicare or you knowingly otherwise fail to advise the Plan of your eligibility or your dependent(s)' eligibility for Medicare, the Plan may rescind your coverage to the date you became eligible for Medicare.

SECTION 5. COBRA CONTINUATION COVERAGE

A. INTRODUCTION

The following paragraphs explain COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The Plan provides continued health and welfare coverage pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1985, commonly known as COBRA. Eligible Employees and their dependents are offered the opportunity for a temporary extension of health coverage called "continuation coverage" after certain life events called "qualifying events," which would otherwise cause coverage to end.

B. THINGS TO CONSIDER WHEN DECIDING WHETHER TO TAKE COBRA COVERAGE

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you have the special right to enroll in any other group health plan for which you may be eligible (such as a plan sponsored by your spouse's employer) within 30 days after your regular coverage under this Plan terminates due to a qualifying event, even if that plan does not usually accept late enrollees. Other options may be available to you through Medicare, Medicaid, or the Children's Health Insurance Program (CHIP). You can learn more about many of these options at www.healthcare.gov.

C. CONTACT FOR COBRA QUESTIONS

If you have any questions regarding this Plan's COBRA continuation coverage, you should call or write the Benefit Office at:

Greater St. Louis Construction Laborers' Welfare Fund
2357 59th Street
St. Louis, MO 63110
Telephone: (314) 644-2777 or toll free (800) 489-0228
E-Mail: benefits@stllaborers.com

For more information about your rights under the Employee Retirement Income Security Act (ERISA) including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.healthcare.gov.

D. QUALIFYING EVENTS THAT GIVE RISE TO RIGHT TO ELECT COBRA CONTINUATION COVERAGE

The events described below which might result in eligibility for COBRA continuation coverage are referred to as "Qualifying Events." The Eligible Employee, spouse or child who becomes entitled to COBRA continuation coverage as the result of a Qualifying Event is referred to as a "Qualified Beneficiary." A child born to, adopted by or placed for adoption with an Eligible Employee who is a Qualified Beneficiary, after a Qualifying Event, is also a Qualified Beneficiary. No other dependent is a Qualified Beneficiary.

If coverage ends because a Contributing Employer stops making contributions to the Plan, a Qualifying Event (as defined below) has not occurred.

1. For Employees

As an Eligible Employee, you have the right to choose COBRA continuation coverage if you lose your coverage under the Plan due to:

a. a reduction in hours of employment; or

b. termination of employment for reasons other than gross misconduct on your part.

2. For Spouses

The spouse of an Eligible Employee has the right to choose COBRA continuation coverage if the spouse loses coverage under the Plan for any of the following reasons:

a. the death of the Eligible Employee;

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

c. divorce or legal separation from the Eligible Employee; or

d. the Eligible Employee becomes entitled to Medicare benefits.

3. For Dependent Children

The eligible dependent child of an Eligible Employee has the right to choose COBRA continuation coverage if the child loses group health coverage under the Plan for any of the following reasons:

a. the death of the Eligible Employee;

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

c. the Eligible Employee's divorce or legal separation;

d. the Eligible Employee becomes entitled to Medicare benefits; or

e. the child ceases to be an eligible "dependent child" under the Plan.

4. For Certain Retired Employees and Their Dependents

A Retired Eligible Employee, or the dependent of a Retired Eligible Employee, whose former employer is bound to continue making contributions to the Plan for the Retired Eligible Employee, has the right to choose COBRA continuation coverage if the Retired Eligible Employee or dependent loses group health coverage under the Plan by reason of the former employer's filing a bankruptcy proceeding under Chapter 11 of the United States Code on or after July 1, 1986.

E. BENEFITS AVAILABLE UNDER COBRA CONTINUATION COVERAGE

The benefits available under COBRA continuation coverage are:

- Medical benefits;
- Vision benefits;
- Dental benefits;
- MAP benefits;
- Behavioral care benefits;
- Prescription drug benefits; and
- Hearing aid benefits.

Death, accidental death and dismemberment benefits and weekly Disability benefits coverage are not continued under COBRA.

If you choose COBRA continuation coverage, the Plan is required to provide you coverage that, at the time the coverage is being provided, is identical to the medical coverage provided under the Plan to similarly situated Eligible Employees or dependents.

F. REQUIRED NOTICES, ELECTION AND PAYMENTS

1. Notice to the Plan

Under the law, the Eligible Employee or dependent has the responsibility to provide written notice to the Benefit Office of a divorce, legal separation or a child losing dependent status under the Plan within 60 days of such event or, if later, within 60 days after coverage would terminate because of that event. Otherwise all rights to continue coverage are lost.

In addition, if a person who has COBRA continuation coverage has a second Qualifying Event, that person (or someone on that person's behalf) must provide written notice to the Plan of that

second Qualifying Event within 60 days after the occurrence of that second event in order to qualify. If the Benefit Office does not receive written notice of the second Qualifying Event, rights to additional COBRA continuation coverage, if any, will be lost.

Notices should be sent or hand-delivered to the Benefit Office at:

Greater St. Louis Construction Laborers' Welfare Fund
2357 59th Street
St. Louis, Missouri 63110

Oral notice, including notice by telephone, is not acceptable. If mailed, the notice must be postmarked no later than the deadline described above. If hand-delivered, the notice must be received at the address specified above no later than the deadline described above.

The notice must include the following information:

- name and address of Eligible Employee;
- names and addresses of dependents who will lose coverage;
- date of Qualifying Event;
- nature of Qualifying Event; and
- the signature, name and contact information of the individual sending the notice.

The Contributing Employer making contributions on behalf of an employee has the responsibility to notify the Plan of the employee's death, termination of employment or reduction in hours of employment, Medicare entitlement or the employer's bankruptcy. Nevertheless, employees and their dependents are encouraged to provide the Benefit Office with written notification of these events as well.

2. Plan's Notice to Employee and Dependents

Within 30 days after the Benefit Office receives notice that one of the Qualifying Events has occurred, it will in turn notify you, your dependents, or both of the procedures for electing COBRA continuation coverage.

3. Election of COBRA Continuation Coverage

a. Time Limit for Election

Under the law, you and your dependents have 60 days from the later of the date you would lose coverage because of one of the events described above or the date you are notified of your continuation rights to inform the Benefit Office that you want COBRA continuation coverage.

If you or your dependents do not choose COBRA continuation coverage within the required time, all rights to continue coverage will end.

b. Who May Elect COBRA Coverage

Each employee and eligible dependent who was covered under the Plan on the day before the Qualifying Event and whose coverage terminates because of the Qualifying Event is entitled to make his or her own decision regarding COBRA continuation coverage. This is true even if the former employee chooses not to continue coverage. However, one family member can elect and pay for coverage on behalf of all Qualified Beneficiaries.

In addition to an employee's dependents who were covered under the Plan on the day before the Qualifying Event, any child born to an employee or placed with an employee for adoption while the employee has COBRA continuation coverage will also have an independent right to elect to retain COBRA continuation coverage for the balance of the original COBRA period in the event the employee's COBRA continuation coverage ends before the end of the maximum period.

4. Payment for Continuation Coverage

Qualified Beneficiaries who elect COBRA continuation coverage must pay directly to the Plan such amounts as the Trustees shall from time to time require in accordance with regulations governing the amount, frequency and manner of such payment. Contact the Benefit Office to obtain this information. The Trustees will determine annually the premium rates applicable to COBRA continuation coverage. This rate cannot exceed 102% of the cost of benefits (150% for qualified beneficiaries receiving the 11-month disability extension of coverage discussed below).

A grace period of 45 days from the election date will be allowed for the initial payment of the premium for COBRA continuation coverage and a grace period of 30 days from the beginning of each month of coverage will be allowed for payment of each subsequent COBRA continuation coverage premium. If the first premium is not postmarked or received by the end of the 45-day grace period, COBRA continuation coverage will not take effect and the right to COBRA continuation coverage is forfeited. If any subsequent premium is not postmarked or received by the end of the 30-day grace period, COBRA continuation coverage will be terminated as of the end of the period for which the last timely premium was received and will not be reinstated.

Premiums are required in full each month, but if a timely payment is made in an amount that is not significantly less than the amount required, the Qualified Beneficiary will be notified and will have 30 days to pay the deficient amount due. This 30-day period will be measured from the original due date or the date of the notice, whichever is later. In the event your COBRA premium check is returned due to insufficient funds or otherwise does not clear, you will be required to make all subsequent COBRA premium payments with a cashier's check or money order for the balance of the COBRA coverage period.

G. DURATION OF COBRA CONTINUATION COVERAGE

1. Termination or Reduction of Hours of Employment

a. Generally

If the Qualifying Event is the termination of your employment or reduction in hours of your employment, the required period of COBRA continuation coverage ends 18 months after the date of the Qualifying Event.

b. Extensions

(1) Disability

If any of the Qualified Beneficiaries who elected COBRA is determined by Social Security to be disabled and you notify the Plan in a timely fashion, all Qualified Beneficiaries may be entitled to get up to an additional 11-months of COBRA continuation coverage for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. If the disabled person is covered during this 11-month extension, the premium will be 150% of the cost of benefits.

Note: You must notify the Benefit Office, in writing, of the Social Security disability determination before the end of the original 18-month period and within the later of 60 days after Social Security makes the determination or 60 days after your COBRA continuation coverage began. The persons who get this extended coverage must also notify the Benefit Office within 30 days after the Social Security Administration determines the disability has ended.

(2) Medicare Entitlement

If an Eligible Employee becomes entitled to Medicare and then subsequently incurs a Qualifying Event that is a termination of employment or reduction in hours of employment, the COBRA continuation coverage period for the employee's dependents will not end until 36 months after the date the employee became entitled to Medicare. For example, if you became entitled to Medicare in May of

2020, and then terminated employment in June of 2020, your COBRA continuation coverage period ends December of 2021, but your eligible dependents can continue their COBRA coverage until May of 2023, which is 36 months after your Medicare entitlement.

(3) Second Qualifying Event

If a second Qualifying Event occurs during the 18-month (or 29-month) period, the maximum continuation period will be extended to 36 months from the date of the original Qualifying Event for the Qualified Beneficiaries affected by that second Qualifying Event. For example, if your employment is terminated on December 31, 2020, and you elect COBRA continuation coverage for yourself and your covered dependents, you and your dependents are entitled to COBRA continuation coverage until June 30, 2022. However, if in May of 2021, your son turns 26, that child has had a second Qualifying Event, and the child's COBRA continuation period can continue until December 31, 2023 (36 months from the date of the original Qualifying Event).

Note: The affected person must notify the Benefit Office, in writing, of this second Qualifying Event within 60 days after the occurrence of the second Qualifying Event. Otherwise, the COBRA period will not be extended to 36 months.

2. Other Qualifying Events

For all Qualifying Events other than the termination of employment or the reduction in hours of employment, the maximum COBRA continuation coverage period is 36 months from the date of the Qualifying Event.

H. TERMINATION OF COBRA CONTINUATION COVERAGE

All rights to COBRA continuation coverage permanently end on the earliest of the following occurrences:

1. the expiration of the applicable maximum COBRA continuation coverage period;
2. the failure to make a payment before the end of the applicable grace period;
3. after the date that COBRA is elected, the Covered Individual becomes covered under Medicare or under another group health plan;
4. for COBRA coverage that is extended due to disability, the first day of the first month that begins more than 30 days after the date that a disabled Qualified Beneficiary is finally determined by the Social Security Administration to be no longer disabled; or
5. the Plan and the Contributing Employer for whom the employee was working stops providing group health benefits.

If a Contributing Employer stops making contributions to the Plan, and establishes a new group health plan (or starts participating in another multi-employer plan) for a substantial number of employees who were formerly covered under this Plan, then the new plan established by the employer (or the other multi-employer plan) has the obligation to make COBRA continuation coverage available to that employer's COBRA Qualified Beneficiaries.

I. COORDINATION OF COBRA CONTINUATION COVERAGE WITH OTHER PERIODS OF CONTINUED COVERAGE

If you exercise your rights under the Plan to "self-pay," your COBRA continuation coverage period will be reduced by the number of months during which you self-pay. Your COBRA continuation coverage period will also be reduced by the number of months for which you are granted a disability extension.

The 36-month maximum COBRA continuation coverage period for surviving dependents of a deceased Eligible Employee will begin on the date that the dependents' period of eligibility for Active Employee coverage ends, based on exhaustion of the Eligible Employee's worked and/or banked hours.

J. KEEP BENEFIT OFFICE INFORMED OF ADDRESSES

In order for the Plan to make sure that you and all of your covered dependents get all of the notices about COBRA, you must keep the Benefit Office informed of your current address and the addresses of any covered dependents.

K. SPECIAL RULES FOR MEDICARE-ELIGIBLE INDIVIDUALS

In general, if you do not enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an eight-month special enrollment period[1] to sign up for Medicare Part A or B, beginning on the earlier of:

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you do not enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan will terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you and https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods.

L. SPECIAL COBRA RULES FOR INDIVIDUALS ELIGIBLE FOR TRADE ADJUSTMENT ASSISTANCE

Special COBRA rights apply to Eligible Employees who lost health coverage as a result of a termination or reduction of hours and who qualify for "trade readjustment assistance" or "TAA" under a federal law called the Trade Act of 2002. These Eligible Employees are entitled to a second opportunity to elect COBRA coverage for themselves and certain family members (if they did not already elect COBRA coverage) during a special second election period. This special second election period lasts for 60 days and begins on the first day of the month in which an Eligible Employee is determined to be eligible for TAA. The election must be made within the six months immediately after the Eligible Employee's group health plan coverage ended. If you qualify or may qualify for assistance under the Trade Act of 2002, contact the Benefit Office for additional information. YOU MUST CONTACT THE BENEFIT OFFICE PROMPTLY AFTER QUALIFYING FOR ASSISTANCE UNDER THE TRADE ACT OF 2002 OR YOU WILL LOSE YOUR SPECIAL COBRA RIGHTS.

M. EXTENDED COVERAGE FOR SOME RETIRED ELIGIBLE EMPLOYEES AND THEIR ELIGIBLE DEPENDENTS

Certain individuals may be eligible for continued benefits on a self-pay basis after retirement. See Section 14. of this Booklet. Retired Eligible Employee coverage is an alternative to COBRA. If you choose COBRA at the time of your retirement, you will not be able to choose Retired Eligible Employee coverage later.

In the event your eligible covered dependent subsequently loses Retired Eligible Employee coverage due to circumstances that would be considered a COBRA Qualifying Event prior to the end of the 36-month period following the start of your Retired Eligible Employee coverage, your dependent is entitled to elect to receive COBRA coverage for the balance of that 36-month period. Those COBRA Qualifying Event circumstances include your becoming divorced or legally separated from your eligible covered spouse and your eligible covered dependent losing dependent status under the Plan. The COBRA notice, election and payment provisions described in Subsection F. above govern the administration of this period of COBRA continuation coverage as well.

---

[1] https://www.medicare.gove/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods.

SECTION 6. MEDICAL BENEFITS

A. SCHEDULE OF BENEFITS

Set forth below is a Schedule of Medical Benefits for Eligible Employees, Retired Eligible Employees who are not Medicare eligible, and their respective eligible dependents.

This Schedule of Medical Benefits summarizes your responsibility towards the cost of certain covered services. Detailed explanations of the various benefits and the limitations and exclusions that apply follow this schedule.

To receive Network benefits, all covered services, except for Emergency services, must be performed or referred by a participating Network Provider or authorized in advance by the Plan.

All services must be Medically Necessary as a condition of coverage and not otherwise limited or excluded.

You should obtain prior authorization for certain benefits listed below. See the Prior Authorization and Predetermination for Medical and Behavioral Care Services subsection following this Schedule of Medical Benefits for more information on prior authorization and the benefits that are subject to prior authorization.

Please note the Plan's claims limitation periods in Section 18.

BENEFITS AND SERVICES		ELIGIBLE EMPLOYEE RESPONSIBILITY	
		Tier 1 Network	**Tier 2 Out-of-Network**
1.	**Annual Deductible** The amount you are required to pay each calendar year before the Plan pays any benefit other than preventive care. Your Covered Charges are accumulated from each tier to determine if you have met the Deductible for each tier. The annual Deductible need only be met once per Covered Individual per calendar year. Co-payments do not count toward the annual Deductible.	Individual ..... $400 Family $800	Individual .....$500 Family $1,000

BENEFITS AND SERVICES		ELIGIBLE EMPLOYEE RESPONSIBILITY	
		Tier 1 Network	**Tier 2 Out-of-Network**
2.	**Annual Out-of-Pocket Maximum** The limit on the total amount you are required to pay in a calendar year for in-network Covered Charges before the Plan pays 100% of in-network covered benefits. Your Covered Charges are accumulated from the Tier 1 Network benefit tier to determine if you have reached the Out-of-Pocket Maximum. The annual Out-of-Pocket Maximum need only be met once per covered individual per calendar year. The Out-of-Pocket Maximum does not apply to Vision or Dental Benefits. There is a separate limit on the total amount you are required to pay in a calendar year for Prescription Benefits before the Plan pays 100% of Covered Charges from Participating Pharmacies. Your Prescription Benefits are accumulated from the Participating Pharmacy tier to determine if you have reached the Out-of-Pocket Maximum. The annual Out-of-Pocket Maximum need only be met once per covered individual per calendar year. The difference in cost between an available and medically appropriate generic drug and a multi-source brand drug does not count toward the Out-of-Pocket Maximum. Co-payments, Co-Insurance, and the annual Deductible count toward the Out-of-Pocket Maximum.	<u>Medical</u>: Individual.....$4,000 Family .....$5,000 <u>Prescription Drugs</u>: Individual.....$2,600 Family $8,200	<u>Medical</u>: Individual / No Maximum Family / No Maximum <u>Prescription Drugs</u>: Individual / No Maximum Family / No Maximum
3.	**Physician Office Visit – Preventive Care** Services include routine health assessment, well-woman care, well-child care, immunizations, hearing test, annual self-referred gynecological examination and pap smear, colonoscopies, PSA tests, mammogram screening, obesity screening, and other services determined to be preventive care, in accordance with and as required by the Patient Protection and Affordable Care Act and the standards established by that law, including the United States Preventative Services Task Force A and B recommendations, the Advisory Committee on Immunization Practices of the CDC, the Health Resources and Services Administration guidelines, and the American Academy of Pediatrics *Bright Futures* guidelines.	Co-pay, Deductible and Co-insurance do not apply.	After Deductible is met, 40% Co-insurance applies.

BENEFITS AND SERVICES		ELIGIBLE EMPLOYEE RESPONSIBILITY	
		Tier 1 Network	**Tier 2 Out-of-Network**
4.	**Physician Office Visit – Medical Services** Primary and specialty care physician office visit only.	$15 Co-pay per visit, then Deductible.	After Deductible is met, 40% Co-insurance per visit applies.
	Other services in office setting.	After Deductible is met, 10% Co-insurance per visit applies.	After Deductible is met, 40% Co-insurance per visit applies.
5.	**Chiropractic Services** Office visit only.	$15 Co-pay per visit, then Deductible.	Only covers spinal manipulation and manual medical intervention services. After deductible is met 40% Co-insurance per visit applies
	Other services in office setting. Maximum of 60 visits per calendar year for Network and Out-of-Network benefits combined; only 26 of those visits can be Out-of-Network.	After Deductible is met, 10% Co-insurance per visit applies.	Not covered.
6.	**Emergency Room Services** Coverage is provided for worldwide Emergency health services as defined in this Booklet.	$75 Co-pay per visit, then Deductible. After Deductible is met, 10% Co-insurance applies. Co-pay is waived if admitted to hospital.	$75 Co-pay per visit, then Deductible. After Deductible is met, 10% Co-insurance applies. Co-pay is waived if admitted to hospital.
7.	**Emergency Ambulance Services** Coverage is provided for Emergencies as defined in this Booklet. Please refer to Section 6.F.3.b. below.	After Deductible is met, 10% Co-insurance per occurrence.	After Deductible is met, apply Co-insurance per occurrence based on the tier of the facility to which the Covered Individual is transported (10% (Tier 1 Network) or 40% (Tier 2 Out-of-Network)).

BENEFITS AND SERVICES		ELIGIBLE EMPLOYEE RESPONSIBILITY	
		Tier 1 Network	**Tier 2 Out-of-Network**
8.	**Urgent Care Services** Physician office visit only.	$15 Co-pay per visit, then Deductible.	After Deductible is met, 40% Co-insurance applies.
	Other services in Urgent Care setting.	After Deductible is met, 10% Co-insurance applies.	After Deductible is met, 40% Co-insurance applies.
9.	**Physician Care – Maternity** Covered services include routine pre-natal examinations, tests and educational services, and, if included in a customary global physician package for pre-natal care, other physician services for mother and delivery.	Co-pay, Deductible, and Co-insurance do not apply.	After Deductible is met, 40% Co-insurance. No coverage for dependent child pregnancy.
	Other services in office setting, including post-natal care for Eligible Employee or spouse only. No coverage for dependent child post-natal care or other services not required as preventive care. Co-payment, Deductible and Co-insurance do not apply to maternity services when provided by a Network Provider and that are determined to be preventive care in accordance with and as required by the Patient Protection and Affordable Care Act and the standards established by that law. (See the "Physician Office Visit – Preventive Care" section of this Schedule of Benefits.)	After Deductible is met, 10% Co-insurance applies.	After Deductible is met, 40% Co-insurance applies for Eligible Employee and/or spouse.
10.a.	**Maternity Care at Inpatient Hospital – Eligible Employee or Spouse** Includes newborn nursery services and hospital facility charges. Covered services include semi-private room.	$100 Co-pay per day up to $500 per stay, then Deductible. After Deductible is met, 10% Co-insurance per admission applies.	After Deductible is met, 40% Co-insurance per admission applies.
10.b.	**Maternity Care at Inpatient Hospital – Dependent Child** No other costs of dependent child pregnancy are covered and no coverage is provided for postnatal care of dependent child's newborn.	No coverage.	No coverage.

BENEFITS AND SERVICES		ELIGIBLE EMPLOYEE RESPONSIBILITY	
		Tier 1 Network	**Tier 2 Out-of-Network**
11.	**Outpatient Services and Diagnostic Procedures and Tests** Coverage includes diagnostic procedures and tests, including but not limited to lab and radiology. Certain procedures and tests are considered surgery, including but not limited to colonoscopy and endoscopy. Refer to the Outpatient Surgery section below. Co-payment, Deductible and Co-insurance do not apply to services, procedures and tests when provided by a Network Provider and that are determined to be preventive care in accordance with and as required by the Patient Protection and Affordable Care Act and the standards established by that law. (See the "Physician Office visit – Preventive Care" section of this Schedule of Benefits.)	After Deductible is met, 10% Co-insurance applies.	After Deductible is met, 40% Co-insurance applies.
12.	**High Technology Diagnostic Services, Tests and Procedures** Including, but not limited to: MRI, MRA, CT Scans, Thallium Scans, Nuclear Stress Tests, PET Scans, Echocardiograms and Ultrasounds (regardless of where service is performed).	After Deductible is met, 10% Co-insurance per visit applies.	After Deductible is met, 40% Co-insurance per visit applies.
13.	**Outpatient Surgery** Outpatient Hospital Benefits are provided for covered services rendered at an outpatient Hospital. Ambulatory Surgery Center Out-of-Network Ambulatory Surgery Center is not covered.	After Deductible is met, 10% Co-insurance applies. After Deductible is met, 10% Co-insurance per visit applies.	After Deductible is met, 40% Co-insurance applies. Not covered.
14.	**Inpatient Hospital Services** Coverage is provided for physician and surgeon services, semi-private rooms, operating rooms and related facilities, intensive and coronary care units, laboratory, x-rays, radiology services and procedures, medications and biologicals, anesthesia, special duty nursing as prescribed, short-term rehabilitation services, nursing care, meals and special diets.	$100 Co-pay per day up to $500 per stay, then Deductible. After Deductible is met, 10% Co-insurance per admission applies.	After Deductible is met, 40% Co-insurance per admission applies.

BENEFITS AND SERVICES		ELIGIBLE EMPLOYEE RESPONSIBILITY	
		Tier 1 Network	**Tier 2 Out-of-Network**
15.	**Skilled Nursing Facility** Coverage is provided in lieu of an inpatient Hospital admission for a semi-private room. Maximum of 90 days per calendar year for Network and Out-of-Network benefits combined.	After Deductible is met, 10% Co-insurance per admission applies.	After Deductible is met, 40% Co-insurance per admission applies.
16.	**Home Health Care** Maximum of 100 visits per calendar year for Network and Out-of-Network benefits combined.	After Deductible is met, 10% Co-insurance per visit applies.	After Deductible is met, 40% Co-insurance per visit applies.
17.	**Hospice Care** Available as long as a Physician certifies that the Covered Individual is terminally ill with a life expectancy of less than six months. Hospice care includes coverage for patient counseling and for up to 15 bereavement counseling visits paid at 50% for family members per calendar year.	After Deductible is met, 10% Co-insurance per inpatient day or hospice care visit applies.	After Deductible is met, 40% Co-insurance per inpatient day or hospice care visit applies.
18.	**Durable Medical Equipment** Coverage is provided for the Usual and Reasonable Charge for the purchase or rental of covered equipment, as appropriate. Co-payment, Deductible and Co-insurance do not apply to the rental or purchase of breastfeeding equipment during breastfeeding after the birth of a child or other items when provided by a Network Provider which are determined to be preventive care in accordance with and as required by the Patient Protection and Affordable Care Act and the standards established by that law. (See the "Physician Office Visit – Preventive Care" section of this Schedule of Benefits.)	After Deductible is met, 10% Co-insurance applies.	After Deductible is met, 40% Co-insurance applies.
19.	**Physical, Occupational, Speech, Vision, Cardiac and Pulmonary Therapy** Coverage is provided for outpatient rehabilitation for Physical Therapy, Occupational Therapy, Speech Therapy, medically necessary vision therapy, and cardiac and pulmonary therapies.	After Deductible is met, 10% Co-insurance per visit applies.	After Deductible is met, 40% Co-insurance per visit applies. Limited to 30 visits per calendar year, except cardiac and pulmonary therapies which are not subject to visit limits.

BENEFITS AND SERVICES		ELIGIBLE EMPLOYEE RESPONSIBILITY	
		Tier 1 Network	**Tier 2 Out-of-Network**
20.	**Medically Supervised Weight Loss Program** A $100 Deductible per calendar year applies in addition to the overall Annual Deductible. Maximum lifetime benefit of $1,500.	After both Deductibles met, 10% Co-insurance per visit applies.	After both Deductibles met, 40% Co-insurance per visit applies.
21.	**Bone Growth Stimulators** Maximum of $2,000 per procedure.	After Deductible is met, 10% Co-insurance per visit applies.	After Deductible is met, 40% Co-insurance per visit applies.
22.	**Transplants** Coverage includes replacement of organs or tissues.	After Deductible is met, 10% Co-insurance applies.	After Deductible is met, 40% Co-insurance applies.
23.	**Hearing Aid Benefits**	$25 Co-pay per hearing aid. Maximum benefit of $1,500 per hearing aid and one hearing aid per ear in a 48-month period.	
24.	**Behavioral Care Inpatient Services**	$100 Co-pay per day up to $500 per stay, then Deductible. After Deductible is met, 10% Co-insurance applies.	After Deductible is met, 40% Co-insurance applies.
25.	**Behavioral Care Outpatient Services** Licensed Behavioral Care provider office visit only. Other outpatient services.	$15 Co-pay per visit, then Deductible. After Deductible is met, 10% Co-insurance applies.	After Deductible is met, 40% Co-insurance applies. After Deductible is met, 40% Co-insurance applies.
26.	**Tobacco Cessation** Services include screening for tobacco use, counseling, and interventions. Limit of two tobacco cessation attempts per calendar year. Each tobacco cessation attempt limited to four tobacco cessation counseling sessions of at least 10 minutes each (including telephone counseling, group counseling and individual counseling) and a prescription for a 90-day treatment regimen, including all Food and Drug Administration (FDA)-approved tobacco cessation medications (including both prescription and over-the-counter medications), when prescribed by a heath care provider.	No charge.	After Deductible is met, 40% Co-insurance applies.

BENEFITS AND SERVICES		ELIGIBLE EMPLOYEE RESPONSIBILITY	
		Tier 1 Network	Tier 2 Out-of-Network
27.	**Telemedicine Services provided by Teladoc** Telemedicine services other than those provided by Teladoc are subject to Co-pay, Deductible and Co-insurance applicable to an office visit with the provider.	No charge.	No charge.

NOTE: Effective March 1, 2020 and until such time as determined by the Trustees in accordance with applicable law, COVID-19 testing performed by Network and Out-of-Network providers shall be covered at 100% with no co-pay and no deductible as long as such testing is:

- Medically Necessary,
- consistent with guidelines established by the Centers for Disease Control and Prevention (CDC), and
- not covered by the CDC or a state program or agency.

In addition, the cost of the initial physician's office, telemedicine, emergency room or urgent care visit that results in an order for testing for COVID-19 shall be covered at 100% with no co-pay and no deductible. Treatment for COVID-19 will remain at the normal Plan benefit as stated herein.

NOTE: The reasonable cost of immunizations for COVID-19, and the accompanying office visit shall be covered at 100% with no Co-pay, Co-insurance or Deductible for both Network and Out-of-Network providers through the end of the COVID-19 Public Health Emergency as declared by the U.S. Department of Health and Human Services.

B. PRIOR AUTHORIZATION AND PREDETERMINATION FOR MEDICAL AND BEHAVIORAL HEALTH CARE BENEFITS

YOU ARE REQUIRED to obtain prior authorization for all Hospitalizations and certain other benefits provided under the Plan before the services are rendered or the supplies are received, as more fully discussed below. If prior authorization of those benefits is not obtained, a claim for those benefits under the Plan may be denied regardless of whether the service or supply is otherwise covered by the Plan, and you may be responsible for the full cost of the service or supply.

If you receive services or supplies that are subject to prior authorization and your health care provider is a Network Provider, the Network Provider is responsible for obtaining the required prior authorization. If your health care provider is an Out-of-Network Provider, you or your Out-of-Network Provider should contact the Medical Network and Managed Care Administrator or the Behavioral/Mental Health Administrator, as applicable, to obtain the required prior authorization (as more fully discussed below). In any event, you are responsible for obtaining prior authorization if your Out-of-Network Provider fails to do so, and you may be responsible for the full cost of the service or supply if prior authorization is not obtained.

It is also VERY IMPORTANT that you obtain predetermination before services are rendered or supplies are received, in order to confirm that you are eligible for coverage under the Plan and that the proposed services or supplies are covered by the Plan, as more fully discussed below.

1. Prior Authorization

Prior authorization is a process for confirming that proposed services and supplies are considered by the Plan to be Medically Necessary and appropriate. This includes evaluation of the Medical Necessity and appropriateness of the proposed service or supply as well as where the service or supply is provided (e.g., whether Hospitalization is Medically Necessary and appropriate and the duration).

To obtain prior authorization of Hospitalization, surgery and other services, you, your physician or Hospital should contact the Medical Network and Managed Care Administrator or the Behavioral/Mental Health Administrator, as applicable, by calling the telephone number shown on your medical ID card. When prior authorization of Hospital care is requested, the Medical Network and Managed Care Administrator or the Behavioral/Mental Health Administrator, as applicable, will conduct ongoing review of the Hospital stay (called concurrent review) in order to ensure the Medical Necessity of all care provided.

Prior authorization applies for all medical inpatient care, all Behavioral inpatient Care benefits, most outpatient medical services, and a number of other services and supplies. A complete list of all services and supplies that are subject to prior authorization can be obtained by using the prior authorization contact information for the Medical Network and Managed Care Administrator or the Behavioral/Mental Health Administrator, as applicable, provided on the Insert to this Booklet, or by referring to the back of your medical ID card.

2. Predetermination

Predetermination is a process for confirming that proposed services and supplies are covered by the Plan and that the patient is eligible for coverage under the Plan.

To obtain predetermination of coverage and eligibility, you should refer to the back of your medical ID card.

3. Response to Prior Authorization and Predetermination Requests

You and your physician will be notified in writing of the decision made by the Medical Network and Managed Care Administrator or the Behavioral/Mental Health Administrator, as applicable, in response to your request for prior authorization or predetermination. Caution should be taken not to incur expenses until you receive such written notification.

4. Review of Prior Authorization and Predetermination Decisions

If you or your physician disagrees with a prior authorization or predetermination decision, you or your physician may contact the Medical Network and Managed Care Administrator or the Behavioral/Mental Health Administrator, as applicable, to review the situation. If you disagree with the decision, you may submit a written appeal to the Medical Network and Managed Care Administrator or the Behavioral/Mental Health Administrator, as applicable, as described in Section 18. of this Booklet. Or you may obtain the services and, when the claim is submitted after the services have been performed, the claim will be reviewed by the Plan without deference to the negative predetermination decision. If retrospective review results in a determination that the services are not Medically Necessary or appropriate, you may be responsible for incurred expenses.

C. USE OF NETWORK PROVIDERS

The Plan has an agreement with the Medical Network and Managed Care Administrator identified in the Insert to this Booklet to provide you and your dependents with access to a network of doctors, Hospitals and other medical care providers (Network Providers), who will provide services and supplies at negotiated rates that are typically lower than the rates of Out-of-Network providers.

The amounts due from you will be determined by whether the facility is a Tier 1 – Network Provider or a Tier 2 – Out-of-Network Provider. The Deductible, Co-payments, and Co-insurance you pay at a Network Provider are generally significantly lower than the Deductible, Co-payments and Co-insurance you must pay when you use an Out-of-Network Provider.

Further, when you or your dependent uses a Network Provider, the Plan will treat the Network Provider's entire charge for covered services as covered. This is because the Medical Network and Managed Care Administrator has negotiated with the Network Providers for specific fees for covered services. By contrast, when you or a dependent uses an Out-of-Network Provider, the Plan will not cover any portion of that Out-of-Network Provider's charges which exceed the Usual and Reasonable Charges for the covered services you or your dependent receives. (See definition of Usual and Reasonable Charge in the Definitions in Section 1. of this Booklet). So, not only do you have to pay a higher Deductible and a Co-insurance, you will be responsible for paying any part of the Out-of-Network Provider's charges that are in excess of the Usual and Reasonable Charge.

Please note there are some services and supplies which are simply not covered unless you use Network Providers.

D. GEOGRAPHICAL RESTRICTION

Care is restricted to inpatient and outpatient facilities inside the Geographic Area of this Plan, as defined in Section 1.B., unless:

1. Comparable services are not available within the Geographic Area of the Plan; or
2. Such care is a medical emergency requiring immediate attention (see Section 1.B., "Emergency", for a definition of emergency care);
3. You are wait-listed for the care for a time period that is unreasonable for the medically necessary service, and such wait-listing can only be avoided by going to a facility outside of the Geographic Area.

E. MAXIMUMS, DEDUCTIBLES AND CO-PAYMENTS

1. Calendar Year Deductible

a. Individual Deductible

The Deductible, as listed in the Schedule of Benefits, is the amount of Covered Charges that must be incurred by a Covered Individual after paying any applicable Co-payment before the Plan will pay benefits. The Covered Individual is responsible for the calendar year Deductible before the Plan pays any benefits other than preventive care. The Deductible is normally applied to the first Covered Charges the person incurs and for which the Plan receives claims. Co-payment amounts do not count toward the calendar year Deductible.

b. Family Deductible

When, in a calendar year, the total of all Covered Charges applied toward satisfaction of individual Deductibles among all the covered members of your family equal the amount of two individual Deductibles, as listed in the Schedule of Benefits, no further Deductible amount will be required for any covered family member.

c. Accumulation of Covered Charges

Your Covered Charges are accumulated from both tiers of benefits (Tier 1 Network and Tier 2 Out-of-Network) to determine if you have met the Deductible for each tier.

d. Carry-Over

If Covered Charges are incurred during October, November or December of a calendar year that are applied towards that year's Deductible amount, those same charges will be used to help satisfy the Deductible for the following calendar year.

e. Common Accident

If two or more covered members of your family are injured in the same Accident, only one individual Deductible amount will be subtracted from all covered family members as the result of that accident during the rest of the calendar year in which the Accident occurred.

2. Co-payment (Co-pay) Amounts

For certain covered services, you are responsible for a Co-payment amount before the Plan pays any benefits. The Co-payment must be paid before the calendar year Deductible and the Co-insurance amount are applied. Co-payments should be paid directly to the provider at the time of service. Co-payment amounts will NOT be applied towards the calendar year Deductible.

Each time a Covered Individual visits an emergency room for any reason, the person must pay a Co-payment of $75. Emergency room care rendered outside the Tier 1 – Network geographic

coverage area (as determined by the Medical Network and Managed Care Administrator) will be paid as if the care were rendered in a Tier 1 – Network emergency room.

3. Co-insurance

Co-insurance is the amount you pay after first making any applicable Co-payment and then satisfying the calendar year Deductible. For all benefits, it requires you to cost-share 10% (for Tier 1 – Network benefits) or 40% (for Tier 2 – Out-of-Network benefits other than emergency room care, which is 10%). After you have paid any applicable Co-payment and then satisfied the calendar year Deductible for the balance of the Covered Charges, you are required to pay the percentage shown in the Schedule of Benefits under "Eligible Employee Responsibility." The Plan's share of the balance of the Covered Charges is the remaining percentage.

4. Preventive Care

Preventive care services obtained from a Network Provider are covered at 100% and are not subject to a Co-payment, Deductible or Co-insurance. These are services performed for screening purposes, and include colonoscopies, mammograms, pap smears, PSA tests and immunizations. A more detailed discussion of these services can be found in the Schedule of Benefits. Preventive care services obtained from an Out-of-Network Provider are subject to any applicable Co-payment, Deductible and Co-insurance shown in the Schedule of Benefits.

5. Network Benefits for Out-of-Network Providers

a. Benefits for services and supplies received from emergency room physicians, anesthesiologists, radiologists or pathologists who are Out-of-Network Providers will be payable based on the Network participation level of the facility at which services are received (i.e., services received at a Network facility will be paid at the Network benefit level).

b. Benefits for Emergency ambulance services provided by an Out-of-Network provider will be payable based on the tier of the facility where the Covered Individual is transported. If the facility is a Tier 1 Network facility, the Emergency ambulance services are paid at the Tier 1 Network benefit level (10% Co-insurance). For an Out-of-Network facility, the Emergency ambulance services are paid at the Tier 2 Out-of-Network benefit level (40% Co-insurance).

6. Out-of-Pocket Maximum

This is the maximum amount you and your family will pay in a calendar year.

F. COVERED CHARGES

1. Covered Medical Facility Charges

a. Hospital room and board and general nursing care up to:

(1) the actual amount charged for a ward or semi-private room;

(2) the actual amount charged for confinement in an intensive care unit or other special care unit of a Hospital such as coronary care; or

(3) the Hospital's average semi-private room rate for confinement in a private room (the cost of a private room will be paid if a private room is determined by the Plan to be Medically Necessary because the Covered Individual must be isolated from other patients because of Illness that is highly contagious or because the patient's immunodefense system has been so compromised that the patient must be protected from all bacteria).

b. All other Medically Necessary services and supplies furnished by a Hospital for patient care on an inpatient or an outpatient basis. (Personal comfort items and incidental items such as telephone or television are not covered services.)

c. Medically Necessary services and supplies furnished by a licensed network ambulatory surgical center or other licensed surgical site; Medically Necessary services and supplies furnished by a licensed urgent care facility.

d. Medically Necessary services and supplies furnished by a licensed birthing center when used in lieu of a Hospital for delivery of a child.

e. Confinement in a licensed Skilled Nursing Facility, subject to the following conditions:

(1) the confinement is not for routine Custodial Care;

(2) the doctor visits the patient at least once each seven days; and

(3) if extended care was not available, the patient would need to remain hospitalized.

If these conditions are met, benefits are available for the facility's usual semi-private charge for daily care to a maximum of 90 days of extended care facility confinement in a calendar year.

f. The following hospice care services and supplies furnished by a licensed hospice for a terminally ill person with a life expectancy of less than six months:

(1) room and board for confinement in a hospice;

(2) services and supplies furnished by the hospice while the patient is confined there;

(3) part time nursing care by or under the supervision of a registered nurse (RN);

(4) home health aide services;

(5) nutrition services;

(6) special meals;

(7) counseling services by a licensed social worker or a licensed pastoral counselor;

(8) bereavement counseling by a licensed social worker or a licensed pastoral counselor for the patient's immediate family following the patient's death, subject to the following:

(a) 50% of the Reasonable and Customary charges for such services will be paid;

(b) a maximum of 15 visits will be covered for the patient's immediate family; and

(c) such services will only be covered during the six-month period following the patient's death.

g. The following home health care services are covered if furnished by a licensed home health care agency, if such care is provided in lieu of confinement in a Hospital or Skilled Nursing Facility, and if the patient is under the direct care of a doctor who has established a written treatment plan, which is certified at least once every month, and that doctor visits the patient at least once every 60 days:

(1) part-time or intermittent nursing care by a licensed practical nurse (LPN) or a registered nurse (RN);

(2) part-time or intermittent home health aide services;

(3) Occupational Therapy, provided such therapy is performed by a licensed therapist (if licensing is required in the state where therapy is performed);

(4) social work, performed by a licensed social worker if licensing is required in the state where services are performed; if not, a master's degree in social work and at least one or more years of clinical experience are required;

(5) home infusion services;

(6) nutrition service, performed by a licensed nutritionist (if licensing is required in the state where performed); and

(7) special meals.

A maximum of 100 home health care visits are covered in a calendar year (services not specifically listed here may be covered if pre-approved by the Plan as part of the written home health care plan).

Note: If you or your dependent needs home health care services, you must submit a written home health care plan to the Medical Network and Managed Care Administrator for prior authorization.

Home health care benefits are not available for:

(1) charges you are not legally obligated to pay;

(2) services rendered by members of the immediate family or persons residing in the patient's home;

(3) general housekeeping services;

(4) Custodial Care, except services rendered directly to the patient and the patient's surrounding area; or

(5) services and supplies not specifically listed as covered home health care charges.

Note: If benefits are paid under the hospice or home health care provisions of the Plan, those services will not be considered eligible for payment under any other Plan provision.

2. Covered Professional Services

a. Services of a doctor for:

(1) medical care, including home and office visits, when such services are rendered in the presence of the patient (either physically or by telephone or video);

(2) performing surgical procedures;

(3) diagnostic services; and

(4) charges for pap smears, well-childcare, mammograms, physical examinations not required for employment, and immunizations.

b. Private duty nursing by a registered nurse (RN), or private duty nursing by a licensed practical nurse (LPN) if rendered to a patient confined as a bed patient in a Hospital;

c. Physical Therapy and treatment by a licensed Physical Therapist and Occupational Therapy by a licensed Occupational Therapist and Speech Therapy rendered by a Speech Therapist. (See Special Provisions later in this Section for limitations);

d. X-ray examinations; microscopic and laboratory tests; diagnostic services; x-ray or radioactive therapy (these services are not available for dental care);

e. Attendance of a certified or licensed nurse midwife at the birth of a child instead of a doctor;

f. Telemedicine Services.

g. The following services rendered by a Physician Assistant or Nurse Practitioner are covered, provided:

- the Physician Assistant or Nurse Practitioner is employed by a licensed physician or clinic, which also employs supervisory physician;
- services are rendered under the supervision of the employing physician or clinic; and
- the employing physician or clinic and Physician Assistant or Nurse Practitioner are Network Providers.

Drugs, medications, devices, therapies or services rendered, furnished or prescribed by a Physician Assistant or Nurse Practitioner must be rendered, furnished or prescribed

pursuant to a supervision agreement that is specific to the clinical condition diagnosed and treated by the supervising physician.

(1) Covered Physician Assistant/Nurse Practitioner services include:

(a) taking patient histories;

(b) performing physical examinations;

(c) performing or assisting in the performance of routine laboratory and patient screening procedures;

(d) performing routine therapeutic procedures;

(e) recording diagnostic impressions and evaluating situations calling for attention of a physician to institute treatment procedures;

(f) instructing and counseling patients regarding mental and physical health using procedures reviewed and approved by the employing physician;

(g) assisting the supervising physician in institutional settings, including review of treatment plans, ordering tests, diagnostic laboratory and radiological procedures and therapies, and using procedures reviewed and approved by the employing physician; and

(h) assisting at surgery, provided that expenses for surgical assistance to a Network Provider physician are billed by the Network Provider physician.

(2) The following Physician Assistant/Nurse Practitioner services are not covered by the Plan:

(a) services or tasks prohibited by law;

(b) services not rendered under the supervision of a physician;

(c) services that the Physician Assistant or Nurse Practitioner has not adequately been trained or is not proficient to perform;

(d) abortion;

(e) lenses, prisms and contact lenses for the aid, relief or correction of vision or the measurement of visual power or acuity;

(f) administration or monitoring of general or regional block anesthesia during diagnostic tests, surgery or obstetrical procedures; and

(g) expenses for surgical assistance billed by a Hospital or surgical facility or an independent Physician Assistant, Nurse Practitioner or Out-of-Network Provider physician.

(3) Level of Reimbursement for Physician Assistant/ Nurse Practitioner Services

Covered Charges for services rendered by a Physician Assistant or Nurse Practitioner are paid at the same benefit level as if a physician had rendered the services. Such Covered Charges are subject to the Plan's applicable Network reimbursement level and subject to all of the Plan's limitations and exclusions.

Note: Professional services are not eligible for payment if they are rendered by any person who ordinarily lives with you, or who is related by blood, marriage or legal adoption to you or your spouse.

3. Covered Miscellaneous Services and Supplies

a. Anesthetics and their professional administration, including general anesthesia under limited circumstances in connection with a dental procedure as provided in and subject to the provisions of Section 10., Subsection C.5. of this Booklet;

b. Medically Necessary transportation by professional ambulance service, railroad, or regularly scheduled airline flight to and from the nearest Hospital equipped to treat the patient's illness. All transportation must be within the United States and Canada;

c. Any of the following Medical Supplies when recommended by a doctor:

(1) blood and other fluids to be injected into the circulatory system (to the extent blood is not donated or replaced by anyone);

(2) artificial limbs and eyes — initial purchase and replacement if medically necessary due to biological and medical changes and not solely to upgrade (repairs are not covered, unless determined by the Plan to be cost-effective);

(3) casts, splints, trusses, braces and crutches;

(4) surgical dressings;

(5) rental of hospital type equipment, including a wheelchair and a hospital bed;

(6) rental of an iron lung or other mechanical equipment to help with breathing and treatment of respiratory paralysis, or other Durable Medical Equipment;

(7) rental of equipment for the administration of oxygen and the cost of oxygen;

(8) continuous passage airway pressure machine;

(9) bone growth stimulators up to a maximum of $2,000 per procedure;

(10) orthopedic shoes for a patient treated for diabetes (limited to two pair during each 12-month period); and

(11) custom orthotic shoe inserts limited to one pair during a 12-month period.

Note: If your doctor recommends any type of medical equipment, you are encouraged to contact the Benefit Office to find out whether it will be covered and what the reasonable cost of such equipment is. The Plan will cover only the part of the cost which it determines is a Usual and Reasonable Charge for that medical equipment. Before you purchase any piece of equipment, the Medical Network and Managed Care Administrator can tell you what a Usual and Reasonable Charge is. Prices charged by providers can vary dramatically, so it is in your best interest to contact the Medical Network and Managed Care Administrator. It will be less likely that you purchase equipment that is not covered by the Plan or that you purchase a piece of covered equipment but pay too much for it;

d. acupuncture services performed by a licensed acupuncturist or a licensed chiropractor;

e. foot care provided by a licensed health care professional;

f. insertion and removal of intrauterine devices (IUDs);

g. specialty drugs dispensed or administered by a physician or medical facility. Specialty drugs are drugs that are used in treating serious Illnesses and conditions such as cancer, hemophilia, growth hormone deficiency and rheumatoid arthritis, and which are sometimes administered by injection or infusion. The benefit is managed through the Medical Network and Managed Care Administrator, and is paid in accordance with the usual cost-sharing requirements;

h. cochlear implants and bone anchored hearing aids;

i. continuous positive airway pressure (CPAP) and bi-level positive airway pressure (BPAP) equipment, studies and tests.

4. Special Provisions/Maximum Allowances

a. Chiropractic Care

Charges for chiropractic care, including x-rays and other services rendered or prescribed by a licensed chiropractor for treatment of an Illness or Injury are limited to:

(1) one visit on any one day (visit means each time you see a chiropractor and all services furnished at that time regardless of the name given the treatment);

(2) up to the maximum number of visits in a calendar year set out in the Schedule of Benefits.

Limitations: All services prescribed or provided by a chiropractor are paid as chiropractic care. Services rendered for maintenance or comfort are not covered.

b. Physical or Occupational Therapy

Charges for Physical Therapy or Occupational Therapy for treatment of an Illness or Injury are limited to one visit on any one day (a visit means each time you see a therapist and all services furnished at that time, regardless of the name given the treatment). Out-of-Network visits are limited to the maximum number per calendar year set out in the Schedule of Benefits.

These limitations do not apply to therapy administered in a rehabilitation program approved by the Benefit Office and administered through case management procedures.

c. Speech Therapy

Charges for Speech Therapy performed by a licensed Speech Therapist under direct supervision of a physician for restorative Speech Therapy for speech loss or impairment due to an Illness or Injury, or due to surgery performed on account of an Illness or Injury, other than a functional nervous disorder. Out-of-Network visits are limited to the maximum number per calendar year set out in the Schedule of Benefits.

d. Temporomandibular Joint Syndrome or Dysfunction (TMJ) Surgery

Medically Necessary surgery for TMJ will be paid pursuant to the same rules as other surgical procedures, including medical facility, surgery and anesthesia Covered Charges. All other Medically Necessary TMJ treatment will be covered to the extent not covered under the Plan's dental provisions.

e. Dental Care

Although medical benefits are not generally available for dental care, an exception is made for Medically Necessary care and treatment of Accidental Injuries and damage to formerly sound natural teeth (including replacement of such teeth) and setting of a fractured or dislocated jaw needed because of an Accident. Treatment must start within 12 months after the date of the Accident, and charges must be incurred within 24 months after the date of the Accident. The individual must remain covered by this Plan during that time to receive these benefits. If such services are also covered under the Plan's dental benefits, dental benefits will be paid first and the balance of the charges will then be considered under this provision. All other treatment will be paid only under the dental benefits provisions of this Plan as provided under Section 10. of this Booklet.

f. Replacement of Organs or Tissue

Benefits will be available on the same basis as for any other Illness for any non-Experimental tissue or organ transplant in accordance with the rules described in the table below.

Situation	***Coverage***
The recipient is covered under this Plan and receives the organ from a cadaver.	The recipient's expenses, including the charge for the organ, are covered.
The recipient is covered under this Plan and receives the organ from a donor bank.	The recipient's expenses, including the charge for the organ, are covered.
The recipient and the donor are both covered under this Plan.	The donor's expenses are covered under the donor's claim.

Situation	***Coverage***
The recipient is covered under this Plan, and the donor's expenses are not covered under any other plan.	The donor's expenses are covered under the recipient's claim.
The recipient is covered under this Plan, and the donor's expenses are covered under another plan.	Only the recipient's expenses are covered.
The donor is covered under this Plan but the recipient is not.	The expenses of neither the donor nor the recipient are covered unless the recipient is a parent, sibling or child of the donor, in which case only the donor's expenses are covered.

Organ transplant expenses include:

- pre-transplant testing and consultation;
- all services and supplies incurred for the transplant procedure, including natural and artificial replacement materials;
- postoperative care in the Hospital (inpatient or outpatient);
- extended care in a facility or at home;
- pharmaceuticals and their administration, including but not limited to, high-dose chemotherapy or anti-rejection drugs;
- Durable Medical Equipment; and
- to the extent provided above, the donor's expenses.

g. Alternate Care Methods

In certain circumstances the Trustees may request a review of your treatment by a case management organization designated by the Trustees. If the case management organization recommends a special treatment program which is expected to result in less cost to the Plan and which is acceptable to the Trustees, the patient, and the patient's doctor, the expense of such special treatment program shall constitute a Covered Charge under the Plan.

Charges for the case management organization's fees and medical review fees will be paid as a medical expense under the Plan. Such fees will be payable at 100% and are not subject to the calendar year Deductible. Charges for services and supplies that are part of an approved alternate care treatment program will be paid according to regular Plan benefits.

Please contact the Benefit Office if your doctor or nurse case manager recommends alternative care that is not on the list of Covered Charges.

h. Maternity Expense Provision

The Plan covers you or your spouse's pregnancy or the routine pregnancy of your dependent child in-network. No coverage is provided for Hospital facility charges for pregnancy or delivery, newborn nursery services or other post-natal care of your dependent child's newborn.

Pursuant to federal law, the Plan will cover your or your spouse's Hospital stay of at least 48 hours for the mother and infant following a vaginal delivery, and at least 96 hours following delivery by caesarian section. However, the mother's or newborn's provider, after consulting with the mother, may discharge the mother or her newborn before the expiration of the 48-hour (or 96-hour, as applicable) period. In any case, the Plan may not, under federal law, require that a provider obtain authorization from the Plan for prescribing a length of stay not in excess of 48 hours (or 96 hours).

i. Abortions

Benefits are not provided for an elective abortion, unless carrying the fetus to full term would seriously endanger the life of the mother. If complications arise after the performance of any abortion, any Covered Charges incurred to treat those complications will be eligible, but the initial costs relating to the abortion will not be covered, except as noted in the prior sentence.

j. Newborn Care

Hospital and doctor care of a newborn baby will be considered Covered Charges. However, such charges will be paid under the baby's own claim, and will be subject to a Deductible and the Co-insurance shown in the Schedule of Benefits. The Hospital inpatient Co-payment will not apply to the baby's claim.

k. Medically Supervised Weight Loss Program

Participation in a non-surgical medically supervised weight loss program is covered up to $1500 in a Covered Individual's lifetime. You must be at least 50 pounds overweight, your doctor must certify weight loss is Medically Necessary, and your doctor must supervise the program.

Not all weight loss programs are covered. Contact the Medical Network and Managed Care Administrator to determine whether the program you are considering is covered and whether you meet the above eligibility requirements.

Benefits payable are subject to an additional Deductible and separate lifetime benefit maximum as shown in the Schedule of Benefits.

Payments are not made for food supplements or charges for services not actually received.

l. Preventive Care

Although benefits are not generally provided for procedures that are not Medically Necessary, charges for the following are covered under the Plan when performed in accordance with generally accepted medical guidelines:

(1) routine pap smears;

(2) routine mammograms;

(3) well-woman care;

(4) well-child care;

(5) lactation support and counseling;

(6) costs of renting or purchasing breastfeeding equipment;

(7) physicals and immunizations not required for employment;

(8) immunizations, including vaccines for Human Papilloma Virus (HPV);

(9) flu mist;

(10) routine colonoscopies; and

(11) other preventive services and items, in accordance with and as required by the Patient Protection and Affordable Care Act and the standards established by that law, including the United States Preventative Services Task Force A and B recommendations, the Advisory Committee on Immunization Practices of the CDC, the Health Resources and Services Administration guidelines, and the American Academy of Pediatrics *Bright Futures* guidelines.

m. Reconstruction Following Mastectomy

Reconstructive breast surgery benefits will be provided following a mastectomy in a manner determined in consultation with the attending doctor and patient for:

(1) all stages of reconstruction of the breast on which the mastectomy was performed;

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

(3) prostheses; and

(4) physical complications for all stages of a mastectomy, including lymphedema (swelling associated with the removal of the lymph nodes).

n. Food Supplements

The Plan generally does not cover over-the-counter drugs or food supplements. However, food supplements which are Medically Necessary and prescribed by a physician for a patient with cancer or end stage renal disease will be covered for a period not to exceed twelve months during the Covered Individual's lifetime, including the initial visit for nutrition counseling.

o. Home Health Care, Hospice Care and Physical, Occupational and Speech Therapy Visit Limitations

For purposes of applying the home health care, hospice care and Physical, Occupational and Speech Therapy visit limits, a visit is each four hours or each portion of four hours during which the benefit is received. For example, if a Covered Individual receives five consecutive hours of service, that will count as two visits.

p. Diabetes Counseling

One nutritional counseling session will be provided in conjunction with an initial diagnosis of diabetes.

G. EXCLUSIONS AND LIMITATIONS APPLICABLE TO ALL HEALTH BENEFITS

These limitations and exclusions govern all health benefits provided under this Plan to the extent applicable. You should note, however, that there are a number of other limitations. You should read the subsections about specific benefits to make sure you are aware of all of the limitations and exclusions.

If a dependent spouse or child is covered by another group health plan that is primary under this Plan's coordination of benefits rules and the benefits of the other plan are affected by the fact that the dependent is also covered under this Plan, no benefits of any kind will be provided under this Plan.

Example: The other plan would normally pay the first $1,000 of Covered Charges at 100% and then pays the remainder at 80%. But, because of this Plan's coverage, the other plan only pays the amounts above $1,000 that are not covered by this Plan. In this situation, this Plan will not pay any benefits. This rule takes precedence over any coordination of benefits rule to the contrary in the other plan.

No medical benefits of any sort are payable for any of the following:

1. charges for any services and supplies which are not Medically Necessary;
2. charges which would not have been made if the individual were not eligible for medical insurance or benefits;
3. charges which the Covered Individual is not legally obliged to pay;
4. charges which are in excess of the Usual and Reasonable Charges for the services performed by an Out-of-Network Provider and the materials furnished. (See definition in Section 1. of this Booklet);
5. charges for treatment by a doctor or other professional which is not within the scope of the doctor's or other professional's license;
6. charges for care, treatment, services or supplies that are Experimental or Investigative in nature with reference to the Illness being treated. (See definition in Section 1. of this Booklet);

7. charges for medical equipment whose primary function is for other than therapeutic treatment of an Illness or Injury;

8. charges for care, treatment or surgery on the teeth, gums or alveolar process, or dentures, appliances or supplies used in such care or treatment, except the Plan will pay dental charges arising out of an Accidental Injury as set forth above at Section 6., Subsection F.4.e. of this Booklet, and as provided under the Plan's dental benefits program set forth in Section 10. of this Booklet;

9. charges for the purchase of hearing aids and related charges, except as provided under the Plan's hearing aid benefits program set forth in Section 9. of this Booklet;

10. charges for the treatment of refractive errors, including but not limited to, eye exams, radial keratotomy procedures and other forms of surgery, except as provided under the Plan's vision benefits program set forth in Section 11. of this Booklet;

11. charges for eyeglasses and contact lenses or the fitting of them, except as provided under the Plan's vision benefits program set forth in Section 11. of this Booklet;

12. charges for any treatment for cosmetic purposes or for cosmetic surgery which are not medically necessary, including any complications resulting from such non-covered treatments or surgeries, except the Plan will pay for cosmetic treatment or surgery due solely to an Accidental Injury or solely to a birth defect, provided such treatment is undertaken as soon as it is medically feasible. Cosmetic surgery or treatment is surgery or treatment intended to alter (a) the texture or configuration of the skin or (b) the configuration or relationship with contiguous structures of and features of the human body, and that is performed primarily for psychological purposes that are not medically necessary or that does not correct or materially improve a bodily function. For specific information regarding reconstructive surgery following mastectomy, see Section 6., Subsection F.4.m. of this Booklet;

13. charges for Custodial Care;

14. charges made by an institution which is primarily a rest facility or facility for the aged (unless otherwise specifically included as a Covered Charge);

15. charges for Hospital stays beginning on Friday, Saturday or Sunday, unless surgery is performed within 24 hours of the admission or the admission is for an acute Illness or Injury requiring immediate medical attention;

16. charges incurred in an Out-of-Network ambulatory surgery center;

17. charges for in vitro fertilization, artificial insemination or any other artificial means of conception. This exclusion does not apply to other treatment rendered to treat or repair a medical condition that prevents conception;

18. complications of pregnancy of your dependent child will not be covered. In addition, no coverage is provided for your dependent child for delivery or for the newborn child, unless such services are part of the customary global physician package for pre-natal care. No out-of-network coverage is provided for the pregnancy of your dependent child;

19. charges for the surrogate pregnancy of any person;

20. charges for reversal of sterilization;

21. charges for gastric bypass, stomach stapling, laparoscopic adjustable gastric banding or any other surgical treatment of obesity including any complications resulting from such non-covered procedures;

22. charges in excess of $2,000 per procedure for bone stimulators;

23. charges for Vax-D treatments;

24. charges for genetic testing and counseling, except that genetic testing and counseling to assist in the treatment of an existing Illness will be covered;

25. charges for prophylactic surgery or treatment, except that prophylactic surgery or treatment to assist in the treatment of an existing Illness or to prevent a related Illness or to lessen the likelihood of reoccurrence of an existing Illness will be covered;

26. charges for services for attention deficit disorder, autism spectrum disorders, speech therapy and other behavioral and developmental disorders that are educational in nature or are available to a Covered Individual through a public school system or other government agency. See Section 8. of this Booklet for further details;

27. charges for drug testing in connection with a Covered Individual's employment or school;

28. charges for care or treatment due to any act of war, declared or undeclared;

29. charges for the treatment of any Illness or Injury that arises out of or in the course of any employment for any employer or any self-employment for which the Covered Individual is entitled to benefits under any worker's compensation or occupational disease law. The Trustees in their discretion may make conditional payment of benefits for such Injury or Illness, subject to completion and submission of the Plan's Reimbursement Agreement (which is available from the Benefit Office upon request);

30. charges for personal comfort items, including but not limited to: television, newspaper, telephone, books, slippers, etc.;

31. charges for air conditioners, air purifiers or humidifiers whether or not ordered by a doctor;

32. charges for treatment of an Injury or Illness resulting directly or indirectly from or occurring during the commission by the injured Covered Individual of a grossly reckless, willful or drug- or alcohol-induced act that constitutes a felony, involves violence, or a threat of violence, or in which the Covered Individual illegally used a firearm, explosive or other weapon likely to cause physical harm, as determined by the Plan and the Trustees in their sole discretion. For purposes of the preceding sentence, the term "grossly reckless" means the Covered Individual's total disregard for the consequences of the Covered Individual's actions. The lack of conviction or issuance of a citation by a law enforcement body is not conclusive as to whether the charges for Plan benefits resulted from or during the commission of a felony or other excluded act;

33. a claim submitted by a Network Provider outside of the time period provided under the Network Provider's contractual guidelines with the Medical Network and Managed Care Administrator or the Behavioral/Mental Health Administrator, as applicable, for which neither the Plan nor the Covered Individual will be liable for payment of the claim;

34. any service or supply not specifically listed or described as a Covered Charge;

35. charges for service, supplies, care, drugs or treatment related to gene therapy.

Note: This Section 6. does not apply to Retired Eligible Employees and dependents of Retired Eligible Employees who are covered by Medicare and an associated benefit under this Plan as described in Section 14.

SECTION 7. PRESCRIPTION DRUG BENEFITS

Prescription drug charges are payable only under this benefit and not under any other provision of the Plan.

A. WHAT WILL IT COST ME TO HAVE MY PRESCRIPTIONS FILLED?

The Plan includes the following prescription drug benefits to help make medications more affordable for Covered Individuals. You must be enrolled in the Plan to be eligible to receive prescription drug benefits. The prescription drug benefit is for Eligible Employees, Retired Eligible Employees who are not Medicare eligible, and their respective eligible dependents.

Your out-of-pocket costs for prescription drug benefits are capped at $2,600 for an individual or $8,200 for a family. Co-payments for prescription drug benefits count toward the prescription drug Out-of-Pocket Maximum. The difference in cost between an available and medically appropriate generic drug and a multi-source brand drug does not count toward the Out-of-Pocket Maximum.

B. PARTICIPATING NETWORK PHARMACIES

To obtain benefits you must have your prescriptions filled at one of the participating network pharmacies and you must use your prescription card. Participating network pharmacies have contracted with the Prescription Benefits Administrator to offer enrollees reduced prices for covered prescription drugs. Contracted retail pharmacies are included in the network. Network pharmacies can be located by contacting the Prescription Benefits Administrator listed in the contact information provided on the Insert to this Booklet. Benefits are also available through the Plan's mail order and specialty pharmacy program by contacting the Mail Order and Specialty Pharmacy listed in the contact information provided on the Insert to this Booklet.

C. NON-PARTICIPATING PHARMACIES

If a covered drug is purchased from a non-participating pharmacy or a participating network pharmacy when the Covered Individual's ID card is not used, the Covered Individual must pay the entire cost of the prescription.

D. LIMITED REIMBURSEMENT BENEFIT

Generally, you must obtain your prescriptions from a participating network pharmacy, you must use your Plan ID card and must pay the required Co-payment amount in order to receive the prescription drug benefits. However, under the very limited circumstances set forth here, the Plan will reimburse you for covered prescription drugs for which you pay the pharmacy full price.

1. If your name is omitted from the participating pharmacy's computer list of Covered Individuals at a time when you are, in fact a Covered Individual, and the participating network pharmacy requires you to pay for the prescription, the Plan will reimburse you for the amount it would have paid to the pharmacy if your name had been on the list and the drug was covered on the date is was dispensed.

2. If you purchase a drug from a non-participating pharmacy because you are unable to get to a participating network pharmacy or you are unable to find a participating network pharmacy that can provide the drug prescribed, the Plan will reimburse you for the amount it would have paid to a participating network pharmacy if the drug was covered on the date it was dispensed. You should note that the network of participating pharmacies is a very extensive nationwide network with hundreds of stores in the Metropolitan St. Louis area, and you will be expected to demonstrate to the satisfaction of the Trustees that you could not, in fact, get to a participating network pharmacy or get the drug in question from a participating network pharmacy in order to be entitled to reimbursement.

E. MAINTENANCE DRUGS

The Plan offers two options for you to fill prescriptions for maintenance drugs. After the initial 30-day fill of a maintenance medication, you may receive a quantity of medication prescribed by your physician, not to exceed a 90-day supply. The pharmacy that filled your initial supply may participate in the Retail 90 program and can refill your prescription with a 90-day supply. To determine if your pharmacy is a participating Retail 90 pharmacy, contact the Prescription Benefits Administrator at the contact information provided on the Insert to this Booklet.

After the initial filling of a maintance drug prescription, you may also order drugs using the Plan's mail order program through the Prescription Mail Order and Specialty Pharmacy. Please contact the Prescription Mail Order and Specialty Pharmacy at the contact information provided on the Insert to this Booklet for mail order forms and additional information.

You may also obtain up to a 90-day supply of maintenance drugs at retail pharmacies that participate in the Prescription Benefits Administrator's 90-day supply program. To find a participating pharmacy for this program, please use the Prescription Benefits Administrator's website or call their customer service department. Contact information for the Prescription Benefits Administrator is available on the Insert to this Booklet.

F. HOW DO I USE THE PRESCRIPTION DRUG PLAN?

You must obtain your prescriptions from a participating network pharmacy (see Subsection B. above) and use your prescription ID card.

Present your ID card when making a purchase and you will only be required to pay the applicable Co-pay amount. The Plan will pay the balance of the prescription cost based on a negotiated rate between the pharmacy and the Plan.

G. CO-PAYS

The following chart illustrates the Co-pay of the covered prescription item that will be your responsibility.

	Max. Day Supply	Generic Co-pay	Single-Source Brand Co-pay	Multi-Source Brand* Co-pay
Retail	30 days	$5.00	$25.00	$5 plus difference between brand and generic cost.
Mail Order/ Choice 90	90 days	$12.50	$62.50	$12.50 plus difference between brand and generic cost.

*A multi-source brand drug is a brand name drug that has a generic equivalent drug available, whereas a single-source brand drug is a brand name drug that does not have a generic equivalent drug available.

NOTE: The reasonable cost of immunizations for COVID-19 provided by participating network pharmacies and non-participating pharmacies shall be covered at 100% with no Co-pay through the end of the COVID-19 Public Health Emergency as declared by the U.S. Department of Health and Human Services.

Generic medications should be dispensed when available. Coverage for single-source brand or multi-source brand drugs is provided following the normal Co-pay and Co-insurance requirements above. If you purchase a brand name drug or high cost generic when a lower cost generic drug is available, you will be responsible for the generic Co-pay plus the difference between the brand or higher cost generic drug and the lower costing generic drug. That cost difference may be waived if your physician provides information to the Prescription Benefits Administrator that documents that you have tried the generic drug and the drug did not provide the desired or expected benefit. Your physician can send this information to the Prescription Benefits Administrator at the address or phone number provided in the Insert to this Booklet. Prescriptions for high cost generic drugs which were in place on December 31, 2019 shall be grandfathered and this provision shall not apply to those drugs.

When prescribed by a Physician and obtained from a participating network pharmacy, the Plan provides coverage without Co-pays or Co-insurance for FDA-approved generic and over the counter drugs and devices which are determined to be preventive care, in accordance with and as required by the Patient Protection and Affordable Care Act and the standards established by that law, including the United States Preventative Services Task Force A and B recommendations, the Advisory Committee on Immunization Practices of the CDC, the Health Resources and Services Administration guidelines, and the American Academy of Pediatrics *Bright Futures* guidelines, as appropriate. Coverage under this paragraph is limited to generic or over-the-counter drugs and devices, unless your physician provides information to the Prescription Benefits Administrator that document that you

have tried the generic or over-the-counter drug or device and the drug or device did not provide the desired or expected benefit. Your physician can send this information to the Prescription Benefits Administrator at the address or phone number provided in the Insert to this Booklet.

H. SPECIALTY DRUGS

Specialty drugs (pharmaceuticals, biotech or biological drugs) are indicated for the treatment of complex, chronic, rare, life threatening, and/or genetic conditions, including but not limited to: cancer, multiple sclerosis, chronic kidney failure, organ transplants, rheumatoid arthritis, Hepatitis C and HIV/AIDS. Specialty drugs have one or more of the following characteristics: (i) special administration, monitoring, management or handling requirements and a route of administration that includes oral, injection, topical, inhalation or implantation; (ii) administration by a physician or another specially trained licensed health care provider; (iii) availability only through a limited distribution network; (iv) orphan drug classification; (v) high cost; and/or (vi) reimbursable under a major medical provision of the Plan (see Section 6., Subsection F.3.g. for information on this benefit)or requiring non-standard billing and reimbursement practices. Some examples of specialty drugs include oral, combination anti-viral therapies, such as Harvoni or Sovaldi, and injectable treatments for hyperlipidemia, hemophilia, Factor VIII/von Willebrand Factor Complex, Alphanate, Kogenate FS, or similar anti-hemophiliac factor drugs.

You can use the Prescription Mail Order and Specialty Pharmacy to obtain specialty drug medications that are not dispensed or administered by a physician or medical facility. See Section 6., Subsection F.3.g. for information on Plan benefit for specialty drugs dispensed or administered by a physician or medical facility.

Specialty drugs that you can obtain directly may be subject to prior authorization or other clinical guidelines determined by the Prescription Benefits Administrator (see Subsection I below for more information on clinical guidelines). For mail order forms and additional information, please contact the Prescription Mail Order and Specialty Pharmacy at the contact information provided on the Insert to this Booklet.

I. CLINICAL GUIDELINES DESIGNED TO IMPROVE THE HEALTH OF COVERED INDIVIDUALS

In an ongoing effort to effectively manage your prescription drug benefits and promote the best possible medical outcomes for Covered Individuals, the Prescription Benefits Administrator's clinical department, in agreement with the Plan, has implemented clinical guidelines as part of your prescription benefit plan design. These clinical guidelines are known as First Fill Starter Quantity, Prior Authorization, Step Therapy, Quantity Limitations and other guidelines that the Prescription Benefits Administrator deems appropriate for particular drugs. The following is intended to explain these guidelines and their purpose, and to identify examples of common medications that are managed under these guidelines. Information about these clinical guidelines is also available by contacting the Prescription Benefits Administrator at the contact information provided on the Insert to this Booklet.

1. Why are clinical guidelines necessary

Clinical guidelines are necessary because there are certain medications that require closer review to support their benefit(s) to the patient. In order to deliver the safest, most effective and economical treatments possible, pharmacists, physicians, drug manufacturers, the Food and Drug Administration and other healthcare professionals developed these guidelines. Medications selected to be included for prior authorization, step therapy, quantity limits or other guidelines are typically newer, more expensive medications that may have off-label uses (not approved by the FDA), the potential to be used inappropriately, or less known side effects. Clinical guidelines may be applied to existing and newly approved medications.

In most cases, Eligible Employees and dependents taking one or more of the medications subject to review will not experience a delay in obtaining their medicine. You may experience a delay, however, if the appropriate documentation cannot be obtained immediately. If a delay occurs, we apologize for any inconvenience, but please understand that the purpose of this review is to make sure the medications are being dispensed for the appropriate reason and to protect the integrity of the prescription drug plan.

For further information regarding the clinical guidelines, please contact the Prescription Benefits Administrator at the contact information provided on the Insert to this Booklet. If you still have questions, you may contact the Benefit Office at (314) 644-2777 or toll free (800) 489-0228.

2. What is first fill starter quantity

To help reduce the volume of prescription drugs that may be wasted because a patient cannot tolerate or fails to benefit from a new medication, and to help avoid the harm caused when "leftover" drugs are taken by accident or inappropriately, all Covered Individuals are required to obtain coverage for a starter quantity of medication, not to exceed a 30-day supply, before the Covered Individual can obtain coverage for up to a 90-day as prescribed. A medication is considered new if you have not previously taken the medication, if it has not been filled for 6 months, if the strength or dosage form changes, or if you have not previously received coverage for the medication through the Plan.

3. What is prior authorization

Prior Authorization means that the Prescription Benefits Administrator will conduct a clinical review of certain medications prior to authorizing payment under the Plan. This review consists of two steps:

a. A medical diagnosis is obtained from the prescribing doctor (some medications may require additional information). Your pharmacist may supply the Prescription Benefits Administrator with the necessary information required to perform the review if the information is provided on the prescription, or your doctor can call or fax the appropriate medical documentation to the Prescription Benefits Administrator.

b. Clinical personnel at the Prescription Benefits Administrator then determine if the condition falls within the appropriate clinical guidelines, which are based on both clinical judgment and current medical literature. The decision of the Prescription Benefits Administrator's clinical department will determine if the medication in question will be covered by the Plan. Please refer to the list below for some common medications that require Prior Authorization.

Examples of drugs that require Prior Authorization are:

- Self-injectable medications that are not subcutaneous;
- Medications that can be used to treat conditions that are not a covered benefit;
- Medications that treat erectile dysfunction (Viagra, Cialis, Levitra, etc.).

4. What is a quantity limitation

Quantity Limitation means that the Plan will only cover a certain number of pills or units (i.e., injections or nasal spray bottles) each time you fill your prescription. This limitation is typically in place for medications that have an abuse potential, or for medications that have been deemed by the Food and Drug Administration (FDA) to be safe only in limited amounts or for short-term treatment. A Quantity Limitation is typically in place for only a limited number of medications; however, this clinical guideline may be added to newly approved medications as well.

J. REQUIRED PREFERRED FIRST-LINE SOURCE OF CERTAIN DRUGS

The Plan requires you to try a generic drug prior to extending coverage for certain brand name drugs. This generic drug first-line source requirement applies to the following drugs and/or drug categories covered by the Plan:

1. nonsteroidal anti-inflammatory drugs (NSAIDS) and Celebrex;
2. antihyperlipidemics (in other words, a cholesterol lowering agent);
3. peptic ulcer therapy.

K. INCLUSIONS, LIMITATIONS AND EXCLUSIONS

As used in this provision "prescription drug" means: a drug which by law must say "Caution: Federal Law Prohibits Dispensing without Prescription," and is prescribed for an FDA approved use or a well-documented standard of medical treatment. Certain medications may be covered (inclusions) or may not be covered (exclusions) under the prescription drug plan. The following is a list of therapeutic categories or drugs that are defined as included* or excluded* under the Plan:

*Please keep in mind that these lists may not be all-inclusive. Please contact the Prescription Benefits Administrator at the contact information provided on the Insert to this Booklet if you have a question regarding the coverage of a specific medication.

In addition to those medications shown as "excluded" in the chart below, no coverage is provided under this subsection for:

1. therapeutic devices or appliances;
2. support garments;
3. treatments approved solely for cosmetic purposes;
4. biological sera, blood or blood plasma, injectables (except as shown as "included" in the chart below);
5. drugs labeled: "Caution-limited by federal law to investigational use";
6. Experimental drugs;
7. refills dispensed more than one year after the date the doctor wrote the prescription;
8. refills for more than the amount shown on the prescription unless approved by the doctor who wrote the order;
9. prescriptions that exceed the applicable Quantity Limitation, as described in Subsection I.4. above;
10. drugs and medicines furnished to you while confined in any medical facility;
11. drugs which are or could be covered by worker's compensation;
12. compound bulk chemical drugs and medicines;
13. drugs newly approved by the FDA are presumptively excluded, and will be subject to the Prescription Benefits Administrator's clinical guidelines in the event such drugs become included;
14. gene therapy drugs.

L. CHART OF COVERED ITEMS

Certain items listed as excluded in this Chart may otherwise be covered under "Medical Benefits", Section 6. of this Booklet, or covered as preventive care services in accordance with and as required by the Patient Protection and Affordable Care Act and the standards established by that law, including the United States Preventative Services Task Force A and B recommendations, the Advisory Committee on Immunization Practices of the CDC, the Health Resources and Services Administration guidelines, and the American Academy of Pediatrics *Bright Futures* guidelines. Contact the Medical Network and Managed Care Administrator or the Benefit Office for more information.

DRUG CATEGORY		Included	Excluded	Prior Authorization Required	Days' Supply, Quantity, Sex and Age Limits
1	**AIDS DRUGS**	X			Injectables are limited to one-month supply per prescription filling.
2	**ANTI-FUNGALS, ORAL**	X			
3	**ANTI-OBESITY & ANOREXIANT**		X		
4	**ATTENTION DEFICIT DISORDER DRUGS**	X			

	DRUG CATEGORY	Included	Excluded	Prior Authorization Required	Days' Supply, Quantity, Sex and Age Limits
5	**COMPOUNDED DRUGS**	X			Compound must include covered FDA approved ingredients that require a prescription. Must not include bulk chemicals. Prior authorization required for Compounded drug prescriptions in excess of $250.
6	**CONTRACEPTIVES**				
	Oral contraceptives packaged in one-month supplies	X			
	Oral contraceptives packaged in 3-month supplies	X			Covered at Retail 90 and mail order programs.
	Medroxyprogesterone Acetate and other 3-month injectable contraceptives	X			
	Plan B	X			
	Diaphragms	X			
	IUD's (See Section 6., Subsection F.3.F.)	X			
7	**COSMETICS**				
	Retin A, Renova, Avita, Differin and other acne treatments	X			Not covered over age 26.
	Rogaine, Propecia		X		
8	**DESI DRUGS**		X		
9	**DIAGNOSTIC AGENTS**		X		
10	**DURABLE MEDICAL EQUIPMENT** (e.g. crutches, walkers, bandages)		X		
11	**FERTILITY** (non-injectable)		X		
12	**FLUORIDE PREPS & WASHES**	X			Dependent children only; prescription required.
13	**GROWTH HORMONES**			X	
14	**HEMATINICS**	X			
15	**IMPOTENCY DRUGS**			X	
16	**INJECTABLES: Self-Administered (subcutaneous administration)**				All injectables are limited to a one-month supply per claim.
	Epipen, Anakit	X			Limit of 2 per prescription filling.
	Fertility		X		
	Glucagon	X			
	Pralvent, Repatha	X		X	Additional clinical guidelines apply.
17	**INJECTABLES: Administered in Medical Setting**		X		

	DRUG CATEGORY	Included	Excluded	Prior Authorization Required	Days' Supply, Quantity, Sex and Age Limits
18	**INSULIN**	X			
	Blood Glucose Monitors	X			
	Blood Sugar Testing Supplies	X			
	Syringes/Needles (insulin only)	X			
19	**LEGEND VITAMINS**		X		
	Pediatric Fluoride Vitamins	X			Dependent children only; prescription required.
	Prescription Pre-Natal Vitamins	X			
20	**MIGRAINE MEDICATIONS**	X			May be subject to quantity limits.
21	**OSTOMY SUPPLIES**		X		
22	**OVER THE COUNTER PRODUCTS**		X		Unless covered by the Patient Protection and Affordable Care Act.
23	**SERUMS / TOXOIDS / ALLERGENS**		X		
24	**SMOKING DETERRENTS**	X			Prescription only.
25	**OTHER SPECIFIC COVERAGES:**				
	Flumist	X			
	Opiate Medications	X			Limited to a one-month supply per claim.
	Skin Depigmentation Products		X		
	Vaginal Estrogen	X			

The limitations and exclusions described in the above table are in addition to the limitations and exclusions listed in Section 6., Subsection G., to the extent applicable.

Please note the Plan's claims limitation periods in Section 18.

SECTION 8. BEHAVIORAL CARE BENEFITS

A. OVERVIEW

There are three types of Behavioral Care benefits available under the Plan:

- Member Assistance Program (MAP), which is administered by the MAP Administrator and provides limited counseling benefits; and
- Inpatient and outpatient benefits, which are administered by the Behavioral/Mental Health Administrator; and
- The Addiction Program, which is administered by the Welfare Director.

You are not required to use the MAP or to contact the MAP Administrator before accessing inpatient or outpatient benefits.

B. MEMBER ASSISTANCE PROGRAM

1. Introduction

The Trustees have contracted with the MAP Administrator to establish the Member Assistance Program (MAP), which provides prepaid assistance for short-term professional counseling and other daily need support services for you and members of your family who need assistance. You may use the MAP for problems or issues such as alcoholism, drug abuse, emotional distress, marital problems, legal problems, and financial difficulties. The MAP provides a number of tools which are detailed on the MAP Administrator's website provided on the Insert to this Booklet.

If there is a need for more extensive counseling, other treatment services for a Mental Health or Substance Use Disorder, or you choose to utilize additional Behavioral Care benefits under the Plan, the MAP Counselor will assist and refer you to services matched to your assessed needs and work with the provider of those services to ensure you get the best care possible.

If you or a member of your family needs help with respect to a personal problem or issue, you are encouraged to contact the MAP for a free telephone consultation. The MAP counselor will discuss the problem or issue and work with you to develop a plan to help. The MAP counselor can also refer you to an appropriate person, organization, or Behavioral Care provider for further assistance. You may access the MAP by contacting the MAP Administrator at the telephone number provided on the Insert to this Booklet or on the back of your medical ID card. You may speak with MAP counselors 24 hours a day, seven days a week.

2. Confidentiality

The MAP provides procedures that will protect each individual's right of privacy. Utilization of the program will be strictly confidential unless you specifically request otherwise.

All discussions that take place with MAP counselors, as well as all MAP records, will remain strictly confidential, unless disclosure is ordered by law.

3. Counseling Services

If, during the initial call with a counselor, it is determined that you would benefit from in-person counseling, the call center counselor will refer you to the most appropriately matched counselor. The counselor's first objective is to determine the nature of the personal problem. Secondly, the counselor will outline the best course of action to resolve the problem, and will support you in working your action plan to assure the best possible result. The number of counseling sessions with the local counselor will vary depending on the problems and individual circumstances involved in formulating and implementing the action plan.

4. Types of Referral

a. Self-Referral

Any Covered Individual may call the MAP for assistance at the number listed on the Insert to this Booklet. Live counselors are available 24 hours a day, 7 days a week. Anyone who wishes to seek assistance is able to do so with privacy.

b. Business Agent or Other Union Representative Referral

Your union representatives are educated about your MAP benefit and may from time to time refer an Active Employee to the MAP. For example, a business agent might refer an Active Employee if the business agent saw a noticeable decline in the Active Employee's work performance. Such a referral is not mandatory.

5. Availability

The MAP is available to all Eligible Employees, all Retired Eligible Employees who are not Medicare eligible, and their respective eligible dependents.

6. Acceptance or Refusal of Help

The MAP has been designed to serve the needs of all Covered Individuals, including those who may be facing problems that are resulting in a work-hampering situation on the job.

The final decision to seek assistance rests solely with each person, and it is hoped that Covered Individuals will act in their own best interests.

7. Costs Involved

There is no cost to you or your eligible dependents for counseling services provided by the MAP. As noted below, the Plan may cover additional expenses if inpatient or outpatient treatment facilities and services are required to help the Covered Individual in accordance with the provisions of the Plan.

8. How Do I Know if I Need Help?

It does not hurt to ask. Often it helps just to get an unresolved problem out into the open and discuss it. Through discussion of your issue, the MAP counselor will be able to assess the extent and seriousness of your problem. But remember, you are not alone. Everyone is troubled by problems or personal issues from time to time. Seeking professional help is a positive step that indicates a desire to resolve one's problems.

9. Help is Available for:

Any issues that are taking a toll on your day-to-day life. This could be stress and anxiety, alcohol or drugs, marital and family issues, legal and financial issues, as well as depression. Again, a counselor is available to speak to you at any time, day or night, at the MAP telephone number provided on the Insert to this Booklet.

For legal and financial issues, the resource specialist or MAP counselor can link you directly to an attorney for consultation of up to 30 minutes at no cost to you. Should the attorney determine that you need further legal assistance, you will be referred to a local attorney at a 25% discount on fees. You and your eligible dependents are each entitled to 30 days of free telephonic counseling per year with the MAP Administrator's financial coaching staff.

10. Why Professional Counseling is Effective

Professionally trained counselors can provide an objective viewpoint and guide you toward a better understanding of your particular problem or issue and its causes. Additionally, the counselor is familiar with many service agencies, professional people and treatment centers in the community dealing with personal problems, such as alcoholism, drug abuse, emotional illness, parenting issues and family stress. The counselor can direct you to the proper agency, ranging from self-help groups such as Alcoholics Anonymous to private facilities or physicians best equipped to provide the help you need.

11. How to Access your MAP Benefits

For Assistance from MAP call at any time, day or night, the MAP telephone number provided on the Insert to this Booklet.

If counseling is necessary, a call-center counselor will refer you to a local counselor who works with the MAP.

You can also access a wide range of useful information to assist you with your day-to-day life at the MAP website provided on the Insert to this Booklet.

C. INPATIENT AND OUTPATIENT TREATMENT BENEFITS

1. Accessing Your Inpatient and Outpatient Benefits

Inpatient and outpatient treatment benefits are available to you if you choose not to use the MAP or if your need for personal assistance with a Mental Health or Substance Use Disorder is beyond the scope of the MAP services.

Your confidentiality and privacy rights are preserved when you access your Behavioral Care benefits. The Behavioral/Mental Health Administrator will share only enough information with Plan administrators to support payment for services covered by your Behavioral Care benefits.

2. Prior Authorization and Predetermination

Certain Behavioral Care services and supplies are among the Plan benefits to which prior authorization and predetermination apply. Please see Section 6., Subsection B., "Prior Authorization and Predetermination for Medical and Behavioral Care Benefits", for more information on prior authorization and predetermination of Behavioral Care Benefits.

3. Benefits

The benefits provided for professional treatment of Mental Health and Substance Use Disorders, of any type or cause (other than in connection with short-term professional counseling under the MAP), whether received on an inpatient or an outpatient basis, are described in Items 24 and 25 of the Schedule of Benefits in Section 6. of this Booklet.

4. Learning Disabilities, Attention Deficit Disorder, Autism Spectrum Disorders and Other Behavior Disorders

Medically necessary therapies, including applied behavior analysis, that are approved by the Behavioral/Mental Health Administrator will be covered. No payment will be made for educational tutoring, schooling or any other services that are not medical in nature or that are available to a Covered Individual through a public school district or other government agency.

Charges other than those listed in this Subsection C. are not covered.

D. ADDICTION PROGRAM

Effective February 1, 2018, you may participate in a comprehensive outpatient program through either of two local vendors, ARCA or Clayton Behavioral Care. Effective April 1, 2021, this program has been expanded to include Sana Lake Recovery Center. The program is offered at the 10% coinsurance rate described in Item 25 of the Schedule of Benefits in Section 6 of this Booklet. Additionally, the deductible is waived for participation in the program. The program includes outpatient detoxification, counseling (group, family and individual), urine drug screenings, and prescribing medications, including medication treatment follow up. The program will require you to make direct payments to the provider at specified times.

There is no Tier 2 Out-of-Network provider for this program; the program is limited to the providers referenced above.

You must contact the Welfare Director at the Benefit Office to initiate your participation in the program.

Note: This Section 8. does not apply to Retired Eligible Employees and dependents of Retired Eligible Employees who are covered by Medicare and an associated benefit under this Plan as described in Section 14.

Please note the Plan's claims limitation periods in Section 18.

SECTION 9. HEARING AID BENEFITS

A. SCHEDULE OF BENEFITS

Individual Hearing Aid Co-payment

Per hearing aid	$25

Benefit Amount

Limit per hearing aid	$1,500
Benefit Period	One hearing aid per ear each 48 months

The Plan will pay up to a total of $1,500 for each hearing aid, including any related charges as described below. The Covered Individual must pay a $25 Co-payment and any amount over $1,500. The one hearing aid per ear each 48 months limitation does not apply to hearing aids for newborns.

B. DESCRIPTION OF BENEFITS

Hearing aid charges are payable for Covered Individuals only under this program and not under any other provision of the Plan.

The Plan pays for hearing aid(s) subject to the applicable Co-payment and limits set forth herein. After you pay the applicable Co-payment, the Plan pays the balance of the cost of a Medically Necessary hearing aid or aids up to the maximum limit as provided in this program.

You will be reimbursed for eligible expenses upon submitting a receipt or other proof of payment to the Benefit Office. Eligible expenses may also be paid directly to the hearing aid service provider.

The total amount payable under the Plan's hearing aid benefit is limited to $1,500 per ear every 48 months. The $1,500 limit includes the charge for the hearing aid itself, as well as the following covered services and supplies:

1. audiometric testing;
2. follow up exam to determine effectiveness of hearing aid;
3. hearing aid analysis;
4. first set of batteries if dispensed and billed with hearing aid;
5. ear molds, cords, etc.;
6. fittings and adjustments; and
7. repairs.

For purposes of applying the 48-month benefit period, a Covered Charge is considered incurred on the date you make your first visit to the service provider.

C. LIMITATIONS AND EXCLUSIONS

No coverage is provided under this section for:

1. replacement of a lost, broken, missing or stolen appliance;
2. batteries after the first set;
3. a hearing aid required by an employer as a condition of employment, required by a labor agreement, or required by a government body or agency;
4. services or supplies for which benefits are available through worker's compensation or similar legislation;
5. charges which you are not legally obligated to pay;
6. items furnished to you without cost, or which you can obtain through any federal, state, county, municipality or special district organization or agency.

The above limitations and exclusions are in addition to the limitations and exclusions listed in Section 6., Subsection G., to the extent applicable.

D. HOW TO OBTAIN BENEFITS

To use the hearing aid program, you should simply make an appointment with a hearing aid service provider. It is a good idea to check with the Benefit Office to make sure you or your dependent has not used this hearing aid benefit within the past 48 months.

If your hearing aid costs less than the maximum benefit under the Plan, you merely pay the Co-pay; the Benefit Office will either reimburse you for the costs you incurred (less the Co-pay), or pay the balance directly to the provider.

If your hearing aid is more than the maximum allowed under the Plan, you must pay the provider, in addition to the Co-pay, any amount over the maximum allowable by the Plan.

E. SPECIAL REQUIREMENT

According to FDA guidelines, eight (8) red flags must be observed during ear testing. If any of these flags are found to be positive, you must have medical clearance to be fitted with a hearing aid. The Plan will not pay for hearing aids in this case unless such medical clearance is obtained.

Note: This Section 9. does not apply to Retired Eligible Employees and dependents of Retired Eligible Employees who are covered by Medicare and an associated benefit under this Plan as described in Section 14.

Please note the Plan's claims limitation periods in Section 18.

SECTION 10. DENTAL BENEFITS

The Plan's dental benefits are administered through the Dental Benefits Administrator indicated on the Insert to this Booklet. The Dental Benefits Administrator may be contacted at the contact information provided in the Insert to this Booklet. You have the option, at the commencement of your coverage and again during the month of May of each Plan year, to elect to opt out of Dental coverage through the Fund. If you choose to opt out of Dental coverage, you must complete a form confirming this choice and turn that form into the Benefit Office. **There is NO monthly or annual premium for Dental coverage through the Fund and you will not receive any money or thing of value for opting out of the Plan.**

A. SCHEDULE OF BENEFITS

1. Dental Care Deductibles Per Calendar Year

Individual: $75

Family: $225

The Dental Care Deductible does not apply to Type A Covered Charges.

2. Covered Percentages of Benefit Payment:

	Dental Benefits Administrator PPO Dentists **These dentists agree to be reimbursed from a fee schedule and no balance billing.**	**Dental Benefits Administrator Premier Dentists** **These dentists agree to a contractual reimbursement and no balance billing.**	**Non-Network Dentists** **Benefit payments are made up to the maximum Plan allowance by reimbursing the Covered Individual. The dentist may balance bill the Covered Individual for the rest of the dentist's fee.**
Type A—Routine & Preventive Care	100%*	100%*	100%*
Type B—Basic Services	90%*	80%*	80%*
Type C—Prosthetics	60%*	50%*	50%*
Type D—Orthodontics	80%*	80%*	80%*

*The percentage payable for covered services is based on the Dental Benefits Administrator's negotiated rate with dentists who participate in the Dental Benefits Administrator's provider network. Neither PPO nor Premier dentists are allowed to balance bill patients for the amount in excess of the contracted fee. If you use a non-network dentist, you will be responsible for the applicable Co-insurance in addition to any balance bill that the non-network dentist may send you – the difference between the Dental Benefits Administrator rate and the amount actually charged by your dentist.

3. Maximum Dental Benefits Per Covered Individual

For all covered sealants, Type B charges and Type C charges (except TMJ)	$1,500 per calendar year**
For all covered TMJ charges	$3,000 lifetime
For all covered Type D (Orthodontic) charges	$2,000 lifetime

**Charges for examinations, cleanings, x-rays and fluoride treatments do not apply towards your annual maximum.

Please note the Plan's claims limitation periods in Section 18.

B. DESCRIPTION OF DENTAL CARE BENEFITS

Benefits are immediately payable for 100% of the Dental Benefits Administrator rate for Type A Covered Charges. If you go to a non-network dentist, 100% of the Dental Benefits Administrator rate may not cover that dentist's full charge for Type A services.

Before benefits are available for other dental expenses, an individual Deductible must be satisfied each calendar year. This is the first $75 of Covered Charges incurred by a Covered Individual in each year. You pay this amount yourself.

If you have family coverage, when the total of all Covered Charges applied toward satisfaction of individual Deductible amounts in the same calendar year equals $225, no further Deductible amount will be required for that year for any covered member of your family.

When the Deductible is satisfied (or does not apply), benefits will be paid at the applicable covered percentages shown in the preceding Schedule of Benefits for the following covered dental charges.

Charges for exams, cleanings, x-rays and fluoride treatments do not apply towards your annual maximum.

C. COVERED DENTAL CHARGES

All Plan benefit amounts are based on the Dental Benefits Administrator negotiated rate with dentists who participate in the Dental Benefit Administrator's provider network. Fees for the following dental services and supplies will be considered Covered Charges when incurred upon recommendation of a licensed dentist.

1. Type A Covered Charges

a. Two routine periodic examinations in a calendar year.

b. Diagnostic x-rays as required.

c. Full mouth x-rays, once in a calendar year.

d. Dental prophylaxis (cleaning, scaling and polishing), including periodontal maintenance, two times in a calendar year.

e. Topical application of fluoride for Covered Individuals under age 19, once in a calendar year.

f. Sealants for cavity free permanent molars.

2. Type B Covered Charges

a. Emergency treatment for relief of pain.

b. Restorative services using amalgam, synthetic porcelain and plastic filling material.

c. Endodontics, including pupil therapy and root canal filling.

d. Surgical periodontics—surgical procedures necessary for the treatment of diseases of the gums and bones supporting the teeth; periodontal splinting.

e. Non-surgical periodontics, including treatment for diseases of gums.

f. Extractions and other oral surgery, including pre-operative and post-operative care.

g. Space maintainers that replace prematurely lost teeth of covered dependent children under age 16.

h. Treatment of temporomandibular joint syndrome or dysfunction (TMJ) furnished by a licensed doctor or dentist.

3. Type C Covered Charges

a. Prosthetics—bridges, implants (up to the cost of a bridge), partial dentures and complete dentures.

b. Precious metal restorations or porcelain/ceramic onlays, crowns and jackets when the teeth cannot be restored with another filling material, once in five years.

c. If an existing appliance, other than a bridge or denture, cannot be made satisfactory, a replacement will be covered only once in five years, except for Accidental Injuries.

d. If an existing bridge or denture cannot be made satisfactory, a replacement appliance will be covered only once in five years, but not during the first year of coverage.

4. Type D Covered Charges

Orthodontic care and appliances for the treatment of malposed or malpositioned teeth.

5. General Anesthesia

In connection with a dental procedure requiring treatment in a Hospital or other medical facility, general anesthesia is covered under Section 6., Subsection F.3.a. of this Booklet, if determined by the Medical Network and Managed Care Administrator to be Medically Necessary or if the Covered Individual's primary care physician provides a letter of Medical Necessity.

D. ALTERNATE SERVICE

If more than one type of dental care would satisfactorily treat a dental condition, benefits will be based on the cost of the least expensive course of treatment. If you choose a more expensive treatment, you will be responsible for the applicable Deductible and Co-insurance as well as the difference in the cost of treatment allowed by the Plan and the treatment received.

E. DENTAL CARE LIMITATIONS AND EXCLUSIONS

Dental care benefits are not provided for:

1. services rendered by a dental or medical department maintained by or on behalf of an employer, a mutual benefit association, trustee or similar person or group;
2. services for which you are not charged;
3. services for which coverage is available through worker's compensation or similar legislation;
4. services provided or paid for by any government agency, or under any governmental program or law, unless you are legally obligated to pay those charges (this exception extends to any benefits provided under the U.S. Social Security Act and its amendments);
5. services performed for cosmetic purposes or to correct congenital malformations;
6. charges for courses of treatment, including prosthetics, which were initiated within 6 months prior to your enrollment date in the Plan will be excluded for 12 months from your enrollment date, although this 12-month exclusion period will be reduced by any period of coverage you have with an equivalent plan;
7. any services or supplies not specifically included as dental Covered Charges, including Hospital and prescription drug charges;
8. replacement of prosthetic appliance due to loss or theft;
9. services rendered by a dentist which are not included in the scope of the dentist's license;
10. charges for denture adjustments during the first six months following delivery (this service should be included in the total cost for the dentures);
11. charges for complete occlusal adjustments, crowns for the occlusal correction, athletic mouthguards, nightguards, and bite therapy appliances;
12. charges for bases, liners and anesthetics used in conjunction with permanent restorations;
13. charges for Experimental services;
14. diseases contracted or Injuries or conditions sustained as a result of any act of war;
15. separate charges for analgesia, including nitrous oxide, duplication of radiographs, temporary appliances, implants and related procedures (other than as an alternate benefit);
16. separate charges for tooth preparation, temporary crowns, bases, impressions and anesthesia or other services which are part of the complete dental procedure. These services are considered components of, and included in the fee for the procedure. Separate fees may not be charged by participating dentists;
17. services or supplies that a dentist determines for any reason, in the dentist's professional judgment, should not be provided;
18. separate charges for instructions in dental hygiene, dietary planning or plaque control;

19. charges for missed appointments or claim form completion;

20. separate charges for infection control, including sterilization of supplies and equipment;

21. services or supplies for which the Covered Individual, absent coverage under the Plan, would normally incur no charge, such as care rendered by a dentist to an Eligible Employee of the dentist's immediate family or the immediate family of the dentist's spouse.

The above limitations and exclusions are in addition to the limitations and exclusions listed in Section 6., Subsection G. to the extent applicable.

F. HOW TO OBTAIN YOUR DENTAL BENEFITS

1. At a Dental Benefits Administrator Participating Dentist

As long as you go to a dentist who has signed a participating agreement with the Dental Benefits Administrator, the dentist should file your claim for you. If you do not know whether your dentist is a participating dentist, ask the dentist or call the Dental Benefits Administrator office at the telephone number provided in the Insert to this Booklet.

If you go to a participating dentist, present your Identification Card when you arrive for your appointment. If the care you need:

a. costs less than $250 or is Emergency care, your dentist will proceed with treatment.

b. costs more than $250 and is not Emergency care, your dentist will determine what treatment you need and submit a treatment plan to the Dental Benefits Administrator for pre-determination of benefits. This will enable you to estimate in advance how much you will be responsible for paying. Please note that any estimate by the Dental Benefits Administrator is not a guarantee of benefits, since payment will be based upon Plan benefits and eligibility at the time the services are actually rendered.

Most participating dentists submit claims electronically. However, for paper claims, your dentist may ask you to complete some portions of the claim form. Your dentist will submit the claim for you.

You will be responsible for the Deductible amount, if applicable, the Co-insurance amount and any non-covered charges. Your dentist may request payment at the time of treatment or bill you later.

2. At a Non-Participating Dentist

When possible, obtain a claim form from the Dental Benefits Administrator before your appointment, and complete it. If a claim form is not available, obtain an itemized bill from the dentist, showing the dentist's name and office address, the name of the patient, the reason for treatment and the charge for each service provided. Send this, along with your name, address, group number and identification number to the Dental Benefits Administrator at the address shown in the Insert to this Booklet.

You will be responsible for all charges not paid by the Dental Benefits Administrator.

G. DENTAL BENEFITS ADMINISTRATOR CONTACT INFORMATION

For dental claim inquiries, you may contact the Dental Benefits Administrator at the telephone number provided in the Insert to this Booklet.

Note: This Section 10. does not apply to Retired Eligible Employees and dependents of Retired Eligible Employees who are covered by Medicare and an associated benefit under this Plan as described in Section 14.

SECTION 11. VISION BENEFITS

A. ROUTINE VISION CARE BENEFITS

This benefit is provided through an arrangement with the Vision Benefits Administrator indicated on the Insert to this Booklet. The Vision Benefits Administrator may be contacted at the contact information provided in the Insert to this Booklet. The benefits are paid out of the assets of the Plan; however, the Vision Benefits Administrator handles all of the claims. Further, the Vision Benefits Administrator has a contracted network of doctors and providers of vision services. If you use these providers, you receive greater benefits. The Vision Benefits Administrator will provide you with a list of participating providers. You have the option, at the commencement of your coverage and again during the month of May of each Plan year, to elect to opt out of Vision coverage through the Fund. If you choose to opt out of Vision coverage, you must complete a form confirming this choice and turn that form into the Benefit Office. **There is NO monthly or annual premium for Vision coverage through the Fund and you will not receive any money or thing of value for opting out of the Plan.**

Covered Charges - Whether you use a participating provider or other licensed optometrist or ophthalmologist, the following services and supplies will be considered Covered Charges. Eyewear may be purchased through any licensed dispensing optician.

1. Vision Exam

complete analysis of the eyes and related structures, once every 12 months by a licensed ophthalmologist or optometrist;

2. Frames

once every 12 months;

3. Lenses

a. Prescription Eyeglass Lenses – once every 12 months; or

b. Contact Lenses – (instead of eyeglasses – lenses and frames) once every 12 months

- **Vision Benefits Administrator Provider –** Limited to a maximum benefit of $300 per 12-month period for both the contact lens exam and lenses combined. 15% discount off the contact lens exam (fitting and evaluation). Discount does not apply to contacts.

- **Non-Vision Benefits Administrator Provider** – When you use a provider who is not a member of the Vision Benefits Administrator network, your benefits will be limited to $210 per 12-month period for "Visually Necessary" contact lenses (as described below). For Elective (not Visually Necessary) contact lenses, your benefits are limited to $105 per 12-month period when using a provider who is not a member of the Vision Benefits Administrator network.

  Visually Necessary. Contact lenses will be considered visually necessary for:

  - original or replacement lenses following cataract surgery;
  - to correct extreme visual acuity problems which are not correctable to 20/70 or better in the better eye through the use of glasses; or
  - to correct significant anisometropia or keratoconus. Anisometropia is a condition of unequal refractive state for the two eyes, one eye requiring a different lens correction than the other. Keratoconus is a development or dystrophic deformity of the cornea, in which the cornea becomes cone-shaped due to a thinning and stretching of the tissue in its central area.

  Your doctor should contact the Vision Benefits Administrator to get prior approval for Visually Necessary contact lenses.

  Eyeglasses and contacts will not be covered in the same 12-month period.

B. BENEFIT AMOUNT

Plan Benefits	***Participating Provider Benefit***	***Non-Participating Provider Benefit***
1. Vision Care Services		
Complete Vision Examination – once every 12 months	Covered in full, subject to $10 Co-payment	Up to $45
2. Vision Care Materials		
Lenses per pair – once every 12 months		
Single Vision	Covered in full*	Up to $30*
Bifocal	Covered in full*	Up to $50*
Trifocal	Covered in full*	Up to $60*
Lenticular	Covered in full*	Up to $75*
Frames – once every 12 months	Up to $180*	Up to $70*
3. Contact Lenses		
Instead of glasses – once every 12 months		
Visually Necessary Professional Fees and Materials	Covered in full, subject to $20 Co-payment	Up to $210, subject to $20 Co-payment
Elective (not Visually Necessary) Professional Fees and Materials	Up to $300 for contact lens exam (fitting and evaluation) and contacts	Up to $105
4. Eyeglass Lens Options		
Scratch coating	Covered in full	Not covered
Tinted/Photochromic for eyeglass lenses	Covered in full	Up to $5

*Subject to $20 Co-payment, when you obtain lenses, frames, or lenses and frames combined.

If you choose a frame over the group allowance of $180, you will be responsible for the difference in the amount, after receiving a 20% discount from your Vision Benefits Administrator network provider.

Frame allowance may be applied towards non-prescription sunglasses for post PRK, LASIK or Custom LASIK patients.

Additional glasses and sunglasses, including lens options, may be obtained from any Vision Benefits Administrator Provider at a 20% discount if purchased within 12 months of your most recent Complete Vision Examination.

If you use both participating and non-participating providers, you will be reimbursed as shown above for the service each provided. For example, if you go to a participating doctor for your vision examination, after you pay your Co-payment the rest of the doctor's charge is paid in full. If you then buy glasses from a non-participating provider, you receive the scheduled dollar benefits for your frames and lenses.

C. LASER VISION CORRECTION SURGERY BENEFITS

1. Covered Services

Laser Vision Correction Surgery is used to correct vision problems, such as nearsightedness, farsightedness, and astigmatism. Covered individuals are eligible for the laser vision correction benefits described in this Subsection after being covered by the Plan for one year, when the benefits are obtained from a Vision Benefits Administrator Participating Laser Vision Correction Primary Eye Care Doctor, Participating Laser Vision Correction Surgeon and Participating Laser Vision Correction Facility, subject to the payment of the balance of the charges not covered by the allowances listed in the second column.

Covered Service	***Benefit Amount***
Initial consultation	No additional cost
Preoperative Exams	No additional cost*
LASIK or Custom LASIK Surgery	$900 allowance per eye**
PRK Surgery	$750 allowance per eye**
Postoperative examinations	No additional cost (included in surgery fee)
Enhancement surgery (Only covered if needed and if performed within the time period specified by the Participating Laser Vision Correction Facility.)	No additional cost

* If a Covered Individual obtains initial consultation services and/or preoperative exams and surgery is not performed, the Plan will cover the costs of the preoperative services. However, payment by the Vision Benefits Administrator for such preoperative services counts towards the Covered Individual's allowance as if surgery had been performed. Thus, if the Covered Individual attempted to obtain Laser Vision Correction Surgery services at a later date, no benefit would be available.

** The Vision Benefits Administrator has contracted with the Participating Laser Vision Correction Facilities to provide discounts to Covered Individuals. The discounted price will not exceed $900 per eye ($1,800 for both eyes) for LASIK, $750 per eye ($1,500 for both eyes) for PRK, and $900 per eye ($1,800 for both eyes) for Custom LASIK. In the event that a Covered Individual receives Laser Vision Correction Surgery on one eye only, any remaining balance may not be applied towards the cost of surgery in the second eye. Laser Vision Correction Surgery benefit is covered only once in a lifetime.

2. How do the Laser Vision Correction Benefits Work?

STEP ONE: Call the Vision Benefit Administrator's Customer Service Department at the telephone number provided in the Insert to this Booklet to locate a primary eye care doctor and identify yourself as a Covered Individual under the Plan. Your Vision Benefit Administrator's participating doctor may be a laser vision correction primary eye care doctor. When you call the Vision Benefit Administrator's Customer Service Department, you may verify your doctor's participation.

STEP TWO: Call a Participating Laser Vision Correction Primary Eye Care Doctor and identify yourself as a Covered Individual under the Plan. Tell the doctor that you are using the laser vision care benefit. The doctor will need your identification number (usually Social Security Number) and your group name.

STEP THREE: The Participating Laser Vision Correction Primary Eye Care Doctor will perform an examination to determine if you are a candidate for Laser Vision Correction Surgery and discuss the benefits, risks and alternatives to surgery. If you wear contact lenses, you may need to see your regular Vision Benefits Administrator participating doctor several times before you are ready for surgery, to ensure your vision is stable. If you are a candidate for Laser Vision Correction Surgery, a regular Vision Benefits Administrator participating doctor will refer you to a Participating Laser Vision Correction Surgeon and Participating Laser Vision Correction Surgeon Facility.

STEP FOUR: Make an appointment with the Vision Benefits Administrator's Participating Laser Vision Correction Surgeon and Participating Laser Vision Correction Facility. Your Participating Laser Vision Correction Primary Eye Care Doctor may schedule this appointment for you at a Participating Laser Vision Correction Facility. The Participating Laser Vision Correction Surgeon will:

- Discuss the procedure and answer any questions.
- Have you review and sign the informed consent documentation.
- Perform the surgery.

Prior to the surgery, the Participating Laser Vision Correction Facility will collect your share of the surgery fee.

STEP FIVE: Post-surgical care will be coordinated by your Participating Laser Vision Correction Primary Eye Care Doctor and Participating Laser Vision Correction Surgeon. You will likely visit the doctor several times after the surgery to ensure your eyes heal properly.

3. Definitions

Participating Laser Vision Correction Primary Eye Care Doctor: A Vision Benefits Administrator participating doctor who performs consultation, preoperative examinations and postoperative examinations. Laser Vision Correction Primary Eye Care Doctors are doctors with special training in the co-management of laser vision correction patients.

Laser In Situ Keratomileusis (LASIK): A procedure performed with a laser light beam during which a small, thin flap is made on the cornea allowing the laser to reshape the exposed corneal tissue.

Participating Laser Vision Correction Facility: A facility that has contracted with the Vision Benefits Administrator to provide Laser Vision Correction services to Covered Individuals in coordination with Participating Laser Vision Correction Surgeons.

Participating Laser Vision Correction Surgeon: A Vision Benefits Administrator participating provider, who is licensed as a doctor of ophthalmology in the state in which the provider practices and who is contracted with the Vision Benefits Administrator to perform surgical and advanced eye care, including Laser Vision Correction services.

Photorefractive Keratectomy (PRK) Laser Refractive Surgery: A procedure to correct nearsightedness, which is performed with an excimer laser using a laser light beam to reshape the surface of the cornea.

Laser Vision Correction Surgery: The surgical procedures used to correct vision problems (such as nearsightedness, farsightedness, and astigmatism) covered under the Plan and provided by a coordinated network of Participating Laser Vision Correction Primary Eye Care Doctors, Participating Laser Vision Correction Surgeons and Participating Laser Vision Correction Facilities.

Custom LASIK: A type of technology used in LASIK surgery, also called wavefront-guided LASIK. This wavefront technology measures the eye from front to back to create a three-dimensional corneal map. This measurement then guides the laser to reshape the cornea.

D. LIMITATIONS AND EXCLUSIONS

Vision Care Benefits are not provided for:

1. optional cosmetic processes; anti-reflective coating; color coating; mirror coating; blended lenses; cosmetic lenses; laminated lenses; oversize lenses; polycarbonate lenses (except for children); progressive multifocal lenses; UV (ultraviolet) protected lenses;
2. orthoptics or vision training and any associated supplemental testing; plano lenses (less than ±.50 diopter power); or two pairs of glasses in lieu of bifocals;
3. replacement of lenses and frames furnished under the Plan which are lost or broken, except at the intervals specified when benefits are otherwise available;

4. corrective vision treatment of an Experimental or Investigational nature;

5. forms of laser vision correction surgery other than PRK, LASIK, and Custom LASIK, including but not limited to Radial Keratotomy;

6. pathological treatment;

7. Laser Vision Correction services provided by a provider who is not a Participating Laser Vision Correction Primary Eye Care Doctor, Participating Laser Vision Correction Surgeon or a Participating Laser Vision Correction Facility;

8. eye examinations required by an employer as a condition of employment, required by a labor agreement, or required by a government body or agency;

9. services and supplies for which benefits are available through worker's compensation or similar legislation;

10. charges which you are not legally obligated to pay; items furnished to you without cost, or which you can obtain through any federal, state, county, municipality or special district organization or agency;

11. costs for services or materials above the limits indicated above;

12. charges which are not specifically listed as covered.

The above limitations and exclusions are in addition to the limitations and exclusions listed in Section 6., Subsection G. above, to the extent applicable.

E. HOW DO I USE THE PLAN'S VISION BENEFITS?

To use the Plan's vision benefits, you must tell your doctor you are with the Vision Benefits Administrator. The doctor will confirm your eligibility for benefits before your appointment. You may obtain a list of participating providers from the Vision Benefits Administrator by calling the telephone number provided in the Insert to this Booklet. If emergency services are required, contact the Customer Service Department of the Vision Benefits Administrator for assistance, and if you go to a non-Vision Benefits Administrator provider, submit copies of bills to the Vision Benefits Administrator at the address shown below.

F. SUBMISSION OF CLAIM DOCUMENTS

If you receive vision services from a Vision Benefits Administrator provider, that provider will provide you with the services and supplies upon your payment of appropriate co-payments and the portion of any costs not covered by the Plan. The Plan then reimburses the provider. You do not normally need to file a claim. However, if you use a non-Vision Benefits Administrator provider, you must submit an itemized receipt from your own doctor and include a completed claim form to the address provided in the Insert to this Booklet.

If you believe a participating provider charged you too much or did not provide the benefits to which you are entitled, you may file a claim by writing to the Vision Benefits Administrator at the above address. You should include any relevant documents.

Direct all questions about vision care benefits to the Vision Benefits Administrator at the telephone number in the Insert to this Booklet.

Note: This Section 11. does not apply to Retired Eligible Employees and dependents of Retired Eligible Employees who are covered by Medicare and an associated benefit under this Plan as described in Section 14.

Please note the Plan's claims limitation periods in Section 18.

SECTION 12. LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

A. INTRODUCTION

The life insurance benefits for you and your dependents and the accidental death and dismemberment (AD&D) insurance benefits that cover you are provided under a policy of insurance issued by the Life Insurance Company selected by the Trustees, as identified in the Insert to this Booklet. Set out below is a summary of the provisions of that policy. If you would like a complete copy of the policy or certificate of insurance issued by the Life Insurance Company, please contact the Benefit Office. In the event of a conflict between this summary and the life insurance policy, the policy controls.

Please note the claims limitation periods in Section 18 of this Plan and in the certificate of insurance issued by the Life Insurance Company.

B. SCHEDULE OF BENEFITS

1. Eligible Employees and their Dependents

Life Insurance	***Maximum Benefit***
Eligible Employees	$10,000
Covered Dependents:	
Spouse	$2,000
Child	$2,000
Accidental Death and Dismemberment	***Maximum Benefit***
Eligible Employees only	$10,000

2. Retired Eligible Employees

Life Insurance	***Maximum Benefit***
Eligible Employees only	$2,500

C. ELIGIBILITY

As an Active Employee, you are eligible for life and AD&D insurance at the same time you are eligible for other benefits provided under the Plan by virtue of having met the eligibility requirements described in Section 3., Subsection A. of this Booklet. Coverage for your life and AD&D benefits will terminate on the date you retire or otherwise no longer qualify for Active Employee life insurance coverage under the Plan.

Your dependents who are eligible for life insurance under the Plan pursuant to Section 3, Subsection B. of this Booklet are covered for dependent life insurance from birth until age 26, in accordance with those eligibility provisions. Dependents are not eligible for accidental death and dismemberment benefits. Dependent coverage terminates on the date the eligible Employee's coverage terminates.

A Retired Eligible Employee is eligible for life insurance and a death benefit will be paid if the Retired Eligible Employee is covered under any Retiree coverage provided or negotiated by the Plan at the time of death (see Section 14. of this Booklet). Retired Eligible Employees are not eligible for dependent death benefits or accidental death and dismemberment benefits.

D. DISABILITY EXTENSION BENEFITS

If you become totally disabled while covered as an Eligible Employee, the Plan will pay premiums to keep your life insurance in effect until the earliest of the date:

1. you attain age 65; or
2. you cease to be totally disabled.

You must present proof of total disability to the Benefit Office as soon as possible after you become totally disabled. After that, you must submit proof of continuation of your total disability upon request within three months prior to the anniversary date of the original proof of total disability. Forms for

providing proof of total disability are available from the Benefit Office. If you do not submit the required proof of total disability upon request, your life insurance coverage will terminate.

For purposes of the disability extension life insurance benefits, "total disability" or "totally disabled" means your complete inability, due to injury or illness, to engage in any business, occupation or employment for pay, profit or compensation, for which you are qualified or become qualified by reason of education, training or experience.

E. LIFE INSURANCE BENEFITS

As a result of your death from any cause, life insurance benefits are payable to the Beneficiary you have designated in writing. The amount of the benefit is set out in the Schedule of Benefits above.

As a result of a covered dependent's death from any cause, life insurance benefits in the amount set out in the Schedule of Benefits will be paid to you. If you die prior to your dependent, the life insurance benefit will be paid to your estate.

F. ACCELERATED LIFE INSURANCE BENEFIT

If you were not totally disabled at the time the life insurance policy became effective and have been covered under the policy for two years, you will be eligible for a lump sum payment while you are alive if you have been diagnosed with:

1. a terminal illness which results in a life expectancy of not more than six months;
2. a medical condition which requires extraordinary medical intervention, such as, but not limited to, major organ transplant or conditions for artificial life support, without which death would result;
3. a medical condition which requires continuous confinement in an eligible Institution if you have been confined a minimum of six months, and you are expected to remain in such or similar Institution for the remainder of your life.

   "Institution" means a nursing home or skilled nursing facility, which is licensed as such by the state, and which provides skilled nursing care by registered graduate nurses, under the direction of at least one Doctor; or
4. a medical condition which would, in the absence of extensive or extraordinary medical treatment, result in a drastically limited life span. Such conditions may include, but are not limited to, one or more of the following:
   a. coronary artery disease which results in acute infarction or which requires surgery;
   b. permanent neurological deficit which results from cerebral vascular accident;
   c. end stage renal failure; or
   d. acquired immune deficiency syndrome.

Payment of the accelerated benefit is subject to diagnosis and proof acceptable to the Life Insurance company of the terminal illness or condition. The accelerated life insurance benefit is not available if the illness or injury which caused the medical condition is caused by intentional self-inflicted injury or attempt at suicide. Payment of an accelerated life insurance benefit will reduce the amount of the life insurance benefit payable to your Beneficiary.

If you are diagnosed with a terminal illness or a medical condition described above, please contact the Benefit Office for complete details about this benefit.

G. ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) BENEFITS (FOR ELIGIBLE EMPLOYEES ONLY)

1. When Payable

Benefits will be paid if while covered under the life insurance policy as an Eligible Employee you sustain an accidental injury, and as a direct result of that accident, and independent of all other causes, you suffer a covered loss within 90 days after the accident.

2. Schedule of Covered Losses

FOR LOSS OF:	*THE BENEFIT IS:*
Life…	$10,000
Two Hands	$10,000
Two Feet	$10,000
Sight of Two eyes	$10,000
One Hand and One Foot	$10,000
One Hand and Sight of One Eye	$10,000
One Foot and Sight of One Eye	$10,000
One hand or One Foot	$5,000
Sight of One Eye	$5,000
Thumb and Index Finger	$2,500

If the Eligible Employee suffers more than one loss in any one accident, payment will be made only for that loss for which the largest amount is payable.

3. Exclusions

No Accidental Death and Dismemberment Benefits will be paid for any loss which results directly or indirectly, wholly or partially, from:

a. intentionally self-inflicted injury;

b. suicide or attempted suicide while sane;

c. bodily or mental illness or disease of any kind;

d. infections (except pyogenic infections which result from an accidental bodily injury and bacterial infections which result from the accidental ingestion of contaminated substances, that occur in consequence of an accidental injury on the exterior of the body);

e. medical or surgical treatment of an illness or disease;

f. service in the armed forces of any country while such country is engaged in war;

g. war or act of war (including any armed aggression resisted by the armed forces of any country or combination of countries), whether declared or undeclared, or any act related to war or insurrection;

h. police duty as a member of any military, naval or air organization;

i. participation in, or the result of participation in, the commission of an assault, a felony, a riot or a civil commotion;

j. travel or flight as pilot or crew member in any kind of aircraft including, but not limited to a glider, a seaplane, or a hang kite;

k. intake of any drug, medication or sedative unless prescribed by a Doctor, or the intake of any alcohol in combination with any drug, medication or sedative;

l. use of alcohol, non-prescriptive drugs or controlled substances, such as PCP (also known as "angel dust"), LSD or any other hallucinogens, cocaine, heroin or any other narcotics, amphetamines or other stimulants, barbiturates or other sedatives or tranquilizers, or any combination of one or more of these substances; or

m. any poison or gas voluntarily taken, administered, absorbed, or inhaled.

H. NO ASSIGNMENT OF BENEFITS

With the exception of an assignment to a funeral home to pay funeral expenses, life insurance and AD&D benefits cannot be assigned to any individual or entity under any circumstances.

I. CONVERSION TO INDIVIDUAL POLICY

You or a dependent may be able to convert a part or all of your group term life insurance to an individual life insurance policy when your coverage or your dependent's coverage ends due to your retirement or otherwise no longer qualifying for Eligible Employee life insurance coverage under the Plan, your dependent losing eligibility for benefits provided under the Plan, or due to the termination of the group life insurance policy. If your coverage ends because the Plan's contract with the Life Insurance Company to provide life insurance ends, you must have been covered for five years in order to be eligible for conversion. The Life Insurance Company will determine the individual premium. You must apply and pay for conversion coverage within 31 days after your group life insurance coverage ends. If the Benefit Office fails to notify you of your conversion rights within 15 days after your group coverage ends, the application period may be extended for up to 15 days from the date the Benefit Office sends or gives you such written notice. In no event will the application period extend beyond 91 days from the date of the termination of the life insurance group coverage.

If you are interested in obtaining a conversion policy, contact the Benefit Office as soon as you determine your or your dependent's coverage under the group policy is going to end.

NOTE: If you or a dependent dies during the 31-day conversion application period, the Life Insurance Company will pay the maximum amount you or the dependent could have converted, but will pay no other benefits.

J. DEFINITIONS APPLICABLE TO THE LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE PROGRAM

1. Illness

A disorder or disease of the body or mind. Illness includes:

a. pregnancy;

b. childbirth; and

c. related medical conditions.

2. Injury

Bodily harm that:

a. the Covered Individual sustains while the group term life insurance policy is in force; and

b. is not the result of an illness.

SECTION 13. WEEKLY DISABILITY BENEFITS (FOR ELIGIBLE EMPLOYEES ONLY)

A. SCHEDULE OF BENEFITS

Benefits Begin: On the 3rd working day following the date you became temporarily Disabled.

Benefit Amount: $200 per week ($40 per day, excluding Saturdays and Sundays, for any incomplete week of Disability).

Benefits Continue: For a maximum of 13 weeks for each period of Disability.

This benefit is not available to dependents or participants covered under the NBUE group.

Please note the Plan's claims limitation periods in Section 18.

B. BENEFIT DESCRIPTION

If you, the Eligible Employee, should become Disabled as a result of a non-occupational Illness or Injury while covered by this Plan, benefits will be available according to the preceding schedule to help supplement your income during the loss of working time. Benefits are not payable for weekends, and weekends will not be counted in determining when benefit payment begins.

House confinement during Disability is not required. However, the Disability must be severe enough to prevent you from doing any part of your normal occupation. You must be under the direct care of a licensed doctor, nurse practitioner, or physician assistant who must certify the period of your Disability.

C. SUCCESSIVE PERIODS OF DISABILITY

Two or more successive periods of Disability will be considered one Disability period for the purposes of this benefit, unless:

1. the Disabilities are due to totally unrelated causes, and you have returned to active work for at least five consecutive days, excluding Saturdays and Sundays, between periods of Disability; or
2. the Disabilities are due to the same or related causes, and you have either (a) returned to active work for 10 consecutive days, excluding Saturdays and Sundays, between periods of Disability, or (b) are available for work, based on a medical release to return to work from your doctor and your name is listed on the Union's "out-of-work" list.

D. LIMITATIONS AND EXCLUSIONS

1. Benefits are not paid if your loss of work is from a non-Contributing Employer.
2. Benefits are not payable for individuals covered under the Plan as dependents, Retired Eligible Employees or Eligible Employees on COBRA (other than Eligible Employees with self-payment coverage).
3. Benefits are not payable if your Disability is due to any Accident, Injury or Illness arising from your employment or self-employment of any type or character (whether or not the employment or self-employment is in your primary occupation). The Trustees in their discretion may make conditional payment of benefits for such Disability, subject to completion and submission of the Plan's Reimbursement Agreement (which is available from the Benefit Office upon request).

SECTION 14. RETIRED ELIGIBLE EMPLOYEE BENEFITS

A. INTRODUCTION

1. Generally

If you meet the eligibility requirements described in Subsection B. below, you and your dependents may continue certain benefits under the Plan through the Plan's Retiree Benefit option and Medicare Advantage Benefit option after you retire. Please read this subsection carefully if you think you may want to continue to be covered under this Plan when you retire. If you choose COBRA continuation coverage at the time you retire, you may not choose the Retiree Benefit or the Medicare Advantage Benefit later.

If you or a dependent has a lapse in coverage at or after your retirement, that person will permanently lose the opportunity for coverage under both the Retiree Benefit and the Medicare Advantage Benefit and will no longer be eligible to participate in the Plan on that basis. Exceptions: if you do not enroll in the Retiree Benefit or the Medicare Advantage Benefit because you have coverage under your spouse's group health plan, when you retire or you later drop the Retiree Benefit or the Medicare Advantage Benefit, you will be permitted to enroll or reenroll if you lose coverage under your spouse's group health plan because of one of the following events:

a. your spouse dies;

b. you are divorced from your spouse;

c. your spouse retires;

d. your spouse's employment terminates;

e. your spouse's employer discontinues or ceases contributing to your spouse's group health plan.

In the case of a. or b. above, you and your children who were your eligible dependents at the time of your retirement may be enrolled or reenrolled. In the case of c., d. or e. above, you, your spouse to whom you were married at the time of your retirement and your children who were your eligible dependents at the time of your retirement may be enrolled or reenrolled. Enrollment and reenrollment rights of children are subject to Subsection B.3.

"Group health plan" means group health coverage through your spouse's employer and to which that employer contributes.

You must notify the Benefit Office and complete an enrollment form within 90 days of the event that resulted in loss of coverage and must make premium payments for the period beginning no later than the first day of the month following the date the other group health plan coverage ends.

Additional exceptions are set forth in Section 14.D. and E.

2. Retiree Benefit

The Retiree Benefit is for Retired Eligible Employees and for Retired Eligible Employees' eligible dependents, who are not eligible for Medicare. Covered Individuals who are eligible for the Retiree Benefit receive the same medical, prescription drug, behavioral care, dental, vision and hearing aid benefits as are available to Eligible Employees and their eligible dependents. Disability benefits are not available to Retired Eligible Employees. The life insurance benefit for Retired Eligible Employees is reduced to $2,500, as described in Section 12. of this Booklet.

3. Medicare Advantage Benefit

If a Retired Eligible Employee or the eligible dependent of a Retired Eligible Employee is eligible for Medicare and enrolled in both Parts A and B of Medicare, the Covered Individual may select from one of the Medicare Advantage Health Organizations (HMOs or PPO) made available through the Plan. This opportunity will be provided at the time the Medicare eligible Covered Individual initially qualifies for Medicare based enrollment and during the annual Medicare open enrollment process. From time to time the Trustees will determine the amount, if any, that a Covered Individual is required to contribute towards the cost of coverage for each available

Medicare Advantage option. The eligibility requirements of Subsection B. apply. The life insurance benefit for Retired Eligible Employees is reduced to $2,500, as described in Section 12 of this Booklet.

4. Coordination of Benefits and Medicare

Retiree Benefits are only available to a Retired Eligible Employee or an eligible dependent of a Retired Eligible Employee who is not eligible for Medicare. A Retired Eligible Employee or an eligible dependent of a Retired Eligible Employee who is eligible for Medicare is only eligible for the Medicare Advantage Benefit. You **must** enroll in both Medicare Parts A and B in order to be eligible to participate in a Medicare Advantage.

B. ELIGIBILITY

1. In order to be eligible for any retiree coverage provided or negotiated by the Plan ("Retiree Coverage"), a normal or early Retired Eligible Employee or an unmarried surviving spouse of a Retired Eligible Employee must meet ALL of the following requirements.

   a. The Retired Eligible Employee or the unmarried surviving spouse of a Retired Eligible Employee must be or have been receiving monthly benefits* from the Construction Laborers' Pension Trust of Greater St. Louis or a pension plan to which a Contributing Employer was required to contribute pursuant to the same collective bargaining agreement which required contributions to this Plan.

      For a Retired Eligible Employee who is not a participant in the Construction Laborers' Pension Trust of Greater St. Louis or a pension plan to which a Contributing Employer was required to contribute pursuant to the same collective bargaining agreement which required contributions to this Plan, this requirement may be met if the Retired Eligible Employee establishes that he would have met the requirements of any monthly retiree benefit under the Construction Laborers' Pension Trust of Greater St. Louis if he had been a participant and executes an Affidavit that he is not engaged in and does not intend to engage in future employment in the industry.

   b. Each person for whom any Retiree coverage provided or negotiated by the Plan is sought must have been covered under this Plan at the time those monthly benefits commenced and remain continuously covered under the Plan from that date, except as otherwise provided in Subsection A.1. above; see also Subsections (D) or (E) below.

      This eligibility requirement will be deemed to have been met if the only reason that coverage under this Plan was not in effect at the time monthly pension benefits commenced is because of a proven failure of an employer to make required contributions within the one-year period immediately preceding the commencement of the monthly pension benefits.

      To show that there has been a proven failure of an employer to make required contributions, you must be able to produce pay stubs or otherwise prove that you would have had the hours for coverage if it were not for the employer delinquency.

   c. The Retired Eligible Employee must have been covered under this Plan for a total of 20 quarters. Those quarters may be cumulative over the Retired Eligible Employee's career and need not be continuous.

   *****If, at the time the Retired Eligible Employee retires, the Retired Eligible Employee does not choose a form of pension benefit that provides payments to the Retired Eligible Employee's spouse after the Retired Eligible Employee's death, the spouse to whom the Retired Eligible Employee was married at the time of the Retired Eligible Employee's retirement may nevertheless continue any Retiree Coverage provided or negotiated by the Plan after the Retired Eligible Employee's death, provided the Retired Eligible Employee's spouse meets the other eligibility requirements.

2. Upon retirement the following Eligible Employees will be treated as having automatically met the above requirements:

   a. Eligible Employees who (1) were Eligible Employees of Laborers International Union of North America (LIUNA) Local 718 when Local 718 was merged into LIUNA Local 110 on

May 1, 2007, and (2) at the time of that merger elected to transfer their welfare plan coverage from the Construction Industry Laborers' Welfare Fund to the Greater St. Louis Construction Laborers' Welfare Fund; and

b. Eligible Employees (1) who were covered under the Construction Industry Laborers' Welfare Fund as of January 1, 2010, as a result of their work under a quarry collective bargaining agreement, and (2) who elected prior to July 1, 2011, to transfer their welfare plan coverage from the Construction Industry Laborers' Welfare Fund to the Greater St. Louis Construction Laborers' Welfare Fund.

3. The eligibility of a Retired Eligible Employee's dependents for coverage under this Section 14. is determined in accordance with the rules for dependent coverage set forth in Section 3., Subsection B. of this Booklet. Coverage for an eligible dependent child of a Retired Eligible Employee is available only while the Retired Eligible Employee or the eligible dependent spouse of a Retired Eligible Employee is covered by any Retiree Coverage provided or negotiated by the Plan ("Retiree Coverage").

   a. If the child is not eligible for Medicare, or the child is eligible for Medicare but neither the Retired Eligible Employee nor the eligible dependent spouse of the Retired Eligible Employee is covered under the Medicare Advantage Benefit, the child must be enrolled in the Retiree Benefit.

   b. If the child is eligible for Medicare and either the Retired Eligible Employee or the eligible dependent spouse of a Retired Eligible Employee is covered under the Medicare Advantage Benefit, the child must enroll in both Parts A and B of Medicare and must be enrolled in the Medicare Advantage Benefit.

   When the Retired Eligible Employee and the eligible dependent spouse of a Retired Eligible Employee (or the survivor of them) is no longer covered under the Retiree Benefit and is covered under Medicare and an associated Plan benefit under this Plan, an eligible dependent child who is not eligible for Medicare may elect to (1) continue to receive the Retiree Benefit, or (2) receive COBRA continuation coverage for 36 months in accordance with the provisions of Section 5. of this booklet. That election will be effective the first day of the month in which neither the Retired Eligible Employee nor the eligible dependent spouse of a Retired Eligible Employee is covered under the Retiree Benefit. If the eligible dependent child chooses COBRA continuation coverage, the child may not later choose the Retiree Benefit or an associated Medicare benefit.

   Note: In order for your eligible dependent to qualify for coverage under this Section 14., the dependent must be covered under the Plan at the time of the Retired Eligible Employee's retirement. Except as otherwise provided in Subsection A.1. above, a dependent cannot be added after the Retired Eligible Employee retires and initially qualifies for coverage under this Section 14.

C. PAYMENT FOR BENEFITS

1. You must pay for the Retiree Coverage in advance each month. The cost will be automatically deducted from your monthly pension benefit check if you are receiving benefits from the Construction Laborers' Pension Trust of Greater St. Louis. If your monthly pension check is not sufficient to pay for these benefits, or if you are not receiving benefits from the Construction Laborers' Pension Trust of Greater St. Louis, you must pay the balance or the full payment, as the case may be, prior to the beginning of the month for which you are paying. If you fail to make timely payments for these benefits, your eligibility for these benefits will permanently terminate.

2. There are two rate levels – un-subsidized and subsidized. In order to qualify for subsidized rates, the Retired Eligible Employee or the unmarried surviving spouse of a Retired Eligible Employee must meet all of the following requirements.

   a. Each person for whom the Retiree Coverage is sought must have been covered under this Plan for 12 of the last 20 quarters immediately prior to retirement. These quarters need not be continuous; and

b. The Retired Eligible Employee must have been contributed on and covered under this Plan for a total of 40 quarters. These quarters may be cumulative over the Retired Eligible Employee's career and need not be continuous.

3. Upon retirement the following Eligible Employees will be treated as having automatically met the above requirements:

   a. Eligible Employees who

      (1) were members of Laborers International Union of North America (LIUNA) Local 718 when Local 718 was merged into LIUNA Local 110 on May 1, 2007, and

      (2) at the time of that merger elected to transfer their welfare plan coverage from the Construction Industry Laborers' Welfare Fund to the Greater St. Louis Construction Laborers' Welfare Fund.

   b. Eligible Employees who

      (1) were covered under the Construction Industry Laborers' Welfare Fund as of January 1, 2010, as a result of their work under a quarry collective bargaining agreement, and

      (2) elected prior to July 1, 2011, to transfer their welfare plan coverage from the Construction Industry Laborers' Welfare Fund to the Greater St. Louis Construction Laborers' Welfare Fund.

4. **Note:** These benefits are not vested and are subject to modification or termination at any time. The cost will be reviewed periodically by the Trustees and the amounts charged to you may be adjusted by the Trustees at any time.

D. RESUMPTION OF COVERED EMPLOYMENT

1. If a Retired Eligible Employee who is covered by the Retiree Coverage of the Plan returns to work in Covered Employment, the Retired Eligible Employee's coverage under the Plan may be continued at the Retiree Coverage premium rates established by the Trustees until the Retired Eligible Employee meets the requirements of Section 3. for Active Employee coverage under the Plan. When the Eligible Employee ceases to be eligible for Active Employee coverage, the Eligible Employee will be entitled to elect continued coverage through self-payment and COBRA as provided in Sections 3. and 5. of this Booklet. When the Eligible Employee's pension benefits resume, the Eligible Employee's Active Employee self-payment or COBRA continuation coverage will cease and the Eligible Employee may resume the Eligible Employee's coverage under the Retiree Coverage of the Plan.

2. Special Program for Resumption of Covered Employment after Retirement from May 1 to October 31.

   If a Retired Eligible Employee who is covered by the Retiree Coverage of the Plan returns to work in Covered Employment and meets the following requirements, the Retired Eligible Employee will continue coverage under the Retiree Coverage of the Plan:

   a. The Retired Eligible Employee works no more than 474 hours during the time period of May 1 through October 31. If the Retired Eligible Employee works 475 hours or more, he or she would be subject to the rules of Section 14.D.1 above.

   b. The Retired Eligible Employee does not work in the position filled until after the Contributing Employer contacted the St. Louis Laborers' Local Unions 42-110 or the Eastern Missouri Laborers' District Council seeking a qualified Active Employee and the position remained unfilled for 48 hours.

   c. The Retired Eligible Employee continues to make any and all required self-pay contributions towards the Retiree Coverage of the Plan unless the retiree meets the requirements of Section 3 for Active Employee coverage under the Plan.

   d. The Contributing Employer pays the Retired Eligible Employee the same rate as an Active Employee, including remitting hourly contributions to the Plan and to the affiliated benefit funds.

This program does not change the rules in Section 14.D.1. for any employment for the period from November 1 to April 30.

E. DISQUALIFYING WORK

If the Retired Eligible Employee is disqualified from receiving monthly benefits from the Construction Laborers' Pension Trust of Greater St. Louis for reasons other than resumption of covered employment, the Retired Eligible Employee can only retain coverage by privately paying the full, unsubsidized cost of coverage until he/she resumes monthly benefits from the Construction Laborers' Pension Trust of Greater St. Louis. A Retired Eligible Employee will be permitted to private pay contributions no more than three consecutive months; thereafter, retiree coverage will be permanently terminated.

SECTION 15. COORDINATION OF BENEFITS

A. GENERALLY

The coordination of benefits provision is intended to prevent the payment of benefits which exceed expenses. It applies when you or any eligible dependent covered by this Plan is also covered by any other plan or plans. COB also applies when you or your dependent is covered by this Plan in more than one capacity. For example, you may be covered as an Active Employee or Retired Eligible Employee and as an eligible dependent of an Active Employee or Retired Eligible Employee. Alternatively, an eligible dependent may be covered as the natural or adopted child of one Active Employee or Retired Eligible Employee and as the stepchild of another Active Employee or Retired Eligible Employee. When more than one coverage exists, one plan normally pays its benefits in full and the other plan or plans pay reduced benefits. This Plan will always pay either its benefits in full or a reduced amount which, when added to the benefits payable by the other plan or plans, will not exceed 100% of Covered Charges. Only the amount paid by this Plan will be charged against the Plan maximums.

B. DEFINITIONS FOR THIS COB PROVISION

1. "Coordinating Plan" means any of the following coverages, including policy coverage, and any coverage that is declared to be "excess" to all other coverages, which provide benefit payments or services to a Covered Individual that may include Hospital, medical, surgical, prescription drug, dental or vision care:

    - This Plan.
    - Any group, blanket or franchise health insurance.
    - A group contractual prepayment or indemnity plan.
    - A Health Maintenance Organization (HMO), whether group practice or individual practice association.
    - A labor-management trusteed plan or a union welfare plan.
    - An employer or multi-employer plan or employee benefit plan.
    - A government program.
    - Insurance required or provided by statute.
    - Insurance provided by a school or school district to cover Injuries incurred as a result of school sponsored athletic activities, whether or not the eligible dependent was enrolled in the program or if application was made for such enrollment.
    - Medical payments coverage under automobile (including uninsured or underinsured motorist coverage), homeowners and general liability insurance policies, regardless of whether individual or group, fault or no fault.

    "Coordinating Plan" does not include any individual or family policies or contracts or public medical assistance programs. Eligibility for coverage will not be affected by the fact that a person is eligible for or is provided medical assistance under Medicaid, that is, a state plan for medical assistance approved under Title XIX of the Social Security Act. In addition, this Coordination of Benefits provision will not apply to benefits a person is entitled to receive under Medicaid.

2. "Claimant" means the Covered Individual for whom the claim is made.

3. "Covered Expense" means any expense which is covered by at least one Coordinating Plan during a Claim Period. Where a Coordinating Plan provides benefits in the form of a service rather than cash payments, the reasonable cash value of the service during a Claim Period will also be considered a Covered Expense.

C. HOW COB WORKS

The Primary Plan (which is the Coordinating Plan that pays benefits first) pays the benefits that would be payable under its terms in the absence of this provision.

The Secondary Plan (which is the Coordinating Plan that pays benefits after the Primary Plan) will limit the benefits it pays so that the sum of its benefit and the benefits paid by the Primary Plan will not exceed 100% of total Covered Expense. When paying as the Secondary Plan, the Benefit Office will apply the lower of its own re-pricing or the Primary Plan's re-pricing of the claims.

When this Plan is Secondary, this Plan will pay for Covered Charges in accordance with its terms and conditions, including, for example, application of the appropriate Co-pay, Deductible and Co-insurance. If the amount of Covered Charges that the Primary Plan does not pay exceeds what this Plan would have paid if it was not coordinating with the Primary Plan, this Plan will limit its payment to the amount of Covered Charges that this Plan would have paid if it was not coordinating with the Primary Plan. If the amount of Covered Charges paid by this Plan is less than the amount of Covered Charges that this Plan would have paid if it was not coordinating with the Primary Plan, the difference or "savings" that this Plan realizes as a result of the Primary Plan paying a portion of the Covered Charges may be set aside as a credit reserve and will be used to offset any Co-pay, Deductible or Co-insurance that the Covered Individual is required to pay during the rest of the calendar year.

The "Order of Benefit Determination" paragraph below explains the order in which Coordinating Plans must pay.

1. Order of Benefit Determination

a. When another Coordinating Plan does not have a COB provision or provides that it always pays second, that Coordinating Plan must pay its benefits first.

There is one exception – coverage obtained by virtue of membership in a group designed to supplement part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the Coordinating Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base Hospital and surgical benefits and insurance type coverages that are written in connection with a Closed Panel Plan to provide Out-of-Network benefits.

b. When another Coordinating Plan does have a COB provision, the first of the following rules which apply governs:

(1) If a Coordinating Plan covers the Claimant other than as a dependent, for example, as an Eligible Employee, subscriber or retiree, then that Coordinating Plan will pay its benefits before the Coordinating Plan that covers the Claimant as a dependent.

Please note: The Medicare laws may change the above rule. When the Claimant is covered as a dependent of the Claimant's spouse who is actively employed, and the Claimant is also covered as a retiree or former employee, the Medicare statute and regulations provide that Medicare is primary to the Coordinating Plan that covers the Claimant as other than a dependent and secondary to the Coordinating Plan that covers the Claimant as a dependent. In such circumstances, the Coordinating Plan that covers the Claimant as a dependent of an active employee pays first, Medicare pays second, and the Coordinating Plan that covers the person as other than a dependent pays last.

(2) If the Claimant is a dependent child whose parents are married, or not married but live together, then the Coordinating Plan of the parent whose birthday is earlier in the calendar year will pay first; except:

(a) If both parents' birthdays are on the same day, the Coordinating Plan of the parent covered longer will pay first; or

(b) If another Coordinating Plan does not include this COB rule based on the parents' birthdays, but has the gender rule and if, as a result, the Coordinating Plans do not agree on the order of benefits, the birthday rule will determine the order of benefits.

(3) If the Claimant is a dependent child whose parents are divorced, separated or not living together, then the following rules apply:

(a) The Coordinating Plan which covers a child as a dependent of a parent who by court decree must provide health coverage will pay first, provided, the Coordinating Plan of that parent has actual knowledge of the terms of the decree;

(b) When there is no court decree which requires one parent to provide health coverage to a dependent child, the following rules will apply:

i. The Coordinating Plan of the parent who has custody of the child, or, if the parents have joint custody, the Coordinating Plan of the parent who has primary residence of the child, will pay first;

ii. Then, the Coordinating Plan of the spouse of the parent who has custody of the child will pay;

iii. Then the Coordinating Plan of the parent without custody will pay;

iv. Finally, the Coordinating Plan of the spouse of the noncustodial parent will pay.

(4) If a Coordinating Plan covers the Claimant as an active employee (who is not terminated, laid off or retired) or the dependent of an active employee, that Coordinating Plan will pay its benefits before a Coordinating Plan that covers the Claimant as a terminated, laid off or retired employee or the dependent of a terminated, laid off or retired employee.

(5) The Coordinating Plan which covers the Claimant as a spouse pays before the Coordinating Plan which covers the Claimant as a dependent child.

(6) The Coordinating Plan which covers the Claimant as a current employee or the dependent of a current employee pays before the Coordinating Plan which covers the Claimant under COBRA or similar continuation coverage.

(7) If this Plan covers the Claimant as a step-child of an Eligible Employee, this Plan will pay after any Coordinating Plan(s) covering the Claimant. However, this provision shall not be effective for those Claimants with existing coverage under a Coordinating Plan on July 1, 2021 which coverage is still in effect at the time of receipt of benefits.

(8) If none of the above rules apply, the Coordinating Plan which has covered the Claimant for the longer period of time will pay its benefits first.

2. Excess Coverage

If one or more of the other Coordinating Plans involved (as defined in this Coordination of Benefits provision) provides benefits on an Excess Insurance or Excess Coverage basis, this Coordinating Plan will pay as excess coverage.

3. Medical Payments under Automobile, Homeowners and General Liability Policies

This Plan will always be secondary to medical payments coverage under automobile, homeowners and general liability insurance policies. This Plan may pay as primary, however, on a claim that is subject to homeowner's medical payment coverage, provided that this Plan's normal liability for such claim is under $1,500.

4. Coordination of Benefits when Primary Plan's Requirements Not Met

When this Plan's benefits are secondary to another Coordinating Plan or to Medicare (traditional Medicare, Medicare HMOs and other Medicare + Choice Plans), or would have been secondary had the Claimant enrolled in Medicare when eligible, and the Claimant elects not to follow the Primary Plan's requirements to receive maximum benefits, this Plan will coordinate benefits as though those requirements had been met and this Plan's benefits will be offset by the amount that would have been payable under the Primary Plan's benefits had the

Primary Plan's requirements been met. This restriction will not apply in the case of an Emergency, as defined in this Plan.

D. FACILITY OF PAYMENT

If benefits which this Plan should have paid are instead paid by another Coordinating Plan, this Plan may reimburse the other Coordinating Plan. Amounts reimbursed are benefits of this Plan and are treated like other benefits in satisfying the liability of this Plan.

Should this Plan pay benefits which should have been paid by another Coordinating Plan, this Plan has the right to recoup those benefits from the other Coordinating Plan, the provider, the Covered Individual or any other person or organization that received or benefited from this Plan's payment.

E. PRIMARY PLAN CANNOT SHIFT LIABILITY TO THIS PLAN

Notwithstanding any other provisions of these Coordination of Benefits rules, the following paragraphs shall apply to prevent a Coordinating Plan that is primary under these rules from shifting its liability to this Plan:

1. When another Coordinating Plan, including one made up of separate contracts or arrangements, which is primary under this Plan's rules, contains a sub-plan/no loss provision, this Plan will not pay as the Secondary Plan until the Primary Plan has exhausted its benefits under any no loss or similar provisions.

2. If another Coordinating Plan, including one made up of separate contracts or arrangements, is primary under this Plan's rules, and it contains a provision that has the effect of capping its benefits for an individual covered under this Plan and of shifting coverage liability to this Plan in a manner designed to avoid the usual operation of this Plan's coordination of benefits rules, this Plan shall not be liable to provide benefits until the other Coordinating Plan provides its customary benefits as the Primary Plan without regard to such cap.

3. If another Coordinating Plan, including one made up of separate contracts or arrangements, is primary under this Plan's rules, no benefits of any kind will be provided by this Plan to or for the affected Covered Individual unless the amount and type of benefits paid by that other Coordinating Plan are unaffected by the Covered Individual's coverage under this Plan.

F. SPECIAL MEDICARE COB RULES

1. Medicare for Active Employees and their Dependents

If you are an Active Employee and either:

- you or your eligible dependent spouse is age 65 or older and eligible for Medicare for reasons other than kidney dialysis or end stage renal disease, or
- you or your eligible dependent spouse or child is disabled under Social Security and eligible for Medicare for reasons other than kidney dialysis or end stage renal disease,

This Plan is the Primary Plan and will pay its regular medical benefits. Medicare is the Secondary Plan and may supplement the benefit you or your eligible dependent receives under this Plan.

2. Medicare for Covered Individuals with End Stage Renal Disease (ESRD)

If you or your under age 65 eligible dependent is eligible for Medicare due solely to End Stage Renal Disease (ESRD), this Plan will be primary during the first thirty (30) months of Medicare coverage. Thereafter, this Plan will be secondary with respect to Medicare coverage.

3. When Medicare is Primary

When Medicare is primary and this Plan is secondary, Medicare (Parts A and B) will be considered a Coordinating Plan for the purposes of coordination of benefits. This Plan will coordinate benefits with Medicare Parts A and B whether or not you or your dependents are enrolled in Medicare Parts A and B or receiving Medicare benefits. If the Covered Individual does not enroll in Part A and Part B of Medicare, the Covered Individual's benefits under this Plan will be reduced by the amount of the Medicare benefits which would have been payable had the Covered Individual enrolled in Medicare Part A and Part B.

REMEMBER: Medicare provisions apply from the date you are first ELIGIBLE for Medicare regardless of whether you are actually enrolled or receiving benefits. For this reason, you need to exercise your options promptly.

G. COVERED INDIVIDUAL RESPONSIBILITIES

It is the responsibility of all Covered Individuals to provide complete and accurate information to the Benefit Office, including information pertaining to other health or prescription coverage and/or insurance benefits (including, but not limited to, prescription coverage or benefits), which each Covered Individual may have or have access to.

H. COORDINATION OF MEDICAL BENEFITS WITH DENTAL BENEFITS

To the extent that a treatment, service, or supply is covered under both the medical provisions of this Plan and the dental provisions of this Plan, a claim for such treatment, service or supply, will be considered first under the dental provisions of the Plan and then under the medical provisions.

SECTION 16. PLAN'S RIGHTS TO SUBROGATION AND REIMBURSEMENT

A. GENERALLY

If this Plan pays out major medical, weekly disability benefits, dental, vision and prescription benefits to or on behalf of a "covered person" (as defined below) in connection with an Illness or an Injury for which a "third party" (as defined below) may be responsible, the Plan has the right to recover those benefits either directly from the third party or from the covered person. While these subrogation and reimbursement provisions are most often relevant in connection with automobile accidents, they also apply in any situation in which a covered person's Injury or Illness is caused by a third party. For example, these provisions apply if a covered person is injured by a faulty product, by medical malpractice, or by some defective condition of a third party's property.

B. DEFINITIONS

1. For purposes of these reimbursement and subrogation provisions, a "covered person" is a person to or on whose behalf this Plan pays out benefits. The term "covered person" also includes such individual's guardian, estate, heirs or other representative.

2. For purposes of these reimbursement and subrogation provisions, a "third party" is a person who caused the covered person's Injury or Illness and any other person or entity that has an obligation to pay compensation of any sort to the covered person as a result of that Injury or Illness. For example, both the insurer of the responsible third party and the insurer of the covered person are included in the meaning of "third party" to the extent such insurers are obliged to compensate the covered person as a result of the Injury or Illness. Thus, to the extent the injured person's own insurer is obliged to compensate the injured person under the injured person's uninsured or underinsured motorist coverages, the injured person's own insurer will be a "third party".

C. PLAN'S RIGHT TO REIMBURSEMENT

If this Plan pays out benefits of any sort to or on behalf of a covered person in connection with an Illness or an Injury for which a third party may be responsible, such benefits are paid on the express condition that the covered person must reimburse the Plan from the proceeds of any settlement or recovery that the covered person receives from or through such a third party or parties. The Plan has the right to recover the amount of the benefits it paid out in connection with the Injury or Illness if the covered person recovers any amount from or through any third party or parties. The covered person's spouse is also required to reimburse the Plan to the extent the spouse recovers from any third party by reason of the Injury to the covered person.

The description or characterization of any recovery from any third party does not affect the Plan's right to reimbursement. By accepting benefits from the Plan, the covered person and his or her spouse acknowledge the Plan's right to reimbursement and agree to make such reimbursement and agree to hold any recovery received from a third party in trust for the Plan, to the extent of the amount of benefits the Plan paid out in connection with that Injury or Illness. The covered person and his or her spouse must reimburse the Plan in full from any recovery from any third party or parties for benefits the Plan paid in connection with the Injury or Illness before any other amounts are deducted from the recovery paid by the third party or parties. However, the Plan, in the sole and absolute discretion of the Plan, based on all of the circumstances, including the total amounts of the recovery and the costs and attorney's fees incurred by the covered person, may determine it is in the best interests of the Plan to reduce their claim for reimbursement.

D. PLAN'S RIGHT TO SUBROGATION

"Subrogation" means the substitution of one person in the place of another with respect to a claim, demand or right.

To the extent of benefits it pays out, the Plan will be subrogated to all claims, demands, actions and rights of the action the covered person may have against any third party or parties. This means that to the extent the covered person has a claim against anyone as a result of an Injury or Illness for which the Plan pays out benefits, the Plan has a right to pursue the covered person's claim. In effect, the Plan "stands in the place" of the covered person with respect to such claim or claims. For example, if you are injured in an auto accident caused by another person and the Plan pays out benefits for the

treatment of your Injury, the Plan could, on its own, sue the person who caused the accident or, if you sued that person, the Plan could join in your lawsuit.

The Plan's subrogation and reimbursement liens are subject to challenge and/or enforcement exclusively in accordance with the provisions of ERISA in the federal courts of the United States.

The amount of the Plan's subrogation interest is equal to the amount it paid out in connection with the Injury or Illness, plus the attorney's fees and costs it incurs in pursuing the claim against the third party or parties. However, the Plan's reimbursement may be reduced by its proportionate share of the attorney's fees and costs incurred by the covered person (and spouse) in connection with the recovery, but in no event will the Plan's reimbursement be reduced by more than one-third for fees and costs.

The Plan may assert its claim against any third party even if the covered person does not, or the Plan may join in any action the covered person brings against any third party or parties. The Plan does not waive any of its rights to reimbursement by not independently asserting its claim against any third party or by not joining in any action brought by the covered person against any third party.

By accepting benefits from this Plan in connection with any Injury or Illness for which a third party may be responsible, the covered person expressly acknowledges the Plan's rights to subrogation and agrees to do nothing to prejudice those rights and to cooperate fully with the Plan in asserting those rights.

E. COVERED PERSON'S RESPONSIBILITIES

In order to receive benefits from this Plan in connection with an Injury or Illness for which a third party may be responsible to compensate the covered person, that covered person (and, if applicable, his or her spouse) must do all of the following:

1. notify the Plan when the covered person suffers an Injury or Illness for which a third party may be required to compensate the covered person;
2. provide the Plan with any and all documents and information regarding the Injury or Illness the Plan may request;
3. execute an agreement setting forth the Plan's rights and the covered person's obligations and the obligations of the covered person's spouse under these subrogation and reimbursement provisions. If the covered person is represented by an attorney, that attorney must also sign the subrogation agreement;
4. provide the Plan with notice if the covered person or the covered person's spouse asserts a claim or claims against any third party and keep the Plan informed as to the status of such claim or claims;
5. notify the Plan or its designee prior to settling any claim to which this Plan is subrogated;
6. notify the Plan of any compensation the covered person or the covered person's spouse receives from any third party in connection with the Injury or Illness and immediately reimburse the Plan upon the receipt of such compensation;
7. cooperate fully with the Plan in its efforts to protect and exercise its rights to subrogation and reimbursement; and
8. take no actions to compromise or impair the Plan's rights to reimbursement or subrogation.

If the covered person or the covered person's spouse fails to comply with these obligations, the Plan will not pay out benefits in connection with that Injury or Illness. If the covered person or the covered person's spouse fails to reimburse the Plan for the benefits it paid out from any recovery they receive from the third party or parties as required, the Plan may withhold future benefits due the covered person and his or her covered family members or may take any other such action necessary to enforce the Plan's right to reimbursement.

F. REJECTION OF "MAKE-WHOLE" DOCTRINE

This Plan specifically rejects the "make-whole" doctrine. The Plan's rights to reimbursement and subrogation do not depend on whether the covered person or the covered person's spouse recovers

from third parties monies sufficient to fully compensate the covered person or the covered person's spouse, or both, for their losses.

G. PLAN'S ENFORCEMENT OF THESE PROVISIONS

In the event the covered person or his or her spouse fails to fulfill his or her obligations under these reimbursement and subrogation provisions, the Plan may take any action the Trustees deem necessary to enforce the Plan's rights under these provisions. The Plan may refuse to pay benefits in connection with the Injury or Illness if the covered person or the covered person's spouse fails to fulfill his or her obligation to provide information and documents or fails to execute the required reimbursement and subrogation agreement. If the Plan does pay benefits and the covered person or the covered person's spouse later fails to fulfill his or her duties, the Plan may withhold future benefits from the covered person and the covered person's family members, may bring an action against the covered person and the covered person's spouse, or may recoup amounts it paid out from the providers to whom such amounts were paid or any other sources. Should the Trustees bring legal action to enforce the Plan's rights under these reimbursement and subrogation provisions, and succeed in whole or in part in such action, the covered person or the covered person's spouse shall pay the legal fees and costs the Trustees incur in that action.

H. FUTURE CLAIMS RELATING TO THE SAME INJURY OR ILLNESS

Once the covered person's claims against the third party or parties are resolved, the Plan will not pay out any additional benefits in connection with the Injury or Illness caused by the third party until the total claims that would otherwise be covered under the Plan exceed the total amount of compensation paid to or on behalf of the covered person and/or the covered person's spouse by the third party or parties. In such a situation only the excess portion of the otherwise covered claims will be treated as covered.

SECTION 17. ENROLLMENT, BENEFICIARY DESIGNATIONS AND CLAIMS REQUIREMENTS

A. ENROLLMENT AND UPDATES

You must complete an individual enrollment form in order to activate your eligibility for benefits. You may obtain the enrollment form from the Benefit Office, your employer or your union hall. Return the completed form to the Benefit Office.

As indicated in Section 3. of this Booklet, in order to enroll your dependents, you may be required to furnish proof of their status as eligible dependents. If you have any questions about your dependents' eligibility, please contact the Benefit Office.

You must also complete an information form updating information about yourself and your eligible dependents once each calendar year and whenever there is a change in information, including changes in a spouse's employment or other insurance coverage for any Covered Individuals. The Benefit Office will send you this form. Benefits will not be paid until the Benefit Office has received the requested updated information form.

Your failure to complete an original enrollment form or updated information form for yourself or any dependent can cause the coverage effective date for that individual to be delayed. Further, if you fail to provide the enrollment form or annual information form within the time limit for filing a particular claim, that claim will not be covered.

Children will also be enrolled as required by any Qualified Medical Child Support Order (QMCSO) (see definition in Section 1. of this Booklet) on the date the Benefit Office receives such an order. If you would like information about the Plan's procedures for processing a QMCSO, call the Benefit Office.

B. DESIGNATION OF BENEFICIARY

You can designate in writing the Beneficiary to whom benefits for the loss of your life are payable. You may change your Beneficiary at any time. However, to be effective, any change of Beneficiary must be made upon appropriate forms supplied by the Benefit Office and must be in writing signed by you and received by the Benefit Office before a death benefit for your life is paid out to any Beneficiary. Benefits payable on account of the death of a covered dependent will be paid to you. If you have named more than one Beneficiary, and have not designated the share for each, the benefits will be paid in equal shares to those Beneficiaries who survive you. If you have named no Beneficiary or if no named Beneficiary is surviving at the time of your death, payment will be made to the first surviving class in the following order of preference:

1. your surviving spouse;
2. your children, as defined singularly in the Eligibility Section of this SPD, in equal shares;
3. your parents, in equal shares;
4. your brothers and sisters, in equal shares; or
5. the executors or administrators of your estate.

In order to determine which class of individuals is entitled to the death benefit, the Life Insurance Company may rely on an affidavit made by any individual listed above. If payment is made based on such affidavit, the Life Insurance Company will be discharged of its liability for the amount so paid, unless written notice of claim by another individual listed above is received before payment is made.

C. FILING OF CLAIMS AND SUPPORTING DOCUMENTATION

1. Generally

IMPORTANT NOTE REGARDING "CLAIMS": In order to file a "claim", a request for the payment of benefits for services or supplies that have already been provided by a physician, Hospital, pharmacy or other provider must be submitted in writing on an authorized form to the appropriate address. However, claims from physicians and other providers submitted in electronic format will also be accepted to the extent permitted by the Plan or required by law.

Claims and appeal procedures for death and accidental death and dismemberment, disability, medical, behavioral care, prescription drug, dental, vision, and hearing aid benefits are described below.

All claims should be submitted as soon as possible after services or supplies are rendered or received. Except as noted below, you must submit a claim for a benefit within one year after you receive the service or after you incur the expense or loss for which the benefit is claimed. The claim should be accompanied by all supporting documentation. Claims not filed within one year of the date of service will not be paid, regardless of the reason for delay.

A claim is considered filed when the appropriate claims administrator receives the required documents.

2. Death and Accidental Death and Dismemberment Benefit Claims

You must submit a claim for a life insurance or AD&D insurance benefit through the Benefit Office within 90 days after the death or other loss. However, the Life Insurance Company will not deny a claim if it was not reasonably possible to file a claim on time and the claim is submitted as soon as reasonably possible.

If you or your Beneficiary has a claim for death benefits or accidental death and dismemberment benefits, contact the Benefit Office. The Benefit Office will prepare and submit the appropriate claim forms to the Life Insurance Company or its designated claims administrator and will tell you or your beneficiary what documentation you must supply in support of the claim. When the claim is for death benefits, you or your Beneficiary must submit a certified copy of the death certificate of the deceased individual, but additional information or documentation may also be required.

3. Weekly Disability Benefit Claims

You must obtain the claim form for weekly Disability benefits from the Benefit Office. The form must be completed by you (or your authorized representative) and your physician and returned to the Benefit Office. The completed claim form must be submitted no later than one year after the Disability commences. The completed claim form should be accompanied by all supporting documentation.

Weekly Disability benefits are paid only to you or your authorized representative.

4. Medical Benefit Claims

Generally, you will not be required to submit a claim for medical benefits. Your doctor, Hospital or other provider will submit a claim electronically in accordance with the Electronic Data Interchange (EDI) rules or via a standard industry billing statement that includes the Covered Individual's name and identification number, patient's name, date of service, type of service and amount of charge. If the provider does not submit the claim, then you must submit a written request for benefits to the Medical Network and Managed Care Administrator, which includes all of the information required for provider claims. Receipt of the electronic submission, billing statement or other written request for benefits will be regarded as receipt of a claim.

In the event of an Accidental Injury, a claim form is often necessary. If so, the Benefit Office, will send you a claim form, which you are required to complete. The claim form will be sent to you automatically in conjunction with an Accidental Injury; you do not need to request a claim form from the Medical Network and Managed Care Administrator.

You and your dependents should always show your identification card at the time services are rendered.

In some instances, a provider may wish to obtain patient eligibility details, check on the status of a claim, request a service review or obtain a remittance advice in electronic format. Conducting these electronic transactions should be handled as described on your identification card or by having the provider contact the Medical Network and Managed Care Administrator.

Electronic claims should be submitted as shown on your medical identification card. Paper claims should be mailed to the Medical Network and Managed Care Administrator at the address provided on the Insert to this Booklet.

5. Behavioral Care Benefit Claims

You normally do not submit a claim form for benefits for the treatment of Mental Health or Substance Use Disorders. Rather you contact the Behavioral/Mental Health Administrator and your treatment will be arranged for you. Providers will submit their bills to the Behavioral/Mental Health Administrator. Submission of these bills will normally constitute the claim. Further, if your request for approval of treatment is denied by the Behavioral/Mental Health Administrator, your request for that approval will be treated as a claim.

6. Prescription Drug Benefit Claims

It is usually not necessary for you to submit a claim in order to receive your prescription drug benefits. You simply present your ID card to a participating pharmacy, pay the Co-pay and get your prescription. Or you can arrange to receive your prescription drug by mail order through the Prescription Mail Order and Specialty Pharmacy. Submission of a prescription to a retail or mail order pharmacy does not constitute the filing of a claim. However, you may submit a claim by sending the pharmacy prescription receipt or the itemized pharmacy billing statement to the Benefit Office if any of the following apply:

a. if you believe the Co-payment you were required to pay by a participating pharmacy or by the mail order service was wrong; or

b. if you were denied a prescription by a retail pharmacy or by the mail order pharmacy.

7. Dental Benefit Claims

If you are using a network dentist, the dentist will file any claims for you. If you are using a non-network dentist, you may be required to submit your own dentist's claim to the Dental Benefits Administrator at the address provided on the Insert to this Booklet.

Please contact the Dental Benefits Administrator for claim forms.

8. Vision Benefit Claims

If you are using a network vision provider, the vision provider will file any claims for you. If you are using a non-network vision provider, you may be required to submit your own vision claim to the Vision Benefits Administrator at the address provided on the insert of this Booklet.

Please contact the Vision Benefits Administrator for claim forms.

If you believe a participating provider did not provide the appropriate vision benefits, you may file a claim by writing to the Vision Benefits Administrator at the address provided on the Insert to this Booklet.

9. Hearing Aid Benefit Claims

You or your provider should submit an itemized bill for hearing aids and related services to the Benefit Office or the Medical Network and Managed Care Administrator.

10. Additional Information or Examination

The Plan (including the Life Insurance Company and all other Plan claim administrators) reserves the right and opportunity to require the submission of additional information regarding a claim for benefits. They also reserve the right to examine the person whose Injury or Illness is the basis of a claim as often as necessary during the duration of the condition for which a claim is made.

Nurse care management services may also be secured to evaluate care, negotiate fees, assist in the selection of home health care needs, and provide other benefit and claim related services to the Plan.

D. PAYMENT OF CLAIMS

1. Generally

The benefits payable on account of your death will be paid to your Beneficiary. Dismemberment benefits will be paid to you. Benefits payable on account of the death of a dependent will be paid to you. Weekly disability benefits will be paid directly to you or your designated representative. Medical, prescription drug, dental, vision, behavioral care, and hearing aid benefits will be paid directly to the doctor, hospital, or other provider who provided the services unless you prove you paid the provider. If you submit sufficient proof that you paid the provider, reimbursement will be made to you or to the person indicated in a QMCSO or in accordance with applicable law governing the payment of benefits.

The Plan reserves the right to allocate the deductible amounts to any eligible charges.

2. Plan's Right to Recover Overpayments or Mistaken Payments

If a payment for a claim filed by or for you or one of your dependents is found to be more than the amount payable under the terms of the Plan or is found to have been made in error, then a refund of the excess or erroneous payment may be requested. If a requested refund is not paid or if none is requested, the Plan may take whatever action they deem necessary to recover the overpaid or mistakenly paid amounts, including, but not limited to, reducing benefits payable for future claims filed by or for you or your dependents to offset the overpaid or mistakenly paid amounts or bringing a legal action against you to collect the overpayment. If it is necessary for the Plan to institute legal proceedings to collect an overpayment and the Plan prevails, you will be responsible for paying the reasonable attorney's fees and costs the Plan incurs in connection with such action.

In addition to the other remedies provided in this Subsection, the Plan may prospectively credit employer contributions on behalf of an Eligible Employee towards the amount of the erroneous or excessive payment. When such employer contributions are so credited, the hours of employment for which such contributions were made will not count as Covered Employment for eligibility purposes. Self-payments will not be allowed should the Eligible Employee lose coverage because contributions made on the Eligible Employee's behalf are being applied to the amount the Eligible Employee owes the Plan.

SECTION 18. CLAIM AND APPEAL PROCEDURES

A. DEATH AND ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

Claim and appeal procedures for death and accidental death and dismemberment benefits are described in the Certificate of Coverage and other materials issued to you by the Life Insurance Company.

B. BENEFITS BASED ON DISABILITY (WEEKLY DISABILITY INCOME, EXTENSION OF COVERAGE)

1. Initial Decision

The Plan will evaluate and make a decision with respect to a claim for benefits based on Disability within 45 days after the claimant submits such a claim. This 45-day limit may be extended twice by up to 30 days each time. Prior to the expiration of the original 45-day period, or first 30-day extension, the Plan will notify you of the reason for the delay and the date by which a decision can be expected. The Plan will also explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision, and the additional information needed to resolve the claim. The claimant will be given 45 days to provide such additional information. (The Plan's time limits are tolled while the Plan is waiting for the claimant to provide additional information.)

If the Plan determines that the claimant is not entitled to benefits, that the claimant is entitled to a lesser benefit than the amount claimed or makes any other adverse benefit determination, the Plan will provide in writing or by electronic communication, a notice stating:

- the specific reason(s) for the adverse benefit determination;
- a reference to the Plan provision(s) on which the adverse benefit determination is based;
- an explanation of the Plan's basis for disagreeing with or not following:
  - the views presented by you to the Plan of the healthcare professionals treating you and the vocational professional who evaluated you;
  - the views of medical or vocational experts whose advice was obtained by the Plan, without regard as to whether the advice was relied upon by the Plan in making its decision; and
  - a disability determination by the Social Security Administration.
- a description of any additional material or information necessary to complete the claim, and an explanation of why such material or information is necessary;
- a description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on review;
- a copy of the specific rule, guideline, protocol or other similar criterion that the Plan relied upon in making the adverse benefit determination will be included with the notice or the notice will include a statement that such rule, guideline, protocol or other similar criterion does not exist;
- if the adverse benefit determination is based on a medical opinion, either: (i) an explanation of the scientific or clinical judgment applying the exclusion or limit to the claimant's medical circumstances; or (ii) a statement that the same will be provided to the claimant upon request and without charge; and
- 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.

2. Appeal

The claimant may appeal from an adverse determination of a claim for Disability benefits within 180 days after the claimant is notified of the adverse determination. If a claim is denied and

the denial is not appealed within 180 days from the date the claimant is notified of the denial, such denial will be final. To appeal, the claimant should write to:

Board of Trustees
Greater St. Louis Construction Laborers' Welfare Fund
2357 59th Street
St. Louis, Missouri 63110

The claimant may include any comments, documents, or information that the claimant wishes. The Plan will provide to the claimant, free of charge, upon the claimant's request, copies of all documents, records, and other information relevant to the claimant's claim.

The Board of Trustees will review all comments, documents, records and other information the claimant submits with the claimant's original claim or with the claimant's appeal. The review on appeal will not afford deference to the initial denial. If the original denial was based in whole or in part on a medical judgment, the Trustees will consult with a health care professional who has appropriate training and experience in the relevant field of medicine and who is not the same expert or the subordinate of any expert the Plan consulted in connection with the original denial. Any experts consulted in connection with the appeal will be identified upon request.

If the Plan considers, relies upon, or generates new or additional evidence in making its decision on appeal, or if the Plan intends to base its decision on a new or additional rationale, it will provide the new or additional evidence and/or the new or additional rationale to the claimant as soon as possible and sufficiently in advance of the decision on appeal to allow you a reasonable opportunity to respond.

The Trustees will review and decide the claimant's appeal no later than the date of the next regularly scheduled meeting of the Board of Trustees following their receipt of the claimant's appeal, unless the claimant's appeal is received within 30 days of that meeting. In such case, the Trustees will decide no later than the date of the second meeting following receipt of the claimant's appeal. If special circumstances require further time, the Trustees will notify the claimant prior to the commencement of the extension of the need for such extension, the reasons for the extension and the date as of which a decision will be made. In such case, the Trustees will decide no later than the third meeting following the Trustees' receipt of the appeal.

The claimant will be notified, in writing, of the Trustees' decision not later than five days after the decision is made. If the Trustees reach an adverse benefit determination, the notice must include:

- the specific reason(s) for the adverse determination;
- a reference to the Plan provision(s) on which the adverse determination is based;
- an explanation of the Plan's basis for disagreeing with or not following:
  - the views presented by you to the Plan of the healthcare professionals treating you and the vocational professional who evaluated you;
  - the views of medical or vocational experts whose advice was obtained by the Plan, without regard as to whether the advice was relied upon by the Plan in making its decision; and
  - a disability determination by the Social Security Administration.
- a statement that the claimant is entitled to receive, upon request and without charge, reasonable access to, and copies of, all documents, records and other information in the Plan's files which is relevant to the claimant's claim for benefits;
- a statement describing the claimant's right to bring an action for judicial review under ERISA Section 502(a), which will also set forth the applicable contractual limitations period that applies to your right to bring a civil action, including the calendar date on which the contractual limitations period will expire;

- a copy of the specific rule, guideline, protocol or other similar criterion that the Plan relied upon in making the adverse benefit determination will be included with the notice or the notice will include a statement that such rule, guideline, protocol or other similar criterion does not exist;
- if the adverse determination on review is based on a medical opinion, either: (i) an explanation of the scientific or clinical judgment on which the determination was based, applying the terms of the Plan to the claimant's medical circumstances; or (ii) a statement that such an explanation will be provided to the claimant upon request and without charge; and
- the following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and, if your benefit is an insured benefit, your State insurance regulatory agency."

C. MEDICAL AND BEHAVIORAL CARE BENEFITS

This section describes the procedures that apply to claims for medical and Behavioral Care benefits. As used in this section, the term "medical" includes claims for Behavioral Care benefits.

1. Initial Claim Determination

a. Urgent Care Claim

If the claimant's medical claim is an urgent care claim, the Benefit Office, will notify the claimant of the benefit determination as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim by the Benefit Office, unless the claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. In the case of such a failure, the Benefit Office will notify the claimant as soon as possible, but not later than 24 hours after receipt of the urgent care claim, of the specific information necessary to complete the claim. The notification may be oral unless written notification is requested by the claimant. The claimant will be afforded a reasonable amount of time, taking the circumstances into account, but not less than 48 hours, to provide the specified information.

The Benefit Office, will notify the claimant of the reviewer's determination as soon as possible, but in no case later than 48 hours after the earlier of (1) the reviewer's receipt of the specified additional information, or (2) the end of the period afforded the claimant to provide the specified additional information. If the determination is adverse to the claimant, the notice will contain the information described in Subsection C.1.f. below.

A medical claim is considered an urgent care claim if the application of the time periods for making a non-urgent care claim determination could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function or, in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that could not be adequately managed without the care or treatment which is the subject of the claim.

b. Concurrent Care Claim

If the Plan has approved a concurrent or ongoing course of health care treatment to be provided over a period of time or number of treatments, any reduction or termination by the Plan of the previously approved course of treatment (other than by Plan amendment or termination) before the approved time period or number of treatments constitutes an adverse benefit determination. In such a case, the Benefit Office, will notify the claimant of the adverse benefit determination at a time sufficiently in advance of the reduction or termination to allow the claimant to appeal and obtain a determination on review of that adverse benefit determination before reduction or termination of the benefit. The notice of the adverse benefit determination will contain the information described in Subsection C.1.f. below.

Any request by a claimant to extend a previously approved concurrent or ongoing course of treatment involving an urgent care claim beyond the approved period of time or number of treatments shall be decided as soon as possible, taking into account the medical exigencies, and the Benefit Office, will notify the claimant of the benefit determination within 24 hours after receipt of the claim by the reviewer, provided that any such claim is made to the Plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.

c. Request for Prior Authorization or Other Pre-Service Medical Benefit Claim

In the case of a request for prior authorization of a medical benefit or other pre-service medical benefit claim, the Medical Network and Managed Care Administrator or the Behavioral/Mental Health Administrator, as applicable, will notify the claimant of the benefit determination within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim by the reviewer. If, due to matters beyond the control of the Plan, the reviewer needs additional time to process the claim, the reviewer may extend the time for notifying the claimant of the benefit determination for up to 15 days, provided that within 15 days after the Plan receives the claim the reviewer notifies the claimant of those special circumstances and when the reviewer expects to make its decision. However, if such an extension is necessary due to a failure of the claimant to submit the information necessary to decide the claim, the notice of extension must specifically describe the required information, and the claimant will be afforded at least 45 days from receipt of the notice to provide the specified information.

If the determination is adverse to the claimant, the notice will contain the information described in Subsection C.1.f. below.

A medical benefit claim is considered a request for prior authorization or other pre-service claim if the claim requires approval, in part or in whole, in advance of obtaining the medical benefit in question.

d. Post-Service Medical Benefit Claim

In the case of a post-service medical benefit claim, the Benefit Office will notify the claimant of the adverse benefit determination within a reasonable period of time, but not later than 30 days after receipt of the claim. If, due to special circumstances, additional time is needed to process the claim, the Benefit Office may extend the time for notifying the claimant of the Plan's benefit determination on a one-time basis for up to 15 days, provided that within 30 days after the Benefit Office receives the claim the claimant is notified of those special circumstances and the date by which the Benefit Office expects to make a decision. However, if such a decision is necessary due to the failure of the claimant to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information, and the claimant will be afforded at least 45 days from receipt of the notice to provide the specified information.

If the determination is adverse to the claimant, the notice will contain the information described in Subsection C.1.f. below.

A medical benefit claim is considered a post-service claim if it is a request for payment of services which the claimant has already received.

e. Calculation of Time Periods

For purposes of these time periods relating to the Plan's initial benefit determination, the period of time during which an initial benefit determination is required to be made begins at the time a claim is filed in accordance with the Plan procedures without regard to whether all the information necessary to make a decision accompanies the request. If a period of time is extended due to a claimant's failure to submit all information necessary, the period for making the determination is "frozen" from the date the notification is sent to the claimant until the date the claimant responds to the request for additional information.

f. Manner and Content of Denial of Initial Medical Claims

If the reviewer of a medical claim makes an initial adverse benefit determination, it must provide to the claimant, in writing or by electronic communication, a notice stating:

- the specific reason(s) for the adverse benefit determination, including the denial code and its corresponding meaning;
- reference to the specific Plan provision(s) on which the adverse benefit determination is based;
- where applicable, information sufficient to identify the claim involved (including the date of service, the health care provider, and the claim amount (if applicable). The diagnosis code and its corresponding meaning and the treatment code and its corresponding meaning are also available upon request;
- a description of any additional information or material that the claimant must provide in order to perfect the claim, and an explanation of why the additional material or information is necessary;
- a description of the Plan's internal and external review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under a federal law called "ERISA" following any denial on review of the initial denial;
- if an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse benefit determination, a statement that such rule, guideline, protocol or other similar criterion was relied upon in making the adverse benefit determination, and that a copy of such rule, guideline, protocol or other similar criterion will be provided to the claimant upon request and without charge;
- if the adverse benefit determination is based on the Medical Necessity standard, that the treatment is Experimental or Investigational, or a similar exclusion or limit, either: (i) an explanation of the scientific or clinical judgment applying the exclusion or limit to the claimant's medical circumstances; or (ii) a statement that such an explanation will be provided to the claimant upon request and without charge;
- a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claimant's claim for benefits;
- in the case of an adverse benefit determination concerning an urgent care claim, a description of the expedited review process applicable to such claim; and
- contact information for any applicable office of health insurance consumer assistance or ombudsman established under Public Health Services Act Section 2793 to assist individuals with the internal claims and appeals and external review processes.

NOTE: The information described in this Subsection 18.C. with regard to an urgent care claim may be provided to the claimant orally within the permitted time frame, provided that a written or electronic notification in accordance with this subsection is furnished to the claimant no later than 3 days after the oral notification.

No claim or charges will be paid unless submitted within one year after the expenses were incurred, or within one year after the date of the final determination by the claimant's primary insurance carrier when the Plan is paying secondary. Please note, while the providers, both Network and Out-of-Network, generally file the medical and Behavioral Care claims, it is the claimant's responsibility to ensure that a claim for charges

the claimant incurs with an Out-of-Network Network Provider is filed within the one-year time limit.

2. Appeal of Denied Claim

If a claimant submits a claim for Plan benefits and it is denied under the procedures described above, the claimant may file an appeal and request a review of that denial under the following procedures.

a. Filing Request for Review of Denied Claim

A claimant for medical benefits has 180 days following receipt of a notification of an adverse initial benefit determination within which to file an appeal and request a review of the adverse initial benefit determination. If a claim is denied and an appeal is not requested within 180 days from the date the claimant is notified of the denial, the denial of the claim will be final.

If the claimant requests review of an adverse initial benefit determination, the review will meet the following requirements:

- The Plan will provide a review that does not afford deference to the adverse initial benefit determination and that is conducted by an appropriate named fiduciary of the Plan who did not make the adverse initial benefit determination that is the subject of the appeal, nor is a subordinate of the individual who made the adverse initial determination.
- The appropriate named fiduciary of the Plan will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment before making a decision on review of any adverse initial benefit determination based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug or other item is Experimental, Investigative or not Medically Necessary. The professional engaged for purposes of a consultation in the preceding sentence shall be an individual who was neither an individual who was consulted in connection with the adverse initial benefit determination that is the subject of the appeal, nor the subordinate of any such individual.
- The Plan will identify to the claimant the medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the adverse initial benefit determination, without regard to whether the advice was relied upon in making the adverse initial benefit determination.
- In the case of a requested review of an adverse initial benefit determination of an urgent care claim, the review process shall meet the expedited deadlines described below. The claimant's request for such an expedited review may be submitted orally or in writing by the claimant and all necessary information, including the Plan's determination on review, shall be transmitted between the Plan and the claimant by telephone, facsimile or other available similarly expeditious method.
- The reviewer of the appeal will afford the claimant an opportunity to review and receive, without charge, all relevant documents, information and records relating to the claim for benefits and to submit issues and comments relating to the claim for benefits in writing to the Plan. The reviewer of the appeal will take into account all comments, documents, records and other information submitted by the claimant relating to the claim regardless of whether the information was submitted or considered in the initial benefit determination.
- If the determination on the appeal review is adverse to the claimant, the claimant will receive a notice containing the information described in Subsection C.3. below.

All requests for review of prior authorization must be submitted to the Medical Network and Managed Care Administrator or the Behavioral/Mental Health Administrator, as

applicable. All other requests for review of initially denied claims (including all relevant information) must be submitted to the Board of Trustees at the following address:

Board of Trustees
Greater St. Louis Construction Laborers' Welfare Fund
2357 59th Street
St. Louis, Missouri 63110

b. Deadline for Appeal Review Decisions

(1) Urgent Care Claim

In the case of a request for review of the denial of an urgent care medical benefit claim, the reviewer will decide the appeal and notify the claimant of the determination on review as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claimant's request for review of the adverse initial benefit determination. The reviewer's decision on the appeal is final and not subject to further review under the Plan's internal claim review procedures.

(2) Concurrent Care Claim

In the case of a request for review of a determination by the Plan to reduce or terminate a previously approved concurrent or ongoing course of medical treatment to be provided over a period of time or number of treatments, the reviewer will decide the appeal and notify the claimant of the determination on review before the reduction or termination of the benefit, if the claimant files an appeal that allows for sufficient time to conduct the review. In all other cases, the reviewer will notify the claimant of the determination on review within a reasonable period of time appropriate to the medical circumstances, but in no event later than 15 days after receipt of the claimant's request for review of the adverse initial benefit determination. The reviewer's decision on the appeal is final and not subject to further review under the Plan's internal claim review procedures.

If the claimant is appealing an adverse determination in response to the claimant's request to extend a previously approved concurrent or ongoing course of treatment involving an urgent care claim beyond the approved period of time or number of treatments, the reviewer will decide the appeal and notify the claimant of the determination on appeal as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claimant's request for review of the adverse initial benefit determination. The reviewer's decision on the appeal is final and not subject to further review under the Plan's internal claim review procedures.

(3) Request for Prior Authorization or Other Pre-Service Claim

In the case of a request for review of the denial of prior authorization of a medical benefit or other pre-service medical benefit claim, the reviewer will decide the appeal and notify the claimant of the determination on review within a reasonable period of time appropriate to the medical circumstances, but in no event later than 15 days after receipt of the claimant's request for review of the adverse initial benefit determination. The reviewer's decision on the appeal is final and not subject to further review under the Plan's internal claim review procedures.

(4) Post-Service Claim

In the case of a request for review of the denial of a post-service medical benefit claim, the Board of Trustees of the Greater St. Louis Construction Laborers' Welfare Plan will decide the appeal and notify the claimant of the determination on appeal no later than the date of the next regularly scheduled meeting of the Board of Trustees after receipt of the request for review, unless the request is filed

within 30 days before that meeting, in which case the benefit determination will be made by no later than the date of the second meeting after receipt of the request. If special circumstances require a further extension of time for processing, a benefit determination will be rendered not later than the third meeting of the Board of Trustees following receipt of the request for review. The Plan will notify the claimant in writing if such an extension is needed, describing the special circumstances and the date by which the benefit determination will be made, prior to the commencement of the extension. The Plan will notify the claimant of the benefit determination as soon as possible, but no later than five days after the benefit determination is made. The Board of Trustees' decision on the appeal is final and not subject to further review under the Plan's internal claimant review procedures.

(5) Calculation of Time Periods

For purposes of the time periods specified in this Subsection C.2., the period of time during which a benefit determination on review is required to be made begins at the time the appeal and request for review of an adverse initial benefit determination is filed in accordance with the Plan procedures without regard to whether all the information necessary to make a benefit determination on review accompanies the request for review. If a period of time is extended due to a claimant's failure to submit all information necessary, the period for making the determination shall be "frozen" from the date the notification requesting the additional information is sent to the claimant until the date the claimant responds to the request for additional information.

3. Manner and Content of Notice of Decision on Review

Upon completion of its review of an adverse initial benefit determination, the Medical Network and Managed Care Administrator, the Behavioral/Mental Health Administrator or the Board of Trustees, as applicable, will give the claimant, in writing or by electronic communication, a notice containing the reviewer's decision. If the reviewer reaches an adverse benefit determination, the notice must include:

- the specific reason(s) for the adverse determination, including the denial code and its corresponding meaning, if applicable;
- reference to the specific Plan provision(s) on which the adverse determination is based;
- where applicable, information sufficient to identify the claim involved (including the date of service, the health care provider, and the claim amount (if applicable.) The diagnosis code and its corresponding meaning and the treatment code and its corresponding meaning are also available upon request;
- a statement that the claimant is entitled to receive, upon request and without charge, reasonable access to, and copies of, all documents, records and other information in the Plan's files which is relevant to the claimant's claim for benefits;
- a description of the Plan's external review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under a federal law called "ERISA" following any denial on review of the initial denial;
- if an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination on review, a statement that such rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol or other similar criterion will be provided to the claimant upon request and without charge;
- if the adverse determination on review is based on the Medical Necessity standard, that the treatment is Experimental or Investigational, or a similar exclusion or limit, either: (i) an explanation of the scientific or clinical judgment on which the determination was based, applying the terms of the Plan to the claimant's medical circumstances; or (ii) a

statement that such an explanation will be provided to the claimant upon request and without charge;

- contact information for any applicable office of health insurance consumer assistance or ombudsman established under Public Health Services Act Section 2793 to assist individuals with the internal claims and appeals and external review processes; and
- the following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and, if your benefit is an insured benefit, your State insurance regulatory agency."

D. HEARING AID, PRESCRIPTION DRUG, DENTAL AND VISION BENEFITS

Hearing aid benefit claims will be processed by the Benefit Office in accordance with the same procedures that apply to medical benefit claims as described in Subsections C.1., C.2., and C.3. above, except that the appeal from an initial adverse benefit determination is decided by the Board of Trustees. That determination is made by the Board of Trustees in accordance with the procedures described in Subsection C.2.b.(4) above.

Claims for prescription drug benefits, dental benefits and vision benefits will be processed generally in accordance with the same procedures that apply to claims under Subsection C.1. above, except that the Prescription Benefits Administrator will make the initial determination regarding network pharmacy, mail order prescription and specialty pharmacy drug benefits, the Dental Benefits Administrator will make the initial determination regarding dental benefits, and the Vision Benefits Administrator will make the initial determination regarding vision benefits. Each of those benefit administrators has procedures for addressing appeals of denied claims that are generally consistent with the procedures described in Subsections C.2. and C.3. above, and in the event the claimant's claim is denied, that administrator will advise the claimant of its appeal procedures. If the claimant wishes to file a second level appeal from an adverse benefit determination by one of those benefit administrators, the claimant may file the appeal with the Board of Trustees at the address provided in Subsection C.2. above, which will decide the appeal and notify the claimant of the determination in accordance with the procedures described in Subsection C.2.b.(4) above.

No claim or charges for hearing aid, prescription drug, dental or vision benefits will be paid unless submitted within one year after the expenses were incurred, or within one year after the date of the final determination by the claimant's primary insurance carrier when the Plan is paying secondary. Please note, while the network or participating providers generally file the dental and vision benefit claims, it is the claimant's responsibility to ensure that a claim for charges the claimant incurs with a non-network or non-participating provider is filed within the one-year time limit.

E. EXTERNAL REVIEW PROCEDURE

1. Deadline for External Review

If the claimant receives notice of an adverse benefit determination or final adverse internal appeal determination involving medical judgment or a rescission of coverage, the claimant may file a request for an external review within 4 months after the date the claimant receives notice of the adverse benefit determination or final adverse internal appeal determination. The claimant is eligible for external review if the adverse benefit determination or final adverse internal appeal determination involves medical judgment or rescission of the claimant's coverage under the Plan.

The claimant's request for an external review should be sent to the Benefit Office unless the claimant is specifically instructed otherwise in the appeal determination notice that is sent to the claimant. If there is no corresponding date 4 months after the date of receipt of the notice, then the request must be filed by the first day of the fifth month following the receipt of the notice. For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date falls on a Saturday, Sunday, or Federal holiday, the filing deadline is extended to the next day that is not a Saturday, Sunday or Federal holiday.

2. Preliminary Review

Within 5 business days following receipt of the claimant's request for an external review, the Plan will complete a preliminary review of the request to determine whether:

a. the claimant is or was covered under the Plan at the time the health care item, service or other benefit was requested or, in the case of a retrospective review, was covered under the Plan at the time the health care item, service or other benefit was provided;

b. the adverse benefit determination or final adverse internal appeal determination does not relate to the claimant's failure to meet the requirements for eligibility under the terms of the Plan;

c. the claimant has exhausted the Plan's internal appeal process, unless the claimant is not required to exhaust the internal appeal process under the federal interim final regulations (which involved certain limited exceptional circumstances); and

d. the claimant has provided all of the information and forms required to process an external review.

3. Notice of Preliminary Review

Within one (1) business day after completion of the initial review, the Plan will issue the claimant a notice in writing regarding the claimant's eligibility for external review. If the claimant's request for external review is complete but not eligible for external review, the notice will include the reasons for the request's ineligibility and contact information for the Employee Benefits Security Administration (toll-free 866-444-3272). If the claimant's request for external review is not complete, the notice will describe the information or materials needed to make the request complete and the claimant will be allowed to perfect the claimant's request for external review within the 4-month filing period or within the 48-hour period following the claimant's receipt of the notice, whichever is later.

4. Review by Independent Review Organization

a. If the claimant's request for external review is eligible for submission to an Independent Review Organization (IRO), the Plan will assign the claimant's request for external review to an IRO to evaluate the claimant's eligibility for external review and conduct the external review in accordance with procedures established under federal law. The IRO will be assigned in accordance with the Plan's rules, which provide an assignment or rotation method that ensures independence and against a bias towards the Plan. The IRO is not eligible for any financial incentive or payment based on the likelihood that the IRO would support the denial of benefits.

b. Upon receipt of the claimant's request for external review, the IRO will timely notify the claimant in writing of the request's eligibility and acceptance for external review. This notice will include a statement that the claimant may submit in writing to the assigned IRO within 10 business days following the date the claimant receives this notice additional information that the IRO will consider when conducting the external review. The IRO may, but is not required to, accept and consider additional information submitted after 10 business days.

c. Within 5 business days after the date of assignment to the IRO, the Plan will provide to the IRO any documents and any information considered in making the adverse benefit determination or final adverse internal appeal determination. Failure by the Plan to provide documents cannot delay the conduct of the external review. If the Plan fails to timely provide the documents and information, the assigned IRO may terminate the external review and make a decision to reverse the adverse benefit determination or the final adverse internal appeal determination. Within one (1) business day after making the decision, the IRO will notify the claimant and the Plan.

d. Upon receipt of any information submitted by the claimant in accordance with Subsection E.4.b. above, within one (1) business day the assigned IRO will forward that information to the Plan. Upon receipt of that information, the Plan may reconsider its adverse benefit determination or final adverse internal appeal determination that is the

subject of the external review. Reconsideration by the Plan cannot delay the external review. The external review may be terminated as a result of the reconsideration only if the Plan decides, upon completion of its reconsideration, to reverse its adverse benefit determination or final adverse internal appeal determination and provide coverage or payment. Within one (1) business day after making such a decision, the Plan will provide written notice of its decision to the claimant and the assigned IRO. The assigned IRO will terminate the external review upon receipt of the notice from the Plan.

e. The IRO will utilize legal experts where appropriate to make coverage determinations under the Plan.

f. The IRO will review all information and documents timely received. 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 Plan's internal claims and appeals process. However, the IRO must observe the terms of the Plan to ensure that the IRO's decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law. The IRO also must observe the Plan's applicable standards for clinical review criteria, including Medical Necessity, appropriateness, health care setting, level of care and effectiveness of a covered benefit, unless the criteria are inconsistent with the terms of the Plan or with applicable law. In addition to the documents and information provided, the assigned IRO will consider the following, to the extent available and to the extent the IRO considers them appropriate, in reaching an external review decision:

   (1) the claimant's medical records;

   (2) the attending health care professional's recommendation;

   (3) reports from appropriate health care professionals and other documents submitted by the Plan, the claimant or the claimant's treating health care provider;

   (4) appropriate medical practice guidelines, including evidence-based standards; and

   (5) the opinion of the IRO's clinical reviewer or reviewers based on the documents and information provided and to the extent the clinical reviewer or reviewers consider those documents and information appropriate.

g. The IRO will provide written notice of the final external review decision to the claimant and the Plan within 45 days after the IRO receives the request for external review. The IRO's external review decision will contain:

   (1) a general description of the reason for the request for external review, including, where applicable, information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous denial);

   (2) the date the IRO received the assignment to conduct the external review and the date of the IRO's decision;

   (3) references to the evidence or documentation, including the specific coverage provisions and evidence-based standards that were considered in reaching the IRO's decision;

   (4) a discussion of the principal reason or reasons for the IRO's decision, including the rationale for the decision and any evidence-based standards that were relied on in making the decision;

   (5) a statement that the determination is binding except to the extent that other remedies may be available under state or Federal law, as applicable, to either the Plan or to the claimant;

   (6) a statement that judicial review may be available to the claimant; and

(7) current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under Public Health Services Act Section 2793 to assist individuals with the external review processes.

5. Expedited External Review

a. Request for Expedited External Review

The Plan will allow the claimant to make a request for an expedited external review with the Plan at the time you receive:

(1) an adverse benefit determination if the adverse benefit determination involves a medical condition for which the timeframe for completion of an expedited internal appeal under the federal interim final regulations would seriously jeopardize the claimant's life or health or would jeopardize the claimant's ability to regain maximum function and the claimant has filed a request for an expedited internal appeal; or

(2) a final internal adverse benefit determination, if the claimant has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize his/her life or health or would jeopardize the claimant's ability to regain maximum function, or if the final internal adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or service for which the claimant received emergency services but has not been discharged from a health care provider's facility.

b. Preliminary Review

Upon receipt of the request for the expedited external review, the Plan will conduct the Preliminary Review described in Subsection E.2. above as soon as possible, except that the Plan will complete that review as soon as possible without regard to the five business day time period referred to in Subsection E.2. above. Upon its determination of the Preliminary Review, the Plan will send the notice described in Subsection E.3. above as soon as possible.

c. Review by Independent Review Organization

Upon a determination that the request meets the threshold requirements for external review following the preliminary review under Subsection E.2. above, the Plan will assign an IRO in accordance with Subsection E.4.a. above. The Plan will provide or transmit all documents and information considered in making the adverse benefit determination or final adverse internal appeal determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method.

The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the information or documents described in Subsection E.4.f. above under the procedures for standard review. In reaching a decision, the assigned IRO will review the claim de novo (as if it is new) and is not bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. However, the IRO must observe the terms of the Plan to ensure that the IRO's decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law. The IRO also must observe the Plan's applicable standards for clinical review criteria, including Medical Necessity, appropriateness, health care setting, level of care and effectiveness of a covered benefit, unless the criteria are inconsistent with the terms of the Plan or with applicable law.

d. Notice of Final External Review Decision

The IRO will provide notice of the final external review decision, in accordance with the requirements set forth in Subsection E.4.g. above, as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice of the expedited external review decision is not in writing, then within 48 hours after the date the notice is

provided the assigned IRO will provide written confirmation of the decision to the claimant and the Plan in accordance with Subsection E.4.g. above.

6. After External Review

Upon receipt of a notice of a final external review decision reversing the adverse benefit determination or final adverse internal appeal determination, the Plan will provide coverage or payment for the claim, including authorizing or paying benefits, as soon as possible in accordance with applicable law. The Plan reserves the right to pursue judicial review or other remedies available or that may become available to the Plan under applicable law. The Plan will provide benefits (including making payment on the claim) without delay pursuant to a final external review decision in the claimant's favor, regardless of whether the Plan intends to seek judicial review of the external review decision and unless or until there is a judicial decision otherwise.

If the final external review upholds the Plan's adverse benefit determination or final adverse internal appeal determination, the Plan will continue not to provide coverage or payment for the reviewed claim. If the claimant is dissatisfied with the external review determination, the claimant may seek judicial review as permitted under ERISA Section 502(a).

The external review standards provide that an external review decision is binding on the Plan, as well as on the claimant, except to the extent other remedies are available under state or Federal law.

7. IRO Maintenance of External Review Records

After a final external review decision, the IRO will maintain records of all claims and notices associated with the external review process for a minimum of 6 years. An IRO will make such records available for examination by the claimant, the Plan, or state or Federal government oversight agency upon request, except where such disclosure would violate state or Federal privacy laws.

F. MISCELLANEOUS PROVISIONS PERTAINING TO CLAIMS AND APPEALS

The claimant may designate another person to act as the claimant's authorized representative for purposes of the Plan's claims and appeals procedures. To designate an authorized representative the claimant will need to fill out a form, which may be obtained from the Benefit Office.

Under federal law the claimant has a right to bring a civil action under Section 502(a) of the Employee Retirement Income Security Act ("ERISA") if the claimant is dissatisfied with the decision on appeal. Before bringing such an action, the claimant must exhaust the Plan's claims and appeals procedures. Any such action under ERISA must be filed within one (1) year of the date on which the claimant's appeal was denied. Bringing an action under ERISA will not toll the Plan's time requirements for submitting claims and appeals.

The Trustees, the Life Insurance Company, the Medical Network and Managed Care Administrator, and the Behavioral/Mental Health Administrator, the Prescription Benefits Administrator, the Dental Benefits Administrator, and the Vision Benefits Administrator, as applicable, have the discretionary authority to rule on all appeals and their decisions shall be final and binding on all parties, including but not limited to employers, unions, Eligible Employees, retirees, dependents and Beneficiaries and their service providers. Benefits will be paid only if the applicable reviewer decides in the reviewer's discretion that the applicant is entitled to the benefits.

The Trustees, the Life Insurance Company, the Medical Network and Managed Care Administrator, and the Behavioral/Mental Health Administrator, the Prescription Benefits Administrator, the Dental Benefits Administrator, and the Vision Benefits Administrator, as applicable, shall have discretion to make determinations of fact, interpret all documents and other matters pertaining to the appeal, to determine eligibility for benefits, and to exercise such authority as set forth in this Plan Document and Summary Plan Description.

Decisions on claims and appeals are uniformly made in accordance with the terms and conditions of the Plan and cannot be paid unless authorized by the Plan.

G. ASSIGNMENT OF BENEFITS

With the exception of the assignment of life insurance benefits as permitted under the policy of insurance issued by the Life Insurance Company, no Covered Individual has the right to anticipate, alienate, sell, transfer, pledge, assign, or otherwise encumber any interest in benefits payable under the Plan

Further, no Covered Individual has the right to anticipate, alienate, sell, transfer, pledge, assign, or otherwise encumber any right (legal, equitable, or otherwise) to which he or she is entitled by virtue of coverage under the Plan, including but not limited to requesting documents or filing any court proceeding.

All or a portion of benefits payable under the Plan may be, at the Board of Trustees' option, paid directly to the hospital or provider that rendered the services being claimed. The Plan's direct payment does not validate any attempted assignment or other action prohibited under this section.

SECTION 19. ERISA INFORMATION

A. PLAN NAME

Greater St. Louis Construction Laborers' Welfare Fund

B. PLAN NUMBER

501

C. EMPLOYER IDENTIFICATION NUMBER

43-0688695

D. PLAN SPONSOR AND PLAN ADMINISTRATOR

Board of Trustees
Greater St. Louis Construction Laborers' Welfare Fund
2357 59th Street
St. Louis, Missouri 63110
Phone: (314) 644-2777
Toll Free: (800) 489-0228

As of July 1, 2021, the Trustees are:

Union Trustees

Matt Andrews
Richard McLaughlin
Laborers' Local 42
301 South Ewing Avenue
St. Louis, Missouri 63103

Brandon Flinn
Missouri and Kansas Laborers District Council
951 Corporate Parkway
Wentzville, Missouri 63385

Gary Elliott
Ronny Griffin
Steve MacDonald
Laborers' Local 110
4532 South Lindbergh Blvd.
St. Louis, Missouri 63127

Management Trustees

Bradley Grant
Grant Contracting
777 Rudder Road
Fenton, Missouri 63026

David A. Gillick
Mason Contractors Association
1429 South Big Bend
St. Louis, Missouri 63117

Robert Bieg, Jr.
Bieg Plumbing Co., Inc.
2015 Lemay Ferry Road
St. Louis, Missouri 63125

Mike Shepard
SITE Improvement Assoc.
2071 Exchange Drive
St. Charles, Missouri 63303

Corey Black
McCarthy Building Co.
1341 North Rock Hill Road
St. Louis, Missouri 63124

Michael Lutz
Ben Hur Construction
3783 Rider Trail South
Earth City, Missouri 63045

E. TYPE OF PLAN

The Plan is a welfare benefit plan that currently provides insured life and accidental death and dismemberment benefits as well as the following self-funded benefits:

- medical;
- prescription drug;
- Behavioral Care;

- dental;
- vision,
- hearing aid; and
- weekly Disability benefits.

Not all Covered Individuals are eligible for all benefits.

All self-funded benefits are paid directly out of the assets of the Plan.

F. PLAN YEAR ENDS

The Plan's financial records are maintained on a Plan year basis that runs from July through June 30. Benefit records are maintained on a calendar year basis. Deductibles, Out-of-Pocket Maximums, and certain individual benefit limits are determined and applied during each calendar year.

G. PLAN COST

The Plan Sponsor pays the cost of the Plan out of the assets of the Welfare Trust, which is funded by contributions from Contributing Employers. In certain instances, contributions may also be made by Covered Individuals directly.

H. TYPE OF ADMINISTRATION

The Board of Trustees administers the overall operation of this Plan.

1. Medical Benefits

The Plan has entered into an agreement with the Medical Network and Managed Care Administrator, indicated on the Insert to this Booklet, to provide Covered Individuals with access to the Medical Network and Managed Care Administrator's medical care Network Providers. Further, the Medical Network and Managed Care Administrator performs the prior authorization services for the medical benefits.

The Medical Network and Managed Care Administrator are not financially responsible for any of the benefits provided by the Plan.

2. Prescription Drug Benefits

The Plan has entered into a pharmacy benefit management agreement with the Prescription Benefits Administrator, indicated on the Insert to this Booklet, to provide Covered Individuals with access to a network of pharmacies and administer claims for prescription drug benefits.

Also, the Plan has entered into an arrangement for prescription mail order and specialty pharmacy services with the Prescription Mail Order and Specialty Pharmacy, indicated on the Insert to this Booklet.

Neither the Prescription Benefits Administrator nor the Prescription Mail Order and Specialty Pharmacy are financially responsible for any of the benefits provided by the Plan.

3. Behavioral Care Benefits

The Plan has entered into an agreement with the Behavioral/Mental Health Administrator, indicated on the Insert to this Booklet, to provide Covered Individuals with access to the Behavioral/Mental Health Administrator's Behavioral Care Network Providers. Further, the Behavioral/Mental Health Administrator performs prior authorization and case management services with respect to Behavioral Care benefits.

Also, the Plan has entered into an arrangement for Member Assistance Program services with the MAP Administrator, indicated on the Insert to this Booklet.

Neither the Behavioral/Mental Health Administrator nor the MAP Administrator are financially responsible for any of the benefits provided by the Plan.

4. Dental Benefits

The Plan has entered into an arrangement with the Dental Benefits Administrator, indicated on the Insert to this Booklet, to provide Covered Individuals with access to a network of dentists and to administer claims for dental benefits.

The Dental Benefits Administrator is not financially responsible for any of the benefits provided under the Plan.

5. Vision Benefits

The Plan has entered into an arrangement with the Vision Benefits Administrator, indicated on the Insert to this Booklet, to provide Covered Individuals with access to a network of vision care providers and to administer claims for vision benefits.

The Vision Benefits Administrator is not financially responsible for any of the benefits provided under the Plan.

6. Life Insurance and AD&D Benefits

The Plan has entered into insurance policies with the Life Insurance Company to provide life insurance and accidental death and dismemberment benefits for Active Employees and life insurance for dependents of Active Employees and Retired Eligible Employees.

I. AGENT FOR SERVICE OF LEGAL PROCESS

Legal process may be served upon the Board of Trustee by serving the Welfare Director at the above Benefit Office address. Additionally, service of legal process may be made upon any Trustee at the above address.

J. COLLECTIVE BARGAINING AGREEMENTS

The Plan is established and maintained pursuant to collective bargaining agreements, a copy of which may be obtained by written request to the Board of Trustees. Such collective bargaining agreements are also available for examination by Eligible Employees and beneficiaries at the Benefit Office. If for any reason, you wish to review a collective bargaining agreement, please contact the Benefit Office to make an appointment.

You may receive from the Plan Administrator, upon written request, information as to whether a particular employer or labor organization participates in the Plan and, if so, you can receive the address of the employer or labor organization.

K. BOARD OF TRUSTEES TO INTERPRET, CONSTRUE, AND APPLY TERMS OF PLAN DOCUMENTS

The Board of Trustees, the Life Insurance Company and the Plan third-party administrators identified in this Booklet and the Insert to this Booklet have the discretionary authority, as applicable and appropriate, to determine, pursuant to the terms of this Plan Document and Summary Plan Description, the Trust Agreement and other relevant documents, questions concerning eligibility for benefits, questions concerning whether the expense of any given treatment or service is a Covered Charge, and any other questions which may arise in the administration of the Plan. The Trustees, the Life Insurance Company and the third-party administrators also have the discretionary authority, as applicable and appropriate, to interpret, construe, and apply the terms of the Plan documents, including any ambiguous terms. Any interpretation, construction or application shall be binding on all parties. It is intended that the most deferential standard of judicial review shall apply to the decisions of the Trustees, the Life Insurance Company and the third-party administrators.

L. TERMINATION OR AMENDMENT OF THE PLAN OR TRUST

The Plan may be amended or terminated by a majority vote of the Trustees at any regular or special meeting of the Board of Trustees, subject to applicable collective bargaining agreement provisions. The benefits described in this Booklet are those currently provided by the Plan. Those benefits can be altered, modified, reduced, or terminated at any time the Trustees determine, in their sole discretion, such action is necessary.

Should it occur that no employers are obligated to contribute to the Trust or should the Trustees determine to terminate the Trust, any assets remaining in the Trust shall be used consistently with the purposes of the Trust. No assets of the Trust shall revert to any employer.

M. TRUSTEES ARE FIDUCIARIES

The Trustees are fiduciaries with respect to the Plan. The Trustees in exercising their powers and duties are doing so at all times in their fiduciary capacity.

N. PARTICIPATING EMPLOYERS

An Eligible Employee or beneficiary may receive from the Plan Administrator, upon written request, a statement as to whether a particular employer is a Contributing Employer and the address of that Contributing Employer.

O. STATEMENT OF ERISA RIGHTS REQUIRED BY FEDERAL LAW AND REGULATIONS

As a participant in the Greater St. Louis Construction Laborers' Welfare Fund, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

1. Receive Information About Your Plan and Benefits

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

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

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

2. Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents will have to pay for this coverage. (See Section 5. of this Booklet for information on the rules governing your COBRA continuation coverage rights).

3. Prudent Actions by Plan Fiduciaries

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

4. Enforce Your Rights

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

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

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

5. Assistance With Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you should have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

P. TRUST FUND

The assets used to provide benefits under the Plan are held in trust by the Board of Trustees. Those assets can only be used to provide benefits to the employees and former employees of contributing employers, and the dependents of such employees, and to defray the reasonable administrative expenses of operating the Plan.

Q. PATIENT PROTECTION NOTICE

Federal regulations require us to advise you that the Greater St. Louis Construction Laborers' Welfare Fund generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in the Medical Network and Managed Care Administrator's network who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Benefit Office at (314) 644-2777 or toll free (800) 489-0228.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from the Greater St. Louis Construction Laborers' Welfare Fund or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the Medical Network and Managed Care Administrator's network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Benefit Office at (314) 644-2777 or toll free (800) 489-0228.

SECTION 20. NOTICE OF PRIVACY PRACTICES (REVISED 3/31/2016)

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

The Greater St. Louis Construction Laborers' Welfare Plan (the Plan) has a duty under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to outline its legal obligations regarding your private medical information. In general, the Plan is required by this law to maintain the privacy of your health information. The Plan must also provide you with a notice of its legal duties and current privacy practices.

The Plan has the legal obligation to abide by the terms of this notice, but retains the right to change those terms when necessary. Any changes may be effective for any current health information about you and any information that may be obtained in the future. Such changes will be appropriately reflected in this Notice of Privacy Practices. The most recent version of our full notice will always be available to you through our office.

A. STANDARD USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION

The Plan is permitted by law to use or disclose your protected health information (PHI) to provide payment of health benefits and to conduct necessary healthcare operations. There are other purposes for which the Plan may use or disclose your PHI, but these are the primary instances. Federal law permits the Plan to conduct these activities without express written consent from you. The following are some examples of what these uses and disclosures may entail:

1. Treatment

The Plan may use or disclose your health information to facilitate your health care treatment. For example, we might disclose information to your health care provider to assist the provider in making a determination on a course of treatment for you or we may disclose your health information to a case manager retained by the Plan.

2. Payment

The Plan may be required to use or disclose your medical information in order to facilitate payment for medical services you receive. This may include, but is not limited to the following actions:

- **Determining your eligibility for plan benefits** – For example, the Plan may use information obtained from your employer to determine whether you have met the Plan's requirements for active eligibility.
- **Determining and fulfilling benefit obligations** – For example, the Plan may review your health care claims to determine if specific services or treatments that you received are covered by the Plan.
- **Providing payment for treatment and services** – For example, the Plan may send your doctor a payment with an explanation of how the amount paid was determined.
- **Pre-certifying or pre-authorizing health care services** – For example, the Plan may consider a request from you or your Physician to verify coverage for a specific hospital admission or surgical procedure.
- **Subrogating health claim benefits for which a third party is liable** – For example, the Plan may exchange information about an accidental injury with your attorney who is pursuing reimbursement from another party.
- **Coordinating benefits with other plans under which you have health coverage** – For example, the Plan may disclose information about your Plan benefits related to a specific claim to another group health plan in which you or a dependent may participate.
- **Obtaining payment under a contract of reinsurance** – For example, if the total amount of your claim(s) exceeds a certain amount the Plan may disclose the necessary information about your claim(s) to a stop-loss insurance carrier in order to obtain payment.

3. Health Care Operations

The Plan may also use and disclose your medical information in their everyday health care operations. This may include, but is not limited to the following actions:

- **Case management and care coordination** – For example, a case manager may contact home health agencies to determine whether they may be of assistance in providing you with services that you need, or may contact you or a provider regarding treatment alternatives.
- **Conducting quality assessment and improvement activities** – For example, a contracted third party auditor may review your data while performing a claim audit. All third parties who have access to the PHI maintained by the Plan will be contractually obligated to uphold the Plan's high privacy standards.
- **Employee training** – For example, the Plan may need to demonstrate the processing of claims for health benefits for a new employee. Generally, generic data will be used, but in some cases, it may be necessary to train the employee using actual data while under close supervision.
- **Contracting for reinsurance** – For example, your PHI may be disclosed to carriers of stop loss insurance to obtain premium quotes. However, consistent with the Genetic Information Nondiscrimination Act (GINA), the Plan is prohibited from disclosing genetic information for underwriting purposes.
- **Reporting to Trustees** – For example, the Plan may disclose information to the Board of Trustees of the Greater St. Louis Construction Laborers' Welfare Plan, acting as Plan Sponsor, for appeals or other Plan operations.

B. THE PLAN'S DISCLOSURE OF PHI TO THE TRUSTEES

In the course of business practices, the Plan may disclose information to Board of Trustees of the Greater St. Louis Construction Laborers' Welfare Plan, acting as Plan Sponsor, for reviewing and making determinations regarding an appeal or for monitoring benefit claims or analyzing benefit structure and claim experience including those that may or do involve stop-loss insurance. Generally, the Plan will disclose PHI to the Plan Sponsor only if necessary for Plan operations. With respect to PHI, the Plan Sponsor agrees to:

- Not use or further disclose PHI other than as permitted or required by the Plan documents or as required by law;
- Ensure that any agents, including subcontractors, to whom it provides PHI received from Health Plan agree to the same restrictions and conditions that apply to Plan Sponsor with respect to such information;
- Not use or disclose PHI for employment-related actions and decisions;
- Not use or disclose PHI in connection with any other benefit or employee benefit plan of Plan Sponsor;
- Report to Health Plan's Privacy or Security Officer any PHI use or disclosure that it becomes aware of which is inconsistent with the uses or disclosures provided for;
- Make PHI available to an individual based on HIPAA access requirements;
- Make PHI available for amendment and incorporate any PHI amendments based on HIPAA amendment requirements;
- Make available the information required to provide an accounting of disclosures;
- Make its internal practices, books and records relating to the use and disclosure of PHI received from the Health Plan available to the Secretary of the U.S. Department of Health and Human Services to determine the Health Plan's compliance with HIPAA;
- Ensure that the adequate separation between the group health plan and the Plan Sponsor is established as required by HIPAA (45 CFR 164.504(f)(2)(kkk)); and

- If feasible, return or destroy all PHI received from the Health Plan that Plan Sponsor still maintains in any form and retain no copies of such PHI when no longer needed for the specified disclosure purpose. If return or destruction is not feasible, Plan Sponsor will limit further uses and disclosures to those purposes that make the return or destruction infeasible.

The Plan Sponsor agrees to the preceding protections with respect to electronic PHI (ePHI) and also to:

- 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.
- Ensure "adequate separation" 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 purposes unrelated to Plan administration. Any employee or fiduciary of the Plan or Plan Sponsor who uses or discloses ePHI in violation of the Plan's security or privacy policies and procedures shall be subject to the Plan's disciplinary procedure.
- Ensure that any agent or subcontractor to whom it provides ePHI agrees to implement reasonable and appropriate security measures to protect the information.
- Report to the Plan Security Officer any Security Incident of which it becomes aware.

C. ADDITIONAL USES AND DISCLOSURES

In addition to the general uses and disclosures of your information mentioned above, there may be other special situations where it is necessary, and permissible, for the Plan to use or disclose of your health information. Examples include, but are not limited to:

- **As Required by Law** – The Plan may use or disclose PHI to the extent that such use or disclosure is required by law and complies with and is limited to the relevant requirements of such law. The covered entity also must comply with other requirements, including notifying the individual of such disclosure except as otherwise provided.
- **For Public Health Activities** – Where disclosures are necessary for public health activities, the Plan may disclose to certain designated agencies, authorities and organizations.
- **About Victims of Abuse, Neglect, or Domestic Violence** – The Plan may disclose PHI about an individual whom the covered entity reasonably believes to be a victim of abuse, neglect or domestic violence to an appropriate government authority.
- **For Health Oversight Activities** – A health oversight agency may receive PHI for designated oversight activities.
- **For Judicial and Administrative Proceedings** – the Plan may disclose PHI in the course of any judicial or administrative proceeding; in response to an order of a court or administrative tribunal, provided only that PHI expressly authorized is disclosed; or in response to a subpoena, discovery request or other lawful process if certain specific requirements are met.
- **For Law Enforcement Purposes** – the Privacy Standards prescribe several specific circumstances of appropriate disclosure for law enforcement purposes, including: pursuant to legal process and as otherwise required by law; for identification and location purposes, as long as no more than the specified limited information is released; for identification of a victim of a crime if certain protective requirements are met; about decedents; to report crime on the covered entity's premises; and to report crime in emergencies. Again, disclosure is appropriate only in the specific situations described in the Privacy Standards and only after the specific requirements are met.
- **About Decedents** – Certain disclosures may be made to coroners, medical examiners and funeral directors related to deceased individuals.
- **For Cadaveric Organ, Eye or Tissue Donation Purposes** – The Plan may use or disclose PHI to organ procurement organizations or other entities engaged in the procurement, banking or transplantation of cadaveric organs, eyes or tissue for donation and transplantation purposes.

- **For Research Purposes** – Certain limited uses and disclosures of PHI may occur for academic research purposes. Research falling under the auspices of general data analysis is not affected by this requirement.
- **To Avert a Serious Threat to Health or Safety** – The Plan may disclose limited PHI, consistent with applicable laws and standards of ethical conduct, if the covered entity, in good faith, believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to health or safety. Further, such disclosure must be to the person reasonably able to appropriately act or must be necessary for law enforcement authorities to identify or apprehend an individual.
- **For Specialized Government Functions** – The Privacy Standards recognize the need for special disclosure rules for certain military and veterans' activities, national security and intelligence activity, protective services for the President and others, medical suitability determinations, correctional institutions and other law enforcement custodial situations and covered entities that are government programs providing public benefits.

D. ALL OTHER USES OR DISCLOSURES

We may not use or disclose your health information for any purpose other than as described above without your specific written authorization. You may revoke any such authorization in writing at any time. However, any revocation is limited to the extent that the Plan has already taken action in reliance upon your authorization.

E. YOUR RIGHTS

The federal law (HIPAA) that protects the privacy of your health information provides you with several individual rights. It is important to recognize that the majority of PHI in the possession of the Plan is contained in copies of records owned by the covered entity that provided the information. Therefore, to invoke some of the following rights you may need to contact the owner of the records. For more details on the processes to follow in order to invoke these rights, please contact the Plan Privacy Officer at the address shown in F below.

- You have the right to have a copy of this notice of privacy practices. Additional copies can be obtained by contacting the Plan Privacy Officer.
- You have the right to inspect and copy information in the permanent health care record that the Plan maintains.
- You may also request changes to the information contained in your record, which the Plan may approve or deny.
- You have the right to request that restrictions be placed on the use and disclosure of your health information. The Plan may approve or deny this request.
- You also have the right to receive a list of the uses and disclosures of your health information made by the Plan. Certain limitations may apply.
- You have the right to receive communications from the Plan regarding your health information in a confidential manner.

F. COMPLAINTS

If you believe that your privacy rights have been violated, you may complain to the organization you believe is at fault. You may also complain to the Department of Health and Human Services. You are protected from retaliation for any and all complaints you make. For additional information on the complaints process or for any questions related to this notice, contact the Plan at:

Greater St. Louis Construction
Laborers' Welfare Plan
ATTENTION: Privacy Officer
2357 59th Street
St. Louis, Missouri 63110

G. BREACH NOTIFICATION

The plan is subject to the HITECH breach notification rules. In the unlikely event that your protected health information is breached, as that term is defined under HITECH, we will provide you with written notice of the breach. The notice will be sent without unreasonable delay and in no case later than 60 calendar days after discovery of a breach. The notice will be written in plain language and will contain the following information: (1) a brief description of what happened, the date of the breach if known, and the date of discovery; (2) the type of PHI involved in the breach; (3) any precautionary steps you should take; (4) what we are doing to mitigate the breach and prevent future breaches; and (5) how you may contact us to discuss the breach. We will also report the breach to the U.S. Department of Health and Human Services, and in some cases to the media.

IN WITNESS WHEREOF, the Greater St. Louis Construction Laborers' Welfare Fund Plan Document and Summary Plan Description is thus restated effective July 1, 2021.

UNION TRUSTEES		**MANAGEMENT TRUSTEES**	
Brandon Flinn	Date	David A. Gillick	Date
Matthew Andrews	Date	Bradley Grant	Date
Steve McDonald	Date	Robert Bieg, Jr.	Date
Richard McLaughlin	Date	Mike Shepard	Date
Gary Elliott	Date	Corey Black	Date
Ronny Griffin	Date	Michael Lutz	Date