WEST VIRGINIA LABORERS' TRUST FUND

HEALTH & WELFARE PLAN

Group Health Plan for Retirees

Summary Plan Description

Restated January 1, 2022

West Virginia Laborers' Trust Fund Health & Welfare Plan

To Retired Participants:

This newly revised Summary Plan Description (SPD) describes and summarizes your benefits and rights under the West Virginia Laborers' Trust Fund Health & Welfare Plan (the Plan), effective January 1, 2021.

Plan BB (Pre-Medicare) Changes and Enhancements
Since the last SPD was issued, the Board of Trustees has approved a number of Plan improvements for pre-Medicare eligible retirees. Here are some highlights and reminders:

- **New dental benefit.** We are thrilled to add dental coverage through United Concordia to our Plan of benefits for retired participants and dependents, effective January 1, 2022. A separate insurance card will be provided. See page 81 for a description of the plan benefits.

- **New vision benefit.** We are introducing a new vision plan through VSP, also effective January 1, 2022, that includes benefits for eye exams, glasses, and contact lenses. A separate insurance card will be provided. See page 87 for more information.

- **Telemedicine.** We have been utilizing **Teladoc**, a virtual-visit provider for Plan participants to use when in-person medical visits aren't convenient or timely. Talk to a board-certified physician from the safety and comfort of your own home, or when you are traveling, right from your mobile device. To get started, call 1-800-Teladoc (835-2362) or visit http://www.teledoc.com.

- **Highmark is our new PPO** effective July 1, 2021. Be sure to visit providers within the Highmark network for lower-cost services.

- **Prescription drug cost-saving programs.** Last year, we introduced a number of new cost-saving initiatives to help contain the ever-increasing costs of prescription drugs to our members and to the Plan.

    - First, there's SaveOnSP, a new variable copay program for specialty drugs that allows participants to save on specialty drug copays if enrolled in this program. (See page 76.)

    - Keep in mind that the Plan may require prior authorization (usually for expensive specialty drugs) before certain prescriptions can be filled. (See page 77.)

- We also use a step therapy program for certain prescriptions that may require participants to try a first-line medication before moving to a more expensive second-line prescription drug. (See page 78.)

Coverage for Plan D (Medicare-Eligible) Retirees
Although the changes above do not apply to Plan D retirees because Medicare is their primary payer, the Plan does supplement certain Medicare-eligible services. See pages 100-102 for details.

Keep Informed!
We strongly encourage you to visit our Plan website at wvlaborers.com for more information about the West Virginia Laborers' Trust Fund benefits for active and retired members. A new section is in the process of being developed that will be dedicated to life events—what you need to do and know about your benefits and coverage in the event of marriage, divorce, birth of a child, retirement, or death—and will be posted in the coming months.

Thank you for taking the time to review this SPD. Keep it handy—it's important that you understand the Plan's requirements and the benefits it provides for you and your family.

Sincerely,

THE BOARD OF TRUSTEES

WEST VIRGINIA LABORERS' TRUST FUND
TABLE OF CONTENTS

Article I. Basic Plan Information

1.01 Formal Plan Name

West Virginia Laborers' Trust Fund Health & Welfare Plan.

The term "Plan" is used throughout this document as a shorthand reference to the West Virginia Laborers' Trust Fund Health & Welfare Plan.

1.02 The Purpose of this Document

Section 402 of the Employee Retirement Income Security Act of 1974, as amended (ERISA), requires every employee benefit plan to be maintained pursuant to a written instrument. Section 101 of ERISA requires that a summary plan description (SPD) be furnished to each Plan Participant and beneficiary.

This document serves as the written instrument and the SPD required by ERISA for the Plan and contains all of the Plan's terms. It establishes and summarizes the Plan terms as in effect January 1, 2022, and it replaces and supersedes all prior SPDs and Plan terms. You should read this SPD and refer to it whenever you have questions about the Plan.

This SPD applies only to individual Plan Participants that are retired from Covered Employment. No active Employees are covered by this SPD.

1.03 Plan Type

The Plan is an employee welfare benefit plan as defined by the Employee Retirement Income Security Act of 1974, as amended (ERISA), which provides group health and other benefits in the event of sickness, accident, disability or death.

1.04 Name and Address of Plan Sponsor

Board of Trustees
West Virginia Laborers' Trust Fund
One Union Square, Suite 200
Charleston, WV 25302
(304) 342-5142

The Board of Trustees is the Plan's "named fiduciary" as described in Section 402 of ERISA.

1.05 Board of Trustees

Union Trustees

Mr. Jessie King, Chairman
WV & Appalachian Laborers' District Council
One Union Square, Suite 5
Charleston, WV 25302

Mr. Shane Dillon
Laborers Local Union #1353
One Union Square, Suite 1
Charleston, WV 25302

Mr. Matt Freeland
Laborers Local Union #1085
3205 Dudley Avenue
Parkersburg, WV 26104

Mr. Justin Gray
Laborers Local Union #1149
2110 Lumber Avenue
Wheeling, WV 26003

Mr. Jason Hershman
Laborers Local Union #379
2161 Dents Run Blvd.
Morgantown, WV 26501

Mr. Byron McGrady
Laborers Local Union #984
217 North 27th Street
Clarksburg, WV 26301

Employer Trustees

Ms. Mary K. Prim, Secretary
Constructors' Labor Council of West Virginia
P.O. Box 297
Scott Depot, WV 25560

Mr. James R. Carney, Jr.
Oval Construction
P.O. Box 401
Charleston, WV 25322

Mr. Edgar Dodds
Grae-Con Construction
880 Kingsdale Road
Steubenville, OH 43952

Mr. Timothy E. Gooden
Easley & Rivers, Inc.
3800 Morgantown Industrial Park
Morgantown, WV 26501

Mr. Dan Loy
JD&E Inc.
200 GC&P Road, P.O. Box 6253
Wheeling, WV 26003-0610

Ms. Kelly Young
Lane & Young
1538 Kanawha Blvd. East,
Charleston, WV 25311

1.06 Plan Administration

The Plan is administered by the Board of Trustees.

1.07 Name and Address of Plan

Administrator
Board of Trustees
West Virginia Laborers Trust Fund
Nathanael Aylestock, Administrative Manager
One Union Square, Suite 200
Charleston, WV 25302
(304) 342-5142

1.08 Administrative Manager

The Administrative Manager manages the day-to-day affairs of the Plan under the supervision and direction of the Board of Trustees. The Administrative Manager manages benefit enrollment, makes initial determinations of benefit eligibility, and processes benefit payments based on rules established by the Board of Trustees. Questions about the Plan may be addressed to the Administrative Manager, who will answer the question if it is routine or forward it to the Board of Trustees for review if it is not. The Administrative Manager is:

Nathanael Aylestock, Administrative Manager
West Virginia Laborers Trust Fund Office
One Union Square, Suite 200
Charleston, WV 25302
(304) 342-5142

The Administrative Manager has no discretion in the interpretation or administration of the Plan.

1.09 Employer Identification Number and Plan Number

The Employer Identification Number assigned to the Plan Sponsor by the Internal Revenue Service is 55-0451207. The Plan Number is 501. The plan number identifies the Fund with the Internal Revenue Service and the United States Department of Labor.

1.10 Agent for Service of Legal Process

The following individual is designated as agent for service of legal process:

Jason Mettley, Fund Counsel
Meyer, Unkovic & Scott LLP
Henry W. Oliver Building
535 Smithfield Street, Suite 1300
Pittsburgh, PA 15222-2315

In addition, service of legal process may be made upon any member of the Plan's Board of Trustees.

1.11 Collective Bargaining

The Plan is maintained pursuant to Collective Bargaining Agreements between employee organizations affiliated with the West Virginia Appalachian Laborers' District Council (collectively the "Union") and

various Employers (collectively the "Employers"). The Collective Bargaining Agreements are available for examination by Participants and Beneficiaries at:

West Virginia Appalachian Laborers' District Council
One Union Square, Suite 5
Charleston, WV 25302

A copy of the Collective Bargaining Agreements may be obtained by Participants and Beneficiaries upon written request to the Plan Administrator. The Plan Administrator will charge a reasonable amount to cover the costs of furnishing a copy of the Collective Bargaining Agreement.

A complete list of the Employers and employee organizations sponsoring the Plan may be obtained by Participants and Beneficiaries upon written request to the Plan Administrator. Also, Participants and Beneficiaries may receive from the Plan Administrator, upon written request, information as to whether a particular Employer or employee organization is a sponsor of the Plan and if the Employer or employee organization is a Plan sponsor, the sponsor's address.

1.12 Funding Medium

Benefits payable by the Plan are funded by Employer Contributions to the West Virginia Laborers' Trust Fund (the "Fund"). Employer Contributions held by the Fund are invested and any investment earnings accumulate with the Employer Contributions to pay the benefits provided by the Plan and the Plan's administrative expenses.

1.13 Source of Plan Contributions

Contributions to the Fund are made by Employers that have a Collective Bargaining Agreement with the Union, or a participation agreement with the Board of Trustees, that require contributions to be made to the Fund.

The amount of contributions required is established under the terms of the applicable Collective Bargaining or participation agreement. In general, the calculation of contributions owed by an Employer under a Collective Bargaining or participation agreement is a certain amount of money for each hour of Covered Employment. Under certain circumstances outlined in this SPD, Participants are also required to make contributions to the Fund.

1.14 Plan Year

The Plan Year is April 1 through March 31, which is the end of the year for purposes of maintaining the Plan's fiscal records.

Article II. Definitions

The following are definitions of important terms used throughout this SPD.

2.01 Agreement

Agreement means the agreement and declaration of trust establishing and governing the West Virginia Laborers' Trust Fund, as amended from time to time.

2.02 Allowed Charge

Allowed Charge is determined by the Trustees or their designee to be as follows:

(1) With respect to an in-network provider, the provider's actual billed charge unless there is a negotiated fee/rate set forth in the agreement between Highmark and the Plan; or

(2) With respect to an out-of-network provider, the lower of the scheduled dollar amounts the Plan has determined it will allow for Covered Expenses performed by out of network providers, or the provider's actual billed charge, unless the Plan has agreed to pay another amount as set forth in the agreement with Highmark.

The Plan's Allowed Charges are not based on or intended to be reflective of fees that are or may be described as usual and customary (U&C), reasonable and customary (R&C), usual, customary and reasonable (UCR), prevailing or any similar term.

In determining the Allowed Charge, the Trustees will take into account any unusual circumstances involving medical complications or requiring additional time, skill and experience.

2.03 Beneficiary

Beneficiary means the person(s) or parties properly designated by an Eligible Participant to receive the proceeds of the Death or Accidental Death Benefit under the Plan, or any other benefits otherwise payable (excluding those benefits previously assigned) after the death of an Eligible

Retiree. If there is no Beneficiary designated, any death benefits payable will be made in a single sum to the first surviving class of the following classes of successive preference Beneficiaries: the Participant's (a) widow or widower; (b) surviving children (to be shared equally); (c) surviving parents (to be shared equally); and (e) executors or administrators of the Participant's estate.

2.04 Board of Trustees

Board of Trustees means those persons, and their successors, who are appointed under the Agreement to administer the Fund.

2.05 Bodily Injury

Bodily Injury means accidental bodily injury occurring directly and independently of all other causes.

2.06 Change of Address

Any circumstances resulting in your change of address. **Be sure to notify the Fund Office of any change in your address.**

2.07 Collective Bargaining Agreement

Collective Bargaining Agreement means the contracts or labor agreements as amended, between the Union and an Employer covering terms and conditions of employment and contributions to the Fund.

2.08 Covered Employment

Covered Employment means work for which an Employer is required to make contributions to the Fund pursuant to a Collective Bargaining Agreement.

2.09 Covered Expense

Covered Expense means a charge that is allowable under the Plan for a service or supply that is Medically Necessary for the diagnosis, treatment, or cure of an Illness or Injury to a structure or function of the mind or body. No amount in excess of the actual charge for a service or supply shall be considered a Covered Expense.

2.10 Covered Person

Covered Person means a Retiree or Dependent thereof who satisfies the requirements for coverage set forth in Article III hereof. The terms

"Covered Retiree" and "Covered Dependent" are used, where appropriate, to describe that category of "Covered Person".

2.11 Deductible

Deductible means the sum of out-of-pocket expenses that must be paid each calendar year before a benefit is payable.

2.12 Dentist

Dentist means a person who is duly licensed and acting within the scope of his license to practice dentistry and includes a Physician furnishing dental care which he is licensed to provide.

2.13 Dependent

Dependent means: (1) the individual to whom an Eligible Retiree is legally married under applicable law, (the "dependent spouse"), and (2) each child of an Eligible Retiree prior to the last day of the month of the child's nineteenth (or twenty-third if a full-time student) birthday (a "dependent child").

The term "child" shall include an eligible Retiree's stepchild, foster children, legally adopted children and children under the Retiree's legal guardianship.

The term "dependent" shall also mean an unmarried child that, prior to age 19 (or until the last day of the month in which the child turns age 23 if the child is a full-time student or is on a medically necessary leave of absence from the school or educational program for up to 12 months),becomes incapable of self-sustaining employment because of a physical disability or mental retardation, and such child is totally Dependent upon the Participant for support. Such Dependent child's eligibility shall continue so long as the disability continues, provided the Participant remains eligible for benefits.

You are required to provide proof of Dependent eligibility. In the case of a Dependent spouse, a marriage certificate is required to confirm eligibility. In the case of a Dependent child, a birth certificate, court order of record, or another document deemed necessary by the Board of Trustees is required to confirm eligibility. Failing to furnish the proof required will result in the denial of Dependent eligibility.

If you remarry following Divorce, Legal Separation or the death of your spouse, you may add a new spouse as a Dependent, provided you notify

the Fund Office within 60 days of the marriage and submit all required forms and documentation.

2.14 Disabled Child

Disabled Child shall mean an unmarried covered Dependent, that is a child, and that, prior to age 19, becomes incapable of self-sustaining employment because of physical disability or mental retardation, and such child is totally Dependent upon the Participant for support, such Dependent child's eligibility will be continued so long as disability continues, but not beyond the date the Participant ceases to be eligible for benefits. Proof of the continued existence of such incapability may be requested by the Trustees from time to time.

2.15 Divorce or Legal Separation

Divorce or Legal Separation means a Retiree is divorced or legally separated from his spouse under applicable state law. In the event of Divorce or Legal Separation, the Retiree must notify the Fund Office immediately as to his legal obligations regarding any Dependent as defined above.

2.16 Doctor or Physician

Doctor or Physician shall specifically refer to a Physician or surgeon licensed to practice medicine or perform surgery. The term shall also include osteopath, chiropractor, podiatrist and any other health care provider who is acting within the scope of his or her license or certification under applicable state law.

2.17 Effective Date

Effective Date means the date a Retiree's coverage and that of his Dependents will commence.

2.18 Eligible Participant or Eligible Retiree

Eligible Participant or Eligible Retiree means a Participant who has met the Eligibility Requirements of the Plan and is entitled to benefits at the time a claim is Incurred.

2.19 Employee

Employee means a person in a job category covered by a Collective Bargaining Agreement on whose behalf an Employer makes, or is obligated to make, the required contributions to the Fund or any other

person who satisfies the requirement established for participation and on whose behalf an Employer makes, or is obligated to make, the required contributions to the Fund.

2.20 Employer

Employer means any employer (including any individual, partnership, corporation, contractor, joint venture or other entity) that is required to make contributions to the Fund pursuant to a Collective Bargaining Agreement or a participation agreement or who, in fact makes contributions to the Fund, which shall include the Union.

2.21 Employer Contributions

Employer Contributions means the payments by a participating Employer to the Fund as required by a Collective Bargaining Agreement or participation agreement.

2.22 Fund

Fund means the West Virginia Laborers' Trust Fund.

2.23 Fund Office

Fund Office means the office of the Fund's Administrative Manager, which is located at One Union Square, Suite 200, Charleston, West Virginia 25302.

2.24 Hospital

Hospital means only an institution which meets fully, every one of the following tests: (1) it is primarily engaged in providing on an inpatient basis, diagnostic and therapeutic facilities for the surgical and medical diagnosis, treatment and care of injured and sick persons, or under the supervision of a staff of Physicians, and (2) it continuously provides 24 hour a day nursing services by registered graduate nurses, and (3) it is not, other than incidentally, a place of rest, a place for the aged, a place for drug addicts, a place for alcoholics, a place for the mentally ill, a nursing home, a hotel or the like. A Hospital must be accredited as a hospital by the Joint Commission on Accreditation of Health Care Organizations.

2.25 Illness

Illness means a disease or disorder resulting in an unsound condition of the mind or body.

2.26 Incurred

Incurred refers to the date a service or supply is furnished.

2.27 Injury

Injury means a wound or damage to the body sustained accidentally and by external force.

2.28 Medically Necessary

Medically Necessary means services or supplies furnished or prescribed by a Physician or other licensed provider to identify or treat a diagnosed or reasonably suspected Illness or Injury, the furnishing of which is consistent with the diagnosis and treatment of the patient's condition; in accordance with standards of good medical practice; required for reasons other than the convenience of the patient, Physician, or other licensed provider; and the most appropriate level of service or supply that can be provided safely for the patient. When the term "Medically Necessary" is used to describe inpatient care in a Hospital, it means that the patient's medical symptoms and condition are such that the service or supply cannot be provided safely to the patient on an outpatient basis. The fact that services or supplies are furnished or prescribed by a Physician or other licensed provider does not necessarily mean that the services and supplies are "Medically Necessary."

2.29 Newborn Children

Newborn Children means the newly born child of a Covered Person. If a Newborn Dependent Child remains confined in a Hospital from the day of birth, Plan benefits will be paid at the same level as for any other confinement due to Illness.

2.30 Nurse Practitioner

Nurse Practitioner shall specifically refer to a Registered Nurse who has received certification from a certification body recognized by the West Virginia Board of Examiners for Registered professional Nurses.

2.31 Outpatient Facility

Outpatient Facility means a clinic or other establishment that maintains and operates facilities for surgery, diagnosis, and treatment on an outpatient basis, which facility shall have an attending medical staff consisting of at least one Physician and anesthesiologist (or a nurse anesthetist under the supervision of a Physician). This term shall not mean a convalescent

home, nursing home, home for the needy, home for nursing and domiciliary care, infirmary or orphanage, sanatorium, maternity home for pre-natal or post-natal care, mental health facility, or other home or institution.

2.32 Participant

Participant means (a) any person covered under a Collective Bargaining Agreement between an Employer and the Union and who has performed work in employment with respect to which the Employer is obligated to make contributions to the West Virginia Laborers Trust Fund, and (b) any salaried employee of the Union on behalf of whom the Union makes periodic payments to the Fund at the time and at the rate equal to that made by the Employers, and (c) any member of any other class of employees accepted for participation by the Trustees and not otherwise prohibited from participation by law or governmental regulations.

2.33 Physician Assistant

Physician Assistant shall specifically refer to an assistant who has received certification from a certification body recognized by the West Virginia Board of Examiners for Registered Physician Assistants.

2.34 Plan

Plan means the West Virginia Laborers' Trust Fund Health & Welfare Plan, as amended from time to time.

2.35 Retiree

Retiree means an individual eligible for Plan benefits under Article III of this SPD.

2.36 Schedule of Benefits

Schedule of Benefits means the Schedule of Benefits and Deductibles set forth in Article X.

2.37 Self-Contributions

Self-Contributions mean payments made by Retirees for the purpose of maintaining eligibility under the Plan.

2.38 Union

Union means the WV Appalachian Laborers District Council of Charleston, West Virginia and each of its affiliated Local Unions, who have in effect

with the Associations or with other Employers, Collective Bargaining Agreements providing for the payment of contributions to the Trust Fund.

Article III. Eligibility

3.01 Initial Eligibility

You and your Dependents are eligible for Retiree Plan coverage if you satisfy the following conditions:

- You retire from Covered Employment with a normal, reduced, unreduced, early or disability pension benefit from the West Virginia Laborers' Pension Trust Fund;
- You were actively employed in Covered Employment during the twenty-four (24) month period immediately preceding the date you applied for a pension benefit;
- You were eligible for benefits under Plan A as an active Employee on the date you applied for a pension benefit;
- You accumulated at least ten (10) years or forty (40) quarters of Plan eligibility as an active Employee prior to the date you applied for a pension benefit; and
- You begin making timely Self-Contributions to the Plan as set forth in Section 3.02.

Medicare-eligible Retirees seeking coverage under Plan D can enroll at the time their Plan A or Plan BB coverage ends, or when they reach Medicare Age, or during Medicare's annual enrollment period.

3.02 Continued Eligibility

You and your Dependents will continue your Retiree Plan coverage provided you timely pay your Self-Contributions. The Plan BB Self-Contribution rates are determined periodically by the Trustees and are based on Years of Service, with the rates decreasing for Retirees with more Years of Service. As of January 1, 2022, the Self-Contribution rate for each pre-Medicare Retiree and their Dependent(s) enrolled in Plan BB is as follows:

Years of Service*	Monthly Self-Contribution Rate Effective 1/1/2022 (per person)
0-19	$618
20	$515
21	$510

22	$505
23	$500
24	$495
25	$490
26	$485
27	$479
28	$474
29	$469
30+	$464
Over 50,000 Hours of Service*	$0 (no charge)
Dependent Child Surcharge	$20 per Dependent Child

* For purposes of determining the applicable Self-Contribution rate for pre-Medicare Retirees in Plan BB, your Years of Service and Hours of Service is determined based on the record of your Years of Service and Hours of Service maintained by the West Virginia Laborers' Pension Trust Fund.

As of January 1, 2022, the Self-Contribution rate for Medicare-Eligible Retirees enrolled in Plan D is $150 per month per Retiree and for each covered Dependent.

The Board of Trustees has the right to change the Self-Contribution rates at any time, with or without advance notice. Participants will be notified of changes to the Self-Contribution rates as required by law.

Your Self-Contributions must be paid in a timely manner in order to maintain your eligibility for coverage. Self-Contributions are deemed to be timely paid if they are received by the Fund Office on or before the first day of the month coverage is to be provided. For instance, Self-Contributions must be paid on or before January 1 for coverage during the month of January.

If a Retiree's eligibility is terminated because of Medicare eligibility, the Retiree's spouse may continue to maintain eligibility under the Plan by making timely Self-Contributions as described above.

3.03 Reinstatement of Eligibility following Divorce or Legal Separation

If you are receiving Plan benefits as the Dependent of a Retiree, but are

otherwise an eligible Retiree, and your Plan eligibility would terminate as the result of Divorce or Legal Separation, you may reinstate your eligibility as a Retiree provided you pay Self-Contributions for coverage beginning the first of the month following your Divorce or Legal Separation. You will have a period of sixty (60) days from the date of your Divorce or Legal Separation to pay your Self-Contributions; otherwise, you will forfeit your right to reinstate Plan eligibility under this Section. Once you have forfeited your right to reinstate Plan eligibility under this Section you will be offered COBRA continuation coverage (see Section 5.02).

Article IV. Termination of Eligibility for Benefit Coverage

4.01 Termination of Eligibility for Retirees

Failure to timely pay Self-Contributions as set forth in Section 3.02 will result in the automatic termination of coverage on the last day of the calendar month for which you were eligible for coverage.

The benefits described in this SPD are intended to be provided only to eligible individuals that have retired from Covered Employment. In the event you return to Covered Employment after you have been retired, your retiree benefits hereunder will be terminated as of the last day of the calendar month following the date the Fund Office receives a report of your Covered Employment. From that point forward your eligibility for medical benefits will be governed by the eligibility rules for Retirees Returning to Covered Employment as described in the SPD for Active Employees.

4.02 Termination of Eligibility for Dependents

A Dependent's eligibility for Plan benefit coverage automatically terminates as of the last day of the month in which:

- The Retiree of whom they are a Dependent has their Plan benefit eligibility terminated (except when the Retiree becomes eligible for Medicare);
- The Dependent no longer meets the definition of Dependent as set forth in Section 2.13; or
- The Dependent becomes eligible for Plan benefits as a Retiree.

Upon the Retiree becoming eligible for Medicare, the Retiree's Dependent spouse may continue to maintain eligibility under Plan BB by making timely Self-Contributions as described in Section 3.02. The Dependent Spouse's

eligibility will terminate if they fail to make timely Self-Contributions, or if they become Medicare-eligible.

Upon the death of the Retiree, coverage for the Retiree's covered spouse will terminate as of the last day of the month in which the Retiree dies, subject to the spouse's right, if any, to continue coverage under COBRA.

Article V. COBRA Coverage

5.01 General Explanation

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires that most employers sponsoring group health plans offer Retirees and their qualified beneficiaries the opportunity for a temporary extension of health coverage (called "continuation coverage") at group rates in certain instances where coverage under the Plan would otherwise end. Qualified beneficiaries include your Dependents who, on the day before a qualifying event, were covered by the Plan. A child who is born to or placed for adoption with you during the period of COBRA continuation coverage is a qualified beneficiary and will be eligible to elect continuation coverage if a second qualifying event occurs.

Plan Participants have a right to choose this continuation coverage if they lose health benefits from the Plan health benefits because of a qualifying event. The length of COBRA continuation coverage for Participants and their Dependents varies depending on the qualifying event that occurs.

COBRA Coverage will only be offered to Retirees and their qualified beneficiaries enrolled in Plan BB or Plan D who subsequently experience one of the Qualifying Events identified below.

5.02 COBRA Qualifying Events and Length of Coverage

The following table contains the length of continuation coverage available for each of the various COBRA qualifying events.

Qualifying Events	Length of Coverage
• You lose eligibility due to failure to make timely Self-Contributions	18 months for you and/or your covered Dependents[1]

• You die[2] • You Divorce or Legally Separate from your spouse[2] • Your child turns 26 years of age[2] • You become entitled to Medicare[3]	36 months for your covered Dependents

[1] *This period is extended to 29 months for any qualified Dependent(s) if the Social Security Administration determines that the individual was or became totally disabled at any time during the first 60 days of COBRA coverage.*

[2] *The Participant or a family member of the Participant is responsible for notifying the Fund Office within 60 days of the qualifying event, or the right to elect COBRA continuation coverage is lost.*

5.03 Electing COBRA Coverage

When the Fund Office is notified that a qualifying event has happened, a written notice will be sent to Participants and Dependents advising them of the right to choose continuation coverage. Participants and Dependents have 60 days to inform the Fund Office in writing that they want COBRA continuation coverage. This 60-day election period starts on the date the Participant and/or Dependents would otherwise lose coverage because of the qualifying event or the date that the election form was issued, whichever is later.

Medical coverage from the Plan will terminate for Participants and/or Dependents that do not elect COBRA continuation coverage within the election period.

5.04 Paying for COBRA Coverage

If continuation coverage is elected, the Plan is required to offer the same coverage that is offered at that time to similarly situated employees. Participants and Dependents must pay 100% of the cost of COBRA continuation coverage plus a 2% administrative fee (unless the administrative fee is waived by the Board of Trustees). The monthly Plan D COBRA Premium Rate shall be equal to the Self-Contribution rate established for Medicare-Eligible Retirees.

Full payment of the initial premium is required by the 45th day after COBRA continuation coverage is elected. The due date for each month's premium is prior to the first day of the month of coverage. Participants and Dependents are responsible for making timely payments. If the first payment is not made within 45 days the COBRA election, or subsequent payments within 30 days of the due date, COBRA continuation coverage will be permanently terminated retroactive to the last date for which premiums were paid. COBRA continuation coverage cannot be reinstated once it is terminated.

Although COBRA continuation coverage is retroactive to the date of the initial qualifying event, no benefits will be paid until the full premium payment is received.

5.05 When COBRA Coverage Ends

COBRA coverage ends when any of the following occurs:

- The premium for continuation coverage is not paid on a timely basis.
- The maximum period for continuation coverage expires as it applies to the qualifying event.
- The Participant or Dependent becomes an employee covered under another group health plan.
- The Participant or Dependent becomes entitled to Medicare.
- A Dependent becomes Divorced from a Participant, subsequently remarries, and is covered under the new spouse's group health plan.

At the end of the COBRA period, Participants and Dependents will be allowed to enroll in an individual conversion health plan if such a plan is provided under the Plan.

5.06 Multiple Qualifying Events

Dependents entitled to 18 months of COBRA continuation coverage due to a Participant's failure to make timely Self-Contributions can extend the length of their coverage period if a second qualifying event occurs during the initial 18 month period. The extension generally cannot exceed 36 months from the date of the first qualifying event and applies to individuals who were Dependents under the Plan as of the first qualifying event and who were covered under the Plan at the time of the second qualifying event.

For example, if a Participant loses coverage because of his failure to make timely Self-Contributions, his Dependents are eligible for 18 months of

COBRA continuation coverage. If the Participant dies after 15 months, a second qualifying event has occurred for the Participant's Dependents. This second qualifying event extends coverage for an additional 21 months for a total of 36 months, the normal period for continuation coverage resulting from the death of an employee.

An exception to this rule is if a Participant is receiving COBRA continuation coverage due a change in employment status and then becomes entitled to Medicare. In this case, the COBRA continuation coverage for the Participant ends upon becoming entitled to Medicare, but the Participant's Dependents will become eligible for an additional 36 months of COBRA continuation coverage.

5.07 Alternatives to COBRA Coverage

Non-Medicare eligible Participants may be eligible to buy an individual health insurance plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, Participants may qualify for lower monthly premiums and lower out-of-pocket costs. The cost of comparable health care coverage through the Marketplace could be substantially lower than the cost of COBRA coverage through the Plan.

Additionally, Participants may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

For more information about the Marketplace, visit www.HealthCare.gov.

5.08 Questions about COBRA Coverage

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the Fund Office.

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) or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Article VI. General Provisions

6.01 General Plan Exclusions

The Plan **does not cover** loss caused by:

- accidental Bodily Injury which arises out of or occurs in the course of any occupation or employment for wage or profit, or sickness for which you are entitled to benefit under any Workers Compensation or Occupational Disease Laws, unless specifically provided for in the Schedule of Benefits; or

- loss caused while serving in the military service of this country for which benefits are payable due to a service related Injury or Illness

6.02 Enrollment Cards

Every Retiree must submit an enrollment card completed fully by the Retiree and his Union Office. Enrollment Cards may be obtained by calling or writing the Fund Office or online at www.wvlaborers.com.

6.03 Special Enrollment Rights & Changes in Family Status

Changes in family status or your address may affect a Participant's or Beneficiary's eligibility for Plan benefits and may also create special enrollment rights. Also, the failure to notify the Fund Office of family status changes may impact a Participant's or Beneficiary's rights to COBRA continuation coverage after the occurrence of a qualifying event. For these reasons, Participants and their Beneficiaries must provide prompt written notice to the Fund Office about any change in your address and about any of the following changes in your family status:

- The Participant's or any Beneficiary's marriage;

- The Participant's Divorce, Legal Separation or annulment from a Beneficiary spouse;

- The birth of the Participant's child, or the Participant's adoption or placement for adoption of a child;

- The Participant's or Beneficiary's loss of other health coverage;

- The death of any Beneficiaries; or

- The 26th birthday of any Dependent child.

If you are declining enrollment for yourself or your Dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your Dependents in this Plan if you or your Dependents lose eligibility for that other coverage (or

if the employer stops contributing toward your or your Dependents' other coverage). However, you must request enrollment within 30 days after your or your Dependents' other coverage ends (or after the employer stops contributing toward the other coverage). In addition, if you have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your Dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. To request special enrollment or obtain more information, contact the Fund Office.

These family status changes are material facts in determining whether Participants and beneficiaries are entitled to receive Plan benefits. Any Participant or Beneficiary misreporting or failing to report a family status change, which results in the Plan providing benefits to any individual who is not eligible for benefits, will have their Plan benefits terminated immediately and permanently. The Retiree and/or Dependent will also be responsible for restoring to the Plan any benefits improperly awarded (or the value thereof) as a result of the concealment or misrepresentation of family status changes.

For all of these reasons, Participants and beneficiaries must promptly report family status or address changes to the Fund Office.

6.04 Effective Date of Coverage

Benefit coverage for Retirees and their Dependents will become effective on the date on which the Retiree becomes eligible for coverage as provided in Article III, provided all required enrollment cards have been completed and submitted to the Fund Office (see Section 7.02).

6.05 Benefit Amount

For any claim which the benefit is not expressly stated, the Trustees shall have the right to determine an amount, which in their opinion would be consistent with the Plan's provisions and with payments made on similar claims or claims of a like nature.

6.06 Payment of Benefits

Benefits will be paid for the period covered by the statement of claim form. If disability or confinement continues beyond that period, an additional claim must be filed. Unless a receipt marked "paid-in-full" accompanies the claim form, such benefit payments are made directly to the provider.

No benefit payments made by the Fund will exceed what is determined as

the Allowed Charge for any covered services rendered in connection with the necessary care and treatment of a non-occupational Illness or Injury.

Notwithstanding anything herein to the contrary, the Trustees shall have the sole prerogative to determine the Allowed Charge of any Doctor, Hospital or other provider of medical service, and such determination shall be consistently applied in all similar situations, and shall be in accordance with the benefit provisions hereinafter set forth.

6.07 Errors in Benefit Payments

The Trustees specifically retain the right to recover all monies paid in error to, or on behalf of any person, from such person. Upon the discovery of a payment "made in error" the Trustees shall notify the recipient or Beneficiary of such payment, indicating the circumstances and amount of such payment, together with a request for repayment. Upon failure to repay the amount due within a reasonable time after such notification, the Trustees may take such legal action as they deem necessary, or in the case of a Fund Participant, the amount of the payment made in error may be deducted from any future benefit payments which such Participant or his Dependents or Beneficiary may become entitled to under this plan. If legal action is required to recover a payment "made in error", the recipient of the erroneous payment shall be responsible for the Fund's attorney's fees and legal costs.

6.08 Right of Recovery

The Plan reserves the right to recover any monies paid in error to or on behalf of any Covered Person or to any health care providers. To the extent that payments are made by the Plan which are either in excess of the maximum amount necessary to satisfy the obligations of the Plan or are subsequently determined to have been incorrectly made, regardless of to whom such payments have been made, the Plan shall have the right to recover such excess or incorrect payments from any person or other entity to whom or for whom such payments were made (including the Covered Person), any insurance companies, or any other person or entity from whom repayment is appropriate as the Plan shall determine. Any Covered Person may be required by the Plan to furnish information, to execute and deliver such documents, and otherwise to cooperate in whatever manner may reasonably be required to secure the Plan's right to recover such payments.

6.09 Right of Subrogation and Refund

The Plan does not provide coverage for medical claims that would

otherwise be covered if those claims are Incurred as the result of the actions of a third party or a work-related Injury ("Third Party Liability").

The Plan will provide, however, temporary coverage and pay medical claims for which there is Third Party Liability pending a resolution of the Participant's or Dependent's legal claims against the third party (or their insurance company), provided these conditions are satisfied by the Participant or Dependent:

- The Participant or Dependent must notify the Plan Administrator within thirty (30) days of any medical claims Incurred as a result of a Third Party Liability;

- The Participant or Dependent must execute and deliver such documents as the Plan may require to protect its right to reimbursement;

- The Participant or Dependent (or, if represented by an attorney, their attorney) must notify the Plan Administrator of any Third Party Liability settlement or other recovery, and the amount of said settlement payment or other recovery, no later than two (2) business days after the receipt of the settlement payment or the recovery proceeds;

- If the Participant or Dependent is represented by an attorney with respect to their Third Party Liability claims, the Participant or Dependent must instruct their attorney to hold the entire amount of any Third Party Liability settlement payment or recovery proceeds in the attorney's client trust account for a period of at least twenty-one days from the date of receipt, or until the Plan Administrator releases its subrogation lien over the settlement payment or recovery proceeds, whichever comes first; and

- If the Participant or Dependent is not represented by an attorney with respect to their Third Party Liability claims, the Participant or Dependent must hold the entire amount of any Third Party Liability settlement payment or recovery, dissipating no amount of the same, for a period of at least twenty-one days from the date of receipt, or until the Plan Administrator releases its subrogation lien over the settlement payment or recovery proceeds, whichever comes first.

The Plan has a right to reimbursement from any recovery made by a Participant or Dependent for Third Party Liability, whether by settlement,

judgment or otherwise, including any payments made by an insurance company under an applicable automobile, homeowner's or workers' compensation policy. The Plan's right to reimbursement is limited to an amount equal to the medical claims paid by the Plan on behalf of the Participant or Dependent for injuries sustained as a result of Third Party Liability. The Plan will further offset its right to reimbursement by 33⅓% of the claims paid on behalf of the Participant or Dependent to account for the Participant's or Dependent's recovery costs. For these purposes, recovery costs include all of the Participant's or Dependent's attorney's fees and litigation expenses in relation to the Third Party Liability settlement or other recovery.

Any amounts recovered by a Participant or Dependent because of Third Party Liability are Plan assets up to the amount of the medical claims paid by the Plan on behalf of the Participant or Dependent as the result of Third Party Liability. Accordingly, the Participant or Dependent (and their agents, including their attorney) are Plan fiduciaries with respect to amounts recovered as the result of Third Party Liability.

If the Participant or Dependent violates any of the terms or conditions in this section, the Plan Administrator may, in its sole discretion: 1) reject future medical claims and deny further benefit payments in relation to the injuries sustained by the Participant or Dependent because of the Third Party Liability; 2) offset any future benefits due to the Participant or Dependent from the Plan for any amounts not reimbursed under this section; and/or 3) permanently terminate the Participant's or Dependent's coverage in the Plan.

If the Plan Administrator must file suit to protect the Plan's right to reimbursement as set forth in this section, the Participant or Dependent shall be liable for the Plan's attorney's fees and litigation expenses. Any agent or attorney of the Participant or Dependent that fails to honor or protect the Plan's right to reimbursement regarding any Third Party Liability settlement or other recovery shall be jointly and severally liable with the Participant or Dependent for the Plan's damages, including attorney's fees and litigation expenses.

The Plan Administrator's failure to insist on strict compliance with any provision of this section shall not be deemed a waiver of any other provision, and any waiver of any provision shall not be deemed to be a waiver of any other provision.

6.10 Assignment

No assignment of death or weekly disability benefits shall be valid.

6.11 Limitations on Legal Actions

No action at law or in equity to recover Plan benefits shall be brought before the claims and appeals procedures set forth in Article XVI has been exhausted or after three years from the date a claim for benefits was made or submitted on your behalf to a network provider for payment.

6.12 Misrepresentation or Fraud

A claimant who receives benefits under the Plan as a result of false information or a misleading or fraudulent representation shall repay all amounts paid by the Fund and shall be liable for all costs of collection, including reasonable attorneys' fees.

6.13 Qualified Medical Child Support Orders (QMCSOs)

(1) General Explanation

ERISA requires the Plan to extend health care coverage to the child(ren) of a Participant who is Divorced, Separated, or never married when ordered to do so by state authorities. Generally, a State court or agency may require the Plan to provide health benefits coverage to children by issuing a medical child support order. The Plan is required to determine whether such an order is "qualified". The Plan will only comply with qualified medical child support orders (QMCSOs).

(2) What is a QMCSO?

A QMCSO is a medical child support order that creates or recognizes the right of an alternate recipient to receive medical benefits for which a Participant or Beneficiary is eligible to receive from the Plan, and which is recognized by the Plan as "qualified".

(3) Who is an alternate recipient?

Any child of a Plan Participant who is recognized under a medical child support order as having a right to enrollment under the Plan with respect to such Participant is an alternate recipient.

(4) What makes a medical child support order "qualified"?

In order to be qualified, a medical child support order must contain the following information:

- The name and last known mailing address of the Participant and each alternate recipient. The order may substitute the name and mailing address of a State or local official for the mailing address of any alternate recipient;

- A reasonable description of the type of health care coverage to be provided to each alternate recipient (or the manner in which such coverage is to be determined); and

- The period to which the order applies.

In general, the order may not require the Plan to provide any type or form of benefit, or any option, not otherwise provided under the Plan.

(5) Who determines whether an order is "qualified" and what is the process?

The Trustees determine whether a medical child support order is qualified. The Trustees will make this determination within a reasonable period of time after receiving the order. The Fund Office maintains written procedures for making these types of determinations. To obtain a free copy of the Plan's procedures for QMCSO Determinations, please call or write the Fund Office.

Article VII. Miscellaneous Plan Provisions

7.01 Exclusive Rights

No individual shall have a right to benefits provided under the Plan, except as specified herein; and in no event shall any right to benefits under the Plan be vested.

7.02 Burden of Proof

The Board of Trustees shall have the right to require, from time to time and as often as it determines reasonably necessary, satisfactory proof of any status or condition of any person claiming benefits under the Plan. The Board of Trustees also shall have the right to require a Participant or Dependent to submit to an examination, at the expense of the Fund, by a Physician selected by the Board of Trustees for proof of an existing or continuing disability. The Board of Trustees shall have the right to require such examinations, from time to time and as often as it determines reasonably necessary. Failure to provide proof satisfactory to the Board of Trustees shall result in a loss of eligibility under the Plan or denial of the claim for benefits.

7.03 Workers' Compensation

The benefits provided by the Plan are not in lieu of and do not affect any requirement for coverage by Workers' Compensation or similar laws.

7.04 Disclaimer

None of the benefits provided under the Plan are guaranteed or vested. The total liability for the payment of all benefits as provided herein shall be limited to the assets of the Fund and neither the Trustees, any contributing Employer, or the Union shall at any time be liable for the payment or non-payment of benefits.

7.05 Agreement and Declaration of Trust

The Plan is subject to and controlled by the provisions of the Agreement and Declaration of Trust, and in the event of a conflict between the provisions of the Plan and the provisions of the Agreement and Declaration of Trust, the provisions of the Agreement and Declaration of Trust shall prevail.

7.06 Plan Year

For purposes of ERISA, the Plan Year for the Plan shall be the period beginning April 1 and ending March 31st. Benefits, however, are administered on a calendar year basis.

7.07 Construction

The Board of Trustees, subject to the requirements of law, shall be the sole judge of the standard of proof required in any case and has complete discretion in the application and interpretation of the Plan. All decisions of the Board of Trustees shall be final and binding on all parties.

7.08 Governing Law

The Plan is created and accepted in the State of West Virginia; and all questions pertaining to the validity or construction of the Plan and of the acts and transactions of the parties hereto shall be determined in accordance with the laws of the State of West Virginia except as to matters preempted by ERISA or other federal law.

7.09 Savings Clause

Should a provision of the Plan be held to be unlawful, or unlawful as to a person or instance, such fact shall not adversely affect other provisions of

the Plan or the application of other provisions to other persons or instances unless the illegality shall make impossible the functioning of the Plan.

7.10 Captions

The caption of an article, section or provision of the Plan is for convenience and reference only and is not to be considered in interpreting the terms and conditions of the Plan.

7.11 Gender

Words used in the Plan in the masculine gender shall be construed as though they also are used in the feminine gender in all situations where they would so apply. Words used in the Plan in the singular form shall be construed as though they also are used in the plural form in all situations where they would so apply, and vice-versa.

7.12 Resolution of Disputes; Venue

Any and all disputes concerning the Plan or Fund shall be resolved exclusively in Kanawha County, West Virginia. The venue for any suit or cause of action arising out of the Plan shall be exclusively in the federal courts for the Southern District of West Virginia or in the state courts of Kanawha County, West Virginia.

Article VIII. Amendment and Termination of the Plan

8.01 Right to Amend or Terminate Plan

The Board of Trustees expressly reserves the right, at will, in its sole discretion, at any time and from time to time, but upon a nondiscriminatory basis, to:

(1) add, modify, eliminate, or charge for coverage for all Retirees and Dependents;

(2) amend or terminate the existence, amount or nature of benefits payable except that no amendment or termination shall affect claims that have already been Incurred;

(3) alter or postpone the conditions for or method of payment of a benefit;

(4) amend or rescind a provision of the Plan; and

(5) terminate the Plan in its entirety.

8.02 Effect of Termination

If the Plan is terminated, the Board of Trustees shall use any remaining assets to satisfy existing claims for benefits under the terms of the Plan and to pay reasonable administrative expenses until the assets of the Fund are exhausted. Any then remaining assets shall be distributed in accordance with the terms of the Agreement and Declaration of Trust.

Article IX. Benefit Schedule for Plan BB – Pre-Medicare Eligible Retirees

9.01 Benefit Schedule

Pre-Medicare eligible Retirees and their Dependents eligible for benefits under Article III shall receive the following benefits under what is referred to as Plan "BB":

HOSPITALIZATION BENEFITS	
DAILY ROOM ALLOWANCE:	**UP TO $400 PER DAY**
MAXIMUM PER DAYS OF CONFINEMENT:	**70**
MISCELLANEOUS HOSPITAL EXPENSE BENEFITS:	**80% OF INTENSIVE CARE AND SPECIAL UNIT CHARGES IN EXCESS OF $400 PER DAY, UP TO A MAXIMUM OF $40,000**
MAXIMUM ANNUAL COVERED EXPENSES:	**$50,000 (80% OF $62,500)**
MAJOR MEDICAL BENEFITS	
CO-INSURANCE (IN NETWORK):	**80% OF COVERED CHARGES**
EMERGENCY ROOM MAXIMUM BENEFIT:	**$400 PER VISIT**
SURGICAL PROCEDURES MAXIMUM BENEFIT:	**$18,750 PER PROCEDURE**
OFFICE VISIT MAXIMUM BENEFIT:	**$200 PER VISIT**
MAXIMUM OFFICE VISITS PER YEAR:	**50**
MAXIMUM ANNUAL BENEFIT FOR COVERED MEDICAL EXPENSES:	**$250,000**
PRESCRIPTION DRUGS	
CO-INSURANCE:	**80%**

9.02 More Detail

More details regarding these benefits can be found in the folowing Atice

Article X. Coordination of Medical and Prescription Drug Benefits (Plan BB Only)

10.01 Definitions of Terms Used in this Article

(1) **"Plan"** shall mean any of the plans set forth below which provide services or benefit payments to an eligible person or Dependent for Hospital, medical, surgical, or prescription drug:

(a) group, blanket or franchise insurance (except student accident insurance);

(b) group Blue Cross and/or Blue Shield and other pre-payment coverage on a group basis, including HMOs (Health Maintenance Organizations);

(c) coverage under a labor-management trusted plan, a union welfare plan, an employer organization plan or an employee benefits plan;

(d) coverage under government programs, other than Medicare or Medicaid, and any other coverage required or provided by law;

(e) Other arrangements of insured or self-insured group coverage; and,

(f) any plan that provides benefits for charges or services in excess of all other coverages of eligible member or Dependent, except those specifically exempted by State of Federal Law.

(2) **"Claimant"** means the Covered Person for whom the claim is made.

(3) **"Claim Period"** means part or all of a calendar year during which the claimant is covered under the Plan.

(4) **"Covered Expense"** means any Medically Necessary, usual and customary item of expense which is covered at least in part by any of the plans involved during a claim period. However, any expense

which is not payable by the primary plan because of the claimant's failure to comply with cost containment requirements (such as second surgical opinions, preadmission testing, preadmission review of Hospital confinement, mandatory outpatient surgery, etc.) will not be considered a Covered Expense by the secondary plan. Where a 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. The difference in cost of a private Hospital room and the cost of a semi-private room is not considered a Covered Expense unless the claimant's stay in a private room is Medically Necessary.

10.02 Coordination of Benefits (COB)

If the claimant is covered by another plan or plans, the benefits under the plan and the other plan(s) will be coordinated. This means one plan pays its full benefits first, and then the other plan(s) pay(s) only those in excess or not covered in full by the primary plan, in accordance with the following arrangement:

(1) The primary plan (which is the plan that pays benefits first) pays the benefit that would be payable under its terms in the absence of this provision.

(2) The secondary plan (which is the plan that pays benefits after the primary plan) will limit the benefits it pays so that the sum of its benefits and other benefits paid by the primary plan will not exceed the greater of:

(a) 100% of total Covered Expense; or

(b) the amount of benefits it would have paid had it been the primary plan.

10.03 Order of Benefit Determination

When another plan does not have a COB provision or if it has a COB provision which differs from these rules, that plan must determine benefits first. When another plan does have a COB provision in accord with these rules, the first of the following rules which applies govern:

(1) If the other plan covers the claimant as an employee, member, subscriber or non-dependent, then that plan will pay its benefits first; except when:

(a) one plan covers the claimant as a laid-off or retired employee (or a Dependent of such an employee); and

(b) the other plan includes this COB rule for laid-off or retired employees (or is issued in a state which requires this COB rule by law), in which case the plan that covers the claimant as other than a laid-off or retired employee (or a Dependent of such an employee) will pay first. If the other plan does not have this laid-off or retired employee rule, and if, as a result, the plans do not agree on the order of benefits, this rule will not apply.

(2) If the claimant is a Dependent child whose parents:

(a) are not Divorced or Legally Separated; or

(b) are Divorced or Legally Separated, but the court decree states the parents will share joint custody, without requiring one parent to be responsible for coverage;

then the plan of the parent whose birthday anniversary is earlier in the calendar year will pay first, except:

(c) if both parents' birthdays are on the same day, Section 10.03 (5) below will apply;

(d) If another plan does not include this COB rule based on the parents' birthdays, but instead has a rule based on the gender of the parent, then that plan's COB rule will determine the order of benefits.

(3) If the claimant is a Dependent child whose parents are Divorced or Legally Separated (except when sharing joint custody), then the following rules apply:

(a) a plan which covers a child as a Dependent of a parent who by court decree must provide health coverage will pay first, providing that plan has actual knowledge of the court decree; and

(b) when there is no court decree which requires a parent to provide health coverage to a Dependent child, or when the plan covering the parent has no knowledge of the court decree, the following rules will apply:

1. when the parent who has custody of the child has not remarried, that parent's plan will pay first; and

2. when the parent who has custody of the child has remarried, then benefits will be determined by that parent's plan first, by the step-parent's plan second, and by the plan of the parent without custody third.

(4) If the claimant is provided coverage under a right of continuation pursuant to Federal or State law and is also covered under another plan, the following shall be the order of benefit payments:

(a) the plan covering the person as an employee, member of subscriber will pay first; and

(b) the continuation coverage will pay second.

However, if the other plan does not have the rule described above, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

(5) If none of the above rules in Section 10.03 (1) through (4) apply, the plan which has covered the claimant for the longer period of time will pay its benefits first. To determine the length of time a person has been covered under a plan, two plans shall be treated as one if the claimant was eligible under the second within twenty-four (24) hours after the first ended.

(a) The start of a new plan does not include:

1. a change in the amount of scope of a plan's benefits;

2. a change in the entity which pays, provides or administers the plan's benefits; or

3. a change from one type of plan to another (such as from a single employer plan to a multiple employer plan).

(b) The claimant's length of time covered under a plan is measured from the claimant's first date of coverage under that plan. If that date is not readily available, the date the claimant first became a member of the group shall be

used as the date from which to determine the length of time the claimant's coverage under the present plan has been in force.

Where part of a plan coordinated benefits and a part does not, each part will be treated like a separate plan.

10.04 How COB Affects Policy Benefit Limits

If COB reduces the benefits payable under more than one plan provision, each benefit will be reduced proportionately. Only the reduced amount will be charged against any benefit limit in those plan provisions.

10.05 Right to Collect and Release Needed Information

In order to receive benefits, the claimant must give the plan any information which is needed to coordinate benefits. With the claimant's consent, the insured may release to or collect from any person or organization any needed information about the claimant.

10.06 Facility of Payment

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

10.07 Right of Recovery

If the Plan pays more for a Covered Expense than is required under this Article, the excess payment may be recovered from:

(1) the claimant;

(2) any person to whom the payment was made; or

(3) any insurance company, service plan or any oter organization which sould have mde pamet

10.08 Coordination with Medicare for Active and Disabled Participants

(1) Medicare Secondary for Pre-Medicare Retirees with a Spouse who is Age 65. Health Care Benefits for an age 65 spouse of a pre-Medicare Retiree at the time the items or services are furnished, and who is eligible for Medicare will not have her

benefits coordinated with Medicare. The foregoing does not apply to an individual who is, or would be entitled to, benefits as a result of an End Stage Renal Disease.

(2) Medicare Secondary for Disabled Retirees under Age 65. A Retiree or Dependent who is eligible for benefits under their plan, and who is also eligible for Medicare as a result of total and permanent disability will have secondary coverage under the plan if he or she has been receiving Social Security disability benefits for twenty-four (24) months consecutive months (at less than twenty-four (24) consecutive months, the Plan is primary).

(3) End Stage Renal Disease ("ESRD") Beneficiary. Benefits shall be payable under the plan without regard to a Participant's or Dependent's entitlement to Medicare if the Participant or Dependent is entitled to Medicare as an ESRD beneficiary, and not more than eighteen (18) months have elapsed since the earliest of the following months:

(a) the month in which the Participant or Dependent began a regular course of renal dialysis;

(b) the month in which the Participant or Dependent received a kidney transplant;

(c) the month in which the Participant or Dependent was admitted to the Hospital in anticipation of kidney transplant that was performed within the next two (2) months; or

(d) the second month before the month in which the kidney transplant that was performed, if performed more than two (2) months after admission.

(4) All Other Circumstances. Under any circumstances, the benefits will be reduced by the amount of benefits provided (or which would have been provided) had the Covered Person been enrolled under all parts of Medicare.

(5) Election of Primary Provider. A Retiree or Dependent may elect the Plan or Medicare to be his primary provider of medical benefits. If a Participant or Dependent elects Medicare as his primary provider of medical benefits, he will not be entitled to any benefits under the Plan of a type provided in whole or in part by Medicare. However, he will still be entitled to these types of benefits, if any, which are not covered by Medicare. If a Participant or Dependent

elects the Plan as the primary provider of medical benefits, he will receive coverage for the benefits under the Plan, and he will also be entitled to those benefits under Medicare that are not covered by the Plan.

Article XI. Provider Network (Plan BB Only)

The Board of Trustees has contracted with Highmark Blue Cross Blue Shield West Virginia (Highmark) to access Highmark's Preferred Provider Organization (PPO). The PPO network provides discounts on medical and Hospital bills with participating Doctors and Hospitals. A list of Doctors and providers in the Highmark PPO can be obtained by contacting the Fund Office.

Highmark has established a preferred network of Doctors and Hospitals, which provide reduced prices to members of The West Virginia Laborers' Trust Fund. Utilizing the PPO network can provide valuable savings to the Fund and reduce your out-or-pocket costs. The Fund strongly urges you to utilize the Highmark PPO network of Doctors and providers. Discounts are not available from non-participating Doctors and providers. For more information regarding the Highmark PPO, please contact the Fund Office.

When Participants go outside the Highmark PPO network of Doctors and providers there may be substantial disadvantages. Since there are no pre-negotiated rates or contracts with Doctors and providers outside of the Highmark PPO network, no discounts are available. This means you are likely to be charged more for a service than if you had obtained the same service from a Highmark PPO network Doctor or provider. Also, you could be balance billed by the out-of-network provider for the full cost of the service.

Obtaining services from providers outside the Highmark PPO network is your option under the Plan. However, you should carefully consider the financial consequences of out-of-network care before obtaining services.

Article XII. Special Provisions Regarding Benefits for Hospital Stays (Plan BB Only)

12.01 Room and Board Benefits

If you or a Dependent are confined in a Hospital while eligible, you or the Hospital will be paid for semi-private room and board charges for each day you or an eligible Dependent are confined in a lawfully operated Hospital due to a non-occupational accident or physical disease and mental Illness for which benefits are not payable under Workers' Compensation Laws, not to exceed the semi-private room allowance schedule of benefits.

If you or a Dependent are confined in an intensive care unit (or other similar special care unit) for medical reasons, and the per diem charges for such unit exceed the plan's semi-private room allowance, such excess charges shall be treated and paid as a miscellaneous Hospital expense.

(1) Bodily Injury or Illness - benefits will be payable for an accidental Bodily Injury or physical and mental Illness.

(2) Benefits for Alcoholism and Drug Abuse - if you are admitted on an in-patient basis for detoxification, benefits will be provided.

12.02 Miscellaneous Hospital Expenses

You and the Hospital will also be paid for charges actually made by the Hospital for miscellaneous items, such as use of operating room, X-rays, anesthesia, laboratory examinations, medicine, etc.

12.03 Emergency Medical Care or Treatment

Charges made by a Hospital for emergency medical care or treatment rendered within twenty-four (24) hours from the time of the accident and which was required because of Bodily Injuries sustained in a non-occupational accident.

12.04 Successive Periods of Confinement

Successive periods of Hospital confinement shall be considered one period of confinement unless (1) the subsequent confinement commences after complete recovery from the Injury or sickness causing the previous confinement, or (2) unless the subsequent confinement is due to causes entirely unrelated to the causes of the previous confinement, or (3) unless you have returned to work for at least two weeks of continuous active, full time employment, or (4) with respect to a Dependent only, the subsequent confinement is separated by a period of 90 or more days as measured from the date of discharge to the date of re-admittance.

12.05 Pre-Admission Testing

If an Eligible Participant or Dependent undergoes diagnostic tests and x-rays and such tests are conducted in the outpatient department of a Hospital within seven days of an actual admission to a Hospital, the Fund will pay for those Allowed Charges made by the Hospital provided (1) such tests are ordered by a Physician, (2) tests are related to conditions to be treated during such admission, and (3) the Participant or Dependent is scheduled for subsequent admission to the Hospital for treatment of the diagnosis which made the test necessary.

In the event your scheduled admission does not take place, the testing will still be covered, but only if the admission is postponed or cancelled for one or more of the following reasons:

(1) the tests indicate, that, contrary to the attending Physician's expectation, the admission is not necessary;

(2) the tests show a condition requiring medical treatment prior to admission; or

(3) a medical condition develops that delays the admission; or

(4) a Hospital bed is not available on the scheduled date of admission.

12.06 Hospice Care

"Hospice Care" is defined as a program that provides an integrated set of services and supplies designed to provide palliative and supportive care to terminally ill patients (individuals certified by their Physician to have a life expectancy of less than six (6) months) and their families. Hospice care services are centrally coordinated through an inter-disciplinary team directed by a Physician.

The Plan will pay for hospice care ordered and approved by the Physician directing the hospice program. The maximum days per period of confinement are one hundred forty (140) days. Each covered service must be furnished within six (6) months from the date the Participant or Dependent entered the hospice program.

Article XIII. Comprehensive Medical Benefits (Plan BB Only)

13.01 Reimbursement of "Covered Medical Expenses"

If an Eligible Participant or Dependent incurs charges for a "Covered Medical Expense" as a result of a non-occupational accident or physical or mental Illness, the Fund will reimburse the Participant on the basis of 80% of the Allowed Charge for such services, subject to the terms and limitations as hereinafter set forth.

13.02 Basis of Payment

Benefit payments will be based on the "Allowed Charge" as determined by the Trustees or their designee. The Trustees retain the right to determine

the amount of all benefit payments, and such payments shall be uniformly applied to all similar circumstances.

13.03 Maximum Benefit Payment: Bodily Injuries and Illnesses

The maximum amount payable for all non-occupational Bodily Injuries, physical Illness (including complications with pregnancy) is $250,000 per calendar year.

13.04 Covered Medical Expenses

Covered Medical Expenses are those services or supplies and hereinafter defined, and which are certified by the attending Physician as being essential in the treatment of an Injury, Illness or pregnancy or for preventive care.

Charges for services, supplies or treatment by a Hospital, including room and board charges, dressings, use of the operating room and other charges billed by the Hospital.

(1) Surgical Services – Consisting of operative and cutting procedures (including such postoperative care as is normally provided and the cost of which is normally included as part of the surgical charge) for the treatment of diseases, injuries, fractures or dislocations which are performed by a Doctor of medicine, a Doctor of osteopathy or other health care provider acting within the scope of his/her license. Surgical services which could be covered if performed by a Doctor of medicine or of osteopathy shall also be covered when performed by a duly licensed podiatrist, acting within the scope of his license. If the claimant is confined as an in-patient in an accredited Hospital, benefits will also be provided for the services of a medical Doctor who actively assists the operating surgeon in the performance of such surgical services when the condition of the patient or the type of surgical service requires such assistance, and the Hospital does not employ surgical interns, resident or house staff who are utilized for such assistance.

(2) Outpatient Second Opinion Consultation for Surgery to determine the medical necessity of an elective surgical procedure. Elective Surgery is that surgery which is not of an emergency or life threatening nature. Such services must be performed and billed by a Doctor other than the Doctor who provided the patient with the initial surgical consultation or the Doctor who is to perform the surgery. One additional

consultation, as a third opinion, will be covered on those cases where the second opinion disagrees with the initial recommendation. In such situations, the claimant will be eligible for a maximum of two consultations involving elective surgery, but limited to one consultation per consultant.

(3) Oral Surgical Services of a Doctor of medicine, Doctor of osteopathy, Dentist or dental surgeon, consisting of (a) any cutting procedure for the treatment of an Injury of the jaw; (b) the treatment of fractures and dislocations of the jaw or any facial bone, (c) the excision of partially or completely un-erupted impacted teeth; (d) incision or excision procedures on the gums and tissues of the mouth when not performed in connection with the extraction or repair of teeth. Services performed on the teeth and nerves of the teeth are specifically excluded. Covered are the treatments by medical Doctor, Dentist or dental surgeon for injuries to natural teeth, including capping of each tooth and related x-rays when required as a result of a non-occupational accident and such services are rendered within 90 days from the date of such accident.

(4) Obstetrical Benefits for Female Employees, Dependent Spouses and Eligible Dependent Children. Complications of Pregnancy including pernicious vomiting, toxemia with convulsions, extra-uterine pregnancy, or complications requiring intra-abdominal surgery after the termination of pregnancy, will be treated the same as any other disability. Similarly, in the event of the premature termination of pregnancy due to natural causes (miscarriage), payment of the related medical charge of the attending Physician will be treated the same as any other disability. Payment will be made for charges relating to elective abortions, but not to exceed $250 per elective abortion procedure.

(5) In-Hospital medical visits by a Doctor of medicine or of osteopathy when the patient is confined as an overnight patient in an accredited Hospital as defined herein, because of a non-occupational disease or Injury during a period for which Hospital room and board benefits are payable hereunder, subject to maximum allowance of $80 per visit, one visit per day of confinement.

(6) Charges for home and office visits for a Doctor of medicine, Nurse Practitioner, Physician Assistant, psychiatrist, psychotherapist, professional clinical counselor or other

health care provider acting within the scope of his/her license for the treatment of a physical Illness or accidental Bodily Injury, subject to a maximum allowance of $200 per visit, one visit per day.

(7) Emergency Medical Care for first aid required as a result of accidental Injury; and for medical care required as a result of a severe and sudden medical emergency when rendered in the Out-Patient Department of a Hospital or medical clinic. Such care must be rendered within 24 hours from the time of the accident or the onset of the medical emergency and must be provided by a Doctor of medicine, a Doctor of osteopathy or other health care provider acting within the scope of his/her license.

(8) Chiropractor Medical Visits rendered by a Doctor of medicine, osteopath, or chiropractor for the treatment of a physical Injury or Illness. Reimbursement will be made on the basis of 80% of the charge for such visit, subject to a maximum payment of $40.00 per visit (one per day), and annual (calendar year) maximum payment of $500.

(9) Charges made by a registered graduate nurse (R.N.) for private duty nursing if other than for a nurse who ordinarily resides in your home, or is a member of you or your spouse's family.

(10) Physiotherapy by a licensed physiotherapist, providing such physiotherapist is not related by blood or marriage. Included are charges by a qualified speech therapist to restore speech loss, or correct impairment due to accidental Injury. Physiotherapy services rendered by a massage therapist are not covered.

(11) Electroconvulsive Therapy when performed and billed for by a Doctor of medicine or osteopathy or other health care provider acting within the scope of his/her license.

(12) Chemotherapy and Radiotherapy. This includes medical charges for chemical therapy, radiotherapy, radium or radioisotope therapy.

(13) Administration of Anesthetics except local infiltration anesthetics, provided in or out of a Hospital in surgical, oral surgical, obstetrical or electroconvulsive therapy cases, when

such services are administered by a health care provider acting within the scope of his/her license other than the operating surgeon or his assistant, and further when such Doctor is not an employee of, nor compensated by the Hospital.

(14) Blood or Blood Plasma (or for Administration of), providing a charge is made which the patient is required to pay.

(15) Oxygen and the rental of equipment for its administration.

(16) Trusses, braces or crutches or the rental of such devices.

(17) Medical Equipment including wheel chairs, Hospital beds, and other durable equipment required in connection with the treatment of an Illness or Injury. Specifically, coverage is provided for:

(a) the rental of durable Medical Equipment (but only up to the allowed purchase price of the durable Medical Equipment);

(b) the purchase of standard model equipment only (i.e., not deluxe model equipment);

(c) the repair, adjustment or servicing of durable Medical Equipment due to normal wear and tear. Repairs required as a result of misuse or abuse are not covered;

(d) the replacement of durable Medical Equipment, but no more frequently than once every five (5) years. In order to be covered: (i) there must have been a change in the Covered Person's physical condition requiring replacement of the durable Medical Equipment; or (ii) routine wear and tear on the durable Medical Equipment must have rendered it non-functional and the Medical Equipment cannot be satisfactorily repaired at a lesser expense; and

(e) supplies that are necessary for the function of the durable Medical Equipment.

If more than one piece of durable Medical Equipment can meet the Covered Person's functional needs, benefits are available only for the most cost-effective piece of durable Medical Equipment.

Claimants are required to check with the Fund Office to

determine if such equipment is covered before renting or purchasing any of the foregoing or similar equipment. The Trustees will decide whether, and on what basis the Fund will pay for the rental or purchase of such equipment when covered.

(18) Surgical Dressings, splints and casts. This includes application and removal of surgical dressings, splints, casts and other devices for the reduction of fractures and dislocations.

(19) Outpatient Diagnostic X-Rays, including Dental X-Rays, and Laboratory Tests required in connection with the diagnosis or treatment of a definite Illness or Injury. X-rays and Diagnostic Tests taken while confined as Hospital In-Patient (billed by the Hospital) will be paid as Special In-Hospital Service Benefit. The charges for Diagnostic X-Rays and Laboratory Tests taken in connection with routine physical check-ups, or which are not directly related to the treatment or diagnosis of a physical Illness or Injury will not be covered under the Plan, except for covered preventive care.

(20) Ambulance Service – Professional ambulance service where medically necessitated and directly from where he is injured or stricken by Illness to a Hospital, Doctor's office or clinic (medical emergency). This allowance limited to $500.00. Ambulance service when an individual is being transferred from one facility to another is limited to $100.

(21) Allergy Tests and Related Treatments. Injection treatment will be paid on the basis of 80%.

(22) Pelvic Exams for female Retirees and Dependents, limited to a maximum of $100 per exam.

(23) Breast Prosthesis limited to a purchase of two (2) every six (6) months.

(24) Allowed Charges for hearing examinations, exclusive of charges for hearing aids which are not covered.

(25) Smoking cessation treatment – the Plan will pay a maximum benefit of $500 for Retirees and their spouse Dependents, subject to a maximum of two treatments per year. Allowable Charges for purposes of this sub-section include over-the-counter treatments such as nicotine gum and nicotine patches,

as well as Physician prescribed treatments such as nicotine nasal spray, nicotine inhalers, and non-nicotine prescription drugs such as Zyban and/or Chantix.

(26) Inpatient and outpatient mental health and substance use disorder treatment, including mental health and substance use disorder treatment in a residential treatment center, an intensive outpatient treatment program or a partial hospitalization program. Benefits for care in a residential treatment center are provided in the same manner as benefits for care in a skilled nursing facility. Benefits for treatment in an intensive outpatient treatment program or partial hospitalization program are provided in the same manner as benefits for home health care.

The Plan requires that inpatient mental health and/or substance use disorder facilities and mental health and/or substance use disorder residential treatment centers be accredited by the Joint Commission on Accreditation of Healthcare Organizations (hereinafter "Joint Commission"). The Plan also requires that skilled nursing facilities and rehabilitation Hospitals be accredited by the Joint Commission.

(27) Telemedicine services provided by Teladoc. The Plan covers consultations regarding medical, behavioral and mental health advice, diagnoses and basic prescription medications performed by telephone or electronic video conference over the internet. Telemedicine services are 100% covered by the Fund and available to you free of charge. The provider of telemedicine services for the Plan is Teladoc. You may access Teladoc online, by phone, or via its mobile app for consultations with board-certified, state-licensed medical providers 24 hours a day for non-emergency medical issues such as allergies, bronchitis, common cold or cough, headaches, influenza, pink eye, sinus problems, stomach ache, and ear infection. You may also use Teladoc for advice, diagnosis and treatment of behavioral and mental health issues such as weight management, physical fitness, depression and substance abuse among others. Contact information will be provided by Teladoc and you will also be able to access Teladoc on the Fund's website.

(28) Urine drug testing or screenings that are Medically Necessary and ordered by the health care provider who is treating the patient; that is, the health care provider who furnishes a

consultation or treats the patient for a specific medical problem and who uses the results in the management of the patient's specific medical problem. Tests not ordered by the Physician who is treating the patient are not covered.

Criteria to establish Medical Necessity for drug testing must be based on patient-specific elements identified during the clinical assessment. Tests used for routine screening of patients without regard to their individual need, such as for pre-employment screening, are not covered by the Plan.

Presumptive drug testing, also known as drug screening, is used when necessary to determine the presence or absence of drugs or a drug class. The Plan covers one encounter per day and up to twelve (12) encounters per 12-month period.

Definitive drug testing, also known as confirmation testing, is used when it is necessary to identify specific medications, illicit substances and metabolites. Definitive testing is only covered if the presumptive testing indicates a positive result for the drug. The Plan allows one encounter per day up to eight (8) encounters per 12-month period.

Drug testing by hair analysis is not a Covered Expense.

(29) Home health care services provided by a licensed Home Health Care Agency.

Home Health Care Agency means an agency or organization that provides a program of home health care and meets one of the following three tests:

(a) It is approved by Medicare and/or accredited by the Joint Commission;

(b) It is licensed as a Home Health Care Agency by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located; or

(c) If licensing is not required, it meets all of the following requirements: (i) it has the primary purpose of providing a home health care delivery system bringing supportive skilled nursing and other therapeutic services under the supervision of a Physician or registered nurse (RN) to the home; (ii) it has a full-time administrator; (iii) it is run according to rules

established by a group of professional health care providers including Physicians and registered nurses (RNs); (iv) it maintains written clinical records of services provided to all patients; (v) its staff includes at least one registered nurse (RN) or it has nursing care by a registered nurse (RN) available; (vi) its employees are bonded; and (vii) it maintains malpractice insurance coverage.

(30) Hospice services, including inpatient hospice care and outpatient home hospice care, for terminally ill persons assessed to have a life expectancy of six months or less.

(31) Short term active, progressive rehabilitation services (occupational, physical, or speech therapy) performed by licensed or duly qualified therapists as ordered by a Physician or other health care provider acting within the scope of his or her license.

(32) Services directly related to Medically Necessary and non-Experimental transplants of human organs or tissue including bone marrow, peripheral stem cells, cornea, heart, heart/lung, intestine, islet tissue, kidney, kidney/pancreas, liver, liver/kidney, lung(s), pancreas, bone, tendons or skin, along with the facility and professional services, FDA-approved drugs, and Medically Necessary equipment and supplies.

(33) Care in a skilled nursing facility, provided such facility is accredited by the Joint Commission.

(34) Charges for services, supplies or treatment provided by an ambulatory surgery center.

(35) The following items and services related to the individualized diagnosis of COVID-19, as determined by a health care provider, without cost sharing, prior authorization, or other medical management requirements as follows:

(a) COVID-19 tests as follows:

(1) In vitro diagnostic tests as approved under the Federal Food, Drug, and Cosmetic Act;

(2) Tests that have not been FDA-approved, but are or will be subject to emergency use authorization;

(3) Tests developed in and authorized by a State that has notified the Secretary of Health and Human Services (HHS) of its intent to review tests; and

(4) Other tests that the Secretary of HHS determines appropriate in guidance.

(a) Associated in-network and out-of-network visits that result in an order for or administration of a COVID-19 test described above, including office and telehealth or virtual visits, urgent care visits, emergency room visits, and visits in non-traditional settings (such as drive through testing sites where licensed providers administer tests), as well as other items or services (such as flu or blood tests) provided during those visits to the extent that they relate to the furnishing or administration of the COVID-19 diagnostic test or the evaluation of whether the test is needed.

(b) Tests that are not for the individualized diagnosis of COVID-19, including tests for employment or public health surveillance purposes, will not be covered by the Plan.

(37) Preventive services and vaccines for COVID-19

(a) Preventive services within 15 business days of the date they become Qualifying Coronavirus Preventive Services on an in-network basis, without Participant cost sharing (such as copayments, coinsurance, or Deductibles), prior authorization, or other medical management requirements;

(b) Preventive services within 15 business days of the date they become Qualifying Coronavirus Preventive Services on an out-of-network basis, without Participant cost sharing (such as copayments, coinsurance, or Deductibles), prior authorization, or other medical management requirements. The Plan will reimburse an out-of-network provider for the item or service in an amount that the Plan determines is reasonable, as determined in comparison to prevailing market rates for such services. A reasonable amount shall include the amount that the provider would be paid under Medicare for the item or service.

(c) Qualifying Coronavirus Preventive Service means an item, service, or immunization that is intended to prevent or mitigate coronavirus disease (COVID-19) and that is, with respect to the

individual involved: (1) An evidence-based item or service that has in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force; or (2) An immunization that has in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC), which has been adopted by the Director of the CDC. This provision is in effect regardless of whether the immunization is recommended for routine use

13.05 Comprehensive Medical Expenses Not Covered

(1) Charges for services, supplies or treatment unless such charges were recommended by a health care provider acting within the scope of his/her license.

(2) Charges for services, supplies or treatment that the person is not required to pay.

(3) Dental work or cosmetic surgery (Except as specifically provided under the Plan).

(4) Eye refraction, eye glasses or the fitting thereof (Except as specifically provided under the Plan).

(5) Hearing tests, aids or the fitting thereof.

(6) Transportation, except local ambulance service.

(7) Charges for services, supplies or treatments, which are paid by Medicare or Medicaid.

(8) Charges for over the counter drugs, except as otherwise provided herein.

(9) Expenses for medical care and treatment of (a) Bodily Injury which arises out of, or occurs in the course of any occupation or employment for wage or profit; or (b) sickness for which the claimant is entitled to benefits under Workers Compensation or Occupational Disease Law.

(10) Anything not ordered by a health care provider acting within the scope of his/her license or not essentially for the care and treatment of the Injury or Illness, including charges for research, medical observations or diagnostic studies where no

disease or Injury is revealed or where there is no symptomatic condition of disease or Injury other than hypochondria.

(11) Radial Keratotomy or similar procedures used to correct myopia and astigmatism unless: (a) such surgical procedures are pre-authorized by Trustees; (b) satisfactory medical evidence is submitted which clearly demonstrates the need for such surgery, and (c) the vision of the patient cannot be corrected to at least 20/70 through normal corrective lenses.

(12) Pre-Marital examinations or any examination or service for the purpose of licensing.

(13) Expenses for cosmetic surgery, unless due to an accident or for breast reconstruction surgery in connection with a mastectomy as provided under the Women's Health and Cancer Rights Act of 1998.

(14) Treatment of (a) weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions, except open cutting operations; calluses or toenails, except for total removal of nail or roots, and care prescribed by a Doctor of medicine, Doctor of osteopathy, or podiatrist (acting within the scope of his license) connected with the treatment of metabolic or peripheral vascular disease.

(15) Medical Services related to weight reduction, visits and treatments in weight control centers, or diet supplements, vitamins or other drugs taken in connection with such programs of weight control or reduction, except as otherwise provided herein.

(16) Gastroenterostomy, gastric stapling or by-pass and section assisted lipectomy (relating to treatment of obesity) or related surgical procedures unless:

(a) patient has received prior authorization and approval from the Trustees (including approval of the Trustees' medical review board);

(b) patient condition of morbid obesity exists as indicated by the fact that he or she has a body mass index (BMI) of 40 or more;

(c) this condition has existed for at least thirty-six months;

(d) all other normal methods of weight reduction have failed; and

(e) the patient is age 25 or over.

(17) Charges for Air Conditioners, Air Filters, Humidifiers or other similar type appliances which are commercially available to the general public, even though such equipment may be deemed necessary in connection with the treatment of an Illness or disease.

(18) Expenses for an autopsy, forensic examination and any related expenses, except as required by the Plan.

(19) Expenses for preparing or completing claim forms; mailing, shipping or handling expenses; charges for broken/missed appointments, telephone calls, e-mailing charges, interest charges, late fees, mileage costs, provider administration fees, concierge/retainer agreement fees, membership/ surcharge fees and photocopying fees.

(20) Expenses that exceed any Plan benefit limitation or annual maximum plan benefit.

(21) Any portion of the expenses for covered medical services or supplies that exceed the Covered Expense.

(22) Expenses for services or supplies for which a determination has been made that a third party is required to pay.

(23) Expenses for services rendered or supplies provided before the patient became covered under the Plan; or after the date the patient's coverage ends, except under those conditions described in the COBRA section of this document.

(24) Expenses for any medical services, supplies, drugs or medicines that are Experimental and/or Investigational. Experimental and/or Investigational means a service or supply that, in the opinion of the Plan, based on the information and resources available at the time the service was performed or the supply was provided, meets any of the following conditions:

(a) The service or supply is described as an alternative to more conventional therapies in the protocols (the plan for the course of medical treatment that is under investigation) or consent document (the consent form signed by or on behalf of the

patient) of the health care provider that performs the service or prescribes the supply;

(b) The prescribed service or supply may be given only with the approval of an Institutional Review Board as defined by federal law;

(c) There is either an absence of authoritative medical, dental or scientific literature on the subject, or a preponderance of such literature published in the United States; and written by experts in the field; that shows that recognized medical, dental or scientific experts: classify the service or supply as experimental and/or investigational or unproven; or indicate that more research is required before the service or supply could be classified as equally or more effective than conventional therapies.

(25) Services in a U.S. Department of Veterans Affairs Hospital or other military medical facility on account of a military service-related Illness or Injury.

(26) Expenses Incurred in the treatment of any condition, Injury or disability that has arisen from participation in, or commission or attempted commission of, a felony, or criminal act that endangers their health. This exclusion does not apply if the condition, Injury or disability results from being the victim of domestic violence, or if the commission of the illegal act was a direct result of an underlying health factor.

(27) Services or supplies that are not Medically Necessary, except for covered preventive services.

(28) Expenses for construction or modification to a home, residence or vehicle required as a result of an Injury, Illness or disability of a Covered Person, including, without limitation, construction or modification of ramps, elevators, hand rails, chair lifts, spas/hot tubs, air conditioners, dehumidification devices, asbestos removal, air filtration/purification devices, swimming pools or emergency alert system.

(29) Expenses for patient convenience, comfort, hygiene, or beautification, including, but not limited to, care of family members while the Covered Person is confined to a Hospital or other health care facility, guest meals, television, telephone, barber or beautician services, house cleaning or maintenance and shopping.

(30) Expenses for services provided by any Physician or other health care practitioner who is the parent, Spouse, sibling (by birth or marriage, such as a brother-in-law), aunt/uncle, or child of the Covered Person.

(31) Expenses for the services of a medical student or intern or resident.

(32) Expenses for any Physician or other health care provider who did not directly provide or supervise medical services to the patient, even if the Physician or health care practitioner was available to do so on a stand-by basis.

(33) Expenses Incurred as a result of an Injury or Illness due to any act of war, either declared or undeclared, war-like act, riot, insurrection, rebellion, or invasion, except as required by law.

(34) Expenses Incurred by any Covered Person arising from an attempt at suicide or from a self-inflicted Injury or Illness, including complications thereof, unless the attempt arises as a result of a physical or mental health condition or as a result of domestic violence.

(35) Expenses for biofeedback.

(36) Expenses for hypnosis/hypnotherapy.

(37) Expenses for court-ordered services, parental custody services or adoption services.

(38) Expenses for Custodial Care. Custodial Care means care and services provided mainly for personal hygiene or to perform the activities of daily living. Some examples of Custodial Care are helping patients get in and out of bed, bathe, dress, eat, use the toilet, walk (ambulate), or take drugs or medicines that can be self-administered. These services are Custodial Care regardless of where the care is given or who recommends, provides, or directs the care. Custodial Care can be given safely and adequately (in terms of generally accepted medical standards) by individuals who are not trained or licensed medical or nursing personnel.

(39) Expenses for services rendered by a massage therapist.

(40) Expenses for gene therapies, including, but not limited to, Chimeric Antigen Receptor T-Cell (CAR-T) Therapies (e.g., Kymriah and Yescarta) and ocular gene therapy (e.g., Luxturna).

(41) Expenses for or related to in vitro fertilization. In vitro fertilization is a series of procedures used to help with fertility or prevent genetic problems and assist with the conception of a child.

(42) Nondurable goods or supplies that cannot withstand repeated use and/or that are considered disposable and limited to either use by a single person or one-time use, including, but not limited to, bandages, hypodermic syringes, diapers, soap or cleansing solutions, etc.

(43) Nutritional supplements and formulas, except for formula needed for the treatment of inborn errors of metabolism [fructose intolerance, Galactosemia, maple sugar urine disease (MSUD), and phenylketonuria (PKU)]

13.06 Voluntary Sterilization

If you or your spouse incurs expenses in connection with an operation for the purpose of sterilization, you will be reimbursed for the Hospital charges and Covered Medical charges in accordance with the terms of the Plan as herein provided. However, no payment will be made to reverse the foregoing procedure at a later date, nor for any subsequent complications resulting from such procedures.

13.07 Medical Benefit Grid

The following grid summarizes the coverage of medical benefits provided by the Plan, subject to the limitations noted in the preceding section.

Benefit Provision	**In Network**	**Out of Network**
Plan-Wide Provisions		
Benefit Period	Calendar Year	
Coinsurance	Plan pays 80% up to the maximum benefit payment of $250,000 per calendar year; you pay 20% before the maximum benefit payment and 100% after	Plan pays 80% of Allowed Charges up to the maximum benefit payment of $250,000 per calendar year; you pay 20% before the maximum benefit payment and 100% after
Deductible	Individual - None Family - None	Individual - None Family - None
Maximum Out-of-Pocket (Medical only)	Individual - None Family - None	Individual - None Family - None
Program Type	PPO	PPO
Inpatient Facility Services		
Inpatient Hospital Facility Services	80%, maximum 70 days per confinement	80% of Allowed Charges, maximum 70 days per confinement
Skilled Nursing Facility	80% No Day Limit	80% of Allowed Charges No Day Limit

Benefit Provision	In Network	Out of Network
Maternity	80%	80% of Allowed Charges
Maternity for Dependent Daughters	80%	80% of Allowed Charges
Nursery Care	80%	80% of Allowed Charges
Short-Term Inpatient Rehabilitation Therapy	80%	80% of Allowed Charges
Outpatient Facility Services		
Emergency Room Care	$400 copay per visit; 80%	$400 copay per visit; 80% of Allowed Charges
Emergency Accident	Covered	Covered
Emergency Medical	Covered	Covered
Outpatient Surgery	80%; Limited to a maximum benefit allowance of $18,750 per surgery	80% of Allowed Charges; Limited to a maximum benefit allowance of $18,750 per surgery
Outpatient Diagnostic Services	80%	80% of Allowed Charges
Advanced Imaging	80%	80% of Allowed Charges
Standard Imaging	80%	80% of Allowed Charges

Benefit Provision	**In Network**	**Out of Network**
Pathology/ Laboratory	80%	80% of Allowed Charges
Diagnostic Medical	80%	80% of Allowed Charges
Allergy Testing	80%	80% of Allowed Charges
Mammogram	80%	80% of Allowed Charges
Outpatient Therapy and Rehabilitation Services	80%	80% of Allowed Charges
Occupational Therapy	80%	80% of Allowed Charges
Speech Therapy	80%; No visit limits	80% of Allowed Charges; No visit limits
Physical Medicine	80%; No visit limits	80% of Allowed Charges; No visit limits
Respiratory (includes Pulmonary) Therapy	80%	80% of Allowed Charges
Cardiac Rehabilitation Therapy	80%	80% of Allowed Charges
Dialysis	80%	80% of Allowed Charges
Chemotherapy	80%	80% of Allowed Charges
Radiation Therapy	80%	80% of Allowed Charges

Benefit Provision	In Network	Out of Network
Infusion Therapy	80%	80% of Allowed Charges
Clinic	80%	80% of Allowed Charges
Professional Services		
Inpatient Medical Care	80%; Physician visits during a Hospital stay are subject to a maximum payment of $80 per visit (one visit per day per Physician).	80% of Allowed Charges; Physician visits during a Hospital stay are subject to a maximum payment of $80 per visit (one visit per day per Physician).
Skilled Nursing Facility Medical	80%	80% of Allowed Charges
Second Surgical Opinion Consultations	80%	80% of Allowed Charges
Emergency Accident	80%	80% of Allowed Charges
Emergency Medical	80%	80% of Allowed Charges
Specialist Office/ Outpatient Visit and Consultation	80%; Limited to a maximum payment of $200 per visit; Limited to 50 visits per year	80% of Allowed Charges; Limited to a maximum payment of $200 per visit; Limited to 50 visits per year
Physician Office/ Outpatient Visit and Consultation	80%; Limited to a maximum payment of $200 per visit; Limited to 50 visits per year	80%; Limited to a maximum payment of $200 per visit; Limited to 50 visits per year

Benefit Provision	In Network	Out of Network
Telemedicine (via Teladoc)	100%	
Surgery	80%	80% of Allowed Charges
Tubal Ligation	80%	80% of Allowed Charges
Vasectomy	80%	80% of Allowed Charges
Sterilization Reversal	Not covered	Not covered
Gender Reassignment Surgery	Not covered	Not covered
Assistant Surgery	80%	80% of Allowed Charges
Anesthesia	80%	80% of Allowed Charges
Diagnostic Services	80%	80% of Allowed Charges
Advanced Imaging	80%	80% of Allowed Charges
Standard Imaging	80%	80% of Allowed Charges
Pathology/ Laboratory	80%	80% of Allowed Charges
Diagnostic Medical	80%	80% of Allowed Charges
Allergy Testing	80%	80% of Allowed Charges
Mammogram	80%	80% of Allowed Charges

Benefit Provision	In Network	Out of Network
Maternity	80%	80% of Allowed Charges
Maternity for Dependent Daughters	Not covered	Not covered
Newborn Care	80%	80% of Allowed Charges
Professional Therapy and Rehabilitation Services	80%	80% of Allowed Charges
Occupational Therapy	80%	80% of Allowed Charges
Speech Therapy	80%; No visit limits	80% of Allowed Charges; No visit limits
Physical Medicine	80%; No visit limits	80% of Allowed Charges; No visit limits
Respiratory (includes Pulmonary) Therapy	80%	80% of Allowed Charges
Cardiac Rehabilitation Therapy	80%	80% of Allowed Charges
Dialysis	80%	80% of Allowed Charges
Chemotherapy	80%	80% of Allowed Charges
Radiation Therapy	80%	80% of Allowed Charges
Infusion Therapy	80%	80% of Allowed Charges

Benefit Provision	In Network	Out of Network
Spinal Manipulations	80%	80% of Allowed Charges
Allergy Extracts	Covered as prescription drugs	Covered as prescription drugs
Allergy Injections	80%	80% of Allowed Charges
Retail Clinic	80%	80% of Allowed Charges
Urgent Care	80% ($200 per visit maximum)	80% of Allowed Charges ($200 per visit maximum)
Preventive Care		
Routine Physical Exam	80%	No Coverage
Routine Gynecological Exam	80%	No Coverage
Routine Pap Smear	80%	No Coverage
Routine Mammogram	80%	No Coverage
Adult Immunizations	80%	No Coverage
Travel Immunizations	No Coverage	No Coverage
Pediatric Immunizations	80%	No Coverage
Well Baby Care	80%	No Coverage
Neonatal Circumcision	80%	No Coverage

Benefit Provision	In Network	Out of Network
Adult Care	80%	No Coverage
Routine Foot Care	No Coverage	No Coverage
Hearing Care	**No Coverage**	**No Coverage**
Routine Hearing Screening	100% - Pediatric only	No Coverage
Hearing Aid	No Coverage	No Coverage
Hearing Aid Exam	No Coverage	No Coverage
Tinnitus Maskers Device that masks persistent sounds in one or both ears.	No Coverage	No Coverage
Other Services		
Ambulance	80%	80% of Allowed Charges
Durable Medical Equipment and Supplies	80%	80% of Allowed Charges
Prosthetic Devices	80%	80% of Allowed Charges
Orthotics	80%	80% of Allowed Charges
Home Infusion Therapy	80%	80% of Allowed Charges
Blood/Blood Components/ Blood Derivatives	80%	80% of Allowed Charges
Private Duty Nursing	No Coverage	No Coverage
Home Health	80%	80% of Allowed Charges

Benefit Provision	In Network	Out of Network
Visiting Nurse	No Coverage	No Coverage
Hospice	80%; Limited to 140 days per confinement.	80% of Allowed Charges; Limited to 140 days per confinement.
Experimental/ Investigational Services	No Coverage	No Coverage
Nicotine Cessation Program	Covered (2 attempts per year)	Covered (2 attempts per year)
Assisted Fertilization	No Coverage	No Coverage
Elective Abortion	80%	80% of Allowed Charges
Elective Abortion for Dependent Daughter	80%	80% of Allowed Charges
Transplant Services	80%	80% of Allowed Charges
Oral Surgery	80%	80% of Allowed Charges
Impacted Teeth	80%	80% of Allowed Charges
Surgery to Mouth	80%	80% of Allowed Charges
Mastectomy and Breast Cancer Reconstruction	80%	80% of Allowed Charges
Dental Accident	80%	80% of Allowed Charges
Enteral Formulae	80%	80% of Allowed Charges
Contraceptives	100%	80% of Allowed Charges

Benefit Provision	In Network	Out of Network
Injections	80%	80% of Allowed Charges
Acupuncture	80%	80% of Allowed Charges
Bariatric Surgery	80%	80% of Allowed Charges
Women's Health Services (Federal Mandated Benefits)	80%	80% of Allowed Charges
Conditions		
Mental Health		
Inpatient Mental Health Services	80%	80% of Allowed Charges
Outpatient Mental Health Services	80%	80% of Allowed Charges
Substance Abuse		
Inpatient Substance Abuse Rehabilitation	80%; maximum 70 days per confinement	80% of Allowed Charges
Inpatient Substance Abuse Detoxification	80%; maximum 70 days per confinement	80% of Allowed Charges
Outpatient Substance Abuse Services	80%	80% of Allowed Charges
TMJ	80%, if Medically necessary	80% of Allowed Charges, if Medically Necessary
Cleft Palate	80%, if Medically necessary	80% of Allowed Charges, if Medically Necessary

Benefit Provision	In Network	Out of Network
Obesity	80%	80% of Allowed Charges
Diabetes	80%	80% of Allowed Charges
Infertility Diagnosis or treatment of general infertility as a medical condition.	No Coverage	No Coverage
Cosmetic Surgery - Elective	No Coverage	No Coverage
Autism	80%	80%

Article XIV. Prescription Drug Benefits (Plan BB Only)

14.01 Definitions of Terms Used in this Article

(1) **"Brand Name Drug"** means any drug that has been approved by the U.S. Food and Drug Administration ("FDA") and granted a 20-year patent, which means that only the company holding the patent has the right to sell that Brand Name Drug, no other company may make it for the entire duration of the patent period, and the Brand Name Drug cannot have competition from a generic drug until after the brand name patent or other marketing exclusivities have expired and the FDA grants approval for a generic version.

(2) **"Compound Drug"** means any drug that has more than one ingredient, at least one of which is a Federal Legend Drug or a State Restricted Drug.

(3) **"Federal Legend Drug"** means any medicinal substance that the Federal Food, Drug and Cosmetic Act requires to be labeled, "Caution – Federal Law prohibits dispensing without prescription."

(4) **"Generic Drug"** means any generic version of a Brand Name Drug that is approved by the FDA and that is the same (or a bio-

equivalent) as the Brand Name Drug in the following respects: (a) it has the same active ingredients which are the ingredients responsible for the drug's effects, the same dosage amount, the same safety and requires the same amount of time to be absorbed into the body; and (b) it must be taken in the same way. A Generic Drug is basically a copy of a Brand Name Drug, although it may have a different name, shape, color and/or inactive ingredient(s) than the original Brand Name Drug.

(5) **"Prescription Drug"** means a Federal Legend Drug, a Compound Drug or a State Restricted Drug and includes Generic Drugs and Brand Name Drugs.

(6) **"State Restricted Drug"** means any drug that requires a prescription under state law but not under federal law.

14.02 Pharmacy Benefits Manager (PBM)

The Plan has contracted with Express Scripts to provide benefits for outpatient Prescription Drugs through its Retail Drug Program, Mail Order Program and Specialty Pharmacy Program.

14.03 Formulary

A formulary is a list of Prescription Drugs selected by Express Scripts based on evaluations of efficacy, safety, and cost-effectiveness. Prescription Drugs on the formulary are referred to as Preferred Brand Name Drugs and Prescription Drugs not on the formulary are referred to as Non-Preferred Brand Name Drugs. If you select a Preferred Brand Name Drug, your cost will generally be lower than if you elect to receive a Non-Preferred Brand Name Drug. Drugs that are excluded from coverage under the formulary are called Non-Covered drugs.

14.04 Retail Drug Program

You may purchase Prescription Drugs using your Express Scripts identification card at retail pharmacies that participate with Express Scripts. Prescription Drugs purchased at retail pharmacies are limited to a maximum 30-day supply.

You must present your Express Scripts identification card every time you purchase Prescription Drugs in order to receive the discounted rates. If you do not present your Express Scripts identification card at the time of purchase, you will pay the non-discounted price at that time and must file a claim for reimbursement with Express Scripts. Please contact Express Scripts for additional information on how to file prescription drug claims for

reimbursement. Reimbursement from Express Scripts will be based on the discounted rates that would have been paid had the Prescription Drug been purchased at an Express Scripts participating retail pharmacy, subject to the applicable coinsurance. To receive the maximum reimbursement, you should have all prescriptions filled at an Express Scripts participating retail pharmacy, or through the Express Scripts Mail Order Program or the Express Scripts Specialty Pharmacy Program.

14.05 Mail Order Program

You may purchase "maintenance" Prescription Drugs through the Express Scripts Mail Order Program. Maintenance Prescription Drugs are Prescription Drugs that are commonly used to treat conditions that are considered chronic or long-term. These conditions usually require regular, daily use of Prescription Drugs. Examples of maintenance drugs are those used to treat high blood pressure, heart disease, asthma and diabetes. Prescription Drugs purchased through the Mail Order Program are limited to a maximum 90-day supply.

The Mail Order Program is generally the easiest and least expensive way to obtain many Prescription Drugs. To use the Mail Order Program, have your Doctor write the prescription for a 90-day supply, with the appropriate number of refills. Then, mail your prescription, coinsurance and the mail order form to the Mail Order Program. Mail order forms may be obtained from Express Scripts. Prescription Drugs obtained through the Mail Order Program are delivered to your home. You should allow up to 14 days to receive your order.

You may realize additional savings by enrolling in Express Scripts' voluntary "Smart 90" program. For a full description of the program, contact Express Scripts.

14.06 Specialty Pharmacy Program

You may purchase "specialty" Prescription Drugs and injectable Prescription Drugs through Express Scripts' Specialty Pharmacy Program (SaveOnSP). Specialty Prescription Drugs are drugs, such as biologicals and other "high-tech" medications, which require special handling and typically are not available through retail pharmacies.

Specialty pharmacies are generally better equipped to provide the required special handling of these drugs. In addition, when you purchase drugs through the Express Scripts' specialty pharmacy, Accredo, a dedicated pharmacist is available to answer your questions and provide advice concerning the administration and care of the drug.

All specialty Prescription Drugs are limited to a maximum 30-day supply through Accredo.

14.07 Deductible, Coinsurance and Minimum Copayments

Prescription Drugs are not subject to a Deductible; however, you must pay the applicable coinsurance amount for each prescription or refill.

Your coinsurance is subject to a minimum copayment. This is the minimum amount you must pay for each prescription or refill.

Coinsurance varies based on whether the Prescription Drug is obtained through the Retail Drug Program, the Mail Order Program or the Specialty Drug Program. Minimum copayment amounts vary based on whether the Prescription Drug is a Generic Drug, a Preferred Brand Name Drug or a Non-Preferred Brand Name Drug.

The coinsurance and minimum copayment amounts vary from time to time and you will be notified of any changes.

Variable Copay Program for Specialty Drugs

The Plan provides a variable copay program for specialty drugs, managed by SaveOnSP and Express Scripts, our pharmacy benefit manager.

If you agree to participate in this program, your copays for certain specialty drugs are set to match the copays available through manufacturer-funded copay assistance programs. This will enable you to receive maximum savings and reduce costs for the Plan and its Participants.

Although this program is voluntary, you are encouraged to enroll and participate in the program in order to receive maximum savings on specialty drugs. If you choose not to participate, your specialty drug copays may be higher.

14.08 Covered Prescription Drugs

The following Prescription Drugs are covered under the Plan, provided a written prescription from a licensed Physician is issued and the drugs are not listed in Section 14.10, “Prescription Drug Exclusions.”

(1) Federal Legend Drugs.
(2) Compound Drugs.
(3) Insulin.
(4) Retin-A up through age 24.

(5) Emergency allergic kits.
(6) Glucagon emergency kits.
(7) Over-the-counter diabetic supplies (all forms except GlucoWatch products and Insulin Pumps).
(8) Oral contraceptive medications and implants.
(9) Allergy serum.
(10) Chantix for smoking cessation, limited to 90 days of treatment and two courses of treatment per lifetime.
(11) Pediatric fluoride products (e.g., Luride and Poly-Vi-Flor).
(12) Prenatal vitamins or minerals requiring a prescription.

14.09 Prior Authorization Requirements and Utilization and Clinical Management Programs

Certain Prescription Drugs require prior authorization by Express Scripts before they are covered. The prior authorization program requires you to obtain authorization from your Physician before certain prescriptions are filled. In general, specialty prescription drugs, as well as certain brand name prescription drugs, are subject to prior authorization.

The prescription drugs that are subject to the prior authorization requirement can change from time to time. To determine whether a prescription drug requires prior authorization, you can call the customer service phone number on the back of your Express Scripts identification card, log into the Express Scripts website (www.express-scripts.com), or access the Express Scripts mobile phone app. In addition, your pharmacist should advise you whether a prescription drug requires prior authorization.

If your prescription drug requires prior authorization, your Physician must contact Express Scripts to obtain the required authorization. Express Scripts' prior authorization phone lines are available 24 hours a day, seven days a week. A determination regarding authorization generally can be made quickly.

If prior authorization is obtained, you will pay your normal coinsurance or copay. If prior authorization is not obtained and you have the prescription filled, you must self-pay the full price for the drug.

Prescription Drug coverage is also subject to utilization and clinical management programs implemented through Express Scripts. These programs include, but are not limited to, drug quantity management (quantity limits on certain Prescription Drugs), alerts to Physicians and pharmacists concerning drug interactions and drug allergies, and step therapy (where you first try a proven, cost-effective medication before moving to a more costly Prescription Drug option).

Step Therapy Program (Plan BB Only)

Under the step therapy program, you are generally required to try "first-line" prescription drugs before you move to using more expensive "second-line" prescription drugs.

First-line prescription drugs are generic and lower-cost brand-name medicines approved by the U.S. Food & Drug Administration (FDA). They are proven to be safe, effective and affordable. First-line prescription drugs should be tried first because, in most cases, they provide the same health benefit as more expensive drugs, but at a lower cost.

Second-line prescription drugs typically are brand-name drugs and are the most expensive options. They are best suited for patients who do not respond to first-line prescription drugs.

The prescription drugs that are subject to the step therapy requirement can change from time to time. To determine whether a prescription drug is subject to the step therapy program, you can call the customer service phone number on the back of your Express Scripts identification card, log into the Express Scripts website (www.express-scripts.com), or access the mobile phone app. In addition, your pharmacist should advise you whether a prescription drug is subject to the step therapy program.

If your prescription drug is subject to the step therapy program (i.e., your prescription drug is a second-line prescription drug and you initially have not tried a first-line prescription drug), you or your pharmacist should contact your Physician to obtain a new prescription for a first-line prescription drug. Failure to do so will result in higher out-of- pocket costs to you.

If you obtain a new prescription for a first-line prescription drug subject to the terms of the step therapy program, you will pay your normal coinsurance or copay. If you have a prescription filled for a second-line prescription drug, without having used a first-line medicine to treat your condition, as set forth under the terms of the step therapy program, you will self-pay full price for that second-line prescription drug.

Quantity Management Program (Plan BB Only)

The drug quantity management program is designed to ensure that you receive the right amount of medication, and that it is prescribed in the most affordable and least wasteful way.

For example, your Physician prescribes a prescription drug and instructs you to take two 20-mg. tablets each morning. If that prescription drug is

available in 40-mg. tablets, Express Scripts would contact your Physician about prescribing one 40-mg. tablet each day instead of two 20-mg. tablets.

The drug quantity management program also ensures that your prescriptions do not exceed the amount of medication covered under the Plan.

The prescription drugs that are subject to the drug quantity management program can change from time to time. To determine whether a drug is subject to drug quantity management, you can call the customer service phone number on the back of your Express Scripts identification card, log into the Express Scripts website (www.express-scripts.com), or access the Express Scripts mobile phone app. In addition, your pharmacist should advise you whether a drug is subject to the drug quantity management program.

Any prescription drug that exceeds the quantity limit under the Plan will not be covered by the Plan. You have the option to self-pay the full price for any prescription drug not covered by the Plan.

Utilization Management Programs (Plan BB Only)

The Plan has contracted with Express Scripts to provide various other prescription drug utilization management programs designed to provide maximum benefits in the most efficient way. For example, certain specialty prescription drugs (e.g., hepatitis drugs, certain cholesterol drugs and drugs for inflammatory conditions) must be filled through Express Scripts' specialty pharmacy, Accredo.

If such prescription drugs are not obtained through the Express Scripts mail order program, the costs are not covered benefits under the Plan. As a clarification, the costs for such medications not obtained through the Express Scripts mail order program are considered out-of-network services that do not accrue toward your out-of-pocket maximum, and are not subject to coverage at 100% once you reach the out-of-pocket maximum.

These utilization management programs and the prescription drugs subject to these programs may change from time to time.

14.10 Prescription Drug Exclusions

The following are excluded from coverage unless specifically listed as covered under Section 14.08, "Covered Prescription Drugs."

(1) Non-federal legend drugs.
(2) Fertility agents.
(3) Anti-obesity and weight loss drugs to suppress appetite and/or control fat absorption (e.g., Xenical, Adipex-P, Lomaira, Bontril, Regimex, and/or Didrex).
(4) Dental fluoride preparations, (other than pediatric) such as toothpaste, gel or mouthwash.
(5) Homeopathic drugs.
(6) Growth hormones/releasing hormones.
(7) Mifeprex.
(8) GlucoWatch products.
(9) Insulin pumps (however, these devices may be covered as durable medical equipment, under the medical Plan).
(10) Therapeutic devices or appliances.
(11) Drugs whose sole purpose is to promote or stimulate hair growth, including Minoxidil, Propecia, Rogaine, or for cosmetic purposes only, including Renova, Avage.
(12) Blood or blood plasma products.
(13) Drugs labeled "Caution-limited by Federal law to investigational use," or experimental drugs, even though a charge is made to the individual.
(14) Prescription Drugs for which the cost is recoverable under any workers' compensation or occupational disease law of any state or governmental agency, or medication furnished by any other drug or medical service for which no charge is made to the individual.
(15) Medication which is to be taken by or administered to an individual, in whole or in part, while he or she is a patient in a licensed Hospital, rest home, sanitarium, extended care facility, Skilled Nursing Facility, convalescent Hospital, nursing home or similar institution which operates on its premises or allows to be operated on its premises, a facility for dispensing pharmaceuticals.
(16) Any prescription refilled in excess of the number of refills specified by the Physician, or any refill dispensed after one year from the Physician's original order.
(17) Charges for the administration or injection of any drug, except as provided by the Express Scripts' pharmacy vaccine program.
(18) Charges for the administration or injection of any drug.
(19) Respiratory supplies and inhaler assisting devices.
(20) Prescription drugs for which a Covered Person is not required to pay or that are obtained without cost, or for which there would be no charge if the Covered Person receiving the treatment were not covered by the Plan.

(21) Prescription drugs required due to any loss caused by war or any act of war.

(22) Prescription drugs required while engaged in military, naval, or air service, except to the extent prohibited by USERRA.

(23) Prescription Drugs related to the treatment of any and all medical conditions stemming from a work-related Injury or Illness, including but not limited to accidental injuries, Injury or Illness caused by non-accidental work-related activity, occupational diseases, and/or the aggravation of a pre-existing condition as a result of work-related activity.

(24) Prescription Drugs that are not Medically Necessary.

(24) Charges for foods and nutritional supplements, including but not limited to formulas, foods, diets, vitamins and minerals (whether they can be purchased over-the-counter or require a prescription, except for prenatal vitamins or minerals requiring a prescription).

14.11 For Additional Information

For a list of Prescription Drugs on the Express Scripts formulary, or other information about your Prescription Drug benefits, call **Express Scripts at 1-800-767-8866** or go **to www.express-scripts.com.**

Article XV. Dental Benefits (Plan BB only)

Dental benefits are provided to Participants and Covered Beneficiaries on a self-insured basis by the Fund's contracted claims administrator, United Concordia.

United Concordia's address is:

United Concordia Companies, Inc.
1800 Center Street
Camp Hill, PA 17011

Below is a summary of the dental benefits that are provided under the Concordia Flex Plan. The complete terms and conditions for dental benefits are set forth in the documents provided by United Concordia, which are incorporated into this SPD by reference as if the same were fully set forth herein. The documents will be furnished to Participants and Beneficiaries as they are updated. Also, Participants and Beneficiaries may o a copy of the documents by submitting a request to the Fund Office.

In the event any of the terms of this SPD conflict with any of the terms of the United Concordia documents, the terms of the United Concordia documents shall prevail.

15.01 How the Plan Works

To help you and your family maintain good dental health, dental coverage is available through United Concordia Flex Plan. Preventive services are covered at 100%. For Basic and Major services, the percentage depends on the service. Surgical, prosthetics, repairs, and orthodontics are not covered.

15.02 Maximum Allowable Charge

What United Concordia pays for covered services is known as the Maximum Allowable Charge (MAC). If the amount charged is less than the MAC, United Concordia pays the charge. When you receive covered services from a participating Dentist, the Dentist can bill you for the remaining balance of the MAC allowance not paid by United Concordia, but not for any charges that are more than the MAC allowance.

15.03 Schedule of Benefits

<table>
<tr><th><u>Benefit Category</u></th><th><u>In-Network</u></th><th><u>Non-Network</u></th></tr>
<tr><td colspan="3">Class I – Diagnostic/Preventive Services</td></tr>
<tr><td>Exams</td><td rowspan="8">100%</td><td rowspan="8">100%</td></tr>
<tr><td>X-Rays</td></tr>
<tr><td>Cleanings</td></tr>
<tr><td>Fluoride Treatments (for Children to age 19)</td></tr>
<tr><td>Sealants</td></tr>
<tr><td>Space maintainers</td></tr>
<tr><td>Consultations</td></tr>
<tr><td>Palliative Treatment</td></tr>
<tr><td colspan="3">Class II – Basic Services</td></tr>
<tr><td>General Anesthesia</td><td>100%</td><td>100%</td></tr>
<tr><td>Basic Restorative (Fillings)</td><td rowspan="3">50%</td><td rowspan="3">50%</td></tr>
<tr><td>Simple Extractions</td></tr>
<tr><td>Nonsurgical Periodontics</td></tr>
<tr><td colspan="3">Class III – Major Services</td></tr>
</table>

Inlays, Onlays, Crowns	Not Covered	Not Covered
Complex Oral Surgery		
Repairs of Crowns, Inlays, Onlays, Bridges & Dentures		
Endodontics		
Surgical Periodontics		
Prosthetics (Bridges, Dentures)		
Orthodontics		
Diagnostic, Active, Retention Treatment	Not Covered	Not Covered
Included Plan Features		
Pregnancy Benefit	Covers one additional cleaning (Members must enroll on UnitedConcordia.com)	
The College Tuition Benefit® - College Savings Program	• Earn Tuition Rewards® points redeemable for tuition discounts • Receive 2,000 at signup, then 2,000 points/ year • Each child enrolled receives a one-time bonus of 500 Tuition Rewards points • One Tuition Rewards point = $1 reduction in full tuition • Use Tuition Rewards points at participating private colleges and universities (Must enroll through Sage Scholars, Inc.)	
Maximums & Deductibles (applies to the combination of services received from network and non-network Dentists)		
Calendar Year Deductible	$100 per individual / $300 per family (Does not apply to Class I)	
Calendar Year Maximum	$1,000 per person	
Reimbursement	**Elite Prime**	**Advantage MAC**

15.04 Exclusions and Limitations

Payment will not be made for the following:

- Services not specifically listed as covered services
- Started prior to the Member's Effective Date or after the Termination Date of coverage under the Plan (for example, but not limited to, multi-visit procedures such as endodontics, crowns, bridges, inlays, onlays, and dentures).
- For house or Hospital calls for dental services and for hospitalization costs (facility-use fees).
- That are the responsibility of Workers' Compensation or employer's liability insurance, or for treatment of any automobile-related Injury in which the Member is entitled to payment under an automobile insurance policy. The Plan's benefits would be in excess to the third-party benefits and therefore, the Plan would have right of recovery for any benefits paid in excess.
- For prescription and non-prescription drugs, vitamins or dietary supplements.
- Administration of nitrous oxide and/or IV sedation, unless specifically indicated on the Schedule of Benefits.
- Which are Cosmetic in nature as determined by the Plan Administrator (for example, but not limited to, bleaching, veneer facings, personalization or characterization of crowns, bridges and/or dentures).
- Elective procedures (for example, but not limited to, the prophylactic extraction of third molars).
- For congenital mouth malformations or skeletal imbalances (for example, but not limited to, treatment related to cleft lip or cleft palate, disharmony of facial bone, or required as the result of orthognathic surgery including orthodontic treatment).
- For dental implants and any related surgery, placement, restoration, prosthetics (except single implant crowns), maintenance and removal of implants unless specifically covered.
- Diagnostic services and treatment of jaw joint problems by any method unless specifically covered. Examples of these jaw joint problems are temporomandibular joint disorders (TMD) and craniomandibular disorders or other conditions of the joint linking the jaw bone and the complex of muscles, nerves and other tissues related to the joint.
- For treatment of fractures and dislocations of the jaw.
- For treatment of malignancies or neoplasms.
- Services and/or appliances that alter the vertical dimension (for example but not limitation, full-mouth rehabilitation, splinting, fillings) to restore tooth structure lost from attrition, erosion or abrasion, appliances or any other method.

- Replacement or repair of lost, stolen or damaged prosthetic or orthodontic appliances.
- Preventive restorations.
- Periodontal splinting of teeth by any method.
- For duplicate dentures, prosthetic devices or any other duplicative device.
- For which in the absence of dental benefits under a plan the Member would incur no charge.
- For plaque control programs, tobacco counseling, oral hygiene and dietary instructions.
- For any condition caused by or resulting from declared or undeclared war or act thereof, or resulting from service in the National Guard or in the Armed Forces of any country or international authority.
- For treatment and appliances for bruxism (night grinding of teeth).
- For any claims submitted to the Plan Administrator by the Member or on behalf of the Member in excess of twelve (12) months after the date of service.
- Incomplete treatment (for example, but not limited to, patient does not return to complete treatment) and temporary services (for example, but not limited to, temporary restorations).
- Procedures that are:
    - part of a service but are reported as separate services; or
    - reported in a treatment sequence that is not appropriate; or
    - misreported or that represent a procedure other than the one reported.
- Specialized procedures and techniques (for example, but not limited to, precision attachments, copings and intentional root canal treatment).
- Fees for broken appointments.
- Those not Dentally Necessary or not deemed to be generally accepted standards of dental treatment. If no clear or generally accepted standards exist, or there are varying positions within the professional community, the opinion of the Plan Administrator will apply.
- Orthodontic services, supplies and appliances.

Note that some of these or other dental services may be covered under the Plan's comprehensive medical benefits. If a claim is billed as a medical expense it will be covered under the Plan's medical benefit rather than a dental benefit.

Some covered services are subject to the limitations as detailed below (services are covered until 12:01 a.m. of the birthday when the patient reaches any stated age):

- Full mouth x-rays – one (1) every 36 months.
- Bitewing x-rays – two (2) set(s) per calendar year.
- Oral Evaluations:
    - Comprehensive and periodic – two (2) of these services per calendar year. Once paid, comprehensive evaluations are not eligible to the same office unless there is a significant change in health condition or the patient is absent from the office for three (3) or more year(s).
    - Limited problem focused and consultations – one (1) of these services per Dentist per patient per 12 months.
    - Detailed problem focused – one (1) per Dentist per patient per 12 months per eligible diagnosis.
- Prophylaxis – two (2) per calendar year. One (1) additional for Members under the care of a medical professional during pregnancy.
- Fluoride treatment – one (1) per calendar year under age nineteen (19).
- Space maintainers – one (1) per five (5) year period for Members under age fourteen (14) when used to maintain space as a result of prematurely lost deciduous molars and permanent first molars, or deciduous molars and permanent first molars that have not, or will not, develop.
- Sealants – one (1) per tooth per 3 year(s) under age nineteen (19) on permanent first and second molars.
- Periodontal Services:
    - Full mouth debridement – one (1) per lifetime.
    - Periodontal maintenance following active periodontal therapy – two (2) per calendar year in addition to routine prophylaxis.
    - Periodontal scaling and root planing – one (1) per 24 months per area of the mouth.
- Replacement of restorative services only when they are not, and cannot be made, serviceable:
    - Basic restorations – not within 12 months of previous placement of any basic restoration.
- An alternate benefit provision (ABP) will be applied if a covered dental condition can be treated by means of a professionally acceptable procedure which is less costly than the treatment recommended by the Dentist. The ABP does not commit the Member to the less costly treatment. However, if the Member and the Dentist choose the more expensive treatment, the Member is responsible for the additional charges beyond those allowed under this ABP.
- Intraoral Films:
    - Periapical – four (4) per 12 months.
    - Occlusal – two (2) per 24 months under age eight (8).

- General anesthesia and IV sedation: a total of sixty 60 minutes per session.

15.05 Payment of Benefits

Services performed by a participating Dentist: If you have treatment performed by a participating Dentist, United Concordia pays covered benefits directly to the Dentist. Payment will be based on the Maximum Allowable Charge the treating participating Dentist has contracted to accept. Both you and the Dentist will receive an explanation of the benefits covered, payment made, and any amounts you owe (such as for your annual Deductible).

Services performed by a nonparticipating Dentist: If you receive treatment from an out-of-network Dentist, you may have to complete and submit a claim form along with an itemized bill. Please follow the instructions on the claim form so that your claim will not be delayed. You can print claim forms on United Concordia's website at www.unitedconcordia.com.

Article XVI. Vision Benefits (Plan BB only)

Below is a summary of the vision benefits that are provided effective January 1, 2022. The complete terms and conditions for vision benefits are set forth in the documents provided by **VSP**, which are incorporated into this SPD by reference as if the same were fully set forth herein. The documents will be furnished to Participants and Beneficiaries as they are updated. Also, Participants and Beneficiaries may obtain a copy of the documents by submitting a request to the Fund Office.

In the event any of the terms of this SPD conflict with any of the terms of the **VSP** documents, the terms of the **VSP** documents shall prevail.

16.01 How the Plan Works

Vision benefits help offset the cost of eye examinations and eyeglasses or contact lenses for you and your Covered Beneficiaries. The Plan pays benefits for vision services that are treated or prescribed by a licensed ophthalmologist, optometrist, or optician. The level of coverage depends on whether services are received from a participating VSP In-network provider.

16.02 Schedule of Benefits

In-Network Benefits	Every other Plan year
Comprehensive Exam	**$20 Copay**
Prescription Glasses	**$20 Copay**
Frames	**$100 frame allowance** **$120 featured frame brands allowance** **20% savings on the amount over your allowance** **$55 Costco® frame allowance**
Lenses **Clear plastic lenses in any single vision, bifocal, trifocal or lenticular prescription**	**Included with $20 Prescription Glasses Copay**
Lens enhancements	**$0 Standard progressive lenses** **$95-$105 Premium progressive lenses** **$150-$175 Custom progressive lenses** **Average savings of 20-25% on other lens enhancements**
Contact Lenses (instead of eyeglasses)	
Copay	**None**
Fitting and Follow Up Care Copay	**$60**
Lenses	**$100 allowance for contact lenses**

Out-of-Network Reimbursement	
Exams	**Reimbursement of up to $40**
Frames	**Reimbursement of up to $50**
Lenses: Single / Bifocal / Trifocal and Lenticular	**Reimbursement of up to $30, $50, $60 and $75, respectively**

Contacts	**Elective: $100 allowance; Medically Necessary: $210 allowance**
Limitations	
Exams	**Once every 24 months**
All Lenses	**One pair in any 24 months**
Contact Lenses	**Once every 24 months**

Optional Frames/Lenses- Member Price	
Tinting of Plastic Lenses	**$15-$17 Fee**
Scratch-Resistant Coating	**$17 Fee**
Premium Scratch-Resistant Coating	**$33 Fee**
Ultraviolet Coating	**$10 Fee**
Anti-Reflective Coating: Standard / Premium / Ultra	**$41-$85**
Polycarbonate Lenses (Children / Adults)	**$0 / $31-$35**
High-Index Lenses	**20% discount**
Progressive Lenses: Standard / Premium / Ultra	**Covered in full / $95-$105 / $150-$175**
Polarized Lenses	**20% discount**
Plastic Photosensitive Lenses	**$75**
Scratch Protection Plan: Single Vision / Multifocal Lenses	**Not covered**

Primary Eyecare	As needed
Retinal screening for members with diabetes	$0

Additional exams and services for members with diabetes, glaucoma, or age-related macular degeneration.	$20 per exam; limitations may apply
Treatment and diagnoses of eye conditions, including pink eye, vision loss, and cataracts for all members.	$20 per exam; limitations may apply

16.03 Plan Limitations

Some materials, services, and treatment may not be covered by the Plan's vision benefit. Note that some of these or other vision services may be covered under the Plan's comprehensive medical benefits. If a claim is billed as a medical expense it will be covered under the Plan's medical benefit rather than a vision benefit.

16.04 Filing a Claim

When you receive covered services from an in-network provider, you do not need to file any claim forms. You are responsible to pay any copayments at the time of service.

If you obtain glasses contact lenses or receive covered services from an out-of-network provider, you pay the provider in full at the time of your visit and contact VSP to request an out-of-network reimbursement form.

Article XVII. Claims and Appeals Provisions (Plan BB Only)

17.01 Applicability

(1) Claims for benefits provided under any insurance contract, and any appeal of a denial of such claim, shall be filed and made in accordance with the claims procedures of the insurance contract. The insurer under the insurance contract shall have full power and authority to apply and interpret the terms of the insurance contract and to make all determinations and decide all questions, including factual, to consider and review a claims for benefits and any appeal of a denied claim for benefits.

(2) Claims for benefits related to the eligibility of a Retiree, Spouse or Dependent to participate in the Plan and for benefits provided

directly by the Plan shall be filed and made in accordance with the claims procedures set forth in this Article.

(3) The Agreement establishing the Fund grants the Board of Trustees with the power to make, amend, and modify rules governing benefit eligibility and to determine all questions of eligibility for benefits. Accordingly, the Board of Trustees have the sole discretion to interpret the provisions of this SPD, to make findings of fact as necessary to determine benefit eligibility, and to make the final determination of benefit eligibility, provided their determination is not arbitrary and capricious.

(4) A claimant may voluntarily agree to extend any of the periods to decide a claim for benefits or an appeal of a denied claim.

(5) At the claimant's expense, an authorized representative of a claimant may act on behalf of the claimant in filing a claim for benefits or requesting a review of any denial thereof. The Board of Trustees may establish reasonable procedures for determining whether an individual has been duly authorized to act on behalf of a claimant.

17.02 General Claims and Appeals Procedure

(1) This Section sets forth the claims procedures related to the eligibility of a Retiree or Dependent to participate in the Plan and for benefits not provided under an insurance contract, excluding) group health plan claims (covered by Section 17.03).

(2) Claims for benefits shall be filed in accordance with the procedures established for this purpose and on forms available from the Plan upon request.

(3) A claim for benefits shall be decided within a reasonable period of time following the Plan's receipt of the claim, but not later than 90 days after receipt. If special circumstances require, the initial 90-day period may be extended for up to an additional 90 days. Written or electronic notice of an extension shall be provided to the claimant before the end of the initial 90-day period describing the circumstances requiring the extension and the date by which the Plan expects to decide the claim.

(4) In the event a claim for benefits is wholly or partially denied:

(a) Written or electronic notice of the denial shall be provided

to the claimant by the date established by subsection (c) of this Section to decide the claim.

(b) The denial notice shall set forth (i) the specific reasons for the denial, (ii) specific references to the pertinent provisions of the Plan, (iii) a description of any additional material or information necessary for the claimant to perfect the claim and an explanation why it is necessary, (iv) an explanation of the procedures for review of the denied claim, including the applicable time limits, and (v) a statement of the claimant's right to bring a civil action under ERISA following an adverse determination upon review.

(5) A claimant may appeal a denial of benefits to the Administrator for review. Such appeal shall be made in writing no later than 60 days of the date of the denial. An appeal shall set forth all of the reasons the claim should not have been denied and shall identify and include all of the issues related to the claim for benefits. A claimant shall be entitled to review all relevant documents and to receive copies free of charge and to submit written documents, records and other information related to the claim and have the same taken into account whether or not previously submitted or considered.

(6) If an appeal of a denial of benefits is timely filed, the Board of Trustees shall conduct a full and fair review of the claim that takes into account all comments, documents, records and other information submitted by the claimant, whether or not submitted or considered in the denial of the benefit. The appeal will be determined by the Board of Trustees at its next regular meeting after it is received, unless it is received within 30 days of the next regular meeting. In such a case, the Board of Trustees will determine the appeal no later than the date of the second meeting following receipt of your appeal. If special circumstances require a further extension, the Board of Trustees shall determine the appeal no later than the third meeting following receipt of the appeal. If such an extension is required, the claimant will be notified in writing of the extension and the special circumstances necessitating the extension. The claimant will also be told at that time the date on which your appeal will be determined.

(7) Claimants will be notified by the Board of Trustees of its determination claim on appeal within five (5) days of the meeting at which the Board of Trustees makes its determination. If the

decision on the review of an appeal of a denied claim is adverse, the notice of the decision shall set forth (i) the specific reasons for the decision, (ii) specific references to the pertinent provisions of the Plan, (iii) a statement that the claimant is entitled to review all relevant documents and to receive copies free of charge, and (iv) a statement of the claimant's right to bring a civil action under ERISA.

17.03 Group Health Plan Claims and Appeals Procedure

(1) This Section sets forth the claims procedures for group health plan benefits (not provided under an insurance contract).

(2) For purposes of this Section, the following terms have the meaning given to them in this subsection:

(a) Group health plan benefits shall mean benefits that are medical care within the meaning of ERISA § 733(a).

(b) A pre-service claim shall mean a claim for group health plan benefits for which the terms of the Plan condition the payment of benefits on approval in advance of obtaining medical care.

(c) A post-service claim shall mean a claim for group health plan benefits that is not a pre service claim.

(d) An urgent-care claim shall mean a pre service claim where a delay in receiving the benefits for which the claim is made either (i) could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function or (ii) in the opinion of a Physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the services or treatment that is the subject of the claim.

(e) A concurrent care decision shall mean one of the following after the Plan has approved an ongoing course of treatment for a specified period of time or a specified number of treatments: (i) a reduction or termination by the Plan of the previously approved course of treatment; or (ii) a request by the claimant to extend the previously approved course of treatment.

(3) Claims for group health plan benefits shall be filed in accordance with the procedures established for this purpose and on forms available from the Plan upon request. For purposes of this Section, any rescission of coverage shall be treated as a claim. A rescission of coverage is any retroactive cancellation of coverage other than a termination of coverage for non-payment of premiums. The Plan will provide thirty (30) days' advance notice of any rescission of coverage.

(4) If a claimant fails to follow the procedures to file a pre-service claim or urgent care claim, the claimant shall be notified of the failure and the procedure to file said claim if (i) the improperly made claim is received by the person (or unit) customarily responsible for benefit matters and (ii) the claim names a specific claimant, a specific medical condition or symptom, and a specific treatment, service or product for which approval is requested. Said notice shall be given as soon as possible, but not later than 5 days after the failure in the case of pre-service claim and 24 hours in the case of an urgent care claim. Said notification may be given orally, unless the claimant has requested written notification.

(5) A pre-service claim and post-service claim shall be processed as follows:

(a) A pre-service claim shall be decided, and written or electronic notice of the determination provided to the claimant, within a reasonable period of time following the Plan's receipt of the claim, but not later than 15 days after receipt.

(b) A post-service claim shall be decided, and written or electronic notice of an adverse benefit determination provided to the claimant, within a reasonable period of time following the Plan's receipt of the claim, but not later than 30 days after receipt.

(c) The 15-day period to consider a pre-service claim and the 30-day period to consider a post-service claim may be extended for up to an additional 15 days if the extension is necessary due to matters outside the control of the Plan. Written or electronic notice of an extension shall be provided to the claimant before the end of the initial period describing the circumstances requiring the extension and the date by which the Plan expects to decide the claim.

(d) If the reason for extending a period to decide a pre-service claim or a post service claim is due to the claimant's failure to submit information necessary to decide the claim, the notice of extension shall describe the required information, and the claimant shall be provided with at least a 45 day period to provide the information. In such case, the period to decide said claim shall be tolled, and a decision on the claim shall be made no later than 15 days after the earlier of (i) the date the claimant responds to the request for additional information or (ii) the date the period to submit the additional information ends.

(6) An urgent care service claim shall be processed as follows:

(a) An urgent care claim shall be decided, and written, electronic or oral notice of the determination provided to the claimant, as soon as possible following the Plan's receipt of the claim, but not later than 24 hours after receipt.

(b) If the claimant fails to submit sufficient information necessary to decide an urgent care claim, the claimant shall be so notified as soon as possible, but not later than 24 hours after receipt of the claim. The claimant shall be provided with a reasonable amount of time to provide the information, but not less than 48 hours. In such case, the period to decide said claim shall be tolled, and a decision on the claim shall be made no later than 48 hours days after the earlier of (i) the date the claimant responds to the request for additional information or (ii) the date the period to submit the additional information ends.

(7) Subject to the oral notice for an urgent care claim, a claimant shall be notified of the approval of a claim for group health plan benefits by a written or electronic explanation of benefits or other manner established under the Plan for this purpose. The approval notice for a pre-service claim or urgent care claim shall be made at the times specified in subsections (5) and (6) of this Section, respectively.

(8) In the event a claim for group health plan benefits is wholly or partially denied:

(a) Written or electronic notice of the denial shall be provided to the claimant by the times specified in subsections (5)

and (6) of this Section to decide the claim. If an urgent care claim, oral notice may be given provided that a written or electronic notice is provided to the claimant no later than 3 days after the oral notice.

(b) The denial notice shall set forth (i) information sufficient to identify the claim (date of service, health care provider, claim amount, and any diagnosis, treatment and denial codes and the corresponding meaning of such codes), (ii) the specific reasons for the denial, (iii) specific references to the pertinent provisions of the Plan, (iv) an explanation of the standard used in denying the claim, (v) a description of any additional material or information necessary for the claimant to perfect the claim and an explanation why it is necessary, (vi) an explanation of the internal and external procedures for review of the denied claim, including the applicable time limits, (vii) the contact information for any applicable office of health insurance consumer assistance, and (viii) a statement of the claimant's right to bring a civil action under ERISA following an adverse determination upon review. If for an urgent care claim, the denial notice shall set forth a description of the expedited review process for an urgent care claim.

(c) If applicable, the denial notice shall also include (i) any internal rule, guideline, protocol or other similar criterion relied on for the denial, or a statement that it was relied on and a copy will be provided free of charge upon the claimant's request and (ii) if the denial was based on a medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the denial, applying the plan terms to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon the claimant's request.

(9) A claimant may appeal a denial of group health plan benefits to the Board of Trustees for review no later than 180 days of the date of the denial. If a pre-service claim or post-service claim, the appeal shall be made in writing. If an urgent care claim, the appeal shall be made orally or in writing. An appeal shall set forth all of the reasons the claim should not have been denied and shall identify and include all of the issues related to the claim for benefits. A claimant shall be entitled to review all relevant documents and to receive copies free of

charge and to submit written documents, records and other information related to the claim and have the same taken into account whether or not previously submitted or considered.

(10) If an appeal of a denial of group health plan benefits is timely filed, the Board of Trustees shall conduct a full and fair review of the claim and provide written or electronic notice of its decision on review to the claimant as follows:

(a) The review shall not be made until the claimant has been allowed to review the claim file and present evidence and written testimony. The Plan will provide the claimant, free of charge, with any additional evidence relied upon, considered or generated by the Plan in connection with the claim sufficiently in advance of the review and give the claimant a reasonable opportunity to respond. Further, if the review involves a new or additional rationale, the Plan will provide the claimant with the rationale, free of charge, sufficiently in advance of the review in order to give the claimant an opportunity to respond.

(b) The review shall take into account all comments, documents, records and other information submitted by the claimant, whether or not submitted or considered in the denial of the benefit.

(c) The review shall not afford any deference to the initial benefit determination, and it shall not be made by the individual who made the initial benefit determination or by a subordinate of that individual.

(d) If the initial benefit determination was based on a medical judgment, the determination shall be made after consultation with a health care professional who has appropriate training and experience in the relevant field of medicine. Said health care professional shall not be an individual who was consulted with respect to the initial benefit determination or a subordinate of that individual.

(e) It shall provide for the identification of medical or vocational experts whose advice was obtained on behalf of the plan in connection with an adverse benefit determination, without regard to whether the advice was relied on in making the determination.

(11) The decision on review of an appeal of a claim for group health plan benefits shall be made as follows:

(a) If a pre-service claim, the decision on review shall be made, and written or electronic notice of the decision provided to the claimant, within a reasonable period of time following the Plan's receipt of the request for review, but not later than 30 days after receipt.

(b) If a post-service claim, the decision on review shall be made, and written or electronic notice of the decision provided to the claimant, within a reasonable period of time following the Plan's receipt of the request for review, but not later than 60 days after receipt.

(c) If an urgent care claim, the decision on review shall be made, and notice of the decision provided to the claimant by telephone, facsimile or other available similarly expeditious method, as soon as possible following the Plan's receipt of the request for review, but not later than 72 hours after receipt.

(12) If the decision on the review of an appeal of a denial of a claim from group health plan benefits is adverse:

(a) The notice of the decision on review shall set forth (i) information sufficient to identify the claim (date of service, health care provider, claim amount, and any diagnosis, treatment and denial codes and the corresponding meaning of such codes), (ii) the specific reasons for the denial and a discussion of the denial decision, (iii) specific references to the pertinent provisions of the Plan, (iv) an explanation of the standard used in denying the claim, (v) a description of any additional material or information necessary for the claimant to perfect the claim and an explanation why it is necessary, (vi) an explanation of the external procedures for review of the denied claim, including the applicable time limits, (vii) the contact information for any applicable office of health insurance consumer assistance, and (viii) a statement of the claimant's right to bring a civil action under ERISA following an adverse determination upon review.

(b) If applicable, the notice of decision shall also include (i) any internal rule, guideline, protocol or other similar criterion relied on for the decision, or a statement that it

was relied on and a copy will be provided free of charge upon the claimant's request and (ii) if the decision was based on a medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the decision, applying the plan terms to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon the claimant's request.

(13) Concurrent care decisions shall be treated as follows:

(a) If the concurrent care decision is the Plan's reduction or termination of a previously approved course of treatment:

1. The reduction or termination shall be treated as a denial of a group health plan benefit and written or electronic notice setting forth the information required by subsection (8) (a) and (b) of this Section shall be provided to the claimant.

2. Said notice shall be provided sufficiently in advance of the reduction or termination to allow the claimant a reasonable period (but not a 180 day period) to file an appeal and to receive a decision on appeal before the reduction or termination is effective.

(b) If the concurrent care decision is the claimant's request to extend a previously approved course of treatment:

1. If the request involves an urgent care claim made at least 24 hours before the end of the course of treatment, the claim shall be decided, and written, electronic or oral notice of the determination provided to the claimant, as soon as possible following the Plan's receipt of the claim, but not later than 24 hours after receipt. If oral notice is given, a written or electronic notice shall be provided to the claimant no later than 3 days after the oral notice.

2. If the request involves an urgent care claim that is not made at least 24 hours before the end of the course of treatment, the claim shall be processed as a new urgent care claim.

3. If the request does not involve an urgent care claim, the claim shall be processed as a new pre service claim or post-service claim, as applicable.

17.04 Appeal of Denied Dental Services

You have a legal right to appeal when your claim for dental benefits is denied in whole or in part. To appeal, call United Concordia at the toll-free number listed on your identification card. All appeal requests must be made within 180 days of the date your claim has been denied or the date your benefits have been terminated. United Concordia will review your claim and notify you of its decision within 60 days of your request for appeal. The written or electronic notice will include the specific reason for the appeal decision and reference to specific Plan provisions on which the decision was based.

17.05 Appeal of Denied Vision Claims

You have a legal right to appeal when your claim for vision benefits is denied in whole or in part. To appeal, call VSP. All appeal requests must be made within 60 days of the date your claim has been denied or the date your benefits have been terminated. VSP will review your claim and notify you of its decision within 30 days of your request for appeal. The written or electronic notice will include the specific reason for the appeal decision and reference to specific Plan provisions on which the decision was based.

Article XVIII. Plan D – Medicare-Eligible Retirees

18.01 Benefit Schedule

Plan D Benefits are provided, subject to the limits below, only for claims that are Medicare-eligible. Claims not covered by Medicare are not covered by Plan D.

Hospitalization Benefits	
Co-insurance:	Plan pays Medicare Part A Deductibles
Daily Room Allowance:	Not applicable
Maximum per Days of Confinement:	90
Maximum Annual Covered Expenses:	Not applicable
Major Medical Benefits	
Annual Deductible:	You pay your Medicare Part B Deductible
Co-insurance (In Network):	20% of Covered Medical Expenses
Surgical Procedures Maximum Benefit:	Not applicable
Office Visit Maximum Benefit:	Not applicable
Maximum Office Visits per Year:	Not applicable
Maximum Annual Benefit for Covered Medical Expenses:	$5,000
Prescription Drugs	No Prescription Drug Coverage

18.02 Other Provisions Relevant to Plan D

Articles I, II, III, IV, VI, VII, VIII, XVIII, XIX, and XX of this SPD **apply** to Plan D.

Articles V, IX, X, XI, XII, XIII, XIV, XV, XVI and XVII of this SPD **do not apply** to Plan D.

Article XIX. Privacy and HIPAA Provisions

19.01 Application and Interpretation

(1) This Article sets forth provisions that apply to medical benefits provided by the Plan subject to the HIPAA Privacy Rules.

(2) This Article is intended to comply with the HIPAA Privacy Rules as may be applicable to medical benefits, and it shall be construed and interpreted in such manner as to give effect to such intent.

19.02 Definitions

For purposes of this Article, the following terms shall have the meaning given to them in this Section:

(1) **CFR** shall mean the Code of Federal Regulations (and each applicable section) as the same may be amended from time to time.

(2) **HIPAA Privacy Rules** shall mean the Standards for Privacy of Individually Identifiable Health Information, 45 CFR Parts 160 and 164, Subparts A and E.

(3) **PHI or Protected Health Information** shall mean protected health information as defined in 29 CFR § 501.

(4) **Required by Law** shall mean required by law as defined in 29 CFR § 501.

(5) **Summary Health Information** shall mean summary health information as defined in 29 CFR § 164.504(a).

19.03 Conditions on Disclosure of PHI to the Board of Trustees

(1) The Plan may disclose PHI to the Board of Trustees as follows:

(a) pursuant to an authorization under 45 CFR § 164.508;

(b) if the Board of Trustees requests Summary Health Information for the purpose of (i) obtaining premium bids from health plans to provide insurance coverage for the Plan or (ii) amending or terminating the Plan; and

(c) information on whether an individual is participating, enrolled or disenrolled in the Plan.

(2) The Plan may also disclose PHI to the Board of Trustees, and the Board of Trustees may use and disclose PHI, for Plan administration functions performed by the Board of Trustees on behalf of the Plan. The uses and disclosure of PHI by the Board of Trustees for Plan administration functions shall generally be consistent with the uses and disclosures of PHI permitted or required to be made by the Plan under the HIPAA Privacy Rules and shall specifically be subject to the following requirements:

(a) The Board of Trustees shall not use or further disclose PHI other than as specified in this Article or as Required by Law.

(b) The Board of Trustees shall ensure that any agents, including a subcontractor, to whom it provides PHI agree to the same restrictions and conditions that apply to the Board of Trustees with respect to the PHI.

(c) The Board of Trustees shall not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Board of Trustees.

(d) The Board of Trustees shall report to the Administrator and the HIPAA privacy official for the Medical Benefits any use or disclosure of PHI of which the Board of Trustees is aware that is inconsistent with the uses and disclosures provided for in this Article.

(e) The Board of Trustees shall make PHI available for access as required by 45 CFR § 164.524.

(f) The Board of Trustees shall make PHI available for amendment and incorporate any amendments as required by 45 CFR § 164.526.

(g) The Board of Trustees shall make available the information required to provide an accounting of disclosures as required by 45 CFR § 164.528.

(h) The Board of Trustees shall make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the U.S. Department of Health and Human Services for purposes of determining compliance.

(i) If feasible, the Board of Trustees shall return or destroy all PHI received from the Plan that it maintains in any form and retain no copies of the PHI when no longer needed for the purpose for which disclosure was made, and if not feasible, the Board of Trustees shall limit further uses and disclosures of the PHI to those purposes that make the return or destruction of the PHI infeasible.

(j) The Board of Trustees shall provide for the required separation between the Plan and the Board of Trustees as reflected in Section 17.04, including the mechanism for resolving issues of noncompliance by persons with access to PHI as reflected in Section 17.04.

(k) The Board of Trustees shall certify to the Plan Administrator (i) that the Plan has been amended to incorporate the requirements of this subsection and (ii) the Board of Trustees' agreement to comply with said requirements.

19.04 Adequate Separation Between Plan and Board of Trustees

(1) The classes of employees or other persons under the control of the Board of Trustees who shall have access to PHI for the purposes set forth in this Article are limited to:

(a) the claims administrator appointed to initially review and decide claims for medical benefits;

(b) the individual(s) who acts on behalf of the Administrator in reviewing appeals of denied claims for medical benefits;

(c) the individual(s) responsible for employee benefit matters appointed by the Board of Trustees;

(d) the HIPAA privacy official and complaint officer for the medical benefits;

(e) any individual(s) who works on any information technology and software related to the administration of medical benefits;

(f) any in-house counsel who advises on matters involving medical benefits; and

(g) the individual(s) responsible for processing payroll and salary reduction contributions related to medical benefits.

(2) Any employee or person set forth in subsection (a) of this Section who uses or discloses PHI in violation of the provisions reflected in this Article shall be subject to disciplinary action and sanctions by the Board of Trustees, including the possibility of termination of employment. If the Board of Trustees becomes aware of any such violation, the Board of Trustees shall promptly report the violation to the HIPAA privacy official for the medical benefits and shall cooperate with the Plan to correct the violation, to impose appropriate sanctions, and to mitigate any harmful effects of the violation.

Article XX. Legal Notices

20.01 Your Rights Under ERISA

As a Fund Participant, 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

You have the rights to:

(a) Examine, without charge, at the Fund 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.

(b) Obtain, upon written request to the Board of Trustees, 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 may make a reasonable charge for the copies.

(c) Receive a summary of the Plan's annual financial report. The Board of Trustees 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 and your Dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

(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 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

(a) 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 decisions without charge, and to appeal any denial, all within certain time schedules.

(b) 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 Board of Trustees 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 Board of Trustees. 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 Board of Trustees. If you have any questions about this statement or about your rights under ERISA, 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 NW, Washington, DC 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.

20.02 Premium Assistance under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your Dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your Dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your Dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your Dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2021. Contact your State for more information on eligibility –

ALABAMA-Medicaid	CALIFORNIA-Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Email: hipp@dhcs.ca.gov

ALASKA-Medicaid	COLORADO-Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.asx	Health First Colorado Website: https://www.healthfirstcolorado.com Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
ARKANSAS-Medicaid	**FLORIDA-Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA-Medicaid	MASSACHUSETTS-Medicaid and CHIP
Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131	Website: https://www.mass.gov/info-details/masshealth-premium-assistance-pa Phone: 1-800-862-4840
INDIANA-Medicaid	**MINNESOTA-Medicaid**
Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584	Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739
IOWA-Medicaid and CHIP (Hawki)	**MISSOURI-Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005

KANSAS-Medicaid	MONTANA-Medicaid
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084
KENTUCKY-Medicaid	**NEBRASKA-Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
LOUISIANA-Medicaid	**NEVADA-Medicaid**
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618- 5488 (LaHIPP)	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900

MAINE-Medicaid	NEW HAMPSHIRE-Medicaid
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218
NEW JERSEY-Medicaid and CHIP	**SOUTH DAKOTA-Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: http://dss.sd.gov Phone: 1-888-828-0059
NEW YORK-Medicaid	**TEXAS-Medicaid**
Website: https://www.health.ny.gov/health care/medicaid/ Phone: 1-800-541-2831	Website: http://gethipptexas.com/ Phone: 1-800-440-0493
NORTH CAROLINA-Medicaid	**UTAH-Medicaid and CHIP**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669

NORTH DAKOTA-Medicaid	VERMONT-Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
OKLAHOMA-Medicaid and CHIP	**VIRGINIA-Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: https://www.coverva.org/hipp/ Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-855-242-8282
OREGON-Medicaid	**WASHINGTON-Medicaid**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
PENNSYLVANIA-Medicaid	**WEST VIRGINIA-Medicaid**
Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx Phone: 1-800-692-7462	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
RHODE ISLAND-Medicaid and CHIP	**WISCONSIN-Medicaid and CHIP**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002

SOUTH CAROLINA-Medicaid	WYOMING-Medicaid
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since December 1, 2014, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Dept. of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

20.03 Newborns' Act Disclosure

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

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